IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201636 SEPTEMBER 6, 2016

IHCP reminds providers lead screening is required for children

The Indiana Health Coverage Programs (IHCP), in collaboration with the Indiana State Department of Health (ISDH), reminds providers that screening for blood lead toxicity is a federal requirement for all children enrolled in Medicaid.

The IHCP requires that all enrolled children receive a blood lead screening test at 9 months, 12 months, and 24 months of age. If the member is at high risk for lead exposure, the initial screening should be performed at the 6-month visit. Children between the ages of 36 months and 72 months of age must receive a blood lead screening if they have not been previously tested for lead poisoning.

The ISDH, through the Indiana Lead and Healthy Homes Program (ILHHP), monitors lead poisoning. Providers are required to report ***all*** results of blood lead screenings to the ISDH no later than one week after completing the examination. The ILHHP provides medical and environmental case management follow-up for those children who are identified with elevated levels of lead in their blood.

IHCP coverage and billing

Prior authorization is not required for coverage of screening services. Providers should reference the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch provider reference module for billing guidance.

IHCP will mass adjust chiropractor claims for spinal x-rays that paid incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claims processing issue that affects certain fee-for-service (FFS) claims billed by chiropractors for dates of service (DOS) on or after January 1, 2016. Component spinal x-rays are individually reimbursable; however, if components are billed separately, total reimbursement is limited to the allowable amount for the full series of spinal x-rays. With the 2016 annual Healthcare Common Procedure Coding System (HCPCS) update, effective January 1, 2016, the rate for a full series of spinal x-rays changed from $56.60 to $43.75, due to national coding changes. The reimbursement limitation was not revised accordingly in the claims processing system.

continued

MORE IN THIS ISSUE

- NDC code no longer required for HCPCS code J7327

The claims processing system has been corrected. Chiropractor claims for codes in Table 1 with DOS on or after January 1, 2016, that paid in excess of $43.75 with the following explanations of benefit (EOBs) will be mass adjusted:

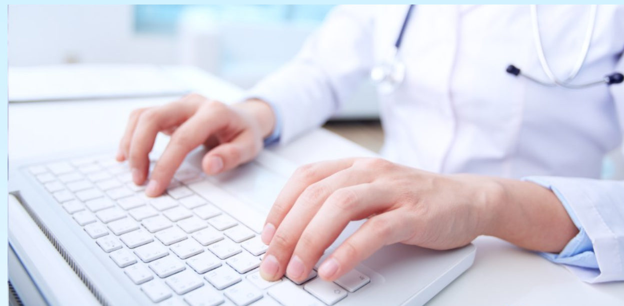
- 9058 – *Service is priced by RBRVS fee*
- 6323 – *Maximum reimbursement for any combination of spinal series x-ray components to a chiropractor is $56.60 per year*

Providers will begin seeing the adjusted claims on the Remittance Advice (RA) dated October 18, 2016, identified with internal control numbers (ICNs) that begin with region codes 56 (mass adjusted). If a claim was overpaid, the net difference appears as an accounts receivable. The accounts receivable will be recouped at 100% from future claims paid to the respective provider number.

Table 1 – Chiropractic codes that may have paid incorrectly based on the reimbursement limitation for spinal x-rays for DOS on or after January 1, 2016

Procedure Code	Description
72020	Radiologic examination, spine, single view, specify level
72040	Radiologic examination, spine, cervical; 2 or 3 views
72050	Radiologic examination, spine, cervical; 4 or 5 views
72052	Radiologic examination, spine, cervical; 6 or more views
72070	Radiologic examination, spine; thoracic, 2 views
72072	Radiologic examination, spine; thoracic, 3 views
72074	Radiologic examination, spine; thoracic, minimum of 4 views
72080	Radiologic examination, spine; thoracolumbar, 2 views
72081	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view
72082	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); 2 or 3 views
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views
72110	Radiologic examination, spine, lumbosacral; minimum of 4 views
72114	Radiologic examination, spine, lumbosacral; complete, including bending view, minimum of 6 views
72120	Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views

NDC code no longer required for HCPCS code J7327



Effective October 6, 2016, a National Drug Code (NDC) will no longer be required when billing Healthcare Common Procedure Coding System (HCPCS) code J7327 – *Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose*. This change applies retroactively to fee-for-service (FFS) claims with dates of service (DOS) on or after **January 1, 2015**.

Beginning October 6, 2016, providers may resubmit claims for DOS on or after January 1, 2015, that previously denied for the following explanations of benefits (EOBs) for reimbursement consideration:

- 0217 – *NDC missing*
- 4004 – *NDC not on file*
- 4300 – *Invalid NDC to procedure code combination*

Claims resubmitted beyond the original one-year filing limit must include a copy of this banner page as an attachment and must be filed within one year of the publication date.

This change will be reflected in the *Procedure Codes that Require NDCs* code table on the *Code Sets* web page at indianamedicaid.com.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-577-1278.

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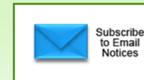

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