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All Providers

Hysteroscopic Sterilization Procedure

Reimbursement is available for hysteroscopic sterilization with an implant device, which provides a nonincision permanent sterilization option. The Indiana Health Coverage Programs (IHCP) covers this procedure for eligible female members 21 years old and older. This procedure can be performed in the office, as an outpatient procedure, or in an ambulatory surgical center (ASC).

Providers should bill the procedure using Current Procedural Terminology (CPT®[1]) code 58565 – *Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants*. CPT code 58579 – *Unlisted hysteroscopy procedure, uterus*, is not appropriate billing for the procedure, and claims will suspend for manual review.

The implant device must be billed separately on the CMS-1500 claim form using Healthcare Common Procedure Coding System (HCPCS) code A9900 – *Miscellaneous supply, accessory, and/or service component of another HCPCS code*. This is the only code billable for the device.

An outpatient hospital or ASC must adhere to the following billing instructions to receive reimbursement for the implant device in addition to the outpatient ASC rate. No additional reimbursement is available for the implant device if performed in an inpatient setting. Table 1 provides billing instructions for these services.

Table 1 – Billing Instructions for the Hysteroscopic Sterilization Procedure with Implant Device

Provider	Claim Type	Bill for the Procedure and the Supply	Additional Billing Requirements
Outpatient Hospital or ASC	UB-04	58565 with appropriate revenue code	• Print the name of the implant device in the body of the claim form or on the accompanying invoice. • Submit a valid, signed Sterilization Consent Form with the claim. • Enter **ICD-9 CM V25.2-Sterilization** as the primary diagnosis on the claim.
	CMS-1500 bill for the device under the professional or durable medical equipment (DME) provider number	Bill the device using A9900 – include a cost invoice with the claim to support the actual cost of the device	
Physician	CMS-1500	58565	
		Bill the device on a separate line using A9900 – include a cost invoice	

Providers must submit a cost invoice with the claim to support the cost of the device. The IHCP reimburses 130 percent of the amount listed on the manufacturer's cost invoice, up to a statewide maximum of $686.

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

Updated Pricing for Procedure Codes Previously Denying for "No Pricing on File"

For *Care Select* and Traditional Medicaid, the IHCP has established rates for the following HCPCS codes listed in Table 2. These are covered procedures that were previously denying (primarily error codes 4209, 4205, and 4014) for no pricing segment on file. The pricing changes have been made retroactive to the effective date of the code. Providers may rebill claims with these procedure codes if the claims have denied due to no rate on file. Similarly, the codes in Table 3

will be covered by *Care Select* and Traditional Medicaid retroactive to the effective date of the code with the following rate changes. Providers may rebill claims with these procedure codes if the claims have been denied due to noncoverage. Providers may submit this banner page along with the claims to waive the one-year filing limit. Table 4 lists codes that are covered but nonreimbursable. *BT200734*, dated December 27, 2007, previously identified these codes as covered rather than nonreimbursable.

Table 2 – Codes with No Rates on File

Procedure Code	Code Description	New Rate	Effective Date of Code
A5083	Continent device, stoma absorptive cover for continent stoma	Max Fee rate of $0.50	January 1, 2008
E0856	Cervical traction device, cervical collar with inflatable air bladder	Max Fee rate of $154.03 NU and $15.42 RR	January 1, 2008
E2227	Manual wheelchair accessory, gear reduction drive wheel, each	Max Fee rate of $1,569.13 NU and $156.93 RR	January 1, 2008
E2228	Manual wheelchair accessory, wheel braking system and lock, complete, each	Max Fee rate of $936.26 NU and $93.62 RR	January 1, 2008
K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each	Max Fee rate of $1.10	January 1, 2004
K0602	Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each	Max Fee rate of $6.36	January 1, 2004
K0603	Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each	Max Fee rate of $0.57	January 1, 2004
K0604	Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each	Max Fee rate of $6.09	January 1, 2004

Table 3 – Codes Previously Noncovered

Procedure Code	Code Description	New Rate	Effective Date of Code
L7007	Electric hand, switch, or myoelectric controlled, adult	Max Fee rate of $3,072.89	January 1, 2007
L7008	Electric hand, switch, or myoelectric controlled, pediatric	Max Fee rate of $4,765.16	January 1, 2007
L7009	Electric hook, switch, or myoelectric controlled, adult	Max Fee rate of $3,143.94	January 1, 2007

Table 4 – Nonreimbursable Codes

Procedure Code	Code Description	Effective Date of Code
1127F	New episode for condition (ML)5	January 1, 2008
1128F	Subsequent episode for condition (ML)5	January 1, 2008

Notification of Pregnancy Billing Procedures for UB-04

Effective December 1, 2009, hospitals can submit claims for Notification of Pregnancy (NOP). Submit claims for NOP using the UB-04 claim form to the appropriate managed care organization following the guidelines below for reimbursement. NOPs previously completed by hospitals that have not yet been reimbursed can also be submitted using the date of service when the NOP was completed.

