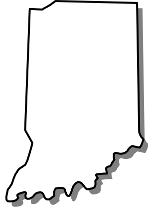

BANNER PAGE

BR200544 NOVEMBER 1, 2005

To All Providers:

- On November 1, 2005, the IHCP will implement the Prior Authorization Web application, which will allow providers the capability of submitting non pharmacy prior authorization requests and to inquire on requests via the Web interchange. Providers can continue submission of PA requests on paper, phone or fax and should continue to follow existing policies when submitting PA requests. Please note, to inquire on existing PAs, providers will need to have a PA number or be the requesting or service provider of the PA. Providers who can submit requests are doctors, dentists, home health agencies, hospice, optometrists, health service providers in psychology (H.S.P.P.), chiropractors, hospitals, and transportation providers. Detailed information on the usage of this new Web application can be obtained by accessing www.indianamedicaid.com

- The Indiana Health Coverage Programs (IHCP) currently covers three types of stereotactic radiosurgery (SRS) as represented by Healthcare Common Procedure Coding System (HCPCS) codes G0173, G0242, and G0251. In addition, the IHCP covers pre-operative planning under HCPCS code G0243 or G0338. Reimbursement for physician services is bundled into the pre-operative planning service.

  Currently, all SRS procedures are manually priced by the IHCP. In order to more closely align IHCP pricing with Medicare, the IHCP will amend pricing for SRS procedures as reflected in **Table 1** below, effective December 15, 2005. Providers must bill SRS therapy and pre-operative planning with revenue code 333 on the UB-92 claim form or 837I transaction.

Table 1 – New IHCP SRS Reimbursement Rates, Effective December 15, 2005

Code	Description	Reimbursement
G0173	Linear accelerator based stereotactic radiosurgery, complete course of therapy in one session	$5,250
G0242	Multi-source photon stereotactic radiosurgery (cobalt 60 multi-source converging beams) plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment	$1,450
G0243	Multi-source photon stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, all lesions	$5,250
G0251	Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum five sessions per course of treatment	$1,150
G0338	LINAC based stereotactic radiosurgery plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course	$1,450

	of treatment	

Providers should direct questions to customer assistance at (317) 655-3240 in the Indianapolis local area or toll free at 1-800-577-1278.

- Currently, the Vaccines For Children (VFC) program cannot distribute a sufficient supply of TdaP and MCV4 vaccines to all VFC-participating providers. Due to this shortage crisis, the Indiana Health Coverage Programs (IHCP) is not limiting reimbursement for TdaP, Tetanus diphtheria toxoids and acellular pertussis vaccine (CPT 90715 – Adecel and Boostrix) and MCV4, meningococcal conjugate vaccine, tetravalent (CPT 90734 – Menactra) to the VFC Vaccine Administration Fee of $8.00 or less. This policy allows providers to obtain reimbursement for using privately purchased TdaP or meningococcal vaccines if they cannot obtain a VFC vaccine. When administering privately purchased TdaP or meningococcal vaccines, providers may bill for the cost of the vaccine plus its administration, and the IHCP-allowable reimbursement will include payment for both.

> *Note: If a provider administers a free VFC vaccine, the provider should bill the appropriate TdaP or meningococcal vaccine procedure code but not charge more than the $8.00 VFC vaccine administration fee, and not bill the separate administration CPT code.*

When a provider administers immunizations using the provider's private stock, refer to IHCP provider bulletin *BT200151* for use of the administration code 90782 *(*Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular)*,* as appropriate, for the additional $2.84 rate.

- To address an immediate need for immunizations and a shortage of available influenza vaccines, the IHCP is not limiting reimbursement for any influenza vaccines, regardless of availability from the VFC program. This policy will allow providers to obtain reimbursement for using a privately purchased influenza vaccine if they do not have a VFC vaccine due to the shortage crisis. When administering a privately purchased influenza vaccine, providers may bill for both the cost of the vaccine plus its administration, and the IHCP-allowable reimbursement will include payment for both. Refer to banner page *BR200442*, published October 19, 2004, regarding detailed billing instructions when administering private stock.
- The Centers for Medicare and Medicaid Services (CMS) is consolidating the Medicare crossover process under a new Coordination of Benefits Agreement (COBA) initiative. In this initiative, CMS is contracting with one national Coordination of Benefits Contractor (COBC) to handle all crossover processing. The IHCP will begin working with the COBC on January 1, 2006. The COBC will consolidate adjudication data from each of the Medicare intermediaries and send one transmittal of crossover adjudicated claims to the IHCP. Crossovers should continue to process as they do today, but because the interface is changing, providers need to monitor their crossover claims to ensure the process is working as expected.

