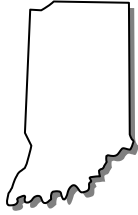

BANNER PAGE

BR200902 JANUARY 13, 2009

All Providers

Correct Billing Codes for Botox Injections

The Office of Medicaid Policy and Planning (OMPP) has determined that the seven Current Procedural Terminology (CPT®[1]) codes listed in Table 1 are no longer the most appropriate codes for chemodenervation with the drug Botulinum Toxin Type A and Botulinum Toxin Type B, according to most current CPT billing guidelines. Effective November 1, 2008, these CPT codes are no longer reimbursable when billed with Healthcare Common Procedure Coding System (HCPCS) J0585 – *Botulinum Toxin Type A, per unit* and HCPCS J0587 – *Botulinum Type B, per 100 units*, and will deny because of Audit 6612 – *Botox and Myobloc Injections Limited to Diagnosis Codes*.

Table 1 – CPT Codes for Chemodenervation No Longer Reimbursable with Botox

64640	95860	65861	65867
65868	95869	95870	

Effective November 1, 2008, the two International Classification of Diseases, 9th Revision (ICD-9) diagnosis codes listed in Table 2 are no longer appropriate for billing with HCPCS J0585 – *Botulinum Toxin Type A, per unit* and HCPCS J0587 – *Botulinum Type B, per 100 units*. Claims billing HCPCS J0585 – *Botulinum Toxin Type A, per unit* and HCPCS J0587 – *Botulinum Type B, per 100 units* with the two diagnosis codes will not be reimbursed and will deny because of Audit 6612 – *Botox and Myobloc Injections Limited to Diagnosis Codes*.

Table 2 – ICD-9 Diagnosis Codes No Longer Reimbursable with Botox

333.7	378.6

Effective November 1, 2008, the additional 10 CPT codes for chemodenervation listed in Table 3 and additional 20 ICD-9 diagnosis codes listed in Table 4 will be reimbursable when billed with HCPCS J0585 – *Botulinum Toxin Type A, per unit* and HCPCS J0587 – *Botulinum Type B, per 100 units*.

Table 3 – Additional CPT Codes for Chemodenervation with Botox

46299	43201	43236	46505
53899	64650	64653	67345
95873	95874		

Table 4 – Additional ICD-9 Diagnosis Codes with Botox

333.71	333.79	341.22	344.00
344.02	344.03	344.04	344.09
344.1	344.3	344.31	344.32
344.40	344.41	344.42	374.03
374.13	527.7	596.54	596.55

[1] CPT® is a registered trademark of the American Medical Association.

Mandate of Red Claim Forms Postponed

Banner page BR200852, dated December 23, 2008, stated that standard red-ink claim forms would be mandated beginning January 19, 2009. The implementation date has been postponed indefinitely. Claims submitted on black-ink claim forms will still be accepted after January 19.

You are encouraged to submit claims electronically or on the standard red-ink form to speed claim processing and improve the accuracy of data entry. The Indiana Health Coverage Programs (IHCP) has implemented software that uses an optical character recognition (OCR) program to read the data for claim processing from the red-ink claim forms.

All claims are processed within the required time frames for paper claims. Claims submitted electronically are processed with less human interaction, therefore reducing processing time. Red-ink claims are processed with less interaction than black-ink claims forms. Black-ink claims require the most time to adjudicate.

Update on the Shortage of VFC Hemophilus Influenza B Vaccine

Hemophilus influenza b vaccine (Hib) HbOC conjugate (four-dose schedule) for intramuscular use is still in short supply, resulting from the Hib recall by Merck as of December 12, 2007. Effective **February 1, 2008**, the IHCP is not limiting reimbursement for CPT codes 90645, 90647, 90648, 90698, 90721, and 90748 – regardless of availability from the Vaccines for Children (VFC) program. This policy allows you to obtain reimbursement for using privately purchased Hib vaccine for VFC-eligible members, even if a VFC vaccine is not available because of delays in receiving the VFC supply. If you administer a free VFC vaccine, you should bill the appropriate CPT code, but not charge more than the $8 VFC vaccine administration fee and not bill the separate administration CPT code.

When administering a privately purchased vaccine that contains Hib as a component, you may bill for the cost of the vaccine and administration. The IHCP-allowable reimbursement is based on the average wholesale price (AWP) of the vaccine. Providers may separately bill an appropriate CPT administration code, in addition to the HCPCS CPT code.

> *Note: CPT administration codes listed in earlier banner pages are no longer valid after December 31, 2008. See Table 5 for new codes effective January 1, 2009.*

Table 5 – New Codes Effective January 1, 2009

Former Code	Description	New Code
90772	Therapeutic, Prophylactic, or Diagnostic Injection (Specify Substance or Drug); Subcutaneous or Intramuscular	96372
90773	Therapeutic, Prophylactic, or Diagnostic Injection (Specify Substance or Drug); Intra-Arterial	96373
90774	Therapeutic, Prophylactic, or Diagnostic Injection (Specify Substance or Drug); Intravenous Push, Single, or Initial Substance/Drug	96374

If an evaluation and management (E/M) code is billed with the same date of service as an office-administered immunization, you should not bill a separate administration fee. Reimbursement for the vaccine administration is included in the E/M code allowed amount. Separate reimbursement is allowed when the administration of the vaccine is the only service provided and billed by the practitioner. In addition, if more than one immunization is provided on the same date of service, and no E/M code is billed, you may bill a separate administration fee for each immunization that is provided separately, as appropriate.

You must continue to submit claims to the appropriate delivery system – EDS or the appropriate managed care organization (MCO) – for each member, regardless of the source of the vaccine stock. Claims are eligible for postpayment review. You must maintain documentation and invoices related to private stock when substituting for VFC vaccine.

Rural health clinic (RHC) and Federally Qualified Health Center (FQHC) rates include payment for the vaccine and administration fee, and cannot be billed separately on claims submitted to EDS. RHCs and FQHCs must separately verify the billing policy for each MCO to which they submit claims.

FQHC and RHC Providers

Federally Qualified Health Center and Rural Health Clinic Workshop, January 28, 2009

EDS Provider Relations is offering a workshop for the FQHC and RHC provider community. Participating with EDS will be representatives from the MCOs and the care management organizations (CMOs) who help administer *Care Select*. This is an excellent opportunity to become more familiar with Medicaid policies, procedures, and billing specific to FQHCs and RHCs.

The workshop will be Wednesday, January 28, 2009. Details are below:

Daviess Community Hospital
Education Room 1
1314 E. Walnut St.
Washington, IN 47501
Time: 8:30 a.m.-noon

The agenda includes the following:

- How to check eligibility
- How to file a claim
- How to bill services
- What causes claims to deny
- Avenues to resolve denied claims
- Extensive question-and-answer period

Providers may enroll in the workshop at http://www.indianamedicaid.com/ by selecting Provider Services, Education Opportunities, Workshop Registration. If you have questions, please call Provider Relations at (317) 488-5072.

Dental Providers

Pricing for Prefabricated Stainless Steel Crowns

Effective November 25, 2008, the IHCP began covering prefabricated esthetic coated stainless steel crowns – Current Dental Terminology (CDT) code D2934 – for primary anterior teeth only. The service is reimbursed at a Max Fee rate of $155.86. Members are restricted to one type of crown per tooth, and billing for more than one crown per tooth will result in claim denial.

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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