To be eligible for reimbursement of an NOP:

1. The NOP must be submitted via Web interChange no more than five calendar days from the date the risk assessment was completed. The NOP cannot be a duplicate of a previously submitted NOP, and the member's gestation must be 29 weeks or less.
2. NOP claim forms must be coded with:
   - Revenue Code 960
   - CPT code 99354 **and** modifier TH

> *Note: The revenue code, CPT code, and the modifier must be billed together to be reimbursed the NOP fee when billed on the UB claim.*
>
> *Duplicate NOPs will not be reimbursed.*

Inpatient Hospital Providers

Present on Admission Indicator for Newborns

Per provider bulletin *BT200928*, dated August 25, 2009, the Present on Admission (POA) indicator is not required for exempt diagnosis codes. Hospitals that are not exempt from the Hospital Acquired Condition reporting may have experienced denials when diagnosis codes V30 through V39 were billed on claims with dates of service between October 1, 2009, through December 6, 2009. These claims are being systematically reprocessed and should appear on the December 22, 2009, Remittance Advice. Reminder: The POA indicator of "1" should be used only with exempt diagnosis codes.

Outpatient Providers

Positron Emission Tomography Claims Denying with Audit 6288

Positron Emission Tomography (PET) scan imaging claims have denied with audit 6288 – *PET scan imaging limited to specific diagnosis codes* when more than one diagnosis code was reported on a claim. This occurred because only the first diagnosis code on the claim was considered during processing. As a workaround, providers were required to remove the PET scan procedure code from the claim and submit it separately on a new claim. Effective January 1, 2010, the IHCP will consider all diagnosis codes reported on PET scan claims during processing. Providers with dates of service that are more than one year old should submit claims with this article to waive the filing limit.

New Audit 6290 for Hyperbaric Oxygen Therapy

Hyperbaric Oxygen Therapy (HBO) claims may have paid inappropriately because some of the diagnosis codes on the claims were not considered during processing. Effective January 1, 2010, providers billing HBO services may see a new audit 6290 – *HBO limited by diagnosis code*. This will prevent claims from paying inappropriately.

Prescribing Providers and Pharmacy Providers

Revised Implementation Date for Pharmacy Benefit Consolidation

As advised in previous IHCP Provider Bulletins, the Office of Medicaid Policy and Planning (OMPP) had planned to assume responsibility for the administration of the Hoosier Healthwise (HHW) managed care organizations (MCOs) and Healthy Indiana Plan (HIP) pharmacy benefits for claims with dates of service of January 1, 2010, or later. The implementation date has now been revised to include claims with dates of service beginning December 31, 2009.

A member notice was mailed December 1, 2009. For a copy of the letter, please refer to Pharmacy Benefit Consolidation Member Notices. A revised version of the member notice was posted at the link referenced above after December 22, 2009.

Due to the revised implementation date, copays will be waived for HHW Packages A, B, and C members for pharmacy claims with dates of service of December 31, 2009 only.

Please refer to IHCP bulletin *BT200948*, dated December 22, 2009, for additional information.

Provider Workshops

Regional Workshops for Dental, Home Health, and Hospice Providers

Provider Relations will present regional workshops for home health, hospice, and dental providers. Providers may choose any of the following dates to attend. The morning session covers home health and hospice education, and the afternoon is for the dental provider community.

Date: January 20, 2010

Location: Indiana University School of Dentistry
1121 W. Michigan St.
Room DS 114
Indianapolis, IN 46202

Date: January 28, 2010
Location: Bloomington Hospital Auditorium
601 West 2nd Street
Bloomington, IN 47403

Date: February 2, 2010
Location: Union Hospital
Landsbaum Center
1433 6 ½ Street
Terre Haute, IN 47804

Home Health/Hospice Providers

Home Health: 9 – 10 a.m.

Hospice: 10:10 – 11:30 a.m.

This is an excellent opportunity to become more familiar with Medicaid home health and hospice policies, procedures, and billing tools and methodology.

The agenda includes the following:

- Benefit coverage
- Prior authorization requirements
- Billing procedures
- Eligibility requirements
- Reimbursement methodology
- Hospice process
- Common denials

Dental Providers

1:00 – 3:30 p.m.

This is an excellent opportunity to become more familiar with Medicaid dental policies, procedures, and billing tools and methodology.

The agenda includes a live demonstration and discussion of all facets of Web interChange, including:

- Spend-down
- Managed care
- Third-party liability and qualified Medicare beneficiary eligibility
- Dental cap
- Benefit limitations

Providers may enroll in the workshop on www.indianamedicaid.com under **Provider Services** > **Education Opportunities** > **Workshop Registration**. If you have questions, please call Provider Relations at (317) 488-5072.

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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