B A N N E R P A G E

BR200732 AUGUST 7, 2007

All Providers

Deficit Reduction Act of 2005: HCPCS and NDC Requirement Reminder – Update to Bulletin BT200713

Provider bulletin, *BT200713*, specified an implementation date of August 1, 2007, for the inclusion of National Drug Codes (NDCs) for certain procedure codes on professional claims, including the paper CMS-1500 and electronic 837P as required by the *Federal Deficit Reduction Act of 2005*. Providers should note that that this requirement is not applicable to claims submitted to a Medicaid managed care organization (MCO).

The Indiana Health Coverage Programs (IHCP) previously communicated that for procedure codes that involve multiple NDCs, providers must bill the first procedure code, procedure code units, NDC and NDC units, and NDC unit qualifier utilizing a KP modifier. The second, and any subsequent line item(s) with the same procedure code, must be billed utilizing the KQ modifier to bypass the duplicate logic. However, the implementation of this modifier logic is temporarily delayed.

Providers should still bill the information as instructed, but the second and subsequent line items will suspend for manual review. The suspended line items will be reviewed and adjudicated within the normal parameters for processing suspended claims. The IHCP will notify providers when the duplicate logic is updated to include automatic processing utilizing the KP and KQ modifiers.

Children Diagnosed with Birth Defects

Indiana State Health Commissioner and Medicaid Medical Director Dr. Judith Monroe asks the IHCP to remind all physicians, audiologists, and other health providers that children diagnosed with birth defects must be reported to the Indiana Birth Defects and Problems Registry (IBDPR). In October 2006, conditions involving hearing loss (ICD-9_CM 389.00-389.99) were added to the list of reportable birth problems for which all newborn infants who are born in the state of Indiana will be screened. Audiologists are now required to report these conditions when they are discovered during the screening process. The revised Physician's Reporting Form is available on the ISDH Web site at http://www.in.gov/isdh/programs/ibdpr. If you have questions, please contact Ruwanthi Silva at (317) 233-7571.

All DME and HME Providers

Reimbursement Rate for HCPCS Code E2374

The rate for E2374, *power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only*, has been revised. During the 2007 Annual Healthcare Common Procedure Coding System (HCPCS) update, pricing for E2374 was listed by the Centers for Medicare and Medicaid Services (CMS) as $143.96. The CMS corrected this rate.

Effective January 1, 2007, the IHCP will reimburse providers for E2374 using the corrected fee of $534.02. Providers may submit adjustments for previously paid claims.

Reimbursement Rate for HCPCS Code L0637

Effective January 1, 2006, the IHCP will reimburse providers for L0637, *Lumbar orthosis, sagittal control*, using the max fee of $856.21. During the 2006 annual HCPCS update, pricing for L0637 was incorrectly priced as $67.50. Providers may submit adjustments for additional payment. This banner may be used as documentation for waiving the filing deadline.

All Hospital, Physician, and Ambulance Providers

Please refer to the Indiana Medicaid Web site at http://www.indianamedicaid.com for important messages regarding changes to the Hospital Care for the Indigent Program.

All Home Health Providers

Home Health Claims – Cut Back Overhead at Detail Line

EDS determined that from October 2004 to July 2007, the overhead amount was not accurately applied to some of the detail lines on home health claims. Home health claims from October 1, 2004, to July 31, 2007, will be mass adjusted and will appear on RAs dated on or after September 4, 2007. Providers are not required to take any action.

Effective August 1, 2007, home health providers who have previously billed the same procedure with the same modifier for the same date of service on multiple detail lines must now bill on one detail line.

Home Health Claims Reimbursement

Provider bulletin, *BT200716*, dated June 26, 2007, announced the rule changes impacting home health rates for State fiscal year (SFY) 2008 and 2009. The rule was signed and is effective as of July 18, 2007, for SFY 2008 rates. However, Medicaid cannot begin to reimburse home health claims for SFY 2008 until the Office of Medicaid Policy and Planning (OMPP) receives approval from the Centers for Medicare and Medicaid Services (CMS) of the State plan amendment. Once the State plan amendment has been approved by CMS, the new rates will be entered into the Medicaid system and will be effective July 18, 2007. Please monitor forthcoming banner articles announcing the approval of the State plan amendment and information on the mass adjustment that will occur on home health claims with dates of service on or after the effective date of the new rates.

All Optometry Providers

Vision Code Set Reprocessing

The IHCP will reprocess and mass adjust professional claims that were denied with edit 1012, *Rendering provider specialty not eligible to render this procedure code* for CPT®[1] codes 99307, 99308, 99309, and 99310, listed below:

- 99307, *Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: problem focused interval history, problem focused exam, straightforward medical decision making. Usually patient is stable, recovering, or improving.*
- 99308, *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: expanded problem focused interval history, expanded problem focused exam, medical decision making of low complexity. Usually, the patient is responding inadequately to therapy or has developed a minor complication.*
- 99309, *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history, a detailed examination, medical decision making of moderate complexity. Usually the patient has developed a significant complication or a significant new problem.*
- 99310, *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a comprehensive interval history, a comprehensive examination, medical decision making of high complexity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.*

These codes were not included as valid codes for provider specialty 180 – Optometrist. The oversight has been corrected, and the reprocessed and mass adjusted claims will begin appearing on RA statements dated July 31, 2007.

Contact Information

If you have questions about the articles published in this banner page, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll-free at 1-800-577-1278, unless otherwise noted.

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