All Providers

Claims Billed and Paid for Procedure Code J3370 to Be Mass Adjusted

Fee-for-service claims that were billed and paid for procedure code J3370 – *Injection, Vancomycin HCL, up to 500mg*, for dates of service October 1, 2007, to March 31, 2008, were paid at the rate of $.091. The correct rate is $4.04. Claims that were paid incorrectly will be mass adjusted. These claims will be identified with a "56" as the first two digits of the claim or internal control number (ICN).

Hoosier Healthwise managed care claims paid by managed care organizations at the incorrect rate will be internally adjusted, and providers can expect to see those adjustments by March 31, 2010. For Hoosier Healthwise-specific questions, please contact the appropriate managed care organization.

How to Obtain Prior Authorization for Coverage of 17P Injections

Effective January 1, 2010, the Indiana Health Coverage Programs (IHCP) began providing coverage for 17 alpha-hydroxyprogesterone caproate (17P) with prior authorization (PA). The IHCP considers weekly injections of 17P between 16 and 36 weeks of gestation medically necessary in pregnant women with prior histories of preterm delivery before 32 weeks of gestation. Use of 17P to prevent preterm labor in other pregnant women who do not meet the above criteria, and in women with other risk factors for preterm delivery, including but not limited to multiple gestations, short cervical length, or positive tests for cervicovaginal fetal fibronectin, is considered investigational, and therefore, is not a covered therapy.

Only one PA is required per member per pregnancy. Providers should request the anticipated number of weekly injections up through gestation week 36 from the appropriate PA department listed below.

Table 1 – Prior Authorization for 17P Injections

PA Company	Address	Phone Number	Fax Number
ADVANTAGE Health Solutions[SM] – FFS	Attn: Prior Authorization Department P.O. Box 40789 Indianapolis, Indiana 46240	1-800-269-5720	1-800-689-2759
ADVANTAGE Health Solutions – *Care Select*	Attn: Prior Authorization Department P.O. Box 80068 Indianapolis, Indiana 46280	1-800-784-3981	1-800-689-2759
MDwise	Attn: Prior Authorization Department P.O. Box 44214 Indianapolis, Indiana 46244-0214	1-866-440-2449	1-877-822-7186

17P injections are available only through sterile compounding pharmacies. The IHCP has been advised that the compounding pharmacies listed below are able to supply 17P in a 1250mg/5ml vial for Indiana Medicaid members. Please note additional pharmacies may be available to supply 17P.

> *Note: The pharmacies listed are not inclusive of which ones can provide the 17P injections; HP will not restrict which pharmacies can provide the injection and bill for reimbursement.*

Williams Bros HealthCare Pharmacy
574 S. Landmark Avenue
Bloomington, Indiana 47403
1-800-216-7072, press 3 for pharmacy
Attn: JD Faulkner, PharmD, Nicole Lucas, PharmD, or Paula Reed, CPhT
http://www.wbhcp.com/index.htm

Boothwyn Pharmacy
2341 Chichester Avenue
Boothwyn, Pennsylvania 19061
(610) 485-1130
http://boothwynpharmacy.com

Matria Women's and Children's Health, LLC – now known as Alere
6525 East 82nd Street, Suite 101
Indianapolis, Indiana 46250-1545
(317) 842-2677

Precision RX Specialty Solutions
2825 West Perimeter Road, Suite 116
Indianapolis, Indiana 46241-3614
1-800-870-6419

Compounding pharmacy providers will bill the unclassified drug procedure code C9399 – *Unclassified drugs or biologicals*, along with the National Drug Code (NDC) for the compounding powder and 17P after the NDC. Since 17P will be compounded as a 1250mg per 5ml vial, the IHCP will allow the compounding pharmacy providers to be reimbursed for five doses at a time. To minimize waste, multiple vials for the same member should not be ordered at the same time. The billing provider should bill one procedure code unit per 5ml vial dispensed. The reimbursement rate will be $65.00 per procedure code unit billed.

As with all injectables, providers may separately bill an appropriate Current Procedural Terminology (CPT®[1]) administration code. If an Evaluation and Management (E&M) code is billed with the same date of service as a physician-administered drug, separate reimbursement is not available for the administration of the drug because the administration is already included in the E&M code allowed amount. However, if documentation supports the E&M visit as a separate identifiable event, the provider may receive reimbursement for both the E&M visit and the administration by billing modifier 25. If no E&M code is billed, and more than one injection is given on the same date of service, providers may bill a separate administration fee for each injection using the appropriate administration code.

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

Update: Hysteroscopic Sterilization Procedure – Implant Device Rate

Effective for dates of service on or after April 1, 2010, the statewide maximum for an implant device, such as Essure, billed using Healthcare Common Procedure Coding System (HCPCS) code A9900 – *Miscellaneous supply, accessory, and/or service component of another HCPCS code* will be $1,700. The IHCP will continue to reimburse a maximum of one unit of service at 130 percent of the amount listed on the manufacturer's cost invoice, up to the statewide maximum of $1,700 for dates of service on or after April 1, 2010.

