IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201825 JUNE 19, 2018

IHCP to cover CPT code 22857

Effective July 19, 2018, the Indiana Health Coverage Programs (IHCP) will cover Current Procedural Terminology (CPT®[1]) 22857- *total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar*. The IHCP will cover only those lumbar prosthetic intervertebral discs billed with procedure code 22857 that are approved by the U.S. Food and Drug Administration (FDA). Coverage applies to all IHCP programs, subject to limitations established for certain benefit plans. Coverage applies to dates of service (DOS) on or after July 19, 2018.

The following reimbursement information applies:

- Pricing: Resource-based relative value scale (RBRVS)
- Billing guidance: Standard billing guidance applies
- Prior authorization (PA): Required

PA for lumbar arthroplasty requires the following criteria be met:

- Chronic, unremitting, discogenic lower back pain and disability secondary to single-level degenerative disc disease (DDD) as medically necessary in a skeletally mature (fully formed and grown) individual
- Unremitting low back pain and significant functional impairment is refractory to at least six consecutive months of structured*, physician-supervised, conservative medical management, which includes ALL of the following components:
  - Exercise, including core stabilization exercises
  - Nonsteroidal and/or steroidal medication (unless contraindicated)
  - Physical therapy, including passive and active treatment modalities
  - Activity/lifestyle modification

  * Note: Structured medical management consists of medical care that is delivered through regularly scheduled appointments, including follow-up evaluation, with licensed healthcare professionals.

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- Single-level disc degeneration has been confirmed on complex imaging studies [that is, computerized tomography (CT) scan, magnetic resonance imaging (MRI)]
- Implant will be inserted at a FDA-approved lumbar/sacral level specific to the implant being used
- No anatomic deformity or malignancy at affected level
- No osteoporosis
- No previous lumbar surgery at affected level
- No systemic infection or localized infection at site of implantation
- Members must be 60 years of age or younger

Coverage information for procedure code 22857 will be reflected in the next regular update to the *Professional Fee Schedule* at indianamedicaid.com.

Reimbursement, PA, and billing information apply to services delivered under the fee-for-service (FFS) delivery system. Questions about FFS PA should be directed to Cooperative Managed Care Services (CMCS) at 1-800-269-5720. Individual managed care entities (MCEs) establish and publish reimbursement, PA, and billing criteria within the managed care delivery system. Questions about managed care billing and PA should be directed to the MCE with which the member is enrolled.

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IHCP to require NDCs on claims for low osmolar contrast material

The Federal Deficit Reduction Act of 2005 mandates that the Indiana Health Coverage Programs (IHCP) require the submission of National Drug Codes (NDCs) on claims billing certain procedure codes for physician-administered drugs (PADs). This mandate applies to claims under all IHCP programs, whether managed care or fee-for-service (FFS).

The IHCP has identified that the FFS claim-processing system currently does not require an NDC when adjudicating claims for the Healthcare Common Procedure Coding System (HCPCS) codes in Table 1. Effective July 19, 2018, the system will be updated to require an NDC be included on the claim when billing these codes. This change will apply to dates of service (DOS) on or after July 19, 2018. FFS claims submitted for these codes for the indicated DOS without an NDC will deny with explanation of benefits (EOB) 217 – *NDC number is missing or not on file– an NDC number can be up to eleven numeric characters. For further information, see the pharmacy chapter in your provider manual. Please provide and resubmit.*

Individual managed care entities (MCEs) establish and publish billing guidance within the managed care delivery system. Questions about managed care billing for the codes in Table 1 should be directed to the MCE being billed for the service.

continued

Table 1 – Procedure codes that must be billed with an NDC for FFS claims, effective *for DOS on or after July 19, 2018*

Procedure code	Description
Q9965	Low osmolar contrast material, 100-199 mg/ml iodine concentration, per ml
Q9966	Low osmolar contrast material, 200-299 mg/ml iodine concentration, per ml
Q9967	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml

This information will be reflected in the *Procedure Codes that Require NDCs* on the Code Sets web page at indianamedicaid.com.

IHCP to cover home INR monitoring codes

Effective July 19, 2018, the Indiana Health Coverage Programs (IHCP) will cover the Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT®[1]) codes in Table 2 for home international normalized ratio (INR) monitoring. Coverage applies to all IHCP programs, subject to limitations established for certain benefit plans. Coverage applies to dates of service (DOS) on or after July 19, 2018.

