



All Providers

Updated Pricing for Procedure Codes Previously Manually Priced

Indiana Health Coverage Programs (IHCP) has established rates for the Healthcare Common Procedure Coding System (HCPCS) codes in Table 1. These codes, which are currently manually priced, did not have pricing available from the Centers for Medicare & Medicaid Services (CMS) at the time the procedure codes were created but have had rates established since the date the codes were created. The new rates are effective for dates of service on or after December 1, 2009.

Table 1 – Healthcare Common Procedure Coding System Codes Effective December 1, 2009

Procedure Code	Code Description	Rates Effective for Dates of Service on or after December 1, 2009
82045	<i>Albumin; Ischemia modified</i>	Lab Fee rate of \$40.56
82656	<i>Elastase, Pancreatic (EL-1), fecal, qualitative or semi-quantitative</i>	Lab Fee rate of \$15.95
83009	<i>Helicobacter pylori, blood test analysis for urease activity, non-radioactive isotope</i>	Lab Fee rate of \$93.09
83037	<i>Hemoglobin, glycosylated (A1C) by device cleared by FDA for home use</i>	Lab Fee rate of \$13.42
87338	<i>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Helicobacter pylori, stool</i>	Lab Fee rate of \$19.88
91132 with modifier 26	<i>Electrogastrography</i>	Resource-based relative value scale (RBRVS) rate of \$20.46 for Professional Component
91133 with modifier 26	<i>Electrogastrography w/test</i>	RBRVS rate of \$25.68 for Professional Component
99091	<i>Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional</i>	RBRVS rate of \$37.91
99174	<i>Ocular photoscreening</i>	RBRVS rate of \$18.01
E0672	<i>Segmental gradient pressure pneumatic appliance, full arm</i>	Max Fee rates of \$307.83 NU and \$30.79 RR
E1030	<i>Wheelchair accessory, ventilator tray, gimbaled</i>	Max Fee rates of \$1054.57 NU and \$105.46 RR
E1035	<i>Multi-positional patient transfer system, with integrated seat, operated by care giver</i>	Max Fee rate of \$613.20 for RR
E1355	<i>Stand/rack</i>	Max Fee rate of \$22.40
E1391	<i>Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen</i>	Max Fee rate of \$175.79 for RR

Procedure Code	Code Description	Rates Effective for Dates of Service on or after December 1, 2009
	<i>concentration at the prescribed flow rate, each</i>	
E2397	<i>Power wheelchair accessory, lithium-based battery, each</i>	Max Fee rates of \$414.13 NU and \$41.41 RR
G0239	<i>Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals</i>	RBRVS rate of \$7.80
G0306	<i>Complete CBC, automated (Hgb, HCT, RBC, WBC, without platelet count) and automated WBC differential count</i>	Lab Fee rate of \$10.86
G0307	<i>Complete CBC, automated (Hgb, HCT, RBC, WBC, without platelet count)</i>	Lab Fee rate of \$9.04
K0730	<i>Controlled dose inhalation drug delivery system</i>	Max Fee rates of \$1724.02 NU and \$172.40 RR
K0801	<i>Power operated vehicle, group 1 heavy duty, patient weight capacity 301 to 450 pounds</i>	Max Fee rates of \$1886.22 NU and \$188.60 RR
K0802	<i>Power operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds</i>	Max Fee rates of \$2134.59 NU and \$213.45 RR
L2232	<i>Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only</i>	Max Fee rate of \$78.20
L3001	<i>Foot insert, removable, molded to patient model, Spenco, each</i>	Max Fee rate of \$106.49
L3003	<i>Foot insert, removable, molded to patient model, silicone gel, each</i>	Max Fee rate of \$140.27
L3911	<i>Wrist hand finger orthosis, elastic, prefabricated, includes fitting and adjustment</i>	Max Fee rate of \$18.15
L5782	<i>Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system, heavy duty</i>	Max Fee rate of \$3402.47
L6694	<i>Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism</i>	Max Fee rate of \$633.97
L6695	<i>Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism</i>	Max Fee rate of \$528.30
L6696	<i>Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only</i>	Max Fee rate of \$1061.04
L6697	<i>Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only</i>	Max Fee rate of \$1061.04
L6698	<i>Addition to upper extremity prosthesis, below</i>	Max Fee rate of \$398.91

Procedure Code	Code Description	Rates Effective for Dates of Service on or after December 1, 2009
	<i>elbow/above elbow, lock mechanism, excludes socket insert</i>	
L7400	<i>Addition to upper extremity prosthesis, below elbow/wrist disarticulation, ultralight material</i>	Max Fee rate of \$247.22
L8511	<i>Insert for indwelling tracheoesophageal prosthesis, with or without valve, replacement only, each</i>	Max Fee rate of \$58.66
L8512	<i>Gelatin capsules or equivalent, for use with tracheoesophageal voice prosthesis, replacement only, per 10</i>	Max Fee rate of \$1.76
L8513	<i>Cleaning device used with tracheoesophageal voice prosthesis, pipet, brush, or equal, replacement only, each</i>	Max Fee rate of \$4.19
L8514	<i>Tracheoesophageal puncture dilator, replacement only, each</i>	Max Fee rate of \$76.08
L8603	<i>Injectable bulking agent, collagen implant, urinary tract, 2.5 ml syringe, includes shipping and necessary supplies</i>	Max Fee rate of \$325.11

Centers for Medicare & Medicaid Services Quarterly Updates

The CMS has published the October quarterly updates with new and revised codes. Table 2 outlines the program coverage and shows the new HCPCS coverage, effective October 1, 2009.

