IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201809 FEBRUARY 27, 2018

IHCP revises policy regarding outpatient mental health services limitation

Indiana Health Coverage Programs (IHCP) outpatient mental health services policy identifies Current Procedural Terminology (CPT®[1]) codes that, in combination, are limited to 20 units per member, per provider, per rolling 12 month period. Effective March 27, 2018, the IHCP will no longer include the codes in Table 1 in this limitation. This policy change applies to dates of service (DOS) on or after March 27, 2018.

Table 1– Mental health codes not included in the 20 units per member, per provider, per rolling 12 months limitation, effective for (DOS) on or after March 27, 2018

Procedure Code	Description
96151	Health and behavior re-assessment each 15 minutes
96152	Health and behavior intervention, individual each 15 minutes
96153	Health and behavior intervention, group each 15 minutes
96154	Health and behavior intervention, family and patient each 15 minutes
96155	Health and behavior intervention, family each 15 minutes

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Providers may submit replacement claims for J7340 that may have paid incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain fee-for-service (FFS) claims for Healthcare Common Procedure Coding System (HCPCS) code J7340 – *Carbidopa 5 mg/levodopa 20 mg enteral suspension, 100 ml.* Claims for J7340 with dates of service (DOS) on or after January 1, 2017 may have paid incorrectly.

continued

The claim-processing system has been corrected. Beginning immediately, providers who believe their claims for code J7340 for the affected DOS paid incorrectly may submit replacement claims for adjudication. Providers must first void the original claim and then submit a new replacement claim. The replacement claim must include the same attachments that were submitted with the original claim. Additionally, 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.

IHCP to assign ASC pricing indicators to CPT codes 62321, 62323, 62325, and 62327

Effective March 27, 2018, the Indiana Health Coverage Programs (IHCP) will assign ambulatory surgical center (ASC) pricing indicators to the Current Procedural Terminology (CPT®[1]) codes in Table 2, as specified. The ASC pricing indictor assignment is retroactive to dates of service (DOS) on or after **October 1, 2017**. The IHCP will reimburse these CPT codes as outpatient services for the affected DOS.

Table 2 – CPT codes assigned ASC pricing indicators, effective for DOS on or after October 1, 2017

Procedure Code	Description	ASC Pricing Indicator
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)	3
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)	3
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)	4
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); with imaging guidance (ie, fluoroscopy or CT)	4

Beginning March 27, 2018, fee-for-service (FFS) claims for the CPT codes in Table 1 with DOS on or after October 1, 2017, that denied with explanation of benefit (EOB) 4108 – *There is no ASC on file for this procedure code,* may be resubmitted for reimbursement consideration. Providers should reach out to the appropriate managed care entity (MCE) for proper billing instructions regarding affected managed care claims.

These changes will be reflected in the next regular update to the *Outpatient Fee Schedule* at indianamedicaid.com. The ASC rates are listed in the ASC Codes/Rates table, accessible on the *IHCP Outpatient Fee Schedule* web page.

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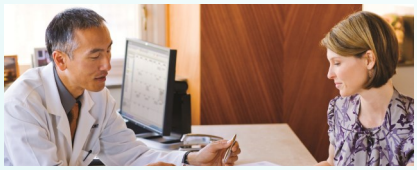
Providers may resubmit claims for HCPCS code J3490 billed with NDC 50419-042-401 that may have denied incorrectly

The Indiana Health Coverage Programs (IHCP) identified a claim-processing issue that affects certain fee-for-service (FFS) claims for Healthcare Common Procedure Coding System (HCPCS) code J3490 – *Unclassified drugs* billed with National Drug Code (NDC) 50419-042-401 for Kyleena®. The issue affects claims with dates of service (DOS) from **February 13, 2017 through June 30, 2017**, that may have denied incorrectly with an explanation of benefits (EOB) 4300 – *Invalid NDC to procedure code combination*.



The claim-processing system error has been corrected. Beginning immediately, providers may resubmit previously denied claims for the affected DOS 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.

Providers billing for Kyleena for DOS after June 30, 2017 are reminded of the following:

- For DOS from July 1, 2017 through December 31, 2017, providers must use Q9984 – *Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg*
- For DOS on or after January 1, 2018, providers must use J7296 – *Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg*

IHCP to update pricing for CPT code 50590

Effective March 30, 2018, the Indiana Health Coverage Programs (IHCP) will update the pricing for Current Procedural Terminology (CPT®[1]) code 50590 - *Lithotripsy, extracorporeal shock wave*. The pricing for this procedure code will change from ambulatory surgical center (ASC) pricing to flat rate pricing. The rate will reimburse based on the rate applied to the revenue code billed.

This pricing change will be reflected in the next regular update to the *Outpatient Fee Schedule* at indianamedicaid.com.

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Portal account managers are reminded to deactivate delegates no longer with the organization

The Indiana Health Coverage Programs (IHCP) reminds all Provider Healthcare Portal (Portal) *Provider Account* managers of their responsibility to deactivate delegate access when staff changes occur. A *Delegate Account* remains active with a provider until the provider deactivates the delegate. To protect the security of your organization's information, it is imperative that the *Provider Account* manager deactivate all delegates that are no longer employed by your organization.

To deactivate a delegate, the account manager must log on to the Portal, choose **Manage Accounts**, and select the name of the delegate to be made inactive. On the delegate assignment panel, the manager must change the delegate's status to "Inactive" and confirm the change. When a delegate is made inactive he or she will no longer be able to access that *Provider Account*. This process must be completed for all accounts (service locations) to which the delegate has access.

QUESTIONS?

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

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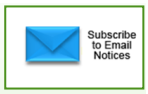

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