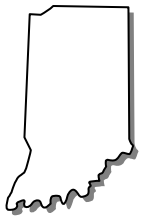

B A N N E R P A G E

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All Providers

Screening and Brief Intervention Services

Beginning October 1, 2008, the Indiana Health Coverage Programs (IHCP) began reimbursing providers for screening and brief intervention (SBI) services. SBI identifies and intervenes with individuals who are at risk for substance abuse-related problems or injuries. SBI services use established systems, such as trauma centers, emergency rooms, community clinics, and school clinics, to screen patients who are at risk for substance abuse and, if necessary, provide the patients with brief interventions or referrals to appropriate treatment.

The IHCP reimburses providers when they bill procedure codes 99408 or 99409. The descriptions for the procedure codes are listed in Table 1.

Table 1 – Procedure Codes for Screening and Brief Intervention Services

Code	Description
99408	Alcohol and/or substance abuse structured screening and brief intervention services, 15-30 minutes
99409	Alcohol and/or substance abuse structured screening and brief intervention services, greater than 30 minutes

The new Current Procedural Terminology (CPT®[1]) codes were developed by the American Medical Association (AMA) to make it possible for the healthcare system to "efficiently report screening services for drug and alcohol abuse." Providers can bill procedure code 99408 or 99409 only after an individual has been screened for alcohol or drug abuse by a healthcare professional.

SBI services currently do not require prior authorization. Procedure codes 99408 and 99409 are limited to one structured screening and brief intervention per individual, every three years, when billed by the same provider. This does not count toward the number of annual office visits allowed per year for an individual. Providers can submit claims for services rendered for dates of service beginning October 1, 2008.

Reprocessing Medical Claims for Carved-out Services

The services listed below are not typically included in the coordination by the Restricted Card Program (RCP). These services are carved out and do not require a written referral unless the member is going to receive prescriptions from the provider. On October 19, 2008, a modification was made to ensure that claims billed by these provider specialties process in accordance with the policy:

- Behavioral health
- Chiropractic services
- Dental services
- Diabetes self-management training services
- Family planning services
- HIV/AIDS targeted case management services
- Home healthcare
- Hospice

[1] CPT® is a registered trademark of the American Medical Association.

- Podiatric services
- Transportation
- Vision care (except surgery)
- Waiver services

EDS will systematically reprocess medical claims for these carved-out services with dates of service November 1, 2007, through November 21, 2008, that denied for Explanation of Benefits 7502 – *Recipient Locked in to a Specific Provider*. Reprocessed claims will appear on February 3, 2009, Remittance Advice statements.

Claims Denied for Error Code 520 – *Invalid Revenue Code/Procedure Code Combination for HCPCS Codes A9542-A9545* and Revenue Code 636

Providers that received denials since January 1, 2006, with error code 520 – *Invalid revenue code/procedure code combination* for the Healthcare Common Procedure Coding System (HCPCS) codes in Table 2 with revenue code 636 may resubmit those claims. Providers may submit this banner page along with the claims to waive the one-year filing limit.

Table 2 – HCPCS Codes for Claims Denied for Error Code 520

Code	Description
A9542	Indium In-111 Ibritumomab Tiuxetan, Diagnostic, per Study Dose, up to 5 Millicuries
A9543	Yttrium Y-90 Ibrutumomab Tiuxetan, per Treatment Dose, up to 40 Millicuries
A9544	Iodine I-131 Tositumomab, Diagnostic, per Study Dose
A9545	Iodine I-131 Tositumomab, Therapeutic, per Treatment Dose

Additions to MHQAC Utilization Edits

On June 19, 2007, the Mental Health Quality Advisory Committee's (MHQAC's) recommended utilization edits for mental health medications were implemented (refer to *Provider Bulletin* BT200709, dated May 3, 2007). The utilization edits are reviewed quarterly, and the additions listed in Table 3 will be made March 13, 2009:

Table 3 – Additions to MHQAC Utilization Edits

Name of Medication and Strength	Utilization Edit
D-amphetamine Sulfate, 5mg/5mL solution	40mL/day
Dexedrine spansules, 5mg capsules	2/day
Dexedrine spansules, 15mg capsules	2/day
Pexeva, 40mg tablets	1/day

Correct Billing Codes for Botox Injections

The Office of Medicaid Policy and Planning (OMPP) has determined that the seven CPT codes listed in Table 4 are no longer the most appropriate codes for chemodenervation with the drug Botulinum Toxin Type A and Botulinum Toxin Type B, according to most current CPT billing guidelines. Effective November 1, 2008, these CPT codes are no longer reimbursable when billed with HCPCS J0585 – *Botulinum Toxin Type A, per unit* and HCPCS J0587 – *Botulinum Type B, per 100 units*, and will deny because of Audit 6612 – *Botox and Myobloc Injections Limited to Diagnosis Codes.*

