IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201149 DECEMBER 6, 2011

IHCP to adopt 2012 Medicare rates for select clinical laboratory services

Pursuant to Section *1903(i)(7)* of the *Social Security Act*, Medicaid reimbursement for individual clinical laboratory procedures cannot exceed the Medicare rate of reimbursement. Therefore, in accordance with the clinical laboratory reimbursement methodology set out in *405 IAC 5-18-1* and in the approved Medicaid State Plan (Attachment 4.19B, page 2), the Indiana Health Coverage Programs (IHCP) will adopt the 2012 Medicare rates for any clinical laboratory procedure code for which the IHCP's current reimbursement rate exceeds the 2012 Medicare rate. The 2012 Medicare clinical laboratory fee schedule is expected to be available on the Centers for Medicare & Medicaid Services (CMS) website at cms.gov in mid-December, after which time, the IHCP will publish the affected clinical laboratory procedure codes and rates. The rate changes will be effective for dates of service on or after January 1, 2012.

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Claims for certain procedure-coded drugs submitted to MCEs must include NDCs

Effective for dates of service on or after January 1, 2012, in compliance with the *Federal Deficit Reduction Act of 2005*, claims submitted to Indiana Health Coverage Programs (IHCP) managed care entities (MCEs) containing certain procedure-coded drugs must include the product's National Drug Code (NDC).

The *Federal Deficit Reduction Act of 2005* mandated the submission of NDCs on claims submitted for certain procedure-coded drugs. The IHCP implemented these requirements for fee-for-service (FFS) professional claims effective August 1, 2007 (see BT200713), and for FFS outpatient claims effective July 1, 2008 (see BT200731). Procedures for billing compound drugs and multiple NDCs for the same Healthcare Common Procedure Coding System (HCPCS) code on FFS claims were further clarified in BT200908, effective April 1, 2009.

To comply with the legislation, for dates of service on or after January 1, 2012, providers must submit the product NDC, the NDC unit of measure (UOM), and NDC quantity of units, along with the procedure code, when submitting claims to IHCP MCEs for certain procedure-coded drugs. This applies to drugs dispensed in both professional (medical) and institutional (facility) outpatient settings. A list of the procedure codes that require NDCs is located on indianamedicaid.com. This list is updated quarterly.

The bulletins referenced previously provide general information regarding billing requirements. Each MCE will also send provider communications with specific billing instructions. Contact the following MCE provider help lines for answers to your NDC billing or other questions:

MDwise
1-800-356-1204; (317) 630-2831

Anthem
1-866-408-6132; fax: 1-866-408-7087

Managed Health Services (MHS)
1-877-647-4848; fax: 1-866-912-4244

CPT code 88112 linked to revenue codes 310, 311, and 319

Effective January 6, 2012, for dates of service on or after April 1, 2011, the Indiana Health Coverage Programs (IHCP) has linked Current Procedural Terminology (CPT®[1]) code 88112 – *Cytopathology, selective cellular enhancement technique with interpretation* to revenue codes 310 – *Pathology Lab*; 311 – *Pathology/Cytology*; and 319 – *Pathology/ Other*. For reimbursement, providers must bill the procedure code with the Technical Component (TC) modifier and the revenue code. The maximum reimbursement rate for CPT code 88112 will be $36.48.

Providers with claims for CPT code 88112 billed with modifier TC and revenue code 310, 311, or 319, for dates of service on or after April 1, 2011, that denied with error code 6000 – *Manual pricing required* or error code 520 – *Invalid revenue code/procedure code combination* may resubmit those claims.

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QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

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