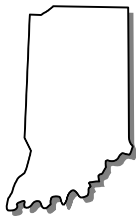

I M P O R T A N T  I N F O R M A T I O N

BR200422 JUNE 1, 2004

## To All Providers:

- Effective June 1, 2004, the Indiana Health Coverage Programs (IHCP) has implemented changes to the eligibility verification system (EVS). These changes have resulted in the ability of chiropractic, dental, and durable medical equipment (DME) providers to inquire about additional benefit limitations, and for all providers to receive additional level of care information in the eligibility response system. In addition, nursing home residency information, and the level of care information provided by the EVS will also identify hospice or waiver level of care. For in-depth articles about this EVS update, please refer to the *IHCP Monthly Newsletter* published May 15, 2004.

  The automated voice response system (AVR) and Web interChange will be updated automatically with no provider action required. Providers using the OMNI system must download new OMNI software available June 1, 2004, that includes these updates. Complete download instructions are available in IHCP provider bulletin, *BT200303,* published January 31, 2003*,* and is available at www.indianamedicaid.com. Providers using other software packages for batch or other interactive 270/271-eligibility verification must contact their software vendors to ensure that the correct software is being used.

  Providers requiring specific information about dates of each level of care segment and the specific type of hospice or waiver assignment must contact the Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278. If a specific level of care cannot be identified for the period searched, providers may contact Health Care Excel (HCE) for hospice level of care or the waiver or long-term care units at the OMPP for the appropriate information.

- Remittance advices (RA) dated May 4, 2004, through May 18, 2004, may have claims inappropriately denied for explanation of benefits (EOB) *0399 – The referring provider number is not in a valid format*. The system has been updated and the denied claims will be reprocessed and will begin appearing on the May 25, 2004, RA. Please direct questions to the Customer Assistance Unit at (317) 655-3240 in the local Indianapolis area or 1-800-577-1278.

## To Pharmacy Providers and Prescribing Practitioners:

- Effective May 26, 2004, the State Maximum Allowable Cost (SMAC) rate for the following drug group has been updated.

| Group | Drug Group Name | SMAC |
|---|---|---|
| 25 | ORPHENADRINE 100MG TAB SA | $0.6388 |

  Please direct questions concerning the SMAC to the Myers and Stauffer Pharmacy Unit at 317-846-9521 or 1-800-877-6927, or by e-mail at pharmacy@mslc.com.

## 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 percent 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 percent 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 Providers:

- Healthcare Common Procedure Coding System (HCPCS) durable medical equipment (DME) codes K0023, K0024, K0040, K0043, K0044, K0045, K0059, K0064, and K0106 are wheelchair accessory codes that will be covered by the IHCP, effective May 25, 2004. Providers should immediately discontinue the use of E1399 for these specific wheelchair accessories. Prior Authorization is not required for these wheelchair accessories.
  HCPCS code *K0045 – Footrest, complete assembly*, includes a footplate, extension tube, and an upper hanger bracket. Therefore, *K0043 – Footrest, lower extension tube each*, and *K0044 – Footrest, upper hanger bracket, each*, are not separately reimbursable when billed on the same date of service as K0045.

The following table lists the HCPCS K codes with their descriptions, appropriate modifiers, and current pricing.

| HCPCS Code | Description | Modifiers | Max Fee Purchase | Max Fee Rental |
|---|---|---|---|---|
| K0023 | Solid back insert, planar back, single density foam, attached with straps | NU | $94.09 | |
| K0024 | Solid back insert, planar back, single density foam, with adjustable hook-on hardware | NU | $111.38 | |
| K0040 | Adjustable angle footplate, each | NU, RR | $74.67 | $7.45 |
| K0043 | Footrest, lower extension tube, each | NU | $19.53 | |
| K0044 | Footrest, upper hanger bracket, each | NU | $16.64 | |
| K0045 | Footrest, complete assembly | NU | $56.62 | |
| K0059 | Plastic coated handrim, each | NU | $31.72 | |
| K0064 | Zero pressure tube, flat free insert, any size, each | NU | $30.41 | |
| K0106 | Arm trough, each | NU, RR | $107.16 | $10.74 |

For wheelchairs owned by nursing facilities and intermediate care facilities for the mentally retarded (ICF/MR), the accessory items listed in the table above are not separately reimbursable. Under no circumstances should DME and medical supply items that are included in the per diem be billed separately by the facility provider or any other provider.

Please direct questions about the information in this article to the EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

## 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.

*CDT-3/2000 and CDT – 4 (including procedure codes, definitions (descriptions) and other data) is copyrighted by the American Dental Association. © 1999 American Dental Association. All rights reserved. Applicable Federal Acquisition Regulation System/Department of Defense Acquisition Regulation System (FARS/DFARS) Apply.*
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