IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201909 FEBRUARY 26, 2019

Providers may resubmit medical claims for HCPCS code E0154 that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain fee-for-service (FFS) medical claims processed from October 10, 2018, through January 7, 2019. Claims billed for Healthcare Common Procedure Coding System (HCPCS) code E0154 – *Walker platform attachment* may have denied inappropriately with either of the following explanation of benefits (EOB):

- EOB 4014 – *Claim being reviewed for pricing*
- EOB 4209 – *No matching pricing segment for the procedure/modifier combo*

In error, the *Professional Fee Schedule* previously indicated that code E0154 required billing with modifier NU – *New equipment.* The *Professional Fee Schedule* has been corrected.

The claim-processing system has been corrected. Beginning immediately, providers may resubmit claims for procedure code E0154 that previously denied inappropriately for either EOB during the indicated time frame, for reimbursement consideration. This correction applies retroactively to claims processed **from October 10, 2018, through January 7, 2019**. Resubmitted claims should bill code E0154 **without** a modifier. Claims submitted beyond the timely filing limit must include a copy of this banner page as an attachment.

Note: Claims with dates of service (DOS) before January 1, 2019, must be resubmitted within 1 year of the banner page's publication date. Claims with DOS on or after January 1, 2019, must be resubmitted within 180 days of the banner page's publication date.

The *Professional Fee Schedule* is accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

MORE IN THIS ISSUE

Providers may resubmit claims for certain DME services that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain claims for Durable Medical Equipment (DME) services with dates of service (DOS) on or after July 1, 2018. Claims billed for the Healthcare Common Procedure Coding System (HCPCS) codes in Table 1 may have denied inappropriately with explanation of benefits (EOB) 6420 – *Service is limited to one unit per date of service.*

Table 1 – Procedure codes that may have denied inappropriately for EOB 6420, for DOS on or after July 1, 2018

Procedure code	Description
B4034	Enteral feeding supply kit; syringe fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape
B4035	Enteral feeding supply kit; pump fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape
B4036	Enteral feeding supply kit; gravity fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape
B4087	Gastrostomy/jejunostomy tube, standard, any material, any type, each
B4088	Gastrostomy/jejunostomy tube, low-profile, any material, any type, each
B4216	Parenteral nutrition; additives (vitamins, trace elements, heparin, electrolytes), home mix, per day
B4220	Parenteral nutrition supply kit; premix, per day
B4222	Parenteral nutrition supply kit; home mix, per day
B4224	Parenteral nutrition administration kit, per day
B9002	Enteral nutrition infusion pump, any type
B9004	Parenteral nutrition infusion pump, portable
B9006	Parenteral nutrition infusion pump, stationary
E0433	Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge
E1036	Multi-positional patient transfer system, extra-wide, with integrated seat, operated by caregiver, patient weight capacity greater than 300 lbs

The claim-processing system has been corrected. Beginning immediately, providers may resubmit claims for the codes in Table 1 that previously denied inappropriately for EOB 6420 during the indicated time frame, for reimbursement consideration. National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUEs) will continue to apply to these codes. This correction applies retroactively to claims with DOS on or after **July 1, 2018**. Claims resubmitted beyond the timely filing limit must include a copy of this banner page as an attachment.

Note: Claims with DOS before January 1, 2019, must be resubmitted within 1 year of the banner page's publication date. Claims with DOS on or after January 1, 2019, must be resubmitted within 180 days of the banner page's publication date.

IHCP to assign ASC pricing indicator to CPT code 22856

Effective March 29, 2019, the Indiana Health Coverage Programs (IHCP) will assign Current Procedural Terminology (CPT®[1]) code 22856 – *Total disc arthroplasty (artificial disc), anterior approach* an ambulatory surgical center (ASC) pricing indicator of M. The IHCP will reimburse for this CPT code as an outpatient service for dates of service (DOS) on or after March 29, 2019. This change applies to fee-for-service (FFS) and managed care outpatient services.

This change will be reflected in the next regular update to the *Outpatient Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers. The ASC rates associated with ASC pricing indicators are listed in the *ASC Code/Rate* table, also accessible from the *IHCP Fee Schedules* page.

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Procedure codes 95808, 95810, and 95811 linked to revenue codes 920, and 929 and assigned maximum fee pricing

Effective March 26, 2019, the Indiana Health Coverage Programs (IHCP) will link the Current Procedural Terminology (CPT®[1]) codes in Table 2 for polysomnography services in the outpatient setting to the following revenue codes. Additionally, the IHCP will assign maximum fee pricing to these procedure codes. These linkages and pricing will apply to fee-for-service (FFS) claims with dates of service (DOS) on or after March 26, 2019.

