B A N N E R P A G E

BR200737 SEPTEMBER 11, 2007

All Providers

Age Restriction Code Changes

The Indiana Health Coverage Programs (IHCP) will be changing the age restrictions for International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes 760-779 effective July 1, 2004. The codes in Table 1, according to the 2007 Expert ICD-9-CM, have the N symbol, making their age restriction 0-1.

Table 1 – ICD-9-CM Codes with Age Restriction 0-1

ICD-9-CM Code	Code Description
760.77	Fetus or newborn affected by maternal conditions, which may be unrelated to present pregnancy; Noxious influences affecting fetus or newborn via placenta or breast milk; Anticonvulsants
760.78	Fetus or newborn affected by maternal conditions, which may be unrelated to present pregnancy; Noxious influences affecting fetus or newborn via placenta or breast milk; Antimetabolic agents
763.81	Fetus or newborn affected by other complications of labor and delivery; Other specified complications of labor and delivery affecting fetus or newborn; Abnormality in fetal heart rate or rhythm before the onset of labor
763.82	Fetus or newborn affected by other complications of labor and delivery; Other specified complications of labor and delivery affecting fetus or newborn; Abnormality in fetal heart rate or rhythm during labor
763.83	Fetus or newborn affected by other complications of labor and delivery; Other specified complications of labor and delivery affecting fetus or newborn; Abnormality in fetal heart rate or rhythm, unspecified as to time of onset
763.89	Fetus or newborn affected by other complications of labor and delivery; Other specified complications of labor and delivery affecting fetus or newborn; Unspecified complications of labor and delivery affecting fetus or newborn
768.7	Intrauterine hypoxia and birth asphyxia; Hypoxic-ischemic encephalopathy [HIE]
770.87	Other respiratory conditions of fetus and newborn; Other respiratory problems after birth; Respiratory arrest of newborn
770.88	Other respiratory conditions of fetus and newborn; Other respiratory problems after birth; Hypoxemia of newborn
771.1	Infections specific to the perinatal period; Congenital cytomegalovirus infection
772.11	Fetal and neonatal hemorrhage; Intraventricular hemorrhage of fetus or newborn; Intraventricular hemorrhage; Grade I
772.12	Fetal and neonatal hemorrhage; Intraventricular hemorrhage of fetus or newborn; Intraventricular hemorrhage; Grade II
775.81	Endocrine and metabolic disturbances specific to the fetus and newborn; Other neonatal endocrine and metabolic disturbances; Other acidosis of newborn
775.89	Endocrine and metabolic disturbances specific to the fetus and newborn; Other neonatal endocrine and metabolic disturbances
779.85	Other and ill-defined conditions originating in the perinatal period; Other specified conditions originating in the perinatal period; Cardiac arrest of newborn

The codes in Table 2, according to the 2007 Expert ICD-9-CM, do not have the N symbol, making their age restriction 0-999.

Table 2 – ICD-9-CM Codes with Age Restriction 0-999

ICD-9-CM Code	Code Description
760.0	Fetus or newborn affected by maternal conditions, which may be unrelated to present pregnancy; Maternal hypertensive disorders
760.2	Fetus or newborn affected by maternal conditions, which may be unrelated to present pregnancy; Maternal infections
760.3	Fetus or newborn affected by maternal conditions, which may be unrelated to present pregnancy; Other chronic maternal circulatory and respiratory diseases
760.4	Fetus or newborn affected by maternal conditions, which may be unrelated to present pregnancy; Maternal nutritional disorders
760.6	Fetus or newborn affected by maternal conditions, which may be unrelated to present pregnancy; Surgical operation on mother
760.8	Fetus or newborn affected by maternal conditions, which may be unrelated to present pregnancy; Other specified maternal conditions affecting fetus or newborn
760.9	Fetus or newborn affected by maternal conditions, which may be unrelated to present pregnancy; Unspecified maternal condition affecting fetus or newborn
761.1	Fetus or newborn affected by maternal complications of pregnancy; Premature rupture of membranes
761.2	Fetus or newborn affected by maternal complications of pregnancy; Oligohydramnios
761.3	Fetus or newborn affected by maternal complications of pregnancy; Polyhydramnios
761.4	Fetus or newborn affected by maternal complications of pregnancy; Ectopic pregnancy
761.5	Fetus or newborn affected by maternal complications of pregnancy; Multiple pregnancy
761.6	Fetus or newborn affected by maternal complications of pregnancy; Maternal death
761.9	Fetus or newborn affected by maternal complications of pregnancy; Unspecified maternal complication of pregnancy affecting fetus or newborn

