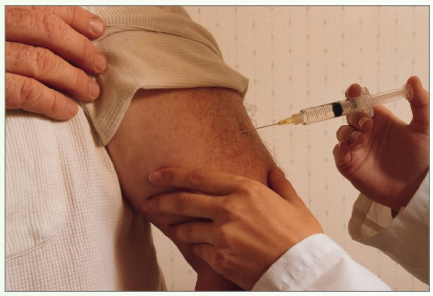
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201832 AUGUST 7, 2018

IHCP to cover CPT code 90750

Effective September 7, 2018, the Indiana Health Coverage Programs (IHCP) will cover Current Procedural Terminology (CPT®[1]) code 90750 – *Shingrix (Zoster Vaccine Recombinant, Adjuvanted)*. The Food and Drug Administration (FDA) approved the product Shingrix in October 2017 for patients 50 years of age and older. Shingrix is administered in a 2-dose series with the second dose given 2 to 6 months after the first dose. Members are restricted to one 2-dose series in a lifetime. Coverage applies to all IHCP programs, subject to limitations established for certain benefit plans. Coverage applies to dates of service (DOS) on or after September 7, 2018.

The following reimbursement information applies:



- Pricing: Maximum fee of $147.00
- Prior authorization: None required
- Billing guidance: 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 the revenue code together, as appropriate.

Reimbursement, PA, 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 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.

This information will be reflected in the *Revenue Codes Linked to Specific Procedure Codes* table on the Code Sets web page, and in the next regular updates to the *Professional Fee Schedule* and the *Outpatient Fee Schedule* at indianamedicaid.com.

MORE IN THIS ISSUE

IHCP will no longer allow outpatient reimbursement for certain procedure codes

Effective September 10, 2018, the Indiana Health Coverage Programs (IHCP) will no longer allow reimbursement of the Current Procedural Terminology (CPT®[1]) codes in Table 1 in the outpatient setting. This change applies to all IHCP programs, subject to limitations established for certain benefit packages, for dates of service (DOS) on or after September 10, 2018.

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

Table 1 – Procedure codes no longer reimbursable in the outpatient setting, effective for DOS on or after September 10, 2018

Procedure code	Description
92559	Audiometric testing of groups
99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)
0042T	Cerebral perfusion analysis using computed tomography with contrast administration, including post-processing of parametric maps with determination of cerebral blood flow, cerebral blood volume, and mean transit time
0111T	Long-chain (C20-22) omega-3 fatty acids in red blood cell (RBC) membranes
0235T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; visceral artery (except renal), each vessel

IHCP to allow outpatient reimbursement for certain procedure codes

Effective September 10, 2018, the Indiana Health Coverage Programs (IHCP) will allow reimbursement of the Current Procedural Terminology (CPT®[1]) and Healthcare Common Procedure Coding System (HCPCS) codes in Table 2 in the outpatient setting when they are billed with the appropriate revenue codes on a *UB-04* (institutional) claim. This change applies to all IHCP programs, subject to limitations established for certain benefit packages, for dates of service (DOS) on or after September 10, 2018.

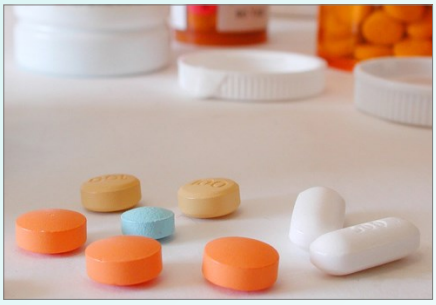
This change will be reflected in the next regular update to the *Outpatient Fee Schedule* at indianamedicaid.com.

continued

Table 2 – Procedure codes reimbursable in the outpatient setting,
effective for DOS on or after September 10, 2018

Procedure code	Description	Pricing
99188	Application of topical fluoride varnish by a physician or other qualified health care professional	Flat rate
J7604	Acetylcysteine, inhalation solution, compounded product, administered through DME, unit dose form, per g	Flat rate
J7676	Pentamidine isethionate, inhalation solution, compounded product, administered through DME, unit dose form, per 300 mg	Flat rate

IHCP assigns maximum-fee pricing for HCPCS codes A9517 and A9563



Effective September 10, 2018, the Indiana Health Coverage Programs (IHCP) will assign maximum-fee pricing to the Healthcare Common Procedure Coding System (HCPCS) codes in Table 3. The maximum-fee amount for each code is noted in the table. This pricing applies to outpatient services with dates of service (DOS) on or after September 10, 2018. Outpatient pricing applies to services rendered under the fee-for-service (FFS) and the managed care delivery systems; some exceptions apply to Healthy Indiana Plan (HIP). Providers should contact the enrolling managed care entity (MCE) regarding outpatient pricing for HIP members.

These pricing changes will be reflected in the next monthly update to the *Outpatient Fee Schedule* at indianamedicaid.com.

Table 3 – Maximum-fee pricing assigned for outpatient services,
effective for DOS on or after September 10, 2018

Procedure code	Description	Maximum-fee amount
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	$19.98
A9563	Sodium phosphate P-32, therapeutic, per millicurie	$256.00

IHCP to mass reprocess or mass adjust outpatient claims that may have adjudicated incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a number of claim-processing issues that affect fee-for-service (FFS) outpatient claims processed on or after February 13, 2017. Outpatient claims billed with certain procedure codes may have been denied or paid incorrectly due to pricing and other system discrepancies associated with outpatient reimbursement.

