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All Providers

To All Providers And Managed Care Organizations: Vaccines for Children and Private Stock Use

To address an immediate need for immunizations and a shortage of available influenza vaccine, effective October 15, 2006, the Indiana Health Coverage Programs (IHCP) will not limit reimbursement for any influenza vaccine, regardless of availability from the Vaccine for Children (VFC) Program. This policy allows providers to obtain reimbursement for using a privately purchased influenza vaccine if they do not have VFC vaccine due to the shortage crisis. When administering a privately purchased influenza vaccine, reimbursement includes payment for both the cost of the vaccine and the administration fee. Claims continue to process by the appropriate delivery system (EDS or managed care organization (MCO)) for each member regardless of the source of the vaccine stock. Claims are eligible for post review and providers must maintain documentation and invoices related to private stock when substituting for VFC vaccine. Rural health clinic (RHC) and federally-qualified health center (FQHC) rates include payment for both the vaccine and administration fee. Refer to bulletin *BT200151* for detailed billing instructions when administering private stock.

Updates to Procedure Codes A4253 and A4259

A4253 – Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips

Effective February 1, 2007, a maximum quantity limitation is placed on Healthcare Common Procedure Coding System (HCPCS) code *A4253 – Blood glucose test or reagent strips for home glucose monitor, per 50 strips.* Providers are permitted to bill up to two units or 100 strips per 30 days. Additional units of A4253 deny unless prior authorization (PA) is obtained.

Effective February 1, 2007, all of the following PA criteria is required for additional units of A4253:

- A signed statement of medical necessity.
- A clear medical recommendation of the number of additional units required to meet the patient's medical need.
- A hemoglobin A1C test dated within 90 days prior to the request for additional units of A4253.

A4259 – Lancets, per box of 100

Effective February 1, 2007, a maximum quantity limitation is placed on HCPCS code *A4259 – Lancets, per box of 100.* Providers are permitted to bill one unit (100 lancets) per 30 days. Additional units of A4259 deny unless PA is obtained.

Effective February 1, 2007, all of the following PA criteria is required for additional units of A4259:

- A signed statement of medical necessity.
- A clear medical recommendation of the number of additional units required to meet the patient's medical need.
- A hemoglobin A1C test dated within 90 days prior to the request for additional units of A4259.

All other billing requirement including crossover claim requirements for reimbursement remain the same for HCPCS codes A4253 and A4259.

Contact Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll free at 1-800-577-1278, with questions about this article.

Planing/Scaling Non-Institutionalized Member Age 21 Years or Older Limited to Four Treatments per Lifetime.

Omni Upgrade Requirements

Beginning November 30, 2006, EDS made enhancements to the managed care information portion of the Omni member eligibility inquiries. In order to view the managed care information, providers who have an Omni terminal must download the latest Omni software version..

Detailed download instructions can be found in Table 1.5 of bulletin *BT200303.* The Omni managed care enhancements are included in bulletin *BT200628* published December 7, 2006. These bulletins can be accessed from the Indiana Health Coverage Programs (IHCP) Web site at http://www.indianamedicaid.com.

Direct questions about the information in this article to the Omni Help Desk at (317) 488-5051 in the Indianapolis local area, or toll free at 1-800-284-3548.

New Version Indiana Health Coverage Programs Provider Manual Is Available

A new version of the *IHCP Provider Manual* is available on the IHCP Web site at http://www.indianamedicaid.com. Providers **will not** automatically receive copies of this version of the manual by mail, and are encouraged to visit the Web site to view, print, or download copies of the manual.

Revisions to the *IHCP Provider Manual* are posted to the IHCP Web site and they are not automatically mailed. Providers and non-providers may request copies of the manual on CD-ROM or paper according to the following schedule:

Providers
- Download from the Web site.....Free
- CD-ROM.....Free
- Original paper copy.....Free
- Additional paper copies.....$105 each

Non-providers
- Download from the Web site.....Free
- CD-ROM.....$20 each
- Paper copies.....$105 each

Requests for copies of the manual must be made by telephone to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 or in writing to the following address:

EDS Written Correspondence Unit
c/o Provider Manual Request
P.O. Box 7263
Indianapolis, IN 46207-7263

Requests that require payment must be made by mail and the requestor must supply a mailing address and include full payment. Make checks payable to EDS and allow 10-14 business days for processing.

Timeline for Revised Paper Claim Forms

The following information does not apply to providers rendering services in the risk based managed care (RBMC) delivery system. These providers should contact the managed care organization (MCO) with whom they are contracted for information about paper claim form transition.

The National Uniform Claim Committee (NUCC), the National Uniform Billing Committee (NUBC), and the American Dental Association (ADA) have revised the layouts of the institutional, professional, and dental paper claim forms. The current institutional UB-92 claim form will be replaced with the institutional UB-04. The current professional CMS-1500 health insurance claim form will be revised to the 08-05 version. The ADA dental claim form will be replaced with J400D. The EDS pharmacy claim forms will be revised to include National Provider Identifier (NPI) information. These forms will be available May 23, 2007, and may be obtained from the *Forms* page of the Indiana Health Coverage Programs (IHCP) Web site at http://www.indianamedicaid.com/ihcp/Publications/forms.asp.

The IHCP will be transitioning to the new paper claim forms with the timelines noted in Table 1. The transition period is where both old and new claim forms will be accepted. All claim forms will have a transition period excluding the Pharmacy claim form. Table 1 outlines the transition period and cutover dates for each type of paper claim form.

