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All Providers

Medicaid Changes Prior Authorization Requirements for Osteogenic Bone-Growth Stimulator

Effective September 1, 2008, the Indiana Healthcare Coverage Programs (IHCP) no longer requires documented evidence of a failed surgery prior to authorizing an Osteogenic Bone-Growth Stimulator, low-intensity ultrasound, noninvasive (E0760) for treatment of nonunion fractures.

The following criteria must be met for diagnosis of a nonunion fracture:

- Serial radiographs must confirm that fracture healing has ceased for three or more months prior to starting treatment with an Osteogenic Stimulator.
- Serial radiographs must include a minimum of two sets of radiographs, each including multiple views of the fracture site, separated by a minimum of 90 days.

Prior authorization (PA) of an Osteogenic Bone-Growth Stimulator is still required and is based on the following indications:

- Nonunion of a fracture documented by a minimum of two sets of radiographs obtained prior to starting treatment with the ultrasound stimulator. The radiographs must be separated by a minimum of 90 days, and each must include multiple views of the fracture site. Also required is a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.
- The ultrasonic Osteogenic Stimulator may not be used concurrently with other noninvasive osteogenic devices.

Centers for Medicare & Medicaid Services Issues Quarterly Updates

The Centers for Medicare & Medicaid Services (CMS) has published the July Quarterly Updates with new and revised codes. Table 1 lists the deleted codes and the appropriate cross walked procedure code effective December 31, 2007. Table 2 lists the new Healthcare Common Procedure Coding System (HCPCS), coverage and prior authorization requirements; and Table 3 lists new modifier.

Table 1 – Deleted Codes

HCPCS Code	Description	Crosswalk Code
G0377	Administration of vaccine for Part D drug	**Effective January 1, 2008, physicians can no longer bill Medicare Part B for the administration of Medicare Part D-covered vaccines, using procedure code G0377**
G0297	Insertion of single chamber pacing cardioverter defibrillator pulse generator	33240

Table 2 – New HCPCS Coverage and Requirements

HCPCS Code	Description	Coverage/Requirements	Comments
C9242	Injection, fosaprepitant, 1mg	Covered all programs No PA requirements	Effective July 1, 2008 NDC 00006-3884-32
C9356	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (Tenoglide Tendon Protector Sheet), per square centimeter	Covered all programs No PA requirements	Effective July 1, 2008
C9357	Dermal substitute, granulated cross-linked collagen and glycosaminoglycan matrix (flowable Wound Matrix), 1cc	Covered all programs No PA requirements	Effective July 1, 2008
C9358	Dermal substitute, native, non-denatured collagen (SurgiMend Collagen Matrix), per 0.5 square centimeter	Covered all programs No PA requirements	Effective July 1, 2008
G0398	Home sleep study test (HST) with Type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort, and oxygen saturation	Not covered	Effective March 13, 2008
G0399	Home sleep test (HST) with Type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation	Not covered	Effective March 13, 2008
G0400	Home sleep test (HST) with Type IV portable monitor, unattended; minimum of 3 channels	Not covered	Effective March 13, 2008

Table 3 – New Modifier

HCPCS Code	Description	Effective Date
CG	Policy Criteria Applied	July 1, 2008

Nursing Facility Providers

EDS to Process 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 of Medicare Part A crossover claims 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 vs. 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 final phase of adjustments will begin appearing on the September 23 remittance advice (RA) statement for claims with dates of service between March 1, 2002, and March 26, 2002. Claims with From dates of service prior to March 26,

2002, but To dates of service after March 26, 2002, will be included in the mass adjustment. Claims that have To dates of service beyond March 26, 2002, without an accommodation revenue code (that is, ancillary services) may need to be resubmitted with the appropriate type of bill, as noted below. These claims will have internal control numbers (ICNs) starting with 56, which reflect mass-adjusted claims. 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* (IHCP) *Provider Manual.*

If you have specific claims that were billed and adjudicated during this time frame (March 2, 2002, to March 26, 2002) and were mass adjusted, and they contain details billed with services that are not included in the nursing facility per diem rate (that is, lab or radiology services), you may resubmit them electronically or via paper for reimbursement consideration. Providers should submit these ancillary services as outpatient crossover claims with the appropriate type of bill, so IHCP can 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 than the Medicaid allowed amount, a portion or all of the coinsurance or deductible amount will be reimbursed.

