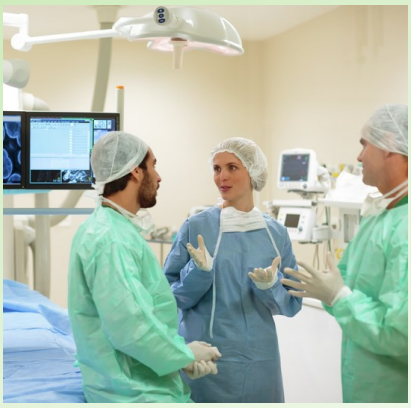
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201610 MARCH 8, 2016

IHCP clarifies hospital inpatient coverage for PE members



The Indiana Health Coverage Programs (IHCP) issued coverage policy and billing guidance regarding benefits for members in the various presumptive eligibility (PE) aid categories in *IHCP Bulletin* BT201528. For PE benefit packages that include inpatient hospital coverage, the bulletin offered guidance about coverage of inpatient services if a member is determined presumptively eligible during their inpatient stay. The following clarifies IHCP policy in this regard and supersedes the language previously issued:

If an individual is admitted to the hospital and a PE determination is made during his or her stay, is that stay covered?

A member's PE coverage period begins on the date that his or her PE application is submitted and the approval determination is made. **Services delivered prior to this date are not covered.** If a hospital admission date is before the PE start date, and the inpatient service is reimbursed using the Diagnosis-Related Grouper (DRG) methodology, no portion of that member's inpatient stay will be considered a PE-covered service. If a hospital admission date is before the PE start date, and the inpatient service is reimbursed on a level-of-care (LOC) *per diem* basis, dates of service (DOS) on or after the member's PE start date will be covered. DOS before the member's PE start date are not covered.

IHCP to cover CPT code 90687

Effective April 8, 2016, the Indiana Health Coverage Programs (IHCP) will cover Current Procedural Terminology (CPT®[1]) code 90687 – *Influenza virus vaccine, quadrivalent (IIV4), split virus, when administered to children 6-35 months of age, for intramuscular use*. 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**.

continued

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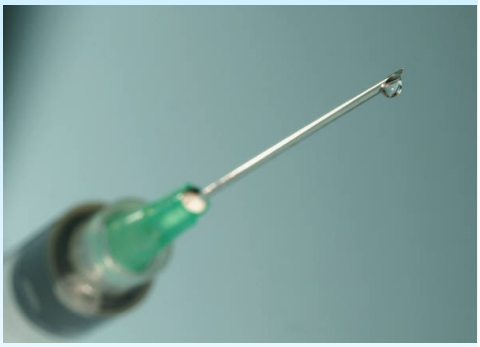
The following reimbursement information applies:



Pricing: Maximum fee of $8.09

Prior authorization (PA): None required

Billing Guidance: See the *Claim Submission and Processing* and the *Injections, Vaccines, and Other Physician-Administered Drugs* modules at indianamedicaid.com for billing guidance.

These changes will be reflected in the next monthly update to the *Fee Schedule* at indianamedicaid.com. Reimbursement and PA 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 managed care delivery system. Questions about managed care billing and PA should be directed to the MCE with which the member is enrolled.

Beginning April 8, 2016, providers may resubmit claims with DOS on or after July 1, 2015, that previously denied for explanation of benefits (EOB) 4021 – *Procedure code vs program indicator,* for reimbursement consideration. Claims resubmitted 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.

IHCP to cover HCPCS code Q9980

Effective April 8, 2016, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code Q9980 – *Hyaluronan or derivative, Genvisc 850, for intra-articular injection, 1 mg*. 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 **January 1, 2016**.

The following reimbursement information applies:

Pricing: Maximum fee of $9.67

Prior authorization (PA): None required

Billing Guidance: See the *Claim Submission and Processing* and the *Injections, Vaccines, and Other Physician-Administered Drugs* modules at indianamedicaid.com for general billing guidance.

These changes will be reflected in the next monthly update to the *Fee Schedule* at indianamedicaid.com. Reimbursement and PA 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 managed care delivery system. Questions about managed care billing and PA should be directed to the MCE with which the member is enrolled.

Beginning April 8, 2016, providers may resubmit claims with DOS on or after January 1, 2016, that previously denied for explanation of benefits (EOB) 4021 – *Procedure code vs program indicator,* for reimbursement consideration. Claims resubmitted 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.

Transportation Provider Code Set updated

The Transportation Provider Code Set has been updated to reflect current IHCP policies and to correct inconsistencies with the claims processing system. The updates are outlined in Tables 1-3.

Table 1 – Procedure code corrections on the Transportation Provider Code Set for Ambulance Providers (Specialty 260)

Procedure Code	Description	Change to Code Set
A0130	Nonemergency transportation: wheelchair van	Added
A0130 U6	Nonemergency transportation: wheelchair van; extra attendant	Added
A0425 U4	Ground mileage, per statute mile; Level 4	Deleted

Table 2 – Procedure code corrections on the Transportation Provider Code Set for Air Ambulance Providers (Specialty 261)

Procedure Code	Description	Change to Code Set
A0431 TN QL	Ambulance service, conventional air services, transport, one way (Rotary Wing) QL-Signify patient death after take off	Deleted

Table 3 – Procedure codes with corrections regarding application of the 20 One-Way Trip Limitation

Procedure Code	Description	20 One-Way Trip Limitation?
A0130	Nonemergency transportation: wheelchair van	No
A0130 U6	Nonemergency transportation: wheelchair van; extra attendant	No
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)	Yes
T2003	Nonemergency transportation; encounter/trip	Yes
T2003 SE	Nonemergency transportation; encounter/trip; State and/or Federally funded programs/service	No
T2004	Nonemergency transport; commercial carrier, multipass	Yes

These changes are reflected in the tables posted under *Transportation Services Codes* on the Code Sets page at indianamedicaid.com.

