IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201718 MAY 2, 2017

IHCP to update MRT procedure codes

Effective June 2, 2017, the Indiana Health Coverage Programs (IHCP) will update the procedure codes covered under the Medical Review Team (MRT) program to reflect current IHCP policies. Table 1 contains the list of procedure codes that will be added to MRT coverage. Table 2 contains the list of procedure codes that will be removed from MRT coverage. These coverage changes apply to dates of service (DOS) on or after June 2, 2017. These changes will be reflected in updates to the Medical Review Team Codes code table on the Code Sets web page at indianamedicaid.com.

As announced in IHCP bulletin *BT201671*, with the implementation of *Core*MMIS, MRT procedure codes must be billed with the modifier SE – *State and/or federally funded programs/services* on the claim detail to be eligible for reimbursement. Additionally, providers are reminded that members approved for MRT services are no longer issued a member identification (RID) that begins with the 850 prefix. In *Core*MMIS, identification numbers for MRT members begin with the prefix "4XX." Providers must use the member's 12-digit IHCP Member ID, as indicated via the IHCP Eligibility Verification System (EVS).

Table 1 – Procedure codes added to the MRT program effective for DOS on or after June 2, 2017

Procedure code	Modifier	Description
72081	SE	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g., scoliosis evaluation); one view
73501	SE	Radiologic examination, hip unilateral, with pelvis when performed; 1 view
73502	SE	Radiologic examination, hip unilateral, with pelvis when performed; 2-3 views
73503	SE	Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views
73521	SE	Radiologic examination, hips, bilateral, with pelvis when performed; 2 views

continued

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Table 1 – Procedure codes added to the MRT program effective for DOS on or after June 2, 2017 (continued)

Procedure code	Modifier	Description
73522	SE	Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views
73552	SE	Radiologic examination, femur; minimum 2 views
73560	SE	Radiologic examination, knee; 1 or 2 views
76700	SE	Ultrasound, abdominal, real time with image documentation; complete
82803	SE	Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation)
85027	SE	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
99203	SE	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 components: a detailed history; a detailed examination; medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family needs. Usually, the presenting problem(s) are moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family
99204	SE	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity; counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family needs. Usually the presenting problem(s) are moderate to high severity. Typically, 45 minutes are spent face to face with the patient and/or family
99205	SE	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patients and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family
99213	SE	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity; counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face to face with the patient and/or family.

continued

Table 1 – Procedure codes added to the MRT program effective for DOS on or after June 2, 2017 (continued)

Procedure code	Modifier	Description
99214	SE	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians. Other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face o-face with the patient and/or family
99215	SE	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

Table 2 – Procedure codes removed from the MRT program, effective for DOS on or after June 2, 2017

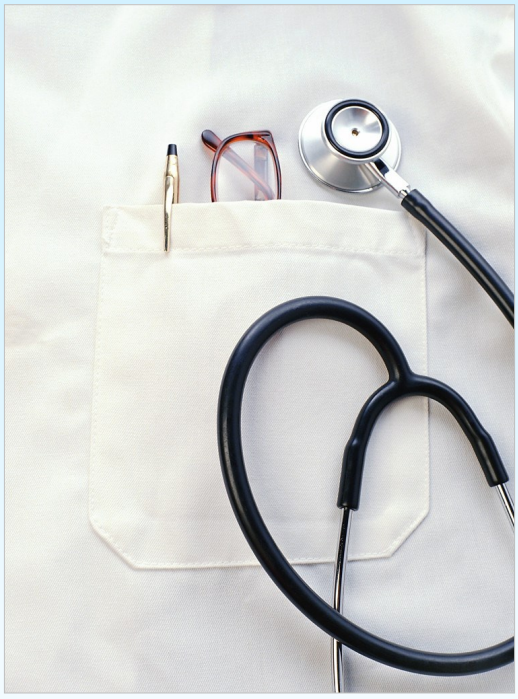
Procedure code	Modifier	Description
70210	SE	Radiologic examination, sinuses, paranasal; less than 3 views
70220	SE	Radiologic examination, sinuses, paranasal; complete, minimum of 3 views
90736	SE	Zoster (shingles) vaccine, live, for subcutaneous injection
99199	SE	Unlisted special service, procedure or report
99244	SE	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family
99245	SE	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.
C8932	SE	Magnetic resonance angiography without contrast, spinal canal and contents

continued

Table 2 – Procedure codes removed from the MRT program effective for DOS on or after June 2, 2017 (continued)

Procedure code	Modifier	Description
D7295	SE	Harvest of bone for use in autogenous grafting procedure
H0035	SE	Partial hospitalization services, less than 24 hours, per diem
Q4129	SE	Unite biomatrix, per sq cm
T1023	SE	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter

IHCP updates FQHC and RHC encounter codes



Effective June 1, 2017, the Indiana Health Coverage Programs (IHCP) will add the Current Procedural Terminology (CPT®[1]) and Healthcare Common Procedure Coding System (HCPCS) codes shown in Table 3 as valid federally qualified health center (FQHC) and rural health clinic (RHC) encounter codes. This update applies retroactively to dates of service (DOS) on or after **January 1, 2017**.

