IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201611 MARCH 15, 2016

IHCP will mass-adjust inpatient hospital claims

As announced in Indiana Health Coverage Programs (IHCP) *Bulletin* BT201559, Myers and Stauffer LC, the IHCP's hospital rate-setting contractor, notified hospitals individually of their new global cost-to-charge ratio and new medical education *per diem* rates. These cost-to-charge ratios and medical education *per diem* rates will be applied retroactively to inpatient claims with dates of service (DOS) on or after **October 1, 2015**. Affected inpatient claims will be mass-adjusted. Adjustments should begin appearing on the provider Remittance Advice (RA) April 19, 2016, 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.

Modifier 62 (co-surgeon) linked to CPT code 62120

Effective April 15, 2016, the Indiana Health Coverage Programs (IHCP) will link modifier 62 – *Co-surgeon* to Current Procedural Terminology (CPT®[1]) code 62120 – *Repair of encephalocele, skull vault, including cranioplasty*. This linkage will apply retroactively to fee-for-service (FFS) claims with dates of service (DOS) on or after **July 1, 2015**.

Modifier 62 is defined as follows:

> "*When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his or her distinct operative work by adding modifier 62 and any associated add-on code(s) for that procedure.*"

When modifier 62 is used, the payment methodology processes the allowed amount for the procedure at 62.5%.

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Beginning April 15, 2016, providers may bill CPT code 62120 for DOS on or after July 1, 2015, with modifier 62 to receive payment consideration based on modifier 62 payment logic. Claims with DOS on or after July 1, 2015, that previously denied for explanation of benefits (EOB) 4033 – *Invalid procedure code modifier combination* may be resubmitted. Claims submitted or 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 defines age ranges for policies or code descriptions that do not specify an age

When a policy or a procedure or diagnosis code description does not designate a specific age range, the IHCP will apply the age range definitions noted in Table 1. These definitions are consistent with those adopted by the World Health Organization.

Table 1 – Age range definitions applied to procedure and diagnosis code descriptions when age is not specifically designated

ICD-10 Description	Age Range Definition
Infant	Younger than 1 year of age
Child/Children	19 years of age or younger
Adolescent	10 through 19 years of age
Adult	20 years of age or older

IHCP adds age restrictions for certain ICD-10 diagnosis codes

Effective April 15, 2016, the Indiana Health Coverage Programs (IHCP) will update age restrictions for certain ICD-10 diagnosis codes.

- Currently, the IHCP restricts diagnosis codes P00 through P96 – *Certain conditions originating in the perinatal period* to newborns only. For dates of service (DOS) on or after April 15, 2016, the IHCP will remove the age restrictions for these diagnosis codes and allow providers to bill these diagnoses for members of all ages.
- Currently, the IHCP has no age restrictions on body mass index (BMI) diagnosis codes Z681 through Z6845 or for BMI diagnosis codes Z6851 through Z6854.
  - For DOS on or after April 15, 2016, the IHCP will restrict diagnosis codes Z681-Z6845 to members 21 years of age and older.
  - For DOS on or after April 15, 2016, the IHCP will restrict diagnosis codes Z6851 through Z6854 to members 2 through 20 years of age.

These age restrictions are consistent with the Centers for Disease Control and Prevention published clinical growth charts and ICD-10 coding guidelines.

IHCP adds gender restrictions for certain ICD-10 diagnosis codes

Effective April 15, 2016, the Indiana Health Coverage Programs (IHCP) will add a gender restriction of *female only* to the ICD-10 diagnosis codes in Table 2. This change will apply retroactively to dates of service (DOS) on or after **October 1, 2015**. This change will not impact any previously adjudicated claims.

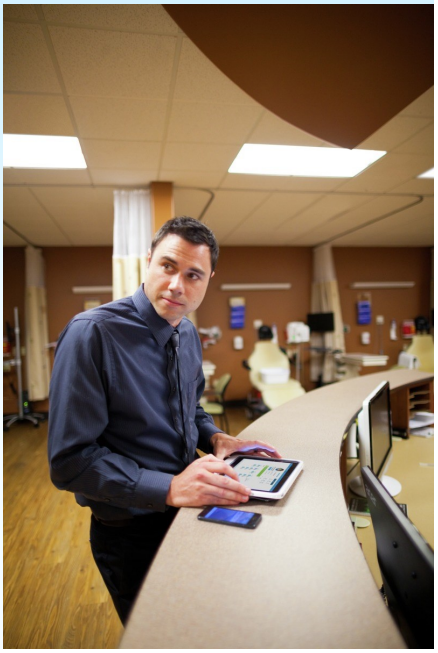
Table 2 – ICD-10 diagnosis codes restricted to females only for DOS on or after October 1, 2015

Diagnosis Code	Description
A514.2	Secondary syphilitic female pelvic disease
Z640	Problems related to unwanted pregnancy
Z641	Problems related to multiparity
Z780	Asymptomatic menopausal state
Z79.890	Hormone replacement therapy (postmenopausal)
Z97.5	Presence of (intrauterine) contraceptive device
Z98.51	Tubal ligation status
Z98.870	Personal history of in utero procedure during pregnancy

IHCP identifies a claims processing issue related to gender restrictions on ICD-10 diagnosis code B37.42

The Indiana Health Coverage Programs (IHCP) has identified a claims processing issue that affects claims billed with ICD-10 diagnosis code B37.42 – *Candidal balanitis* for dates of service (DOS) on or after **October 1, 2015**. Claims billed with B37.42 may have inappropriately denied for explanation of benefits (EOB) 4028 – *Diagnosis code not compatible with recipient's sex. Please verify and resubmit.* In error, this code was restricted in the claims processing system to *females only* rather than *males only*.

