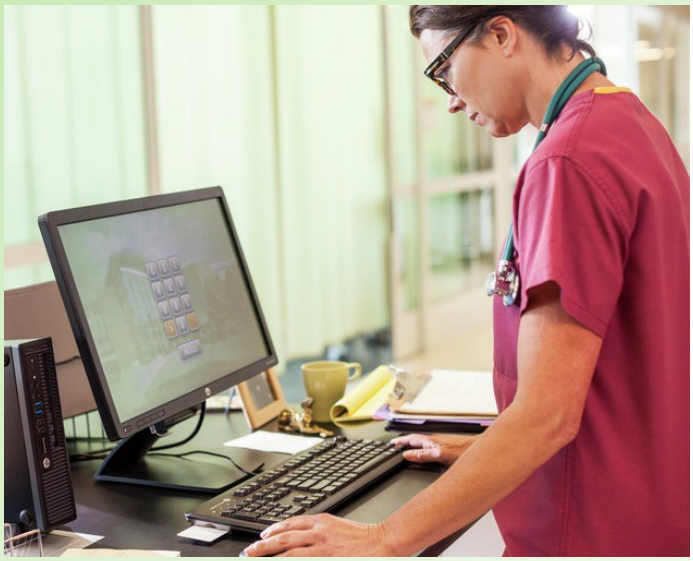
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201440 OCTOBER 7, 2014

New CMS Rule allows flexibility in certified EHR technology for 2014



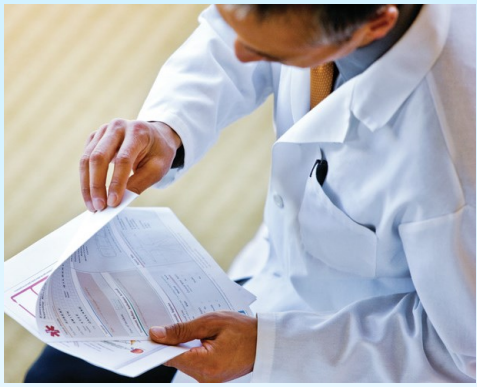
In August 2014, the Centers for Medicare & Medicaid Services (CMS) released a Final Rule that grants flexibility to providers that are unable to fully implement 2014 Edition certified electronic health record technology (CEHRT) for an EHR reporting period in 2014 due to delays in CEHRT availability. The new CMS rule changes the meaningful use time line and the requirements of CEHRT to allow more flexibility in how eligible hospitals and eligible professionals use CEHRT to meet meaningful use requirements for the 2014 reporting period. The rule also sets the requirements for reporting on meaningful use objectives and measures, as well as clinical quality measure (CQM) reporting for providers that use one of the CEHRT options finalized in this rule for their EHR reporting period in 2014.

The Indiana Health Coverage Programs (IHCP) is now updating the Medical Assistance Provider Incentive Repository (MAPIR) system to accommodate these new provisions. If providers wish to attest using the flexibility offered, they must wait until the MAPIR system upgrades are complete. The IHCP anticipates that all system updates will be complete by March 31, 2015.

To view all the program changes in the Final Rule, visit the *CMS EHR Incentive Program* web page at cms.gov. For updates and information related to Program Year 2014 attestations and deadlines, watch IHCP publications and the *Indiana Medicaid EHR Incentive Program* page at indianamedicaid.com. If you have questions, contact the Indiana Medicaid EHR Incentive Program Help Desk toll-free at 1-855-856-9563 or at MedicaidHealthIT@fssa.in.gov.

MORE IN THIS ISSUE

Updates to provider information for 2014 taxes due to the IHCP December 14



In preparation for generating and mailing tax filing documents, the Indiana Health Coverage Programs (IHCP) must receive any updates to "mail to," "pay to," or "home office" addresses, or to your 2014 taxpayer identification information, by December 14 .