Using the 90-Day Provision When a Member Receives Direct Payment from a TPL Carrier

If a provider has proof that an IHCP member received reimbursement from an insurance carrier for provided services, the provider should contact the insurance carrier and advise them that payment was made to the member. The provider should request reimbursement from the third-party carrier. If the provider does not receive reimbursement from the third-party carrier, the provider should document the billing attempts made and submit the claim to the IHCP under the 90-Day provision. The provider should not bill the member.

The 90-Day provision states that when a third-party insurance carrier fails to respond within 90 days of the provider's billing date, the claim can be submitted to the IHCP for payment consideration. However, one of the following must accompany the IHCP claim to substantiate attempts to bill the third party:

- Copies of unpaid bills or statements sent to the third party, whether an individual or an insurance company. Note the date of the billing attempt and the words "**no response after 90 days**" at the top of the claim and attachment. It is imperative that this information is clearly indicated.
- Written notification from the provider indicating the billing dates and explaining that the third party failed to respond within 90 days of the provider's billing date.

If a provider receives payment from a third party after the IHCP has paid a claim, the provider must refund the IHCP by submitting a claims adjustment form within 30 days of receipt of the third-party payment.

Providers need to contact the individual managed care organizations (MCOs) for their policy on this issue. Refer to Chapter 5 of the *IHCP Provider Manual* for additional information.

Managed Care Web Page Enhancements

The *Managed Care* section of the Indiana Medicaid Web site has been restructured to provide a more organized and user-friendly interface to view information regarding the managed care programs. The enhancements include the following items:

- New home pages for each of the managed care programs that contain links for program-specific information
- New links for the MCOs' prior authorization and behavioral health information
- A home page for the new program, *Care Select*, which will provide program-specific information as the program is developed

Utilization Edits for Mental Health Medications

On June 19, 2007, the Mental Health Quality Advisory Committee's (MHQAC's) recommended utilization edits for mental health medications were implemented. Please refer to Provider Bulletin *BT200709*. Based on analysis of prior authorization requests and feedback from the provider community, the utilization edits will be updated as follows:

- Utilization edits will be removed for all strengths and dosage forms of all seizure medications (excluding clonazepam).
- Utilization edits will be removed for guanfacine/Tenex and lithium/lithium ER.
- Utilization edits will be updated for the medications listed in Table 1.

Changes to the utilization edits are effective for all plans as of August 18, 2007.

Table 1 – Utilization Edits Mental Health Medications

Name of Medication and Strength	Updated Utilization Edit	Name of Medication and Strength	Updated Utilization Edit
Adderall XR 20mg, 25mg, 30mg	2/day	Focalin 10mg	4/day
Alprazolam 0.25mg, 0.5mg, 1mg, 2mg	4/day	Focalin XR 15mg, 20mg	2/day
Alprazolam 1mg/1mL oral solution	4mL/day	Lorazepam 0.5mg, 1mg, 2mg	4/day; max quantity 120
Amphetamine salts 15mg, 20mg, 30mg	3/day	Seroquel 25mg, 50mg, 100mg, 200mg	3/day
Concerta 54mg	2/day	Seroquel 300mg, 400mg	4/day
Effexor XR 150mg	2/day	Zyprexa 10mg, Zyprexa Zydis 10mg	2/day

Contact Information: For prior authorization requests or questions, please contact the appropriate entity as follows:

Traditional Medicaid
Telephone: (866) 879-0106
Fax: (866) 780-2198

Anthem
Telephone: (877) 652-1223
Fax: (866) 408-7103

Managed Health Services
Telephone: (866) 399-0928
Fax: (866) 399-0929

MDwise
Telephone: (800) 558-1655
Fax: (877) 234-4274

Refer to Attachment 3 of the *April 2007 provider newsletter* for additional MCO behavioral health contact information.

