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All Providers

Coverage of Tysabri (natalizumab)

Effective April 1, 2007, the Indiana Health Coverage Programs (IHCP) began covering Tysabri (natalizumab) as a physician administered medication for the treatment of relapsing forms of multiple sclerosis. The service is billable using Healthcare Common Procedure Coding System (HCPCS) code *Q4079, Injection, natalizumab, per 1mg.* The Food and Drug Administration (FDA) reintroduced the drug with required provider guidelines and participation in a specific program called TOUCH. This program is a study to monitor and minimize the drug risks and the main features of the TOUCH prescribing program are as follows:

- The drug may only be prescribed, distributed, and infused by prescribers, infusion centers, and pharmacies registered with the program.
- Tysabri will only be administered to members who are enrolled in the program.
- Prior to initiating the therapy, health care professionals are to obtain the patient's magnetic resonance imaging (MRI) scan to help differentiate potential future multiple sclerosis symptoms from progressive multifocal leukoencephalopathy (PML).
- Patients on Tysabri are to be evaluated three and six months after the first infusion and every six months after that, and their status will be reported regularly to Biogen Idec, the company that manufactures Tysabri.

The IHCP will not issue any additional guidelines or restrictions beyond the requirements of the TOUCH prescribing program. For injections provided to members of a managed care organization (MCO), providers will need to contact that particular MCO to determine authorization, coverage, and billing guidelines for those members.

National Provider Identifier and Legacy Provider Identifier Clarification for Omni Users

The April 2007 IHCP provider newsletter *NL200704* contains information about sending National Provider Identifier (NPI) information in an eligibility transaction using the Omni swipe card device. The newsletter stated, "LPI will not be accepted after the HIPAA NPI mandatory date, May 23, 2007." This statement should have read, "Healthcare providers will not be able to submit a LPI after the NPI mandatory date which is scheduled for May 23, 2007. Atypical providers will continue to send the LPI for eligibility transactions. The NPI page of the IHCP Web site at www.indianamedicaid.com contains information about atypical providers." An additional NPI Facts Sheet about who can apply for NPI is located at http://www.indianamedicaid.com/ihcp/ProviderServices/pdf/TR370_npi_facts.pdf.

An IHCP provider bulletin containing detailed download instructions and Omni transaction information will be sent in the near future. Omni users are encouraged to wait until the bulletin is published to perform the terminal download.

Claims Processing – Procedure Codes E0240, E0247, E0248, and E0445

Retroactive to September 29, 2006, procedure codes *E0240 – Bath/shower chair, with or without wheels, any size; E0247 – Transfer bench for tub or toilet with or without commode opening; E0248 – Transfer bench, heavy duty, for tub or toilet with or without commode opening;* and *E0445 – Oximeter device for measuring blood oxygen levels noninvasively*, now bypass the Medicare edits for payment. Providers do not need to submit a Medicare denial for these services before submitting them to the IHCP for reimbursement. Please direct questions to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll-free at 1-800-577-1278.

Claims Processing – Use of Taxonomy Codes with Claim Submissions

Correction to IHCP provider bulletins *BT200702, BT200703*, and *BT200706*: For all provider fields, the taxonomy code is only required if needed to obtain a one-to-one match to the provider's Legacy Provider Identifier (LPI). For claims received with the billing provider NPI only (no taxonomy), and a one-to-one match cannot be obtained from the NPI and service location ZIP Code+4, the IHCP will return the claim to the provider.

First Steps providers must continue to use the appropriate taxonomy codes when submitting claims to ensure their services are reimbursed correctly. In addition, waiver providers submitting claims with an NPI must not bill a taxonomy code on their claim.

Updates of Billing Instructions for Radioimmunotherapy Using Zevalin®

This article supplements articles published in the November 2004 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 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. Providers may resubmit any affected claims prior to the reprocessing. 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. Providers may resubmit any affected claims prior to the reprocessing. 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. The Centers for Medicare & Medicaid Services (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 Updated for NPI

Effective April 1, 2007, Web interChange began accepting the NPI for all Web transactions requiring provider identification. The functionality of Web interChange remains the same; however, the layout of some of the screens has changed to allow users to choose to send either the NPI or the LPI, which is the current IHCP provider number.

Existing Web interChange security mechanisms 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.

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 MCO with which 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 the ADA 2006 Dental claim form. 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 are being 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 Hospice Providers

Hospice Care in Group Homes

Medicaid-eligible group home members can elect the Medicaid hospice program per the CMS. The hospice should bill Medicaid for the hospice services and the group home can bill Medicaid directly for the group home per diem rate. Claims for Group homes were denied by Indiana*AIM* with error code *2027 – Hospice Recipient Being Billed for Non-Hospice Services*. Indiana*AIM* has been updated and group homes should not encounter any denials for error code 2027. Hospice and group home providers should coordinate the overall care for the group home member. It is the responsibility of the hospice to provide all hospice-covered services in frequency and scope to care for the terminal illness and related conditions. Furthermore, the hospice should not delegate any hospice core services to group home staff. Any questions about the Medicaid hospice program should be directed to Michelle Stein-Ordonez, Policy Analyst, Family and Social Services Administration (FSSA) Division of Aging at (317) 233-1956. Any questions about how to bill these claims should be directed to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll-free at 1-800-577-1278.

All Dental Providers

Topical Fluorides

The information in this article supersedes the information in the article titled, *Topical Fluoride - Brush-on Application.* That article ran in the April 10, 2007, banner page (BR200715) and ran in error.

Procedure code *D1206 – Topical Fluoride Varnish*, is non-reimbursable by IHCP. Non-reimbursable indicates the service described in the code is either billable under another code, or is part of a global service. Topical applications of fluoride are billable under procedure codes *D1203 – Topical Application of Fluoride (excluding prophylaxis) – Child, age 1-12 years*, or *D1204 – Topical Application of Fluoride (excluding prophylaxis) – Adult, age 13-20 years*. Topical fluoride applications are not covered for members 21 years of age or older.

Services rendered to members younger than 21 years of age, may be reimbursed for the topical application of fluoride using the brush-on method versus using a dental tray. Topical fluoride includes varnish, gel, or foam.

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 field 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.

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