# IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201525 JUNE 23, 2015

## Reimbursement restrictions added for gender-specific HCPCS codes

Effective August 1, 2015, the Indiana Health Coverage Programs (IHCP) will restrict reimbursement for certain Healthcare Common Procedure Coding System (HCPCS) codes indicated as gender-specific in the code description to either female only or male only, as indicated, except under special circumstances. This change applies to dates of service (DOS) on or after August 1, 2015.

The HCPCS codes in Table 1 have been identified as codes reimbursed for females only, per coding guidelines.

*Table 1 – Female-only HCPCS codes for DOS on or after August 1, 2015*

| | | | | |
|---|---|---|---|---|
| A4327 | A4328 | E0326 | E0602 | E0603 |
| G0147 | G0148 | J7302 | L3215 | L3216 |
| L3224 | L8010 | L8020 | L8030 | L8039 |
| Q0091 | Q0114 | Q0115 | S2400 | S3854 |
| S4005 | S4993 | | | |

The HCPCS codes in Table 2 have been identified as codes reimbursed for males only, per coding guidelines.

*Table 2 – Male-only HCPCS codes for DOS on or after August 1, 2015*

| | | | | |
|---|---|---|---|---|
| A4326 | E0325 | G0416 | G0419 | L3219 |
| L3222 | L3225 | L8330 | | |

## IHCP updates FQHC-RHC encounter codes for crossover claims

Effective August 1, 2015, the Indiana Health Coverage Programs (IHCP) will add the Healthcare Common Procedure Coding System (HCPCS) codes in Table 3 as valid Federally Qualified Health Center (FQHC) and rural health clinic (RHC) encounter codes for dually eligible members. This update applies retroactively to dates of service (DOS) on or after **October 1, 2014**. These codes may be billed for all dually-eligible members; reimbursement is subject to limitations established for certain benefit packages.

Beginning August 1, 2015, FQHC and RHC providers may submit claims for these codes with DOS on or after October 1, 2014. Claims for these codes with DOS on or after October 1, 2014, that previously denied may be resubmitted. Claims submitted beyond the original one-year filing limit must include a copy of this banner page as an attachment and must be filed within one year of the publication date.

*continued*

*Table 3 – Valid FQHC and RHC encounter codes for dually eligible members for DOS on or after October 1, 2014*

| HCPCS code | Description |
|---|---|
| G0466 | FQHC visit, new patient |
| G0467 | FQHC visit, established patient |
| G0468 | FQHC visit, IPPE or AWV |
| G0469 | FQHC visit, mental health, new patient |
| G0470 | FQHC visit, mental health, established patient |

This change is necessary due to a change in the Medicare billing methodology so that crossover claims are reimbursed per the Medicare crossover payment methodology. The IHCP calculates the Medicaid payment amount on Medicare crossover and Medicare Replacement Plan crossover claims as the lesser of:

- The Medicaid-allowed amount less the Medicare or Medicare Replacement Plan payment
- The Medicare or Medicare Replacement Plan coinsurance and deductible amount

Total payment for crossover claims will not exceed the Medicare or Medicare Replacement Plan allowed amount.

The list of valid FQHC and RHC encounter codes is reviewed periodically to account for new and end-dated Current Procedural Terminology (CPT®[1]) and HCPCS codes, and is available on the Myers and Stauffer website at in.mslc.com. If you have questions, contact Berry Bingaman, Myers and Stauffer LC, at (317) 846-9521.



## Pricing updated for certain manually priced dental codes

Effective August 1, 2015, the Indiana Health Coverage Programs (IHCP) will update the pricing for the Current Dental Terminology (CDT®[2]) procedure codes listed in Table 4.

The pricing for these procedure codes will change from manual pricing to maximum fee pricing. The IHCP will adopt maximum fee rates for the listed codes for fee-for-service claims with dates of service (DOS) on or after August 1, 2015. These changes will be reflected in the next monthly updates to the provider *Fee Schedule* at indianamedicaid.com.



*Table 4 – CDT codes updated from manual pricing to maximum fee pricing for DOS on or after August 1, 2015*

| Procedure code | Description |
|---|---|
| D3346 | Retreatment of previous root canal therapy – anterior |
| D3347 | Retreatment of previous root canal – bicuspid |
| D3348 | Retreatment of previous root canal therapy – molar |
| D3421 | Apicoectomy – bicuspid (first root) |

*continued*

*Table 4 – CDT codes updated from manual pricing to maximum fee pricing for DOS on or after August 1, 2015 (continued)*

| Procedure code | Description |
|---|---|
| D3425 | Apicoectomy – molar first root |
| D3426 | Apicoectomy (each additional root) |
| D4240 | Gingival flap procedure, including root planing four or more contiguous teeth or tooth bounded spaces per quadrant |
| D4241 | Gingival flap procedure, including root planing one to three contiguous teeth or tooth bounded spaces per quadrant |
| D4260 | Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant |
| D5281 | Removable unilateral partial denture – one piece cast metal (including clasps and teeth) |
| D5951 | Feeding aid |
| D6930 | Re-cement or re-bond fixed partial denture |
| D6980 | Bridge repair, by report |
| D7261 | Primary closure of a sinus perforation |
| D7282 | Mobilization of erupted or malpositioned tooth to aid eruption |
| D7412 | Excision of benign lesion – complicated |
| D7413 | Excision of malignant lesion up to 1.25 cm |
| D7414 | Excision of malignant lesion greater than 1.25 cm |
| D7415 | Excision of malignant lesion – complicated |
| D7472 | Removal of torus palatinus |
| D7473 | Removal of torus mandibularis |
| D7485 | Surgical reduction of osseous tuberosity |
| D7511 | Incision and drainage of abscess intraoral soft tissue complicated (includes drainage of multiple fascial spaces) |
| D7521 | Incision and drainage of abscess – extraoral soft tissue complicated (includes drainage of multiple fascial spaces) |
| D7610 | Maxilla fracture – open reduction (teeth immobilized if present) |
| D7630 | Mandible fracture – open reduction (teeth immobilized if present) |
| D7650 | Malar and/or zygomatic arch – open reduction |

*continued*

*Table 4 – CDT codes updated from manual pricing to maximum fee pricing for DOS on or after August 1, 2015 (continued)*

| Procedure code | Description |
|---|---|
| D7671 | Alveolus – open reduction, may include stabilization of teeth |
| D7680 | Facial bones – complicated reduction with fixation and multiple surgical approaches |
| D7740 | Mandible fracture – closed reduction |
| D7771 | Alveolus – closed reduction stabilization of teeth |
| D7972 | Surgical reduction of fibrous tuberosity |
| D8010 | Limited orthodontic treatment of the primary dentition |
| D8020 | Limited orthodontic treatment of the transitional dentition |
| D8030 | Limited orthodontic treatment of the adolescent dentition |
| D8040 | Limited orthodontic treatment of the adult dentition |
| D8050 | Interceptive orthodontic treatment of the primary dentition |
| D8060 | Interceptive orthodontic treatment of the transitional dentition |
| D8220 | Fixed appliance therapy |
| D9120 | Fixed partial denture sectioning |

**QUESTIONS?**

If you have questions about this publication, please contact Customer Assistance at 1-800-577-1278.

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