B A N N E R P A G E

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To All Providers:

- The Indiana Health Coverage Programs (IHCP) revised the policy for reimbursement of Current Procedural Terminology (CPT®) codes *53850 - Transurethral destruction of prostate tissue; by microwave thermotherapy* (TUMT), and *53852 -Transurethral destruction of prostate tissue; by radiofrequency thermotherapy* (TUNA). Effective March 1, 2005, the IHCP will reimburse for CPT codes 53850 and 53852 performed in an Ambulatory Surgery Center (ASC) or in the physician office. All claims are subject to post-payment review.
  Billing Requirements and Reimbursement Summary
  In the physician office setting, providers should bill using the CMS-1500 claim form or 837P transaction using the appropriate CPT code to receive global reimbursement. Providers should bill either CPT code 53850 for TUMT or CPT code 53852 for TUNA. Global reimbursement will be the lower of submitted charges, or a global fee of $1,555.16 for TUMT or $1,575.45 for TUNA. In an ASC or outpatient setting, physicians should bill for professional services using the CMS-1500 claim form. Physicians should use CPT code 53850 with modifier 26 for TUMT, or CPT code 53852 with modifier 26 for TUNA. In the ASC or outpatient setting, physician reimbursement will be the lower of submitted charges, or the resource-based relative value scale (RBRVS) fee of $448.44 for TUMT and $468.70 for TUNA. ASC and outpatient facilities should bill for TUMT and TUNA using the UB-92 claim form. CPT codes 53850 and 53852 have been assigned to ASC Group 8, with facility-based reimbursement equal to the lower of charges, or $1,106.60. Providers should direct questions to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.
- This article clarifies the IHCP policy regarding Healthcare Common Procedure Coding System (HCPCS) codes R0070, R0075, and R0076, in addition to modifiers UN, UP, UQ, UR, and US for the transportation of portable X-ray and electrocardiogram equipment. As of April 15, 2005, HCPCS code R0076 - *Transportation of portable EKG to facility or location, per patient*, is a non-covered service for the IHCP. Providers will no longer be reimbursed for this service. HCPCS code *R0070 -Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen*, is reported for one patient served. HCPCS code *R0070* must not be reported with modifiers UN, UP, UQ, UR, or US. One unit must be reported for the trip. When more than one patient is served, providers should report HCPCS code *R0075 - Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen*, with the appropriate modifier representing the number of patients served. One unit must be reported for the trip. The service must be reported on each member's claim with the appropriate modifier. Reimbursement will be prorated according to how many patients are served, as represented by modifiers UN, UP, UQ, UR, and US. Table 1 lists the percentage of the fee schedule amount that each modifier will reimburse when reported with HCPCS code *R0075*.

Table 1 – HCPCS Code R0075 Modifier Reimbursement

Modifier	Description	Fee Schedule Percentage
UN	Two patients served	50
UP	Three patients served	33
UQ	Four patients served	25
UR	Five patients served	20
US	Six or more patients served	16

Providers should direct questions about this article to Health Care Excel (HCE) Medical Policy Department at (317) 347-4500.

- The IHCP revised the ASC reimbursement rates for the cardiac catheterization 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

To All Durable Medical Equipment Providers

- During the 2005 annual 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 inch, 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

To All Outpatient Hospitals and Ambulatory Surgery Centers:

- The IHCP discovered a payment issue related to outpatient surgeries after implementation of the new outpatient reimbursement policy as stated in IHCP provider bulletin BT200420. 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 remittance advice (RA) statement dated March 8, 2005.

To All Acute Care Hospitals:

- As a result of changes to *405 IAC 1-10.5-3 (y),* effective for admissions on or after November 1, 2004, providers are required to bill an inpatient stay of less than 24 hours as an outpatient service. Claims that group to diagnosis-related grouping (DRG) *637 - Neonate, died w/in one day of birth, born here* and DRG *638 - Neonate, died w/in one day of birth, not born here* are exempt from this policy because they are specific to one-day stays. The Office of Medicaid Policy and Planning (OMPP) has received inquiries about potential medical record compliance issues with this rule. Specifically, providers have questioned whether billing for outpatient services when a patient has been admitted as an inpatient will be viewed by the OMPP as non-compliance with program policies concerning internal records and billing requirements. The OMPP will not take action against a provider for adhering to the agency's billing requirements for inpatient stays of less than 24 hours, because this is in compliance with the Indiana regulation and billing requirements. In addition, providers have questioned whether their medical records, which originally indicated an inpatient stay of less than 24 hours, should be amended to show that outpatient services were performed. Providers do not need to amend their medical record keeping to comply with the changes that became effective on November 1, 2004.

To All Pharmacy Providers:

- Effective February 14, 2005, the following drug groups have been removed from the State Maximum Allowable Cost (State MAC) for legend drugs rate list: Kovia Ointment, Oxycontin 80MG Tablet, and Ziox Ointment. Providers that have dispensed any of these drug groups since February 14, 2005, and who have been reimbursed at the former State MAC rate may adjust their claims. Providers should direct any questions about the State MAC for legend drugs to the Myers and Stauffer, LC Pharmacy Unit at (317) 816-4136 or 1-800-591-1183, or e-mail at pharmacy@mslc.com.

To All Crossover Providers:

- Starting February 24, 2005, the IHCP and the OMPP will have the system capability to deny claims for 590 members if the total cost is less than $150.00. (EOB) code *0450 - The total paid amount is less than the $150.00 minimum for the 590 program.* 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.