IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201710 MARCH 7, 2017

IHCP to cover HCPCS code Q0144 - Azithromycin Dehydrate

Effective April 7, 2017, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) Q0144 - *Azithromycin, dehydrate, oral, capsules/powder, 1 gm.* Coverage applies to all IHCP programs, subject to limitations established for certain benefit packages. Coverage applies to dates of service on or after April 7, 2017.

The following reimbursement information applies:

Pricing: $5.90

Prior authorization: None required

Billing guidance: National Drug Code (NDC) required

These changes will be reflected in the next update to the *Procedure Codes That Require National Drug Codes* code table on the *Code Sets* web page and the *Fee Schedule* at indianamedicaid.com. Reimbursement, PA, and billing information apply 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 PA should be directed to the MCE with which the member is enrolled.

IHCP to cover CPT code 61635 – Transcatheter placement of intravascular stents

Effective April 7, 2017, the Indiana Health Coverage Programs (IHCP) will cover Current Procedural Terminology (CPT®[1]) 61635 – *Transcatheter placement of intravascular stent(s), intracranial (eg, artherosclerotic stenosis), including balloon angioplasty, if performed.* Coverage of CPT 61635 is limited to members with stenosis at or above 70% for whom all additional medical treatments have failed. Coverage applies to all IHCP programs, subject to limitations established for certain benefit packages. Coverage applies to dates of service on or after April 7, 2017.

The following reimbursement information applies:

Pricing: Resource-based relative value scale (RBRVS)

Prior authorization: Required

Billing guidance: Standard billing guidelines apply.

continued

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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 Cooperative Managed Care Solutions at 1-800-269-5720. Individual managed care entities (MCEs) establish and publish reimbursement, PA, and billing information 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.

[1] *CPT copyright 2016 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

IHCP to cover HCPCS code C1780 – Lens, intraocular (new technology)

Effective April 7, 2017, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code C1780 – *Lens, intraocular (new technology).* Coverage applies to all IHCP programs, subject to limitations established for certain benefit packages. Coverage applies to dates of service on or after April 7, 2017.

The following reimbursement information applies:

Pricing: Manually priced, 75% of manufacturer's suggested retail price (MSRP) or 120% of cost invoice

Prior authorization: Not required

Billing guidance: A cost invoice or MSRP is required.

These changes will be reflected in the next update to the *Procedure Codes That Require Attachments* code table on the *Code Sets* web page and the Fee Schedule at indianamedicaid.com. Reimbursement, PA, and billing information apply to services delivered under the fee-for-service (FFS) delivery system. Individual managed care entities (MCEs) establish and publish reimbursement, PA, and billing information 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.

Certain Long-Term Care crossover claims denying due to LOC information

The Indiana Health Coverage Programs (IHCP) has identified an issue affecting Long-Term Care (LTC) crossover claims. LTC crossover claims for members with a Level of Care (LOC) on file in *Core*MMIS that does not match with billing provider information are denying for explanation of benefits (EOB) 2008 - *Member not eligible for this level of care for dates of service*. Per IHCP billing guidelines**,** LOC is required on LTC crossover claims. However, to allow crossover claims for nursing home members to pay on an interim basis, the IHCP is making a temporary modification to the system to disregard the member's LOC when it does not align with the billing provider on the claim. Please note that this system modification applies only to LTC crossover (Medicare/Medicaid) claims; regular LTC claims will process per existing IHCP billing guidelines. This modification is effective March 2, 2017, until further notice. Providers who have received denials with EOB 2008 can resubmit these claims for reprocessing. Watch upcoming IHCP publications for further information.

Home health claims for 99600 denying due to issue on PAs

The Indiana Health Coverage Programs (IHCP) has identified an issue with home health prior authorization (PA) requests that has caused some claims to deny in *CoreMMIS*. Home health claims for Current Procedure Terminology (CPT®[1]) 99600 are denying with explanation of benefits (EOB) 3001 – *Dates of service not on the PA master file* when the claim includes the TE modifier (service was provided by a licensed practical nurse) or the TD modifier (service was provided by a registered nurse) but the PA was requested and issued by Cooperative Managed Care Services (CMCS) for procedure code 99600 with **both** the TD and TE modifiers. Although Indiana*AIM* allowed payment of claims in those instances, *CoreMMIS* does not.

