B A N N E R P A G E

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To All Providers:

- EDS completed a review of the Medical Review Team (MRT) claims processed since MRT automated claims processing went into effect on July 10, 2005. Several claims are failing edit 3001, *Dates of Service not on PA database*. Currently, these claims are suspending for review. Effective with this notice, claims failing this edit will deny in accordance with the MRT guidelines.

  Indiana Health Coverage Programs (IHCP) provider bulletin *BT200514*, issued on June 2, 2005, identifies those codes that may be billed to the MRT, and those that require PA. Additionally, providers should be careful to bill the units for the actual time services were rendered for those procedure codes that are based on time. As a reminder, the patient's medical records need to support the services billed.
- Between October 19, 2005, and October 28, 2005, some dental, vision, waiver, and transportation claims erroneously denied for edit *2502, Member covered by Medicare B (no attachment)*. EDS has corrected this error; however, providers who believe their claims denied incorrectly for this edit may resubmit their claims for processing.

  Transportation providers who filed claims for mileage that denied for edit 2502 must file for an adjustment using the Web interChange or a paper adjustment form to adjust the mileage detail. An adjustment is required to allow pricing of the detail for mileage with the base code.
- On November 1, 2005, the IHCP implemented the Prior Authorization (PA) Web application, which allows providers to submit non-pharmacy PA requests and to inquire about requests using the Web interChange. Providers can continue submitting PA requests on paper or by telephone or fax and following existing policies when submitting PA requests. To inquire about existing PAs, providers must have a PA number or be the requesting or service provider of the PA. Doctors, dentists, home health agencies, hospices, optometrists, health service providers in psychology (HSPP), chiropractors, hospitals, and transportation providers may submit PA requests. Providers may obtain detailed information about using this new Web application from the IHCP Web site at www.indianamedicaid.com.
- 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 IHCP is not limiting reimbursement for *TdaP*, Tetanus diphtheria toxoids and acellular pertussis vaccine [Current Procedural Terminology (CPT®) 90715 – Adecel and Boostrix) and *MCV4*, meningococcal conjugate vaccine, tetravalent (CPT *90734 – Menactra*) to the VFC Vaccine Administration Fee of $8 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 includes 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 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, Therapeutic, prophylactic or diagnostic injection (specify material injected; subcutaneous or intramuscular)*, as appropriate, for the additional $2.84 rate.

To All Pharmacies and Prescribing Providers:

- IHCP provider bulletin *BT200369* states that providers can now submit all pharmacy claims electronically. However, some pharmacy claims may require additional documentation to be submitted via paper. One example is a claim billed on the same date of service as the date spend-down was met. If a provider submits a claim via point-of-sale (POS) and that

claim requires additional documentation for adjudication, such as an 8A form, the claim suspends and the provider must fax the supporting documentation to EDS at (317) 488-5163.

Each suspended claim must have a separate Pharmacy Claim Attachment Sheet, indicating the Internal Control Number (ICN) of the claim that needs to be processed. If the ICN on the Pharmacy Claim Attachment Sheet does not match the ICN of the suspended claim, the claim denies. Additionally, if the provider does not submit supporting documentation within 21 days of submission, the claim denies.

Providers may download copies of the Pharmacy Claim Attachment Sheet at www.indianamedicaid.com and click on the forms link. Direct any questions about this process to the EDS Pharmacy Services Helpdesk at 1-800-577-1278 or (317) 655-3240, Option 1.

- IHCP provider bulletin *BT200521*, published September 30, 2005, advised providers of the following change to the Preferred Drug List (PDL) that was to be effective November 1, 2005, as shown in Table 1:

Table 1 – PDL Information from *BT200521*

Drug Class	Drug	PDL Status
Fibric Acid Derivatives	Antara	Non-Preferred
Fibric Acid Derivatives	Tricor	Non-Preferred
Fibric Acid Derivatives	Triglide	Non-Preferred

Subsequently, the manufacturer of generic fenofibrate, one of the recommended preferred agents, advised that it would no longer manufacture the product. For that reason, the Drug Utilization Review (DUR) Board has requested that the Therapeutics Committee re-review the fibric acids class. In the interim and until providers are notified of the final PDL determinations regarding the fibric acids class, the PDL status of the products is the same as previous, as shown in Table 2:

Table 2 – Fibric Acids (M4E)

Preferred Drugs		Non-Preferred Drugs	
gemfibrozil	May 14, 2003	Lofibra 67mg caps	May 14, 2003
Lofibra 200mg caps	May 14, 2003	Lofibra 134mg caps	May 14, 2003
TriCor 160mg tabs	May 14, 2003	Lopid*	May 14, 2003
TriCor 145mg tabs	May 14, 2003	TriCor 54mg tabs	May 14, 2003
		TriCor 67mg caps	May 14, 2003
		TriCor 134mg caps	October 26, 2004
		TriCor 200mg caps	October 26, 2004

Providers who have paper copies of *BT200521* should make a note of the information in Table 1 on that copy to reflect the correct PDL status of this class. Updated information will follow, as necessary.

Direct PA requests and questions about the PDL to the ACS Clinical Call Center at 1-866-879-0106.

- 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.

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

To All Podiatrists:

- The Health Care Excel (HCE) Surveillance and Utilization Review (SUR) Department identified utilization issues related to podiatrists inappropriately billing multiple units of CPT codes 99201-99203 for new patient visits and CPT codes 99211-99213 for established patient visits.

  Office visits for podiatry services are limited to the following:

  – New patient office visits – Limited to one visit per member, per provider, every three years, using CPT codes 99201, 99202, or 99203.

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- Office visits – Limited to one visit per member, per 12 months, without obtaining PA, using CPT codes 99211, 99212, or 99213.

This information can be found in the *IHCP Provider Manual, Chapter 8, Section 3*, and in the Indiana Administrative Code (IAC), *405 IAC 5-26-7*.

SUR is advising all providers to carefully review claims submitted to the IHCP to ensure proper billing of units for these services. The SUR Department is conducting a review of claims to determine any inappropriate reimbursement and recoup overpayments. If a provider identifies overpayments related to these errors, the provider should file an adjustment or contact the SUR Department to arrange for repayment.

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