IMPORTANT INFORMATION

BR200420 MAY 18, 2004

To All Providers:

- Remittance advices (RA) dated January 6, 2004, through April 27, 2004, may have claims inappropriately denied for explanation of benefits (EOB) *6011 – Professional or technical component not separately reimbursable when payment has been made for the complete procedure on the same date of service*. The claims in questions were billed with modifiers TC and 26. The system has been updated and the denied claims will be mass adjusted and will begin appearing on the May 25, 2004, RA. Please direct questions to the Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

To Pharmacy Providers and Prescribing Practitioners:

- Effective June 17, 2004, the preferred drug list (PDL) for non-sedating antihistamines will be changed for the Indiana Health Coverage Programs (IHCP), as referenced in banner pages, *BR200234, BR200235*, and IHCP provider bulletin*, BT200403*. In addition, selected prospective drug utilization review edits will be modified.

  All strengths and formulations of over the counter (OTC) Loratadine will be added to the PDL.
  - A step edit will be implemented for all Allegra® products. Patients must have failed a two-week trial of OTC Loratadine within the previous 3 months. Patients with current prescriptions for Allegra® products are subject to the edit unless they have failed the two-week trial of OTC Loratadine within the previous 3 months. Existing prior authorizations (PA) for non-preferred products will be honored through their expiration date.
  - Zyrtec® syrup remains on the PDL for children 6 years old and under.

  Claims subject to this edit will reject with edit *3017 – NDC Not on preferred drug list*, and will require a PA. Prescribers may request a PA by calling the ACS Clinical Call Center at 1-866-879-0106 or by completing the fax form available at http://www.indianapbm.com .

  In addition, the ProDUR edits: HD, high dose, and TD, therapeutic duplication, will undergo a change from the current "hard edit – requiring a PA" to a "soft edit – informational with point of sale (POS) override allowed by the pharmacy provider." This change applies to all therapeutic classes previously subjected to prior authorization.
- In the IHCP provider bulletin, *BT200409*, published May 3, 2004, the Office of Medicaid Policy and Planning (OMPP) announced a new policy requiring pharmacy providers to dispense a 90-day supply of selected maintenance medications. This policy change was to be effective on May 25, 2004. The purpose of this article is to announce the postponement in implementation of this policy.

  In consideration of concerns recently raised to OMPP and ACS regarding the possible impact of the new policy on a subset of the patient population, OMPP has elected to postpone implementation of this initiative pending further research and investigation of the expressed concern. Providers will be given proper notice of the revised implementation date, as soon as it has been confirmed.

  Please direct questions regarding this new policy and article to the ACS Pharmacy Services Helpdesk at 1-866-645-8344.

To Mental Health Providers, Mental Health Clinics, and Community Mental Health Centers:

- The IHCP has identified the following modifiers for the billing of mental health services rendered by a mid-level practitioner under the supervision of a physician, psychiatrist, or HSPP as indicated in field 24K of the *CMS-1500 Claim Form.* These modifiers must be used with the appropriate procedure code and are as follows:
  - AH – services provided by a clinical psychologist
  - AJ – services provided by a clinical social worker
  - HE in conjunction with SA – services provided by a nurse practitioner or clinical nurse specialist
  - HE – services provided by any other mid-level practitioner as addressed in *405 IAC 5-25*

  Claims billed for mid-level practitioner services and billed with the modifiers noted above will reimburse 75% of the IHCP allowed amount for the procedure code identified. Claims previously billed for mid-level practitioner services without a modifier and paid at 100% of the fee schedule must be adjusted to add the applicable modifiers. Community Mental Health Centers must continue to use the HW modifier to denote MRO services in addition to the modifiers listed above that identify the qualifications of the individual rendering the service. Modifiers are placed in locator 24D, under the modifier heading on the *CMS-1500 Claim Form.*

To Durable Medical Equipment, Pharmacies, and Medical Supply Providers:

- In the IHCP banner page, *BR20019*, published May 11, 2004, there was an article concerning the Indiana Medicaid Statewide Maximum Allowable Fee (maxfee) Schedule for Medical Supplies. In that article, Table 1 listed the maxfee effective date of June 25, 2004, for codes A4215, A6260, A7507, A7525, and A7526. The effective date of the maxfees for these codes should have been May 11, 2004.

