IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201826 JUNE 26, 2018

IHCP to cover CPT code 0398T

Effective July 26, 2018, the Indiana Health Coverage Programs (IHCP) will cover Current Procedural Terminology (CPT®[1]) code 0398T– *Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed.* 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 26, 2018.

The following reimbursement information applies:

- Pricing:
  - Outpatient (*UB-04*) – Maximum fee of $17,500.50 or surgical ASC pricing indicator "M"
  - Professional (*CMS-1500* or *CMS-1500* crossover) – Paid at 90% of billed charges
- Prior authorization (PA): Yes
- Billing guidance: Standard billing guidance applies

PA requires the following criteria be met for coverage of procedure code 0398T for treatment of essential tremors (ET):

- Medication refractory ET, defined as refractory to at least two trials of medical therapy, including at least one first-line agent
- Moderate to severe postural or intention tremor of the dominant hand, defined by a score of ≥2 on the Clinical Rating Scale for Tremor (CRST)
- Disabling ET, defined by a score of ≥2 on any of the eight items in the disability subsection of the CRST
- Not a surgical candidate for deep brain stimulation (DBS) (for example, advanced age, anticoagulant therapy, or surgical comorbidities)

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Code 0398T will not be covered for the following indications or conditions:

- Treatment of head or voice tremor
- Bilateral thalamotomy
- A neurodegenerative condition
- Unstable cardiac disease
- Coagulopathy
- Risk factors for deep-vein thrombosis
- Severe depression – Defined by a score ≥20 on the Patient Health Questionnaire (PHQ-9)
- Cognitive impairment – Defined by a score of <24 on the Mini-Mental State Examination
- Previous brain procedure (transcranial magnetic stimulation, DBS, stereotactic lesioning, or electroconvulsive therapy)
- A skull density ratio (the ratio of cortical to cancellous bone) <0.45
- Magnetic resonance imaging (MRI) contraindicated

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

ASC pricing indicator assigned to CPT code 27447

Effective July 27, 2018, the Indiana Health Coverage Programs (IHCP) will assign the Current Procedural Terminology (CPT) code CPT 27447 – *Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)* the ambulatory surgical center (ASC) pricing indicator of "M." The IHCP will cover this CPT code as an outpatient service retroactively for dates of service (DOS) on or after **January 1, 2018**.

Beginning July 27, 2018, providers that received denials for claims for this code 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. Claims beyond the one-year original filing limit must include a copy of this banner page as an attachment and must be filed within one year of the publication date.

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.

CPT codes 77425, 80500, and 80502 assigned maximum fee pricing

Effective July 26, 2018, the Indiana Health Coverage Programs (IHCP) will assign maximum fee pricing to the Current Procedural Terminology (CPT) codes in Table 1 for services rendered in the outpatient setting. These pricing changes apply to outpatient services with dates of service (DOS) on or after July 26, 2018.

Table 1 – CPT codes assigned maximum fee pricing for outpatient services, effective July 26, 2018

Procedure code	Description
77425	Intraoperative electrons radiation treatment single session
80500	Clinical pathology consultation
80502	Comprehensive, clinical pathology consultation

The pricing change and the rates for these codes will be reflected in the next regular update to the *Outpatient Fee Schedule* at indianamedicaid.com.

New skin substitute HCPCS codes linked to revenue code 636

Effective July 27, 2018, the Indiana Health Coverage Programs (IHCP) will link the Healthcare Common Procedure Coding System (HCPCS) codes in Table 2 to revenue code 636 – *Pharmacy-Extension of 025X-Drugs requiring detailed coding*. These linkages apply **retroactively** to fee-for-service (FFS) claims with dates of service (DOS) on or after **January 1, 2018**.

Table 2 – Skin substitute codes linked to revenue code 636, effective for DOS on or after January 1, 2018

Procedure code	Description
Q4176	NeoPatch, per sq cm
Q4177	FlowerAmnioFlo, 0.1 cc
Q4178	FlowerAmnioPatch, per sq cm
Q4179	FlowerDerm, per sq cm
Q4180	Revita, per sq cm
Q4181	Amnio Wound, per sq cm
Q4182	Transcyte, per sq cm

Beginning July 27, 2018, providers may bill the HCPCS codes in Table 2 with revenue code 636, as appropriate, for reimbursement consideration. Claims with DOS on or after January 1, 2018, that previously denied for explanation of benefits (EOB) 520 – *Invalid revenue code and procedure code combination* may be resubmitted. Claims beyond the one-year original filing limit must include a copy of this banner page as an attachment and must be filed within one year of the publication date.

continued

These linkages will be reflected in the *Revenue Codes Linked to Specific Procedure Codes* tables on the Code Sets web page and in the next regular update to the *Outpatient Fee Schedule* at indianamedicaid.com.

