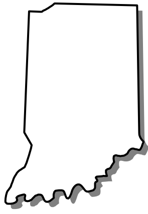

BANNER PAGE

BR200747 NOVEMBER 20, 2007

# All Providers

## Federal Deficit Reduction Act of 2005 - NDCs

The *Federal Deficit Reduction Act of 2005* mandates that all State Medicaid Programs, including Indiana Health Coverage Programs (IHCP) require the submission of National Drug Codes (NDCs) on claims submitted with certain procedure codes for physician-administered drugs. Claims billed for the following procedure codes in Table 1 will require the submission of the product NDC, NDC quantity, and Unit of Measure, along with the procedure code and procedure code billing units. This list does not guarantee coverage of a particular code. Please refer to http://www.indianamedicaid.com/ihcp/Publications/MaxFee/fee_schedule.asp for current procedure code coverage policies. This requirement will be effective as of January 1, 2008.

Table 1 – Procedure Codes

| Procedure Code | Procedure Code Description | Procedure Code | Procedure Code Description |
|---|---|---|---|
| B4164 | Parenteral Dextrose 50% or less (500ml = 1 unit) - homemix | B5100 | Parenteral nutrition solution: with electrolytes, hepatic (freamine hbc, hepatamine) - premix |
| B4168 | Parenteral amino acid 3.5% (500ml=1 unit) - homemix | B5200 | Parenteral nutrition solution: with electrolytes, stress (branch chain amino acids) - premix |
| B4172 | Parenteral amino acid 5.5% through 7% (500ml = 1 unit) - homemix | J0740 | Injection, cidofovir, 375mg |
| B4176 | Parenteral amino acids 7% through 8.5% (500ml = 1 unit) | J1390 | Injection, estradiol valerate, up to 20 mg |
| B4178 | Parenteral amino acids greater than 8.5% (500 ml = 1 unit) - homemix | J1595 | Injection, glatiramer acetate, 20mg |
| B4180 | Parenteral dextrose greater than 50% (500 ml = 1 unit) - homemix | J2850 | Injection, secretin synthetic human, 1mcg |
| B4185 | Parenteral lipids: per 10 grams | J3246 | Injection, tirofiban hcl, 0.25mg |
| B4189 | Parenteral nutritional solution with electrolytes, carbs and 10 to 51 grams of protein - premix | J3465 | Injection, voriconazole, 10mg |
| B4193 | Parenteral nutritional solution with electrolytes, carbs and 52 to 73 grams protein - premix | J7516 | Cyclosporine, Parenteral, 250 mg |
| B4216 | Parenteral nutrition: additives (vitamins, trace elements), per day - homemix per day | J7699 | NOC drugs, inhalation solution administered through DME |
| B5000 | Parenteral nutrition solution: with electrolytes, renal (amirosyn-rf, nephramine, renamin) - premix | J7799 | NOC drugs, other than inhalation drugs, administered through DME |

The following procedure codes in Table 2 have been removed from the requirement for submission of the product NDC, NDC quantity, and Unit of Measure, along with the procedure code and procedure code billing units effective August 1, 2007.

Table 2 – Removed Procedure Code

| Procedure Code | Procedure Code Description |
|---|---|
| Q4083 | Hyaluronan or derivative, Hyalgan or Supartz, for intra-articular injection, per dose |
| Q4084 | Hyaluronan or derivative, Synvisc, for intra-articular injection, per dose |
| Q4085 | Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose |
| Q4086 | Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose |

### Current Procedural Terminology Code (CPT) 37609 – Modifier 50

Providers with claims for Current Procedural Terminology Code (CPT) 37609 - *Ligation or biopsy, temporal artery* with Modifier 50 - *Bilateral procedure* and Error Code 4033 - *Invalid procedure code modifier combination* may resubmit claims. For claims over one year old, this banner page article must be used as documentation to waive the filing limit.

### Limits and Restrictions for Depo-Provera Contraceptive Injection

The following changes will be made 45 days after the initial publication of this article. The following changes will be retroactive to January 1, 2005, for Healthcare Common Procedure Coding System (HCPCS) code J1055-*Injection, medroxyprogesterone acetate for contraceptive use, 150 mg*.

- The gender indicator will be changed to "Female."
- Allowable units per date of service (DOS) will be limited to one.

According to the U.S. Food and Drug Administration (FDA), Depo-Provera Contraceptive Injection (CI) is a long-term contraceptive for women and is indicated only for the prevention of pregnancy. The recommended dose to women is 150 mg every three months. An appropriate HCPCS code for billing medroxyprogesterone for non-contraceptive use is J1051-*Injection, medroxyprogesterone acetate, 50 mg*, which may be billed for multiple units, per member, on a single DOS.

### Eligibility Verifications Systems Managed Care Update

Beginning November 1, 2007, EDS enhanced the managed care labels of the Automated Voice Response (AVR), Omni, and Web interChange member eligibility inquiries to include the new description for the administering organization as a result of the implementation of the new *Care Select* program. The description has been updated from "Managed Care Organization" to "Managed Care Entity." The managed care entities include the *Care Select* – Care Management Organizations (CMOs) and the Hoosier Healthwise – Managed Care Organizations (MCOs). To receive the new managed care description of "Managed Care Entity" on Omni, providers who have an Omni terminal must download the latest Omni software version. Detailed download instructions can be found in Table 1.1 of provider bulletin *BT200711* on the Indiana Health Coverage Programs (IHCP) Web site at http://www.indianamedicaid.com. *Care Select* information displays, even if a download is not performed. Information regarding the *Care Select* program can also be found in provider bulletin *BT200723*.

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.

### 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 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 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 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 3 will be made on December 21, 2007.

Table 3 – 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 |
| 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 |

## 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 Outpatient Hospitals, Ambulatory Surgery Centers, and Physicians

### Rates for Healthcare Common Procedure Coding System C9728

Rates have been established for HCPCS code C9728 - *Placement of Interstitial Device(s) for Radiation Therapy/Surgery Guidance (e.g., fiducial markers, dosimeter), other than prostate (any approach), single or multiple*. The rates are effective for dates of service on or after July 1, 2007. The RBRVS rate for C9728 will be $224.86. The ASC rate for facility services is $267.91.

# All Pharmacy and Prescribing Providers

### Niaspan Mass Adjustment

The IHCP notified providers in banner page *BR200642* that all prescription niacin products, including Niaspan, would be considered covered drugs by Medicare Part D and therefore non-reimbursable by Indiana Medicaid effective January 1, 2007. In accordance with this policy, the IHCP will recoup claim payments for Niaspan dispensed to Medicare D eligible members with dates of service on or after January 1, 2007. The recoupments will be visible on the remittance advice dated January 8, 2008. Providers should bill the appropriate Medicare D Prescription Drug Plan as soon as possible for reimbursement of these claims.

# 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.

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