B A N N E R P A G E

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All Providers

Claims with a 26 Modifier

Medical claims paid during the month of January 2004 and billed with a 26 modifier (professional component) did not cut back to the appropriate resource-based relative value scale (RBRVS) rate for modifier 26. Instead, the procedure code was reimbursed at the combined rate for both the technical and professional component causing an overpayment. Claims identified will be mass adjusted and the overpayment recouped. The adjusted claims will begin appearing on the provider's Indiana Health Coverage Programs (IHCP) remittance advice dated March 4, 2008.

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.

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.

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 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.*

All Hospice Providers

New Disenrollment Fax Number

To facilitate quick turnaround, ADVANTAGE Health Solutions[SM] has established a new fax number for the Medicaid managed care disenrollment of hospice members. Send disenrollment faxes to (317) 810-4488.

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 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.*

All Vaccine for Children Providers

CPT Code 90649 Human Papilloma Virus Vaccine

Effective January 1, 2008, the human papilloma virus (HPV) vaccine procedure code is considered a carved-in procedure for risk-based managed care (RBMC). Providers should submit claims for 90649 directly to the managed care organizations (MCOs).

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.