IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR201933 AUGUST 13, 2019

IHCP to cover CPT codes 72083 and 72084

Effective September 13, 2019, the Indiana Health Coverage Programs (IHCP) will cover the Current Procedural Terminology (CPT®[1]) codes in Table 1 for radiologic examination services. Coverage applies to all IHCP programs, subject to limitations established for certain benefit plans. Coverage applies to claims for dates of service (DOS) on or after September 13, 2019.

Note: Chiropractors (Specialty 150) will be allowed to bill for these services.

Table 1 – Procedure codes covered for radiologic examination services, effective for DOS on or after September 13, 2019

Procedure code	Description
72083	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g., scoliosis evaluation); 4 or 5 views
72084	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g., scoliosis evaluation); minimum of 6 views

The following reimbursement information applies:

- Pricing: See Table 2
- Prior authorization (PA): None required
- Billing guidance: See Table 2

continued

Table 2 – Billing guidance for procedure codes 72083 and 72084, effective for DOS on or after September 13, 2019

Procedure code	Claim form	Pricing
72083	*CMS-1500*	Resource-based relative value scale (RBRVS)
	UB-04	Maximum fee: $40.54
72084	*CMS-1500*	RBRVS
	UB-04	Maximum fee: $47.48

Note: Providers may bill for the codes in Table 2 on professional claims (CMS-1500 form or electronic equivalent) or on institutional claims (UB-04 form or electronic equivalent), as appropriate depending on where services are rendered.

Reimbursement, PA, and billing information apply to services delivered under the fee-for-service (FFS) delivery system. Questions about FFS PA should be directed to Cooperative Managed Care Services (CMCS) at 1-800-269-5720. 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 next regular update to the *Chiropractic Services Codes*, accessible from the *Code Sets* web page at in.gov/medicaid/providers, and to the *Professional Fee Schedule* and the *Outpatient Fee Schedule,* available from the *IHCP Fee Schedules* web page.

IHCP will mass adjust claims for home hospice care that paid incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain fee-for-service (FFS) claims for home hospice care services processed from February 13, 2017, through August 4, 2019. In error, the claim-processing system did not adjudicate claims correctly to reduce payment following a member's first 60 days of hospice care.

The claim-processing system has been corrected. Claims processed during the indicated time frame that previously paid incorrectly will be mass adjusted. Providers should see the adjusted claims on Remittance Advices (RAs) beginning September 18, 2019, with internal control numbers (ICNs)/Claim IDs that begin with 52 (mass replacement non-check related). 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.

For more information about billing and reimbursement for hospice services, see the *Hospice Services* provider reference module at in.gov/medicaid/providers.

IHCP to mass reprocess or mass adjust claims for certain add-on services that may have denied inappropriately

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain fee-for-service (FFS) claims for add-on services with the dates of service (DOS) identified below. Claims billed for the following add-on services may have denied inappropriately for explanation of benefits (EOB) 6390 – *Add-on codes are performed in addition to the primary service or procedure and must never be reported as a stand-alone code.*

The affected add-on services with DOS are:

- Procedure codes within alpha-numeric range 0071U-0076U:
  - This range can include anesthesia codes beginning with "0" (zero) or Category III codes ending with the letter "T."
  - Affected claims for these procedures are for DOS from February 13, 2017, through July 19, 2019.
- Procedure codes 96131, 96133, 96137, and 96139:
  - These codes were deactivated as add-on procedures by the Centers for Medicare & Medicaid Services (CMS) on April 1, 2019, effective retroactively January 1, 2019.
  - Affected claims for these procedure codes are for DOS from January 1, 2019, through July 19, 2019.

The claim-processing system has been corrected. Claims or claim details for the add-on services and time frames indicated that denied inappropriately will be mass reprocessed or mass adjusted, as appropriate. Providers should see the reprocessed or adjusted claims on Remittance Advices (RAs) beginning September 11, 2019, 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 RAs.

Providers may resubmit outpatient claims for HCPCS code J1670 that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain fee-for-service (FFS) outpatient claims (*UB-04* form or electronic equivalent) with dates of service (DOS) from February 13, 2017 through July 30, 2019. Claims or claim detail lines billed for Healthcare Common Procedure Coding System (HCPCS) code J1670 – *Injection, tetanus immune globulin, human, up to 250 units* may have denied inappropriately with one of the following explanation of benefits (EOB):

- EOB 4218 – *Service billed is not allowed on this claim type*
- EOB 4014 – *Claim being reviewed for pricing*

The claim-processing system has been corrected. Beginning immediately, providers may resubmit claims for procedure code J1670 that previously denied for either EOB during the indicated time frame, for reimbursement consideration. This correction applies retroactively to claims with DOS **from February 13, 2017, through July 30, 2019**. Claims beyond the original 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 filed within 180 days of the publication date.

IHCP to mass reprocess school corporation claims for NEMT services that denied incorrectly

The Indiana Health Coverage Program (IHCP) has identified a claim-processing issue that affects certain fee-for-service (FFS) claims for nonemergency medical transportation (NEMT) services billed by school corporations, processed from June 1, 2018, through July 25, 2019. Claims billed for the procedure codes in Table 3 may have denied incorrectly.

