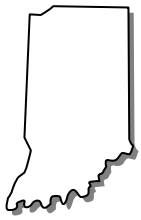

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All Providers

Use National Provider Identifier When Submitting Claims via Web interChange

Bulletin *BT200926*, dated August 19, 2009, announced the changes that occurred as a result of the full implementation of the National Provider Identifier (NPI) mandate. Healthcare providers are required to submit all Health Insurance Portability and Accountability (HIPAA) transactions, including claims, using the NPI instead of the legacy provider identifier (LPI).

Providers who submit medical (CMS-1500 format) claims via Web interChange have encountered an error message when both the LPI and NPI are entered for the referring or rendering provider. To resolve the error, remove the LPI from all fields on Web interChange; report only the NPI for the referring or rendering provider.

Providers who submit institutional (UB-04 format) claims via Web interChange have encountered an error message when entering the attending physician license number in the Attending Prov NPI field. Please note that only the NPI is accepted in this field; the license number of the attending physician should not be entered on the claim.

Updated Pricing for Procedure Codes Previously Manually Priced

Indiana Health Coverage Programs (IHCP) has established rates for the Healthcare Common Procedure Coding System (HCPCS) codes in Table 1. These codes, which are currently manually priced, did not have pricing available from the Centers for Medicare & Medicaid Services (CMS) at the time the procedure codes were created, but rates have now been established. The new rates are effective for dates of service on or after December 1, 2009.

Table 1 – HCPCS Codes Effective December 1, 2009

Procedure Code	Code Description	Rates Effective for Dates of Service on or after December 1, 2009
82045	Albumin; Ischemia modified	Lab Fee rate of $40.56
82656	Elastase, Pancreatic (EL-1), fecal, qualitative or semi-quantitative	Lab Fee rate of $15.95
83009	Heliobacter pylori, blood test analysis for urease activity, non-radioactive isotope	Lab Fee rate of $93.09
83037	Hemoglobin, glycosylated (A1C) by device cleared by FDA for home use	Lab Fee rate of $13.42
87338	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Helicobacter pylori, stool	Lab Fee rate of $19.88
91132 with modifier 26	Electrogastrography	Resource-based relative value scale (RBRVS) rate of $20.46 for Professional Component
91133 with modifier 26	Electrogastrography w/test	RBRVS rate of $25.68 for Professional Component
99091	Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified	RBRVS rate of $37.91

Procedure Code	Code Description	Rates Effective for Dates of Service on or after December 1, 2009
	health care professional	
99174	Ocular photoscreening	RBRVS rate of $18.01
E0672	Segmental gradient pressure pneumatic appliance, full arm	Max Fee rates of $307.83 NU and $30.79 RR
E1030	Wheelchair accessory, ventilator tray, gimbaled	Max Fee rates of $1054.57 NU and $105.46 RR
E1035	Multi-positional patient transfer system, with integrated seat, operated by care giver	Max Fee rate of $613.20 for RR
E1355	Stand/rack	Max Fee rate of $22.40
E1391	Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each	Max Fee rate of $175.79 for RR
E2397	Power wheelchair accessory, lithium-based battery, each	Max Fee rates of $414.13 NU and $41.41 RR
G0239	Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals	RBRVS rate of $7.80
G0306	Complete CBC, automated (HgB, HCT, RBC, WBC, without platelet count) and automated WBC differential count	Lab Fee rate of $10.86
G0307	Complete CBC, automated (HgB, HCT, RBC, WBC, without platelet count)	Lab Fee rate of $9.04
K0730	Controlled dose inhalation drug delivery system	Max Fee rates of $1724.02 NU and $172.40 RR
K0801	Power operated vehicle, group 1 heavy duty, patient weight capacity 301 to 450 pounds	Max Fee rates of $1886.22 NU and $188.60 RR
K0802	Power operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds	Max Fee rates of $2134.59 NU and $213.45 RR
L2232	Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only	Max Fee rate of $78.20
L3001	Foot insert, removable, molded to patient model, Spenco, each	Max Fee rate of $106.49
L3003	Foot insert, removable, molded to patient model, silicone gel, each	Max Fee rate of $140.27
L3911	Wrist hand finger orthosis, elastic, prefabricated, includes fitting and adjustment	Max Fee rate of $18.15
L5782	Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system, heavy duty	Max Fee rate of $3402.47
L6694	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism	Max Fee rate of $633.97
L6695	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism	Max Fee rate of $528.30

