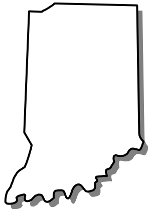

BANNER PAGE

BR200841 OCTOBER 7, 2008

All Providers

Annual Update of the International Classification of Diseases

The annual update of the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* was effective for the IHCP beginning October 1, 2008. You may see the new, revised, and discontinued codes at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#. To ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA), 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 dates of service. Codes not valid for dates of service will deny. The new ICD-9-CM diagnosis and procedure codes are billable and reimbursable as of October 1, 2008.

However, AP diagnosis-related grouping (DRG) Mapper for inpatient claims is not available at this time. Therefore, inpatient claims submitted with the new codes will deny for Explanation of Benefit Code 4116 – *Diagnosis code is not valid for DRG pricing*. Upon completion of the component linkage, EDS will systematically reprocess all inpatient claims with the new ICD-9-CM diagnosis and procedure codes. Please watch future banner pages for the claim reprocess date.

The ICD-9-CM diagnosis codes in Table 1 below will be added to Table 8.17 – *Emergency Department Diagnosis Codes* in the *IHCP Provider Manual*, *Chapter 8, Section 2*. These codes are effective for dates of service on or after October 1, 2008.

Table 1 – ICD-9-CM Diagnosis Codes

Effective for Dates of Service On or After October 1, 2008

(**Additions** to Table 8.17 – *Emergency Department Diagnosis Codes* of the *IHCP Provider Manual*)

136.21	136.29	209.22	249.11	249.20	249.21	249.30
249.31	249.40	249.41	249.50	249.51	249.60	249.61
249.70	249.71	249.80	249.81	249.90	249.91	279.50
279.51	279.52	279.53	289.84	339.00	339.01	339.02
339.03	339.04	339.05	339.09	339.10	339.11	339.12
339.20	339.21	339.22	339.3	339.41	339.42	339.43
339.44	339.81	339.82	339.83	339.84	339.85	339.89
346.02	346.03	346.12	346.13	346.22	346.23	346.30
346.31	346.32	346.33	346.40	346.41	346.42	346.43
346.50	346.51	346.52	346.53	346.60	346.61	346.62
346.63	346.70	346.71	346.72	346.73	346.82	346.83
346.92	346.93	349.31	414.3	511.81	511.89	530.13
535.70	535.71	569.44	599.70	599.71	599.72	695.10
695.14	695.15	695.55	695.56	695.57	695.58	695.59
707.20	707.22	707.23	707.24	733.97	733.98	760.61
760.62	760.63	760.64	777.50	777.51	777.52	777.53
780.60	780.61	780.62	780.63	780.64	780.65	997.31
997.39	998.30	998.33	999.81	999.82	999.88	999.89

V87.01	V87.09	V87.11	V87.12	V87.19	V87.2	V87.31
V87.39						

The ICD-9-CM diagnosis codes in Table 2 below will be removed from Table 8.17 – *Emergency Department Diagnosis Codes* in the *IHCP Provider Manual, Chapter 8, Section 2*. These codes are invalid for dates of service on or after October 1, 2008.

Table 2 – ICD-9-CM Diagnosis Codes

Invalid for Dates of Service On or After October 1, 2008

(**Deletions** from Table 8.17 – *Emergency Department Diagnosis Codes* of the *IHCP Provider Manual)*

136.2	511.8	599.7	695.1	777.5	780.6	997.3
999.8						

The ICD-9-CM diagnosis codes in Table 3 below will be added to Table 8.71 – *High Risk Pregnancy – ICD-9-CM Diagnosis Codes* in the *IHCP Provider Manual*, *Chapter 8, Section 4*. These codes are effective for dates of service on or after October 1, 2008.

Table 3 – ICD-9-CM Diagnosis Codes

Effective for Dates of Service On or After October 1, 2008

(**Additions** to Table 8.71 – *High Risk Pregnancy – ICD-9-CM Diagnosis Codes* of the *IHCP Provider Manual*)

