IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR201912 MARCH 19, 2019

# Procedure codes 95976, 95977, and 95983 linked to revenue codes 920 and 929

Effective April 23, 2019, the Indiana Health Coverage Programs (IHCP) will link the Current Procedural Terminology (CPT®[1]) codes in Table 1 to the following revenue codes. These linkages will apply to fee-for-service (FFS) claims with dates of service (DOS) on or after April 23, 2019.

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

*Table 1 – Procedure codes linked to revenue codes 920 and 929, effective April 23, 2019*

| Procedure code | Description |
|---|---|
| 95976 | Electronic analysis of implanted brain, spinal cord or peripheral stimulation device with simple cranial nerve stimulator programming |
| 95977 | Electronic analysis of implanted brain, spinal cord or peripheral stimulation device with complex cranial nerve stimulator programming |
| 95983 | Electronic analysis of implanted brain, spinal cord or peripheral stimulation device with brain stimulator programming, first 15 minutes face-to-face time with qualified health care professional |

Beginning April 23, 2019, providers may bill any of the procedure codes in Table 1 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.

These linkages 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*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.



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## IHCP revises reimbursement guidelines for BRCA genetic testing services

The Indiana Health Coverage Programs (IHCP) reimburses for genetic testing for breast and ovarian cancer (BRCA1 and BRCA2) when medically necessary. These genetic testing procedure codes are manually priced and reimbursed at 90% of billed charges.

Consistent with IHCP billing guidelines, IHCP reimbursement for BRCA1 and BRCA2 genetic testing is limited to once per member per lifetime. To maintain consistency with other bundled laboratory codes, the IHCP considers certain aspects of these genetic tests to be components of more comprehensive tests. Accordingly, effective April 19, 2019, the IHCP will not reimburse for certain additional tests if a claim for BRCA1 and BRCA2 testing has previously paid, as indicated in Table 2.

Claims for additional nonpayable genetic testing procedure codes (fourth column in Table 2) will deny with explanation of benefits (EOB) 6276 – *Breast cancer analysis (BRCA1 & BRCA2) is not payable when a breast cancer analysis code has already been paid*.

*Table 2 – Reimbursement guidelines for genetic testing procedure codes, effective April 19, 2019*

| Procedure code previously paid | Description | Procedure code(s) payable in future | Procedure code(s) not payable in future |
|---|---|---|---|
| 81162 | BRCA1, BRCA2 (breast cancer 1 and 2) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants in BRCA1 (i.e., exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb) | 81163, 81164, 81165, 81166, 81167, 81215, 81216, 81217 | 81212 |
| 81163 | BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence | 81164, 81166, 81167, 81215, 81217 | 81162, 81165, 81212, 81216 |
| 81164 | BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full duplication/ deletion analysis (i.e., detection of large gene rearrangements) | 81162, 81163, 81165, 81212, 81215, 81216, 81217 | 81166, 81167 |
| 81165 | BRCA1 (BRCA1, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence | 81162, 81163, 81164, 81166, 81167, 81212, 81215, 81216, 81217 | None |
| 81166 | BRCA1 (BRCA1, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (i.e., detection of large gene rearrangements) | 81162, 81163, 81164, 81165, 81167, 81212, 81215, 81216, 81217 | None |

*continued*

*Table 2 – Reimbursement guidelines for genetic testing procedure codes, effective April 19, 2019 (continued)*

| Procedure code previously paid | Description | Procedure code(s) payable in future | Procedure code(s) not payable in future |
|---|---|---|---|
| 81167 | BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (i.e., detection of large gene rearrangements) | 81162, 81163, 81164, 81165, 81166, 81212, 81215, 81216, 81217 | None |
| 81212 | BRCA1, BRCA2 (breast cancer 1 and 2) (e.g., hereditary breast and ovarian cancer) gene analysis; 185 del AG, 5385insC, 6174 del T variants | 81162, 81163, 81164, 81165, 81166, 81167, 81215, 81216, 81217 | None |
| 81215 | BRCA1 (breast cancer 1) (e.g., hereditary breast and ovarian cancer) gene analysis; known familial variant | 81162, 81163, 81164, 81165, 81166, 81167, 81212, 81216, 81217 | None |
| 81216 | BRCA2 (breast cancer 2) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis | 81162, 81163, 81164, 81165, 81166, 81167, 81212, 81215, 81217 | None |
| 81217 | BRCA2 (breast cancer 2) (e.g., hereditary breast and ovarian cancer) gene analysis; known familial variant | 81162, 81163, 81164, 81165, 81166, 81167, 81212, 81215, 81216 | None |

The IHCP allows prior authorization (PA) for genetic testing related to breast and ovarian cancer when medically necessary in the circumstances described in the *Genetic Testing* provider reference module. Providers are required to obtain PA and bill using the appropriate Current Procedural Terminology (CPT®[1]) codes.

The IHCP considers BRCA testing of men with breast cancer medically necessary for either of the following indications:

- To assess the man's risk of recurrent breast cancer
- To assess the breast cancer risk of a female member where the affected male is a first- or second-degree blood relative of that member

The IHCP considers BRCA1 and BRCA2 testing to assess the risk of breast or prostate cancer in men *without breast cancer* to be not medically necessary.

# IHCP clarifies billing for psychotherapy, evaluation, and management services on the same day

The Indiana Health Coverage Programs (IHCP) does not enroll mid-level providers with their own National Provider Identifiers (NPIs); therefore mid-level providers must bill using the supervising physician in the Rendering field (on a professional *CMS-1500* claim form or electronic equivalent), appending the appropriate modifier (for example, AJ, AH, HE, HM). In these cases, the rendering NPI will be the psychiatrist or physician enrolled with the IHCP. If there are multiple detail lines on a claim with the same date of service (DOS), and one service is performed by a mid-level provider and one service is performed by a psychiatrist or physician, the details would be compared in National Correct Coding Initiative (NCCI) procedure to procedure (PTP) edits. However, the IHCP considers the use of the mid-level modifiers as a separately provided service and does not apply the PTP edits.

According to the *Mental Health and Addiction Services* provider reference module, Current Procedural Terminology (CPT®[1]) codes 90833, 90836, and 90838 for psychotherapy with medical evaluation and management are *medical* services. Therefore, the IHCP does not reimburse clinical social workers, clinical psychologists, or any mid-level practitioners (excluding nurse practitioners and clinical nurse specialists) for these codes. In these circumstances, it is appropriate to bill the stand-alone psychotherapy service with the mid-level modifier, and for the supervising practitioner to bill the evaluation and management service. The mid-level modifier will override the applicable NCCI PTP edit.

For more information about the modifiers, billing requirements, and reimbursement, please see the *Mental Health and Addiction Services* provider reference module at in.gov/medicaid/providers.

This policy is for all programs, including managed care, effective immediately. For DOS on or after July 1, 2018, fee-for-service (FFS) claims or claim detail lines that denied for explanation of benefits (EOB) 6396 – *This service is not payable with another service on the same date of service due to National Correct Coding Initiative* will be mass reprocessed or mass adjusted. Providers should see the reprocessed or adjusted claims on Remittance Advices (RAs) beginning April 19, 2019, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims) or 52 (mass replacements non-check related). For claims that were underpaid, the net difference will be paid and reflected on RAs.



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