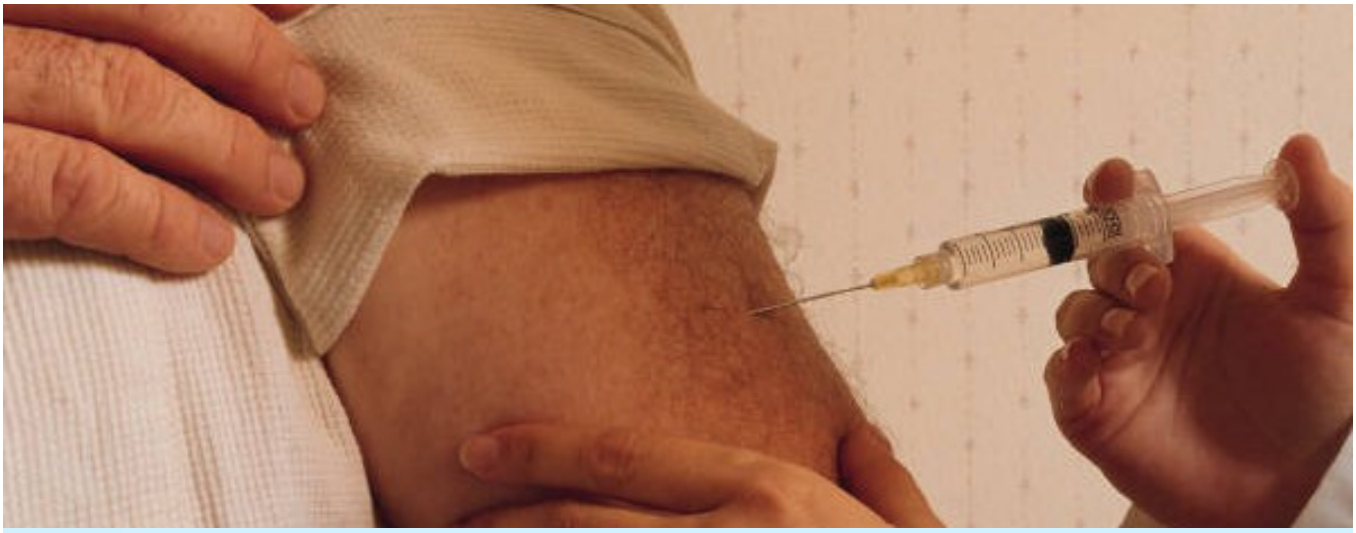
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201414 APRIL 8, 2014



IHCP to cover CPT code 90661

Effective July 1, 2014, the Indiana Health Coverage Programs (IHCP) will cover Current Procedural Terminology (CPT®[1]) code 90661 – *Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use*. The Food and Drug Administration (FDA) approved the product Flucelvax in November 2012. Coverage applies to all IHCP programs, subject to limitations established for certain benefit packages. Coverage applies retroactively to dates of service on or after January 1, 2014.

The following reimbursement information applies:

Pricing: This code will pay a maximum fee. See the Fee Schedule.

Prior Authorization: None required.

Billing Guidance: See *Chapter 8: Billing Instructions* of the *IHCP Provider Manual* for additional billing instructions.

The provider Code Sets and Fee Schedule will be updated on indianamedicaid.com to reflect this coverage and reimbursement information. Reimbursement and billing information applies to services delivered under the fee-for-service (FFS) delivery system. Individual managed care entities (MCEs) establish and publish reimbursement and billing criteria within the risk-based managed care (RBMC) delivery system.

[1] *CPT copyright 2012 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

MORE IN THIS ISSUE

Speech evaluation codes to be mass adjusted

Claims for Current Procedural Terminology (CPT) codes 92521-92524 (see Table 1 for definitions) that mistakenly denied between January 1, 2014, and March 25, 2014, for explanation of benefits (EOB) 4034 – *Procedure code billed not compatible with recipient's age* will be mass adjusted. No age restriction is indicated for these procedure codes.

