IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR201631 AUGUST 2, 2016

IHCP updates system to require NDCs for certain physician-administered drugs

The Federal Deficit Reduction Act of 2005 mandates that the Indiana Health Coverage Programs (IHCP) require the submission of National Drug Codes (NDCs) on claims billing certain procedure codes for physician-administered drugs. This mandate applies to claims under all IHCP programs, whether managed care or fee-for-service (FFS). The Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 1 are included in the codes that must be billed with an NDC.

The IHCP has identified that the FFS claims processing system does not currently require an NDC when adjudicating claims for the codes in Table 1. Effective September 2, 2016, the FFS system will be updated to require an NDC be included on the claim when billing these codes. This change will apply to dates of service (DOS) on or after September 2, 2016. FFS claims submitted for these HCPCS codes for the indicated DOS without an NDC will deny with explanation of benefit (EOB) 217 – *NDC number is missing – an NDC number can be up to eleven numeric characters. For further information, see the pharmacy chapter in your provider manual. Please provide and resubmit.*

Table 1 – Procedures codes that must be billed with an NDC on FFS claims effective for DOS on or after September 2, 2016

Procedure Code	Description
J0716	Injection, Centruroides immune f(ab)2, up to 120 mg
J0840	Injection, crotalidae polyvalent immune fab (ovine), up to 1 g
J1590	Injection, gatifloxacin, 10 mg
J7330	Autologous cultured chondrocytes, implant
J7518	Mycophenolic acid, oral, 180 mg
J9031	BCG (intravesical) per instillation
J9320	Injection, streptozocin, 1 g

This information will be reflected in the next update to the *Procedure codes that Require NDCs* on the *Code Sets* web page at indianamedicaid.com.

MORE IN THIS ISSUE

IHCP updates CLIA procedure codes and mass adjusts/ reprocesses claims

Procedure codes associated with laboratory testing are regulated under the Clinical Laboratory Improvement Amendment (CLIA). Indiana Health Coverage Programs (IHCP) policy requires compliance with the Centers for Medicare & Medicaid Services (CMS) recommendations regarding CLIA regulations under all IHCP programs, whether managed care or fee-for-service (FFS).

The IHCP identified inconsistencies in its FFS claims processing system with respect to the classification of certain Current Procedural Terminology (CPT ®1) and Healthcare Common Procedure Coding System (HCPCS) codes. Effective September 2, 2016, the FFS system will be updated to make the following changes to correct these inconsistencies:

- The procedure codes in Table 2 were considered CLIA-waived tests as of January 1, 2016. Claims for these codes with dates of service (DOS) on or after that date should be billable by laboratories who qualify for the CLIA certificate of waiver. The FFS claims processing system will be updated to classify the codes in Table 2 as CLIA-waived tests. This change will be retroactively effective for DOS on or after **January 1, 2016**.
- The procedure codes in Table 3 are no longer CLIA-regulated tests. Claims for these codes should not be subject to CLIA edits. The FFS claims processing system will be updated to remove the codes in Table 3 as CLIA-regulated tests. This change will be retroactively effective for DOS on or after **January 1, 2015**.

Table 2 – Procedure codes added as CLIA-waived tests effective for DOS on or after January 1, 2016

Procedure Code	Description
86780	Antibody; Treponema pallidum
87502	Detection test for multiple types influenza virus
87389	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result
87650	Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, direct probe technique
87651	Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, amplified probe technique
87806	Detection test for HIV-1
G0472	Hepatitis C antibody screening, for individual at high risk and other covered indication(s)
G0477	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service

continued

Table 3 – Procedure codes removed as CLIA-regulated tests for FFS claims effective for DOS on or after January 1, 2015

Procedure Code	Description
88738	Hemoglobin (Hgb), quantitative, transcutaneous
88740	Hemoglobin, quantitative, transcutaneous, per day; carboxyhemoglobin
88741	Hemoglobin, quantitative, transcutaneous, per day; methemoglobin
89049	Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report

FFS claim details billed for the procedure codes in Table 2 or Table 3 that denied for explanation of benefits (EOB) 4208 – *Invalid CLIA certification/procedure code combination* will be mass adjusted or mass reprocessed. Providers should begin seeing adjusted or reprocessed claims on Remittance Advices (RAs) beginning September 20, 2016, with internal control numbers that begin with 56 (mass adjusted) or 80 (mass reprocessed).

QUESTIONS?

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