Table 2- Home INR monitoring codes, effective for DOS on or after July 19, 2018

Procedure code	Description	Special billing guidance	PA required
G0248	Demonstrate use of home INR monitoring	Covered on *CMS-1500* crossover claims and *UB-04* outpatient crossover claims only	No
G0249	Provide INR testing materials and equipment	Covered on *CMS-1500* crossover claims and *UB-04* outpatient crossover claims only	No
93792	Patient or caregiver training for home INR	No	Yes
93793	Anticoagulation management for patients on warfarin	No	Yes

The following reimbursement information applies:

- Pricing: Resource-based relative value scale (RBRVS)
- Billing guidance: Standard billing guidance applies except as noted in Table 2
- Prior authorization (PA): Refer to Table 2

continued

PA for home INR monitoring requires the following criteria be met:

- The patient must have been anticoagulated for at least 3 months prior to use of the home INR monitoring device.
- The patient must have undergone a face-to-face educational program on anticoagulation management and must have demonstrated the correct use of the device prior to its use in the home.
- The management plan requires documentation that the patient is correctly using the device for anticoagulation management as a condition for the continuation of home monitoring services.
- Self-testing with the device should not occur more frequently than once a week.

This coverage information will be reflected in the next regular updates to the *Outpatient Fee Schedule* and the *Professional Fee Schedule* at indianamedicaid.com.

Reimbursement, PA, and billing information apply to services delivered under the fee-for-service (FFS) delivery system. Questions about FFS PA should be directed to Cooperative Managed Care Services (CMCS) at 1-800-269-5720. Individual managed care entities (MCEs) establish and publish reimbursement, PA, and billing criteria within the managed care delivery system. Questions about managed care billing and PA should be directed to the MCE with which the member is enrolled.

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IHCP adds coverage of fenestrated endovascular repair procedures for aortic aneurysms

The Indiana Health Coverage Programs (IHCP) currently covers endovascular repair of aortic aneurysms. Effective July 19, 2018, the IHCP will add coverage of fenestrated endovascular repair procedures for aortic aneurysms. Accordingly, the Current Procedural Terminology (CPT®[1]) codes in Table 3 will be covered for dates of service (DOS) on or after July 19, 2018. Coverage applies to all IHCP programs, subject to limitations established for certain benefit packages.

Table 3 – CPT codes covered, effective for DOS on or after July 19, 2018

Procedure code	Description
34841	Endovasc visc aorta 1 graft
34842	Endovasc visc aorta 2 graft
34843	Endovasc visc aorta 3 graft
34844	Endovasc visc aorta 4 graft
34845	Visc & infraren abd 1 prosth
34846	Visc & infraren abd 2 prosth
34847	Visc & infraren abd 3 prosth
34848	Visc & infraren abd 4+ prost

continued

The following reimbursement information applies:

- Pricing: Manually priced when billed on a *CMS-1500* claim form (or electronic equivalent); reimburses 20% of billed charges
- Prior authorization (PA): Required
- Billing guidance: Standard billing guidance applies; codes are not reimbursable in the outpatient setting

These changes will be reflected in the next regular update to the *Professional Fee Schedule* at indianamedicaid.com.

Reimbursement, PA, and billing information apply to services delivered under the fee-for-service (FFS) delivery system. Questions about FFS PA should be directed to Cooperative Managed Care Services (CMCS) at 1-800-269-5720. Individual managed care entities (MCEs) establish and publish reimbursement, PA, and billing criteria within the managed care delivery system. Questions about managed care billing and PA should be directed to the MCE with which the member is enrolled.

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IHCP reminds providers of policy alignment with Medicare for inpatient-only codes

The Indiana Health Coverage Programs (IHCP) reminds providers that IHCP follows Medicare policy with respect to inpatient-only procedure codes. Accordingly, the codes on the Medicare Inpatient Only (IPO) list published by the Centers for Medicare & Medicaid Services (CMS) are covered by IHCP in the inpatient setting only.

As an additional reference for providers, IHCP will add a column to the *Outpatient Fee Schedule* to identify those codes that are included on the Medicare IPO list. In the new column, “Yes” will be indicated for codes that are considered ”inpatient-only” and “No” will be indicated for codes that are not on the Medicare IPO list.

Additionally, IHCP clarifies that the *Procedure Codes Payable as an Inpatient Service When Delivered in an Inpatient Setting for Stays of Less Than 24 Hours* code table published on indianamedicaid.com is not meant to be a full listing of inpatient-only codes recognized by IHCP. Rather, this code table is a subset of procedure codes from the Medicare IPO list that IHCP has determined to be billable as an inpatient procedure, even when the member is in the hospital for less than 24 hours. Please refer to the *Inpatient Hospital Services* provider reference module at indianamedicaid.com for further clarification of the IHCP’s inpatient policies.

