B A N N E R P A G E

B R 2 0 0 8 0 6 F E B R U A R Y 5 , 2 0 0 8

All Providers

Prior Authorization of Growth Hormones

As of January 1, 2008, Indiana Health Coverage Programs (IHCP) implemented updated prior authorization (PA) forms for the medication class of growth hormones. The new PA criteria were approved by the Drug Utilization Review (DUR) Board in November 2007. The *Growth Hormone Prior Authorization Request Form For Adults (≥ 18 Years of Age)* and the *Growth Hormone Prior Authorization Request Form For Children (< 18 Years of Age)* are located on the following Web site: http://www.indianamedicaid.com/ihcp/Publications/forms.asp under the category Pharmacy Forms or by calling the ACS call center at 1-866-879-0106.

Prior Authorization Rejections

During the transition of PA services to ADVANTAGE Health Solutions[SM] and MDwise, Inc., paper or faxed PA requests submitted to the wrong care management organization (CMO) were forwarded by the CMO to the correct organization.

Beginning February 1, 2008, paper or faxed PA requests submitted to the wrong CMO will be rejected and a notification letter will be sent to the provider.

Electronic PA requests submitted to the incorrect CMO via the 278 PA Request and Response transaction will be rejected regardless of the certification type with reason code 78 – *Subscriber/Insured not in Group/Plan* identified. A PA decision form will not be generated.

When providers receive notification that a PA request was rejected, a new PA or a PA update request must be submitted to the correct CMO.

When electronic PA requests are submitted via Web interChange, the system determines which CMO should receive the information and forwards the request to the correct vendor. This process will continue after February 1, 2008.

Providers must verify member eligibility to determine the member's primary medical provider (PMP) and CMO. PA requests must be submitted to the organization to which the member is assigned on the date of the request. This also applies to PA updates submitted for review.

As a reminder, each CMO is responsible for processing medical service PA requests and updates for members assigned to their organization at the time of the request. Additionally, ADVANTAGE Health Solutions - FFS will be responsible for processing the following:

- PA requests and updates for all Traditional Medicaid fee-for-service (FFS) members
- PA requests for risk-based managed care (RBMC) carve-out services
- PA request for *Medicaid Select* services for members who have not yet transitioned to a *Care Select* program

ACS will continue to serve as the pharmacy PA contractor. For pharmacy PA information, contact 1-866-879-0106.

CPT Code 90660 Influenza Virus Vaccine, Live for Intranasal Use

The age restriction for Current Procedural Terminology (CPT[1]) code *90660 – Influenza Virus Vaccine, Live for Intranasal Use* has been updated from ages 5 through 49 to ages 2 through 49. Claims that denied for edit *4034 – Procedure code vs. age restriction* will be reprocessed and/or mass adjusted and begin appearing on remittance advice letters January 30, 2008.

[1] CPT copyright 2007 American Medical Association. All rights reserved.

Claims with a 26 Modifier

Medical claims paid during the month of January 2004 and billed with a 26 modifier (professional component) did not cut back to the appropriate resource-based relative value scale (RBRVS) rate for modifier 26. Instead, the procedure code was reimbursed at the combined rate for both the technical and professional component causing an overpayment. Claims identified will be mass adjusted and the overpayment recouped. The adjusted claims will begin appearing on the provider's Indiana Health Coverage Programs (IHCP) remittance advice dated March 4, 2008.

Claims Denied for Error Code 520 – Invalid Revenue Code/Procedure Code Combination

Providers who received denials with error code 520 – *Invalid revenue code/procedure code combination* for the following CPT codes since January 1, 2006, may resubmit those claims:

- 22523 – *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); thoracic*
- 22524 – *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); lumbar*
- 22525 – *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)*

Providers may submit this banner page along with the claims to waive the one-year filing limit.

All Hospice Providers

New Hospice Member Disenrollment Fax Number

To facilitate quick turnaround, ADVANTAGE Health Solutions has established a new fax number for the Medicaid managed care disenrollment of hospice members. Send disenrollment faxes to (317) 810-4488.