Procedure Code	Code Description	Rates Effective for Dates of Service on or after December 1, 2009
L6696	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only	Max Fee rate of $1061.04
L6697	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only	Max Fee rate of $1061.04
L6698	Addition to upper extremity prosthesis, below elbow/above elbow, lock mechanism, excludes socket insert	Max Fee rate of $398.91
L7400	Addition to upper extremity prosthesis, below elbow/wrist disarticulation, ultralight material	Max Fee rate of $247.22
L8511	Insert for indwelling tracheoesophageal prosthesis, with or without valve, replacement only, each	Max Fee rate of $58.66
L8512	Gelatin capsules or equivalent, for use with tracheoesophageal voice prosthesis, replacement only, per 10	Max Fee rate of $1.76
L8513	Cleaning device used with tracheoesophageal voice prosthesis, pipet, brush, or equal, replacement only, each	Max Fee rate of $4.19
L8514	Tracheoesophageal puncture dilator, replacement only, each	Max Fee rate of $76.08
L8603	Injectable bulking agent, collagen implant, urinary tract, 2.5 ml syringe, includes shipping and necessary supplies	Max Fee rate of $325.11

Prescribing Providers and Pharmacy Providers

Active Pharmaceutical Ingredients (APIs)

The CMS, through the pharmacy technical advisory group, notified states that it will be removing additional nondrug products (Active Pharmaceutical Ingredients) used in compounded prescriptions from the CMS covered outpatient drug file. These nondrug products will remain reimbursable under Indiana Medicaid but will not require a drug rebate agreement for payment. Nondrug products that are considered APIs are covered by Indiana Medicaid, and as of July 1, 2009, do not require a drug rebate agreement in order to be reimbursed. An API that has recently been questioned is 17 alpha-hydroxyprogesterone caproate. This product is reimbursable even when it is from a nonrebating manufacturer, and may be billed on either the National Council for Prescription Drug Programs (NCPDP) claim or CMS-1500/837P format. When billed using either format, the product is reimbursable only if included in a compound. The required National Drug Code (NDC) information must be provided when billed on the CMS-1500/837P format.

Reminder – National Drug Codes Required for Procedure-Coded Drug Claims

The Federal Deficit Reduction Act of 2005 mandates that the IHCP require the submission of NDCs on claims submitted with certain procedure codes. This mandate affects all providers that submit electronic or paper claims for procedure-coded drugs. NDCs will also be required on Medicare crossover claims for all applicable procedure codes because the State may pay up to the 20 percent Medicare B copayment for dually eligible individuals. Only the NDC that is specified

on the label of the product that is administered to the member is to be billed to the program. It is not permissible to bill the program with an NDC that was not on the label of the product that was administered to the member. For example, do not preprogram your billing system to automatically utilize a certain NDC for a procedure code when that NDC is not the one on the label of the product being administered to the member.

A listing of the above-referenced procedure codes is available at www.indianamedicaid.com under the Provider Services drop-down menu, "Procedure Codes that require NDC."

Physicians, Hospitals, Clinics, Mental Health, and Pharmacy Providers

VFC Flu Vaccine

The flu season has started. To address the need for immunizations and to deal with the potential shortage of available influenza vaccine, the IHCP is not limiting reimbursement for any influenza vaccine, regardless of the availability from the Vaccines for Children (VFC) program. Thus, effective September 1, 2009, providers may obtain reimbursement for privately purchased influenza vaccines for eligible VFC members when VFC vaccines are not available and supplies are delayed.

Providers are reminded that when a free VFC vaccine is administered, the appropriate Current Procedural Terminology (CPT®[1]) vaccine procedure code and the lesser of the usual and customary administration fee or $8 should be billed. A separate CPT administration code should not be billed for a VFC-administered vaccine.

When administering a privately purchased influenza vaccine, providers may bill for both the vaccine and its administration (CPT codes 96372-96374). If an evaluation and management (E/M) service code is billed with the same date of service as an office-administered immunization, providers should not bill the vaccine administration code separately. Reimbursement for the 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 vaccine is administered on the same date of service and no E/M code is billed, providers may bill an administration fee for each injection.

Additionally, providers are reminded that claims should be submitted to the appropriate delivery system – HP or managed care organization (MCO) – for each member, regardless of the source of the vaccine stock. Claims are eligible for postpayment review, and therefore, 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 HP. RHCs and FQHCs must separately verify the billing policy for each MCO to which they submit claims.

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

Coverage for Influenza A (H1N1) Vaccine Administration

The IHCP covers Influenza A (H1N1) vaccine administration. Providers should use the following HCPCS code when billing for the administration:

G9141 – *Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)*

The administration of the Influenza A (H1N1) vaccine is reimbursed at the lower of the usual and customary charge or the IHCP established max fee rate, $12.94. Because the Influenza A (H1N1) vaccine is provided at no cost to providers, the IHCP will not reimburse G9142 – *Influenza A (H1N1) vaccine, any route of administration*. Providers who bill G9142 will receive error code 4209 – *No Pricing Segment for procedure/modifier combination*.

Providers are reminded that if an evaluation and management (E/M) code is billed with the same date of service as an office-administered immunization, the vaccine administration should not be billed separately. Reimbursement for the vaccine administration is included in the E/M code allowed amount. This remains true for the administration of the Influenza A (H1N1) vaccine. Separate reimbursement is allowed when the administration of the vaccine is the only service provided and billed by the practitioner. In addition, if more than one immunization is provided on the same date of service, and no E/M code is billed, separate administration fees for each immunization may be separately billed.

Contact Information

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