- **Verify your provider profile information on Web interChange** – You can review and verify your "mail to," "pay to," and "home office" addresses on Web interChange. Go to your provider profile on Web interChange via indianamedicaid.com.
- **Update your "mail to" or "pay to" address information** – If your "mail to" or "pay to" address has changed, you can update it online or by mail. If you want to update your "mail to" or "pay to" addresses online via Web interChange choose **Provider Profile** and the **Edit/View** option. (You must have Web interChange administrative access to view this page.) You can also request updates by submitting an *IHCP Name and Address Maintenance Form*, available on the *Update Your Provider Profile* page at indianamedicaid.com.
- **Update your "home office" address** – Changes to your "home office" address, which is your legal address, must be submitted by mail and must be accompanied by a revised W-9. You can request updates by submitting an *IHCP Name and Address Maintenance Form*, available on the *Update Your Provider Profile* page at indianamedicaid.com, along with a revised W-9 form.
- **Corrections to your taxpayer identification information** – If your taxpayer identification information, including the name, address, or identification number on the W-9 form on file with the IHCP, needs to be updated, you must submit your update by mail using the *IHCP Tax Identification Maintenance Form* available on the *Update Your Provider Profile* page at indianamedicaid.com. A revised W-9 form must be submitted with the form.

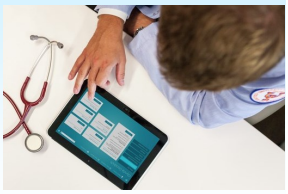
The IHCP removes gender restriction from CPT code 87661

Effective November 7, 2014, the Indiana Health Coverage Programs (IHCP) will remove the gender restriction on Current Procedural Terminology (CPT®[1]) 87661 – Infectious *agent detection by nucleic acid (dna or rna); trichomonas vaginalis, amplified probe technique.* The gender restriction was mistakenly added, resulting in inappropriately denied claims for edit 4035 – *Procedure code billed not compatible with recipients sex*. This change will be applied retroactively to fee-for-service claims with dates of service on or after **January 1, 2014**.

HP will perform a mass reprocessing of claims denied for edit 4035 for dates of service (DOS) beginning January 1, 2014, through November 6, 2014. Providers will see the reprocessed claims on the Remittance Advice (RA) statements dated December 5, 2014, with internal control numbers (ICNs) that begin with region code 80. For claims that were underpaid, the net difference will be paid and reflected on the RA.

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

Pricing updated for CPT code 01966



Effective November 15, 2014, the Indiana Health Coverage Programs (IHCP) will update the price for Current Procedural Terminology (CPT) code 01966 – *Anesthesia for induced abortion procedures* to base anesthesia units. This pricing change will be applied to dates of service on or after November 15, 2014, and be reflected in the next monthly update to the Fee Schedule at indianamedicaid.com.

The IHCP will no longer cover select anesthesia codes

Effective November 7, 2014, to align with national coding guidelines, the Indiana Health Coverage Programs (IHCP) will end-date the anesthesia codes in Table 1, as they are no longer valid. These changes will apply to fee-for-service claims with dates of service (DOS) on or after November 7, 2014, and will be reflected in the next monthly updates to the provider Fee Schedule at indianamedicaid.com.

Table 1 – Anesthesia procedure codes no longer covered by the IHCP effective for DOS on or after November 7, 2014

Procedure Code	Description
00420	Anesthesia for procedures on posterior integumentary system of chest, including subcutaneous tissue
00900	Anesthesia for procedures on perineal integumentary system (including biopsy of male genital system); not otherwise specified
01000	Anesthesia for procedures on anterior integumentary system of pelvis (anterior to iliac crest), except external genitalia
01110	Anesthesia for procedures on posterior integumentary system of pelvis (posterior to iliac crest), except perineum
01240	Anesthesia for all procedures on integumentary system of upper leg
01300	Anesthesia for all procedures on integumentary system of knee and/or popliteal area
01460	Anesthesia for all procedures on integumentary system of lower leg, ankle, and foot
01600	Anesthesia for all procedures on integumentary system of shoulder and axilla
01700	Anesthesia for all procedures on integumentary system of upper arm and elbow
01800	Anesthesia for all procedures on integumentary system of forearm, wrist, and hand

Site-of-service payment adjustment updates

The Indiana Health Coverage Programs (IHCP) reminds providers that procedures performed in an outpatient setting or place of service 22, 23, or 62, which are normally provided in a physician's office, are subject to a site-of-service payment adjustment. The site-of-service adjusted amount is 80% of the practice expense component of the statewide resource-based relative value scale (RBRVS) rate on the Fee Schedule at indianamedicaid.com. See *Chapter 7* of the *IHCP Provider Manual* for additional information.

