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All Providers

Claims Denied for Error Code 520 – Invalid Revenue Code/Procedure Code Combination

Providers who received denials with error code 520-*Invalid revenue code/procedure code combination* for the following Current Procedural Terminology (CPT®) codes since January 1, 2006, may resubmit those claims.

- 22523–*Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); thoracic*
- 22524–*Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); lumbar*
- 22525–*Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)*

Providers may submit this banner page along with the claims to waive the one-year filing limit.

Effective Date for Reporting National Drug Code Information on Institutional Outpatient Claims Extended to July 1, 2008

The Federal Deficit Reduction Act of 2005 mandates that all State Medicaid programs, including Indiana Health Coverage Programs (IHCP) require the submission of National Drug Code (NDC) information on claims submitted with certain procedure codes for physician-administered drugs. This mandate affects all providers who submit claims for procedure-coded drugs via Web interChange, electronic 837I, and the UB-04 paper claim form. Because the State may pay up to the 20 percent Medicare B co-payment for dual-eligible individuals, the NDC is also required on Medicare crossover claims for all applicable procedure codes.

The reporting of NDC information on outpatient and outpatient crossover claims was scheduled to begin January 1, 2008. The State has been granted a six-month extension of the effective date by the Centers for Medicare & Medicaid Services (CMS). The new effective date will be July 1, 2008.

Please contact your vendor to make the necessary software changes. Providers must be compliant by July 1, 2008.

> *Note: The IHCP policy is outlined in BT200713 and BT200731, including specific requirement and submission details. Additional information regarding this policy may be located under the claim information in the IHCP newsletter NL200708. As a reference guide, providers can access the Palmetto GBA Web site at http://www.palmettogba.com/. This Web site is in the public domain and furnishes an NDC crosswalk table, which relates procedure codes, NDCs, and NDC quantity conversion. Providers should utilize this tool as a guide to conversions but should not rely on it as a sole source for NDC quantity information. Providers must also remember that it is imperative that the NDC listed on the claim is representative of the actual product NDC administered to the member by the healthcare provider. Providers must continue to monitor the IHCP Web site for more information regarding submission of NDC.*

Mail Order Incontinence Supplies

The state of Indiana has contracted with three vendors to provide all incontinence supplies via mail order to Indiana Medicaid members. This transition will begin in early 2008. Providers will play a key role by assisting members during this transition. Watch for additional information in upcoming publications.

All Durable Medical Equipment Providers

Claims Denied in Error to be Reprocessed

Claims billed between November 2, 2007, and November 15, 2007, for members enrolled in the *Medicaid Select* program were denied inappropriately for edits *1042 – Certification code is missing-Medicaid Select* and *1044 – Recipient's PMP is missing-Medicaid Select*. EDS will systematically reprocess the denied claims. Reprocessed claims will begin appearing on remittance advice statements beginning December 25, 2007.

All Medical, Institutional, and Pharmacy Providers

Eligibility Verification Systems Healthy Indiana Plan Update

Beginning January 1, 2008, limited information will be available on the IHCP Eligibility Verification Systems (EVS) regarding the new Healthy Indiana Plan (HIP). EDS will provide the following information for HIP members:

- The member's eligibility for HIP
- The member's insurer and telephone number
- The member's emergency room co-pay amount

To receive detailed HIP information on the Omni terminal, providers must download the most recent Omni software version after December 31, 2007. Download instructions can be found in Table 1.1 of provider bulletin *BT200711* on the IHCP Web site at http://www.indianamedicaid.com/ihcp/index.asp. If an Omni software download is not performed, only general HIP information is shown on the device. Information regarding the Healthy Indiana Plan can also be found in provider bulletin *BT200730*.

If you have questions about this article, call the Omni Help Desk at (317) 488-5051 in the Indianapolis local area or toll-free at 1-800-284-3548.

All Pharmacy Providers

Removal of the Federal Upper Limit

Effective January 30, 2008, the Office of Medicaid Policy and Planning (OMPP) is changing the reimbursement policy for legend drugs. The new policy removes the federal upper limit (FUL) pricing from the IHCP reimbursement calculation. Aggregate reimbursement requirements, as required by the Centers for Medicare & Medicaid Services (CMS), will be satisfied by the application of rates established through the State maximum allowable cost program (State MAC).

All pharmacy claims with a date of service on or after January 30, 2008, will follow the updated reimbursement policy.

All Dental Providers

Audits for Bundled Services

Providers billing procedure codes *D1120, prophylaxis – child* and *D1203, total application of fluoride excluding prophylaxis – child* for the same member, on the same date of service will be reimbursed a bundled rate of $56.75. Providers billing procedure codes *D1110, prophylaxis – adult* and *D1204, total application of fluoride excluding prophylaxis – adult* for the same member, on the same date of service will be reimbursed a bundled rate of $70. Two new audits *6247 – Prophy and Fluoride Allowed a Maximum of $70.00 – Adult* and *6248 – Prophy and Fluoride Allowed a Maximum of $56.75 – Child* have been created and are effective for dates of service on or after January 1, 2008.

Dental Cap Audits

On January 1, 2008, dental code *D2390 – Resin-based composite crown, anterior*, will be added to the $600 dental cap audits. Dental claims received on or after January 1, 2008, billed with this code will be subject to audit *6236 – The member has exhausted a benefit limit for dental services. The limit for 21 and older is $600 per year for dental claims.*

Maximum Reimbursement for D7311 and D7321

Effective February 1, 2008, the IHCP will reimburse providers a maximum fee of $157.86 for *D7311, alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.* The IHCP will reimburse providers a maximum fee of $198.94 for *D7321, alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.* These changes will save providers claim processing time as cost invoices will not be required for reimbursement.

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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