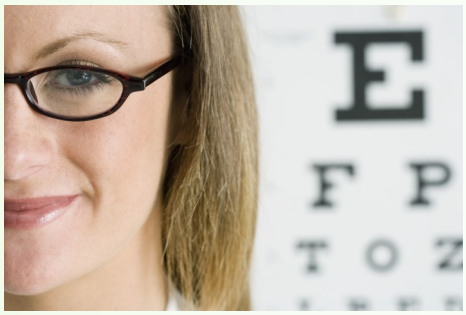
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201915 APRIL 9, 2019

IHCP to correct vision code sets, and reprocess or adjust vision services claims that denied incorrectly



The Indiana Health Coverage Programs (IHCP) has identified errors related to the procedure code sets for vision provider specialties 180 (optometrist) and 190 (optician) in the *Core*MMIS claim-processing system.

The Current Procedural Terminology (CPT®[1]) codes in Table 1 were accurately included in the published code set for the optometrist provider specialty. However, in error, these procedure codes were **not** included in the claim-processing system as allowable for billing by this specialty. This issue affects certain claims for vision services with dates of service (DOS) on or after July 1, 2018, and claims or claim detail lines billed for the codes in Table 1 may have denied inappropriately.

The claim-processing system has been corrected. This correction applies retroactively to claims with DOS on or after **July 1, 2018**, that denied in full or that included detail lines that denied. Claims will be mass reprocessed or mass adjusted as appropriate. Providers should see the reprocessed or adjusted claims on Remittance Advices (RAs) beginning May 14, 2019, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims) and 52 (mass replacement non-check related). For claims that were underpaid, the net difference will be paid and reflected on the RA.

The CPT codes in Table 2 and Table 3 were, in error, included in the published code sets as allowable for billing by provider specialty 180 (optometrist) and specialty 190 (optician), respectively. The code sets were correct in the claim-processing system as not allowable for those specialties. No claims with DOS on or after July 1, 2018 were adversely affected.

The corrected information will be reflected in the *Vision Services Codes* table, accessible from the *Code Sets* page at in.gov/medicaid/providers.

continued

MORE IN THIS ISSUE

Table 1 – Procedure codes allowable for provider specialty 180 (optometrist) and added into the CoreMMIS claim-processing system

Procedure code	Description
66820	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); stab incision technique (Ziegler or Wheeler knife)
66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (1 or more stages)
76510	Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter
76511	Ophthalmic ultrasound, diagnostic; quantitative A-scan only
76512	Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)
76513	Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy
76514	Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)
76516	Ophthalmic biometry by ultrasound echography, A-scan
76519	Ophthalmic biometry by ultrasound echography, A scan; with intraocular lens power calculation
76529	Ophthalmic ultrasonic foreign body localization
80048–89321	Ophthalmic and laboratory procedures as allowed by provider CLIA certification on file

Table 2 – Procedure codes to be removed from published code set for provider specialty 180 (optometrist)

Procedure code	Description
92242	Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)

continued

Table 2 – Procedure codes to be removed from published code set for provider specialty 180 (optometrist) (continued)

Procedure code	Description
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes

Table 3 – Procedure codes not allowable for provider specialty 190 (optician)

Procedure code	Description
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes

IHCP reminds providers of revised billing for ABA therapy services, and of codes to be end dated June 30, 2019

The Indiana Health Coverage Programs (IHCP) revised billing guidance for applied behavioral analysis (ABA) therapy services, as announced in *IHCP Bulletin* BT201867. Based on providers' feedback, some of the previous guidance is clarified as follows.

Effective January 1, 2019, the IHCP began coverage of the 2019 Category I ABA therapy procedure codes in Table 4. Providers may obtain prior authorization (PA) for, and bill for ABA therapy services with dates of service (DOS) on or after January 1, 2019, using the procedure codes in Table 4. The State-defined ABA therapy procedure codes described in *IHCP Bulletin* BT201606 are being end dated, effective June 30, 2019.

Coverage of the procedure codes in Table 4 applies to claims with DOS on or after January 1, 2019, for all IHCP programs, subject to the limitations of the member's benefit package. All ABA therapy services require PA and must be billed on a professional claim (*CMS-1500* form or its electronic equivalent). These newly covered ABA therapy procedure codes are subject to all National Correct Coding Initiative (NCCI) guidelines and edits; allowances to bypass the Medically Unlikely Edits (MUEs) are not in effect. If services are provided in two different locations; providers should follow standard coding to indicate that the services are separate and distinct.

