

# IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS

BR201113

MARCH 29, 2011



## Corrections to the billing instructions for antepartum visits

Providers should bill each antepartum visit separately using the appropriate billing code. Providers may use a new or established patient evaluation and management (E/M) code (99201–99215) for the first antepartum visit to accommodate the greater amount of work involved with this visit. However, to bill all subsequent antepartum visits, providers should use the appropriate antepartum care code, Current Procedural Terminology (CPT<sup>®1</sup>) procedure code 59425 or 59426. If providers report an E/M code for the first visit, they must use the appropriate trimester modifier. For visits two through six, the provider should bill using procedure code 59425 at each visit, along with the appropriate trimester modifier. For the seventh and all subsequent visits, the provider should bill using procedure code 59426 at each visit, along with the appropriate trimester modifier. Providers should include the last menstrual period (LMP) for all obstetric (OB) claims.

## Learn how to make the best use of Web interChange and indianamedicaid.com

In April and May, the Indiana Health Coverage Programs (IHCP) will offer virtual-room training about using the tools available on Web interChange and indianamedicaid.com. This session will focus on commonly used Web interChange functions, as well as other, less familiar features. The presenter will demonstrate how to use indianamedicaid.com to research and resolve questions that arise daily in provider offices, including finding publications, searching the fee schedule, accessing and using the *IHCP Provider Manual*, and many others. Because this is virtual training, your staff doesn't need to leave the office.

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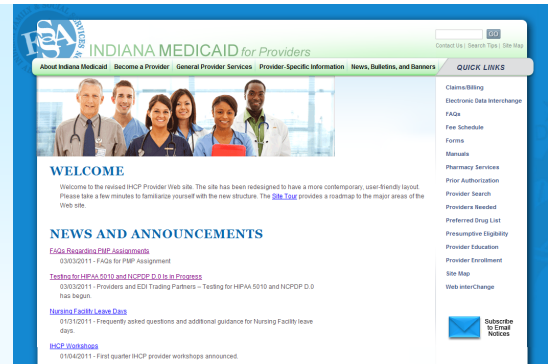
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Register now — participation is limited to 125 per session. Providers have three opportunities to attend:

- April 28, 2011, 1:30 p.m. – 4 p.m. EST\*
- May 6, 2011, 9 a.m. – 11:30 a.m. EST\*
- May 13, 2011, 10 a.m. – 12:30 p.m. EST\*

**\*Please note times listed are Eastern Standard Time.**

Please visit [indianamedicaid.com](http://indianamedicaid.com) (**General Provider Services > Provider Education**) for an opportunity to register for one of these sessions and to check other provider education offerings.



## Reminder of billing guidelines for evaluation and management codes

Providers are reminded that Indiana Health Coverage Programs (IHCP) reimbursement for evaluation and management (E/M) services is limited to a maximum of 30 office visits per member per rolling 12-month period without prior authorization (PA). Additional office visits require PA and must be medically necessary. E/M services must be appropriate to the member’s diagnosis and treatment, and the CPT code billed must most closely describe the services rendered. If a physician uses an emergency room as a substitute for the physician’s office for a nonemergency service, the service should be billed as an office visit, with the site of service indicated. Additionally, providers are reminded that new patient office visits are limited to one per member per provider within the last three years. A new patient is one who has not received any professional services from a provider within the same specialty and group practice within the preceding three years.

### *E/M services codes requiring PA after exceeding allowable quantity limits*

CPT E/M Code	Description
99201 – 99205	Office or other outpatient visit for the evaluation and management for a new patient
99211 – 99215	Office or other outpatient visit for the evaluation and management of an established patient
99241 – 99245	Office consultation for a new or established patient
99381 – 99387	Initial comprehensive preventive medicine evaluation and management of an individual
99391 – 99397	Periodic comprehensive preventive medicine reevaluation and management of an individual

### QUESTIONS?

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