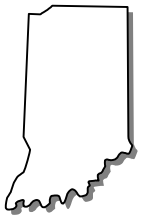

IMPORTANT INFORMATION

BR200445 NOVEMBER 9, 2004

To All Providers:

- The purpose of this article is to remind providers of the correct billing requirements for Current Procedure Terminology (CPT) code 77427 – *Radiation treatment management, five treatments*. Radiation treatment management is reported in units of five fractions or treatment sessions regardless of the actual time period in which the services are furnished. Therefore, when submitting a claim to the Indiana Health Coverage Program (IHCP) for reimbursement of this service it should be billed according to CPT guidelines which reflects that, one unit represents five treatments. Claims research conducted on billing of CPT code 77427, revealed that providers may be submitting claims as one unit for each fraction or treatment session billed. Therefore, providers that may have billed claims for this service as one unit for each fraction have been overpaid based on the number of units that were reflected on the claim. Providers should submit an adjustment for excess units in which they were paid in error.
  Additionally, the IHCP is aware that the billing requirement for CPT code 77427 is different for claims in which Medicare is the primary payer. Medicare procedure is for providers to bill claims as one unit equals one fraction of treatment a system modification has been made for Medicare Part B claims that crossover to the IHCP so that the units are calculated and priced appropriately according to the IHCP reimbursement methodology. A mass adjustment will be conducted to recoup overpayments for this service. Identified claims that processed on or after January 1, 2003, will be mass adjusted in 45 days. This mass adjustment will appear beginning on the remittance advice (RA) dated January 4, 2005.
- 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.

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 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 23, 2004, the following drugs will be added to the SMAC for legend drugs program.

Group	Description	SMAC
454	Amitriptyline hcl 10 mg tablet	0.0305
460	Amitriptyline hcl 75 mg tab	0.1288
465	Amoxicillin 875 mg tablet	0.4989
469	Bisoprolol fumarate 10 mg tb	0.9079
470	Bisoprolol fumarate 5 mg tab	1.3674
482	Carbidopa/levo 25/100 tb sa	0.5788
491	Carbidopa/levo 50/200 tb sa	1.2405
492	Cefadroxil 500 mg capsule	1.2348
493	Dipyridamole 25 mg tablet	0.0500
494	Dipyridamole 50 mg tablet	0.1940
497	Dipyridamole 75 mg tablet	0.1069
509	Doxepin 10 mg capsule	0.0931
512	Doxepin 100 mg capsule	0.0876
512	Doxepin 25 mg capsule	0.0547
513	Doxepin 50 mg capsule	0.0697
514	Etodolac 500 mg tablet	1.0290
515	Fosinopril sodium 40 mg tab	0.8321
518	Gengraf 100 mg capsule	4.3316
519	Gengraf 25 mg capsule	1.2836
520	Imipramine hcl 10 mg tablet	0.1661
521	Imipramine hcl 25 mg tablet	0.1945
522	Isosorbide mn 120 mg tab sa	1.4500

Group	Description	SMAC
524	Levothroid / yroxine 100 mcg tablet	0.1506
530	Levothroid / yroxine 150 mcg tablet	0.1370
534	Levothroid / yroxine 25 mcg tablet	0.1166
536	Levothroid / yroxine 50 mcg tablet	0.1330
538	Levothroid / yroxine 75 mcg tablet	0.1464
547	Lovastatin 10 mg tablet	0.6300
548	Medroxyprogesterone 10 mg tb	0.1537
549	Methylprednisolone 4 mg tab	0.1998
554	Morphine sulf er 15 mg tablet	0.6439
556	Nortriptyline hcl 10 mg cap	0.0801
558	Nortriptyline hcl 50 mg cap	0.1163
566	Nortriptyline 25 mg capsule	0.1238
567	Paroxetine hcl 10 mg tablet	1.7548
569	Paroxetine hcl 20 mg tablet	1.7758
576	Paroxetine hcl 30 mg tablet	1.8160
581	Paroxetine hcl 40 mg tablet	1.9644
584	Phenytoin 125 mg/5 ml suspen	0.1034
585	Potassium cl 10 meq tab sa	0.2678
587	Trinessa tablet	5.8705

Please direct any questions about the SMAC 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.