IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201422 JUNE 3, 2014

Laboratory fee pricing available for CPT code 88112

Effective July 7, 2014, the Indiana Health Coverage Programs (IHCP) will update the pricing for Current Procedural Terminology (CPT®[1]) code 88112 – *Cytopathology, selective cellular enhancement technique with interpretation (e.g., liquid based slide preparation method), except cervical or vaginal* to include lab fee pricing. The pricing update applies retroactively to dates of service (DOS) on or after **July 1, 2013**.

Beginning July 7, 2014, claims for CPT code 88112 billed with one of the following revenue codes that previously denied for explanation of benefits (EOB) 6000 – *Manual pricing required* may be resubmitted for dates of service on or after July 1, 2013.

- 310 – *Pathology lab*
- 311 – *Pathology/cytology*
- 319 – *Pathology/other*

Claims beyond the original one-year filing limit must include a copy of this *Banner Page* as an attachment and must be filed within one year of the publication date.

[1] *CPT copyright 2012 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

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Laboratory CPT codes linked to revenue codes 300 and 309

Effective July 7, 2014, the Indiana Health Coverage Programs (IHCP) will link the Current Procedural Terminology (CPT) codes in Table 1 to one or both of the following revenue codes:

- 300 – *Laboratory-General*
- 309 – *Laboratory-Other Laboratory*

CPT codes 89049, 99000, and 99001 will also have laboratory fee pricing added. Both the revenue code linkages and the laboratory fee pricing apply retroactively to dates of service (DOS) on or after **July 1, 2013**.

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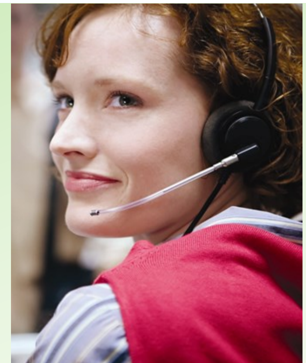
Table 1 – CPT codes linked to revenue codes 300 and 309 for DOS on or after July 1, 2013

Procedure Code	Description	Revenue Code Linkage
83951	Oncoprotein; des-gamma-carboxy-prothrombin (DCP)	300 and 309
86001	Allergen specific IgG quantitative or semiquantitative, each allergen	300 and 309
89049	Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report	300 and 309
99000	Handling and/or conveyance of specimen for transfer from the office to a laboratory	300
99001	Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)	300

Beginning July 7, 2014, for reimbursement consideration, providers may bill the procedure codes and revenue codes together, as appropriate, for DOS on or after July 1, 2013. Claims for these procedure codes that previously denied for invalid revenue code combinations or no pricing on file may be resubmitted. Claims beyond the original one-year filing limit must include a copy of this *Banner Page* as an attachment and must be filed within one year of the publication date.

HCPCS code A9520 linked to revenue code 343



Effective July 7, 2014, the Indiana Health Coverage Programs (IHCP) will link Healthcare Common Procedure Coding System (HCPCS) code A9520 – *Technetium tc-99m, tilmanocept, diagnostic, up to 0.5 millicuries* to revenue code 343 – *Nuclear Medicine-Diagnostic Radiopharmaceuticals*. This linkage applies retroactively to dates of service (DOS) on or after **July 1, 2013**.

Beginning July 7, 2014, for reimbursement consideration, providers may bill HCPCS code A9520 and revenue code 343 together, as appropriate, for DOS on or after July 1, 2013. Claims for procedure code A9520 with revenue code 343 that previously denied for explanation of benefits (EOB) 520 – *Invalid revenue code and procedure code combination* may be resubmitted. Claims beyond the original one-year filing limit must include a copy of this *Banner Page* as an attachment and must be filed within one year of the publication date.

Medical and medical crossover claims denied for edit 6637 to be reprocessed or adjusted

Medical and medical crossover claims billed with the Current Procedural Terminology (CPT) codes in Table 2 erroneously denied for edit 6637 – *Drug administration not payable on the same date of service as an evaluation and management service*. Denials affected claims with dates of service from January 1, 2013, through July 3, 2014.

Table 2 – CPT codes erroneously denied for edit 6637 for DOS from January 1, 2013, through July 3, 2014

CPT Code	Description
90472	Immunization Administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)
90473	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)

Claims for these procedure codes that denied or claims that paid with a denied detail line for edit 6637 will be mass reprocessed or mass adjusted. Reprocessed or adjusted claims will begin appearing on Remittance Advice (RA) statements dated July 15, 2014, identified by internal control numbers (ICNs) that begin with a region code of 80 (mass reprocessed) or 56 (mass adjusted). Any overpayment will appear as an accounts receivable. The accounts receivable will be recouped at 100% from future claims paid to the respective provider number.

