IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201747 NOVEMBER 21, 2017

Providers may resubmit certain claims for HCPCS code J3590 that may have denied incorrectly

The Indiana Health Coverage Programs (IHCP) identified a claim-processing system issue that affected claims for Healthcare Common Procedure Coding System (HCPCS) code J3590 – *Unclassified biologics,* billed with National Drug Code (NDC) 50242-015-001 for *Ocrevus™ (ocrelizumab).* Fee-for-service (FFS) claims for this procedure/NDC code combination for dates of service (DOS) from March 28, 2017, through September 30, 2017, may have denied incorrectly with explanation of benefits (EOB) code 4300 – *Invalid NDC to procedure code combination*. For the specific DOS noted, that NDC-to-procedure code combination was a valid combination and should not have denied for EOB 4300.

The claim-processing system error has been corrected. Beginning immediately, providers may resubmit FFS claims meeting the parameter above, that may have previously denied incorrectly 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.

Effective October 1, 2017, a new procedure code, C9494-*Injection, ocrelizumab, 1 mg,* was established for billing with NDC 50242-015-001. As announced in *Bulletin* BT201764, C9494 is a noncovered procedure code. Accordingly, for DOS on or after October 1, 2017, claims for either J3590 or C9494 when billed with NDC 50242-015-001 will deny.

IHCP to accept and process replacement claims for B4157 that may have paid incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing system error affecting fee-for-service (FFS) claims for Healthcare Common Procedure Coding System (HCPCS) code B4157 – *Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit*. Claims for this code may have paid incorrectly.

The system has been corrected. The IHCP will accept and process replacement claims for code B4157 with dates of service (DOS) on or after January 1, 2017, for reimbursement consideration. Providers who believe that a claim for B4157 for the affected DOS was reimbursed incorrectly must first void the original claim and then submit a new replacement claim. The replacement claim must include the same attachments as were submitted with the original claim. In addition, replacement 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.

MORE IN THIS ISSUE

Providers may resubmit claims for HCPCS codes C9491 and C9493 that may have denied incorrectly

The Indiana Health Coverage Programs (IHCP) identified a claim-processing system issue that affects certain claims for the following Healthcare Common Procedure Coding System (HCPCS) codes:

- C9491– *Injection, avelumab, 10 mg*
- C9493 – *Injection, edaravone, 1 mg*

Fee-for-service (FFS) claims for C9491 and C9493 with dates of service (DOS) on or after October 1, 2017, may have denied incorrectly with explanation of benefits (EOB) code 4300 – *Invalid NDC to procedure code combination*. Although these procedure codes must be billed with an National Drug Code (NDC), the NDC linkages had not been correctly established in the system.

The claim-processing system error has been corrected. Beginning immediately, providers may resubmit claims for DOS on or after October 1, 2017 that may have previously denied incorrectly 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.

IHCP announces IEP-related nursing services rate for calendar year 2018

The Indiana Health Coverage Programs (IHCP) provides coverage for nursing services rendered by a registered nurse (RN) who is employed by or under contract with an IHCP-enrolled school corporation provider. Covered services must be medically necessary, as ordered by a physician, and provided in accordance with an IHCP enrolled student's Individualized Education Plan (IEP). Pursuant to the Indiana Medicaid State Plan, the annual reimbursement rate for Current Procedural Terminology (CPT®[1]) code 99600 TD TM – *IEP-related nursing services* is calculated based on the most recent home health cost reports required from all home health providers billing the IHCP for services. Rates are based on these calculations except in instances where rates would be reduced using the calculation. In these instances, prior-year rates will be maintained in compliance with *Indiana Code IC 12-15-34-14.5*. (See *IHCP Bulletin* BT201740 for information about home health rates for state fiscal year 2018.)

Calculations for IEP-related nursing services for calendar year 2018 resulted in the rate for code 99600 TD TM to remain unchanged from the calendar year 2017 rate. Accordingly, for dates of service (DOS) from January 1, 2018, through December 31, 2018, the maximum reimbursement rate for CPT code 99600 TD TM is $10.87 per 15 minutes. Coverage policy and billing instructions published in the *School Corporation Services* provider reference module remain the same. Pricing for the 2018 calendar year will be reflected in the next update to the *Professional Fee Schedule* at indianamedicaid.com.

IHCP updates attachment requirements for certain procedure codes

Effective December 21, 2017, the Indiana Health Coverage Programs (IHCP) will update the attachment requirements when providers bill the Current Procedural Terminology (CPT®[1]) and Healthcare Common Procedure Coding System (HCPCS) codes in Table 1. Although these procedure codes continue to be manually priced, claims for these codes will no longer require attachments. This change applies to fee-for-service (FFS) claims with dates of service (DOS) on or after December 21, 2017.