Claims Processing – Use of Place of Service Codes with Claim Submissions

When similar services are rendered to the same member at multiple service locations on a single date of service, it is appropriate to bill the total units on a single line item using a single place of service (POS). Documentation in the medical record must contain the more specific POS for each service rendered.

For example: A community mental health center (CMHC) provides four units of case management services to a member in the office at 10 a.m. on July 10, 2007, and then on the same day provides an additional three units of case management at 3 p.m. in the member's home. The CMHC may bill for seven units of service on one detail of the claim at POS 11 (office) and document in the medical record the number of units rendered at each individual POS.

All providers must follow established policy and coding guidelines for their specialty. Fee-for-service Federally Qualified Health Center (FQHC)/rural health clinic (RHC) providers, should bill only one encounter per IHCP member, per provider, per day unless the diagnosis differs.

Risk-based managed care (RBMC) may have other specific reimbursement guidelines. Providers rendering services in the RBMC delivery system should contact the MCO with whom they are contracted, for information about the billing of multiple service locations.

All Hospice Providers

Change to Hospice Process

Please review this banner page article in conjunction with Section 6 of the *IHCP Hospice Provider Manual* (revision date July 2007) titled *Managed Care Members Electing the IHCP Hospice Benefit*.

Effective October 1, 2007, there will be a change in the process. Health Care Excel (HCE), the Medicaid prior authorization contractor, will be entering the following note for hospice members disenrolled from managed care in the Indiana Prior Authorization (PA) Notice. The notice reads, "Member has been authorized for hospice care for the following service dates: (HCE will specify the service dates). The hospice must fax a properly completed claim form and a copy of this PA notice to the attention of Michelle Stein-Ordonez within the FSSA Division of Aging for reimbursement. The facsimile number is (317) 233-2182."

It will be the responsibility of the hospice to develop internal procedures to ensure that the hospice staff member who receives the PA notice coordinates with the hospice biller for the appropriate claims submission to the FSSA hospice program director. The claims submission should only be for those dates of service specified in the PA notice that are eligible for special batch. The service dates that will be special batched will not necessarily be the service dates of the entire hospice benefit period.

All other procedures as outlined in the current *IHCP Hospice Provider Manual* will remain the same with regard to managed care member's election of hospice services.

Hospice billers with any case-specific questions regarding this special batch process can contact Ms. Stein-Ordonez at (317) 233-1956.

All Vision Providers

Adjusted HCPCS Codes

The HCPCS codes listed in Table 3 were published with incorrect reimbursement rates and have been corrected. Effective for dates of service on or after January 1, 2006, the amended reimbursement rates for the codes are as follows:

Table 3 – Adjusted HCPCS Codes

Procedure Code	Description	Max Fee Rate	Procedure Code	Description	Max Fee Rate
V2624	Polishing/Resurfacing of Ocular Prosthesis	$45.20	V2627	Scleral Cover Shell	$920.75
V2625	Enlargement of Ocular Prosthesis	$357.94	V2628	Fabrication and Fitting of Ocular Conformer	$225.89
V2626	Reduction of Ocular Prosthesis	$148.13			

Providers must submit adjustments to EDS Adjustments, P.O. Box 7265, Indianapolis, IN 46207-7265 with a copy of this banner page to waive the filing limit.

Contact Information

If you have questions about the articles published in this banner page, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll-free at 1-800-577-1278, unless otherwise noted.