Indiana Health Coverage Programs

B A N N E R P A G E

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To All Providers:

- Family and Social Services Administration (FSSA) Secretary Mitch Roob has announced that he will not be forced to withhold 2 percent of all Medicaid reimbursements to medical providers. While Roob said he was glad the rollbacks did not have to occur at this point, he warned the FSSA remains in a dire financial crisis.

  In January, Roob announced the possibility of holding the reimbursements due to overwhelming budget shortfalls. The holdback was estimated to save the agency roughly $17.2 million in 2005.

  "After further review of current programs and services, FSSA is able to fill the anticipated shortfall with savings in programs other than Medicaid," Roob said.

  "We must continue to rebuild financial solvency in FSSA," Roob said. "The system does not and will not work."

  The Medicaid shortfall for 2005 is $121 million. Indiana received one-time federal fiscal relief in 2004 which will be used to fund the $121 million shortfall in 2005. Since this federal money is no longer available, FSSA will need an additional $121 million in 2006 just to fund current Medicaid spending levels. Any growth in the program will require funding in addition to the $121 million.

  Roob underscored the agency's need to continue to scrutinize programs by saying, "Financial irresponsibility is the least compassionate course, therefore, FSSA must fundamentally reorganize how it provides service to the citizens of Indiana."

- This article clarifies Indiana Health Coverage Programs (IHCP) policy for billing services under revenue codes *92x - Other Diagnostic Services*, and *94x - Other Therapeutic Services*. The IHCP does not reimburse revenue codes 920, 940, 941, 942, 944, 945, 946, 947, or 949. Effective April 1, 2005, the IHCP will also not reimburse revenue code 929. Providers must use an appropriate revenue code that is descriptive of the service, or where the service was performed.

  Table 1 – Diagnostic and Therapeutic Services Not Reimbursable by the IHCP

Revenue Code	Description
920	Other Diagnostic Services – General
929	Other Diagnostic Service – Other Diagnostic Service
940	Other Therapeutic Service – General
941	Other Therapeutic Service – Recreational Therapy
942	Other Therapeutic Service – Education/Training
944	Other Therapeutic Service – Drug Rehabilitation
945	Other Therapeutic Service – Alcohol Rehabilitation
946	Other Therapeutic Service – Complex Medical Equipment - Routine
947	Other Therapeutic Service – Complex Medical Equipment - Ancillary
949	Other Therapeutic Service – Additional Therapeutic Services

  Therapeutic and diagnostic injections are performed within a number of treatment centers in a hospital, including but not limited to an operating room (360), emergency room (450), or clinic (510). Similar to Medicare policy, IHCP policy requires that hospitals report these injections under the revenue code for the treatment center where injections are performed. This is also consistent with rate setting for treatment rooms as costs for injections were considered when establishing treatment room rates. Injections are included in the reimbursement of the treatment room when other services are provided. However, if a patient is treated and only received the injection service, the provider will be reimbursed the flat fee of the appropriately billed treatment room revenue code. Claims using the revenue codes in the 92x and 94x series listed above may have previously denied with Explanation of Benefits (EOB) code *4014 - No pricing segment on file*. Claims billed with these revenue codes now deny with EOB code *4107 - Revenue code is not appropriate or not covered for the type of service being provided.* Providers should direct questions to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800 577-1278.

- The IHCP revised the ambulatory surgical center (ASC) reimbursement rates for the cardiac catheterization Current Procedural Terminology (CPT®) codes listed in Table 2. The revised rates are effective April 1, 2005. Providers should direct questions to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Table 2 – Revised Cardiac Catheterization Procedure Code ASC Rates

Procedure Code	Description	ASC Group	ASC Rate
93543	Injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography	2	$443.28
93544	Injection procedure during cardiac catheterization; for aortography	2	$443.28
93545	Injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand)	2	$443.28
93555	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography	4	$582.98
93556	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or used in bypass)	2	$443.28

- This article clarifies and updates IHCP policy for HCPCS code *V2785 – Processing, preserving, and transporting corneal tissue*. The IHCP currently provides reimbursement for HCPCS code V2785 separate from the ASC rate for outpatient corneal transplant procedures. Current policy instructs providers to bill this code on the UB-92 claim form with revenue code *362 – Organ/Tissue Transplant.* Effective for claims filed on February 1, 2005, and after, the IHCP requires providers to bill HCPCS code V2785 on the CMS-1500 claim form or 837P transaction for reimbursement separate from the ASC rate for outpatient corneal transplant procedures. A copy of the invoice from the eye bank or organ procurement organization showing the actual cost of acquiring the tissue must be attached to the claim form. When submitting paper attachments with an 837P transaction, providers must follow the instructions provided in the *IHCP Provider Manual*, Chapter 8, Section 1. The IHCP reimburses providers 90 percent of the invoice amount. Providers should direct additional questions to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

To All Hospital Providers:

- Hospital providers may have noticed claims denying for edit *4099 – DRG not on file*, for inpatient newborn claims. These claims denied inappropriately from January 17, 2005, through January 24, 2005. The IHCP reprocessed these claims and they appeared on the February 8, 2005, remittance advice (RA). Providers should direct questions to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

