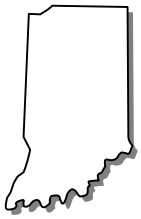

IMPORTANT INFORMATION

BR200444 NOVEMBER 2, 2004

To All Providers:

- This article provides guidance on Healthcare Common Procedure Coding System (HCPCS) code *A4660 – Sphygmomanometer/blood pressure apparatus with cuff and stethoscope*. The Indiana Health Coverage Programs (IHCP) Provider Manual, chapter 8, page 8-144 indicates that this code is a supply for end stage renal disease patients only. Prior to January 1, 2003, the official description of the code contained the designation that it was for dialysis patients only. Centers for Medicare & Medicaid Services (CMS) removed this designation and A4660 is available regardless of diagnosis. Effective November 1, 2004, HCPCS code A4660 is an available supply, as medically necessary, for members on dialysis and other appropriate diagnoses. The medical record should reflect the medical necessity for ordering this supply. Any additional questions on this matter should be directed to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.
- On January 1, 2005, the Annual HCPCS and Current Procedural Terminology (CPT) code updates will be loaded in Indiana*AIM* with program coverage and pricing determinations. Provisions of theHealth Insurance Portability and Accountability Act (HIPAA) require usage of national medical code sets and modifiers that are valid at the time that the service is provided. The new 2005 HCPCS codes will be available for claims processing effective January 1, 2005. Claims billed with deleted 2004 HCPCS and CPT codes, on or after January 1, 2005, will be denied. Providers will receive notification of the deleted 2005 HCPCS and CPT codes and a list of the new HCPCS and CPT codes in a November IHCP provider bulletin. Providers will receive notification in a December IHCP provider bulletin of coverage determinations for the new 2005 HCPCS and CPT codes. Direct any questions to Customer Assistance at (317) 655-3240 in the Indianapolis local area, or 1-800-577-1278.
- To address an immediate need for immunizations and a shortage of available influenza vaccines, the Indiana Health Coverage Programs (IHCP) is **not** limiting reimbursement for any influenza vaccines, regardless of availability from the Vaccines For Children (VFC) program. This will allow providers to obtain reimbursement for using privately purchased influenza vaccine if they do not have VFC vaccine due to the shortage crisis. When administering 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. NOTE: If you administer free VFC vaccine, bill the appropriate influenza vaccine procedure code but do not charge more than the $8.00 VFC vaccine administration fee. Providers that are enrolled with a managed care organization will continue to submit claims to that MCO. For more information about billing for influenza vaccine, refer to the April 2004 provider monthly newsletter available on the IHCP Web site at www.indianamedicaid.com.
  RHCs and FQHCs, please note: RHC- and FQHC-specific encounter rates already include payment for immunizations. When submitting RHC and FQHC claims to track encounters (note: such claims will be denied), bill no more than the $8 VFC administration fee for use of VFC influenza vaccine **or** bill the usual and customary rate for the influenza vaccine CPT plus the administration CPT 90782 for use of provider-purchased influenza vaccine.
- The information outlined in the IHCP provider bulletin, *BT200417*, published August 1, 2004, announced a new billing practice for the submission of End Stage Renal Disease (ESRD) dialysis services claims. New G codes G0308-G0327 were identified in this provider bulletin with an effective date of September 15, 2004. Based on the new G codes being billable on a per month basis, the IHCP is modifying the effective date to October 1, 2004. Direct questions to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

To Durable Medical Equipment Providers:

- The IHCP recently discovered that crossover claims for dually eligible Medicaid and Medicare members for HCPCS codes *E0561 – non-heated humidifier*, and *E0562 – heated humidifier*, are denying when billed with the RR modifier. The IHCP will temporarily cover the RR modifier in order to facilitate processing of crossover claims for these devices. Prior authorization (PA) requests for HCPCS codes E0561 RR or E0562 RR for traditional Medicaid members will be denied. Providers should maintain documentation of medical necessity and member eligibility in the member's chart. Payments of all claims are subject to post payment review and recoupment if paid inappropriately by either a rental or purchase.

To Ophthalmologists:

- The IHCP has determined that CPT code *65775 – Corneal wedge resection for correction of surgically induced astigmatism* is inappropriately non-covered in the Indiana*AIM* system. This procedure is performed to correct surgically induced astigmatisms and not for correcting naturally occurring astigmatisms. Effective immediately, CPT code 65775 is covered retroactively to January 1, 1998.