This billing information applies to services delivered under the FFS delivery system. Individual managed care entities (MCEs) establish and publish reimbursement, prior authorization (PA), and billing criteria within the managed care delivery system. Questions about managed care billing should be directed to the MCE with which the member is enrolled.

These changes will be reflected in the *Procedure Codes That Require Attachments* code table on the Code Sets web page at indianamedicaid.com. This information will also appear in the next weekly update to the *Professional Fee Schedule* at indianamedicaid.com.

Table 1 – CPT and HCPCS codes that no longer require claim attachments, effective for DOS on or after December 21, 2017

Procedure Code	Description
0111T	Measurement of long-chain omega fatty acids in red blood cell (RBC) membranes
A4642	Indium In-111 satumomab pendetide, diagnostic, per study dose, up to 6 millicuries
A9500	Technetium tc-99m sestamibi, diagnostic, per study dose
A9503	Technetium Tc-99m medronate, diagnostic, per study dose, up to 30 millicuries
A9504	Technetium Tc-99m apcitide, diagnostic, per study dose, up to 20 millicuries
A9505	Thallium Tl-201 thallous chloride, diagnostic, per millicurie
A9507	Indium In-111 capromab pendetide, diagnostic, per study dose, up to 10 millicuries
A9508	Iodine I-131 iobenguane sulfate, diagnostic, per 0.5 millicurie
A9510	Technetium Tc-99m disofenin, diagnostic, per study dose, up to 15 millicuries
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie
A9520	Technetium tc-99m, tilmanocept, diagnostic, up to 0.5 millicuries
A9526	Nitrogen N-13 ammonia, diagnostic, per study dose, up to 40 millicuries
A9546	Cobalt Co-57/58, cyanocobalamin, diagnostic, per study dose, up to 1 microcurie
A9550	Technetium Tc-99m sodium gluceptate, diagnostic, per study dose, up to 25 millicurie
A9555	Rubidium Rb-82, diagnostic, per study dose, up to 60 millicuries
A9556	Gallium Ga-67 citrate, diagnostic, per millicurie

continued

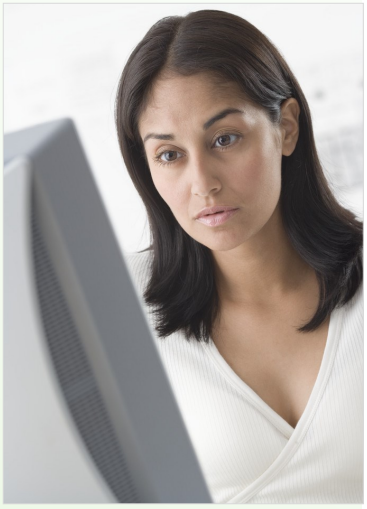
Table 1 – CPT and HCPCS codes that no longer require claim attachments, effective for DOS on or after December 21, 2017 (continued)

Procedure Code	Description
A9557	Technetium Tc-99m bicisate, diagnostic, per study dose, up to 25 millicuries
A9558	Xenon Xe-133 gas, diagnostic, per 10 millicuries
A9560	Technetium Tc-99m labeled red blood cells, diagnostic, per study dose, up to 30 millicuries
A9561	Technetium Tc-99m oxidronate, diagnostic, per study dose, up to 30 millicuries
A9563	Sodium phosphate P-32, therapeutic, per millicurie
A9580	Sodium fluoride F-18, diagnostic, per study dose, up to 30 millicuries
A9700	Supply of injectable contrast material for use in echocardiography, per study
G0186	Destruction of localized lesion of choroid (for example, choroidal neovascularization); photocoagulation, feeder vessel technique (one or more sessions)
G0293	Noncovered surgical procedure(s) using conscious sedation, regional, general, or spinal anesthesia in a Medicare qualifying clinical trial, per day
G0294	Noncovered procedure(s) using either no anesthesia or local anesthesia only, in a Medicare qualifying clinical trial, per day
Q0081	Infusion therapy, using other than chemotherapeutic drugs, per visit
Q0083	Chemotherapy administration by other than infusion technique only (e.g., subcutaneous, intramuscular, push), per visit
Q0084	Chemotherapy administration by infusion technique only, per visit
Q0085	Chemotherapy administration by both infusion technique and other technique(s) (e.g. subcutaneous, intramuscular, push), per visit
Q0181	Unspecified oral dosage form, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen
Q3001	Radioelements for brachytherapy, any type, each
V2790	Amniotic membrane for surgical reconstruction, per procedure

Taxonomy codes for rendering providers not required on claims

The Indiana Health Coverage Programs (IHCP) has received transactions from providers to update or add taxonomy codes on rendering provider profiles for claim-filing purposes. As a reminder, taxonomy codes for rendering providers are not required on claims. If a taxonomy code for a rendering provider is submitted on a claim, the taxonomy code will not be validated. National Provider Identifiers (NPIs) for rendering providers are still required on all fee-for-service (FFS) and managed care claims.

