IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR201834 AUGUST 21, 2018

IHCP to cover HCPCS code J9320

Effective September 21, 2018, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code J9320 – *Injection, streptozocin, 1 g*. Coverage applies to all IHCP programs, subject to limitations established for certain benefit plans, with dates of service (DOS) on or after September 21, 2018.

The following reimbursement information applies:

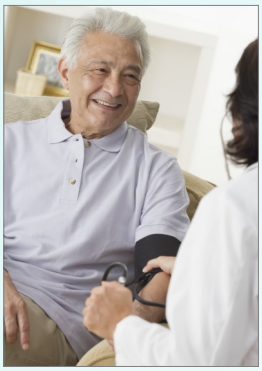
- Pricing: Maximum fee
- Prior authorization (PA): None required
- Billing guidance:
  - Separate reimbursement is allowed under revenue code 636 – *Pharmacy-Extension of 025X-Drugs Requiring Detailed Coding.* For reimbursement consideration, providers may bill the procedure code and the revenue code together, as appropriate.
  - Must be billed with the National Drug Code (NDC) of the product administered

Reimbursement, PA, and billing information applies 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 updates to the *Procedure Codes That Require NDCs* and the *Revenue Codes Linked to Specific Procedure Codes* code tables 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

HCPCS codes for certain brachytherapy services to be covered in the outpatient setting



Effective September 21, 2018, the Indiana Health Coverage Programs (IHCP) will cover the Healthcare Common Procedure Coding System (HCPCS) codes in Table 1 for brachytherapy services in the outpatient setting, including outpatient crossover claims. These codes are not separately reimbursable on professional *CMS-1500* claims. Coverage will apply to all IHCP programs, subject to limitations established for certain benefit plans, and for dates of service (DOS) on or after September 21, 2018.

The following reimbursement information applies:

- Pricing: Maximum fee, manually-priced, or ASC rate assigned, as appropriate
- Prior authorization (PA): See Table 1
- Billing guidance: See Table 1

These changes will be reflected in the next regular updates to the *Professional Fee Schedule* and the *Outpatient Fee Schedule* at indianamedicaid.com. The *Revenue Codes Linked to Specific Procedure Codes* table on the Code Sets web page of the website will be updated to reflect the codes linked to revenue code 636 – *Pharmacy-Extension of 025X-Drugs Requiring Detailed Coding*.

Table 1 – Brachytherapy services codes covered in the outpatient setting, effective for DOS on or after September 21, 2018

Procedure code	Description	PA required	Special revenue code linkage
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	No	RC 636
C1716	Brachytherapy source, non-stranded, gold-198, per source	No	RC 636
C1717	Brachytherapy source, non-stranded, high dose rate iridium 192, per source	No	RC 636
C1719	Brachytherapy source, non-stranded, non-high dose rate iridium-192, per source	No	RC 636
C2616	Brachytherapy source, non-stranded, yttium-90, per source	Yes	RC 636
C2634	Brachytherapy source, non-stranded, high activity, iodine-125, greater than 1.01 mci (NIST), per source	No	RC 636
C2635	Brachytherapy source, non-stranded, high activity, palladium-103, greater than 2.2 mci (NIST), per source	No	RC 636
C2636	Brachytherapy linear source, non-stranded, palladium-103, per 1 mm	No	RC 636
C2637	Brachytherapy source, non-stranded, Ytterbium-169, per source	No	RC 636
C2638	Brachytherapy source, stranded, iodine-125, per source	No	RC 636

continued

Table 1 – Procedure codes covered in the outpatient setting, effective for DOS on or after September 21, 2018 (continued)

Procedure code	Description	PA required	Special revenue code linkage
C2639	Brachytherapy source, non-stranded, iodine-125, per source	No	RC 636
C2640	Brachytherapy source, stranded, palladium-103, per source	No	RC 636
C2641	Brachytherapy source, non-stranded, palladium-103, per source	No	RC 636
C2642	Brachytherapy source, stranded, cesium-131, per source	No	RC 636
C2643	Brachytherapy source, non-stranded, cesium-131, per source	No	RC 636
C2644	Brachytherapy source, cesium-131 chloride solution, per millicurie	No	RC 636
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	No	RC 636
C2645	Brachytherapy planar source, palladium-103, per square millimeter	No	RC 636
C2698	Brachytherapy source, stranded, not otherwise specified, per source	No	RC 636
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	No	RC 636
C9725	Placement of endorectal intracavitary applicator for high intensity brachytherapy	No	None
C9726	Placement and removal (if performed) of applicator into breast for intraoperative radiation therapy, add-on to primary breast procedure	No	None
C9728	Placement of interstitial device(s) for radiation therapy/ surgery guidance (e.g., fiducial markers, dosimeter), for other than the following sites (any approach): abdomen, pelvis, prostate, retroperitoneum, thorax, single or multiple	No	None

IHCP to assign ASC pricing indicator to CPT code 21044

Effective September 21, 2018, the Indiana Health Coverage Programs (IHCP) will assign Current Procedural Terminology (CPT®[1]) code 21044 – *Excision of malignant tumor of mandible* an ambulatory surgical center (ASC) pricing indicator of G. The IHCP will reimburse for this CPT code as an outpatient service for dates of service (DOS) on or after September 21, 2018. This change applies to fee-for-service (FFS) and managed care outpatient services.

