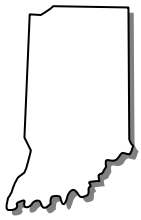

B A N N E R P A G E

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All Providers

2010 Healthcare Common Procedure Coding System Updates Are Available

The 2010 Healthcare Common Procedure Coding System (HCPCS) updates are available for download on the following Web site: http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS.

The new codes, deleted codes, codes with description changes, and new modifiers are currently under review. HP Enterprise Services will publish a provider bulletin containing information about Indiana Health Coverage Programs (IHCP) coverage, prior authorization requirements, and pricing, as applicable. HP anticipates publication of this bulletin during the last week of December 2009.

Care Select Primary Medical Provider Requirement Is Exempt on Claims for the H1N1 Vaccine

Care Select claims are exempt from the *Care Select* Primary Medical Provider (PMP) certification code requirement for Influenza A (H1N1) vaccine administration. If you received denial 1049 – Care Select *member's PMP is missing or invalid*, please resubmit the claim for reprocessing.

Anesthesia Providers

Reimbursement for Procedure Codes 01952 and 01953

Effective for claims with dates of service on or after February 1, 2010, the IHCP will reimburse anesthesia codes 01952 – *Anesthesia for second and third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; one percent to nine percent total body surface area* and 01953 – *Anesthesia for second and third degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; each additional nine percent total body surface area* when billed on the same claim form.

The complete time for the entire procedure must be included in the time reported for 01952. When multiple units are performed for procedure code 01953 (that is, each additional 9 percent), bill all the units on the same detail line. Providers will be reimbursed one base unit for each additional 9 percent of the total body surface area. The current base rate for anesthesia services is $13.88 per unit.

Prescribing Providers and Pharmacy Providers

Mental Health Quality Advisory Committee 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 in Table 1 will be effective February 1, 2010. These updates were approved at the Fourth Quarter 2009 MHQAC meeting and at the November 2009 Drug Utilization Review (DUR) Board meeting.

Table 1 – Updates to MHQAC Utilization Edits

Name of Medication and Strength	Utilization Edit
Edluar 10mg SL tablet	1/day
Edluar 5mg SL tablet	1/day
Invega ER 1.5mg tablet	1/day
Invega Sustenna 39mg prefilled syringe	1/28 days
Invega Sustenna 78mg prefilled syringe	1/28 days
Invega Sustenna 117mg prefilled syringe	1/28 days
Invega Sustenna 156mg prefilled syringe	1/28 days
Invega Sustenna 234mg prefilled syringe	1/28 days
Nuvigil 50mg	2/day
Nuvigil 150mg	1/day
Nuvigil 200mg	1/day
Nuvigil 250mg	1/day
oxazepam 15mg tablet	4/day; max quantity 120
risperidone 0.25mg ODT	2/day
risperidone 1mg/1mL solution	8mL/day
Saphris 5mg sublingual tablet	2/day
Saphris 10mg sublingual tablet	2/day
Sarafem 15mg tablet	1/day
thiothixene 20mg capsule	3/day

Inpatient Hospital Providers

Present on Admission Indicator Claims with Explanation of Benefits 4275 To Be Reprocessed

Per provider bulletin *BT200928*, dated August 25, 2009, the Present on Admission (POA) indicator is not required for the External Cause of Injury, and if entered, it is ignored and not used for all-patient diagnosis-related grouping (AP DRG). Hospitals that are not exempt from the Hospital Acquired Condition reporting may have experienced denials when a POA was not entered in the External Cause of Injury field. Therefore, inpatient claims with dates of service between October 1, 2009, through November 06, 2009, that denied with explanation of benefit (EOB) 4275 – *The twenty-fifth secondary diagnosis POA indicator is not in the correct format. Please check ICD-9-CM official guidelines for coding and reporting effective October 1, 2008,* will be systematically reprocessed. These reprocessed claims will appear on the November 24, 2009, Remittance Advice.

Providers of Obstetric Services

Presumptive Eligibility Process Update: Enrollment Center Referrals and Avoiding Duplicate Applications

Enrollment centers that are not qualified providers for the Presumptive Eligibility (PE) program can assist a pregnant woman by helping complete and submit a Hoosier Healthwise (HHW) Application and providing a referral to a qualified provider. However, **it is critical that only ONE HHW Application be submitted for a member**. To avoid duplicate applications, an enrollment center that completes an HHW application should provide a copy of that application to the

member. Qualified providers should verify that the pregnant woman has submitted an HHW application. Qualified providers should not submit an additional application or fax a duplicate application to the Division of Family Resources (DFR) if the member has already submitted an application.

Contact Information

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