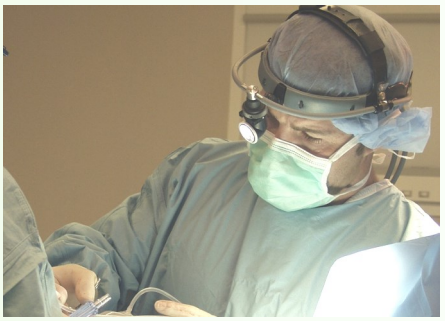
IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR202136 SEPTEMBER 7, 2021

IHCP updates pricing for certain procedure codes in the outpatient setting



Effective Oct. 8, 2021, the Indiana Health Coverage Programs (IHCP) will update pricing for the Current Procedural Terminology (CPT®[1]) and Healthcare Common Procedure Coding System (HCPCS) codes in Table 1 for services in the outpatient setting. The pricing for these codes is changing from manual pricing (reimbursement at a percentage of billed charges) to the pricing shown in Table 1. The new pricing applies to fee-for-service (FFS) outpatient claims (*UB-04* form or electronic equivalent) with dates of service (DOS) on or after Oct. 8, 2021.

This reimbursement and 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 and PA should be directed to the MCE with which the member is enrolled.

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.

Table 1 – Procedure codes no longer reimbursed as a percentage of billed charges for outpatient services, effective for DOS on or after Oct. 8, 2021

Procedure code	Description	New pricing	New amount	ASC code
21088	Impression and custom preparation of facial prosthesis	*ASC	N/A	H
21602	Removal of tumor from chest wall including ribs with plastic reconstruction	ASC	N/A	G
21603	Removal of tumor from chest wall including ribs with plastic reconstruction and removal of lymph nodes from chest cavity	ASC	N/A	G
36473	Mechanochemical destruction of insufficient vein of arm or leg, accessed through the skin using imaging guidance	ASC	N/A	H

continued

Table 1 – Procedure codes no longer reimbursed as a percentage of billed charges for outpatient services, effective for DOS on or after Oct. 8, 2021 (continued)

Procedure code	Description	New pricing	New amount	ASC code
36903	Insertion of needle and/or catheter into dialysis circuit and insertion of stent in dialysis segment, with imaging including radiological supervision and interpretation	ASC	N/A	M
36906	Removal or dissolving of blood clot in dialysis circuit, with balloon dilation of dialysis segment and placement of stent, accessed through skin, with imaging	ASC	N/A	M
38206	Collection of stem cells for transplantation	ASC/**PC	$1,363.16	8
38230	Harvesting of donor bone marrow for transplantation	ASC/PC	$1,363.16	8
38232	Harvesting of patient bone marrow for transplantation	ASC/PC	$4,037.71	G
41870	Relocation of tissue lining the mouth to gum surface	ASC	N/A	8
71271	Low dose CT scan of chest for lung cancer screening	PC	$80.90	N/A
86891	Processing and storage of blood unit or component, intra- or postoperative salvage	PC	$656.15	N/A
86923	Blood unit compatibility test, electronic	PC	$149.16	N/A
86960	Volume reduction of blood unit or blood product	PC	$149.16	N/A
86970	Pretreatment of red blood cells for use in red blood cells antibody analysis and measurement, incubation with chemical agents or drugs	PC	$33.84	N/A
86971	Pretreatment of red blood cells for use in red blood cells antibody analysis and measurement, incubation with enzymes	PC	$291.26	N/A
92229	Imaging of retina for disease detection, with automated review and report at point of care	PC	$55.66	N/A
97610	Low frequency, non-contact, non-thermal ultrasound wound assessment, and instructions for ongoing care, per day	PC	$179.55	N/A
0555T	Bone strength and fracture risk assessment: retrieval and transmission of CT scan data only	PC	$24.67	N/A
0556T	Bone strength and fracture risk assessment: assessment of bone strength and fracture risk and bone mineral density	PC	$230.13	N/A
0571T	Insertion or replacement of implantable cardioverter-defibrillator system with electrodes under breastbone	ASC	N/A	M
0572T	Insertion of implantable defibrillator electrode under breastbone	ASC	N/A	M
0573T	Removal of implantable defibrillator electrode from under breastbone	ASC	N/A	G
0574T	Repositioning of previously implanted defibrillator electrode under breastbone	ASC	N/A	G
0580T	Removal of implantable defibrillator pulse generator from under breastbone	ASC	N/A	G
0583T	Insertion of ventilating tube in eardrum using an automated tube delivery system under local anesthesia	ASC	N/A	8

continued

Table 1 – Procedure codes no longer reimbursed as a percentage of billed charges for outpatient services, effective for DOS on or after Oct. 8, 2021 (continued)

Procedure code	Description	New pricing	New amount	ASC code
0594T	Incision of upper arm bone and insertion of bone-lengthening device in marrow cavity	ASC/PC	$6,264.95	G
0614T	Removal and replacement of substernal implantable defibrillator pulse generator	ASC	N/A	M
0632T	Destruction of nerves to main arteries of lung, accessed through skin via catheter using imaging guidance	***Flat RC	N/A	N/A
C9762	Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging	PC	$482.89	N/A
C9763	Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging	PC	$482.89	N/A