All Pharmacy Providers and Prescribing Practitioners

Updated NCPDP Payer Sheets

Please check the updated National Council for Prescription Drug Program (NCPDP) payer sheets for the following information:

- DAW 6 definition has been updated for use when communicating on a claim when the brand is medically necessary, or when the brand is preferred to its generic equivalent on the Preferred Drug List (PDL).
- (NCPDP) fields 479-H8, "*Other Amount Claimed Submitted Qualifier*," and 480-H9, "*Other Amount Claimed Submitted*," have been added for use when submitting *Other Coverage Code 8* on claims (see Table 4). These fields have always been required, but were omitted from prior versions of the payer sheets in error.

Table 4 – National Council for Prescription Drug Programs Payer Sheets

Field	Field Name	Field Format	Type	Value	Comments
479-H8	*Other Amount Claimed Submitted Qualifier*	x(2)	N	99	Mandatory when segment is present
479-H9	*Other Amount Claimed Submitted*	9(9)v99b or 9(9)v99-	D	s$$$$$$cc s9(6)v99	Required when submitting claim with *Other Coverage Code 8* in field 308-C8 – billing for third-party liability (TPL) copay only

New Web Site for National Drug Code to Procedure Code Unit Conversion

The Palmetto GBA Web site, used for reference when submitting National Drug Codes (NDCs) with Healthcare Common Procedure Coding System (HCPCS) codes on professional and outpatient claims (as found in bulletin *BT200713*, dated May 29, 2007), has changed. The new Web site, hosted by Nordian Administrative Service, is http://www.dmepdac.com

Utilization Edits

On June 19, 2007, the Mental Health Quality Advisory Committee's (MHQAC's) recommended utilization edits for mental health medications were implemented. Please refer to Provider Bulletin *BT200709*. The utilization edits are reviewed quarterly and the following changes and additions in Table 5 will be effective October 20, 2008.

Table 5 – Updates to Utilization Edits

Name of Medication and Strength	Utilization Edit
Lexapro 20mg tablet	One and a half per day
Luvox CR 100mg, 150mg capsules	Two per day
Pristiq 50mg, 100mg tablets	One per day
Sarafem 10mg, 20mg tablets	One per day
Vyvanse 20mg, 40mg, 60mg capsules	One per day

Dental Providers

Dental Paper Claim Form Billing Clarification

Provider bulletin *BT200705* outlined the new American Dental Association (ADA) 2006 paper claim form changes and requirements. All ADA 2006 Dental claim forms must contain the billing provider National Provider Identifier (NPI) in form locator 49. Group practices (those with multiple dentists) are required to indicate the rendering provider NPI in form locator 54.

BT200705 states form locator 50, which is labeled *License Number*, is to contain the billing provider Legacy Provider Identifier (LPI). Claims that contain any number other than the billing provider LPI are returned to the provider unprocessed. Currently, claims are processed when the NPI and LPI are indicated on the paper claim form. In the future, claims will be denied when the LPI is present on the claim. To assist providers with the upcoming transition, the IHCP recommends that form locator 50 remain blank.

All Home Health Providers

Clarification of Billing for Non-waiver Services

Home and Community-Based Services (HCBS) Waiver providers who are also enrolled as non-waiver Medicaid providers must report the billing taxonomy code on all claims for non-waiver services. The billing taxonomy code should be indicated in box 33b of the CMS-1500 claim form and must be preceded by the "ZZ" qualifier. Claims submitted without the taxonomy code for non-waiver services will be processed under your HCBS Waiver billing LPI and will deny with edit 1012 – *Rend Prov Specialty not Eligible to Render Proc Code*. Claims that deny with this edit must be resubmitted with the billing taxonomy code.

As a reminder, claims for waiver services may be submitted with the LPI only; the NPI is not required for these claims.

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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