IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201504 JANUARY 27, 2015

IHCP changes age restriction for J3262

Effective March 1, 2015, the Indiana Health Coverage Programs (IHCP) will change the age restriction for Healthcare Common Procedure Coding System (HCPCS) code J3262 – *Tocilizumab injection, 1 mg*. The current age restriction of 18 years of age and older will be changed to an age restriction of 2 years of age and older. This change applies retroactively to fee-for-service (FFS) claims with dates of service (DOS) on or after **September 1, 2014**.

Beginning March 1, 2015, providers may bill HCPCS code J3262 for individuals ages 2 years of age and older, as appropriate. Claims with DOS on or after September 1, 2014, that previously denied for explanation of benefits (EOB) 4034 – *Procedure code vs. age restriction* may be resubmitted for processing. Claims 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.

System correction: Providers should continue to bill HCPCS code E0936 with RR modifier

Because of a system error, claims billed for Healthcare Common Procedure Coding System (HCPCS) code E0936 – *Continuous passive motion exercise device for use other than knee (rental)* with an RR modifier were denying for explanation of benefits (EOB) 4209 – *No pricing segment for procedure/modifier combination*. Effective March 1, 2015, the Indiana Health Coverage Programs (IHCP) has corrected the pricing error. This pricing correction applies retroactively to fee-for-service (FFS) claims with dates of service (DOS) on or after **January 1, 2014**.

Beginning March 1, 2015, for reimbursement consideration, providers may bill HCPCS code E0936 RR, as appropriate. Claims with DOS on or after January 1, 2014, that previously denied for EOB 4209 may be resubmitted. Claims 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.

This pricing correction will be reflected in the next monthly update to the *Fee Schedule* at indianamedicaid.com.

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The IHCP to cover HCPCS A9564

Effective March 1, 2015, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code A9564 – *Chromic phosphate P-32 suspension, therapeutic, per millicurie*. Coverage applies to all IHCP programs, subject to limitations established for certain benefit packages. Coverage applies to dates of service (DOS) on or after March 1, 2015.

The following reimbursement information applies:

- **Pricing**: Maximum fee
- **Prior Authorization (PA)**: None
- **Billing Guidance**: See *Chapter 8: Billing Instructions* of the *IHCP Provider Manual*

These changes will be reflected in the next monthly update to the *Fee Schedule* at indianamedicaid.com. Reimbursement, PA, and billing information apply to services delivered under the fee-for-service (FFS) delivery system. Questions about FFS-PA should be directed to ADVANTAGE Health Solutions[SM] at 1-800-269-5720. Individual managed care entities (MCEs) establish and publish reimbursement, PA, and billing criteria within the risk-based managed care (RBMC) delivery system. Questions about RBMC-PA should be directed to the MCE with which the member is enrolled.

The IHCP to cover CPT codes 15850, 93740, 94150, 97010, and 97602

Effective March 1, 2015, the Indiana Health Coverage Programs (IHCP) will cover the Current Procedural Terminology (CPT®[1]) codes in Table 1 for outpatient services. Coverage applies to all IHCP programs, subject to limitations established for certain benefit packages, for dates of service (DOS) on or after March 1, 2015.

Table 1 – CPT codes covered for DOS on or after March 1, 2015

Procedure Code	Code Description
15850	*Removal of sutures under anesthesia (other than local), same surgeon*
93740	*Temperature gradient studies*
94150	*Vital capacity, total (separate procedure)*
97010	*Application of a modality to 1 or more areas; hot or cold packs*
97602	*Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet to moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session.*

The following reimbursement information applies:

- **Pricing**: Maximum fee
- **Prior Authorization**: None
- **Billing Guidance**: Providers are instructed to bill these codes with appropriate revenue codes per the national coding guidelines. These codes remain noncovered for physicians. If billed by a physician, the claim detail line will show paid at zero dollars. For more detailed information, see *Chapter 8: Billing Instructions* of the *IHCP Provider Manual*.

continued

These changes will be reflected in the next monthly updates to the provider *Code Sets* and *Fee Schedule* at indianamedicaid.com. Reimbursement, PA, and billing information apply to services delivered under the fee-for-service (FFS) delivery system. Questions about FFS-PA should be directed to ADVANTAGE Health Solutions at 1-800-269-5720. Individual managed care entities (MCEs) establish and publish reimbursement, PA, and billing criteria within the risk-based managed care (RBMC) delivery system. Questions about RBMC-PA should be directed to the MCE with which the member is enrolled.

CPT codes assigned maximum fee pricing

Effective March 1, 2015, the Indiana Health Coverage Programs (IHCP) has assigned maximum fee pricing to the Current Procedural Terminology (CPT) codes listed in Table 2. For reimbursement consideration, providers may bill these CPT codes as outpatient services for dates of service (DOS) on or after March 1, 2015. The pricing changes will be reflected in the next monthly update to the *Fee Schedule* at indianamedicaid.com.

Table 2 – CPT codes assigned maximum fee pricing for DOS on or after March 1, 2015

Procedure Code	Code Description
15850	*Removal of sutures under anesthesia (other than local), same surgeon*
92921	*Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)*
92925	*Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)*
92929	*Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)*
92934	*Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)*
92938	*Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure)*
92944	*Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)*
93740	*Temperature gradient studies*
94150	*Vital capacity, total (separate procedure)*
97010	*Application of a modality to 1 or more areas; hot or cold packs*
97602	*Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session*

Procedure codes linked to revenue codes and assigned maximum fee pricing

Effective March 1, 2015, the Indiana Health Coverage Programs (IHCP) will link revenue codes and assign maximum fee pricing to the procedure codes indicated in *Table 3* in the attachment. The revenue code linkages and pricing changes apply retroactively to fee-for-service claims with dates of service (DOS) on or after **July 1, 2014**.

Where revenue code linkages have been established, beginning March 1, 2015, providers may bill the procedure codes and the revenue codes together, as appropriate, for reimbursement consideration. Claims with DOS on or after July 1, 2014, that previously denied for explanation of benefits (EOB) 520 – *Invalid revenue codes and procedure code combination* may be resubmitted.

Beginning March 1, 2015, for reimbursement consideration, providers may bill the procedure codes assigned maximum fee pricing as outpatient services. Claims with DOS on or after July 1, 2014, that previously denied for EOB 4014 – *Claim being reviewed for pricing* may be resubmitted. The pricing changes will be reflected in the next monthly update to the *Fee Schedule* at indianamedicaid.com.

All claims 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.

QUESTIONS?

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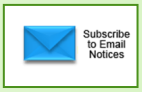

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