Mass-adjusted claims will begin appearing on Remittance Advice (RA) statements on April 15, 2014, identified by internal control numbers (ICNs) that begin with region code 56.

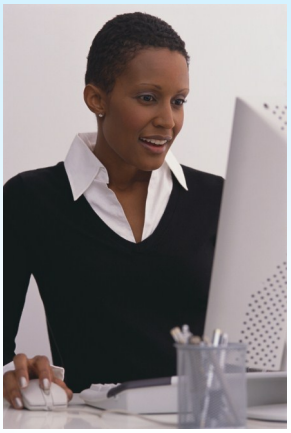
Table 1 – Procedure codes denied in error for EOB 4034

Procedure	Description
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance

Claims to be reprocessed or adjusted

Due to a system issue, providers may have received erroneous denials for the following edits during the week of March 10, 2014, through March 14, 2014:

- 4014 – *No pricing segment on file*
- 4032 – *Procedure code not on file*
- 4098 – *RVU not on file*
- 4209 – *No pricing segment for procedure/modifier combination*



Claims that denied or claims that paid with a denied detail line for these edits will be mass reprocessed or mass adjusted. Adjustments will begin appearing on the provider Remittance Advice (RA) statements dated April 22, 2014, identified by internal control numbers (ICNs) that begin with region code 56 (mass adjusted) or 80 (mass reprocessed).

CPT 31276 linked to revenue code 490

Effective June 1, 2014, the Indiana Health Coverage Programs (IHCP) will link Current Procedural Terminology (CPT) code 31276 – *Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus* to revenue code 490 – *Ambulatory Surgical Care-General* in Indiana*AIM*. This linkage applies to dates of service (DOS) on or after July 1, 2013. For reimbursement consideration, providers may bill the procedure code and revenue code together, as appropriate, for DOS on or after July 1, 2013. Claims beyond the one-year filing limit must include a copy of this banner page as an attachment to the claim.

CPT 78451 linked to revenue code 341

Effective May 8, 2014, the Indiana Health Coverage Programs (IHCP) will link Current Procedural Terminology (CPT) code 78451 – *Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)* to revenue code 341 – *Nuclear Medicine-Diagnostic* in Indiana*AIM*. This linkage applies to dates of service (DOS) on or after July 1, 2013. Beginning May 8, 2014, providers may bill the procedure code and revenue code together, as appropriate, for DOS on or after July 1, 2013. Claims beyond the one-year filing limit must include a copy of this banner page as an attachment to the claim.

CPT 95250 linked to revenue codes 920 and 929 and fee updated

Effective May 8, 2014, Indiana Health Coverage Programs (IHCP) will link Current Procedural Terminology (CPT) code 95250 – *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording* to revenue codes 920 – *Other Diagnostic Services-General* and 929 – *Other Diagnostic Services-Other Diagnostic Service* in Indiana*AIM*.

This linkage applies to dates of service (DOS) on or after July 1, 2013. In addition, a maximum fee will apply to CPT code 95250 effective for DOS on or after May 8, 2014. See the Fee Schedule at indianamedicaid.com for the maximum fee. Beginning May 8, 2014, providers may bill the procedure code and revenue code together, as appropriate, for dates of service on or after July 1, 2013. Claims beyond the one-year filing limit must include a copy of this banner page as an attachment to the claim.

Claims processing for audit 6224 updated

Dental providers are reminded that reimbursement of tooth extractions is limited to one per tooth per lifetime. Effective June 1, 2014, the Indiana Health Coverage Programs will update Audit 6224 – *One extraction per tooth per lifetime* so that the claims for tooth extractions will be accurately reimbursed. Claims will be examined to determine if an extraction has been performed on the same tooth in the recipient's lifetime. If so, the claim detail will be denied with explanation of benefits (EOB) 6224 – *Payment has been made previously for the extraction of this tooth*. If an extraction has been performed for the recipient on a different tooth, the claim detail will be paid. For additional information regarding coverage of dental services, see *Chapter 8: Billing Instructions* of the *IHCP Provider Manual*.

QUESTIONS?

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