To Hospice Providers:

- The information outlined in this banner page updates the section titled *IHCP Managed Care Members Electing The IHCP Hospice Benefit* in section 3 of the *IHCP Hospice Provider Manual*, March 2004 revision date, and replaces the information previously outlined in banner pages, *BR200439, BR200440* and *BR20044,* published September 28, 2004, October 5, 2004, and October 12, 2004 respectively.

  Effective November 1, 2004, the IHCP will no longer issue expenditure payouts as a form of reimbursing hospice providers for one day admissions, weekend admissions and other scenarios that meet the parameters for an expenditure payout but will be paying for these service dates through a special batch claim. A special batch claim is a claim that will be reflected on the provider's upcoming remittance advise (RA) with an internal control number (ICN) starting with the number 90. A special batch claim differs from an expenditure payout in that it will reflect on the RA the member's name, RID number, service dates and the amount paid.

  The Health Care Excel (HCE) Medicaid Prior Authorization Unit will notify providers regarding the authorization of appropriate dates of service that can be billed through the *IHCP Prior Review and Authorization Request Decision Form*. Hospice providers will be able to bill the IHCP directly for dates of service approved on the IHCP Prior Review and Authorization Request Decision Form. However, HCE will also note on the PA notice that the OMPP will contact the provider regarding reimbursement for dates of service that cannot be billed directly to the IHCP. The OMPP will then contact the provider to request a properly completed UB-92 claim form that the IHCP will then special batch. Hospice providers are reminded to check the claim from a quality review perspective so as to ensure a "clean" claim is submitted. Previously submitted claims have reflected errors that include incorrect bill type, failing to list each service date by line item, using home health revenue codes instead of hospice, using the incorrect hospice revenue does. A clean claim should pay within 10 business days of the IHCP receipt of the claim. An improperly completed claim will result in appropriate claim denial.

  Hospice providers are reminded that they must still follow the procedures outlined in the *IHCP Hospice Provider Manual* by checking eligibility and faxing the IHCP Hospice Election Form to the HCE Prior Authorization Unit and comply with the timeliness requirements for subsequent hospice benefit periods. Failure to comply with these policies will result in denial of dates of service for untimely submission. HCE will note which dates of service have been denied on the IHCP Prior Review and Authorization Request Decision Form. It is the hospice provider's responsibility to preserve their appeal rights by filing a timely administrative review or appeals request as outlined in section 3 of the *IHCP Hospice Provider Manual*.

  On another note, the IHCP has performed its analysis of the limitation of payments for inpatient hospice care for the time period beginning November 1, 2002, and ending October 31, 2003. It has been determined that no hospice provider exceeded the limitation.

To Pharmacy and Prescribing Physicians:

- Effective December 16, 2004, the following drugs will be added to the State MAC for legend drugs program.

Description	SMAC
Amitriptyline HCL 25mg tablet	$0.0236
Amitriptyline HCL 50mg tablet	$0.0361
Amox tr-k clv 500-125mg tablet	$2.5554
Buspirone HCL 5mg tablet	$0.0781
Econazole nitrate 1% cream	$0.5263
Fosinopril sodium 10mg tablet	$0.5937
Fosinopril sodium 20mg tablet	$0.8311
Hydrocodone/apap 7.5/500 tablet	$0.0591
Imipramine HCL 50mg tablet	$0.3629
Metformin HCL er 500mg tablet	$0.5363

Description	SMAC
Methotrexate 2.5mg tablet	$0.3119
Metolazone 2.5mg tablet	$0.6303
Nitrofurantoin mcr 100mg cap	$1.3909
Nitrofurantoin mcr 50mg cap	$0.8555
Trazodone 100mg tablet	$0.0626
Trazodone 150mg tablet	$0.1547
Trazodone 50mg tablet	$0.0556
Triamterene/hctz 37.5/25 tablet	$0.0787
Unithroid 125mcg tablet	$0.3608

Please direct any questions about the State MAC for legend drugs to the Myers and Stauffer pharmacy unit at (317) 846-9521 or (800) 877-6927, or by e-mail at pharmacy@mslc.com.