IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201134 AUGUST 23, 2011

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Update to vision services

Effective October 1, 2011, for dates of service on or after October 1, 2011, the Indiana Health Coverage Programs (IHCP) has revised its limitations for routine vision care examinations for children and adults. The covered routine vision care examination limitation for children is revised from one examination per year for a recipient under 19 years of age to **one exam per year for a recipient under 21 years of age**. The covered routine vision examination limitation for adults is revised from one examination every two years for a recipient 19 years of age or older to **one exam every two years for a recipient 21 years of age and older**. If medical necessity dictates more frequent examinations, documentation of such medical necessity must be maintained in the provider's office. The documentation shall be subject to post payment review and audit.

The IHCP now covers HCPCS code C9248

The Indiana Health Coverage Programs (IHCP) now provides coverage for Healthcare Common Procedure Coding System (HCPCS) code C9248 – *Injection, clevidipine butyrate, 1 mg* for dates of service on or after October 1, 2011.

As a reminder, the *Federal Deficit Reduction Act of 2005* mandates that the IHCP require the submission of National Drug Codes (NDCs) on claims submitted with certain procedure codes, including C9248. This mandate affects all providers that submit electronic or paper claims for procedure-coded drugs. NDCs are also required on Medicare crossover claims for all applicable procedure codes. Claims will deny if the NDC is missing, or if the NDC doesn't match the HCPCS code.

Only the NDC that is specified on the label of the product administered to the member can be used to bill for reimbursement. It is not permissible to bill the program with an NDC that was not on the label of the product administered to the member. Therefore, you should not preprogram your billing system to automatically associate a specific NDC with a certain procedure code, as that NDC may not always be the one on the product label being administered to the member. A list of procedure codes requiring NDCs is available on indianamedicaid.com (General Provider Services > Billing and Remittance > Procedure Codes that Require NDCs).

High-risk pregnancy documentation for Hoosier Healthwise members

To document medically high-risk pregnancies for Hoosier Healthwise (HHW) members, providers must complete and submit the Notification of Pregnancy (NOP) through Web interChange. The NOP is the only acceptable method of documentation for high-risk pregnancies; the Prenatal Risk Assessment Form or other standardized risk-assessment tools are no longer accepted forms of documentation.

Although providers must use the NOP to document every high-risk pregnancy, providers are encouraged to use the NOP to document and monitor conditions of all pregnancies, regardless of risk category. The initial NOP must be completed before the 30th week of pregnancy – preferably during the initial visit – to receive the one-time $60 payment. Regardless, if at any time during the pregnancy, a normal pregnancy becomes high-risk, providers must use the NOP to document the high-risk factors.

For a pregnancy to be considered high-risk, the pregnant woman must have at least two medical risk factors in her current pregnancy or obstetrical history that place her at risk for a preterm birth or poor pregnancy outcome. The IHCP recognizes that the care of pregnant women in the medical high-risk category requires greater physician management. The IHCP provides higher reimbursement for prenatal office visits only for patients who present with medical high-risk factors when the provider documents the existence of the high-risk factors through the NOP. When billing, providers must indicate the high-risk diagnoses on the claim.

Please refer to Process for Completion of the Notification of Pregnancy in Chapter 8 of the *IHCP Provider Manual* for more specific guidelines.

Providers in Provider Specialty 250 – DME – can bill HCPCS code A4466 U3

Per bulletin BT201034, published September 7, 2010, Healthcare Common Procedure Coding System (HCPCS) code A4466 U3 – *Garment, belt, sleeve or other covering, elastic or similar stretchable material, any type, each* was covered effective January 1, 2010.

In error, for providers enrolled as Provider Specialty 250 – *DME/Medical supply dealer*, the effective date of coverage for code A4466 U3 was programmed as January 1, 2011, rather than January 1, 2010. HP has corrected its claim processing system to allow providers with Provider Specialty 250 to bill A4466 U3 for claims with dates of service on or after January 1, 2010. This correction is effective immediately to allow providers to bill appropriately.

If you are enrolled as Provider Specialty 250; you billed claims with procedure code A4466 U3 with dates of service on or after January 1, 2010, and before January 1, 2011; and those claims were denied for Error 1012 – *Rendering provider specialty not eligible to render procedure code*, you may resubmit those claims for payment. If a resubmitted claim is beyond the timely filing limit, please use this banner as proof to waive the filing limit.

Revenue code linkage for HCPCS codes J0129 and J1572

For dates of service on or after October 1, 2011, the following physician-administered Healthcare Common Procedure Coding System (HCPCS) drug codes have been linked to revenue code 636 – *Drugs requiring detailed coding*:

- J1572 – *Injection, immune globulin, (flebogamma/flebogamma DIF), intravenous, non-lyophilized (e.g., liquid), 500mg*
- J0129 – *Injection, abatacept, 10mg*

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

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