B A N N E R P A G E

B R 2 0 0 7 1 3 M A R C H 2 7 , 2 0 0 7

All Providers

Updates of Billing Instructions for Radioimmunotherapy Using Zevalin®

This article supplements articles published in the November 2004 Indiana Health Coverage Programs (IHCP) provider newsletter *NL200411* and banner page *BR200513*. Effective for dates of service January 1, 2006, and after, the IHCP provides reimbursement for services reported with Healthcare Common Procedure Coding System (HCPCS) codes *A9542 – Indium In-111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 millicuries*, and *A9543 – Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries*. HCPCS codes A9542 and A9543 replace HCPCS codes C1082 and C1083 respectively, which were end dated December 31, 2005. All other billing requirements remain unchanged. Previously denied claims for A9542 and A9543 will be reprocessed for dates of service January 1, 2006, through the present. Please direct questions to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll-free at 1-800-577-1278.

Outpatient Hospital Rates

New outpatient hospital rates have been set for the new chemotherapy codes effective January 1, 2006. Claims submitted on or after January 1, 2006, will be reprocessed at the new rates. Please direct questions to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll-free at 1-800-577-1278.

CMS-1500 Claim Form Implementation Timeline Change

The timeline for mandating the use of the CMS-1500 (08-05) claim form has been changed from the original date of April 1, 2007. The Office of Medicaid Policy and Planning (OMPP) has not determined a new date for mandating the use of the new form. Providers may continue submitting claims on the CMS-1500 (12-90) until further notice.

The timeline change is due to errors in the formatting of this form by the print vendors. Providers may continue submitting claims on the CMS-1500 (12-90) until further notice. During this time, EDS will continue to accept both versions of this claim form. However, providers using the new CMS-1500 (08-05) claim form must ensure that they use a correctly formatted version. CMS published the following notice related to this finding:

> "It has recently come to our attention that there are incorrectly formatted versions of the revised form being sold by print vendors, specifically the Government Printing Office (GPO). After reviewing the situation, the GPO has determined that the source files they received from the NUCC's authorized forms designer were improperly formatted. This resulted in the sale of both printed forms and negatives which do not comply with the form specifications.
>
> Given the circumstances, ***CMS has decided to extend the acceptance period of the Form CMS-1500 (12-90) version beyond the original April 1, 2007 deadline*** while this situation is resolved. Medicare contractors will be directed to continue to accept the Form CMS-1500 (12-90) until notified by CMS to cease. At present, we are targeting June 1, 2007 as that date. In addition, during the interim, contractors will be directed to return, not manually key, any Form CMS-1500 (08-05) forms received which are not printed to specification. By returning the incorrectly formatted claim forms back to you, we are able to make you aware of the situation which will allow you to begin communications with your form supplier.
>
> The following will help you to properly identify which form is which. The old version of the form contains "Approved OMB-0938-0008 FORM CMS-1500 (12-90)" on the bottom of the form (typically on the lower right corner) signifying the version is the December 1990 version. The revised version contains "Approved OMB-0938-0999 FORM CMS-1500 (08-05)" on the bottom of the form signifying the version is the August 2005 version. The best way to identify if your CMS-1500 (08-05) version forms are correct is by looking at the upper right hand corner of the form. On properly formatted claim forms, there will be approximately a ¼" gap between the tip of the red arrow above the vertically stacked word "CARRIER" and the top edge of the paper. If the tip of the red arrow is touching or close to touching the top edge of the paper, then the form is not printed to specifications."

Web interChange is being updated for NPI

Effective April 1, 2007, Web interChange will begin accepting the National Provider Identifier (NPI) for all Web transactions requiring provider identification. The functionality of Web interChange remains the same; however, the layout of some of the screens is changing to allow users to choose to send either the NPI or the Legacy Provider Identifier (LPI), which is the current IHCP provider number.

Existing Web interChange security mechanisms will ensure that any user is only allowed to view the information for which he or she has been granted access. NPI information will only be available if the provider has reported its NPI to the IHCP. The following is an overview of the changes:

Inquiry Pages – (Member Eligibility Inquiry, Claim Inquiry, Check Inquiry, Prior Authorization Inquiry, and Provider Profile Inquiry). If an NPI has been reported, the user will have the ability to select between NPI or LPI in the search criteria. If an NPI has **not** been reported, the user will **not** have the ability to select between NPI or LPI in the search criteria.

Claim Submission – Prior to the mandatory NPI date (currently May 23, 2007), all of the Claim Submission pages on Web interChange will allow the user to enter his or her NPI or LPI. The tabbing order on the Claim Submission screens remains the same. Provider User Lists will be updated to allow the user to enter NPI or LPI data for each provider in his or her User List. When sending NPI, including the taxonomy codes and nine-digit postal codes increases the chances for matching a unique LPI.

For more information about NPI, including how to receive and report NPI to the IHCP, visit the NPI section of the IHCP Web site at http://www.indianamedicaid.com/ihcp/ProviderServices/npi.asp.

Claims Reprocessing – Procedure Code V5264

The IHCP is reprocessing medical claims submitted for procedure code *V5264 – Ear mold/insert, not disposable, any type* for claims billed between September 5, 2006, and February 1, 2007. During that period, claims billed with procedure code V5264 inappropriately denied for edit *4209 – No Pricing Segment for Procedure/Modifier Combination*. The reprocessed claims will appear on remittance advice (RA) statements dated April 10, 2007.

