IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201742 OCTOBER 17, 2017

Diabetes management codes linked to additional provider specialties

Effective November 17, 2017, the Indiana Health Coverage Programs (IHCP) will link the following diabetes management codes to additional provider specialties:

- G0108 - *Diabetes outpatient self-management training services, individual, per 30 minutes*, with U6 modifier appended
- G0109 - *Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes*, with U6 modifier appended

The IHCP will cover Healthcare Common Procedure Coding System (HCPCS) codes G0108 and G0109 when billed with the U6 modifier by the provider specialties listed below. These changes apply retroactively to the dates of service (DOS) noted for each specialty:

- Podiatrists (provider specialty 140) retroactive to DOS on or after **August 11, 2017**
- Chiropractors (provider specialty 150) retroactive to DOS on or after **July 1, 2017**
- Optometrists (provider specialty 180) retroactive to DOS on or after **July 1, 2017**
- Audiologists (provider specialty 200) retroactive to DOS on or after **July 1, 2017**

Beginning November 17, 2017, affected providers can bill claims or resubmit denied claims for G0108 and G0109 for the DOS indicated, for reimbursement consideration. 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. Billing guidance applies to fee-for-service (FFS) claims.

These changes will be reflected in the next regular update to the applicable code tables on the Code Sets web page at indianamedicaid.com. Please refer to the *Professional Fee Schedule* for reimbursement information. Standard billing guidelines apply.

IHCP to add allowable diagnosis codes for chiropractic services

Effective November 17, 2017, the Indiana Health Coverage Programs (IHCP) will add the following as allowable ICD-10 diagnosis codes for services rendered by chiropractors (provider specialty 150).

- S74.92XS - *Injury of unspecified nerve at hip and thigh level left leg sequela*
- S94.90XS - *Injury of unspecified nerve at ankle and foot level unspecified leg sequela*

This change will apply to dates of service (DOS) on or after November 17, 2017.

The change will be reflected in the next regular update to the chiropractic services codes on the Code Sets web page at indianamedicaid.com.

MORE IN THIS ISSUE

Prior authorization is no longer required for CPT codes 92592 and 92593

Effective November 17, 2017, the Indiana Health Coverage Programs (IHCP) will no longer require prior authorization (PA) when providers bill for the following Current Procedural Terminology (CPT ®[1]) codes:

- 92592 – *Hearing aid check one ear*
- 92593 – *Hearing aid check both ears*

This change applies to dates of service (DOS) on or after November 17, 2017. The change will be reflected in the next regular update to the *Professional Fee Schedule* at indianamedicaid.com.

This PA requirement change applies to services delivered under the fee-for-service (FFS) delivery system. Questions regarding FFS PA should be directed to Cooperative Managed Care Services (CMCS) at 1-800-269-5720. 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 in which the member is enrolled.

IHCP provider enrollment inventory at normal levels

The Indiana Health Coverage Programs (IHCP) has reduced the inventory for provider enrollment transactions to normal levels. Providers who have submitted transactions should follow these guidelines:

- If you received communication requiring a correction or requesting additional documentation for your transaction, follow the instructions that were provided to complete the transaction. Corrections and missing documentation must be submitted timely to keep the transaction in active status.
- If you have not received communication regarding your transaction, check the status of your transaction as follows:
    - If you submitted the transaction through the Provider Healthcare Portal (Portal), check the status of the transaction in the Portal using the application tracking number (ATN) issued when the transaction was submitted.
    - If you submitted the transaction on paper, check the status of the transaction by calling Customer Service at 1-800-457-4584. You will need to provide your National Provider Identifier (NPI), as well as the legal and doing business as (DBA) name on the transaction. For recent submissions, please allow 15 business days plus mailing time before inquiring.

Enrollment transactions are being worked based on the date received, with the oldest being worked first. Providers should continue to submit transactions in a timely manner to allow time for processing before transaction deadlines. In particular, applications for enrollment revalidation should be submitted in response to the initial notice 90 days before the revalidation deadline.

Providers are strongly encouraged to use the Portal for all submissions, if possible, as electronic transactions can be processed more efficiently than paper submissions. Not only is the Portal designed to reduce errors in initial submissions, but the Portal also provides an application tracking number (ATN) that is helpful in tracking subsequent submissions if follow-up is needed for missing information or documents.

IHCP reminds providers of claim requirements for coverage of emergency services

The Indiana Health Coverage Programs (IHCP) reminds providers that coverage of emergency services rendered to members eligible for *Package E - Emergency Services Only*, requires claims be billed with an emergency indicator.

- Professional claims (*CMS-1500*) must have the emergency indicator field marked.
- Institutional outpatient claims (*UB-04*) must include an emergency diagnosis code.
- Institutional inpatient claims (*UB-04*) must include an admit code indicating an emergent admission.
- Dental claims must have the emergency indicator field marked and the procedure must be for an IHCP-designated emergency dental service.
- Pharmacy claims must be for a limited supply prescription associated with a covered emergency medical service, and must be submitted on a paper pharmacy claim.

Further, providers are responsible for maintaining documentation to support the claim and the appropriateness of the service.

QUESTIONS?

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

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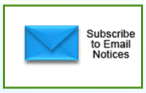

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