B A N N E R P A G E

B R 2 0 0 5 4 2 O C T O B E R 1 8 , 2 0 0 5

To All Providers:

- Currently, the Vaccines For Children (VFC) program cannot distribute a sufficient supply of TdaP and MCV4 vaccines to all VFC-participating providers. Due to this shortage crisis, the Indiana Health Coverage Programs (IHCP) is not limiting reimbursement for TdaP, *Tetanus diphtheria toxoids and acellular pertussis vaccine* (CPT 90715 – Adecel and Boostrix) and MCV4, *meningococcal conjugate vaccine, tetravalent* (CPT 90734 – Menactra) to the VFC Vaccine Administration Fee of $8.00 or less. This policy allows providers to obtain reimbursement for using privately purchased TdaP or meningococcal vaccines if they cannot obtain a VFC vaccine. When administering privately purchased TdaP or meningococcal vaccines, providers may bill for the cost of the vaccine plus its administration, and the IHCP-allowable reimbursement will include payment for both.

  > *Note: If a provider administers a free VFC vaccine, the provider should bill the appropriate TdaP or meningococcal vaccine procedure code but not charge more than the $8.00 VFC vaccine administration fee, and not bill the separate administration CPT code.*

  When a provider administers immunizations using the provider's private stock, refer to IHCP provider bulletin *BT200151* for use of the administration code 90782, as appropriate, for the additional $3.00 rate.

- To address an immediate need for immunizations and a shortage of available influenza vaccines, the IHCP is not limiting reimbursement for any influenza vaccines, regardless of availability from the VFC program. This policy will allow providers to obtain reimbursement for using a privately purchased influenza vaccine if they do not have a VFC vaccine due to the shortage crisis. When administering a privately purchased influenza vaccine, providers may bill for both the cost of the vaccine plus its administration, and the IHCP-allowable reimbursement will include payment for both. Refer to banner page *BR200442*, published October 19, 2004, regarding detailed billing instructions when administering private stock.

- The Centers for Medicare and Medicaid Services (CMS) is consolidating the Medicare crossover process under a new Coordination of Benefits Agreement (COBA) initiative. In this initiative, CMS is contracting with one national Coordination of Benefits Contractor (COBC) to handle all crossover processing. The IHCP will begin working with the COBC on January 1, 2006. The COBC will consolidate adjudication data from each of the Medicare intermediaries and send one transmittal of crossover adjudicated claims to the IHCP. Crossovers should continue to process as they do today, but because the interface is changing, providers need to monitor their crossover claims to ensure the process is working as expected.

  Additional information regarding this change will be published in the IHCP monthly provider newsletter, provider bulletins, or the banner page. For more information about the initiative and to obtain a listing of CMS's suggestions, visit http://www.cms.hhs.gov/medicare/cob/coba/coba.asp.

- The previously published IHCP provider bulletin, *BT200518*, concerning check related adjustments for pharmacy providers indicated an incorrect address. The correct address to make refunds to IHCP for pharmacy claims is as follows:

  EDS Pharmacy Refunds
  P.O. Box 2303 Dept. 130
  Indianapolis, Indiana 46206-2303

- Medicaid will implement an automated spend-down process effective January 1, 2006. This process will eliminate the *Notice to Provider of Recipient Deductible* (Form 8A), reduce paperwork, and accelerate claims payment. Please monitor forthcoming articles in banner pages and newsletters for additional information. In mid-November, EDS will publish a provider bulletin that will include complete billing and payment information about this new automated spend-down process.

- Beginning October 1, 2005, please use the following updated International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes. The new, revised, and discontinued codes may be viewed at

http://www.cms.hhs.gov/medlearn/icd9code.asp. To ensure Health Insurance Portability and Accountability Act (HIPAA) compliance, the 90-day grace period no longer applies to ICD-9-CM updates. Providers must use the appropriate ICD-9-CM diagnosis and procedure codes that are valid for the date of service. Codes not valid for the dates of service will deny. The ICD-9-CM diagnosis and procedure codes are billable and reimbursable October 1, 2005.

