IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR201535 SEPTEMBER 1, 2015

IHCP will mass adjust claims for dental codes that paid incorrectly

The Indiana Health Coverage Programs (IHCP) has identified two claims processing issues that affect certain fee-for-service (FFS) dental claims. *IHCP Bulletin* BT201012 announced a dental rate reduction that applied to dates of service (DOS) on or after April 1, 2010, and ended December 31, 2013. This reduction applied to all dental codes, including those that were manually priced. During the dental rate reduction period, manually priced codes paid at 85% of billed charges. Before and after the dental rate reduction, manually priced dental codes paid at 90% of billed charges.

Reimbursement for certain manually priced dental codes was not reduced during the reduction period

Reimbursement for the manually priced dental codes in Table 1 was not reduced appropriately during the reduction period. Claims for these codes with DOS from April 1, 2010, through December 31, 2013, continued to be paid at 90% of billed charges and therefore were overpaid.

Table 1 – Manually priced dental codes that paid incorrectly for DOS from April 1, 2010 through December 31, 2013

Procedure Code	Description
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

Reimbursement for certain manually priced dental codes was not restored after the reduction period

Reimbursement for the dental codes in Table 2 was not restored appropriately after the rate reduction period ended. Claims for these codes with DOS from January 1, 2014, through July 31, 2015, continued to be paid at 85% of billed charges and therefore were underpaid.

continued

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Table 2 – Manually priced dental codes that paid incorrectly for DOS from January 1, 2014 through July 31, 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
D3425	Apicoectomy – molar first root
D3426	Apicoectomy – each additional root
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth)
D5951	Feeding aid
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report
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
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

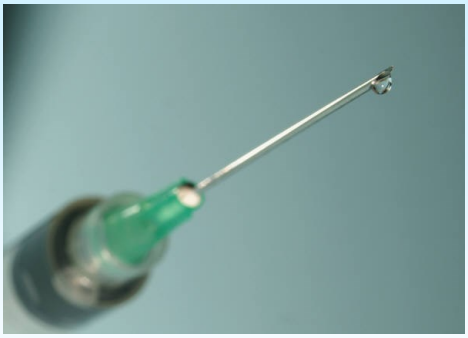
continued

Table 2 – Manually priced dental codes that paid incorrectly for DOS from January 1, 2014 through July 31, 2015 (continued)

Procedure Code	Description
D7972	Surgical reduction of fibrous tuberosity
D7999	Unspecified oral surgery procedure, by report
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

The claims processing system has been corrected. Claims processed during the indicated time frames that previously reimbursed incorrectly will be mass adjusted. Providers should begin to see the adjusted claims on Remittance Advices (RAs) dated October 13, 2015, with internal control numbers (ICNs) that begin with 56 (mass adjusted). For claims that were underpaid, the net difference will be paid and reflected on the RA. If a claim was overpaid, the net difference appears as an accounts receivable. The accounts receivable will be recouped at 100% from future claims paid to the respective provider number.

CPT code 90734 linked to revenue code 636



Effective October 1, 2015, the Indiana Health Coverage Programs (IHCP) will link Current Procedural Terminology (CPT®[1]) code 90734 – *Meningococcal conjugate vaccine, serogroups A, C, Y and W-135, quadrivalent (MenACWY), for intramuscular use* to revenue code 636 – *Pharmacy-Extension of 025X-Drugs Requiring Detailed Coding.* This linkage applies retroactively to fee-for-service (FFS) claims with dates of service (DOS) on or after **July 1, 2015**.

For reimbursement consideration, beginning October 1, 2015, providers may bill CPT code 90734 and revenue code 636 together, as appropriate. Claims with DOS on or after July 1, 2015, that previously denied for explanation of benefits (EOB) 520 – *Invalid revenue code and procedure code combination* 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.

ASC pricing indicators removed from multiple procedure codes

Effective October 1, 2015, the Indiana Health Coverage Programs (IHCP) has removed the ambulatory surgical center (ASC) pricing indicators from the following Current Procedural Terminology (CPT®[1]) codes:

- 36430 - *Transfusion, blood or blood components*
- 36440 - *Push transfusion, blood, 2 years or younger*
- 36455 - *Exchange transfusion, blood; other than newborn*
- 36460 - *Transfusion, intrauterine, fetal*

These procedure codes are not considered surgeries by the national coding guidelines; therefore, the IHCP does not recognize these codes as reimbursable in the outpatient setting via the ASC methodology. As such, the ASC indicators are being removed from the codes. These changes apply to fee-for-service claims with dates of service on or after October 1, 2015.

CPT code 65778 linked to provider specialty 180 – Optometrist

Effective October 1, 2015, the Indiana Health Coverage Programs (IHCP) will link Current Procedural Terminology (CPT®[1]) code 65778 – *Insertion of amniotic membrane to eye surface* to provider specialty 180 – Optometrist. This linkage applies to fee-for-service claims with dates of service (DOS) on or after October 1, 2015.

This change will be reflected in the next monthly update to the Code Sets at indianamedicaid.com. The standard billing guidelines outlined in Chapter 8 of the *IHCP Provider Manual* apply.

IHCP will mass reprocess outpatient claims billed with revenue code 274 that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claims processing issue that affects certain outpatient claims with dates of service (DOS) from July 1, 2014, through July 3, 2015. Outpatient claims billed with revenue code 274 may have been inappropriately denied with the following explanations of benefits (EOBs):

- 4090 – *Drug and supply codes are included in treatment room rate*
- 4091 – *Add-on service was billed without a treatment room or stand-alone service*
- 4105 – *No flat fee on file*

The claims processing system has been corrected. Claims processed for DOS during the indicated time frame that previously denied for EOBs 4090, 4091, and 4105 will be mass reprocessed. Providers should begin to see the reprocessed claims on Remittance Advices (RAs) dated October 6, 2015, with internal control numbers (ICNs) that begin with 80 (mass reprocessed).

PE for Inmates process reminder

As previously announced in *BT201556*, the Indiana Health Coverage Programs (IHCP) will broaden the eligibility parameters of the Presumptive Eligibility (PE) for Inmates process effective September 1, 2015, as follows:

- Inmates from county jails operating under a contract with the Indiana Family and Social Services Administration (FSSA) will be eligible to enroll through the process.
- County jails will be considered qualifying correctional facilities when operating under a signed contract with the FSSA.

Only inmates from a correctional facility with a signed contract or a signed memorandum of understanding (MOU) with FSSA are eligible for enrollment through the PE for Inmates process. Any interested correctional facility that does not have a signed contract or MOU should contact IndianaInmateMedicaid@fssa.in.gov.

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