All Providers

HCPCS Codes Non-Covered by Medicare

The 2006 annual code and modifier updates to the Healthcare Common Procedure Coding System (HCPCS) identified the codes in Table 1 as non-covered by Medicare.

Table 1 – HCPCS Codes Non-Covered by Medicare, Effective February 7, 2006

92630	92633	A6530	A6533	A6534	A6535	A6536
A6537	A6538	A6539	A6540	A6541	A6542	A6543
A6544	A6549	E0172	E0641	J7306	S2078	S2079

EDS will add these codes to the Medicare bypass table in Indiana*AIM*. Claims with these codes will bypass Medicare third party liability edits and process for appropriate adjudication.

Changes to Billing Requirements for Stereotactic Radiosurgery

The purpose of this article is to advise 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 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 2 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 3. All other billing requirements for SRS therapy remain unchanged.

Table 2 – 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 3 – 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.

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.

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Long Term Care Providers

Crossover Reimbursement Clarification and Use of Resident Personal Resource Account Funds

This article clarifies page 4 of IHCP provider bulletin *BT200204* published January 30, 2002, regarding crossover reimbursement information, specifically Medicare Crossover claims payment policy changes. Information published in that bulletin stated, "OMPP has confirmed that Medicare payment policy permits coinsurance and deductible amounts that a nursing facility cannot collect to be treated as a Medicare bad debt, and are generally eligible for reimbursement by Medicare, so any adverse financial impact on the nursing facility should be minimal." Further information was provided on page 4 of the July 2004 IHCP newsletter (*NL200407*) in the section *Long Term Care Services, Nursing Facility Updates*.

The OMPP has received inquires from providers about what claims can be submitted to Medicare as bad debt when Explanation of Benefit (EOB) *9004 – No payment made, personal resource amount is more than the Indiana Health Coverage allowed amount,* has posted to an adjudicated claim on the provider's remittance advice (RA). Until modifications are made to Indiana*AIM*, providers must send bad debt information to Medicare for review. Providers should submit a copy of the IHCP RA to reflect that the IHCP adjudicated the claim and it paid at zero. The RA reflects patient liability deductions included in the adjudicated claim by indicating the specific dollar amount in the *Patient Responsibility* field on the RA, which is located between the *TPL* and the *Paid* field locators. If an amount is indicated in this field, then this is the amount of patient liability that was deducted from the claim. EOB 9004 should **not** be used as the basis for determining whether a patient liability amount was deducted from the claim.

In addition, some long-term care (LTC) providers have misused resident personal resource account funds to satisfy a co-insurance or deductible cost.

> *Note: The IHCP does not allow an LTC facility to use any portion of a member's personal resource account to cover any portion of the co-insurance or deductible amount that is not paid by the IHCP .*

For example, if the Medicare payment is *greater than* the IHCP-allowed amount and the claim is paid at zero, the co-insurance or deductible cannot be collected by the LTC facility from the member's personal resource account. Similarly, if the Medicare paid amount is *less than* the IHCP amount, allowing a portion of the co-insurance or deductible to be

paid, the difference between the payment amount and the difference in the co-insurance amount or deductible cannot be collected from the member's personal resource account. Providers that have not been following the correct policy must begin doing so immediately with publication of this notice.

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/.