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

Providers may resubmit institutional claims for certain procedure codes that denied inappropriately

The Indiana Health Coverage programs (IHCP) has identified a claim-processing issue that affects certain institutional claims. Fee-for-service (FFS) claims for the procedure codes in Table 2, for the dates of service (DOS) indicated, may have denied inappropriately for one of the following explanation of benefits (EOB):

- EOB 4014 – *Claim being reviewed for pricing*
- EOB 4107 – *Revenue code or type of claim is not appropriate / not covered for the type of service or type of provider*

Table 2 – Procedure codes that denied inappropriately for the indicated DOS, which may be resubmitted

Procedure code	Description	DOS on or after
90800	Unlisted psychiatric service or procedure	January 1, 2017
A9604	Samarium sm-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries	April 1, 2018
J0132	Injection, acetylcysteine, 100 mg	January 1, 2017
J0178	Injection, aflibercept, 1 mg	January 1, 2017
J1572	Injection, immune globulin, (Flebogamma/Flebogamma Dif), intravenous, nonlyophilized (e.g., liquid), 500 mg	October 10, 2017
J1670	Injection, tetanus immune globulin, human, up to 250 units	April 1, 2017
J9262	Injection, omacetaxine mepesuccinate, 0.01 mg	April 1, 2018
P9100	Pathogen(s) test for platelets	January 1, 2018

The claim-processing system has been corrected. Beginning immediately, providers may resubmit institutional claims for the affected codes and DOS that previously denied for EOB 4014 or 4107, 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.

IHCP clarifies HCPCS code K0010 is noncovered

As previously announced in Indiana Health Coverage Programs (IHCP) *Bulletin* BT200832, K0010 – *Standard-weight frame motorized/power wheelchair* is one of the codes for Power Mobility Devices (PMD) that is noncovered. This code was incorrectly listed in the *Core*MMIS claim-processing system as covered. The system has been corrected. No previously processed fee-for-service (FFS) claims will be affected by this correction.

This correction will be reflected in the *Durable and Home Medical Equipment and Supplies Codes* table on the Code Sets web page and in the *Professional Fee Schedule* at indianamedicaid.com.

IHCP will mass reprocess crossover physician claims that may have denied inappropriately

The Indiana Health Coverage Program (IHCP) identified a claim-processing issue that affects crossover physician claims from Medicare (claim type B) that processed from January 1, 2018, through August 6, 2018. Fee-for-service (FFS) crossover physician claims may have inappropriately denied for explanation of benefits (EOB) 1010 – *Rendering Provider is not an eligible member of billing group or the group provider number is reported as the rendering provider. Please verify provider number and resubmit.*

The claim-processing issue is due to the way claims were passed through Medicare to the IHCP. Claims processed during the indicated time frame that previously denied for EOB 1010 will be mass reprocessed. Effective August 7, 2018, until further notice, EOB 1010 has been converted to a "post-and-pay" status for crossover physician claims only. A "post-and-pay" status means the claim-processing system allows claims and claim details subject to EOB 1010 to pay, even though the EOB 1010 message continues to post on the provider's Remittance Advice (RA). EOB 1010 will continue to be enforced on other claim types. Providers should see the reprocessed claims on RAs beginning September 25, 2018, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims).

HCPCS codes J2860 and J7503 linked to revenue code 636

Effective September 21, 2018, the Indiana Health Coverage Programs (IHCP) will link the Healthcare Common Procedure Coding System (HCPCS) codes in Table 3 to revenue code 636 – *Pharmacy-Extension of 025X-Drugs Requiring Detailed Coding.* These linkages will apply **retroactively** to fee-for-service (FFS) and managed care outpatient claims for dates of service (DOS) on or after **February 13, 2017**.

Table 3 – HCPCS codes linked to revenue code 636, effective for DOS on or after February 13, 2017

Procedure code	Description
J2860	Injection, siltuximab, 10 mg
J7503	Tacrolimus, extended release, oral, 0.25 mg

Beginning September 21, 2018, providers may bill HCPCS code J2860 or J7503 with revenue code 636 together, as appropriate, for reimbursement consideration. FFS Claims for DOS on or after February 13, 2017, 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. Providers should contact the appropriate managed care entity (MCE) for proper billing instructions regarding affected managed care claims.

These linkages will be reflected in the next regular update to the *Outpatient Fee Schedule* at indianamedicaid.com. The revenue code linkages will also be reflected in the *Revenue Codes Linked to Specific Procedure Codes* table on the Code Sets web page of the website.

IHCP to assign maximum fee pricing to CPT codes for outpatient services

Effective September 21, 2018, the Indiana Health Coverage Programs (IHCP) will assign maximum fee pricing to the Current Procedural Terminology (CPT®[1]) codes in Table 4. This pricing applies to services rendered in the outpatient setting for dates of service (DOS) on or after September 21, 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.

