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

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To All Providers:

- On December 1, 2004, the Indiana Health Coverage Programs (IHCP) will begin accepting Medicare crossover claims for diabetic test strip procedure codes with dates of service that span 90 days. Providers may use Web interchange to submit these claims electronically at that time. Claims for spend-down members that require a *DPW Form 8A* , must have the *DPW Form 8A* attached for only the first month in the span of dates of service. If billing on paper, the *DPW Form 8A* must be attached to the claim. If billing electronically, the *DPW Form 8A* must be sent through the attachment process. Claims that crossover from Medicare will generate a claim correction form (CCF) for the attachment. For example, a claim is submitted for dates of services spanning from October 1, 2004, to December 1, 2004. If the DPW Form 8A is required for processing, the provider must submit a DPW Form 8A for October, not November and December.
  Listed in the table below are the procedure codes and descriptions that will be affected:

Procedure Code	Description	Procedure Code	Description
A4244	Alcohol or peroxide, per pint	A4254	Replacement battery, any type, for use with medically necessary home blood glucose monitor
A4245	Alcohol wipes, per box	A4255	Platforms for home blood glucose monitor, 50 per box
A4246	Betadine or phisohex solution, per pint	A4256	Normal, low and high calibrator solution/chips
A4247	Betadine or iodine swabs/wipes, per box	A4257	Replacement lens shield cartridge for use with laser skin piercing device, each
A4250	Urine test or reagent strips or tablets (100 tablets or strips)	A4258	Spring-powered device for lancet, each
A4253	Blood glucose test or reagent strips, per 50 strips	A4259	Lancets, per box of 100
A4253	Billed with modifier NU will now cross over from Medicare.		

- 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 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.
- 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 All Indiana Hospital Providers:

- Based upon input from the Indiana Hospital and Health Association and the Indiana Council of Community Mental Health Centers the psychiatric level-of-care (LOC) per diem and neonate inpatient diagnosis-related grouping (DRG) changes, which were scheduled to become effective November 1, 2004, as set out in IHCP provider bulletin, *BT200420*, published September 16, 2004, have been modified. The psychiatric LOC per diem will not decrease. It will remain at the current rate of $408.50. Thus, the neonate DRG weights, which had been increased in proportion to the psychiatric LOC rate adjustment, have been modified, effective, November 1, 2004, to reflect the changes supported by both Associations. The IHCP banner page article, *BR200443*, published October 26, 2004, outlines the changes.

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.