IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201448 DECEMBER 2, 2014

CPT codes linked to revenue code 250

Effective January 1, 2015, the Indiana Health Coverage Programs (IHCP) will link the following Current Procedural Terminology (CPT®[1]) codes to Revenue Code 250 – *Pharmacy-General*:

- 90705 – *Measles virus vaccine, live, for subcutaneous use*
- 90706 – *Rubella virus vaccine, live, for subcutaneous use*
- 90707 – *Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use*
- 90708 – *Measles and rubella virus vaccine, live, for subcutaneous use*
- 90710 – *Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use*
- 90712 – *Poliovirus vaccine, (any type[s]) (OPV), live, for oral use*
- 90713 – *Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use*
- 90714 – *Tetanus and diphtheria toxoids (Td) absorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use*

These linkages apply retroactively to fee-for-services (FFS) claims with dates of service (DOS) on or after **July 1, 2014**.

Beginning January 1, 2015, for reimbursement consideration, providers may bill CPT codes 90705, 90706, 90707, 90708, 90710, 90712, 90713, and 90714 with revenue code 250, as appropriate. Claims with DOS on or after July 1, 2014, that previously denied for explanation of benefits (EOB) 520 – *Invalid revenue code/procedure code combination* may be resubmitted for processing.

MORE IN THIS ISSUE

The IHCP revises reimbursement for vagus nerve stimulator device components

Effective January 1, 2015, the Indiana Health Coverage Programs (IHCP) will change how vagus nerve stimulator (VNS) device components are billed and priced. The IHCP has created two Healthcare Common Procedure Coding System (HCPCS) codes by appending the U1 modifier for providers to use when billing neurostimulator device components **for VNS diagnoses only**:

- L8680 U1 – *Implantable neurostimulator electrode, each, VNS only*
- L8686 U1 – *Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension, VNS only*

Reimbursement of HCPCS codes L8680 U1 and L8686 U1 is limited to the following diagnosis codes:

- 345.41 – *Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy*
- 345.51 – *Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, with intractable epilepsy*

Claims submitted for HCPCS codes L8680 U1 and L8686 U1 with other diagnosis codes will deny for explanation of benefits (EOB) 4037 – *This procedure is not consistent with the diagnosis billed. Please verify and resubmit.*

HCPCS codes L8680 U1 and L8686 U1 will be manually priced. Consistent with the IHCP's manual pricing methodology for durable medical equipment (DME), these codes will reimburse at 75% of the manufacturer's suggested retail price (MSRP). Providers will be required to submit **both** proof of the MSRP and a cost invoice with the claim. A cost invoice is an itemized bill issued directly from the supplier to the provider listing the goods supplied and stating the amount of money due to the supplier. If the cost invoice contains more than one item, providers must identify on each attachment which item corresponds to the procedure code and amount identified on the claim form. Documentation of the MSRP must clearly come from the manufacturer of the DME or supply item. Acceptable documentation of the MSRP includes:

- Manufacturer's catalog page showing MSRP, suggested retail price, or retail price
- Manufacturer's invoice showing MSRP, suggested retail price, or retail price
- Quote from the manufacturer showing the MSRP, suggested retail price, or retail price

To receive reimbursement for the cost of the device separate from the implantation procedure, providers should continue to bill the device separately on the *CMS-1500*. Prior authorization (PA) continues to be required, and the PA criteria remain unchanged. For details, see *Chapter 8* of the *IHCP Provider Manual*.

Note that when billing neurostimulator device components **for non-VNS use,** providers should continue to bill HCPCS codes L8680 and L8686 without the U1 modifier. These codes will continue to pay at a flat fee, as indicated on the IHCP Fee Schedule. The billing and pricing for all other diagnoses except the two VNS diagnoses previously listed remain unchanged. All other medical and reimbursement policies described in *Chapter 8* of the *IHCP Provider Manual* remain unchanged.

CPT code 59426 with modifier U3 denied in error

Certain high-risk pregnancy claims for Current Procedural Terminology (CPT) code 59426 U3 – *Antepartum care only; 7 or more visits – Third trimester* recently denied in error for explanation of benefits (EOB) code 6044 – *Only three prenatal visits are reimbursable during the second trimester of pregnancy unless a medically high risk diagnosis is indicated*.

The affected claims were submitted November 1, 2014, through November 17, 2014. Corrections have been made to the Indiana*AIM* claims processing system. For reimbursement consideration, providers may resubmit claims for CPT code 59426 U3 originally submitted November 1 through November 17, 2014, that denied for EOB code 6044.

QUESTIONS?

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