To All Durable Medical Equipment Providers

- During the 2005 annual Healthcare Common Procedure Coding System (HCPCS) review, the IHCP deleted three HCPCS codes used for reimbursement of the Matrix seating system. Previously, the IHCP reimbursed HCPCS code K0116 for the Matrix TMX Composite Shell, K0115 for the Matrix Extra Rigid Support Frame, and E0192 for the Matrix TMX seat cover. Effective January 1, 2005, the IHCP assigned two HCPCS codes for reimbursement of the Matrix seating system. HCPCS code E1399 U1 replaces K0116 and is defined as *Matrix Composite Shell*. HCPCS code E1399 U2 replaces K0115 and is defined as *Matrix Extra Rigid Support Frame*. The IHCP reimburses E1399 U1 at a max fee of $1,736.01, and the IHCP reimburses E1399 U2 at a max fee of $950.00. Providers must request E1399 U1 and E1399 U2 with the HCPCS code and modifier for reimbursement. HCPCS code *E2605 - Positioning wheelchair cushion, width less than 22 inch125, any depth*, replaces E0192 and is reimbursed at a max fee of $321.69. E1399 U1, E1399 U2, and E2605 require prior authorization and are subject to the Matrix seating system policy. In addition, E2605 continues to be reimbursed for positioning wheelchair seat cushions, width less than 22 inches, with prior authorization.

Table 3 – Matrix Seating System Coding

Deleted Code	Crosswalked Code	Max Fee
K0116	E1399 U1	$1,736.01
K0115	E1399 U2	$950.00
E0192	E2605	$321.69

- Effective February 15, 2005, medical supplies, non-medical supplies, and routine durable medical equipment (DME) items billed to the IHCP for members residing in long-term care facilities will deny. Long-term care facilities include nursing facilities, intermediate care facilities for the mentally retarded (ICFs/MR), and community residential facilities for the developmentally disabled (CRFs/DD). The IHCP policy stipulates that providers cannot bill the IHCP directly for medical supplies, non-medical supplies, or routine DME items provided to an IHCP member residing in a long-term care facility. The costs for these services are

included in the facility per diem rate, and the medical supplier, or DME company should bill the long-term care facility directly for such services. For further information, refer to *405 IAC 5-13-3* and *405 IAC 5-31-4*. HCPCS codes for medical supplies, non-medical supplies, or routine DME items billed to the IHCP for members residing in long-term care facilities will deny with explanation of benefit (EOB) code *2034 - Medical and non-medical supplies and routine DME items are covered in the per diem rate paid to the long term care facility and may not be billed separately to the IHCP*.

To All Dental Providers:

- IHCP provider bulletin *BT200433*, published December 23, 2004, stated that procedure code *D7283 – placement of a device to facilitate eruption of an impacted tooth*, was a covered service effective January 1, 2005. Further review indicates that this procedure is performed as an orthodontic service. The IHCP covers comprehensive orthodontic services with prior authorization (PA), as outlined in IHCP provider bulletin *BT200230*, published June 19, 2002. Procedure code D7283 includes placement of an orthodontic bracket or band to facilitate eruption of an unerupted tooth after surgical exposure. Placement of an orthodontic bracket is included in the reimbursement for comprehensive orthodontic services; therefore, procedure code D7283 is not separately reimbursed. Providers should direct questions about this article to the Health Care Excel (HCE) Medical Policy Department at (317) 347-4500.

To All Outpatient Hospitals and Ambulatory Surgery Centers:

- Upon implementation of the new outpatient reimbursement policy as stated in IHCP provider bulletin *BT200420*, published September 15, 2004, the IHCP discovered a payment issue related to outpatient surgeries. When providers billed only one surgery or one unit of service, the system calculated the rate at 150 percent instead of 100 percent. This calculation resulted in overpayments. This impacted outpatient claims with paid dates from October 5, 2004, through November 9, 2004. Therefore, the IHCP will initiate a systematic mass adjustment for all affected claims. Providers can expect adjusted claims to appear on the RA statement dated March 8, 2005.

To All Pharmacy Providers:

- Effective April 1, 2005, the drug groups in Table 4 will be added to the State Maximum Allowable Cost (State MAC) for legend drugs rate list.