Beginning June 1, 2017, FQHC and RHC providers may submit claims for these codes with DOS on or after January 1, 2017. Claims for these codes with DOS on or after January 1, 2017, that previously denied may be resubmitted. 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 IHCP will remove the nationally deleted codes in Table 4 from the list of valid FQHC and RHC encounter codes. This change applies retroactively to DOS on or after **January 1, 2017**. This change will have no impact on previously adjudicated claims.

The list of valid FQHC and RHC encounter codes is reviewed periodically to account for new and end-dated CPT and HCPCS codes and is available on the Myers and Stauffer website at in.mslc.com. If you have questions, contact Berry Bingaman, Myers and Stauffer LC, at (317) 846-9521.

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continued

Table 3 – Codes added as valid FQHC and RHC encounter codes effective for DOS on or after January 1, 2017

Procedure code	Description
27197	Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation
27198	Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; with manipulation, requiring more than local anesthesia (ie, general anesthesia, moderate sedation, spinal/epidural)
31572	Laryngoscopy, flexible; with ablation or destruction of lesion(s) with laser, unilateral
31573	Laryngoscopy, flexible; with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral
31574	Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated
62320	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
62321	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)
62322	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)
62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); wit imaging guidance (ie, fluoroscopy or CT)

continued

Table 3 – Codes added as valid FQHC and RHC encounter codes effective for DOS on or after January 1, 2017 (continued)

Procedure code	Description
76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed
92242	Fluorescein angiography and indosyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral
96377	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection
D1575	Distal shoe space maintainer – fixed – unilateral
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.

Table 4 – Codes no longer valid as FQHC and RHC encounter codes effective for DOS on or after January 1, 2017

Procedure code	Description
77051	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure)
77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure)
77055	Mammography of one breast
77056	Mammography of both breasts
77057	Screening mammography, bilateral (2-view study of each breast)
D0290	Posterior-anterior or lateral skull and facial bone survey radiographic image

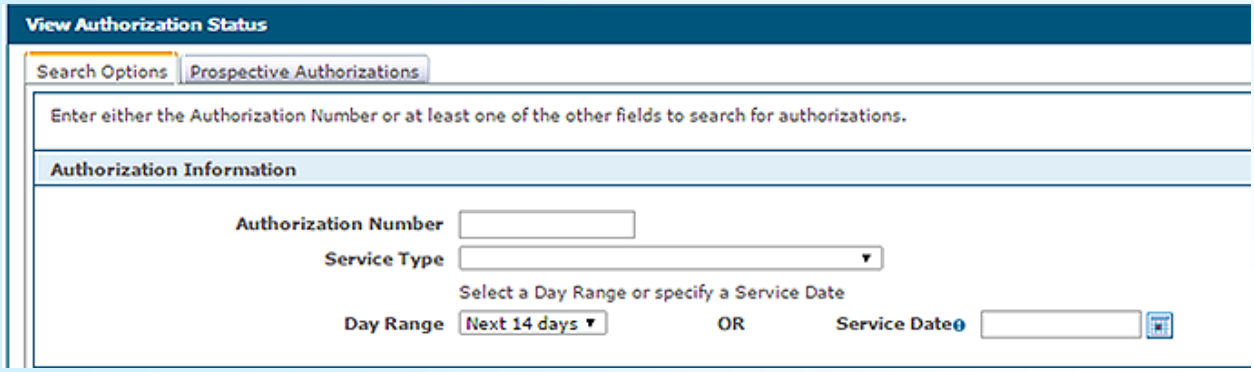
IHCP to mass adjust and mass reprocess waiver claims

As published in Indiana Health Coverage Programs (IHCP) banner page *BR201709*, the IHCP identified a claims processing issue that affected detail line items on waiver claims processed on or after February 13, 2017. The system issue caused paid amounts on waiver claim details with Healthcare Common Procedure Coding System (HCPCS) codes that begin with T2020 U7 and T2022 U7 (that may have additional modifiers) to be applied to the wrong waiver service on prior authorizations (PAs). In turn, these PA errors caused claims and claim details to deny inappropriately for explanation of benefits (EOB) 3006 – *Payment for this service has been denied or cutback due to dollars billed exceeding the dollars prior authorized*.

