IMPORTANT INFORMATION

BR200446 NOVEMBER 16, 2004

To All Providers:

- The Office of Medicaid Policy and Planning (OMPP) will hold a series of public meetings on the transition to mandatory risk-based managed care in southern Indiana. The details of the next scheduled public meeting on the transition to mandatory risk-based managed care is as follows:
  - Clark and Floyd Counties area public meeting: The meeting will be held from noon to 1 p.m. on December 7, 2004, at Floyd Memorial Hospital, 1850 State Street, New Albany. The agenda will include a brief presentation from OMPP and all the Managed Care Organizations (MCO) will be available to answer questions.

- Effective December 1, 2004, the Indiana Health Coverage Programs (IHCP) will only reimburse providers for FluMist, Current Procedure Terminology (CPT) code 90660 – *Influenza virus, live, for, intranasal use*, when administered to IHCP members age 5 years old through 49 years old. This age restriction is consistent with requirements of the U.S. Food & Drug Administration regarding this vaccine. Any additional questions regarding this matter should be directed to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

- This notice corrects inaccurate information previously published in the IHCP provider newsletter, *NL200411*, published November 15, 2004, in an article entitled "Radioimmunotherapy Services Using Zevalin or Bexxar." Effective January 1, 2004, the following pricing changes have been implemented.

Code	Location of Service	Pricing listed in November 2004 IHCP Provider Newsletter	Corrected Pricing
78804	Physician Office	$154.36	$331.72 (RBRVS)
78804	Outpatient Facility	$114.21	$291.57 (Max Fee)

  Please note the following clarifications to reporting J9310 – *Rituximab, 100 mg*, and Q0084 – *Chemotherapy administration by infusion technique only, per visit*, for the Zevalin regimen as listed on pages two and three of this publication. J9310 will reimburse $527.51 for dates of service January 1, 2004, through September 30, 2004, and $548.68 for dates of service beginning October 1, 2004. Q0084 is manually priced. Direct any questions regarding this information to the Health Care Excel (HCE) Medical Policy Department at (317) 347-4500.

- The purpose of this article is to remind providers of the correct billing requirements for CPT code77427 – *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 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.

- 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 Home and Community-Based Services Waiver Providers:

- The purpose of this article is to clarify documentation standards for Home and Community-Based Services (HCBS) Waiver Programs providers rendering services outlined in *BT200305*, published January 15, 2003, and *BT200371*, published December 19, 2003.

  For all services which contain the following documentation requirements: "data record documenting the date of service and the number of units of service delivered that day" or "data record documenting the complete date and time entry (including a.m. or p.m.) and the number of units of service delivered that day" – the intent of the documentation requirement is to record the complete date (mm/dd/yy) and the time in as well as time out. Time in/out must reflect a.m. and p.m. as appropriate, unless your agency chooses to utilize 24-hour clock time notations. Time must be recorded consistently regardless of methodology, either standard time or 24 hour time notation.

  To summarize this clarification, all time bound HCBS Waiver services detailed in the bulletins referenced above must be documented clearly reflecting the complete date (mm/dd/yy) as well as the time in and time out, utilizing either a.m. and p.m. or the 24-hour clock time notation. All documentation entries must reflect the signature of the staff member making the entry, to include at minimum the first initial and last name of the individual along with certification or title, as applicable.

  The above noted procedures are to be implemented immediately. Documentation entries not meeting the above stated criteria will be recouped for all dates of service after December 1, 2004.

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.