All Ambulance Providers

Fee Changes for Certain Ambulance Services

The maximum allowable fee amounts for several Healthcare Common Procedure Coding System (HCPCS) codes have been increased. The affected codes, descriptions, and maximum allowable fee amounts are listed in Table 1. The new maximum allowable fees are effective for services provided on or after January 1, 2008. All billing requirements will remain unchanged.

Table 1 – Fee Changes for Ambulance Services

HCPCS Procedure Code	Procedure Code Modifier	Procedure Code Description	Old Maximum Allowable Fee Amount	New Maximum Allowable Fee Amount
A0225		Ambulance Service, Neonatal	$150.00	$160.84
A0425	U1-ALS	Ground Mileage, Advanced Life Support (ALS)	$4.00	$4.41
A0425	U2-BLS	Ground Mileage, Basic Life Support (BLS)	$3.00	$3.31
A0426		Ambulance Service, ALS	$85.00	$95.84
A0427		Ambulance Service, Emergency, ALS	$150.00	$160.84
A0428		Ambulance Service, BLS	$85.00	$95.84
A0429		Ambulance Service, Emergency, BLS	$100.00	$110.84
A0433		Advanced ALS, Level 2	$150.00	$160.84

All Physician Service Providers Including Providers of Early and Periodic Screening, Diagnosis, and Treatment Services

Fee Changes for Certain Physician and EPSDT Services

The fee amounts for several CPT® codes have been increased. The affected codes, descriptions, and RBRVS or maximum allowable fee amounts are listed in Table 2. The new fees are effective for services provided on or after January 1, 2008.

For procedure code *99051 – Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service*, providers may bill a maximum of one unit per patient per day. Evening hours are defined as routinely scheduled after 5 p.m. in the prevailing time zone. Providers may only bill for the following holidays, which represent days when physician offices are generally closed for the day: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day. When billing for 99051, please document in the medical chart the time, date, or holiday, as applicable. All other billing requirements will remain unchanged.

Table 2 – Fee Changes for Physician and EPSDT Service Provider

CPT Procedure Code	Procedure Code Description	Old RBRVS Fee or Maximum Allowable Amount	New RBRVS Fee or Maximum Allowable Amount
59425	Antepartum Care	$29.31	$40.57
59426	Antepartum Care	$29.31	$43.73
99051	Svcs During Provider's Ext. Hours	N/A	$11.00
99203	Office/Outpatient Visit, New	$46.85	$47.44
99204	Office/Outpatient Visit, New	$70.14	$73.51
99205	Office/Outpatient Visit, New	$88.36	$93.13
99212	Office/Outpatient Visit, Est	$18.20	$19.37
99213	Office/Outpatient Visit, Est	$25.98	$31.96
99214	Office/Outpatient Visit, Est	$40.43	$48.54
99215	Office/Outpatient Visit, Est	$63.87	$65.25
99221	Initial Hospital Care	$48.49	$54.05
99223	Initial Hospital Care	$103.60	$108.09
99232	Subsequent Hospital Care	$37.20	$40.35
99233	Subsequent Hospital Care	$51.86	$57.47
99242	Office Consultation	$52.93	$59.27
99243	Office Consultation	$68.63	$81.03
99244	Office Consultation	$96.82	$121.18
99245	Office Consultation	$130.47	$148.04
99253	Inpatient Consultation	$70.63	$76.19
99254	Inpatient Consultation	$97.44	$110.64
99255	Inpatient Consultation	$132.11	$133.68
99282	Emergency Dept Visit	$23.74	$26.06
99284	Emergency Dept Visit	$66.93	$75.73
99285	Emergency Dept Visit	$105.28	$112.39
99291	Critical Care, First Hour	$142.35	$165.99