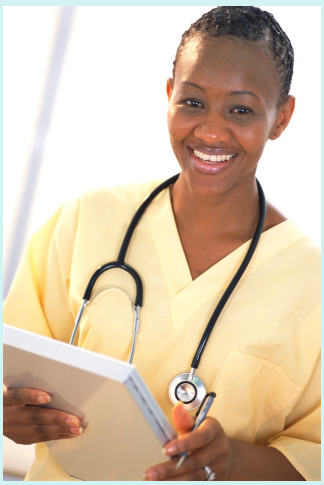
** Ambulatory Surgical Center (ASC). If the procedure code is billed with a surgical revenue code, use the ASC code to determine the price.*

*** PC means sometimes priced on the procedure code (depends on the revenue code billed).*

**** Flat revenue code (RC). The procedure code must be billed with a flat rate revenue code.*

IHCP updates pricing for CPT codes in the outpatient setting, adds linkages to revenue codes

Effective Oct. 7, 2021, the Indiana Health Coverage Programs (IHCP) will assign maximum fee pricing to the Current Procedural Terminology (CPT®[1]) codes in Table 2. CPT codes 0589T and 0590T previously used Ambulatory Surgical Center (ASC) pricing. The updated pricing will apply retroactively to fee-for-service (FFS) outpatient claims with the dates of service (DOS) shown in Table 2.



Additionally, the IHCP will link the CPT codes in Table 2 to revenue codes 920 and 929 as shown in the table. Beginning Oct. 7, 2021, providers should submit outpatient claims for the procedure codes in Table 2 with a revenue code, for reimbursement consideration. These linkages will apply retroactively to FFS outpatient claims with the DOS indicated in Table 2.

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

continued

Table 2 – Procedure codes with maximum fee pricing and linkages to revenue codes, effective retroactively

Procedure code	Description	Outpatient reimbursement (maximum fee)	Linked revenue code	Effective DOS for pricing and linkage to revenue code
0589T	Electronic analysis with simple programming of nerve-stimulating device in posterior tibial nerve	$100.31	920 or 929	Jan. 1, 2020
0590T	Electronic analysis with complex programming of nerve-stimulating device in posterior tibial nerve	$100.31	920 or 929	Jan. 1, 2020
0608T	Data analysis and report transmission to health care professional for remote monitoring of lung fluid monitoring system	$37.15	920	July 1, 2020
0615T	Eye-movement analysis with interpretation and report	$111.95	920	July 1, 2020

The IHCP identified a claim-processing issue that affects FFS outpatient claims for the procedure codes in Table 2. Claims for codes 0589T and 0590T with DOS on or after Jan. 1, 2020, and claims for codes 0608T and 0615T with DOS on or after July 1, 2020, may have denied with explanation of benefits (EOB) 4014 – *Claim being reviewed for pricing*.

The claim-processing system has been updated. Beginning Oct. 7, 2021, providers may resubmit FFS outpatient claims for the CPT codes in Table 2 during the indicated time frames that denied with EOB 4014, for reimbursement consideration. Claims resubmitted beyond the original filing limit must include a copy of this banner page as an attachment and must be submitted within 180 days of the banner page's publication date.

Reimbursement, prior authorization (PA) and billing information applies to services delivered under the 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 pricing information will be reflected in the next regular update to the *Outpatient Fee Schedule*, accessible from the *IHCP Fee Schedules* webpage at in.gov/medicaid/providers. The procedure code to revenue code linkages will be included in the next regular update to *Revenue Codes with Special Procedure Code Linkages*, available from the *Code Sets* page.

[1]*CPT copyright 2021 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

IHCP reminds pharmacy providers of requirements for signature logs and proof of prescription deliveries

The Indiana Health Coverage Programs (IHCP) is reminding pharmacy providers about requirements for keeping signature logs and proof of prescription deliveries.

Outpatient pharmacies must maintain signature logs that include the date the prescription was dispensed and the signature of the IHCP member (or the member's representative) to whom the prescription was dispensed.

Long-Term Care (LTC) facilities must maintain a record of prescriptions received by the facility. These records must include all the following:

- Prescription number
- Name and quantity of the drug
- Date the prescription was received by the facility
- Signature of the individual at the facility who accepted receipt of the prescription

For prescriptions delivered to members via U.S. mail or established couriers, such as FedEx or United Parcel Service (UPS), the pharmacy must document and maintain records demonstrating a linkage between the prescription and the prescription's delivery. Examples of acceptable records include:

- Inclusion of the prescription number on shipping documents
- Documentation of the delivery method and tracking number of the prescription

For prescriptions filled by a pharmacy and delivered to another provider for dispensing or administration, such as to a physician, the pharmacy must obtain proof from the other provider that the member received or was administered the drug. Proof may include a copy of medical chart notes or a form that identifies the drug, has the date and the member's signature.

For more information or questions about prescription requirements under the fee-for-service (FFS) delivery system, email the OptumRx Pharmacy Audit Department at RxAudit.INM@Optum.com. Questions regarding pharmacy benefits for members in Healthy Indiana Plan (HIP), Hoosier Healthwise, or Hoosier Care Connect should be referred to the managed care entity (MCE) with which the member is enrolled.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 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.