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All Providers

Reimbursement to Mid-Level Practitioners – Psychiatric Residential Treatment Facility

Mid-level practitioner services may be reimbursed for services provided on the same date as admission to and/or discharge from a Psychiatric Residential Treatment Facility (PRTF). Submit these claims to EDS with documentation from the mid-level practitioner or PRTF showing the services were rendered outside the PRTF setting. Documentation must include one of the following:

- Patient records that indicate services were rendered in the office or outpatient setting
- Records submitted from the PRTF showing admission and/or discharge date

Providers with previously denied claims for audit 6636-*Mid-level services not reimbursable the same day as a paid PRTF service*, can resubmit claims for special processing only if the denials were for mid-level practitioner services on the same day as an admission to and/or discharge from a PRTF.

Please submit your claim and documentation for special processing to EDS Written Correspondence (WC) at the following address:

EDS Written Correspondence
P.O. Box 7263
Indianapolis, Indiana 46207-7263

2007 October Quarterly HCPCS Update

This article notifies providers about the coverage determinations for the 2007 October Quarterly Healthcare Common Procedure Coding System (HCPCS) codes. The Centers for Medicare & Medicaid Services (CMS) issued a quarterly update to HCPCS codes, dated September 14, 2007, (CR5718, Transmittal 1336 http://www.cms.hhs.gov/transmittals/downloads/R1336CP.pdf), indicating that the assigned HCPCS code for separate payment of eculizumab (Solaris™) in the hospital outpatient setting is effective October 1, 2007. The Indiana Health Coverage Programs (IHCP) will also begin covering this code as outlined in Table 1.

Table 1 – New 2007 October Quarterly HCPCS Codes, Effective October 1, 2007

Procedure Code	Description	PA Requirements	Modifiers	Program Coverage	NDC Required on Claim*
C9236	Injection, eculizumab, 10mg	No for All Programs, No for Package C	No for All Programs, No for Package C	Covered for All Programs, covered for Package C	Yes

**Note: In accordance with the Federal Deficit Reduction Act of 2005, the IHCP requires the submission of a National Drug Code (NDC) with certain physician-administered drugs. The IHCP policy is outlined in BT200713 and BT200731, including specific requirement and submission details. Additional information regarding this policy may be located under the claim information in the IHCP newsletter NL200708. As a reference guide, providers can access the Palmetto GBA Web site at http://www.palmettogba.com/. This Web site is a public domain and furnishes an NDC crosswalk table, which relates procedure codes, NDCs, and NDC quantity conversion. Providers should utilize this tool as a guide to conversions but should not rely on it as a sole source for NDC quantity information. Providers must also remember that it is imperative that the NDC listed on the claim is representative of the actual product NDC administered to the member by the healthcare provider. Providers must continue to monitor the IHCP Web site for more information regarding submission of NDC.*

NPI Edits and the Billing Service Location

One of the requirements for billing with the National Provider Identifier (NPI) is to include the billing service location ZIP Code+4 on all claims, which allows a one-to-one match with the NPI in the claims processing system. The billing provider's service location is defined by the IHCP as the location where the service was rendered.

NPI edit *1108 – Billing NPI has no matching LPI* indicates either the NPI on the claim has not been reported, or the claim was not submitted with a matching *service location* ZIP Code+4. If a provider has more than one service location using the same ZIP Code+4, then there must be a distinct taxonomy code associated with those service locations.

Paper claim form requirements instructed providers about completing the new paper claim forms with the implementation of the NPI. The ZIP Code+4 of the provider service location is required on all paper and electronic claim transactions. Requirements were provided in the bulletins listed in the Table 2.

Table 2 – Bulletins with Paper Claim Form Requirements

Provider Type	Field Locator	Bulletin Number
Dental	48	*BT200705*
Medical	33	*BT200703*
Institutional	1	*BT200702*

During the current NPI implementation Phase II, Edit 1108 is a *post and pay* edit, which does not cause a claim denial. However, after Phase III of the implementation, this edit will cause full claim denial. No date has been established for the implementation of Phase III at this time; however, providers are encouraged to register their NPI now to avoid a delay in payment when Phase III is implemented. The ZIP Code+4 submitted on all claims to the IHCP must match the ZIP Code+4 *service location* on the provider enrollment file database. Web interChange users can verify the enrollment file information under the Provider Profile. Providers are encouraged to resolve **all** NPI edits appearing on the IHCP remittance advices (RAs) prior to implementation of Phase III to avoid denials. NPI edits range from 1100 to 1129.

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. This policy is effective October 1, 2007.

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 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*.

Federal Deficit Reduction Act of 2005 – NDCs

The *Federal Deficit Reduction Act of 2005* mandates that all State Medicaid Programs, including IHCP, require the submission of NDCs on claims submitted with certain procedure codes for physician-administered drugs. Claims billed

for the following procedure codes in Table 3 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 3 – 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 4 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 4 – 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 37609 – Modifier 50

Providers with claims for 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.

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*. *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.

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 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.

All Home Health Providers

Duplicate Logic

On October 1, 2007, EDS implemented modifications to the duplicate logic for the Medical HCFA 1500, Medical Crossover Part B, Outpatient, Outpatient Crossover C, and Home Health claim types. Details about the changes were provided in *BR200741*. On October 9, 2007, a home health claims mass adjustment was performed due to a rate change. Providers can submit adjustment requests for claims that contain details that denied with edit 5001 – *Exact Duplicate*. As a reminder, home health providers must bill like services for the same date of service on the same claim form on one line. Billing separate lines for the same service with the same date of service causes the system to deny one or more of the details as an exact duplicate.

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.

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.