199.2	203.02	203.12	203.82	204.02	204.12	204.22
204.82	204.92	205.02	205.12	205.22	205.32	205.82
205.92	206.02	206.12	206.22	206.82	206.92	207.02
207.12	207.22	207.82	208.02	208.12	208.22	208.82
208.92	209.00	209.01	209.02	209.03	209.10	209.11
209.11	209.12	209.13	209.14	209.15	209.16	209.17
209.20	209.21	209.22	209.23	209.24	209.25	209.26
209.27	209.29	209.30	209.40	209.41	209.42	209.43
209.50	209.51	209.52	209.53	209.54	209.55	209.56
209.57	209.60	209.61	209.62	209.63	209.64	209.65
209.66	209.67	209.69	238.77	259.50	259.51	259.52
289.84	482.42	649.70	649.71	678.11	678.13	V23.85
V23.86	V45.11	V45.12	V61.01	V61.02	V61.03	V61.04
V61.05	V61.06	V61.09	V62.21	V62.22	V62.29	

The ICD-9-CM diagnosis code in Table 4 below will be removed from Table 8.71– *High Risk Pregnancy – ICD-9-CM Diagnosis Codes* in the *IHCP Provider Manual*, *Chapter 8, Section 4*. This code is invalid for dates of service on or after October 1, 2008.

Table 4 – ICD-9-CM Diagnosis Codes

Invalid for Dates of Service On or After October 1, 2008

(**Deletion** from Table 8.71 – *High Risk Pregnancy ICD-9-CM Diagnosis Codes* of the *IHCP Provider Manual*

V45.1						

Indiana Health Coverage Programs to Upgrade System October 11-12

The IHCP will upgrade system servers and databases the weekend of October 11-12, 2008. Usage of the IHCP Web interChange Web site will be limited during this time, as will eligibility verification through Omni and the Automated Voice Response (AVR) System. Providers should review Table 5 below for more information concerning the system maintenance window.

Table 5 – System Maintenance Window

System Function	Unavailable Start Time	Unavailable End Time
Web interChange	12 a.m., Sunday, October 12	5 a.m., Sunday, October 12
Omni Eligibility Verification	12 a.m., Sunday, October 12	5 a.m., Sunday, October 12
Automated Voice Response (AVR)	12 a.m., Sunday, October 12	5 a.m., Sunday, October 12
Pharmacy POS	12 a.m., Sunday, October 12	5 a.m., Sunday, October 12

The completion time for the server upgrade process is an estimate. Web interChange, Omni, AVR, and Pharmacy Point-of-sale (POS) may be available prior to 5 a.m. on October 12, 2008, so providers may attempt to send transactions prior to 5 a.m. Pharmacy and Eligibility Switch Vendors will receive an e-mail when the system is available. This maintenance will not affect providers submitting batch claims using File Exchange. Questions about this system maintenance should be addressed to the Electronic Data Interchange (EDI) Solutions Help Desk at (317) 488-5160 in the Indianapolis local area or at 1-877-877-5182.

Medicaid Changes Prior Authorization Requirements for Osteogenic Bone-Growth Stimulator

Effective September 1, 2008, the IHCP no longer requires documented evidence of a failed surgery prior to authorizing an Osteogenic Bone-Growth Stimulator, low-intensity ultrasound, noninvasive (E0760) for treatment of nonunion fractures.

The following criteria must be met for diagnosis of a nonunion fracture:

- Serial radiographs must confirm that fracture healing has ceased for three or more months prior to starting treatment with an Osteogenic Stimulator.
- Serial radiographs must include a minimum of two sets of radiographs, each including multiple views of the fracture site, separated by a minimum of 90 days.

Prior authorization (PA) of an Osteogenic Bone-Growth Stimulator is still required and is based on the following indications:

- Nonunion of a fracture documented by a minimum of two sets of radiographs obtained prior to starting treatment with the ultrasound stimulator. The radiographs must be separated by a minimum of 90 days, and each must include multiple views of the fracture site. Also required is a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.
- The ultrasonic Osteogenic Stimulator may not be used concurrently with other noninvasive osteogenic devices.

All Pharmacy Providers and Prescribing Practitioners

CMS to Audit Pharmacies for Compliance with TRPP Requirements

The CMS has advised that, at some time in the future, it will audit individual pharmacies for compliance with Tamper Resistant Prescription Pad/Paper (TRPP) requirements. Please be certain that all Medicaid prescriptions you fill that are subject to TRPP requirements – as referenced in *BT200810*, dated February 22, 2008, and *BT200834*, dated August 21, 2008 – are fully compliant with the requirements. Payment for claims arising from noncompliant prescriptions would be recouped in the event of a state or federal audit finding of noncompliance.