The claims processing system was corrected. The IHCP is mass reprocessing and mass adjusting claims affected by this issue. Providers should have begun to see the reprocessed or adjusted claims on Remittance Advices (RAs) beginning April 26, 2017. Due to the complexity of the issue, claim reprocessing and adjusting will need to continue until after the PA corrections have been fully applied. As additional claims are identified, they will be included in the ongoing claim reprocessing and adjustment efforts. It is anticipated providers will see reprocessing and adjustment activity on RAs related to this issue through the week of May 30, 2017, identifiable by internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims) and 52 (mass replacement non-check related). For claims that were underpaid, the net difference would be paid and reflected on the RA.

PA authorization number is case-sensitive in the Provider Healthcare Portal

The Indiana Health Coverage Programs (IHCP) informs providers that the field for the authorization number used to search and review prior authorization (PA) requests in the Provider Healthcare Portal is case-sensitive. Alpha characters in the authorization number must be keyed in UPPER CASE. If the authorization number is keyed incorrectly, providers will receive an "authorization not found" error message. The IHCP plans to modify the Portal to change the case sensitivity of this field. Please monitor future IHCP publications for implementation of this modification.



IHCP to add HCPCS codes as DME/HME items with capped rentals

Effective June 2, 2017, the Indiana Health Coverage Programs (IHCP) will add the Healthcare Common Procedure Coding System (HCPCS) codes in Table 5 as items with capped rentals, to align with the Centers for Medicare & Medicaid Services' (CMS') durable medical equipment (DME) fee schedule.

Note that capped rentals are subject to a 15-month rental period. The IHCP denies claims submitted for these DME and home medical equipment (HME) procedure codes for rentals in excess of 15 months. The 15-month capped rental period applies to the HCPCS codes in Table 5 effective for dates of service (DOS) on or after June 2, 2017.

These changes will be reflected in updates to the **Procedure Codes for DME/HME Capped Rental Items** under the *Durable and Home Medical Equipment and Supplies* code tables on the *Code Sets* page at indianamedicaid.com.

Table 5 – HCPCS codes to be added as capped rental items effective for DOS on or after June 2, 2017

Procedure code	Description
E0140	Walker, with trunk support, adjustable or fixed height, any type
E0149	Walker, heavy-duty, wheeled, rigid or folding, any type
E0197	Air pressure pad for mattress, standard mattress length and width
E0955	Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each
E0985	Wheelchair accessory, seat lift mechanism
E1020	Residual limb support system for wheelchair, any type
E1028	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory
E2228	Manual wheelchair accessory, wheel braking system and lock, complete, each

IHCP transitions certain members from Hoosier Healthwise to Traditional Medicaid

Effective May 1, 2017, the Indiana Health Coverage Programs (IHCP) began enrolling adult refugees eligible for coverage under the low-income parent/caretaker aid category through Traditional Medicaid, rather than through Hoosier Healthwise. This change means these members are receiving services via the fee-for-service delivery system, rather than under a managed care health plan. Members will remain eligible for full comprehensive coverage and can receive services from any enrolled IHCP provider, rather than being limited to a particular managed care network of providers.

Adult refugees previously enrolled under this aid category were transferred from Hoosier Healthwise to Traditional Medicaid on May 1, 2017. Providers are reminded to check member eligibility through one of the IHCP eligibility verification system (EVS) options – the Provider Healthcare Portal, the Interactive Voice Response (IVR) system, or an electronic eligibility transaction – to verify a member's current eligibility status and to know which delivery system applies for prior authorization (PA) and billing purposes.

IHCP to mass adjust outpatient crossover claims billed by LTC providers for therapy services included in *per diem*

The Indiana Health Coverage Programs (IHCP) has identified a claims processing issue that incorrectly allowed payment for therapy services on outpatient crossover claims from long-term care (LTC) providers. The affected claims were processed and paid on or after February 13, 2017. Per IHCP policy, therapy services are included in the *per diem* reimbursement rate for stays in LTC facilities and are not separately reimbursable. For additional information, see the *Long-Term Care Reimbursement Methodologies* section of the *Long-Term Care* (LTC) provider reference module at indianamedicaid.com.

The claims processing system has been corrected. Affected claims will be mass adjusted. Providers should see adjusted claims on Remittance Advices (RAs) beginning June 7, 2017, identifiable by internal control numbers (ICNs)/Claim IDs that begin with 52 (mass replacement non-check related). 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.

QUESTIONS?

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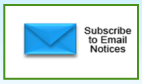

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