Table 3 – Procedure codes that may have denied incorrectly for claims processed from June 1, 2018, through July 25, 2019

Procedure code	Description
A0425	Ground mileage, per statue mile
A0426	Ambulance service, advanced life support, non-emergency transport, level 1
T0428	Ambulance service, basic life support, non-emergency transport (BLS)
T2001	Non-emergency transportation; per diem
T2003	Non-emergency transportation; encounter/trip
T2004	Non-emergency transport; commercial carrier, multi-pass
T2007	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments

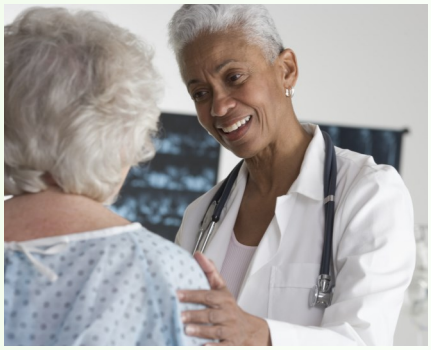
The claim-processing system has been corrected. Claims processed during the indicated time frame that denied incorrectly will be mass reprocessed. Providers should see the reprocessed claims on Remittance Advices (RAs) beginning September 18, 2019, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims).

IHCP to mass reprocess or mass adjust claims for FQHC and RHC services that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain fee-for-service (FFS) professional claims for Rural Health Clinic (RHC) and Federally Qualified Health Clinic (FQHC) services with dates of service (DOS) on or after February 13, 2017. Claims for Healthcare Common Procedure Coding System (HCPCS) code T1015 – *Clinic service encounter* reported with modifiers AH, clinical psychologist, or AJ, clinical social worker, may have denied inappropriately for explanation of benefits (EOB) 4033 – *The modifier used is not compatible with the procedure code billed*.

The claim-processing system has been corrected. Claims or claim details for the identified services and time frame that denied incorrectly for EOB 4033 will be mass reprocessed or mass adjusted, as appropriate. Providers should see the reprocessed or adjusted claims on Remittance Advices (RAs) beginning October 8, 2019, 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.

IHCP clarifies billing instructions for the attending physician field on institutional claims



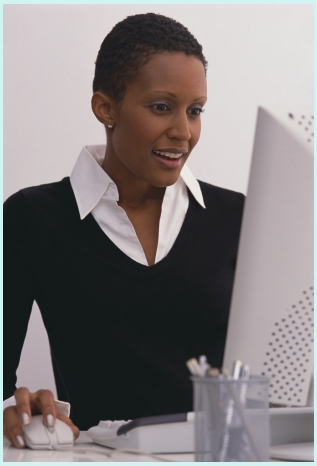
The Indiana Health Coverage Programs (IHCP) is clarifying billing instructions for completing the attending physician field on institutional claims (*UB-04* form or electronic equivalent).

Effective for dates of service (DOS) on or after September 15, 2019, the IHCP will not reimburse institutional claims that have the **group** provider National Provider Identifier (NPI) in the attending physician field of the form. Providers are instructed to enter only the attending physician's 10-digit numeric NPI in that field. The attending provider should always be an individual person.

Claims submitted with a group provider NPI in the attending field will be denied for explanation of benefits (EOB) 1142 – *Missing/Incomplete/Invalid Attending Provider Identifier*, and remark code N253 – *Missing/Incomplete/Invalid Attending Provider Primary Identifier.*

For more information about billing and completing an institutional claim form, see the *Claim Submission and Processing* provider reference module at in.gov.medicaid/providers.

IHCP offers new program integrity provider training – random sampling and extrapolation process



The Indiana Health Coverage Programs (IHCP) is making web-based Program Integrity provider education training available to all providers. These training presentations are intended to supplement the provider reference modules and other IHCP-published provider reference materials.

The latest Program Integrity provider training titled, *Random Sampling and Extrapolation Process*, is now available. The purpose of this training is to help IHCP providers understand Program Integrity's use of random sampling and extrapolation in the audit process.

State Medicaid agencies must implement a statewide surveillance and control program to guard against inappropriate use of Medicaid services and excess payment of Medicaid funds. Program Integrity conducts audits of IHCP providers to evaluate and document patterns of healthcare services provided to members, ensure compliance with Indiana Medicaid guidelines, identify instances of underpayments, and recover any overpayments. One type of audit methodology includes the use of random sampling and extrapolation. The new training course explains the standards and processes in the primary steps for random sampling and extrapolation in the Program Integrity audit process, and defines common terms used throughout the process.

To access the training, navigate to the *Program Integrity Provider Education Training* page at in.gov/medicaid/providers.

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Other training topics posted on the web page are as follows:

- *Non-Emergency Transportation Documentation Requirements and Billing Guidelines*
- *Ambulance Transportation Documentation Requirements and Billing Guidelines*
- *Dental Provider Documentation Requirements and Billing Guidelines*
- *Program Integrity Audit Process Overview*
- *Program Integrity Self-Disclosure Protocol*
- *Behavioral Health and ABA Documentation Guidelines*
- *Indiana FADS Secure Portal Training*

Watch upcoming IHCP provider publications for announcements about future trainings.

QUESTIONS?

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

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