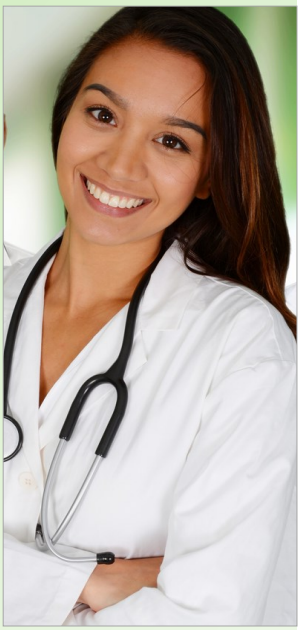
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201715 APRIL 11, 2017

IHCP to cover skin substitutes at a flat, statewide per-unit rate



Effective May 11, 2017, the Indiana Health Coverage Programs (IHCP) will make changes in coverage and reimbursement methodology for skin substitutes. Per a recently approved Indiana State Plan amendment, the skin substitutes in Table 1 on the following page will be covered and reimbursed at a flat, statewide per-unit rate.

- Coverage applies to dates of service (DOS) on or after May 11, 2017, for the newly covered codes identified in Table 1. Coverage applies to all IHCP programs, subject to limitations established for certain benefit plans.
- The flat, statewide, per-unit rate applies to DOS on or after May 11, 2017, for all codes in Table 1.

The following reimbursement information applies to all codes in Table 1.

- **Pricing:** Flat rate $37.56 per unit applies to both *professional (CMS-1500)* and *institutional (UB-04)* claim types.
- **Prior Authorization (PA):** None required
- **Billing Guidance:** The Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 1 will be linked to revenue code 636 – *Pharmacy-Extension of 025X-Drugs Requiring Detailed Coding* for billing in the outpatient setting. For reimbursement consideration, providers may bill the procedure code and the revenue code together, as appropriate.

Coverage and pricing changes will be reflected in updates to the *Fee Schedule* at indianamedicaid.com.

This reimbursement information applies to services delivered under the fee-for-service (FFS) delivery system, as well as to certain services delivered under the managed care delivery system. For some services, managed care entities (MCEs) may establish and publish different reimbursement, PA, and billing criteria. Questions should be directed to the MCE with which the member is enrolled.

continued

MORE IN THIS ISSUE

Table 1 – Skin substitute HCPCS codes covered and reimbursed at a flat, statewide per-unit rate effective for DOS on or after May 11, 2017

HCPCS code	Description
Q4100	Skin substitute, not otherwise specified
Q4101	Apligraf, per sq cm
Q4102	Oasis wound matrix, per sq cm
Q4103	Oasis burn matrix, per sq cm
Q4104	Integra bilayer matrix wound dressing (BMWD), per sq cm
Q4105	Integra dermal regeneration template (DRT) or Integra Omnigraft dermal regeneration matrix, per sq cm
Q4106	Dermagraft, per sq cm
Q4107	GRAFTJACKET, per sq cm
Q4108	Integra matrix, per sq cm
Q4110	PriMatrix, per sq cm
Q4111	GammaGraft, per sq cm
Q4112*	Cymetra, injectable, 1 cc
Q4113*	GRAFTJACKET XPRESS, injectable, 1cc
Q4114*	Integra flowable wound matrix, injectable, 1 cc
Q4115	AlloSkin, per sq cm
Q4116	AlloDerm, per sq cm
Q4117*	HYALOMATRIX, per sq cm
Q4118	MatriStem micromatrix, 1 mg
Q4121	TheraSkin, per sq cm
Q4122*	DermACELL, per sq cm
Q4123*	AlloSkin RT, per sq cm
Q4124*	OASIS ultra tri-layer wound matrix, per sq cm
Q4125*	ArthroFlex, per sq cm
Q4126*	MemoDerm, DermaSpan, TranZgraft or IntéguPly, per sq cm
Q4127*	Talymed, per sq cm
Q4128*	FlexHD, AllopatchHD, or Matrix HD, per sq cm
Q4130*	Strattice TM, per sq cm
Q4131*	EpiFix or Epicord, per sq cm
Q4132*	Grafix Core, per sq cm
Q4133*	Grafix Prime, per sq cm

continued

Table 1 – Skin substitute HCPCS codes covered and reimbursed at a flat, statewide per-unit rate effective for DOS on or after May 11, 2017 (continued)