IHCP implements taxonomy code requirement changes



In Indiana Health Coverage Programs (IHCP) *Bulletin* BT201768, the IHCP outlined revised guidance regarding claim submission requirements. The bulletin stated that taxonomy codes would no longer be required for attending and operating providers on institutional claims and for ordering, prescribing, or referring (OPR) providers on any claim type. These changes were to be effective October 29, 2017, however, a temporary delay was subsequently announced on October 26, 2017.

The IHCP will implement the announced changes to taxonomy code requirements effective November 29, 2017. As stated in *BT201768*, these changes apply to fee-for-service (FFS) and managed care claims regardless of submission format and are retroactive to dates of claim submission on or after **February 13, 2017**.

Beginning November 29, 2017, providers may resubmit FFS claims if they believe their claims were denied inappropriately due to taxonomy codes. Claims resubmitted beyond the original one-year filing limit must include a copy of this banner page as an attachment and be filed within one year of the publication date. Providers should check with the individual managed care entities (MCEs) for additional information regarding the resubmission or reprocessing of managed care claims. For additional questions, please contact an MCE or IHCP Provider Relations field consultant.

Except for the revised effective date for the taxonomy code requirement changes, all other claim guidance in *BT201768* remains unchanged.

Update on *Core*MMIS implementation issues with MRO, AMHH, BPHC, and CMHW benefit packages

The Indiana Health Coverage Programs (IHCP) continues to work on Provider Healthcare Portal (Portal) issues associated with benefit packages for members receiving Medicaid Rehabilitation Option (MRO), Adult Mental Health Habilitation (AMHH), Behavioral and Primary Healthcare Coordination (BPHC), and Child Mental Health Wraparound (CMHW) services. The current status of the identified issues is outlined below.

MRO, AMHH, BPHC, and CMHW benefit packages with overlapping PAs:

Benefit packages were created incorrectly when a member's eligibility was end-dated and then reinstated, resulting in overlapping PAs. This issue has been resolved. If this issue occurs in the future, providers should contact their IHCP Provider Relations field consultant.

Portal to display PA numbers of members receiving MRO services:

Effective November 29, 2017, MRO providers will be able to view prior authorization (PA) numbers in the Portal when verifying coverage details for members receiving MRO services. As is currently the case, only MRO providers will see a hyperlink for the MRO benefit plan on the *Eligibility Verification* page. That link will take those users to the *Coverage Details* page, where PA information for the requested dates is displayed. As a reminder, only the requesting MRO provider can submit a system update to the PA through the Portal. All other MRO providers must submit a system update via paper or fax to Cooperative Managed Care Services (CMCS). See the *Provider Healthcare Portal* and the *Prior Authorization* provider modules for more information.

continued

Conversion errors on MRO and BPHC benefit packages:

Adjustments are being made to the effective dates and end dates on MRO and BPHC benefit packages. (This issue did not affect AMHH and CMHW members.) The correct information should be visible in the Portal as updates are applied. Final resolution of this issue is expected by November 30, 2017. Watch future IHCP provider publications for updates.

Accurate benefit packages for active members:

- MRO services - Accurate MRO benefit packages for active members whose PAs previously denied, have been reprocessed and are visible in the Portal. If future issues occur, providers should contact the Division of Mental Health and Addiction (DMHA).
- AMHH, BPHC, and CMHW services – The IHCP continues to work with the DMHA to create accurate benefit packages for active members whose PAs previously denied. Resolution of these issues is expected by January 1, 2018. Watch future IHCP provider publications for updates.

IHCP will no longer publish one of the vision services code tables on the provider website

The Indiana Health Coverage Programs (IHCP) will no longer publish *Table 3–Procedure codes for eye exams and other Ophthalmological services limited to one unit per member per day* as a vision services code table on the provider website. Vision service limitations are enforced through National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUEs), unless otherwise indicated by the IHCP. The unit restrictions applied to the codes referenced in the table are a reflection of required NCCI edits and do not require separate publication. Accordingly, this table will be removed from the Vision Services Codes accessible through the Code Sets web page at indianamedicaid.com. For more information about NCCI edits, please see the *National Correct Coding Initiative Provider Reference Module* at indianamedicaid.com.

QUESTIONS?

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

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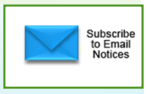

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