B A N N E R P A G E

B R 2 0 0 8 1 9 M A Y 6 , 2 0 0 8

All Providers

Clarification on Billing Food Thickener, Healthcare Common Procedure Coding System Code B4100

Nutritional supplements are not considered drugs or biologics. Please report them to the Indiana Health Coverage Programs (IHCP) with the appropriate Healthcare Common Procedure Coding System (HCPCS) code on the CMS-1500 paper claim form or using the 837P electronic transaction. According to the Health Insurance Portability and Accountability Act (HIPAA), only drugs and biologics may be reported on the pharmacy claim form with a National Drug Code (NDC). The policy for billing changed effective April 3, 2003, and the IHCP discontinued coverage of nutritional supplements billed with an NDC when billed on a drug claim form. B4100 (Food Thickener, administered orally, per oz), requires prior authorization and must be billed on a CMS-1500 claim form.

Billing Guidelines for Retroactive Eligibility

Utilize the following billing instructions when billing a claim that is past the filing limit and the member was awarded retroactive eligibility. In the case of retroactive member eligibility, claims must be submitted within one year of the eligibility determination date. Attach a letter behind the claim explaining the circumstances of the retroactive eligibility. EDS claims processing will review the eligibility award date in Indiana*AIM* for appropriate processing of the claim. Providers are not to contact the Division of Family Resources/Service Center for documentation of retroactive eligibility.

Billing Guidelines for Organ or Disease-Oriented Panels

Organ or disease-oriented panels were developed to allow for coding of a group of tests. Providers are expected to bill the lab panel when all the tests listed within each panel are performed on the same date of service. When one or more of the tests within the panel are not performed on the same date of service, providers may bill each test individually. Providers may not bill for a panel and all the individual tests listed within that panel on the same day. However, tests performed in addition to those listed on the panel on the same date of service may be reported separately in addition to the panel code. Providers must follow Current Procedural Terminology (CPT) [1]coding guidelines when reporting multiple panels. For example, providers cannot report 80048 with 80053 on the same date of service because all of the same lab codes in 80048 are components of 80053.

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)

IHCP members will not be restricted to purchasing the above 10 supplies only through mail order from one of the three contracted vendors.

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

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.*

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 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.

If you need additional copies of this banner page, please download them from the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/banner_results.asp. To receive e-mail notifications of future IHCP publications, subscribe to the IHCP E-mail Notifications at http://www.indianamedicaid.com/ihcp/mailing_list/default.asp.