Home health providers are reminded to follow the guidance provided in the *Home Health Services* module when submitting PA requests to CMCS. **All PA requests should include the procedure code 99600 with only the TD modifier, if skilled nursing care will be provided.** PA requests do not need to indicate whether an RN or an LPN will perform the service. That detail is reported on the *UB-04* paper claim or electronic equivalent. Providers must follow this guidance effective immediately. Moving forward, if CMCS receives a PA request with the TE modifier or with both the TE and TD modifiers, it will automatically enter the PA using only a TD modifier.

Home health providers should continue to bill *99600 TE – Unlisted home visit or service – LPN/LVN* or *9600 TD-Unlisted home visit, service or procedure-registered nurse,* as appropriate for the level of skilled nursing care provided. Both will pay based on PA for 99600 TD.

To allow claims associated with existing PAs to adjudicate properly, IHCP has modified the PAs to remove the TE modifier. Effective March 7, 2017, home health providers can resubmitted affected claims that denied for EOB 3001 for reprocessing.

IHCP will mass reprocess dialysis claims for laboratory services that denied inappropriately

The Indiana Health Coverage Programs (IHCP) has identified a claim processing issue that affects certain claims for laboratory services provided to dialysis patients with dates of service (DOS) on or after **January 1, 2013**. Fee-for-service (FFS) claims properly billed by freestanding renal dialysis clinics for laboratory services provided to dialysis patients may have inappropriately denied for explanation of benefits (EOB) 4207 – *CLIA number not on file for dates of service billed.*

The claims processing system has been corrected. Claims for the DOS indicated that previously denied for EOB 4207 will be mass reprocessed. Providers should begin to see the reprocessed claims on Remittance Advices (RAs) beginning April 11, 2017, with internal control numbers (ICN) that begin with 80 (mass reprocessed). For claims that were underpaid, the net difference will be paid and reflected on the RA.

Claims billed by small ICF/IID with type of bill codes in the 67X series are denying

The Indiana Health Coverage Programs (IHCP) has identified an issue impacting small Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) claims. Claims billed by small ICF/IID with a type of bill code in the 67X series are denying for explanation of benefits (EOB) 274 - *The type of bill is invalid*. Type of bill range 67X is not a HIPAA-compliant code and is not accepted in the new *Core*MMIS claim-processing system. These denials are affecting claims with dates of service on and after February 13, 2017.

This system change this was not communicated prior to the implementation of *Core*MMIS. Consequently, the system has been modified to temporarily allow use of the type of bill codes in the 67X series until replacements are identified and published. Providers should resubmit affected claims immediately for reprocessing. Future changes to billing guidelines will be communicated in upcoming IHCP publications.

IHCP ending extended Customer Service call center hours

With the implementation of *Core*MMIS, the Indiana Health Coverage Programs (IHCP) added temporary evening hours as well as Saturday Customer Service call center hours. There have been low call volumes during these times. Effective March 6, 2017, the extended evening and Saturday call center hours were eliminated. The call center will resume regular hours from 8 a.m. to 6 p.m., Monday through Friday. Resources currently allocated to extended hours will be reallocated to better address member and provider inquires during regular business hours.

IHCP announces temporary workaround to address slow Portal response times

The Indiana Health Coverage Programs (IHCP) has received reports of slow response times and timing out on the Portal for a number of transactions. To help speed response times until a permanent solution to the problem can be implemented, temporary changes have been made to several pages in the Portal. Providers will find that pages now respond faster but that a few functions have been somewhat limited.

- Search Claims pages: Providers will temporarily be unable to see the Remittance Advice (RA) icon or view RAs from the Search Claims pages. Providers can continue to access RAs through the Search Payment History page and are encouraged to use the **RA Copy** icon to see detailed payment information.
- View Authorization Response page - Providers will temporarily be unable to see attachment information associated with a specific prior authorization (PA).
- Right Choices Program Search page - Providers will temporarily be unable to see or retrieve Right Choices Program (RCP) attachments.

Note: Providers can continue to upload attachments to PA and RCP transactions. IHCP continues to work on a permanent solution to improve Portal response times. Watch upcoming publications for more information.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-457-4584.

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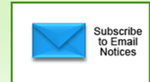

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