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All Providers

Update to bulletin BT200815 – Policy Change For Incontinence, Ostomy, and Urological Supplies

This is an update to bulletin *BT200815* – *Policy Change For Incontinence, Ostomy, and Urological Supplies*. There are instances when the use of tapes, adhesives, gloves, and other supplies are not related to incontinence, ostomy, or urological conditions. The Office of Medicaid Policy and Planning (OMPP) has determined that the following codes are billable by all providers:

- A4364 (adhesive liquid)
- A4365 (adhesive remover wipes)
- A4402 (lubricant)
- A4450 and A4452 (tape)
- A4455 (adhesive remover)
- A4927 (gloves)
- A5120, A5121, and A5122 (skin barrier)

Indiana Health Coverage Programs (IHCP) members will not be restricted to purchasing the above 10 supplies only through mail order from one of the three contracted vendors.

Transition of Wards of the Court and Foster Children into the Indiana *Care Select* Program

Effective July 1, 2008, all wards of the court and foster children currently enrolled in Medicaid will begin transitioning to the Indiana *Care Select* program. Some of these members are currently enrolled in other Medicaid programs and may already be receiving care from physicians enrolled in the IHCP provider network. The following aid categories will transition to *Care Select*:

- MA-3 (Wards not IVE eligible under 18)
- MA-4 (Title IVE foster children under 18)
- MA-8 (Children Receiving Adoption Assistance)
- MA-14 (Former Foster Children)

The Indiana *Care Select* Program is designed to improve the member's health status; enhance quality of life; improve member safety, member autonomy and adherence to treatment plans; and control fiscal growth. Through this program, the State will focus on the following objectives:

- Development of treatment regimens for chronic illnesses will conform to evidence-based guidelines.
- Primary care providers will be able to incorporate knowledge of functional assessments, behavioral changes, self-care strategies, and methods of addressing emotional or social distress into overall patient care.
- Care will be less fragmented and more holistic by addressing a member's physical and behavioral health care needs in addition to his or her medical and social needs.
- Communication will increase across settings and providers.
- Members will have greater involvement in their care management.

For more information on the *Care Select* program, refer to bulletins *BT200723* and *BT200804*.

Provider Enrollment Forms and National Provider Identifier

Provider Enrollment is no longer accepting provider enrollment or update forms that are submitted without a National Provider Identifier (NPI). If the NPI has not been reported, forms must be submitted with the NPI and the LPI to ensure accurate and timely processing. Forms submitted without an NPI cannot be processed and will be rejected and immediately returned to the submitter for resubmission with the appropriate NPI.

> *Note: Atypical providers are excluded from this requirement.*

Outpatient Surgery Providers

Ambulatory Surgical Center Indicators and Revenue Code Linkage

EDS recently updated pricing information for surgical procedure codes in the range 10000-69900 when billed with revenue codes 360 – *Operating Room Services* or 490 – *Ambulatory Surgical Center*. Claims previously denied for error code 4108 – *No ASC on File*, will be reprocessed or adjusted beginning the week of April 28, 2008.

The Current Procedural Terminology[1] (CPT) codes in Table 1 were updated with ambulatory surgical center (ASC) pricing and/or revenue code linkage.

Table 1 – Updated CPT Codes

15001	15170	15171	15175	15176	15340	15341
15360	15361	15365	15366	15431	15829	17311
17312	17313	17314	17315	22526	22527	24343
24344	24345	24346	25394	25430	25607	25608
25609	25651	25915	26340	43237	43238	43770
43771	43772	43773	43774	44901	46505	49324
49325	49326	49435	49436	50021	54865	55875
55876	56442	57106	57107	57109	57295	57296
57425	57558	58110	58541	58542	58543	58544
64449	64650	64653	64681	64910	64911	65781
65782	67225	67346	67912	68371		

Please refer to CPT publications for complete definitions of the procedure codes listed above.

> *Note: Providers who have billed the service under a similar code and received payment may need to adjust the claim after the mass adjustment.*

Nursing Facility Providers

Mass Adjustment of Medicare Part A Crossover Claims

This is an update of a previous banner page article originally published in BR200810, dated March 4, 2008. The mass adjustment announced at that time was delayed.

EDS will process a mass adjustment of Medicare Part A crossover claims with dates of service from October 1, 2001, through March 26, 2002. During this time an emergency rule was in effect that capped Medicaid reimbursement of crossover claims at the Medicaid allowable rate. The State was sued and prevented from implementing this emergency rule as well as three others. On appeal, the court found in favor of the State and sent the case back to the trial court for a

[1] *Current Procedural Terminology (CPT) is copyright 2007 American Medical Association. All Rights Reserved.*

determination of the amount the State was owed in restitution from providers (See IFSSA v. Amhealth et al, 790 N.E.2d162).

The lawsuit involved the nursing facility industry's challenge of four emergency rules that, in aggregate, reduced Medicaid reimbursement. As a result of a settlement with the plaintiffs, only Medicare Part A crossover claims will be adjusted and recouped from nursing facility providers.

The adjustments will begin appearing on the May 13, 2008, remittance advice (RA) statements for claims with dates of service between October 1, 2001 through December 31, 2001. Providers will be notified in a future banner page article the date the mass adjustment will occur for claims with dates of service January 1, 2002 through March 26, 2002. These claims will have an internal control number (ICN) starting with 56, which reflects a mass-adjusted claim. An accounts receivable (A/R) is set up to recover the overpayment. Following review of the RA, providers who disagree with any adjustment amounts may request an administrative review by writing to the following address:

EDS Administrative Review
Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263

In the request explain why you disagree with the adjustment amount and include copies of all pertinent documentation. Detailed information about the administrative review process is available in the IHCP Provider Manual.

Claims included in this mass adjustment that were billed and adjudicated during the specified time frame and contain details billed with services that are not included in the nursing facility per diem rate, such as lab or radiology services, may be resubmitted on paper or electronically for reimbursement consideration. Providers should resubmit these ancillary services as outpatient crossover claims with the appropriate type of bill. The IHCP will calculate the Medicaid allowed amount for each detail submitted and compare this amount to the Medicare paid amount. If the Medicare paid amount is less then the Medicaid allowed amount, a portion or all of the coinsurance and/or deductible amount will then be reimbursed.

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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