To Nurse Practitioners, Clinical Nurse Specialists, Clinics, Physicians, and Physician Assistants:

- The proper billing procedures for billing nurse practitioner and physician assistant services are as follows:
  - Nurse Practitioners – Independently practicing nurse practitioners are reimbursed at 75 percent of the rate on file. The nurse practitioner provider number is included in Locators 24K and 33 of the *CMS-1500 Claim Form.*
  - Nurse practitioners, not individually enrolled in the IHCP, and clinical nurse specialists employed by physicians, in a physician directed group or clinic, bill services with the SA modifier and the physician number in locators 24K and 33 and are reimbursed at 100 percent of the Medicaid allowed amount.
  - Nurse practitioners, with an individual provider number, and employed by a physician(s) should bill using their provider number in locator 24K and the billing group number in locator 33 and are reimbursed at 100 percent of the Medicaid allowed amount.
  - Nurse practitioner services in outpatient hospital settings are not separately billable and are included in the hospital outpatient reimbursement rate.
  - Physician Assistants – Physician assistant services are billed with the HN, bachelors degree, or HO, masters degree, modifier applicable to the level of education of the physician assistant, the physician number in locators 24K and 33, and are reimbursed at 100 percent of the Medicaid allowed amount. Physician assistants are not separately enrolled in the IHCP. However, when a physician assistant provides assistant surgeon services, modifier AS should be used in lieu of the HN or HO modifier. For additional information about billing assistants with surgery claims, please refer to IHCP banner page, *BR200218,* published April 30, 2002.

  Modifiers are placed in locator 24D, under the modifier heading on the *CMS-1500 Claim Form.*

To Dental Providers:

- The *American Dental Association (ADA) CDT-4* book is the current coding reference for dental providers. The ADA distinguishes a sealant from a preventative resin restoration on page 91 of this book as:

  > "If the caries is limited to the enamel, it is still considered a sealant. If the decay penetrates the dentin, then this is considered a restorative procedure."

  IHCP providers should only bill for resin restorations when decay has penetrated the dentin. If only the enamel is affected, the procedure should be billed as a sealant. Pursuant to *405 IAC 5-14-5*, sealants for molars and premolars are covered for members under 21 years old, and limited to one per tooth, per member, per lifetime. Sealants are not a covered service for members 21 years old and older. Dental providers are responsible for maintaining documentation that supports the level of dental decay and the procedure performed when billing these services.

  Please direct any questions about this policy to Health Care Excel (HCE), Medical Policy, at (317) 347-4500.

To Chiropractors and Chiropractic Clinics:

- The IHCP published changes to chiropractic services on May 1, 2003, in IHCP provider bulletin *BT200323*. In this IHCP provider bulletin, ICD-9-CM diagnosis code *723.51 –Torticollis, unspecified*, was listed incorrectly as a secondary ICD-9-CM diagnosis code for chiropractic services. The diagnosis code should read *723.5 – Torticollis, unspecified*.

To Home Health Providers:

- Home health providers that bill like services for the same date of service (DOS) must be billed on the UB-92 claim form on one line. Separate lines that are billed for the same service with the same DOS will deny for explanation of benefits *5001—exact duplicate*. For example: line one billed with DOS of May 5, 2004, revenue code 552 HCPCS code 99600TE ten units. Line two billed with DOS May 5, 2004, revenue code 552 HCPCS code 99600TE seven units. Line two will deny as an exact duplicate of line one. Line one should have been billed as DOS May 5, 2004, revenue code 552 HCPC 99600TE 17 units. For questions, please contact Customer Assistance at (317)655-3240 in the Indianapolis local area or 1-800-577-1278.