IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201244 OCTOBER 30, 2012

Timely completion of revalidation packets is critical

All providers enrolled in the Indiana Health Coverage Programs (IHCP) are now required to periodically revalidate their enrollment. For most, revalidation is required at intervals not to exceed five years. Suppliers of durable medical equipment (DME) and home medical equipment (HME), and pharmacy providers with a DME or HME specialty must revalidate at three-year intervals.

The revalidation process involves completing the IHCP Provider Enrollment Packet and mailing it to HP Provider Enrollment before the revalidation due date. Notification of each provider's revalidation due date is sent to the *Mail To* address on file with the IHCP 90 days in advance. A second reminder is mailed 60 days before the due date. The revalidation due date is the same as the end-date for the provider's current enrollment. Providers are encouraged to submit revalidation paperwork before the deadline to allow for processing. Providers are also encouraged to keep their *Mail To* addresses up-to-date so notices are received. In addition to individual mailings, the Provider Profile feature of Web interChange includes a list of providers currently due for revalidation.

These notification efforts are intended to ensure providers revalidate in a timely manner. Failure to do so will have negative consequences:

- Enrollment in the IHCP will be end-dated as of the revalidation deadline.
- Claims with dates of service on and after the enrollment end-date cannot be paid; even if the provider is re-enrolled, services rendered by the provider during the "enrollment gap" − the time between the end-date of the initial enrollment and the start-date of the new enrollment − cannot be paid.

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- Managed care primary medical providers (PMPs) may lose their panels, as members are reassigned to active PMPs.
- Providers that must re-enroll will be required to pay an enrollment fee, if applicable.

The IHCP encourages you to submit your revalidation paperwork as soon as possible after receiving your first notification letter. Don't delay.

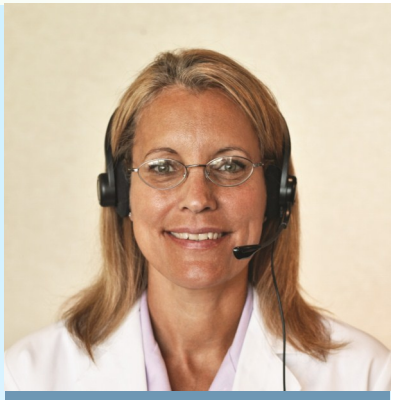
Skin-substitute procedure codes linked to revenue code 636

For dates of service (DOS) on or after December 1, 2012, the Indiana Health Coverage Programs (IHCP) has linked the following covered Healthcare Common Procedure Coding System (HCPCS) codes for skin substitutes to revenue code 636 – *Codes requiring detailed coding*. For reimbursement consideration, providers may bill the procedure code and revenue code together, as appropriate, for DOS on or after December 1, 2012.

Skin-substitute procedure codes linked to revenue code 636 for DOS on or after December 1, 2012

HCPCS code	Description
Q4100	Skin substitute, not otherwise specified
Q4103	Oasis Burn Matrix, per square centimeter
Q4104	Integra Bilayer Matrix Wound Dressing (BMWD), per square centimeter
Q4105	Integra Dermal Regeneration Template (DRT), per square centimeter
Q4107	Graftjacket, per square centimeter
Q4108	Integra Matrix, per square centimeter
Q4110	Primatrix, per square centimeter
Q4111	GammaGraft, per square centimeter
Q4118	Matristem micromatrix, 1 mg
Q4121	Theraskin, per square centimeter

The IHCP outpatient surgery reimbursement methodology remains unchanged – outpatient surgeries are reimbursed at an all-inclusive rate that includes reimbursement for related procedures.



Last call – MDS 3.0 Case Mix Audit Review, SDGs, and PASRR online training!

Online training sessions on the Minimum Data Set (MDS) 3.0 Case Mix Audit Review, the Supportive Documentation Guidelines (SDGs), and Pre-Admission Screening Resident Review (PASRR) are scheduled for October 31 and November 1, 2012. Sessions run from 10-11 a.m. The training will be presented via HP Virtual Room and combined with an audio conference telephone number. For more information, see the MDS 3.0 page on indianamedicaid.com.

Manual pricing for genetic testing codes

Effective December 1, 2012, the following Current Procedural Terminology (CPT®[1]) codes for genetic testing will be manually priced at 90% of billed charges. This pricing will apply retroactively to dates of service on or after April 1, 2012. Providers may resubmit claims for retroactive dates of service for reprocessing.

Genetic testing codes manually priced at 90% of billed charges effective December 1, 2012

CPT code	Description
81211	BRCA1, BRCA2 (breast cancer 1 and 2) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants in BRCA (i.e., exon 13 del 3.835kb, exon 14-20 del 26kb, exon 22 del 510 bp, exon 8-9 del 7.1kb)
81212	185delAG, 5385insC, 6174delIT variants
81213	Uncommon duplication/deletion variants
81214	BRCA1 (breast cancer 1) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants (i.e., exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)
81215	Known familial variant
81216	BRCA2 (breast cancer 2) (e.g., hereditary breast and ovarian cancer) gene analysis; fill sequence
81217	Known familial variant
81251	GBA (glucosidase, beta, acid) (e.g., Gaucher disease) gene analysis, common variants (e.g., (N370S, 84GG, L444P, IVS+1G>A)
81255	HEXA (hexosaminidase A [alpha polypeptide]) (e.g., Tay-Sachs disease) gene analysis, common variants (e.g., 1278insTATC, 1421+1G>C, G269S)
81280	Long QT syndrome gene analysis (e.g., KCNQ1, KCNH2, SCN5A, KNCE1, KNCE1, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, and ANK2); full sequence analysis
81281	Long QT syndrome gene analysis (e.g., KCNQ1, KCNH2, SCN5A, KNCE1, KNCE1, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, and ANK2); known familial sequence variants
81282	Long QT syndrome gene analysis (e.g., KCNQ1, KCNH2, SCN5A, KNCE1, KNCE1, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, and ANK2); duplication/deletion variants

Consistent with coding guidelines, providers may be reimbursed once per lifetime, per member, for only one of the procedure codes in the following code pairs:

- CPT code 81211 or 81214
- CPT code 81211 or 81216

If both codes in the code pair are billed, one of the codes will deny for explanation of benefits (EOB) 6376 – *81214 or 81216 will not pay if 81211 has ever been paid*.

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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