IMPORTANT INFORMATION

BR200214 APRIL 2, 2002

To All Providers:

- Bulletin, *BT200207*, dated February 15, 2002, contained information about 2002 Health Care Procedure Coding System (HCPCS) code updates. The effective date for the new 2002 HCPCS codes originally listed as April 1, 2002, has changed to be retroactive to January 1, 2002. The HCPCS codes deleted for 2002 will be end-dated effective December 31, 2001. EDS will not reprocess claims previously denied for edit *4032 – Procedure not on file*. Providers can resubmit denied claims, or submit an adjustment request for a paid claim, if the old code paid a different rate from the new 2002 code. Direct questions about the date change to EDS Customer Assistance at (317) 655-3240 in the Indianapolis area or 1-800-738-6770 outside the Indianapolis area.
- Bulletin, *BT200207*, dated February 15, 2002, incorrectly listed HCPCS codes to be used for Norplant. Table 1 lists the correct codes:

Table 1 – Correct Codes for Norplant

Deleted Code	Replacement Code	Description
X3000	11975	Insertion, implantable contraceptive capsules
X3001	11976	Removal, implantable contraceptive capsules
X3002	11977	Removal with reinsertion, implantable contraceptive capsules
X3003	11977	Removal with reinsertion, implantable contraceptive capsules

In accordance with *CPT Changes, An Insider's View 2002*, published by the American Medical Association, "Codes 11981—11983 differ from the other implant codes 11975—11977, in that codes 11975—11977 are also a type of non-biodegradable capsule, but are specific for contraceptive use." New 2002 Current Procedure Terminology (CPT) codes, 11981—11983, and the description for clarification, are listed in Table 2:

Table 2 – New 2002 CPT Codes

New 2002 CPT Code	Description
11981	Insertion, non-biodegradable drug delivery implant
11982	Removal, non-biodegradable drug delivery implant
11983	Removal with insertion, non-biodegradable drug delivery implant

Additionally, in Bulletin *BT200207*, HCPCS local codes used to bill prenatal care coordination services for initial assessments, reassessments, and postpartum assessment/outcome will change. *BT200207, page 50, Table 1.4 – Deleted HCPCS Codes*, lists the deletion of local codes used to bill prenatal care coordination services and their replacement national HCPCS codes. Table 3 below lists the deleted local codes, the replacement codes, and a description for clarification, effective with claims for dates of service on or after January 1, 2002.

Table 3 – Correct Codes for Prenatal Care

Deleted Code	Replacement Code	Description
Z5900	H1000	Initial assessment
Z5901	H1004	Reassessment
Z5902	99502	Postpartum Assessment/Outcome

Note: The code originally listed in BT200207 *for postpartum assessment/outcome is incorrectly listed as Z5092. The correct code is* Z5902.

Claims billed with procedure code *Z5900 – Initial Assessment, Z5901 – Reassessment,* and *Z5902 – Postpartum Assessment/Outcome* on or after December 31, 2001, will deny in Indiana*AIM* with an invalid procedure code for associated edits. Procedure codes used to bill prenatal care coordination mileage: *Z5490 – Two round trips per initial assessment, Z5590 – Two round trips per reassessment,* and *Z5690 – One round trip per postpartum assessment,* will remain the same. Refer to the *IHCP Provider Manual, Chapter 8, Section 3, page 8-123,* for care coordination mileage.

- Due to several requests from providers in Allen County for information about mandatory Risk-Based Managed Care (RBMC), EDS Provider Relations, along with managed care entities, will host a questions and answer session in Fort Wayne on April 16, 2002, at Lutheran's Kachmann Auditorium beginning at 1 p.m. The session will be an open forum format for questions, and seating is available on a first-come, first-served basis. Lutheran Hospital is located one block east of Interstate 69 on Jefferson Blvd (exit 102). Refer questions about the session to (317) 488-5150.
- The following 590 policy change is effective May 4, 2002. Submission of 590 claims are subject to the one-year filing limit as stated in the June 2001 *Indiana Health Coverage Programs (IHCP) Provider Manual, Chapter 10, page 23, General Information.*

  All claims for service rendered must be submitted within one year from the date of service. When submitting claims beyond the one-year filing limit, the provider can submit the claim electronically, which generates a claim correction form (CCF) for documentation or on paper with appropriate justification attached for the late filing. Refer to the *Indiana Administrative Code (IAC) 1-1-3* for the complete rule narrative about the filing limitations.

  Checking eligibility is important. If a member verifies as a 590 member, verify the facility where the member resides or the facility where the 590 member resided. If the member claims to no longer reside in a facility, consider the member fee-for-service. Notify the EDS 590 provider representative at (317) 488-5072, with the following information:
  - Provider name and telephone number
  - 590 members' name and member identification (RID) number
  - Facility where the member resided

  All claims less than $150 are billed to the facility where the member resides. All claims more than $500 for a 590 member must have prior authorization (PA) from Health Care Excel (HCE). Send all 590 claims to the following address.

  EDS 590 Program Claims
  P. O. Box 7270
  Indianapolis, IN 46207-7270

To All Dental Providers:

- The *405 IAC 5-14-8 Extractions* states, "If multiple extractions are performed on the same date of service, the maximum allowable payment for additional teeth will be reduced by 10 percent of the maximum allowable for the first tooth." Currently the fee for *D7110, single tooth* is $72.25 and the fee for *D7120, each additional tooth,* is $66.50. The fee for *D7120* should be $65.02. Effective March 25, 2002, the rate for *D7120* has changed to $65.02.

To All Prescribers and Pharmacy Providers:

> *Note: The information referenced below is not directed to those providers rendering services in the RBMC delivery system.*

- Prior authorization (PA) of peptic acid disease drugs is not required for an acute treatment period of 90 days or less with a proton pump inhibitor (PPI) or full dose generic H2-antagonist. Treatment periods beyond 90 days of any dose of PPI requires documentation of a generic H2-antagonist failure or documented medical necessity for PA. If the physician reduces the H2-antagonist therapy to once daily, or maintenance therapy, PA is not required.

  This information is described, in detail, in bulletin *BT200148,* dated November 28, 2001, in the December 2001 edition of the *DUR Board Newsletter,* or on the www.indianamedicaid.com Web site.