Effective November 7, 2014, the site-of-service payment adjustment will be applied to the procedure codes in Table 2

continue

when services are delivered in an outpatient setting. This adjustment will be removed for the procedure codes in Table 3. These changes will apply to fee-for-service claims for dates of service (DOS) on or after November 7, 2014.

Table 2 – Procedure codes to which the site-of-service payment adjustment for outpatient settings will apply for DOS on or after November 7, 2014

Procedure Code	Procedure Code Modifier*	Description
11719		Trimming of nondystrophic nails, any number
78812		Positron emission tomography (PET) imaging; skull base to mid-thigh
78812	TC	Positron emission tomography (PET) imaging; skull base to mid-thigh
78815		Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh
78815	TC	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh

** If a modifier is listed, the adjustment applies when the code and the modifier are billed together.*

Table 3 – Procedure codes to which the site-of-service payment adjustment for outpatient settings will no longer apply for DOS on or after November 1, 2014

Procedure Code	Procedure Code Modifier	Description
22551		Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
29824		Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)
29827		Arthroscopy, shoulder, surgical; with rotator cuff repair
70496	26	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing
70498	26	Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing
70543	26	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences
70544	26	Magnetic resonance angiography, head; without contrast material(s)
70547	26	Magnetic resonance angiography, neck; without contrast material(s)
70549	26	Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences
71275	26	Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing

continue

Table 3 – Procedure codes to which the site-of-service payment adjustment for outpatient settings will no longer apply for DOS on or after November 7, 2014

Procedure Code	Procedure Code Modifier	Description
71552	26	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequence
72191	26	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing
72195	26	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)
72197	26	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences
72291	26	Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance
73218	26	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)
73706	26	Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing
73718	26	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)
73723	26	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s), followed by contrast material(s) and further sequences
74175	26	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing
74182	26	Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)
74183	26	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences
75635	26	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing
76376	26	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation
76377	26	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation
76801	26	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation

continue

Table 3 – Procedure codes to which the site-of-service payment adjustment for outpatient settings will no longer apply for DOS on or after November 7, 2014

Procedure Code	Procedure Code Modifier	Description
76802	26	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)
76817	26	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76819	26	Fetal biophysical profile; without non-stress testing
76937	26	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)
77001	26	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)
77002	26	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)
77003	26	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)
77014	26	Computed tomography guidance for placement of radiation therapy fields
77051	26	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure)
77052	26	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure)
77057	26	Screening mammography, bilateral (2-view film study of each breast)
77059	26	Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral
77072	26	Bone age studies
77073	26	Bone length studies (orthoroentgenogram, scanogram)
77074	26	Radiologic examination, osseous survey; limited (eg, for metastases)
77075	26	Radiologic examination, osseous survey; complete (axial and appendicular skeleton)
77077	26	Joint survey, single view, 2 or more joints (specify)
77080	26	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)
78812	26	Positron emission tomography (PET) imaging; skull base to mid-thigh
78815	26	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh

continue

Table 3 – Procedure codes to which the site-of-service payment adjustment for outpatient settings will no longer apply for DOS on or after November 7, 2014

Procedure Code	Procedure Code Modifier	Description
G0204	26	Diagnostic mammography, producing direct digital image, bilateral, all views
G0206	26	Diagnostic mammography, producing direct digital image, unilateral, all views

QUESTIONS?

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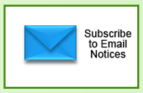

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