- Revenue code 920 – *Other Diagnostic Services-General*
- Revenue code 929 – *Other Diagnostic Services-Other Diagnostic Services*

Table 2 – Procedure codes linked to revenue codes 920 and 929 and assigned maximum fee pricing, effective March 26, 2019

Procedure code	Description
95808	Sleep monitoring of patient in sleep lab
95810	Sleep monitoring of patient (6 years or older) in sleep lab
95811	Sleep monitoring of patient (6 years or older) in sleep lab with continued pressured respiratory assistance by mask or breathing tube

Beginning March 26, 2019, providers may bill the procedure codes in Table 2 with either revenue code listed previously, as appropriate, for reimbursement consideration. This billing information applies to services delivered under the FFS delivery system. Individual managed care entities (MCEs) establish and publish reimbursement, prior authorization (PA), and billing criteria within the managed care delivery system. Questions about managed care billing should be directed to the MCE with which the member is enrolled.

This linkage will be reflected in the *Revenue Codes Linked to Specific Procedure Codes* table on the *Code Sets* web page, and the pricing in the next regular update to the *Outpatient Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

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IHCP reminds providers of early refill requirements for pharmacy claims reimbursement

The Indiana Health Coverage Programs (IHCP) reminds pharmacy providers of early refill requirements for pharmacy claims reimbursement. Policy requires at least 85% of prescription claim's days' supply to elapse to allow subsequent prescription claims to pay or Prior Authorization (PA) requests to be approved. Claims that bypass early-refill edits due to incorrect submission of days' supply are subject to audit and recovery. Use of the emergency supply override to bypass refill-too-soon rejections is strictly prohibited. A change in dose will be approved after confirmation from the pharmacy that 85% of the prescription claim's days' supply has elapsed with the dose change (for example, a dose change from 1 tablet to ½ tablet daily or twice daily would not constitute an early refill approval if 85% had not yet elapsed). Additional early refill scenarios for retail and long-term care pharmacies can be found in the *Pharmacy Services* provider reference module at in.gov/medicaid/providers.

IHCP reminds providers of requirements for medically accepted indication for drug reimbursement

Because of a recent increase in audit findings, the Indiana Health Coverage Programs (IHCP) reminds pharmacy providers of requirements for medically accepted indications for drug reimbursement. Based on federal law *42 United States Code 1396r-8*, a state may exclude or otherwise restrict coverage of a covered outpatient drug if the prescribed use is not for a medically accepted indication. The term "medically accepted indication" means any approved use for a covered outpatient drug under the *Federal Food, Drug, and Cosmetic Act*, or use that is supported by one or more citations included or approved for inclusion in any of the following compedia: American Hospital Formulary Service Drug Information, United Status Pharmacopeia-Drug Information (or its successor publications), the DRUGDEX Information System, as well as peer-reviewed medical literature. The following are the current most commonly identified drugs without member-appropriate medically accepted indications for use:

- *Nuedexta*
- *Doxepin*
- *Fluocinonide 0.1%*
- *EMLA*
- *Lidocaine*
- *Colistemethate*
- *Amphotericin B*
- *Ceftriaxone*
- *Voriconazole*
- *Solaraze*
- *Mupirocin*

For non-Food and Drug Administration (FDA)-approved indications (including appropriate duration for a medically accepted indication), pharmacy providers must review and document approved compedia indications and make them available for audit review upon request. Claims that do not have a medically accepted indication documented are subject to audit and recovery.

Please direct FFS pharmacy reimbursement questions to the OptumRx Clinical and Technical Help Desk by calling toll-free 1-855-577-6317. Questions regarding pharmacy benefits for members in the Healthy Indiana Plan (HIP), Hoosier Healthwise, and Hoosier Care Connect should be referred to the managed care entity with which the member is enrolled.

IHCP corrects revenue code for billing with procedure codes 99217 – 99220 published in *Banner Page BR201908*

The Indiana Health Coverage Programs (IHCP) has identified errors published in *IHCP Banner Page BR201908*. The article, *IHCP clarifies basic instructions for SUD billing of certain services,* in Table 9 incorrectly identifies the revenue code required to be billed with procedure codes 99217 – 99220. The correct revenue code is 762 (not 761).

Additionally, Table 9 incorrectly references procedure code descriptions in Table 7 (for codes 99218 – 99220, and 99224 – 99226). The correct descriptions for those codes are in Table 8 (not Table 7).

The other instructions in the article for billing substance use disorder (SUD) treatment services are accurate.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-457-4584.

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