CPT Procedure Code	Procedure Code Description	Old RBRVS Fee or Maximum Allowable Amount	New RBRVS Fee or Maximum Allowable Amount
99292	Critical Care, ea Add'l 30 Min	$69.31	$76.15
99354	Prolonged Service, Office	$46.85	$59.79
99355	Prolonged Service, Office	$20.82	$60.16
99356	Prolonged Service, Inpatient	$46.85	$54.85
99357	Prolonged Service, Inpatient	$20.82	$54.74
99381*	Init Pm E/M, New Pat, Inf	$39.85	$58.54
99382*	Init Pm E/M, New Pat 1-4 Yrs	$34.52	$64.23
99383*	Prev Visit, New, Age 5-11	$34.82	$63.97
99384*	Prev Visit, New, Age 12-17	$32.00	$69.80
99385*	Prev Visit, New, Age 18-39	$48.94	$69.80
99386	Prev Visit, New, Age 40-64	$48.94	$81.60
99387	Init Pm E/M, New Pat 65+ Yrs	$48.94	$89.84
99391**	Per Pm Reeval, Est Pat, Inf	$24.35	$50.43
99392**	Prev Visit, Est, Age 1-4	$24.36	$56.00
99393**	Prev Visit, Est, Age 5-11	$25.01	$56.00
99394**	Prev Visit, Est, Age 12-17	$25.32	$61.69
99395**	Prev Visit, Est, Age 18-39	$34.82	$61.69
99396	Prev Visit, Est, Age 40-64	$34.82	$67.52
99397	Per Pm Reeval Est Pat 65+ Yr	$34.82	$76.02

The rates listed above are for non-EPSDT services.

For procedure codes marked with one asterisk (*) the current EPSDT rate is $50; the new EPSDT rate is $75.

For procedure codes marked with two asterisks (**) the current EPSDT rate is $37; new EPSDT rate is $62.

All Early and Periodic Screening, Diagnosis, and Treatment Services Providers

Mass Adjustment for Claims with Dates of Service between January 1, 2008, and January 23, 2008

The new rates for EPSDT exams were published in the banner page *BR200805* dated January 29, 2008. The new rates are effective for dates of service on or after January 1, 2008, when the following exam codes are billed with a primary diagnosis of V20.2: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, and 99395.

The new rates were not entered into the system until January 23, 2008. Claims with dates of service from January 1, 2008, through January 23, 2008, will be systematically mass adjusted during the week of February 11, 2008. For the affected exam codes, the EPSDT rate that is currently $50 will be changed to $75, and the EPSDT rate that is currently $37 will be changed to $62.

All Dental Providers

Fee Changes for Certain Dental Services

The maximum allowable fee amounts for several Current Dental Terminology (CDT[2]) codes have been increased. The affected codes, descriptions, and maximum allowable fee amounts are listed in Table 3. The new maximum allowable fee amounts are effective for services provided on or after January 1, 2008. All billing requirements and the annual dental cap amount for certain adult dental services will remain unchanged.

Table 3 – New Maximum Allowable Fee Amounts for CPT Codes

CDT Procedure Code	Procedure Code Description	Old Maximum Allowable Fee Amount	New Maximum Allowable Fee Amount
D0120	Periodic Oral Exam	$20.25	$22.58
D0140	Limited Oral Exam – Problem Focused	$33.25	$37.08
D0270	Bitewing – Single Film	$15.50	$17.29
D0272	Bitewings – Two Films	$22.25	$24.81
D0274	Bitewings – Four Films	$33.25	$35.17
D0330	Panoramic Film	$61.00	$64.52
D1351	Sealant per Tooth	$27.75	$29.35
D1510	Space Maintainer – Fixed - Unilateral	$174.25	$194.34
D1515	Space Maintainer – Fixed - Bilateral	$249.75	$278.54
D2140	Amalgam – One Surface, Primary or Permanent for Tooth Codes A - T = Child	$51.00	$56.88
D2140	Amalgam – One Surface, Primary or Permanent for Tooth Codes 1 - 32 = Adult	$55.50	$61.90
D2150	Amalgam – Two Surfaces, Primary or Permanent for Tooth Codes A - T = Child	$64.50	$71.93
D2150	Amalgam – Two Surfaces, Primary or Permanent for Tooth Codes 1 - 32 = Adult	$72.51	$81.14
D2160	Amalgam – Three Surface, Primary or Permanent for Tooth Codes A - T = Child	$77.75	$86.71
D2160	Amalgam – Three Surfaces Primary or Permanent for Tooth Codes 1 - 32 = Adult	$86.50	$96.47
D2161	Amalgam – Four or More Surfaces, Primary or Permanent for Tooth Codes A - T = Child	$83.50	$93.13
D2161	Amalgam – Four or More Surfaces, Primary or Permanent for Tooth Codes 1 - 32 = Adult	$104.25	$116.27
D2330	Resin – One Surface - Anterior	$71.00	$79.18
D2331	Resin – Two Surfaces - Anterior	$86.50	$96.47
D2332	Resin – Three Surfaces - Anterior	$105.50	$111.58
D2335	Resin – Four or More Surfaces or Involving Incisal Angle (Anterior)	$138.75	$154.74
D2920	Recement Crowns	$52.25	$58.27

[2] CDT is copyrighted by the American Dental Association.

