IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR201811 MARCH 13, 2018

IHCP removes restrictions for dental code D9920 when billed with other dental anesthesia codes

Effective April 13, 2018, the Indiana Health Coverage Programs (IHCP) will remove the reimbursement restriction for Current Dental Terminology (CDT®[1]) code D9920 – *Behavior management, by report* when billed for the same date of service (DOS) as other dental anesthesia codes. Removal of the restriction applies retroactively to fee-for-service (FFS) claims with DOS on or after **July 20, 2017**.

Beginning April 13, 2018, providers may resubmit FFS claims with DOS on or after July 20, 2017, that previously denied for explanation of benefit (EOB) 6275 – *Multiple dental sedation codes are not payable on the same date of service* for reimbursement consideration. 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 continue to restrict reimbursement for other dental anesthesia codes to only one per DOS. The applicable codes are listed in Table 1.

Table 1: Dental anesthesia codes restricted to reimbursement of one code per DOS

Procedure Code	Description
D9222*	Deep sedation/general anesthesia - first 15 minutes
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment
D9230	Inhalation of nitrous oxide/anxiolysis, analgesia
D9239*	Intravenous moderate (conscious) sedation/analgesia -first 15 minutes
D9243	Intravenous moderate (conscious) sedation/analgesia -each subsequent 15 minute increment
D9248	Non-intravenous conscious sedation

** New dental anesthesia codes with the 2018 annual Healthcare Common Procedure Coding System (HCPCS) update, covered effective for DOS on or after January 1, 2018.*

Managed care entities (MCE) establish billing and reimbursement guidance for managed care claims. Providers should contact the appropriate MCE for guidance regarding managed care claims.

MORE IN THIS ISSUE

IHCP to update pricing for certain procedure codes and assign ASC pricing indicator to code 96377

Effective April 13, 2018, the Indiana Health Coverage Programs (IHCP) will update pricing for the Current Procedural Terminology (CPT®[1]) codes listed in Table 2. Pricing for these codes is changing from manual pricing to resource-based relative value scale (RBRVS). This change applies to fee-for-service (FFS) claims with dates of service (DOS) on or after April 13, 2018.

Effective April 13, 2018, the IHCP will assign an ambulatory surgical center (ASC) pricing indicator to CPT code 96377, when billing the service in an outpatient setting.

Table 2 - CPT codes updated from manual pricing to RBRVS pricing, effective for DOS on or after April 13, 2018

Procedure Code	Description
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)
96377	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection
99177	Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with on-site analysis
99188	Application of topical fluoride varnish by a physician or other qualified health care professional

Pricing changes will be reflected in the next regular updates to the *Professional Fee Schedule* and the *Outpatient Fee Schedule* at indianamedicaid.com.

IHCP air ambulance transportation policy applies to rotary-wing and fixed-wing aircraft

The Indiana Health Coverage Programs (IHCP) clarifies that the policy regarding air ambulance transportation services applies to both rotary-wing aircraft and fixed-wing aircraft. This applies to all IHCP programs, subject to limitations established for certain benefit packages.

To further clarify, IHCP's air ambulance policy regarding the transport of expired patients is summarized as follows:

- If a member expires **before take-off** to the point of member pick-up, IHCP will not reimburse for the trip. It is expected that the flight would be aborted.
- If the member expires **after take-off** to the point of member pick-up **but before the member is loaded** on the aircraft, IHCP will reimburse for the base rate, but will not reimburse for mileage.
- If the member expires **after the member is loaded** on the aircraft, the IHCP will reimburse for the base rate and for mileage.

continued

Providers billing fee-for-service (FFS) claims for transports under the second scenario should bill the appropriate base rate code along with the QL modifier for both rotary-wing and fixed-wing aircraft, as shown in Table 3. The mileage code should not be billed. If the mileage code is billed, the FFS claim will deny with explanation of benefits (EOB) 6194 - *Mileage is not payable with this service*.

The IHCP has identified an issue with the FFS claim-processing system for transports under this scenario when billing for fixed-wing aircraft. Effective April 13, 2018, this issue will be corrected. FFS claims for fixed-wing aircraft using A0430 QL should process correctly for dates of service (DOS) on or after April 13, 2018.

Table 3 – Procedure code/modifier combinations for billing air ambulance services when the patient expires after take-off to the point of pick-up, but before the patient is loaded

Procedure Code	Description
A0430 QL	Ambulance service, conventional air services, transport, one way (fixed wing); patient pronounced dead after takeoff to point of pickup, but before the patient is loaded
A0431 QL	Ambulance service, conventional air services, transport, one way (rotary wing); patient pronounced dead after takeoff to point of pickup, but before the patient is loaded

The procedure code/modifier combination A0430 QL will be added to the appropriate *Transportation Services* code table on the Code Sets web page at indianamedicaid.com. This billing guidance will be clarified in the next regular update to the *Transportation Services* provider reference module and the *Medical Policy Manual*.

IHCP clarifies provider requirements for SUD Residential Treatment Facilities

As announced in Indiana Health Coverage Programs (IHCP) *Bulletin BT201801*, effective March 1, 2018, the IHCP created a new provider specialty for substance use disorder (SUD) residential addiction treatment facilities. These facilities are classified as Provider type 35 – *Addiction Services* and provider specialty 836 – *SUD Residential Addiction Treatment Facility*.

To clarify, providers must provide proof they meet one of the following requirements for enrollment:

- Division of Mental Health and Addiction (DMHA) certification as a Sub-Acute Facility that includes an American Society of Addiction Medicine (ASAM) designation of offering either Level 3.1 or Level 3.5 residential services
- Department of Child Services (DCS) licensing as a child care institution or private secure care institution with a DMHA Addiction Services Provider, Regular Certification that includes ASAM designation of offering either Level 3.1 or Level 3.5 residential services

Providers can learn about the ASAM designation process by visiting the DMHA ASAM Designation web page at in.gov/fssa. Providers that wish to be reimbursed by IHCP for SUD residential services must complete the ASAM designation process. Facilities that meet these requirements and are currently enrolled with IHCP under another provider type and specialty can be reimbursed for residential stays for SUD treatment for dates of service (DOS) from March 1, 2018 through June 30, 2018. For DOS on or after July 1, 2018, to be eligible for reimbursement, facilities must be enrolled under the new provider type and specialty 35/836. See *Bulletin BT201801* for more information and billing guidance.

QUESTIONS?

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