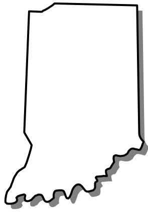

BANNER PAGE

BR200822 MAY 27, 2008

All Providers

Resolving NPI Alerts

A solution for resolving many National Provider Identifier (NPI) alerts is published on the Indiana Health Coverage Programs (IHCP) Web site NPI Overview page: http://www.indianamedicaid.com/ihcp/ProviderServices/npi.asp. Providers receiving NPI-related edit messages on a remittance advice (RA) statement or biller summary report (BSR) should review the information and the related form.

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 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. Submit the claim and a letter stating that the member was given retroactive eligibility. Attach the letter behind the claim explaining the circumstances of the retroactive eligibility. EDS claims processing will review the eligibility award date in IndianaAIM 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 the same lab codes in 80048 are components of 80053.

All Dental Providers

Reimbursement Rates

Because of the increased reimbursement rates that were negotiated with the Indiana Dental Association, the IHCP is no longer reimbursing posterior resin restorations at the same rate as posterior amalgam restorations. Reimbursement rates for resin restorations can be found in the IHCP fee schedule at http://www.indianamedicaid.com/ihcp/Publications/MaxFee/fee_schedule.asp. This change became effective January 1, 2008.

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

All Vaccine for Children Providers

HPV Claims Mass Adjustment

In 2007, several providers sent claims to the RBMC managed care organizations (MCOs) for a carved-out procedure code: *90649 – Human Papilloma Virus (HPV) Vaccine, Types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use.* When the MCOs submitted this service as an encounter claim to EDS, they were identified as paid claims in Indiana*AIM*. Subsequent claim submissions to EDS were denied as duplicates.

The MCO paid claims have been removed from Indiana*AIM*. Claims that denied inappropriately for edit *5001 – This is a duplicate of another claim,* and edit *4021 – Procedure code is not covered for the dates of service for the program,* billed for dates of service January 1, 2007, through December 31, 2007, will be systematically adjusted and reprocessed. Providers can expect to see affected claims on the June 3, 2008, RA statement.

For more information regarding the carve-out of vaccine procedure code 90649 and reimbursement guidelines, please refer to banner pages *BR200727* and *BR200725*.

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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