HCPCS code A0435 linked to provider specialty 261 – Air Ambulance Provider

Effective April 8, 2016, the Indiana Health Coverage Programs (IHCP) will link Healthcare Common Procedural Coding System (HCPCS) code A0435 – *Fixed wing air mileage, per statute mile* to provider specialty 261 – Air Ambulance Provider. This linkage applies retroactively to fee-for-service (FFS) claims with dates of service (DOS) on or after **July 1, 2015**.

This change will be reflected in the next monthly update to the Transportation *Provider Code Set for Air Ambulance Providers (Specialty 261)* under Transportation Services Codes on the *Code Sets* web page at indianamedicaid.com. The standard billing guidelines outlined in the *Claim Submission and Processing* and *Transportation Services* modules at indianamedicaid.com apply.

Beginning April 8, 2016, providers may resubmit claims with DOS on or after July 1, 2015 if you are enrolled as provider specialty 261 and previously billed claims for procedure code A0435 with DOS on or after July 1, 2015, and those claims were denied for explanation of benefits (EOB) 1012 – *Rendering provider specialty not eligible to render procedure code*, you may resubmit those claims for reimbursement consideration. Claims resubmitted 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.

Providers may resubmit claims for ICD-10 procedure codes that may have denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claims processing issue that affects certain fee-for-service claims with dates of service (DOS) on or after **October 1, 2015**. Claims billed with the ICD-10 procedure codes shown in Table 4 may have inappropriately denied.

Table 4 – ICD-10 procedure codes that may have inappropriately denied for DOS on or after October 1, 2015

Procedure Code	Description
0UDB7ZZ	Extraction of endometrium, via natural or artificial opening
0UDB8ZZ	Extraction of endometrium, endo
10D00Z0	Extraction of POC, classical, open approach
10D00Z1	Extraction of POC, low cervical, open approach
10D00Z2	Extraction of POC, extraperitoneal, open approach
10D17ZZ	Extraction of products of conception, retained, via opening
10D18ZZ	Extraction of products of conception, retained, endo

continued

The claims processing system is being corrected. Beginning April 8, 2016, providers may resubmit affected claims for reimbursement consideration. Claims resubmitted 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.

IHCP revises instructions for billing phrenic nerve stimulator implantation in an outpatient setting

Current Indiana Health Coverage Program (IHCP) guidance instructs providers to bill revenue code 360 with Current Procedural Terminology (CPT ®[1]) code 33282 – *Implantation of patient-activated cardiac event recorder* on the *UB-04* claim form when implanting a phrenic nerve stimulator as an outpatient procedure. Effective April 8, 2016, IHCP billing guidance is revised. Providers are instructed to bill revenue code 360 with one of the CPT codes in Table 5, as appropriate, rather than with CPT code 33282. This change applies to fee-for-service claims with dates of service (DOS) on or after April 8, 2016.

Table 5 - Procedure codes for billing phrenic nerve stimulator implantation as an outpatient procedure for DOS on or after April 8, 2016

Procedure Code	Description
64575	Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64580	Incision for implantation of neurostimulator electrode array; neuromuscular

Billing instructions for inpatient procedures and for the device itself remain unchanged. When the phrenic nerve stimulator is implanted as an inpatient procedure, reimbursement for the implantation is included in the inpatient Diagnosis-Related Grouper (DRG) payment. For both outpatient and inpatient procedures, the device itself should be billed as a durable medical equipment (DME) item on a *CMS-1500* claim form. All existing coverage criteria for phrenic nerve stimulators continue to apply.

IHCP will mass reprocess MRT and PASRR claims that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claims processing issue that affects certain Medical Review Team (MRT) and Pre-Admission Screening and Resident Review (PASRR) claims with dates of service on or after February 1, 2015. These claims may have inappropriately denied with the following explanations of benefits (EOBs):

- EOB 2042 (Header) – *The member is enrolled in the Healthy Indiana Plan or Hoosier Care Connect risk based managed care program. The recipient must seek care from the appropriate managed care entity.*
- EOB 2043 (Detail) – *The member is enrolled in the Healthy Indiana Plan or Hoosier Care Connect risk based managed care program. The recipient must seek care from the appropriate managed care entity.*

continued

The claims processing system will be corrected effective April 8, 2016. Claims processed during the indicated time frame that previously denied for EOB 2042 or 2043 will be mass-reprocessed. Providers should begin to see the mass-reprocessed claims, with internal control numbers (ICNs) that begin with 80, on Remittance Advices (RAs) beginning April 12, 2016.

Additional first-quarter workshop scheduled in Indianapolis

The Indiana Health Coverage Programs (IHCP) has scheduled an additional first-quarter workshop in the Indianapolis area to accommodate provider demand. The new workshop will be on May 4, 2016, from 9:00 a.m. to 3:00 p.m. at the following location:

St. Vincent Hospital
Cooling Auditorium
2001 W. 86th Street
Indianapolis, Indiana

The session will follow the same format as the other first-quarter workshops. The schedule and details about the information to be covered are available on the First-Quarter IHCP Workshops page at indianamedicaid.com.

Workshop registration

Registration for this workshop is now open. To register, visit the Workshop Registration page at indianamedicaid.com. The registration page provides instructions, including the Workshop Registration Tool Quick Reference. If you register online, you will receive immediate confirmation. **Be sure to register early before spaces fill up.**

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