IMPORTANT INFORMATION

BR200134 AUGUST 21, 2001

To All Indiana Medicaid Pharmacy Providers:

Note: The information referenced below is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system.

- This is to notify providers that, for pharmacy claims for legend drugs received on or after August 27, 2001, having dates of service (dispense dates) of August 27, 2001, or later, the dispensing fee will be reduced from the current level of a maximum of $4.00 to $3.00. In addition, drug component reimbursement will change from AWP minus 10% to AWP minus 13%.

  These changes in reimbursement will be implemented on August 27, 2001, on an emergency basis pursuant to *Ind. Code 4-22-2-37.1, Ind. Code 12-8-1-12*; and *Public Law 291-2001, Section 48*.

To All Indiana Health Coverage Programs Primary Care Case Management Primary Medical Providers:

- The June and July Hoosier Healthwise administrative fee payment listings are being mailed this week. The mid-June and mid-July mailing of these reports was inadvertently delayed; however, administrative fee payments were not affected. August listings are also being mailed this week. We apologize for any inconvenience the delayed mailing of these reports may have caused.

To All Indiana Health Coverage Programs Outpatient Hospital, and Ambulatory Surgical Center Providers:

- One of the most **frequent claim denials for outpatient treatment services occurs when an evaluation and management (E & M) code is submitted in conjunction with a treatment or emergency room revenue code**. For example, when a claim is submitted on a UB-92 claim form with a 450 revenue code in locator 42 and a HCPCS code in the range 99281 through 99285 in locator 44, the claim denies for edit 4108 - *No ASC on file*.

  As stated in *Chapter 8* of the *Indiana Health Coverage Programs Provider Manual*, treatment rooms are billed using revenue codes 45X, 51X, 52X, 70X, 71X, 72X, and 76X. If a treatment room or emergency room revenue code is billed with a non-surgical HCPCS code, the claim denies for edit 4108 - *No ASC on file*. If a claim denies for edit 4108 and an E & M code was billed with one of the above revenue codes, remove the E & M code and resubmit the claim.

  All professional services, such as the treatment or emergency room physician services, must be reported on the HCFA-1500, using the professional number associated with the facility and the unique rendering provider number assigned to the physician. The facility is paid for claims billed on the UB92, and physician services are paid for claims billed on the HCFA-1500.

To All Indiana Health Coverage Programs Providers:

- Effective July 1, 2001, patients diagnosed with breast or cervical cancer through the Indiana Breast and Cervical Cancer Program of the State Department of Health are eligible for Medicaid during the course of their treatment. In order to be eligible for Medicaid, a woman must meet the following criteria:
  1. Screened through the Indiana Breast and Cervical Cancer Program (BCCP) and determined to need treatment.
  2. Under 65 years of age
  3. Not eligible for other categories of Medicaid or other insurance that covers breast or cervical cancer treatment
  4. Family income of less than 250 percent of the federal poverty level (will be reduced to 200 percent of the federal poverty level effective September 29, 2001).

  Information about this screening program is available on the Web site at http://www.in.gov/isdh/programs/bccp/index.htm. Providers who do not have Web access may contact EDS Customer Assistance at (317) 655-3240 or 1-800-577-1278.

  Women in this program have Hoosier Healthwise Package A coverage, but are not assigned a primary medical provider. Claims are billed to EDS and certification codes are not required. Eligibility is terminated when the treatment period has ended. ***Providers must verify eligibility before any service is rendered.***

- Claims for services rendered to Package B eligible members must be coded to indicate pregnancy as the principal diagnosis in order for claims to pay. The pregnancy-related code must be indicated in form locator 24E of the HCFA-1500 claim form. This includes **V** codes and **600 series** pregnancy diagnosis codes. If the specific reason for the visit/care is not adequately addressed by any pregnancy diagnosis code, the visit/care diagnosis must also be included as a secondary or tertiary diagnosis on the claim form. The pregnancy indicator **P** must be entered in form locator 24H. Services for pregnant women are considered medically necessary if the health or well-being of the mother or baby could be adversely affected if the mother is not treated. Claims for Package B members enrolled in risk-based managed care (RBMC) should be sent to the appropriate managed care organization (MCO). Detailed instructions are available in chapter 8 of the *Indiana Health Coverage Programs Provider Manual*. Please direct questions to the EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

To All Indiana Health Coverage Programs Physician and Chiropractic Providers:

- Effective July 1, 2001, prior authorization is no longer required for electrodiagnostic studies. This affects CPT codes 95857, 95858, 95860, 95861, 95863, 95864, 95867, 95868, 95869, 95870, 95872, 95875, 95900, 95903, 95904, 95925, 95926, 95927, 95930, 95933, 95934, and 95937. Electrodiagnostic studies that involve needle penetration of the skin are only covered when performed by practitioners not restricted by scope of practice to perform such procedures. Medical necessity review for all electrodiagnostic studies may be done by post-payment review. Procedures using CPT code 95999 (Unlisted neurological or neuromuscular diagnostic procedure) continue to require prior authorization.

To All Indiana Health Coverage Programs Dental Providers:

- Bulletin *E98-03* published January 17, 1998, and the *Indiana Health Coverage Programs Provider Manual* include criteria for orthodontia procedures for codes D8010 – D8090 as follows: *No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate*.

  Criteria for the following dental procedure codes was omitted from bulletin *E98-03* and from *Chapter 8* of *Indiana Health Coverage Programs Provider Manual:*

  - D8060 – Interceptive orthodontic treatment of the transitional dentition
  - D8210 – Removable appliance therapy
  - D8220 – Fixed appliance therapy
  - D8680 – Orthodontic retention

  The Office of Medicaid Policy and Planning advises dental providers that effective September 21, 2001, which is 45 days after this banner message first appeared on August 7, 2001, criteria for codes D8060, D8210, D8220, and D8680 will read as follows: *No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.*

  Supporting documentation of the craniofacial deformity or cleft palate must be maintained in the patient's medical records, along with a complete set of orthodontic records, at the provider's office for a period of three years after any procedure. Records are subject to post-payment review for appropriateness of service. Procedures reimbursed that are not in accordance with the policy for coverage are subject to recoupment.

To All Indiana Health Coverage Programs Hospital, Ambulatory Surgical Center, Physician, and Durable Medical Equipment Providers:

- Cyberonics has informed the Office of Medicaid Policy and Planning (OMPP) that they are no longer manufacturing the NCP Model 100 vagus nerve stimulator pulse generator. The NCP Model 101 vagus nerve stimulator pulse generator is in production and will replace the Model 100. The cost of the Model 101 pulse generator is $9,753 compared to $6,900 for the Model 100. The max fee reimbursement has been increased to cover the additional cost of Model 101. Providers billing for the NCP Model 100 system (Z5059) or the NCP Model 100 generator (Z5060) should bill their usual and customary charge. The max fee for the NCP Model 100 **has not been increased.**

Local Code	Description	Maximum Fee Pricing for NCP Model 100	Maximum Fee Pricing for NCP Model 101
Z5059	NCP System (includes NCP generator, bipolar VNS lead, disposable tunneling tool, hand-held telemetry wand programmer, programming software, horseshoe and bar magnet) – one unit	$9,097.00	$11,980.00
Z5060	NCP generator – one unit	$6,900.00	$9,753.00
Z5061	Bipolar VNS lead – one unit	$2,030.00	$2,030.00
Z5062	Disposable tunneling tool – one unit	$167.00	$167.00
Z5063	Hand-held magnet (horseshoe or block) – one unit	$30.00	$30.00