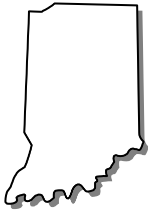

BANNER PAGE

BR200826 JUNE 24, 2008

All Providers

Changes to Targeted Case Management Services

The Office of Medicaid Policy and Planning (OMPP) is submitting a State Plan Amendment to the Centers for Medicare and Medicaid Services detailing changes to Targeted Case Management (TCM) Services that are necessary to comply with the Federal Interim Final Rule published in the Federal Register December 4, 2007.

The OMPP will provide further communication regarding the specific changes being made to each TCM service in future bulletins, newsletters, and/or provider manual updates. Indiana has five TCM target groups. The TCM Groups, as specified within the State Plan, are those Medicaid enrollees determined to have:

- High-risk pregnancies
- Human immunodeficiency virus (HIV)
- Diagnosis of serious mental illness or seriously emotionally disturbed (SED)
- Developmental disability (DD)
- Nursing facility level-of-care (LOC) criteria

Coverage of Lucentis™ and Visudyne™

Effective January 1, 2008, the Indiana Health Coverage Programs (IHCP) will provide coverage of Lucentis (J2778) and Visudyne (J3396). Providers should indicate the appropriate National Drug Code (NDC) and the number of units administered on the claim, or the claim will be denied.

National Drug Code for Institutional Outpatient Claims – Reminder of Implementation Date

On July 1, 2008, the requirement for the NDC submission on Institutional Outpatient claims will be implemented. The *Federal Deficit Reduction Act of 2005* mandates the IHCP require the submission of NDCs on claims submitted with revenue codes 634, 635, and 636 for physician-administered drugs. Providers must bill the NDC on the label of the drug that is administered. This mandate affects all providers who submit electronic claims or UB-04 paper claims. Providers can obtain additional information on the IHCP specific requirements from bulletins *BT200713* and *BT200731*.

Procedure Codes Billable to Medicare as Primary

The OMPP has determined that the following codes will be end-dated on the Medicare Procedure Bypass Table with the end date of May 31, 2007. Claims with dates of service of June 1, 2007, and after must be first submitted to Medicare for payment.. If Medicare denies the claim, it may be submitted to Medicaid with a copy of the Medicare denial for processing.

- A4357-Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each
- A4361-Ostomy faceplate, each
- A4362- Skin Barrier, solid, 4 X 4 or equivalent, each
- A4363-Ostomy clamp, any type, replacement only, each
- A4364-Adhesive, liquid or equal, any type, per oz
- A4365-Adhesive remover wipes, any type, per 50
- A4367-Ostomy belt, each
- A4369-Ostomy skin barrier, liquid (spray, brush, etc.), per oz

- A4380-Ostomy pouch, urinary, with faceplate attached, rubber
- A4390-Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece) each
- A4402-Lubricant, per ounce
- A4404-Ostomy ring, each
- A4430-Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece) each
- A5051-Ostomy pouch, closed; with barrier attached (1 piece), each
- A5052-Ostomy pouch, closed; without barrier attached (1 piece), each
- A5053-Ostomy pouch, closed; for use on faceplate, each
- A5054-Ostomy pouch, closed; for use on barrier with flange (2 piece), each
- A5061-Ostomy pouch, drainable; with barrier attached, (1 piece), each
- A5063-Ostomy pouch, drainable; for use on barrier with flange (2 piece system), each

All Federally Qualified Health Centers and Rural Health Clinics

Encounter Code Updates

Effective June 16, 2008, the Current Procedural Terminology (CPT[1]) and Healthcare Common Procedure Coding System (HCPCS) codes shown in Table 1 were **added as valid** Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) encounter codes for dates of service on or after January 1, 2008.

Table 1 – Encounter Codes Added

0178T	0179T	0180T	10121	11406	11732	21073	27267	27767	27768	32421
32422	32551	51100	51101	57455	60300	67229	68816	76817	76830	90769
90770	90771	90776	96150	96151	96152	96154	96155	D9220		

FQHC and RHC providers who have billed and received denials for these codes for claims with dates of service on or after January 1, 2008, should resubmit those claims.

Effective January 1, 2008, the following CPT and HCPCS codes **are no longer valid** FQHC/RHC encounter codes and will be removed from the list of valid codes: 32002, 32020, L1001, and S0180.

The valid FQHC/RHC encounter code list is reviewed periodically for new and end-dated CPT and HCPCS codes and is available on the Myers and Stauffer Web site at www.mslcindy.com. Please direct questions about the information in this article to Tim Guerrant, at Myers and Stauffer, LC at (317) 846-9521.

Outpatient Providers

Mass Adjustment of Diagnostic Radiopharmaceutical Claims

Effective January 1, 2006, HCPCS code *A9562 – Technetium TC-99M Mertiatide, diagnostic, per study dose, up to 15 millicuries* has been linked to revenue code *343 – Diagnostic radiopharmaceuticals*.

Outpatient claims that previously denied for explanation of benefit (EOB) *520 – Invalid revenue code and procedure code combination – please verify and resubmit* will be mass adjusted and reprocessed. Impacted claims will appear on remittance advice (RA) statements the week of June 30, 2008.

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

DME Providers

Mass Adjustment of DME Claims – Incontinence, Ostomy, and Urological Supplies

Per bulletin *BT200815*, the IHCP has contracted with three vendors to provide incontinence, ostomy, and urological supplies, effective June 1, 2008. Beginning May 28, 2008, claims submitted for these supplies by non-contracted providers may have denied inappropriately for edit *3001 – Date(s) of service not on PA database*. These claims are being systematically adjusted and reprocessed. Providers can expect to see affected claims on their RA statements beginning June 10, 2008.

All Pharmacy Providers and Prescribing Practitioners

Edit for 15-Day Trial Fill for New Atypical Antipsychotic Medications Delayed

The edit for a 15-day trial fill for new, atypical antipsychotic medications will not be implemented June 2, 2008, as previously announced in *BT200805* for the **fee-for-service** Medicaid program. Additional information regarding the implementation date will be published in future provider communications.

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 second phase of adjustments will begin appearing on the June 10, 2008, RA statement for claims with dates of service January 1, 2002, through February 28, 2002. Providers will be notified in a future banner page article the date the mass adjustment will occur for claims with dates of service March 1, 2002, through March 26, 2002, will be mass adjusted. 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 *Indiana Health Coverage Programs Provider Manual.*

In the event you have a specific claim that was billed and adjudicated during this time frame and was mass adjusted that contain details billed with services that are not included in the nursing facility per diem rate (such as lab or radiology services) these may be resubmitted via paper or electronically for reimbursement consideration. Providers should submit these ancillary services as an outpatient crossover claim with the appropriate type of bill for the IHCP to calculate the Medicaid allowed amount for each detail submitted to 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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