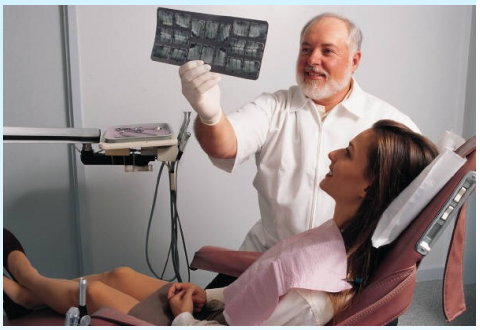
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201542 OCTOBER 20, 2015

Reminder: Claims for D4341 and D4342 require periodontal charts



Providers are reminded that the Indiana Health Coverage Programs (IHCP) requires periodontal charts be submitted with all claims for the following Current Dental Terminology (CDT®[1]) procedure codes:

- D4341 – *Periodontal scaling and root planing, four or more teeth per quadrant*
- D4342 – *Periodontal scaling and root planing, one to three teeth per quadrant*.

As stated in Chapter 8 of the *IHCP Provider Manual*:

> "When IHCP providers submit claims for D4341 – *Periodontal scaling and root planing – Four or more teeth per quadrant* or D4342 – *Periodontal scaling and root planing – One to three teeth per quadrant*, they must submit supporting documentation (periodontal charting) as the medical necessity of providing this service."

Due to an issue with the claims processing system, claims for D4342 may have paid when periodontal charts weren't submitted. The claims processing system has been corrected. Effective December 1, 2015, claims for D4342 submitted without the proper documentation will deny with explanation of benefits (EOB) 4019 – *Procedure code requires attachment*.

IHCP will mass adjust home health claims that denied incorrectly for EOB 4030

The Indiana Health Coverage Programs (IHCP) has identified a claims processing issue that affects certain home health claims that processed with dates of service (DOS) October 1, 2015, through October 16, 2015. Home health claims that denied for explanation of benefits (EOB) 4030 – *The diagnosis given is not compatible with the recipient's age, please verify and resubmit* may have denied inappropriately.

The claims processing system has been corrected. Claims processed with a DOS during the indicated time frame that previously denied for EOB 4030 will be mass adjusted. Providers should begin to see the adjusted claims on Remittance Advices (RAs) beginning November 3, 2015, with internal control numbers (ICNs) that begin with 56 (mass adjusted).

MORE IN THIS ISSUE

IHCP to cover HCPCS code C9250

Effective December 1, 2015, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code C9250 – *Human plasma fibrin sealant, vapor-heated, solvent-detergent (Artiss), 2 ml*. Coverage applies to all IHCP programs, subject to limitations established for certain benefit packages. Coverage applies retroactively to dates of service (DOS) on or after **July 1, 2015**.

Beginning December 1, 2015, providers may submit claims for HCPCS code C9250 with DOS on or after July 1, 2015 for reimbursement consideration. 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. The following reimbursement information applies:

Pricing: Maximum fee of $168.41

Prior authorization (PA): None

Billing Guidance:

- Separate reimbursement is allowed under revenue code 636 – *Drugs requiring detailed coding for separate reimbursement in an outpatient setting*. For reimbursement consideration, providers may bill the procedure code and the revenue code together, as appropriate.
- Must be billed with a National Drug Code (NDC).

These changes will be reflected in the next monthly update to the *Procedure Codes that Require National Drug codes (NDCs)* code table on the Code Sets web page and the Fee Schedule at indianamedicaid.com.

Reimbursement, PA, and billing information applies to services delivered under the fee-for-service (FFS) delivery system. 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.

ICD-10: IHCP reminds HCBS waiver providers about use of ICD-10 diagnosis codes

The Indiana Health Coverage Programs (IHCP) reminds Home and Community Based Services (HCBS) waiver providers that ICD-10 diagnosis codes must be billed on claims for dates of service on or after October 1, 2015.

In general, the IHCP does not provide crosswalks of diagnosis codes from ICD-9 to ICD-10. In instances where the actual diagnosis is known, providers are required to make the necessary crosswalks and bill the proper diagnosis code accordingly, following national coding guidelines. In instances where the actual diagnosis is not known, providers are instructed to bill R69 as the primary diagnosis code.

Providers should utilize their own ICD-10 resources in order to find the proper diagnosis code. Providers may also go to www.roadto10.org/quick-references/ for information on crosswalking codes from ICD-9 to ICD-10. The CMS – 2016 ICD-10-CM and GEMs link on that web page lists codes crosswalked from ICD-9 to ICD-10. Table 1 lists some of the commonly used diagnosis codes for HCBS waivers.

Table 1 – Commonly used HCBS waiver diagnosis codes crosswalked to ICD-10

ICD-9 Codes	ICD-10 Codes
799.9	R69
317	F70
299.xx	F84.0, F84.3, F84.5, F84.8, F84.9
758.0	Q90.9

QUESTIONS?

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