Table 4 – CPT Codes for Chemodenervation No Longer Reimbursable with Botox

64640	95860	65861	65867
65868	95869	95870	

Effective November 1, 2008, the two International Classification of Diseases, Ninth Revision (ICD-9) diagnosis codes listed in Table 5 are no longer appropriate for billing with HCPCS J0585 – *Botulinum Toxin Type A, per unit* and HCPCS J0587 – *Botulinum Type B, per 100 units*. Claims billing HCPCS J0585 – *Botulinum Toxin Type A, per unit* and HCPCS J0587 – *Botulinum Type B, per 100 units* with the two diagnosis codes will not be reimbursed and will deny because of Audit 6612 – *Botox and Myobloc Injections Limited to Diagnosis Codes.*

Table 5 – ICD-9 Diagnosis Codes No Longer Reimbursable with Botox

333.7	378.6

Effective November 1, 2008, the additional 10 CPT codes for chemodenervation listed in Table 6 and additional 20 ICD-9 diagnosis codes listed in Table 7 will be reimbursable when billed with HCPCS J0585 – *Botulinum Toxin Type A, per unit* and HCPCS J0587 – *Botulinum Type B, per 100 units*.

Table 6 – Additional CPT Codes for Chemodenervation with Botox

46299	43201	43236	46505
53899	64650	64653	67345
95873	95874		

Table 7 – Additional ICD-9 Diagnosis Codes with Botox

333.71	333.79	341.22	344.00
344.02	344.03	344.04	344.09
344.1	344.3	344.31	344.32
344.40	344.41	344.42	374.03
374.13	527.7	596.54	596.55

Mandate of Red Claim Forms Postponed

Banner page *BR200852*, dated December 23, 2008, stated that standard red-ink claim forms would be mandated beginning January 19, 2009. The implementation date has been postponed indefinitely. Claims submitted on black-ink claim forms will still be accepted after January 19.

You are encouraged to submit claims electronically or on the standard red-ink form to speed claim processing and improve the accuracy of data entry. The IHCP has implemented software that uses an optical character recognition (OCR) program to read the data for claim processing from the red-ink claim forms.

All claims are processed within the required time frames for paper claims. Claims submitted electronically are processed with less human interaction, therefore reducing processing time. Red-ink claims are processed with less interaction than black-ink claim forms. Black-ink claims require the most time to adjudicate.

First Steps Providers

First Steps Begins Transition to CSC Covansys January 30

Effective January 30, 2009, you will have "view-only" access to Web interChange for First Steps claims submitted prior to January 30, 2009. If you have questions regarding claims, claims payment, or an authorization, please continue to contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278 during the transition period of January 30, 2009, to February 16, 2009. Please understand that CSC Covansys will only be able to answer your questions beginning February 16, 2009.

Therefore, we ask that you refrain from calling CSC Covansys with claims, billing, or authorization questions until after February 16, 2009. Additional information regarding the transition is available at http://www.in.gov/fssa/ddrs/2633.htm under the "What's New?" section.

All Pharmacy Providers

Billing Prilosec OTC™

Effective February 1, 2009, providers are advised to discontinue using the Universal Product Code (UPC) when billing Prilosec OTC. Instead, the corresponding National Drug Code (NDC) should be used for billing all claims for Prilosec OTC. If a claim is submitted with a UPC, it will be denied, and resubmission with the appropriate NDC will be requested. Please refer to Table 8 for the UPC to NDC conversion:

Table 8 – Prilosec OTC UPC to NDC Conversion

Prilosec OTC	UPC	NDC
14 count	37000035905	37000045502
28 count	37000035906	37000045503
42 count	37000035907	37000045504
28 count unit dose	37000005845	37000045505

Vaccines for Children (VFC) Providers

Update on Claims for Hemophilus Influenza B (Hib) Vaccine

In conjunction with banner page *BR200901*, dated January 6, 2009, Vaccines for Children (VFC) providers who provided Hib-containing vaccine from their private stock to VFC-eligible children since February 1, 2008, and received only $8 (using CPT codes 90645, 90647, 90648, 90721, and 90748) will need to submit replacement claims for adjustments to receive the difference for the IHCP Medicaid rate on file. Please refer to the IHCP or managed care organization (MCO), as appropriate, for directions about submitting replacement claims to adjust these claims for reprocessing. Remember to include the invoice as an attachment for immunizations provided from your private stock. Doses provided from the VFC vaccine stock should not be billed for more than the $8 administration fee.

For IHCP claims beyond the one-year filing limit, you must attach a copy of this banner page to each claim for proper processing. For MCO claims, the provider should follow the MCO's claim-processing guidelines.

Provider Workshops

2009 Workshops Are Here!

The IHCP is offering quarterly provider workshops free of charge. Topics include medical review team (MRT) billing, Hoosier Healthwise open enrollment, a managed care roundtable, and more. Workshop agendas, dates, registration deadlines, and locations are online at http://www.indianamedicaid.com/ihcp/ProviderServices/workshops.asp. You may also register online. For more information about the workshops, please contact the workshop line at (317) 488-5072.

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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