HCPCS code	Description
Q4134*	HMatrix, per sq cm
Q4135*	Mediskin, per sq cm
Q4136*	E-Z Derm, per sq cm
Q4137	AmnioExcel or BioDExCel, per sq cm
Q4138	BioDFence DryFlex, per sq cm
Q4139	AmnioMatrix or BioDMatrix, injectable, 1 cc
Q4140	BioDFence, per sq cm
Q4141	AlloSkin AC, per sq cm
Q4142	XCM biologic tissue matrix, per sq cm
Q4143	Repriza, per sq cm
Q4145*	EpiFix, injectable, 1 mg
Q4146	Tensix, per sq cm
Q4147	Architect, Architect PX, or Architect FX, extracellular matrix, per sq cm
Q4148	Neox 1k, per sq cm
Q4149	Excellagen, 0.1 cc
Q4150*	AlloWrap DS or dry, per sq cm
Q4151*	AmnioBand or Guardian, per sq cm
Q4152	DermaPure, per sq cm
Q4153*	Dermavest and Plurivest, per sq cm
Q4154*	Biovance, per sq cm
Q4155*	Neox Flo or Clarix Flo 1 mg
Q4156*	Neox 100, per sq cm
Q4157*	Revitalon, per sq cm
Q4158*	Marigen, per sq cm
Q4159*	Affinity, per sq cm
Q4160*	Nushield, per sq cm
Q4161*	Bio-ConneKt wound matrix, per sq cm
Q4162*	AmnioPro Flow, BioSkin Flow, BioRenew Flow, WoundEx Flow, Amniogen-A, Amniogen-C, 0.5 cc
Q4163*	AmnioPro, BioSkin, BioRenew, WoundEx, Amniogen-45, Amniogen-200, per sq cm
Q4164*	Helicoll, per sq cm

Table 1 – Skin substitute HCPCS codes covered and reimbursed at a flat, statewide per-unit rate effective for DOS on or after May 11, 2017 (continued)

HCPCS code	Description
Q4165*	Keramatrix, per sq cm
Q4166*	Cytal, per sq cm
Q4167*	Truskin, per sq cm
Q4168*	AmnioBand, 1 mg
Q4169*	Artacent wound, per sq cm
Q4170*	Cygnus, per sq cm
Q4171*	Interfyl, 1 mg
Q4172*	PuraPly or PuraPly AM, per sq cm
Q4173*	PalinGen or PalinGen XPlus, per sq cm
Q4174*	PalinGen or ProMatrX, 0.36 mg per 0.25 cc
Q4175*	Miroderm, per sq cm

** Newly covered HCPCS codes effective for DOS on or after May 11, 2017.*

IHCP to cover J8565

Effective May 11, 2017, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code J8565 – *Gefitinib, oral, 250 mg*. Coverage applies to all IHCP programs, subject to limitations established for certain benefit plans. Coverage applies to dates of service (DOS) on or after May 11, 2017.

The following reimbursement information applies:

- **Pricing**: Maximum fee of $265.92
- **Prior Authorization (PA):** None required.

Billing Guidance:

- HCPCS code J8565 will be linked with revenue code 636 – *Pharmacy-Extension of 025X-Drugs Requiring Detailed Coding* for billing in the outpatient setting. For reimbursement consideration, providers may bill the procedure code and the revenue code together, as appropriate.
- Must be billed with the National Drug Code (NDC) of the product administered.

continued

This code will be reflected in the *Procedure Codes That Require National Drug Codes (NDCs)* code table on the *Code Sets* web page. Coverage information will also be reflected in updates to the *Fee Schedule* at indianamedicaid.com.

This reimbursement information applies to services delivered under the fee-for-service (FFS) delivery system, as well as to certain services delivered under the managed care delivery system. For some services, managed care entities (MCEs) may establish and publish different reimbursement, PA, and billing criteria. Questions should be directed to the MCE with which the member is enrolled.

Various procedure codes linked to appropriate revenue codes

Effective May 11, 2017, the Indiana Health Coverage Programs (IHCP) will link the procedure codes to the revenue codes as shown in Table 2. These linkages apply retroactively to dates of service (DOS) on or after **July 1, 2016**.