The following new ICD-9-CM diagnosis codes will be added to Table 8.13 – *Emergency Department Diagnosis Codes* in the *IHCP Provider Manual, Chapter 8, Section 2.* These codes are effective October 1, 2005.

ICD-9-CM Diagnosis Codes Added to Table 8.13 *Emergency Department Diagnosis Codes*						
276.50	276.51	276.52	567.21	567.22	567.23	567.29
567.31	567.38	567.39	567.81	567.82	567.89	585.6
599.60	599.69	651.70	651.71	651.73	760.77	760.78
763.84	770.10	770.11	770.12	770.13	770.14	770.15
770.16	770.17	770.18	770.85	770.86	779.84	799.01
799.02	996.40	996.41	996.42	996.43	996.44	996.45
996.46	996.47	996.49	V46.14	V62.84		

The following ICD-9-CM diagnosis codes will be removed from Table 8.13 – *Emergency Department Diagnosis Codes* in the *IHCP Provider Manual, Chapter 8, Section 2* effective October 1, 2005. These codes are no longer valid codes.

Invalid ICD-9-CM Diagnosis Codes Removed from Table 8.13 *Emergency Department Diagnosis Codes*						
276.5	567.2	567.8	599.6	770.1	799.0	996.4

The following new ICD-9-CM diagnosis codes will be added to Table 8.63 – *High Risk Pregnancy – ICD-9-CM Diagnosis Codes* in the *IHCP Provider Manual, Chapter 8, Section 3.* These codes are effective October 1, 2005.

ICD-9-CM Diagnosis Codes Added to Table 8.63 *High Risk Pregnancy – ICD-9-CM Diagnosis Codes*						
276.50	276.51	276.52	278.02	287.30	287.31	287.33
287.39	291.82	362.07	426.82	567.21	567.22	567.23
567.29	567.31	567.38	567.39	567.81	567.89	585.1
585.2	585.3	585.4	585.5	585.6	585.9	599.60
599.69	651.70	651.71	651.73	V46.13	V46.14	V62.84
V85.0	V85.21	V85.22	V85.23	V85.24	V85.25	V85.30
V85.31	V85.32	V85.33	V85.34	V85.35	V85.36	V85.37
V85.38	V85.39	V85.4				

The following ICD-9-CM diagnosis codes will be removed from Table 8.63 *High Risk Pregnancy – ICD-9-CM Diagnosis Codes* in the *IHCP Provider Manual, Chapter 8, Section 3* effective October 1, 2005. These diagnosis codes are no longer valid.

Invalid ICD-9-CM Diagnosis Codes Removed from Table 8.63 *High Risk Pregnancy – ICD-9-CM Diagnosis Codes*	
287.3	585

The following new ICD-9-CM procedures are not covered by the IHCP. According to the Indiana Administrative Code (IAC) *405 IAC 5-29-1 (3)*, experimental treatment or procedures are not covered by the IHCP.

ICD-9-CM Non-Covered Services	
Code	**Description**
37.41	Implantation of prosthetic cardiac support device around the heart
84.58	Implantation of interspinous process decompression device

For questions contact customer assistance at (317) 655-3240 in the Indianapolis local area, or toll free at 1-800-577-1278.

