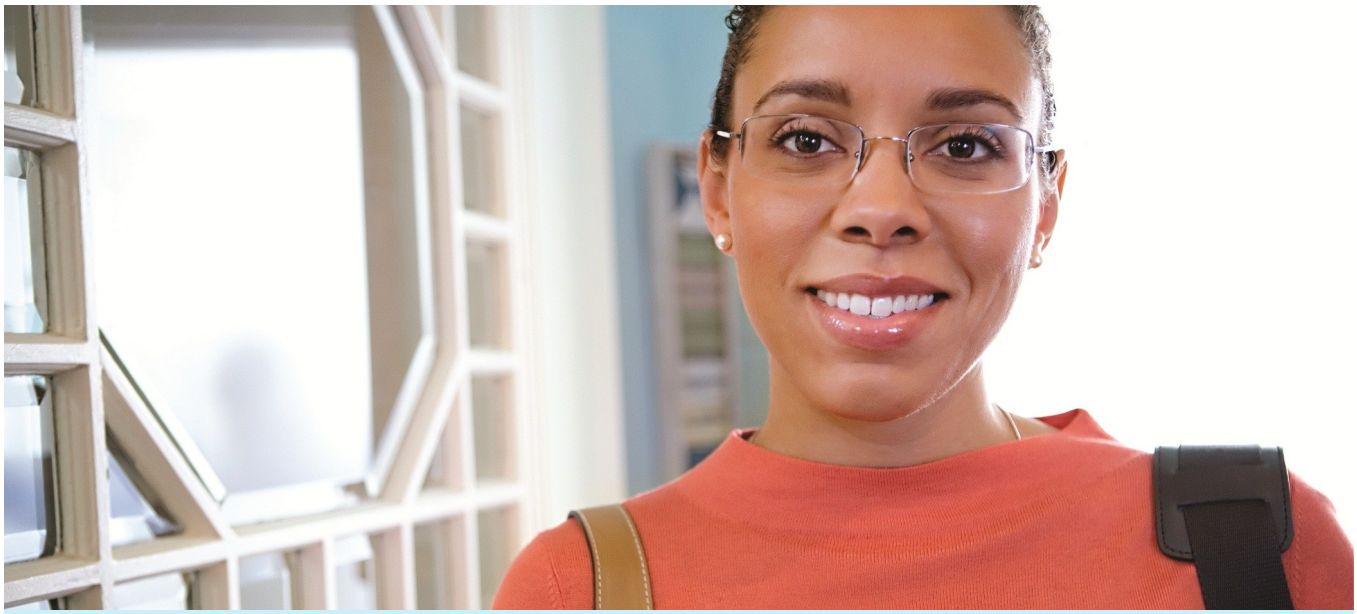
IHCP bulletin

INDIANA HEALTH COVERAGE PROGRAMS BT201303 FEBRUARY 5, 2013



Corrections to Family Planning Eligibility Program guidance in BT201301

In BT201301, dated January 8, 2013, Indiana Health Coverage Programs (IHCP) issued coverage and billing information about the new Family Planning Eligibility Program. Corrections to this bulletin are outlined here.

Radiology procedure code 76977 is not covered

On page 28 of BT201301, *Table 7.0 – Family Planning Eligibility Program – Radiology procedure codes* listed code 76977 – *Ultrasound bone density measurement and interpretation, peripheral site(s), any method* as a covered radiology procedure code. This code was listed in error and **is not** covered under the Family Planning Eligibility Program. A corrected Table 7.0 is republished in this bulletin for ease of reference.

Table 7.0 − Family Planning Eligibility Program − Radiology procedure codes

Procedure Code	Description
71010	Radiologic examination, chest; single view, frontal
71020	Radiologic examination, chest, 2 views, frontal and lateral;
72190	Radiologic examination, pelvis; complete, minimum of 3 views
74000	Radiologic examination, abdomen; single anteroposterior view
74740	Hysterosalpingography, radiological supervision and interpretation
74742	Transcervical catheterization of fallopian tube, radiological supervision and interpretation
76830	Ultrasound, transvaginal
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete

Table 7.0 (continued) − Family Planning Eligibility Program − Radiology procedure codes

Procedure	Description
76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (e.g., for follicles)
76870	Ultrasound, scrotum and contents
76872	Ultrasound, transrectal
76998	Ultrasonic guidance, intraoperative

Revised billing instructions regarding diagnosis codes

On page 6 of BT201301, the following billing instructions were given in error:

"*When billing family planning program services, providers must use the appropriate diagnosis code identified in Table 2.0 as the primary diagnosis, and enter "F" in field 24H on the CMS-1500 or the appropriate field if billing electronically.*"

The corrected instructions are as follows: When billing family planning program services, providers must use the appropriate diagnosis codes identified in *Table 2.0 – Family Planning Eligibility Program – Diagnosis codes*. Outpatient and outpatient crossover claims must include the family planning diagnosis code in the PRIMARY position. Physician and physician crossover claims must include the family planning diagnosis codes on each claim detail. Family planning program services ***do not*** require an "F" in field 24H on the CMS-1500 claim form or in the corresponding field if billed electronically.

The diagnosis codes and related edits applicable to family planning services remain unchanged. Tables 1.0 and 2.0 from BT201301 are republished in this bulletin for ease of reference.

Table 1.0 − Edits applicable to family planning services

New EOB	Explanation of benefits (EOB) description	Submission requirements
2057	Claim denial due to Family Planning procedure required and/or Family Planning diagnosis submitted on claim detail that is not a valid Family Planning diagnoses	Physician and physician crossover claims must include only family planning diagnosis codes on each claim detail. If multiple diagnosis codes are applicable per detail, every diagnosis code must be a family planning diagnosis. A family planning procedure code must be included on each detail to allow payment.
2058	Family Planning procedure/NDC required and/or Family Planning diagnosis not submitted in Primary position	Outpatient and outpatient crossover claims must include a family planning diagnosis in the PRIMARY position. A family planning procedure code must be included on each detail, along with the revenue code to allow payment. Pharmacy and compound claims must include a National Drug Code (NDC) on each applicable family planning product and drug detail.
2059	Invalid claim type for Family Planning Services	Family planning services are not applicable for inpatient, inpatient crossover, and long-term care claims.
2060	Invalid claim type for Family Planning Services	Family planning services are not applicable for home health and dental claims.

Table 2.0 − Family Planning Eligibility Program − Diagnosis codes

Diagnosis code	Description
V25.01	Prescription of oral contraceptives
V25.02	Initiation of other contraceptive measures
V25.03	Encounter for emergency contraceptive counseling and prescription
V25.04	Counseling and instruction in natural family planning to avoid pregnancy
V25.09	Other – Family Planning Advice
V25.11	Encounter for insertion of intrauterine contraceptive device
V25.12	Encounter for removal of intrauterine contraceptive device
V25.13	Encounter for removal and reinsertion of intrauterine contraceptive device
V25.2	Sterilization
V25.3	Menstrual extraction
V25.40	Contraceptive surveillance, unspecified
V25.41	Contraceptive pill
V25.42	Intrauterine contraceptive device (IUD)
V25.43	Implantable subdermal contraceptive
V25.49	Other contraceptive method
V25.5	Insertion of implantable subdermal contraceptive
V25.8	Other specified contraceptive management
V25.9	Contraceptive management, unspecified

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