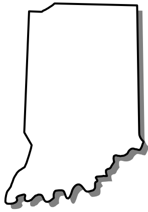

BANNER PAGE

BR200745 NOVEMBER 6, 2007

All Providers

VFC Flu Vaccine

It is now the start of flu season. To address the need for immunizations and to deal with potential 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 policy allows providers to obtain reimbursement for using a privately purchased influenza vaccine for VFC eligible members, even if they do not have a VFC vaccine available due to delays in receipt of the VFC supply. If a provider administers a free VFC vaccine, the provider should bill the appropriate Current Procedural Terminology (CPT) procedure code, but not charge more than the $8 VFC vaccine administration fee and not bill the separate administration CPT code.

When administering a privately purchased influenza vaccine, providers may bill for both the cost of the vaccine and administration. The IHCP allowable reimbursement is based on the average wholesale price (AWP) of the vaccine. Providers may separately bill an appropriate CPT administration code, 90772-90774, 90779, in addition to the HCPCS J-code or CPT drug code. If an evaluation and management (E&M) code is billed with the same date of service as an office-administered drug, the provider should not bill a drug administration code separately. Reimbursement for administration is included in the E&M code allowed amount. Separate reimbursement is allowed when the administration of the drug is the only service billed by the practitioner. In addition, if more than one injection is given on the same date of service and no E&M code is billed, providers may bill a separate administration fee for each injection using 90772 or 90779 as appropriate.

Providers must continue to submit claims to 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-payment 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.

The *Federal Deficit Reduction Act of 2005* mandates that Indiana Health Coverage Programs (IHCP) require the submission of National Drug Codes (NDCs) on claims submitted with certain procedure codes for physician-administered drugs. This mandate affects all providers who submit electronic or paper claims for procedure coded drugs. This applies to professional claims, including the paper CMS-1500 and electronic 837P. Providers can obtain additional information from BT200713.

100-Day Supply – Maintenance Medications

Effective January 1, 2008, fee-for-service claims for maintenance medications will be limited in quantity to no more than a 100-day supply per dispensation. A maintenance medication is a drug that is prescribed for chronic, long-term conditions and is taken on a regular, recurring basis. This policy has been approved by the Indiana Medicaid Drug Utilization Review (DUR) Board and is intended to align Medicaid policy with that of other payers, minimize the possibility of wasted medication, and encourage communication among pharmacists, physicians, and patients.

Utilization Edits

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. The utilization edits are reviewed quarterly and the following changes and additions in Table 1 will be made on December 21, 2007.

Table 1 – Utilization of Edits on December 21, 2007

Name of Medication and Strength	Utilization Edit
Abilify 5mg	1.5/day
Exelon 4.6mg/24HR patch, 9.5mg/24HR patch	1/day

Name of Medication and Strength	Utilization Edit
Methylin 2.5mg chewable tablet	3/day
Risperdal consta 12.5/2mL syringe	2/28 days
Seroquel XR 200mg tablet	1/day
Seroquel XR 300mg tablet	3/day
Seroquel XR 400mg tablet	4/day
Trifluoperazine 10mg tablet	4/day
Vyvanse 30mg, 50mg, 70mg capsule	1/day

Prior Authorization Transition from HCE

Beginning November 1, 2007, the prior authorization (PA) function will transition from Health Care Excel (HCE) to the entities identified in Table 2.

Table 2 – Prior Authorization Transition

PA Entities	Program	Contact Information
ADVANTAGE Health Solutions, Inc. SM	Traditional Medicaid, Medicaid Select, Hoosier Healthwise Carve-Outs (RBMC)	P.O. Box 40789 Indianapolis, IN 46240 1-800-269-5720
ADVANTAGE Health Solutions, Inc. SM	*Care Select* - Care Management Organization (CMO)	P.O. Box 80068 Indianapolis, IN 46280 1-800-784-3981
MDwise	*Care Select* - Care Management Organization (CMO)	P.O. Box 44214 Indianapolis, IN 46244-0214 1-866-440-2449

The aforementioned information was originally published in provider bulletin *BT200723*. It is important for all providers to understand that this change impacts *all* IHCP providers requesting PA. Providers must contact the member's Care Management Organization (CMO) regarding PA and restricted card services when a member is enrolled in the *Care Select* program. The correct CMO can be verified using one of the available Eligibility Verification Systems (EVS). If an EVS does not identify specific CMO information, then the provider must determine the IHCP program with which the member is associated.

Please note that based on the above table, ADVANTAGE Health Solutions SM plays multiple roles in the PA process. The organization will process PA for *Care Select* members who are assigned to a primary medical provider (PMP) contracted with their organization and will *also* process PA requests for members who are assigned to Traditional Medicaid, *Medicaid Select,* and Hoosier Healthwise carve-out services (RBMC) when the member is not in *Care Select*. (*Care Select* does not have carve-out services.) Because ADVANTAGE Health Solutions is processing PAs in two different capacities, they have designated two separate P.O. Boxes for submitting PA requests. It is important for providers to ensure that PA requests are mailed to the correct P.O. Box for the applicable program.

HCE will accept new and updated PA requests through October 31, 2007. After this date, HCE's PA telephone and fax numbers will be disconnected. HCE can still be contacted at 317-347-4500 for information about PAs that were submitted to HCE. Providers must submit all PA requests to the appropriate PA vendor on or after November 1, 2007. Providers may choose to hold any new PA requests and determine member eligibility on November 1 to ensure that the PA request is mailed to the appropriate PA vendor for review.

Provider Enrollment Forms Notice

Provider Enrollment implemented new IHCP applications and profile maintenance (update) forms effective September 27, 2007. Forms are available at http://www.indianamedicaid.com/ihcp/index.asp. Old forms will not be accepted for processing on or after January 1, 2008. Any previous version of the applications and maintenance forms submitted for processing after that date will be returned to providers with a request for completion and submission of a current form.