Table 2 – Quarterly CMS Updates Effective October 1, 2009

HCPCS Code	Description	Program Coverage
Q2024	<i>Bevacizumab Injection, 0.25 mg</i>	Covered – All Programs
S3713	<i>Kras Mutation Analysis Testing</i>	Still under review
S0162	<i>Injection, Efalizumab, 125 mg</i>	Discontinued, effective October 1, 2009

Claims with Edit 4013 To Be Mass Adjusted and Reprocessed

Claims with dates of service between July 1, 2009, through September 30, 2009, billed with any of the HCPCS codes listed in Table 3 and denied with explanation of benefit (EOB) 4013 – *This Procedure Code is not covered for this date of service* will be systematically mass adjusted and/or reprocessed. These adjustments will appear on the October 13, 2009, Remittance Advice.

Table 3 – Mass Adjusted and/or Reprocessed HCPCS Codes

HCPCS Code	Description	Program Coverage
J7611	<i>Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg</i>	Covered – All Programs
J7612	<i>Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg</i>	Covered – All Programs
J7613	<i>Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg</i>	Covered – All Programs
J7614	<i>Levalbuterol, inhalation solution, FDA-approved final</i>	Covered – All Programs

HCPCS Code	Description	Program Coverage
	<i>product, non-compounded, administered through DME, unit dose, 0.5 mg</i>	

Claims Denied with Edit 4019 To Be Mass Reprocessed and Adjusted

The IHCP is performing a systematic mass reprocess and adjustment on claims that denied between August 27, 2009, through September 30, 2009, with EOB Code 4019 – *Attachment required for service rendered*. These claims will have an internal control number (ICN) Region 11 that identifies them as paper claims with attachments. Affected claims will be systematically mass reprocessed and adjusted, and will appear on the October 13, 2009, Remittance Advice statements.

Prescribing Providers and Pharmacy Providers

Active Pharmaceutical Ingredients (APIs)

The CMS, through the pharmacy technical advisory group, notified states that it will be removing additional nondrug products (Active Pharmaceutical Ingredients) used in compounded prescriptions from the CMS covered outpatient drug file. These nondrug products will remain reimbursable under Indiana Medicaid but will not require a drug rebate agreement for payment. Nondrug products that are considered APIs are covered by Indiana Medicaid, and as of July 1, 2009, do not require a drug rebate agreement in order to be reimbursed. An API that has recently been questioned is 17 alpha-hydroxyprogesterone caproate. This product is reimbursable even when it is from a nonrebating manufacturer, and may be billed on either the National Council for Prescription Drug Programs (NCPDP) claim or CMS-1500/837P format. When billed using either format, the product is reimbursable only if included in a compound. The required National Drug Code (NDC) information must be provided when billed on the CMS-1500/837P format.

Reminder – National Drug Codes Required for Procedure-Coded Drug Claims

The Federal Deficit Reduction Act of 2005 mandates that the IHCP require the submission of NDCs on claims submitted with certain procedure codes. This mandate affects all providers that submit electronic or paper claims for procedure-coded drugs. NDCs will also be required on Medicare crossover claims for all applicable procedure codes because the State may pay up to the 20 percent Medicare B copayment for dually eligible individuals. Only the NDC that is specified on the label of the product that is administered to the member is to be billed to the program. It is not permissible to bill the program with an NDC that was not on the label of the product that was administered to the member. For example, do not preprogram your billing system to automatically utilize a certain NDC for a procedure code when that NDC is not the one on the label of the product being administered to the member.

A listing of the above-referenced procedure codes is available at www.indianamedicaid.com under the Provider Services drop-down menu, “Procedure Codes that require NDC.”

Automation of Pharmacy Prior Authorization – Revised Implementation Date

IHCP bulletin [BT200927](#), dated August 24, 2009, notified providers of the implementation of an automated prior authorization system known as Smart PA™. The implementation date of October 1, 2009, has been revised to November 1, 2009, to allow for additional testing. All other information in bulletin [BT200927](#) remains unchanged.

Please contact HP Customer Assistance at (317) 655-3240 or 1-800-577-1278 if you have any questions.

Physicians, Hospitals, Clinics, Mental Health, and Pharmacy Providers

Coverage for Influenza A (H1N1) Vaccine Administration

The IHCP covers Influenza A (H1N1) vaccine administration. Providers should use the following HCPCS code when billing for the administration:

G9141 – *Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)*

The administration of the Influenza A (H1N1) vaccine is reimbursed at the lower of the usual and customary charge or the IHCP established max fee rate, \$12.94. Because the Influenza A (H1N1) vaccine is provided at no cost to providers, the IHCP will not reimburse G9142 – *Influenza A (H1N1) vaccine, any route of administration*. Providers who bill G9142 will receive error code 4209 – *No Pricing Segment for procedure/modifier combination*).

Providers are reminded that if an evaluation and management (E/M) code is billed with the same date of service as an office-administered immunization, the vaccine administration should not be billed separately. Reimbursement for the vaccine administration is included in the E/M code allowed amount. This remains true for the administration of the Influenza A (H1N1) vaccine. 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, separate administration fees for each immunization may be separately billed.

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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