Table 1 – Timeline Revised Paper Claim Forms

Current Form	New Form	Transition Period (Old and New Forms Accepted)		Only New Forms Accepted (Cutover Date)
		Start Date	End Date	
CMS-1500	08-05	February 15, 2007	March 31, 2007	April 1, 2007
UB-92	UB-04	April 1, 2007	May 22, 2007	May 23, 2007
Dental	J400D	April 15, 2007	May 22, 2007	May 23, 2007
Pharmacy	Pharmacy	No Transition Period		May 23, 2007

Contact Information: Providers with questions about this bulletin should contact Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll free at 1-800-577-1278.

All Dental Providers

Dental Claims: Rendering Provider Number Required

This article updates information that was published in IHCP banner page *BR200527* on July 5, 2005, and addressed billing guidelines for dental billing and rendering providers.

The billing guidelines are required for HIPAA compliance and will be implemented again beginning on January 1, 2007. The billing guidelines are as follows:

Per IHCP provider bulletin *BT200511*, published June 1, 2005, all dental group providers must use their rendering provider numbers. To expedite claims, providers should follow these guidelines when submitting claims:

- *Group provider using a paper claim* – Enter the group number and location code(s) in Field 44A on the ADA Dental claim form. Enter the individual rendering number(s) in the *Administrative* column adjacent to each detail.
- *Group provider using Web interChange* – Enter the group number and location code in the provider numbers field. Enter the individual rendering number in the rendering provider field.
- *Individual billing provider using a paper claim* – Enter the individual billing number and location code in Field 44A on the ADA Dental claim form. Enter the individual billing number in the *Administrative* column adjacent to each detail.
- *Individual billing provider using Web interChange* – Enter the individual billing number and location code in the provider number field. Enter their individual billing number in the rendering provider field.

Dental providers will receive denials for the following situations:

- *231 – Rendering provider number is missing – The entire nine-digit number must be used and must be in Field 24K. Please provide and resubmit.*
- *232 – Rendering provider number is invalid – The entire nine-digit number must be used and must be in Field 24K. Please verify and resubmit.*

> *Note: For edits 231 and 232, Field 24K refers to CMS-1500 claim forms. For dental claims, the rendering must be in the* Adm *Field.*

- *1004 – Rendering provider not enrolled in the program billed for the dates of service. Please verify provider number and resubmit.*
- *1008 – The rendering provider must be an individual provider. Please verify provider number and resubmit.*
- *1010 – Rendering provider is not an eligible member of billing group or the billing provider is equal to the rendering provider. Please verify provider number and resubmit.*
- *7509 – Rendering provider on prepayment review.*

Providers who have Administrator access in Web interChange can view their provider profiles to access a list of the rendering providers linked to the group. Providers can contact the Provider Enrollment Helpline at 1-877-707-5750 to discuss any updates that need to be made to the provider group information.

All Durable Medical Equipment Providers

Power Wheelchairs

Pending final review of the expanded power wheelchair codes, providers should continue to bill using the following existing codes and fee schedule amounts. Prior authorization (PA) is required for power wheelchairs and accessories. Refer to existing provider notifications for current PA requirements.

- K0010, *Standard-weight frame motorized/power wheelchair,* $4238.90 new, $282.59 rental
- K0011, *Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking,* $5270.30 new, $351.35 rental
- K0012, *Lightweight portable motorized/power wheelchair,* $3233.10 new, 215.54 rental
- K0014, *Other Motorized/power wheelchair base,* manually priced
- E1230, Power Operated vehicle (three- or four-wheel nonhighway), specify brand name and model number, manually priced
- E1239,Wheelchair, pediatric size, not otherwise specified, manually priced

If you have any questions, contact Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll free at 1-800-577-1278.

All Pharmacies and Prescribing Providers

State MAC Legend Drug Updates

Table 1 contains the updates to the State maximum allowable coverage (MAC) rates effective for dates of service on or after February 2, 2007.

Table 1 – **Decreases** to the State MAC Rates for Legend Drugs
Effective for Dates of Service On or After February 2, 2007

Drug Name	State MAC Rate	Drug Name	State MAC Rate
AMPHETAMINE SALTS 20 MG TABLET	0.26799	OXYCODONE/APAP 7.5/325 MG TABLET	0.46500
MORPHINE SULFATE 30 MG TABLET SA	0.54915	PROMETHAZINE 25 MG SUPPOSITORY	0.60200
NABUMETONE 750 MG TABLET	0.44329		

Direct questions about the State MAC for legend drugs to the Myers and Stauffer Pharmacy Unit at (317) 816-4136 in the Indianapolis local area, or 1-800-591-1183, or by e-mail at pharmacy@mslc.com.

Deficit Reduction Act of 2005: Healthcare Common Procedure Coding System and National Drug Code Requirement and Change in Associated Implementation Deadline

The Office of Medicaid Policy and Planning (OMPP) is announcing a change to the implementation date for requiring the National Drug Code (NDC) for Healthcare Common Procedure Coding System (HCPCS) coded claims involving drugs. The revised implementation date for this requirement will be July 1, 2007. The details of this change and related claim submission requirements are forthcoming in future provider communications pending upcoming guidance from the Centers for Medicare & Medicaid Services (CMS). The previous implementation date of January 1, 2007, was announced in the provider monthly newsletter *NL200607*.

Changes to the Over-the-Counter Drug Formulary

This article is to notify all pharmacy providers, prescribing physicians, and health care workers of changes and updates to the IHCP OTC Drug Formulary. The pharmacy OTC formulary and rates are available at http://www.mslcindy.com. These rates are effective on January 19, 2007.