CPT Code 86701 HIV-1

Claims for CPT code 86701, HIV-1 that are denying for EOB 4208, *The procedure code billed is invalid with your CLIA certification on file,* will be systematically adjusted or reprocessed and will begin appearing on remittance advice (RA) statements dated October 16, 2007.

V5266, Battery for Use in Hearing Device

There is a clarification to the billing requirements for Healthcare Common Procedure Coding System (HCPCS) code V5266, *Battery for use in hearing device.* The IHCP designates one unit of code V5266 to represent four batteries; therefore, when submitting claims to the IHCP for reimbursement, providers are to report one unit of V5266 for each package of four batteries supplied.

CPT Code 83655 – Assay of Lead

The IHCP will reprocess or mass adjust professional claims that were denied or processed incorrectly for providers who submitted claims for CPT code 83655 - *Assay of Lead* with dates of service on or after July 1, 2004. Providers who are CLIA waived certified may have received denials for error code 4208 - *Invalid CLIA certification/procedure code combination* in relation to CPT code 83655. The reprocessed and mass adjusted claims began appearing on remittance advice (RA) statements dated October 9, 2007.

Billing Requirements for Lead Testing

There is a new billing requirement for lead testing in the office setting. The coverage and reimbursement rate for code 83655 is expanded to include tests administered using filter paper and handheld testing devices in the office setting. The following new procedure codes and modifier combinations in Table 3 are effective December 1, 2007.

Table 3 – New Codes for Lead Testing

Procedure Code	Description	Reimbursement Rate
83655 U1	Assay of lead, using filter paper	$10.00
83655 U2	Assay of lead, using handheld testing device	$5.00
83655	Assay of lead (venous blood)	$16.72*

**Note: Coverage and reimbursement of 83655 are not being changed.*

All DME and HME Providers

HCPCS Codes E2386 and E2387

This article notifies durable medical equipment (DME) providers and home medical equipment (HME) providers that the requirement for an attachment has been removed effective January 1, 2007, from HCPCS codes E2386, *Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each* and E2387, *Power wheelchair accessory, foam filled caster tire, any size, replacement only, each*. Codes E2386 and E2387 are no longer manually priced and no longer require an attachment for billing. Providers with previously denied claims may submit adjusted claims for payment. Please view the max fee rates at http://www.indianamedicaid.com/ihcp/Publications/MaxFee/fee_schedule.asp.

All Home Health and Hospice Providers

Prior Authorization Information Specific to Home Health and Hospice Providers

This banner page is meant to supplement information already provided in BT200723 *Indiana Care Select-(Medicaid Care Management for Aged, Blind and Disabled) and Prior Authorization Changes.* This banner page addresses case-specifics for Medicaid home health and hospice providers.

ADVANTAGE Health Solutions is responsible for processing prior authorization requests and updates for all Traditional fee-for-service (FFS) members. This has specific implications for FFS members enrolled in the Medicaid home health and hospice programs.

- The Medicaid home health program covers members who have a spend-down or who are dually eligible Medicare/Medicaid and do not meet Medicare home health criteria. Home health providers will be required to send all prior authorization requests to ADVANTAGE Health Solutions[SM]-FFS.
- The Medicaid hospice program covers Medicaid-only members and dually eligible Medicare/Medicaid members residing in nursing facilities. Hospice providers will be required to send all hospice authorization paperwork to ADVANTAGE Health Solutions-FFS. The Office of Medicaid Policy and Planning (OMPP) has decided to exclude hospice members from the CMO Plans so that hospice providers will only submit hospice authorization request to one contractor (ADVANTAGE).
- ADVANTAGE Health Solutions-FFS prior authorization contact information is as follows:

  ADVANTAGE Health Solutions-FFS
  P.O. Box 40789
  Indianapolis, Indiana 46240
  1-800-269-5720

Home health providers are reminded that members they serve may also be enrolled in one of the CMOs under Indiana *Care Select*. The contact information for prior authorization under these plans is as follows:

ADVANTAGE Health Solutions-CMO
P.O. Box 80068
Indianapolis, Indiana 46280
1-800-784-3981

MDwise-CMO
P.O. Box 44214
Indianapolis, Indiana 46244-0214
1-866-440-2449

It is imperative that home health and hospice providers continue to check Medicaid eligibility on a regular basis to monitor eligibility changes such as managed care auto-enrollment issues or changes in eligibility. It will be particularly crucial that home health providers check eligibility on a regular basis, because *Care Select* members can change enrollment from one CMO to another.

Please visit www.indianamedicaid.com for additional information related to *Care Select* and prior authorization. Home health and hospice providers may submit any questions regarding prior authorization or *Care Select* to the following e-mail address: careselect@fssa.in.gov. For questions regarding claims payment or submission or provider enrollment, please contact EDS at 1-800-577-1278. The OMPP and the Division of Aging (DA) will then prepare a frequently asked questions document if necessary.

All Traumatic Brain Injury Providers

CPT Codes 97532 and 97533

As a reminder, *405 IAC 5-29-1 (25) (I)* states that cognitive rehabilitation is a non-covered service, except for the treatment of traumatic brain injury. The IHCP limits CPT code 97532 – *Development of cognitive skills to improve attention, memory, problem solving (including compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes,* and CPT code 97533 – *Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes*, to the specific traumatic brain injury diagnoses listed in Table 8.76, listed in the *IHCP Provider Manual*, Chapter 8, page 258. Claims billed with a diagnosis that is not listed in Table 8.76, will be denied for Explanation of Benefit Code 6125 - C*ognitive rehabilitation is limited to procedure and diagnosis.*

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.