Providers must continue to adhere to the following procedures:

- Submit a cost invoice with the claim to support the cost of the device.
- Submit a valid, signed Sterilization Consent Form with the claim.
- Ensure the primary diagnosis on the claim is International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) code V25.2 – *Sterilization*.
- Print "Sterilization Implant Device" on the claim form or on the accompanying invoice.

Medicaid Integrity Contractors (MICs) To Conduct Audits

The Medicaid Integrity Group (MIG) of the Centers for Medicare & Medicaid Services (CMS) has entered into a contract with Health Integrity, CMS' Medicaid Integrity Contractor (MIC), to conduct audits of providers enrolled in the Indiana Medicaid Program. For a list of frequently asked questions (FAQs) that explains this process for providers and the involvement by the Indiana Medicaid Program ("State"), click here.

In November 2009, Health Integrity began performing audits of provider records according to Generally Accepted Government Auditing Standards (Yellow Book). If selected for an audit, providers will be required to submit records in a timely manner, as required. The records request letters will be issued on the letterhead of the contractor, Health Integrity. Your full cooperation in responding with the requested documentation will be required, or action will be taken by the Surveillance and Utilization Review (SUR) Unit to recoup the claim(s) as an overpayment.

Long-Term Care Providers

Leave Days Billed Without Accommodation Days Will Adjudicate Systematically

Effective April 1, 2010, system changes will allow claims billed using revenue code 183 – *therapeutic bed hold* and/or revenue code 185 – *hospital bed hold* with no accompanying accommodation days to adjudicate systematically.

These claims previously suspended for manual pricing and have been excluded from the retro rate adjustment process.

The changes allow these claims to be correctly priced systematically and allow them to be included in the retro rate adjustment process.

These changes also allow long-term care (LTC) and hospice claims, which originally paid at zero dollars, to be included in the retro rate adjustment process.

Reminder: The IHCP automatically deducts the member's liability amount from the total reimbursement of the claim. The provider must not indicate the resource contribution anywhere on the claim form. When a member transfers between facilities during a billing period, the member's liability is deducted from the first claim received and processed by Indiana*AIM*. Therefore, the facilities involved in the transfer must coordinate any liability deductions.

Hospice and nursing facility providers are encouraged to develop coordination and payment procedures to address this retro rate adjustment issue in their contracts.

Durable Medical Equipment Providers

Procedure Code K0739 for Durable Medical Equipment Is Covered Effective January 1, 2010

During the annual 2010 HCPCS load, procedure code K0739 – *Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes* was erroneously listed as noncovered. The procedure code is a replacement code for E1340 – *Repair or nonroutine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes* and is now covered effective January 1, 2010. Claims that denied with edit 4021 – *Procedure Code vs. Program Indicator* can now be refiled.

Provider Workshops

Provider Relations Schedules Workshops in March and April for Dental, Home Health, and Hospice Providers

Provider Relations has scheduled dates in March and April for regional workshops for home health, hospice, and dental providers. Providers may choose any of the following dates to attend. The morning session will focus on home health and hospice education, and the afternoon session will be information for the dental provider community.

Table 2 – Workshop Dates

Date	Location
March 2, 2010	Unity Hospital Unity Medical Pavilion 1345 Unity Place Lafayette, Indiana 47905
April 7, 2010	Deaconess Hospital Bernard Schnacke Auditorium 600 Mary Street Evansville, Indiana 47747
April 15, 2010	East Chicago – Regional WS St. Catherine's Hospital Professional Office Building Conference Room 4321 Fir Street East Chicago, Indiana 46312
April 21, 2010	Parkview Hospital Corporate Office 10501 Corporate Drive Fort Wayne, Indiana 46845

Schedule

Home Health/Hospice Providers

Home Health: 9 – 10 a.m.

Hospice: 10:10 – 11:30 a.m.

This is an excellent opportunity to become more familiar with Medicaid home health and hospice policies, procedures, and billing tools and methodology.

The agenda includes the following:

- Benefit coverage
- Prior authorization requirements
- Billing procedures
- Eligibility requirements
- Reimbursement methodology
- Hospice process
- Common denials

Dental Providers

1:00 – 3:30 p.m.

This is an excellent opportunity to become more familiar with Medicaid dental policies, procedures, and billing tools and methodology.

The agenda includes a live demonstration and discussion of all facets of Web interChange, including:

- Spend-down
- Managed care
- Third-party liability and qualified Medicare beneficiary eligibility
- Dental cap

- Benefit limitations

Providers may enroll in the workshop on www.indianamedicaid.com under **Provider Services** > **Education Opportunities** > **Workshop Registration**. If you have questions, please call Provider Relations 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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