IHCP enforces restrictions on dental services through new system audits

The Indiana Health Coverage Programs (IHCP) reminds dental providers that IHCP coverage, coverage restrictions, and billing guidance for dental services are published in the *Medical Policy Manual* and the *Dental Services* provider reference module, available at indianamedicaid.com. The IHCP follows standard American Dental Association (ADA) billing guidance unless guidance is otherwise stipulated in these reference documents.

Current IHCP coverage policy and billing guidance, as well as ADA billing guidance, restricts the reimbursement of certain dental services on the same date of service (DOS). Effective August 1, 2018, the IHCP has enhanced the *Core*MMIS claim-processing system with additional system audits to enforce these restrictions for those dental codes most commonly billed in error. The dental services that are the focus of the new audits are as follows:

- Periodontal services and adult/child prophylaxis services should not be billed on the same DOS. Prophylaxis is considered a preventative procedure for healthy tissue, whereas periodontal services are therapeutic procedures.
- A full-mouth complete series of radiograph images should not be billed on the same DOS as bitewings and/or periapical radiograph images. The complete series is inclusive of bitewings and periapical radiographs.
- Sutures are considered a part of a general extraction and both should not be billed on the same DOS, except when sutures are needed unrelated to the extraction. If this occurs, sutures are payable separately from the extraction. Providers must submit written documentation with the claim to support that the suture is unrelated to the extraction being billed (that is, the suture is in another part of the mouth).

The ADA codes associated with the services described above are listed in Table 3. **Please note that the Current Dental Terminology (CDT®[1]) codes in the table are not a comprehensive list of dental codes that should not be billed on the same DOS, but represent those most commonly billed incorrectly that are being addressed by new system audits.** Dental providers should continue to follow standard ADA billing guidance to understand which other services are not separately reimbursable on the same DOS.

[1]*CDT copyright 2018 American Dental Association. All rights reserved. CDT is a registered trademark of the American Dental Association.*

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Fee-for service (FFS) dental claims billed with the code combinations in Table 3 on the same DOS will deny with explanation of benefits (EOB) 6430 – *This dental service is not payable with another service on the same date of service.*
Managed care entities (MCEs) establish billing and reimbursement guidance for managed care programs. Questions about the billing and reimbursement of dental services for members enrolled in Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise should be directed to the MCE with which the member is enrolled.

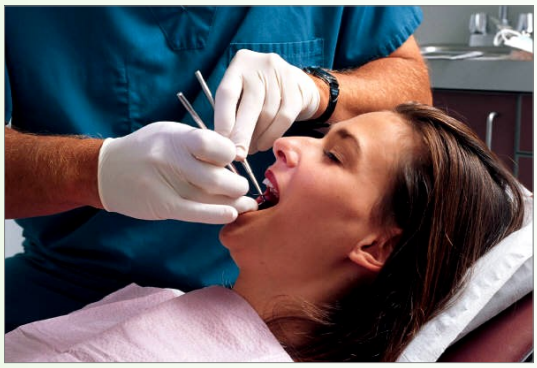


Table 3 – Dental code combinations not reimbursable on the same DOS, to be enforced through CoreMMIS claim-processing audits

Restrictions	Global CDT codes and descriptions			Component CDT codes and descriptions		
Periodontal services not covered for same DOS as prophylaxis	Periodontal scaling and root planing	D4341	Periodontal scaling and root planing-four or more teeth per quadrant	Prophylaxis	D1110	Prophylaxis (adult)
		D4342	Periodontal scaling and root planing-one to three teeth per quadrant		D1120	Prophylaxis (child)
	Full mouth debridement	D4355	Full mouth debridement			
Radiograph images not covered for same DOS as bitewing or periapical images	Full mouth radiograph series	D0210	Intraoral-complete series of radiograph images	Bitewings	D0270	Bitewing (single radiographic image)
					D0272	Bitewings (two radiographic images)
					D0273	Bitewings (three radiographic images
					D0274	Bitewings (four radiographic images)
					D0277	Vertical bitewings (7 to 8 radiographic images)
				Periapical images	D0220	Intraoral-periapical first radiographic image
					D0230	Intraoral-periapical each additional radiographic image

continued

Table 3 – Dental code combinations not reimbursable on the same DOS, to be enforced through CoreMMIS claim-processing audits (continued)