Clarification of FFS timely filing limitation on claims due to retroactive coverage and billing changes

The Indiana Health Coverage Programs (IHCP) policy imposes a one-year timely filing limit on all fee-for-service (FFS) claims. Current policy requires providers to file a claim within one year from the date of service. If a provider files a claim beyond the one-year limitation, the provider must submit acceptable documentation justifying the extension. Chapter 10 of the *IHCP Provider Manual* provides additional information regarding timely filing and acceptable documentation required to waive the limit.

Providers are reminded that the timely filing policy applies to claims affected by retroactive coverage notices and reimbursement or billing changes issued by the IHCP. If retroactive changes allow for an extension of the original one-year filing limit, any resulting claim submission or resubmission is subject to a one-year filing limit based on the date of the publication in which the retroactive change is announced.

Claims filed beyond the original one-year filing limit due to retroactive IHCP changes must include a copy of the related provider publication (*IHCP Bulletin* or *Banner Page*) as an attachment. For reimbursement consideration, the claim must be submitted within one year of the date of that publication.

Indiana EHR Incentive Program documentation requirements updated

For Program Year 2014, Indiana requires that all providers participating in the Indiana Electronic Health Records (EHR) Incentive Program submit documentation as outlined in Table 3.

Table 3 – Required documentation for the Indiana EHR Incentive Program in Program Year 2014

Providers	Year 1	Years 2-6
Eligible providers	1. Acceptable documentation as proof of relationship between provider and EHR vendor * 2. Documentation from the Office of the National Coordinator for Health IT (ONC) showing proof of certified EHR technology. ** 3. The Indiana EHR pre-payment review team will request documentation supporting the provider's current submission of patient volume for variances greater than 20%, as compared to the Medicaid Management Information System (MMIS). 4. If the provider is attesting to public health objectives, confirmation documentation issued by the Indiana State Department of Health (ISDH) must be uploaded to the attestation.***	1. Documentation from the Office of the National Coordinator for Health IT (ONC) showing proof of certified EHR technology. ** 2. The Indiana EHR pre-payment review team will request documentation supporting the provider's current submission of patient volume for variances greater than 20%, as compared to the Medicaid Management Information System (MMIS). 3. If the provider is attesting to public health objectives, confirmation documentation issued by the Indiana State Department of Health (ISDH) must be uploaded to the attestation.***
Eligible hospitals	1. Medicare Cost Report spreadsheet 2. Acceptable documentation as proof of relationship between provider and EHR vendor * 3. Documentation from the Office of the National Coordinator for Health IT (ONC) showing proof of certified EHR technology. ** 4. The Indiana EHR pre-payment review team will request documentation supporting the provider's current submission of patient volume for variances greater than 20%, as compared to the Medicaid Management Information System (MMIS). 5. If the provider is attesting to public health objectives, confirmation documentation issued by the Indiana State Department of Health (ISDH) must be uploaded to the attestation.***	1. Documentation from the Office of the National Coordinator for Health IT (ONC) showing proof of certified EHR technology. ** 2. The Indiana EHR pre-payment review team will request documentation supporting the provider's current submission of patient volume for variances greater than 20%, as compared to the Medicaid Management Information System (MMIS). 3. If the provider is attesting to public health objectives, confirmation documentation issued by the Indiana State Department of Health (ISDH) must be uploaded to the attestation.***

Notes

* Acceptable documentation refers to the certified EHR technology by name and certification number, and includes financial and/or contractual commitment. Examples include the EHR contract, invoice, or receipt that includes provider name and point of contact; vendor name and point of contact; and CEHRT name, version, and ONC-issued CEHRT ID.

** Proof must verify that the current CEHRT version meets program year requirements. A screen shot from the ONC website is acceptable proof.

*** Providers that report public health measures will receive confirmation of registration and/or submission from the ISDH, and should scan and upload this confirmation as documentation for the EHR attestation.

continued

If you have questions regarding these documentation requirements or the Indiana EHR attestation process, please contact Indiana Medicaid EHR Customer Service via email at MedicaidHealthIT@fssa.in.gov or call 1-855-856-9563.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-577-1278.

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