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.

Table 4 – CPT codes assigned maximum fee pricing for outpatient services, effective for DOS on or after September 21, 2018

Procedure code	Description
49180	Biopsy, abdominal or retroperitoneal mass, percutaneous needle
49185	Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed
88366	In situ hybridization (eg, FISH), per specimen; each multiplex probe stain procedure
92227	Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral
95905	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report
95990	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed;
95991	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional
96002	Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles
96003	Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle

IHCP to assign maximum fee pricing to procedure codes 88344 and G0416

Effective September 21, 2018, the Indiana Health Coverage Programs (IHCP) will assign maximum fee pricing to the following procedure codes:

- 88344 – *Immunohistochemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure*
- G0416 – *Surgical pathology, gross and microscopic examinations, for prostate needle biopsy, any method*

This pricing applies to services rendered in the outpatient setting for dates of service (DOS) on or after September 21, 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.

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

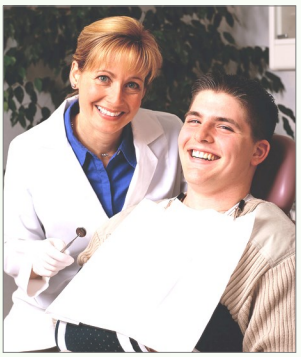
HCPCS code J2724 linked to revenue codes 636

Effective September 21, 2018, the Indiana Health Coverage Programs (IHCP) will link Healthcare Common Procedure Coding System (HCPCS) code J2724 – *Injection, protein C concentrate, intravenous, human, 10 IU* to revenue code 636 – *Pharmacy-Extension of 025X-Drugs Requiring Detailed Coding*. This linkage applies **retroactively** to fee-for-service (FFS) and managed care outpatient claims with dates of service (DOS) on or after **January 1, 2017**.

Beginning September 21, 2018, providers may bill HCPCS code J2724 and revenue code 636 together as appropriate, for reimbursement consideration. FFS claims with DOS on or after January 1, 2017, 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. Providers should contact the appropriate managed care entity (MCE) for proper billing instructions regarding affected managed care claims.

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

IHCP corrects system to apply tooth number restrictions on certain dental claims



The Indiana Health Coverage Programs (IHCP) identified a claim-processing issue that affects certain dental claims. As announced in *IHCP Banner Page BR201725*, the IHCP requires fee-for-service (FFS) dental claims to indicate tooth numbers when providers bill for certain Current Dental Terminology (CDT®[1]) codes. The dental codes in Table 5 are included in this requirement; however, in error, *Core*MMIS did not apply the tooth number restriction to these codes. The issue affects dental claims for these codes for dates of service (DOS) on or after July 20, 2017.

The claim-processing system has been corrected. Beginning immediately, claims processed for the codes in Table 5 will deny if the tooth number is not indicated on the claim. No action will be taken on previously adjudicated claims for these codes.

continued

Table 5 – Dental codes corrected in CoreMMIS to require tooth numbers on claims, for DOS on or after July 20, 2017

Dental code	Description
D1555	Removal of fixed space maintainer
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
D3353	Apexification/recalcification - final visit (includes completed root canal therapy-apical closure/calcific repair of perforations, root resorption, etc.)

This billing information applies to services delivered under the FFS delivery system. Individual managed care entities (MCEs) establish and publish billing information within the managed care delivery system. Questions about managed care billing should be directed to the MCE with which the member is enrolled.

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

IHCP revises EOB descriptions related to audit to enforce limits on clubhouse psychosocial rehabilitation services

As announced in Indiana Health Coverage Programs (IHCP) *Banner Page* *BR201833*, effective September 14, 2018, the IHCP will implement a new audit in *Core*MMIS to enforce the reimbursement limit for Healthcare Common Procedure Coding System (HCPCS) code H2014 HW to 8 units (2 hours) when billed for a member on the same date of service (DOS) as H2017 HW. The descriptions for the explanations of benefits (EOBs) associated with this audit have been revised slightly. The audit scenarios along with the revised EOB descriptions are republished below with the revised descriptions bolded for emphasis.

- If a claim for H2017 HW was previously adjudicated and a subsequent claim for H2014 HW is submitted for the same DOS, the subsequent claim will deny if the number of units billed for H2014 HW is greater than 8 units. The Remittance Advice (RA) will indicate EOB 6376 – ***H2014 HW is not payable with a quantity billed greater than 8 units, when H2017 HW has been paid in history for the same member by any provider. Please resubmit with allowed units***.
- If a claim for H2014 HW was previously adjudicated and a subsequent claim for H2017 HW is submitted for the same DOS, the IHCP will recoup payments previously made for H2014 HW if the number of units previously billed was greater than 8 units. The RA will indicate EOB 6377 – ***A previously paid H2014 HW with a quantity billed greater than 8 for the same date of service is being recouped. Please resubmit with allowed units***.

The other information published in *BR201833* is unchanged.

QUESTIONS?

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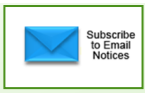

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