Note: Providers are strongly encouraged to file claims electronically. Standard electronic data interchange (EDI) claim transactions (837P, 837I, and 837D) and IHCP Provider Healthcare Portal (Portal) claim transactions allow providers to include necessary detail-level information and are processed more efficiently than paper claims.

To facilitate transition to the new procedure codes (in Table 4) and to reduce the administrative burden on providers, the IHCP will continue to cover the State-defined ABA therapy procedure codes described in *BT201606*. This includes honoring PAs issued before January 1, 2019, and reimbursing claims for these procedure code/modifier combinations for DOS through June 30, 2019 when the State-defined codes will be end dated.

If providers have existing PAs for the codes to be end dated, they should continue using those PAs and bill for the codes until the PAs elapse. Requests for system updates to existing PAs should use the State-defined ABA therapy procedure codes as submitted on the original PA requests. New PA requests for ABA therapy services submitted on or after January 1, 2019, must reference the procedure codes in Table 4.

continued

Table 4 – Newly covered procedure codes for billing ABA therapy services, effective for DOS on or after January 1, 2019

Procedure code	Description	Time/unit	Rate	Attended by
Assessment / reassessment codes				
97151	Behavior identification assessment, administered by a **physician or other qualified healthcare professional**, each 15 minutes of the physician's or other qualified healthcare professional's time face-to-face with patient and/or guardian(s)/ caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/ interpreting the assessment, and preparing the report/treatment plan	Per 15 minutes	40% of billed charges	Member and *QHP
97152	Behavior identification supporting assessment, administered by one **technician** under the direction of a physician or other qualified healthcare professional, face-to-face with the patient, each 15 minutes	Per 15 minutes	40% of billed charges	Member and technician (QHP may substitute for the technician)
0362T	Behavior identification supporting assessment, each 15 minutes of **technicians'** time face-to-face with a patient, requiring the following components: • administered by the physician or other qualified healthcare professional who is on site; • with the assistance of two or more technicians; • for a patient who exhibits destructive behavior; • completed in an environment that is customized to the patient's behavior.	Per 15 minutes	90% of billed charges	Member and two or more technicians and QHP
Treatment codes				
97153	Adaptive behavior treatment by protocol, administered by **technician** under the direction of a physician or other qualified healthcare professional, face-to-face with one patient, each 15 minutes	Per 15 minutes	40% of billed charges	Member and technician (QHP may substitute for the technician)
***97155	Adaptive behavior treatment with protocol modification, administered by **physician or other qualified healthcare professional**, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes	Per 15 minutes	40% of billed charges	Member and QHP (may include technician and/ or caregiver)

continued

Table 4 – Newly covered procedure codes for billing ABA therapy services, effective for DOS on or after January 1, 2019 (continued)

Procedure code	Description	Time/unit	Rate	Attended by
Treatment codes				
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of **technicians**' time face-to-face with a patient, requiring the following components: • administered by the physician or other qualified healthcare professional who is on site; • with the assistance of two or more technicians; • for a patient who exhibits destructive behavior; • completed in an environment that is customized, to the patient's behavior.	Per 15 minutes	90% of billed charges	Member and two or more technicians; QHP on site
Group codes				
97154	Group adaptive behavior treatment by protocol, administered by **technician** under the direction of a physician or other qualified healthcare professional, face-to-face with two or more patients, each 15 minutes	Per 15 minutes	40% of billed charges	Two or more members and technician (QHP may substitute for technician)
97158	Group adaptive behavior treatment with protocol modification, administered **by physician or other qualified healthcare professional**, face-to-face with multiple patients, each 15 minutes	Per 15 minutes	40% of billed charges	Two or more members and QHP
Family codes				
97156	Family adaptive behavior treatment guidance, administered by **physician or other qualified healthcare professional** (with or without the patient present), face-to-face with guardian(s)/ caregiver(s), each 15 minutes	Per 15 minutes	40% of billed charges	Caregiver and QHP (may include member)
97157	Multiple-family group adaptive behavior treatment guidance, administered by **physician or other qualified healthcare professional** (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes	Per 15 minutes	40% of billed charges	Caregivers of two or more members and QHP

*Qualified Healthcare Professional (QHP) is defined as a Board Certified Behavior Analyst-Doctoral (BCBA-D), Board Certified Behavior Analyst (BCBA), psychologist, or other credentialed professional whose scope of practice, training, and competence includes behavior analysis.