The claims processing system will be corrected to change the gender restriction for B37.42 to *males only*. Beginning April 15, 2016, affected claims with diagnosis code B37.42 that previously denied for EOB 4028 may be resubmitted 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.



CPT code 51703 linked to revenue code 360

Effective April 15, 2016, the Indiana Health Coverage Programs (IHCP) will link Current Procedural Terminology (CPT®[1]) code 51703 – *Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)* to revenue code 360 – *Operating room services-general.* This linkage applies retroactively to fee-for-service claims with dates of service (DOS) on or after **July 1, 2015**.

Beginning April 15, 2016, providers may bill CPT code 51703 and revenue code 360 together, as appropriate, for reimbursement consideration. 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 or 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 botulinum toxin injections that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claims processing issue that affects claims for botulinum toxin (Botox) injections with dates of service (DOS) on or after October 1, 2015. The ICD-10 diagnosis codes in Table 3 were erroneously excluded from the list of identified diagnoses for botulinum toxin injections. This error caused claims with these diagnoses to deny inappropriately for explanation of benefits (EOB) 6612 – *Limit botulinum injections to identified diagnosis codes*.

Table 3 – ICD-10 diagnosis codes erroneously excluded from the identified diagnoses for botulinum toxin injections for DOS on or after October 1, 2015

Diagnosis Code	Description
G81.10	Spastic hemiplegia and hemiparesis affecting unspecified side
G81.11	Spastic hemiplegia and hemiparesis affecting right dominant side
G81.12	Spastic hemiplegia and hemiparesis affecting left dominant side
G81.13	Spastic hemiplegia and hemiparesis affecting right nondominant side
G81.14	Spastic hemiplegia and hemiparesis affecting left nondominant side

The claims processing system has been corrected. Beginning immediately, providers may resubmit affected claims that previously denied for EOB 6612 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.

The diagnosis codes in Table 3 have been published in the *Medical Policy Manual* and are included on the *Injections, Vaccines, and Other Physician-Administered Drugs Codes* code table posted on the *Code Sets* page at indianamedicaid.com.

IHCP has updated Place of Service Code Set

The Indiana Health Coverage Programs (IHCP) adheres to the Centers for Medicare & Medicaid Services (CMS) Place of Service (POS) code set. CMS made the following changes to the POS code set effective January 1, 2016:

- POS code 19 – *Off Campus-Outpatient Hospital (new)*
- POS code 22 – *On Campus-Outpatient Hospital (revised description)*

The fee-for-service (FFS) claims processing system was updated to reflect these changes as of February 26, 2016. Claims with dates of service (DOS) on or after January 1, 2016, that were billed using POS 19 and processed before the system update, which denied at the detail level for explanation of benefits (EOB) 0249 – *Place of Service Invalid* will be mass-reprocessed or mass-adjusted. Providers should begin seeing reprocessed or adjusted claims on the provider Remittance Advice (RA) dated April 19, 2016, with internal control numbers that begin with 56 (mass-adjusted) or 80 (mass-reprocessed).

These updates will be reflected in the *Place of Service Codes* table on the *Code Sets* page at indianamedicaid.com. Providers should follow national billing guidelines regarding the use of the appropriate POS code.

Corrections made to new Audiologist Code Set

The new *Audiologist Code Set* effective April 1, 2016, published in Indiana Health Coverage Programs (IHCP) *Banner Page BR201609*, included errors. The IHCP has corrected the Code Set as outlined in Table 4.

Table 4 – Corrections to the Audiologist Code Set for provider specialty 200, effective for dates of service (DOS) on or after April 1, 2016

Procedure Code	Description	Change to Code Set
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording	Deleted (December 31, 2015)
92537	Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)	Added
92538	Caloric vestibular test with recording, bilateral; monothermal (ie, one irrigation in each ear for a total of two irrigations)	Added

These corrections will be reflected in the *Audiologist Code Set* posted to the *Code Sets* page at indianamedicaid.com.

Prior authorization is no longer required for HCPCS code D9243

Effective immediately, the Indiana Health Coverage Programs (IHCP) will no longer require prior authorization (PA) when providers bill D9243 – *Deep sedation/general anesthesia, each 15 minute increment*. This change applies retroactively to dates of service (DOS) on or after **January 1, 2016**.

Beginning immediately, claims for D9243 with DOS on or after January 1, 2016, that denied for explanation of benefits (EOB) 3001 – *Dates of service not on the P.A. master file* may be resubmitted 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.

This PA requirement change applies to services delivered under the fee-for-service (FFS) delivery system. Individual managed care entities (MCEs) establish and publish PA criteria within the managed care delivery system. Questions regarding managed care PA should be directed to the MCE with which the member is enrolled.

This change will be updated in the next monthly update to the provider *Fee Schedule* at indianamedicaid.com.

QUESTIONS?

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