Providers

Changes to Billing Requirements for Stereotactic Radiosurgery

The purpose of this article is to advise Indiana Health Coverage Programs (IHCP) providers of changes to billing requirements for physician's services for stereotactic radiosurgery (SRS). IHCP bulletin *BT200528* advises providers to report the physician's professional services that had previously been billed with Healthcare Common Procedure Coding System (HCPCS) codes G0242 and G0338, with Common Procedural Terminology (CPT©) code 77301; however, services previously billed with these two codes should be billed with procedure identification code 77301 U5. The HCPCS codes listed in Table 1 are end-dated December 31, 2005. Effective for dates of service on and after January 1, 2006, providers are advised to bill the SRS services as reflected in Table 2. All other billing requirements for SRS therapy remain unchanged.

Table 1 – SRS HCPCS Codes End-Dated December 31, 2005

Code	Description
G0242	Multi-source photon stereotactic radiosurgery (cobalt 60 multi-source converging beams) plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment
G0338	LINAC-based stereotactic radiosurgery plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification; all lesions treated, per course of treatment

Table 2 – SRS CPT Codes Effective January 1, 2006

Code	Description	Reimbursement
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications	$1,014.63
77301 U5	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications; multi-source photon or linear accelerator based stereotactic radiosurgery plan optimization for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment	$1,450.00

Medicare and Medicaid COB

Due to differences in Medicare and Medicaid processing, providers now have the ability to bypass entering coordination of benefits (COB) adjustment information at the detail level when a claim is processed by Medicare at the header level. However, Health Insurance Portability and Accountability Act (HIPAA) standards mandate all COB adjustment information be reported at the level in which the provider receives the data from the Medicare intermediary.

The IHCP is in the process of updating Web documentation to support this policy.

Providers Using the Omni System for Eligibility Verification

With the implementation of Medicare Part D (prescription drug coverage), providers using the Omni system must perform a terminal download to ensure that they are receiving complete Medicare coverage information. The download

is **free**. The IHCP provider bulletin, *BT200303*, published January 31, 2003, provides complete download instructions. The bulletin is available from the IHCP Web site at www.indianamedicaid.com.

Contact Information: Omni Help Desk at (317) 488-5051 in the Indianapolis local area or 1-800-284-3548 between the hours of 8 a.m. to 5 p.m., Monday through Friday, excluding State holidays.

Modified Solid Food Supplements

The IHCP reviewed the appropriateness of reimbursement for HCPCS code *S9434, Modified solid food supplements for inborn errors of metabolism* regarding reimbursement for nutritional products billed using this code. This procedure code became effective in January 2004 and the **IHCP determined it to be non-covered**.

The IHCP covers nutritional supplements, food supplements, and infant formulas when no other means of nutrition is feasible or reasonable according to the Indiana Administrative Code (IAC) at *405 IAC 5-24-9*. Currently, liquid nutritional supplements and medical foods are covered. However, the IHCP has determined that modified medical foods in tablet or capsule forms are not covered as nutritional needs may be met through current covered formulations.

Nutritional supplements are not considered drugs or biologics. Please report them to the IHCP with the appropriate HCPCS code on the paper CMS-1500 claim form or electronic 837P electronic transaction. According to HIPAA, only drugs and biologics may be reported on the pharmacy claim form with a National Drug Code (NDC). Therefore, effective April 3, 2003, the IHCP discontinued coverage of nutritional supplements billed with an NDC.

Contact Information: Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll free at 1-800-577-1278.

PET Scan Coding

The IHCP bulletin *BT200516* provided billing guidelines for Positron Emission Tomography (PET) scans. *BT200516* advised providers to bill PET scans using an appropriate CPT code and an appropriate International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code. Table 3 lists additional coding updates for PET scans. CPT codes 78811, 78812, and 78815 are added to PET scan imaging for non-small cell lung carcinoma. CPT code 78815 is added to PET scan imaging for colorectal and esophageal cancer. All other billing requirements remain unchanged.

Note: Reimbursement for PET scan services remains unchanged. Reimbursement for the appropriate CPT code, billed with the technical component (TC) and appropriate ICD-9-CM code, on a UB-92 claim form, is $829.09. Reimbursement for professional services, reported with the appropriate CPT code, modifier 26 (professional services) and the appropriate ICD-9-CM code, and billed on a CMS-1500 or 837P electronic transaction, reimburses from the resource-based relative value scale (RBRVS) fee schedule.

CPT and ICD-9-CM Codes Supporting Medical Necessity

Table 3 – ICD-9-CM Codes Supporting Medical Necessity

PET Scan Imaging	CPT Code	ICD-9-CM Code
Whole body, for non-small cell lung carcinoma	**78811, 78812**, 78813, **78815**, 78816	162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 196.1, V10.11, V71.1
Whole body, for colorectal cancer	78813, **78815**, 78816	153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 197.5, V10.05, V10.06, V71.1
Whole body, for esophageal cancer	78813, **78815**, 78816	150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, V10.03, V71.1

IHCP E-Mail Notifications Program

On January 17, 2006, EDS and the IHCP launched the IHCP E-Mail Notifications program. This program automatically issues e-mails to subscribers when IHCP publications and announcements are posted to the IHCP Web site.

This service is **free** and available to both providers and non-providers. It is possible to have multiple subscriptions to provide notifications at office, home, or to other e-mail addresses for associates and staff. To subscribe to the service, visit the IHCP Web site at www.indianamedicaid.com.

On the *IHCP E-mail Notifications* page, click the **Open New Account** button, complete the profile information, and select the publications for e-mail notifications. You will receive a Welcome e-mail asking you to activate your subscription. You must reply to the Welcome e-mail to activate your registration.

Publications are posted to the Web site on Tuesdays and Thursdays of each week. For a period of time *both* e-mail notifications and paper copies of the publications will be provided.

You may subscribe or unsubscribe at any time. Each notification e-mail contains a link for updating your subscription profile or unsubscribing to the service.

Nursing Facility Providers

Monthly quality assessment fee accounts receivables (A/Rs) are established during the last week of each month for the following month's quality assessment. For example, A/Rs were set up for the November 2005 quality assessment on October 27, 2005. The A/R appeared on the remittance advice dated November 1, 2005; with the reason code 8463 tied to the A/R. If a provider's rate retroactively increased, the A/R on the remittance advice appears with a reason code of 8464 and reports on the same remittance advice as the provider's regular monthly assessment. If a provider's rate retroactively decreased, an expenditure payout appears on the provider's remittance advice with a reason code of 8339 and reports on the same remittance advice as the provider's regular monthly assessment.

Pharmacies and Prescribing Providers

Pharmacy and Compound Claim Forms

All providers who submit pharmacy or compound claims **on paper** must use the new pharmacy and compound claim forms available at http://www.indianamedicaid.com/ihcp/Publications/forms.asp. Effective immediately, EDS will return all pharmacy or compound claims submitted on old claims forms. Providers may also bill pharmacy and compound claims electronically.

Medicare Part D

Effective January 1, 2006, the Centers for Medicare and Medicaid Services (CMS) implemented the new Medicare prescription drug coverage, also known as Medicare Part D. This coverage is a new benefit to help Medicare members pay for prescription drugs.

The IHCP Web site includes a section titled *Medicare Prescription Drug Coverage*. Providers should visit this section periodically at http://www.indianamedicaid.com/ihcp/ProviderServices/MedicareD.asp for the latest information.

For more information about the Medicare prescription drug benefit, visit the CMS Web site at http://www.cms.gov/MedicareReform/.