**Technician is defined as a Board Certified Assistant Behavior Analyst (BCaBA), or Registered Behavior Technician (RBT). A QHP may substitute for the technician.

Note: Services provided by a credentialed technician will be reimbursed as indicated in Table 4. A "cutback" will not be applied.

***Procedure code 97155 may be billed concurrently with technician delivered services for code 97153 when the patient is present, one or more protocols have been modified, and the QHP is directing the technician.

IHCP clarifies revenue code linkages to procedure codes for billing transcranial magnetic stimulation services

The Indiana Health Coverage Programs (IHCP) announced in *Bulletin BT201909*, coverage of certain transcranial magnetic stimulation (TMS) services. Reimbursement and billing guidance explained that Current Procedural Terminology (CPT®[1]) codes 90867, 90868, and 90869 would be linked to revenue codes 920, and 940, effective March 21, 2019.

To clarify, providers may bill these procedure codes together with the revenue codes for reimbursement consideration, as follows:

- All three procedure codes (90867, 90868, and 90869) are linked to revenue code 920 – *Other Diagnostic Services-General Classification*.
- Only procedure codes 90868 and 90869 are linked to revenue code 940 – *Other Therapeutic Services (Also See 095X, An Extension of 094X)-General Classification.*

These revenue code linkages 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, and in *Revenue Codes with Special Procedure Code Linkages*, available from the *Code Sets* page.

Note: IHCP Bulletin BT201909 stated that the code table document, Revenue Codes Linked to Specific Procedure Codes, would be updated for the coverage information. The title of that document has changed to, Revenue Codes with Special Procedure Code Linkages.

IHCP clarifies coverage for Hoosier Healthwise members during retroactive eligibility period

As part of a collaborative workflow improvement project with stakeholders, the Indiana Health Coverage Programs (IHCP) is issuing a clarification to *IHCP Banner Page BR201839*. Members determined as retroactively eligible under Hoosier Healthwise aid categories do not receive a managed care assignment for the retroactive eligibility period. Instead, during the retroactive period, member benefits are covered through the fee-for-service (FFS) delivery system.

However, the exception to this policy is for newborns whose mothers were enrolled with a managed care assignment on the date of the child's birth. In this case, the baby is assigned to the mother's managed care entity (MCE), retroactively effective to the date of birth. The mother's and the baby's coverage remains with the MCE during the baby's retroactive period.

Once a Member ID is assigned to the baby, providers may send claims for the baby's care to the mother's MCE. Prior authorization (PA) for services may be required. Providers should check with the MCE about PA before submitting claims, or retroactive PA requests.

For more information about Hoosier Healthwise, see the *Member Eligibility and Benefit Coverage* provider reference module at in.gov/medicaid/providers.

IHCP reminds providers of new administrative code requirement for documenting medical records

The Indiana Health Coverage Programs (IHCP) recently amended Title 405 of the *Indiana Administrative Code* (IAC) to align with program integrity, as described in *IHCP Bulletin* *BT201914*. This included a new rule, 405 IAC 1-1.4 Program Integrity and Appeals.

Under the new rule, 405 IAC 1-1.4-2 (a) (2) states, "Medical records shall be documented at the time the services are provided or rendered, and prior to associated claim submission."

However, because circumstances can delay providers in documenting services (such as for dictation, transcribing, or staff working off-site), the IHCP will allow for delay of a day or two **if** the reason is documented at the time the service is provided.

Note: All documentation must be complete before it is submitted with the claim to the IHCP.

QUESTIONS?

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

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from the *Banner Pages* page of the IHCP provider website at in.gov/medicaid/providers.

TO PRINT

A printer-friendly version of this publication, in black and white and without photos, is available for your convenience.

SIGN UP FOR IHCP EMAIL NOTIFICATIONS

To receive email notices of IHCP publications, subscribe by clicking the blue subscription envelope or sign up from the IHCP provider website at in.gov/medicaid/providers.