  Additional information regarding this change will be published in the IHCP monthly provider newsletter, provider bulletins, or the banner page. For more information about the initiative and to obtain a listing of CMS's suggestions, visit http://www.cms.hhs.gov/medicare/cob/coba/coba.asp.

To All Pharmacies and Prescribing Providers:

- IHCP provider bulletin *BT200521*, published September 30, 2005, advised providers of the following change to the Preferred Drug List (PDL) that was to be effective November 1, 2005, as shown in Table 1.

Table 1 – PDL Information from *BT200521*

Fibric Acid Derivatives	Antara	Non-Preferred
Fibric Acid Derivatives	Tricor	Non-Preferred
Fibric Acid Derivatives	Triglide	Non-Preferred

Subsequently, the manufacturer of generic fenofibrate, one of the recommended preferred agents, advised that it would no longer manufacture the product. For that reason, the Drug Utilization Review (DUR) Board has requested that the Therapeutics Committee re-review the fibric acids class. In the interim and until providers are

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notified of the final PDL determinations regarding the fibric acids class, PDL status of the products will be the same as previous, as shown immediately below:

Table 2 – FIBRIC ACIDS (M4E)

Preferred Drugs		**Non-Preferred Drugs**	
gemfibrozil	May 14, 2003	Lofibra 67mg caps	May 14, 2003
Lofibra 200mg caps	May 14, 2003	Lofibra 134mg caps	May 14, 2003
TriCor 160mg tabs	May 14, 2003	Lopid*	May 14, 2003
TriCor 145mg tabs	May 14, 2003	TriCor 54mg tabs	May 14, 2003
		TriCor 67mg caps	May 14, 2003
		TriCor 134mg caps	October 26, 2004
		TriCor 200mg caps	October 26, 2004

Providers who have paper copies of BT200521, should make a note of the information in Table 2 on that copy to reflect the correct PDL status of this class. Updated information will follow, as necessary.

Please direct prior authorization requests and questions about the PDL to the ACS Clinical Call Center at 1-866-879-0106.

- Effective January 1, 2006, the CMS is implementing the new Medicare prescription drug coverage. This coverage, also known as Medicare Part D, is a new benefit to help Medicare members pay for prescription drugs.

  The IHCP Web site now includes a new section titled *Medicare Prescription Drug Coverage*. Providers should visit this section periodically at http://www.indianamedicaid.com/ihcp/ProviderServices/medicareD.asp for the latest information. The annual IHCP Seminar and fourth quarter provider workshops will include materials and training about the new Medicare prescription drug benefit.

  For more information about the Medicare prescription drug benefit visit the CMS Web site at http://www.cms.gov/medicarereform/

To All Podiatrists:

- The Health Care Excel Surveillance and Utilization Review (SUR) Department identified utilization issues related to podiatrists inappropriately billing multiple units of Current Procedural Terminology (CPT®) codes 99201-99203 for new patient visits and CPT codes 99211-99213 for established patient visits.

  Office visits for podiatry services are limited to the following:

  – New patient office visits – Limited to one visit per member, per provider, every three years, using CPT codes 99201, 99202, or 99203.
  – Office visits – Limited to one visit per member, per 12 months, without obtaining PA, using CPT codes 99211, 99212 or 99213.

  This information can be found in the *IHCP Provider Manual, Chapter 8, Section 3*, and in the Indiana Administrative Code (IAC), *405 IAC 5-26-7*.

  SUR is advising all providers to carefully review claims submitted to the IHCP to ensure proper billing of units for these services. The SUR Department is conducting a review of claims to determine any inappropriate reimbursement and recoup overpayments. If a provider identifies overpayments related to these errors, the provider should file an adjustment or contact the SUR Department to arrange for repayment.

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