B A N N E R P A G E

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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, all patient (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						

Home Health Providers

Evaluations for Physical, Occupational, and Speech Therapy in Home Settings

This is a follow-up to banner page *BR200832*, dated August 5, 2008, regarding reimbursement of therapy evaluations performed by licensed therapists in home settings.

The Office of Medicaid Policy and Planning (OMPP) has determined that reimbursement for therapy evaluations should be billed using one of the following Common Procedural Terminology (CPT®) codes in conjunction with the appropriate Revenue Code:

Table 5 – CPT Codes for Reimbursement of Therapy Evaluations in Home Settings

Therapy	CPT/Description	Revenue Code/Description	Rate
Physical	97001 – Physical Therapy Eval	424 – Physical Therapy Eval or Re-Eval	$60.72
Occupational	97003 – Occupational Therapy Eval	434 – Occupational Therapy Eval or Re-Eval	$60.48
Speech	92506 – Speech Therapy Eval	444 – Speech Pathology Eval or Re-Eval	$62.80

Note: Occurrence code 53 (Therapy Evaluation – HHA) is no longer required when billing for evaluations.

The rates in Table 5 reflect the current reimbursement for CPT 97001, 97003, and 92506 evaluations when performed in home settings. Prior Authorization is not required for initial therapy evaluations. One unit of service equals one evaluation.

Providers may submit claims for dates of service beginning with October 16, 2003, forward for processing. For claims beyond the one-year filing limit, providers must attach a copy of this banner page to each claim for proper processing.

All Pharmacy Providers and Prescribing Practitioners

CMS to Audit Pharmacies for Compliance with TRPP Requirements

The Centers for Medicare & Medicaid Services (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.

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 6. See the *Healthwatch/EPSDT Provider Manual* at www.indianamedicaid.com for more detailed billing information.

Table 6 – 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:	■	■	■	■	■

Service Provided	Age				
	6-12 months	12-24 months	2-6 years	6-12 years	>12 years
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	■	■	■		
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.