IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201732 AUGUST 8, 2017

IHCP to update CLIA procedure codes and mass adjust claims

Procedure codes associated with laboratory testing are regulated under the Clinical Laboratory Improvement Amendment (CLIA). Indiana Health Coverage Programs (IHCP) policy requires compliance with the Centers for Medicare & Medicaid Services (CMS) recommendations regarding CLIA regulations under all IHCP programs, whether managed care or fee-for-service (FFS).

The IHCP identified inconsistencies in the *Core*MMIS claim processing system with respect to the classification of certain Current Procedural Terminology (CPT® [1]) and Healthcare Common Procedure Coding System (HCPCS) codes. Effective September 15, 2017, the system will be updated to make the following changes to correct these inconsistencies:

- The procedure codes in Table 1 were considered CLIA-waived tests as of January 1, 2017. Claims for these codes with dates of service (DOS) on or after that date should be billable by laboratories who qualify for the CLIA certificate of waiver. The *Core*MMIS claim processing system will be updated to classify the codes in Table 1 as CLIA-waived tests. This change will be retroactively effective for DOS on or after **January 1, 2017**.
- The procedure codes in Table 2 were subject to CLIA edits as of January 1, 2017. The *Core*MMIS claim processing system will be updated to add the codes in Table 2 as CLIA-regulated tests. This change will be retroactively effective for DOS on or after **January 1, 2017**.

Table 1: Procedure codes added as CLIA-waived tests effective for DOS on or after January 1, 2017

Procedure Code	Description
87338	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Helicobacter pylori, stool
87631	Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 3-5 targets

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Table 2: Procedure codes added as CLIA-regulated tests, effective for DOS on or after January 1, 2017

Procedure Code	Description
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service
80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); read by instrument assisted direct optical observation (eg, dipsticks, cups, cards,
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service
81439	Inherited cardiomyopathy (eg, hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy) genomic sequence analysis panel, must include sequencing of at
84410	Testosterone; bioavailable, direct measurement (eg, differential precipitation)
87483	Infectious agent detection by nucleic acid (DNA or RNA); central nervous system pathogen (eg, Neisseria meningitidis, Streptococcus pneumoniae, Listeria, Haemophilus influenzae, E. coli, Streptococcus agalactiae, enterovirus, human parechovirus, herpes simplex virus type 1 and 2, human herpesvirus 6, cytomegalovirus, varicella zoster virus, Cryptococcus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets
G0499	Hepatitis B screening in non-pregnant, high risk individual includes hepatitis B surface antigen (HBSAG) followed by a neutralizing confirmatory test for initially reactive results, and antibodies to
G0659	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes

Providers with a *Certificate of Waiver* or a *Certificate for Provider Performed Microscopy (PPM) Procedures*, as well as providers without a valid CLIA certificate, were inappropriately paid for procedure codes in Table 2. Affected claims will be mass adjusted. Providers should begin seeing adjusted claims on Remittance Advices (RA) beginning September 19, 2017, with Claim IDs/ICNs that begin with 52 (mass adjusted). If a claim was overpaid, the net difference appears as an accounts receivable. The accounts receivable will be recouped at 100% from future claims paid to the respective provider number.

IHCP updates list of dental codes that require a tooth number for billing

The Indiana Health Coverage Programs (IHCP) is updating the dental codes that require a tooth number on fee-for-service (FFS) claims as follows:

- Effective September 8, 2017, dental code D1575 – *Distal shoe space maintainer—fixed—unilateral* will require a tooth number indicated on the claim. This change applies to dates of service (DOS) on or after September 8, 2017.
- Effective immediately, the following dental codes will no longer require a tooth number be indicated on the claim. This change is retro-active to DOS on or after **July 20, 2017**.
    - D1515 - *Space maintainer – fixed – bilateral*
    - D7285 - *Incisional biopsy of oral tissue – hard*
    - D7286 - *Incisional biopsy of oral tissue – soft*

Providers may resubmit dental claims for the codes listed above for DOS on or after July 20, 2017, that denied for explanation of benefits (EOB) 0261 - *Tooth number or letter missing*, for reimbursement consideration. Claims resubmitted beyond the original one year filing limit must include this banner as an attachment and must be filed within one year of the publication date.

These billing changes will be reflected in updates to the Dental Codes That Require a Tooth Number on the Claim table, under the Dental Services Codes on the Code Sets page at indianamedicaid.com. This billing information applies to services delivered under the FFS delivery system. Individual managed care entities (MCEs) establish and publish billing information within the managed care delivery system. Questions about managed care billing should be directed to the MCE with which the member is enrolled.

IHCP clarifies requirements regarding the treatment of assets for nursing facility providers

Indiana Health Coverage Programs (IHCP) nursing facility providers must comply with the Medicaid capitalization policy outlined in *405 IAC 1-14.6-14(e).* This policy requires that a single asset or collection of like assets acquired in quantity that have an estimated useful life of at least 3 years and a historical cost of one thousand dollars ($1,000) or more, be capitalized and included in the provider's property basis. The policy further states that items that do not qualify under this subsection shall be expensed in the year acquired.

Additionally, *405 IAC 1-14.6-14(b)* requires providers to maintain detailed property schedules that provide a permanent record of the historical cost of property. Assets reported on Medicaid cost reports must agree with these records. If an asset is included on the provider's detailed property schedule, the asset should not also be reported as an expense on schedules E and R and removed from schedules J and S. The practice of capitalizing assets based on the provider's capitalization policy and also expensing the cost of the assets, is inconsistent with generally accepted accounting principles, as required by *405 IAC 1-14.6-3(a)(3).*

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Please note that a nursing facility provider may establish a capitalization policy with a lower minimum criteria, but under no circumstances may the minimum capitalization limit of $1,000 be exceeded for Medicaid cost reporting purposes. If a provider establishes a capitalization policy with a minimum criteria lower than $1,000, then the provider's Medicaid cost reporting must adhere to that policy. For example, if a provider's established capitalization policy is to capitalize assets costing $750 or more, assets qualifying under that policy must also be capitalized for Medicaid cost reporting purposes and should not be expensed and removed from the provider's fixed asset schedule.

Providers should direct questions about these requirements to Derris.Harrison@fssa.IN.gov.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-457-4584.

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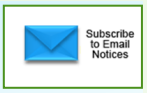

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