Table 2 – Procedure codes linked to revenue codes effective for dates of service (DOS) on or after July 1, 2016

Procedure code and description	Revenue code and description
80165 – Valproic acid (dipropylacetic acid); free	301 – Laboratory-Chemistry
83951 – Oncoprotein; des-gamma-carboxy-prothrombin (DCP)	301 – Laboratory-Chemistry
87498 – Infectious agent detection by nucleic acid (DNA or RNA); enterovirus, amplified probe technique, includes reverse transcription when performed	306 – Laboratory-Bacteriology and Microbiology
87806 – Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies	300 – Laboratory-General
J9225 – Histrelin implant (Vantas), 50 mg	636 – Pharmacy-Extension of 025X-Drugs Requiring Detailed Coding
J9226 – Histrelin implant (Supprelin LA), 50 mg	636 – Pharmacy-Extension of 025X-Drugs Requiring Detailed Coding

Beginning May 11, 2017, providers may submit claims for DOS on or after **July 1, 2016**, with the procedure code and the revenue code together, as appropriate. 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.

Claims with DOS on or after **July 1, 2016**, that paid incorrectly with detail lines that denied for explanation of benefits (EOB) 520 – *Invalid revenue code and procedure code combination* will be mass adjusted. Providers should see the adjusted claims on Remittance Advices (RAs) beginning May 16, 2017, with Claim IDs/ICNs that begin with 52 (mass replacement non-check related). For claims that underpaid, the net difference will be paid and reflected on the RA.

IHCP reminds providers of the PA status codes that display in the Portal

Providers should use the Provider Healthcare Portal (Portal) to inquire on the status of prior authorization (PA) requests submitted to Cooperative Managed Care Services (CMCS). PA status codes displayed on the Portal now comply with the *Health Insurance Portability and Accountability Act* (HIPAA) 278 transaction standards and provide only a high-level, standardized description of the actual working status of the PA request. PA notification letters mailed to the provider and member will continue to provide the more detailed administrative working status that providers are accustomed to, to more clearly explain the current status of the PA request.

Table 3 provides a crosswalk between the HIPAA-compliant 278 transaction standard response terminology that displays on the Portal and the administrative working statuses associated with each standard response category. Providers should reference this table to help them understand the standardized HIPAA-compliant status responses displayed when conducting a Portal PA inquiry. **Providers should refer to their PA notification letters for additional information regarding the more detailed working status of a PA request.**

Table 3 – HIPAA-compliant PA status responses crosswalked with associated administrative working statuses

HIPAA-compliant PA responses (in Portal)	Administrative Working Statuses (in letters)
CERTITIFED IN TOTAL	APPR/CONTIN OF SERV DEC OVERTURN BY ALJ AUTO APPR AFTER 10 APPROVED NON-COV CODE APPROVE APPR THRU ADMIN REV DIS NO HEARING APPR
MODIFIED	DIS NO HEARING MOD MOD THRU ADMIN REV MODIFIED MOD THRU COURT MOD/CONTIN OF SERV
NO ACTION REQUIRED	NO PA REQUIRED NO PA REQ FOR PMP
NOT CERTIFIED	DIS NO HEARING DEN REJECTED INCORRECT PMP DEN/CONTIN OF SERV DENIED NON-COV CODE DENIED DEC UPHELD BY ALJ
PENDED	SUSPENDED PENDING

IHCP to mass adjust or mass reprocess claims for waiver code T2022 U7 that denied or paid incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claims processing issue that affects certain waiver claims processed from February 13, 2017, through March 31, 2017. Claims billed for waiver code T2022 U7 – *Case management* may have denied inappropriately or paid incorrectly due to denied claim detail with an explanation of benefits (EOB) 6353 – W*aiver code T2022 U7 is limited to one unit per provider, per member, per month.* The system incorrectly applied the monthly limitation on a rolling 30-day time span, rather than on a per **calendar** month time frame, causing inappropriate denials.

The claims processing system has been corrected. Claims processed during the indicated time frame that previously denied or paid incorrectly due to denied claim detail for EOB 6353 will be mass reprocessed or mass adjusted. Providers should begin to see the reprocessed/adjusted claims on Remittance Advices (RAs) beginning April 19, 2017, with Claim IDs/ICNs that begin with 80 (reprocessed denied claim) or 52 (mass replacement non-check related). For claims that underpaid, the net difference will be paid and reflected on the RA.

HPE merges with CSC to form DXC Technology

Effective April 3, 2017, the Enterprise Services Division of Hewlett Packard Enterprise (HPE) merged with information-technology corporation CSC to form a new company, DXC Technology. DXC serves nearly 6,000 private and public sector clients across 70 countries. Moving forward, providers will see communications referring to DXC rather than HPE.

DXC.technology

QUESTIONS?

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