Updated NCPDP Payer Sheets

Please check the updated National Council for Prescription Drug Program (NCPDP) payer sheets for the following information:

- DAW 6 definition has been updated for use when communicating on a claim when the brand is medically necessary, or when the brand is preferred to its generic equivalent on the Preferred Drug List (PDL).
- NCPDP fields 479-H8, "*Other Amount Claimed Submitted Qualifier,*" and 480-H9, "*Other Amount Claimed Submitted,*" have been added for use when submitting *Other Coverage Code 8* on claims (see Table 6). These fields have always been required, but were omitted from prior versions of the payer sheets in error.

Table 6 – National Council for Prescription Drug Programs Payer Sheets

Field	Field Name	Field Format	Type	Value	Comments
479-H8	*Other Amount Claimed Submitted Qualifier*	x(2)	N	99	Mandatory when segment is present
479-H9	*Other Amount Claimed Submitted*	9(9)v99b or 9(9)v99-	D	s$$$$$$cc s9(6)v99	Required when submitting claim with *Other Coverage Code 8* in field 308-C8 – billing for third-party liability (TPL) copay only

New Web Site for National Drug Code to Procedure Code Unit Conversion

The Palmetto Government Benefits Administrators (GBA) Web site has changed. This Web site is used for reference when submitting National Drug Codes (NDCs) with HCPCS codes on professional and outpatient claims – as found in bulletin *BT200713*, dated May 29, 2007. The new Web site, hosted by Nordian Administrative Service, is http://www.dmepdac.com.

Dental Providers

Preventive Pediatric Oral Health Care

As part of the requirements for providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) under the federal Medicaid program (Section 1905(r)(3) of the Social Security Act), the Office of Medicaid Policy and Planning has adopted the American Academy of Pediatric Dentistry's updated Recommendations for Preventive Pediatric Oral Health Care. Services expected to be rendered and their frequency are given in the Indiana Health Coverage Programs EPSDT Dental Periodicity Schedule in Table 7. See the *Healthwatch/EPSDT Provider Manual* at www.indianamedicaid.com for more detailed billing information.

Table 7 – Indiana Health Coverage Programs EPSDT Dental Periodicity Schedule

Service Provided	Age				
	6-12 months	12-24 months	2-6 years	6-12 years	>12 years
Clinical oral examination[1,2] to include:	■	■	■	■	■
Assess oral growth and development[3]	■	■	■	■	■
Caries-risk assessment[4]	■	■	■	■	■
Anticipatory guidance/counseling[6]	■	■	■	■	■
Injury prevention counseling[7]	■	■	■	■	■
Counseling for nonnutritive habits[8]	■	■	■	■	■
Counseling for speech/language development	■	■	■		

Service Provided	Age				
	6-12 months	12-24 months	2-6 years	6-12 years	>12 years
Substance abuse counseling				■	■
Counseling for intraoral/perioral piercing				■	■
Assessment for pit and fissure sealants[9]			■	■	■
Transition to adult dental care					■
Radiographic assessment[5]	■	■	■	■	■
Prophylaxis and topical fluoride[4,5]	■	■	■	■	■
Assessment and treatment of developing malocclusion			■	■	■
Assessment and/or removal of third molars					■

[1] First examination at the eruption of the first tooth and no later than 12 months. Repeat every six months or as indicated by child's risk status/susceptibility to disease.

[2] Includes assessment of pathology and injuries

[3] By clinical examination

[4] Must be repeated regularly and frequently to maximize effectiveness

[5] Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

[6] Appropriate discussion and counseling should be an integral part of each visit for care.

[7] Initially play objects, pacifiers, car seats; then, when learning to walk, sports and routine playing, including the importance of mouth guards

[8] At first, discuss the need for additional sucking: digits versus pacifiers; then, the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

[9] For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

Clarification of Dental Paper Claim Form Billing

This clarifies the article originally published in *BR200838. Provider Bulletin* BT200705 outlined the new American Dental Association (ADA) 2006 paper claim form changes and requirements. All ADA 2006 dental claim forms must contain the billing provider National Provider Identifier (NPI) in form locator 49. Group practices (those with multiple dentists) are required to indicate the rendering provider NPI in form locator 54.

BT200705 states that form locator 50, which is labeled *License Number*, is to contain the billing provider Legacy Provider Identifier (LPI). Claims that contain any number other than the billing provider LPI are returned to the provider unprocessed. Currently, claims are processed when the NPI and LPI are indicated on the paper claim form. The IHCP will continue to process claims when form locator 50 contains either the LPI or is blank.

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.

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