Certain procedure codes no longer considered inpatient-only

The Centers for Medicare & Medicaid Services (CMS) removed the procedure codes in Table 4 from the Medicare Inpatient-Only (IPO) list. Accordingly, effective July 20, 2018, the Indiana Health Coverage Programs (IHCP) will no longer consider these procedure codes as inpatient-only codes. The codes in Table 4 can be billed in the outpatient setting for dates of service (DOS) on or after July 20, 2018.

Because these codes are no longer considered inpatient-only, when billing these codes for inpatient stays of less than 24 hours, the codes should be billed as an outpatient service for discharge dates on or after July 20, 2018. The *Procedure Codes Payable as an Inpatient Service When Delivered in an Inpatient Setting for Stays of Less Than 24 Hours* code table under *Inpatient Hospital Services Codes* on the Code Sets page at indianamedicaid.com will be updated to reflect this change.

Table 4 – Procedure codes no longer considered inpatient-only codes, effective for DOS on or after July 20, 2018

Procedure code	Description
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (list separately in addition to code for primary procedure
20938	Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (list separately in addition to code for primary procedure)
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (list separately in addition to code for separate procedure)
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than decompression); each additional interspace (list separately in addition to code for primary procedure)
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (list separately in addition to code for primary procedure)
22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (list separately in addition to code for primary procedure)
22845	Anterior instrumentation; 2 to 3 vertebral segments (list separately in addition to code for primary procedure)
27477	Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)

ASC pricing indicators assigned to CPT codes 27477 and 27485

Effective July 20, 2018, the Indiana Health Coverage Programs (IHCP) will assign the Current Procedural Terminology (CPT®[1]) procedure codes in Table 5 the ambulatory surgical center (ASC) pricing indicator of H. The IHCP will reimburse for these codes retroactively as outpatient services for dates of service (DOS) on or after **January 1, 2018**.

Table 5 – ASC pricing indicators assigned, effective for DOS on or after January 1, 2018

Procedure code	Description	ASC Pricing Indicator
27477	Arrest, epiphyseal, any method (eg, epiphysiodesis); tibia and fibula, proximal	H
27485	Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula (eg, genu varus or valgus)	H

Beginning July 20, 2018, providers that received denials for claims for these codes with DOS on or after January 1, 2018, with explanation of benefits (EOB) 4108 – *There is no ASC on file for this procedure code. Please verify that the appropriate outpatient surgery code was billed,* may resubmit those claims for reimbursement consideration.

This change will be reflected in the next regular update to the *Outpatient Fee Schedule* at indianamedicaid.com. The ASC rates can be found on the ASC Codes and Rates tab of the fee schedule.

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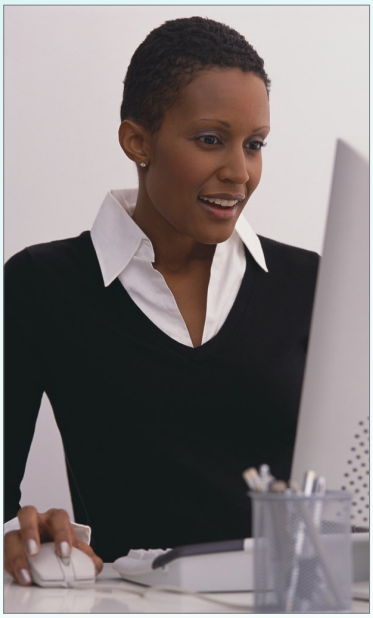
PRTF PA request attachments via the Portal

Effective June 28, 2018, the Indiana Health Coverage Programs (IHCP) will amend its prior authorization (PA) attachments policy specific to Psychiatric Residential Treatment Facility (PRTF) Provider Healthcare Portal (Portal) electronic PA requests. Providers will be able to submit the required attachment information electronically through the Portal. However, PRTF forms will still be accepted via fax or mail.



The electronic attachment feature will automatically display the *PRTF Admission Assessment Form* when the selected Service Type is Residential Psychiatric Treatment. If the requesting provider selects System Update for a previously approved PRTF Service Type PA request, the system will provide the option to display the *PRTF Extension Request Form*. The electronic forms will contain all the information previously contained on the paper forms.

For additional information about requesting prior authorizations electronically through the Portal, please refer to the *Prior Authorization* and the *Provider Healthcare Portal* provider reference modules at indianamedicaid.com.

QUESTIONS?

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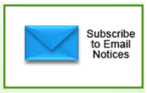

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