The claim-processing system issues have been corrected. Affected claims will be mass reprocessed or mass adjusted, as appropriate. Providers should see the mass reprocessed and mass adjusted claims on Remittance Advices (RAs) beginning September 19, 2018, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims) or 52 (mass replacement non-check related). For claims that were underpaid, the net difference will be paid and reflected on the RA. If a claim was overpaid, the net difference appears as an accounts receivable. The accounts receivable will be recouped at 100% from future claims paid to the respective provider number.

IHCP to assign ASC pricing indicators to certain surgical procedure codes

Effective September 7, 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 4 and Table 5. With this change, the IHCP will reimburse these codes as outpatient services. This change applies to fee-or-service (FFS) and managed care outpatient services.

The ASC pricing indicator assignments will apply **retroactively** to dates of service (DOS) as follows:

- For codes in Table 4, the assignment applies to DOS on or after **January 1, 2017.**
- For codes in Table 5 the assignment applies to DOS on or after **January 1, 2018**.

Beginning September 7, 2018, fee-for-service claims for these codes billed for the affected DOS that denied for 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 be resubmitted for reimbursement consideration. Claims 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 should contact the individual managed care entities for billing guidance regarding managed care claims affected by this change.

This change will be reflected in the next regular update to the *Outpatient Fee Schedule* at indianamedicaid.com. The rates associated with ASC pricing indicators is listed in the ASC Code/Rate table, available on the *IHCP Fee Schedules* web page.

continued

Table 4 – ASC pricing indicators assigned to CPT codes, effective for DOS on or after January 1, 2017

Procedure code	Description	ASC pricing indicator
31584	Laryngoplasty; with open reduction and fixation of (eg, plating) fracture, includes tracheostomy, if performed	G
31587	Laryngoplasty, cricoid split, without graft placement	G

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

Procedure code	Description	ASC pricing indicator
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	M
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	H
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	G
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	H
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	M

CPT 92941 no longer reimbursable in the outpatient setting

The Centers for Medicare & Medicaid Services (CMS) added Current Procedural Terminology (CPT®[1]) code 92941 - *Insertion of stent, removal of plaque and/or balloon dilation of coronary vessel during heart attack, accessed through the skin*, to Medicare's Inpatient-Only (IPO) list. Accordingly, effective September 7, 2018, the Indiana Health Coverage Programs (IHCP) will no longer reimburse CPT 92941 in the outpatient setting. This change applies to all IHCP programs, subject to limitations established for certain benefit packages for dates of service (DOS) on or after September 7, 2018.

The change will be reflected in the next regular update to the *Outpatient Fee Schedule* at indianamedicaid.com. The change does not affect how CPT 92941 is billed and reimbursed on *CMS-1500* (professional) claims.

IHCP updates FQHC and RHC encounter codes

Effective August 15, 2018, the Indiana Health Coverage Programs (IHCP) will add the Current Procedural Terminology (CPT®[1]) and Healthcare Common Procedure Coding System (HCPCS) codes in Table 6 as valid federally qualified health center (FQHC) and rural health clinic (RHC) encounter codes. This update applies **retroactively** to dates of service (DOS) on or after **January 1, 2018**.

Beginning August 15, 2018, FQHC and RHC providers may submit fee-for-service (FFS) claims for these codes for DOS on or after January 1, 2018; claims for these codes for the affected DOS that previously denied may be resubmitted. 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.

The IHCP will remove the nationally deleted codes in Table 7 from the list of valid FQHC and RHC encounter codes. This change applies retroactively to DOS on or after **January 1, 2018,** and will have no impact on previously adjudicated FFS claims.

The list of valid FQHC and RHC encounter codes is reviewed periodically to account for new and end-dated CPT and HCPCS codes, and is available on the Myers and Stauffer website at in.mslc.com. If you have questions, contact Berry Bingaman, Myers and Stauffer LC, at (317) 846-9521.

Table 6 – Procedure codes added as valid FQHC and RHC encounter codes, effective for DOS on or after January 1, 2018

Procedure code	Description
31298	Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (eg, balloon dilation)
41010	Incision of tissue connecting tongue and floor of mouth
41115	Removal of tissue connecting tongue and floor of mouth
D5511	Repair broken complete denture base, mandibular
D5512	Repair broken complete denture base, maxillary
D5611	Repair resin partial denture base, mandibular
D5612	Repair resin partial denture base, maxillary
D5621	Repair cast partial framework, mandibular
D5622	Repair cast partial framework, maxillary
D6096	Remove broken implant retaining screw
D7296	Corticotomy-one to three teeth or tooth spaces, per quadrant
D7297	Corticotomy - four or more teeth or tooth spaces, per quadrant
D7979	Non-surgical sialolithotomy

continued

Table 6 – Procedure codes added as valid FQHC and RHC encounter codes, effective for DOS on or after January 1, 2018 (continued)

Procedure code	Description
D9222	Deep sedation/general anesthesia - first 15 minutes
D9239	Intravenous moderate (conscious sedation/analgesia - first 15 minutes)
G0516	Insertion of non-biodegradable drug delivery implants, 4 or more (services for subdermal rod implant)
G0517	Removal of non-biodegradable drug delivery implants, 4 or more (services for subdermal implants)
G0518	Removal with reinsertion, non-biodegradable drug delivery implants, 4 or more (services for subdermal implants)

Table 7 – Procedure codes no longer valid as FQHC and RHC encounter codes, effective for DOS on or after January 1, 2018

Procedure code	Description
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated
0178T	Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; with interpretation and report
0179T	Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; tracing and graphics only, without interpretation and report
0180T	Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; interpretation and report only
D5510	Repair broken complete denture base
D5610	Repair resin denture base
D5620	Repair cast framework

QUESTIONS?

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