Table 4 – State MAC Rates Effective April 1, 2005

Drug Name	State MAC Rate	Drug Name	State MAC Rate
AMITRIPTYLINE 100MG TAB	0.0993	FLUCONAZOLE 150 MG TABLET	0.4347
AMOX TR-K CLV 600-42.9/5 SUSP	0.2982	FLUCONAZOLE 200 MG TABLET	0.4812
AMOXICILLIN 125MG/5ML SUSP	0.0144	FLUTAMIDE 125 MG CAPSULE	1.0982
BETHANECHOL 10 MG TABLET	0.9237	FLUTICASONE PROP 0.05% CREAM	0.7059
BUTORPHANOL 2 MG/ML VIAL	4.8667	GABAPENTIN 100 MG CAPSULE	0.3256
CIPROFLOXACIN HCL 250 MG TAB	0.1012	GABAPENTIN 300 MG CAPSULE	0.8096
CIPROFLOXACIN HCL 750 MG TAB	0.2485	GABAPENTIN 400 MG CAPSULE	0.9411
CITALOPRAM 20 MG TABLET	0.3073	PEG 3350/ELECTROLYTE SOLN	0.0030
CITALOPRAM 40 MG TABLET	0.3146	PERGOLIDE MESYL 0.25 MG TAB	1.5489
CLINDAMYCIN PHOSP 1% LOTION	0.5098	PERPHENAZINE 16 MG TABLET	0.4066
CLOTRIMAZOLE 10 MG TROCHE	1.2323	POLYETHYLENE GLYCOL 3350	0.0544
CLOTRIMAZOLE-BETAMETHASONE LOT	1.3802	PRAZOSIN 1 MG CAPSULE	0.1311
DILTIAZEM 120 MG TABLET	0.1395	PROMETHAZINE 25 MG TABLET	0.3034
ESTAZOLAM 1 MG TABLET	0.2959	PROPAFENONE HCL 300 MG TAB	1.7681
FELODIPINE 10 MG TABLET SA	1.6176	SELEGILINE HCL 5 MG CAPSULE	0.4557
FELODIPINE 5 MG TABLET SA	0.9008	TRIMETHOBENZAMIDE 300 MG CAP	0.6476
FLUCONAZOLE 100 MG TABLET	0.2781		

- Effective February 15, 2005, the State MAC rates for the following drugs will be updated as shown in Table 5:

Table 5 – State MAC Rates Effective February 15, 2005

Drug Name	State MAC Rate
OXYCODONE W/APAP 5/325 TAB	0.0931
DESOXIMETASONE 0.25% CREAM	0.5547
FLUOCINONIDE 0.05% CREAM	0.0712
HYDRALAZINE 25MG TABLET	0.2230
HYDROCORTISONE 0.2% CREAM	0.3372
PROPRANOLOL 40 MG TABLET	0.0561
TIMOLOL 0.25% EYE DROPS	0.3795
TRIAMCINOLONE 0.1% CREAM	0.0401
TRIAMCINOLONE 0.1% OINT	0.0437

- Providers should direct questions about the State MAC for legend drugs to the Myers and Stauffer Pharmacy Unit by telephone at (317) 816-4136 or 1-800-591-1183, or by e-mail at pharmacy@mslc.com.

Note: The information in the following banner page article is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system.

- The OMPP received notice on January 28, 2005, that the Centers for Medicare & Medicaid Services (CMS) has issued another update regarding information previously communicated by CMS and first published in banner page *BR200452A*, dated December 28, 2004. CMS has since verified that the National Drug Codes (NDCs) listed in Table 2 (below) have been properly listed by manufacturers with the Food and Drug Administration (FDA) and therefore are not being deleted from Medicaid coverage, contrary to what CMS had previously conveyed. Therefore, the NDCs listed in Table 2 are now considered as covered under Medicaid effective, January 1, 2005.

  Banner page *BR200504*, dated January 25, 2005, advised providers that some NDCs originally included in *BR200452A* as non-covered had subsequently been determined by CMS to be covered. With the exception of those NDCs and the ones listed in Table 2 below, all other NDCs referenced in banner page *BR200452A* will remain non-covered by Medicaid unless CMS issues further notice. As previously expressed, the OMPP sincerely regrets any confusion caused to providers by this federally-mandated action.

Table 6 – NDC List

NDC List	NDC List	NDC List	NDC List	NDC List
00062-1650-03	00555-0694-02	00555-0695-02	00555-0696-10	00574-0850-10
00677-1910-37	00677-1911-33	51285-0049-01	51285-0275-01	51285-0275-02
51285-0446-02	60258-0176-09	60258-0429-16	60505-0068-03	62037-0524-01

Providers should direct all questions about this information to the ACS Pharmacy Services Help Desk at 1-866-645-8344.

To All Crossover Providers:

- Starting February 24, 2005, the IHCP and OMPP will have the system capability to deny claims for 590 recipients if the total cost is less than $150.00. Edit 0450 - 590 PAID LESS THAN $150.00 will post for the denied services. Claims less than $150.00 must be submitted to the facility. Claims will continue to pay when the paid amount is $150.00 or greater. Mass adjustments for claims that paid when the total cost {paid amount} was less than $150.00 will be initiated on or after April 1, 2005. This change is in reference to 470 IAC 12-1-1; Section 1 (a) "Affected agency" means the department of correction, the state board of health or the department of mental health. (b) "Eligible individual" means any person, other than a Medicaid recipient, who requires medical or dental services while in custody or care of an affected agency. (e) "Covered medical service" means medical services subject to review by the department, here in above defined, which are provided to an eligible individual in a health facility or place other than an institution, at a total cost of more than $150.00. Such services include any medical or dental procedure, or a series of such procedures related to a specific diagnosis, illness, injury, condition or syndrome. Transportation is excluded from this rule because it is not a covered service for the 590 program.