- This article advises providers that the IHCP-approved coverage of Healthcare Common Procedure Coding System (HCPCS) codes J7303 – *Contraceptive supply, hormone containing vaginal ring, each,* and J7304 – *Contraceptive supply, hormone*

containing patch, each, effective October 1, 2005. Providers must bill J7303 and J7304 instead of a miscellaneous supply code because they are more specific to the service being supplied. HCPCS code J7303 reimburses a max fee rate of $41.48 and HCPCS code J7304 reimburses a max fee rate of $14.31. Direct questions about this article to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

- This article notifies providers of new HCPCS code changes. Based on a recent analysis to identify potential duplicates among temporary and permanent codes (such as, items potentially billable under more than one HCPCS code), the OMPP has determined that durable medical equipment (DME) codes E0953, E1000, and A4632 will no longer be reimbursed effective November 11, 2005. Instead, the corresponding K codes (as listed below) and their Medicare fee will be adopted. Adopting the K codes with established Medicare fees will expedite crossover claims processing. Direct questions about these HCPCS code changes to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

HCPCS Codes	Description	Corresponding HCPCS Codes	Description	Max Fee
E0953	Pneumatic Tire, EA	K0067	Pneumatic Tire, Any Size, EA	$34.77-NU $3.41-RR
E1000	Tire, Pneumatic Caster	K0074	Pneumatic Caster Tire, Any Size	$36.00-NU $3.96-RR
A4632	Repl Batt For External Infusion Pump, Any Type	K0601	Replacement Batt For Ext Inf Pump, Silver Oxide, 1.5 V	$1.10
A4632	Repl Batt For External Infusion Pump, Any Type	K0602	Replacement Batt For Ext Inf Pump, Silver Oxide, 3.0 V	$6.36
A4632	Repl Batt For External Infusion Pump, Any Type	K0603	Replacement Batt For Ext Inf Pump, Alkaline, 1.5 V	$0.57
A4632	Repl Batt For External Infusion Pump, Any Type	K0604	Replacement Batt For Ext Inf Pump, Lithium, 3.6 V	$6.09
A4632	Repl Batt For External Infusion Pump, Any Type	K0605	Replacement Batt For Ext Inf Pump, Lithium, 4.5 V	$14.60

To All Pharmacies and Prescribing Providers:

- This notice advises providers that, in response to rapidly escalating expenditures for Medicaid-covered drugs, and in order to stay within available appropriations while maintaining beneficiary access to services, the office will be adopting an emergency rule that amends pharmacy reimbursement for Medicaid and HoosierRx. Specifically, estimated acquisition cost (EAC) for brand name legend drugs will change from Average Wholesale Price (AWP) minus 13.5 percent to AWP minus 16 percent. At the same time, to bring consistency to reimbursement policy for insulins, OTC insulins will commence being paid in accordance with applicable legend drug EAC methodology. These changes will be effective October 1, 2005. Please disregard the notice in the banner pages issued 9/20/05 and 9/27/05 regarding the change in the estimated acquisition cost ("EAC") for brand name legend drugs.
- Effective January 1, 2006, the CMS is implementing the new Medicare prescription drug coverage. This coverage, also known as Medicare Part D, is a new benefit to help Medicare members pay for prescription drugs.

  The IHCP Web site now includes a new section titled *Medicare Prescription Drug Coverage*. Providers should visit this section periodically at http://www.indianamedicaid.com/ihcp/ProviderServices/medicareD.asp for the latest information. The annual IHCP Seminar and fourth quarter provider workshops will include materials and training about the new Medicare prescription drug benefit.

  For more information about the Medicare prescription drug benefit visit the CMS Web site at http://www.cms.gov/medicarereform/

To All Physical Therapy Providers:

- The IHCP has initiated coverage of hippotherapy for physical therapy effective April 1, 2005. To be covered, services must be provided by a licensed physical therapist and should be billed using the appropriate HCPCS code from the following list:
  - 97110 – Therapeutic exercises to develop strength and endurance, range of motion, and flexibility
  - 97112 – Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
  - 97530 – Therapeutic activities to improve functional performance
  - 97533 – Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands. This code can only be used for patients with a diagnosis of traumatic brain injury (TBI).

  Services must be ordered by a physician and included in the patient's treatment plan. Existing PA requirements for physical therapy apply to hippotherapy.

*Note: Procedure code S8940 (hippotherapy per person, equestrian, hippotherapy, per session) was a new HCPCS code effective January 1, 2005, and is **not** covered by the IHCP.*