Restrictions	Global CDT codes and descriptions			Component CDT codes and descriptions		
Extraction services not covered for same DOS as suture procedures (without medical documentation)	Extractions	D7111	Extraction, coronal remnants (deciduous tooth)	Sutures	D7910	Suture of recent small wounds (up to 5 cm)
		D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)		D7911	Complicated suture (up to 5 cm)
		D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		D7912	Complicated suture (greater than 5 cm)
		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	Surgical removal of residual tooth roots (cutting procedure)			
		D7251	Coronectomy-intentional partial tooth removal			

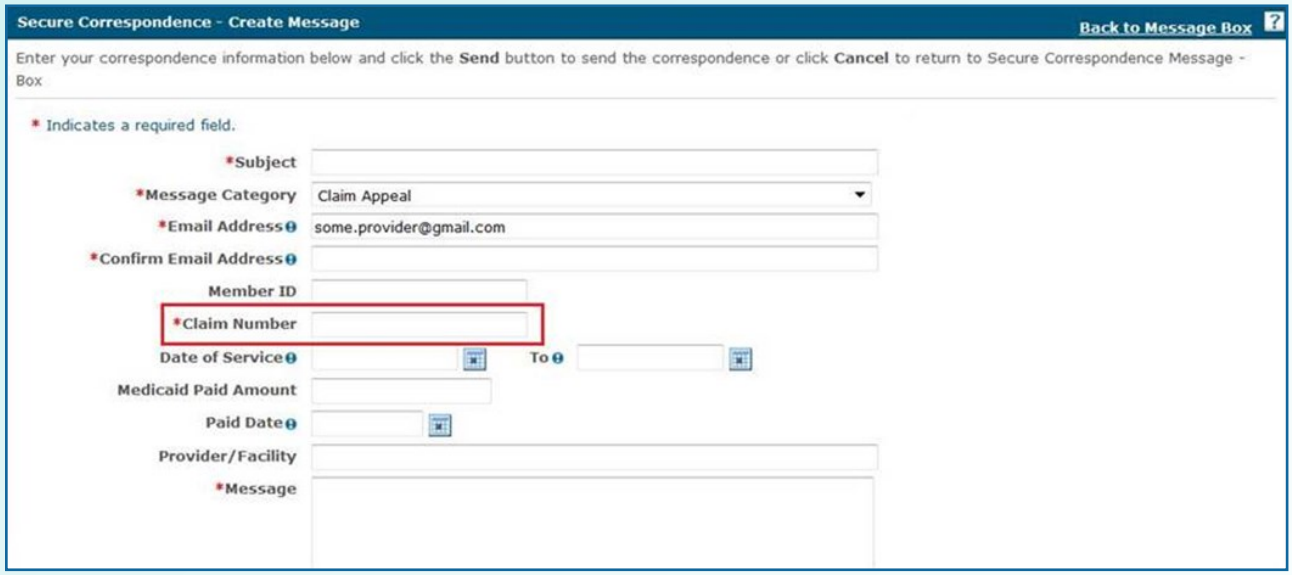
Claim number required for claim administrative review requests and claim appeals

Effective June 28, 2018, the Indiana Health Coverage Programs (IHCP) Provider Healthcare Portal (Portal) will be updated to require a claim number be entered when submitting a Claim Administrative Review Request or Claim Appeal through the Secure Correspondence function. When providers select one of these two options from the Message Category drop-down menu, the claim number will appear as a required field (see Figure 1).

continued

The provider will not be able to submit the secure correspondence unless this field is completed. If the claim number entered is invalid, the provider will receive an error message, "Claim Number is not found." The claim number continues to be optional for other message categories.

Figure 1 – Secure Correspondence displays Claim Number as a required field for claim administrative review requests and claim appeals



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