March RAI and MDS Supportive Documentation Guideline Changes

CMS announced the following March 2007 revision to the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual. In the March 2007 Revision Table, referencing Section P1, page number 3-182, the words "or biological (e.g., contrast material)" are deleted from the following sentence: "Includes any drug ~~or biological (e.g., contrast material)~~ given by intravenous push or drip through a central or peripheral port." No change is necessary for the Minimum Data Set Supportive Documentation Guidelines RUG-III, Version 5.12, 34 Grouper document, as this reference has already been omitted.

Please note there is a change to the Supportive Documentation Guidelines Consolidated Q & A section on page 17 of 21. The second sentence in the first (A:) paragraph currently states: "Either the initial assessment for new treatment or the documentation of ongoing respiratory assessments on or before the A3a date is acceptable." This sentence has been changed to read: "Either the initial assessment for new treatment or the documentation of ongoing respiratory assessments **during the observation period are** acceptable."

Billing on the CMS-1500 Form

The NPI implementation date is May 23, 2007. During the transition period, providers **must** use the 1D qualifier when submitting the Legacy Provider Identifier (LPI) on the CMS-1500 claim form. Qualifiers indicate the value of the next field and allow for multiple uses of the same field. Qualifiers for referring, rendering, and billing must be submitted when supplying an LPI or a taxonomy code. If a valid qualifier is not used, the claim will be returned to the provider.

Field 17a, R*eferring Provider Number*, Fields 24I and 24J, *Rendering Provider Number*, and Field 33b, *Billing Provider Qualifier and 1D Number*, **must** contain the 1D qualifier when submitting an LPI on the claim form.

Providers submitting claims with LPI during the transition period must use the 1D qualifier to the left of the LPI. The 1D qualifier indicates the value to the immediate right. If the 1D qualifier is not used, the claim will be returned to the provider.

Field 17a – Referring Provider Number

17a.	**1D**	**100000000**
17b.	**NPI**	

Field 33b – Billing Provider Qualifier and 1D Number

33. BILLING PROVIDER INFO & PH # ( )	
a.	**b. 1D 100000000A**

Fields 24I and 24J – Rendering Provider Number

24I. ID QUAL	**24J. RENDERING PROVIDER ID #**
1D	**100000000**
NPI	

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 NPI information. The pharmacy claim forms will be available May 16, 2007**, and may be obtained from the *Forms* page of the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/forms.asp. Links to the other new claim forms will be added to the IHCP Web site *Forms* page according to the start date listed in Table 1.

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

***The availability date of the pharmacy claim forms was changed to allow providers additional time to familiarize themselves with the forms.*

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	TBD	TBD
UB-92	UB-04	April 1, 2007	May 22, 2007	May 23, 2007
ADA 2000	ADA 2006	April 15, 2007	May 22, 2007	May 23, 2007
Pharmacy	Pharmacy	No Transition Period		May 23, 2007

Contact Information: Please direct questions to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll-free at 1-800-577-1278.

All Dental Providers

ADA 2006 Claim Form

The adoption of the new ADA 2006 claim form causes changes in IHCP billing requirements. Effective April 15, 2007, emergency services rendered must be noted in field 2 (Predetermination / Preauthorization Number) on the new claim form by entering the word "Emergency." These services were previously noted in box 53 on the ADA 2000 claim form under radiographs. Failure to comply may result in claim denials. Please direct questions to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll-free at 1-800-577-1278.

Topical Fluoride – Brush-on Application

As outlined in the Indiana Administrative Code (IAC) *405 IAC 5-14-4*, "Reimbursement is available for one (1) topical application of fluoride every six (6) months per recipient only for patients who are twelve (12) months of age or older but who are younger than twenty-one (21) years of age. Topical applications of fluoride are not covered for recipients twenty-one (21) years of age or older."

A provider using the appropriate Current Dental Terminology (CDT) codes for services rendered to members less than 21 years of age, may be reimbursed for the topical application of fluoride using the brush-on method versus using a dental tray. Coverage is limited to one unit every six months for institutional and non-institutional members. Topical fluoride includes varnish, gel, or foam.

All Pharmacy and Prescribing Providers

State Maximum Allowable Cost Update

Effective **May 4, 2007,** State MAC rates for the following drugs will be **added** as listed below in Table 2.

Table 2 – Additions to the State MAC Rates for Legend Drugs

Drug Name	State MAC Rate	Drug Name	State MAC Rate
FLUOROURACIL 50 MG/ML VIAL	0.28030	PROMETHAZINE 12.5 MG TABLET	0.40440

Effective **May 4, 2007,** State MAC rates for the following drugs will be **decreased** as listed below in Table 3.

Table 3 – Decreases to the State MAC Rates for Legend Drugs

Drug Name	State MAC Rate	Drug Name	State MAC Rate
CITALOPRAM HBR 20 MG TAB	0.07464	LEVOTHYROXINE 88 MCG TABLET	0.16842
FLUOCINONIDE 0.05% CREAM	0.04730	LEVOTHYROXINE 100 MCG TABLET	0.25389
GABAPENTIN 300 MG CAPSULE	0.11335	LEVOTHYROXINE 200 MCG TABLET	0.28185
HYDROCODONE/APAP 10/500 TABLET	0.14490	SPIRONOLACTONE 25 MG TABLET	0.18599

Contact Information: 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 at 1-800-591-1183, or by e-mail at pharmacy@mslc.com.

If you need additional copies of this banner, please download them from the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/banner_results.asp. To receive e-mail notifications of future IHCP publications, subscribe to the IHCP E-mail Notifications at http://www.indianamedicaid.com/ihcp/mailing_list/default.asp.