IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR201806 FEBRUARY 6, 2018

IHCP to mass reprocess claims for dental codes that denied inappropriately

The Indiana Health Coverage Programs (IHCP) identified a claim-processing issue that affects certain fee-for-service (FFS) claims for dental services with dates of service (DOS) on or after July 20, 2017. Claims for the Current Dental Terminology (CDT®[1]) codes listed in Table 1 on the DOS indicated may have denied inappropriately with an explanation of benefits (EOB) 4211 – *Tooth number/procedure code combination invalid.* Denials were occurring inappropriately when the codes in Table 1 were billed with valid tooth numbers.

Table 1 – Dental codes that may have denied inappropriately for DOS on or July 20, 2017

Dental Code	Description
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220	Removal of impacted tooth-soft tissue
D7230	Removal of impacted tooth-partially bony
D7240	Removal of impacted tooth-completely bony
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications
D7250	Removal of residual tooth roots (cutting procedure)
D7251	Coronectomy - intentional partial tooth removal

The issue has been corrected. Claims for the affected procedure codes for the DOS indicated that previously denied for EOB 4211 will be mass reprocessed. Providers should see the reprocessed claims on Remittance Advices (RAs) beginning March 6, 2018, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims).

MORE IN THIS ISSUE

IHCP clarifies billing guidance for clubhouse psychosocial rehabilitation services

The Indiana Health Coverage Programs (IHCP) has identified issues related to billing and claims processing of psychosocial rehabilitation services. Policy and billing guidance for these services was originally issued in *IHCP Bulletin BT201618*, dated March 31, 2016.

As stated in *BT201618*, psychosocial rehabilitation services must be rendered by a certified clubhouse provider under contract with an IHCP-enrolled Medicaid Rehabilitation Option (MRO) provider. Clubhouse providers must be enrolled as rendering providers with a 613 –*MRO Clubhouse* specialty and must be appropriately linked to the MRO provider. The billing provider identified on the claim must be the MRO provider. The rendering provider identified on the claim must be the clubhouse psychosocial rehabilitation provider with provider specialty 613. **Psychosocial rehabilitation services cannot be rendered or billed by any other specialty**. (For instance, claims for these services cannot indicate provider specialty 339 – *Psychiatrist* as the rendering provider.)

Providers are reminded that the following billing guidelines apply:

- Services must be billed with Healthcare Common Procedure Coding System (HCPCS) code H2017 HW – *Psychosocial rehabilitation services, per 15 min.*
- Services (H2017 HW) are limited to 32 units per date of service (DOS).
- Services (H2017 HW) are limited to 1,820 units (one unit equals 15 minutes) per each 180-day period of a member's MRO eligibility.
- Services (H2017 HW) are not reimbursable when billed on the same DOS as H2012 HW HB U1 – *Adult Intensive Rehabilitative Services (AIRS)*.
- H2014 HW – *Skills Training and Development* is limited to 8 units (2 hours) when billed on the same DOS as H2017 HW.

The IHCP is aware that all claims for DOS on or after May 1, 2016, billing procedure codes H2014 HW and H2017 HW on the same DOS, have denied for EOB 6372 – *Psychological rehabilitation services, per 15 minutes, cannot be billed on the same day as behavioral health day treatment, per 1 hour, and skills training and development, per 15 minutes*. This denial reason does not accurately reflect billing guidance, resulting in some inappropriate denials. Effective March 6, 2018, the IHCP will reprocess all affected claims. Providers should see reprocessed claims on their Remittance Advices (RAs) beginning March 13, 2018. These claims will be identified by internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims). If the services billed on a reprocessed claim exceed the allowable limits outlined above, and the claim pays, the paid amount will be at risk of later recoupment once related system fixes are made.

IHCP to retroactively cover end-dated HCPCS code C9494

In Indiana Health Coverage Programs (IHCP) *Banner Page* BR201802, IHCP announced that Healthcare Common Procedure Coding System (HCPCS) code J2350 - *Injection, ocrelizumab, 1 mg* replaced temporary physician-administered drug (PAD) code C9494 - *Injection, ocrelizumab, 1 mg*, effective for dates of service (DOS) on or after January 1, 2018. Code J2350 is an IHCP-covered code – refer to *IHCP Bulletin* BT201782 for coverage and billing guidance. Code C9494, which was end-dated effective December 31, 2017, was not an IHCP-covered code.

Effective March 6, 2018, the IHCP will add retroactive coverage of C9494, for DOS **from October 1, 2017, through December 31, 2017**. Retroactive coverage applies to all IHCP programs, subject to limitations established for certain benefit packages.

The following billing and reimbursement information applies:

- Prior Authorization (PA) required: No
- Pricing: Maximum fee of $56.87
- Billing guidance:
  - Must be billed with the National Drug Code (NDC) of the product administered
  - Separate reimbursement is allowed under revenue code 636 – *Drugs requiring detailed coding for separate reimbursement in an outpatient setting*. For reimbursement consideration, providers may bill the procedure code and revenue code together, as appropriate.

Beginning March 6, 2018, providers may submit new claims, or resubmit claims that previously denied, for C9494 for DOS from October 1, 2017, through December 31, 2017. 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.

Coverage changes will be reflected in the *Procedure Codes That Require NDCs* and the *Revenue Codes Linked to Specific Procedure Codes* tables on the Code Sets web page at indianamedicaid.com. This information will also be reflected in the next weekly update to the *Professional Fee Schedule* at indianamedicaid.com.

Reimbursement, prior authorization, 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 with the managed care delivery system. Questions about managed care information should be directed to the MCE with which the member is enrolled.

HCPCS code J0606 no longer linked to revenue code 636

Effective March 6, 2018, the Indiana Health Coverage Programs (IHCP) will remove the linkage between Healthcare Common Procedure Coding System (HCPCS) code J0606 – *Injection, Etelcalcetide, 0.1 mg* and revenue code 636 – *Drugs requiring detailed coding for separate reimbursement in an outpatient setting.* This change affects claims with dates of service (DOS) on or after March 6, 2018.

continued

Claims submitted with DOS on or after March 6, 2018, will deny for explanation of benefits (EOB) 0520 – *Invalid revenue code and procedure code combination. Please verify and resubmit.*

This linkage change will be reflected in the *Revenue Codes Linked to Specific Procedure Codes* tables on the Code Sets web page at indianamedicaid.com. This information will also be reflected in the next regular update to the *Outpatient Fee Schedule* at indianamedicaid.com.

QUESTIONS?

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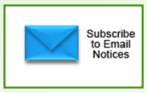

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