CDT Procedure Code	Procedure Code Description	Old Maximum Allowable Fee Amount	New Maximum Allowable Fee Amount
D2930	Prefabricated Stainless Steel Crown – Primary Tooth	$139.75	$155.86
D2931	Prefabricated Stainless Steel Crown – Permanent Tooth	$166.50	$185.69
D2940	Sedative Filling	$54.50	$60.78
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	$94.25	$105.11
D3230	Pulpal Therapy (Resorbable Filling) – Anterior, Primary Tooth (Excluding Final Restoration)	$122.00	$136.06
D3310	Endodontic Therapy – Anterior (Excluding Final Restoration)	$338.50	$377.52
D3320	Endodontic Therapy – Bicuspid (Excluding Final Restoration)	$416.25	$464.23
D3330	Endodontic Therapy – Molar (Excluding Final Restoration)	$524.00	$569.32
D4210	Gingivectomy or Gingivoplasty – Four or More Contiguous Teeth or Bounded Teeth per Quadrant	$333.00	$371.38
D4211	Gingivectomy or Gingivoplasty – One to Three Contiguous Teeth or Bounded Teeth per Quadrant	$114.25	$127.42
D4341	Periodontal Scaling and Root Planing – Four or More Teeth per Quadrant	$138.75	$154.74
D4355	Full Mouth Debridement	$88.00	$98.14
D5110	Complete Upper (Denture) Rate is for members age >= 21. Rate for members under 21 years of age remains unchanged.	$391.25	$436.35
D5120	Complete Lower (Denture) Rate is for members age >= 21. Rate for members under 21 years of age remains unchanged.	394.13	$439.56
D5211	Upper Partial – Acrylic Base (Including any Conventional Clasps and Rests) Rate is for members age >= 21. Rate for members under 21 years of age remains unchanged.	$328.00	$365.81
D5212	Lower Partial – Acrylic Base (Including any Conventional Clasps and Rests) Rate is for members age >= 21. Rate for members under 21 years of age remains unchanged.	$333.00	$371.38
D7140	Extraction – Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	$72.25	$77.24
D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone	$144.25	$154.20
D7220	Removal of Impacted Tooth – Soft Tissue	$166.50	$185.69
D7230	Removal of Impacted Tooth – Partially Bony	$220.00	$247.59
D7240	Removal of Impacted Tooth – Completely Bony	$288.50	$321.76
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	$166.50	$185.69
D7286	Biopsy of Oral Tissue Soft	$154.75	$172.59
D7310	Alveoloplasty in Conjunction with Extractions – Four or More Teeth or Tooth Spaces, per Quadrant	$166.50	$185.69

CDT Procedure Code	Procedure Code Description	Old Maximum Allowable Fee Amount	New Maximum Allowable Fee Amount
D7320	Alveoloplasty not in Conjunction with Extractions – Four or More Teeth or Tooth Spaces, per Quadrant	$222.00	$247.59
D7410	Excision of Benign Lesion up to 1.25 CM	$97.02	$111.48
D7910	Suture of Small Wound up to 5 CM	$105.50	$117.66
D9230	Analgesia	$27.75	$30.95

All Vaccine for Children Providers

CPT Code 90649 Human Papilloma Virus Vaccine

Effective January 1, 2008, the human papilloma virus (HPV) vaccine procedure code is considered a carved-in procedure for risk-based managed care (RBMC). Providers should submit claims for 90649 directly to the managed care organizations (MCOs).

Contact Information

If you have questions about the articles published in this banner page, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll-free at 1-800-577-1278, unless otherwise noted.

If you need additional copies of this banner page, please download them from the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/banner_results.asp. To receive e-mail notifications of future IHCP publications, subscribe to the IHCP E-mail Notifications at http://www.indianamedicaid.com/ihcp/mailing_list/default.asp.