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All Providers

Shortage of Hemophilus Influenza B Vaccine

Hemophilus influenza b vaccine (Hib) HbOC conjugate (4 dose schedule), for intramuscular use, is in short supply resulting from the Hib recall by Merck as of December 12, 2007. Effective February 1, 2008, the Indiana Health Coverage Programs (IHCP) is not limiting reimbursement for Current Procedural Terminology (CPT)[1] code *90645*, regardless of availability from the Vaccines for Children (VFC) program. This policy allows providers to obtain reimbursement for using a privately purchased Hib 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 CPT 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 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 or 90779, in addition to the Healthcare Common Procedure Coding System (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 90772-90774 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 the vaccine and administration fee and cannot be billed separately on claims submitted to EDS. RHCs and FQHCs must separately verify the billing policy for each MCO to whom they submit claims.

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.*

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 are not being accepted for processing on or after January 1, 2008. Any previous versions of the applications and maintenance forms submitted for processing after that date are being returned to providers with a request for completion and submission of a current form.

[1] *Current Procedural Terminology (CPT) is copyright 2004 American Medical Association. All Rights Reserved*

Hospital Providers

Claims Denied for Edit 5009

Providers who have previously submitted inpatient crossover claims that have been denied inappropriately for edit 5009-*suspect duplicate, different provider allowed*: can submit claims for review of appropriate adjudication, along with a copy of this banner page article, to the EDS Written Correspondence Unit. Claims for review must be submitted to the following address:

EDS Administrative Review
Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263

This edit commonly denied when a long-term care (LTC) facility billed appropriately for leave days and the claim paid prior to submission of the inpatient claim. Medicaid will continue to deny when two different hospitals are billing for the same date of service.

Community Mental Health Centers, Area Agencies on Aging, Indiana Associations of Area Agencies on Aging, and Diagnostic and Evaluation Team

Issues with Claims for Pre-Admission Screening and Residential Review

The Division of Aging in collaboration with the Office of Medicaid Policy and Planning, EDS, the Division of Disabilities and Rehabilitative Services, and the Division of Mental Health and Addiction, have been working to resolve issues regarding claims for Pre-Admission Screening and Residential Review (PASRR). Changes to the Indiana*AIM* claims processing system will be implemented March 10, 2008, to systematically deny claims currently in suspense with edit 2037 – *Member Not on file for Non-IHCP Program*.

All the affected claims have an invalid member identification number. The member identification number must contain the 800 prefix followed by the Social Security number. Affected claims will not be automatically reprocessed. Providers must resubmit affected claims after the suspended claims deny. In an effort to assist providers, Indiana*AIM* will be temporarily modified to waive the timely filing requirement for PASRR claims submitted on and after March 10, 2008. Providers are encouraged to validate the member identification number before resubmitting the claim.

In addition, the Division of Aging is scheduling meetings with the local Area Agencies on Aging to assist providers regarding claims resolutions. Meetings will be conducted starting March 19, 2008, and will run through the end of April 2008.

Dental Providers

Dental Paper Claim Form Billing Clarification

Provider bulletin *BT200705* outlines the new American Dental Association (ADA) 2006 paper claim form changes and requirements. The bulletin states the patient name is entered in *Form Locator 20 – Patient Name* and Patient Recipient ID is entered in *Form Locator 23 – Patient ID/Account #*.

A large number of dental claims have denied because the patient name was submitted in *Form Locator 12 – Policyholder/Subscriber Information* and the patient recipient ID was submitted in *Form Locator 15 – Policyholder/Subscriber ID*.

Medicaid now accepts the information for patient name in *Form Locator 20* or *12* and *Patient Recipient ID* in *Form Locator 23* or *15*. The claims processing system has been changed to meet the new requirements.

Nursing Facility Providers

Mass Adjustment of Medicare Part A Crossover Claims

EDS will process a mass adjustment of Medicare Part A crossover claims with dates of service from October 1, 2001, through March 26, 2002. During this time an emergency rule was in effect that capped Medicaid reimbursement of crossover claims at the Medicaid allowable rate. The State was sued and prevented from implementing this emergency rule as well as three others. On appeal, the court found in favor of the State and sent the case back to the trial court for a determination of the amount the State was owed in restitution from providers (See *IFSSA v. Amhealth et al,* 790 N.E.2d162).

The lawsuit involved the nursing facility industry's challenge of four emergency rules that, in aggregate, reduced Medicaid reimbursement. As a result of a settlement with the plaintiffs, only Medicare Part A crossover claims will be adjusted and recouped from nursing facility providers.

The adjustments began appearing on the March 18, 2008, remittance advice (RA). These claims have an internal control number (ICN) starting with **56**, which reflects a mass-adjusted claim. An accounts receivable (A/R) is set up to recover the overpayment. Following review of the RA, providers who disagree with any adjustment amounts may request an administrative review by writing to the following address:

EDS Administrative Review
Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263

In the request explain why you disagree with the adjustment amount and include copies of all pertinent documentation. Detailed information about the administrative review process is available in the *Indiana Health Coverage Programs* (IHCP) *Provider Manual*.

Outpatient Providers

Billing Unlisted Magnetic Resonance Imaging Procedure Code

CPT 76498 – *Unlisted Magnetic Resonance Procedure (e.g., Diagnostic, Interventional)* is manually priced when billed on the CMS-1500 for both the global and professional components. Providers must submit documentation supporting the reason for billing the unlisted magnetic resonance imaging (MRI) procedure. This documentation can include a copy of the operative report, admission or discharge summary, or any documentation from the member's medical chart that supports the need to use an unlisted MRI code rather than a more specific MRI code.

When billing for the technical component of this code on the UB-04 or the CMS-1500 with the TC modifier, the claim is priced at the lesser of the provider's billed amount or $211.22.

Providers may resubmit denied claims for the global (procedure code without a modifier) or professional component (billed with modifier 26) of CPT code 76498 with dates of service on or after January 1, 2003. Include supporting documentation and a copy of this banner page article to waive the one-year filing limit. Send resubmitted claims to the following address:

EDS Administrative Review
Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263

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.