

# IHCP *banner page*

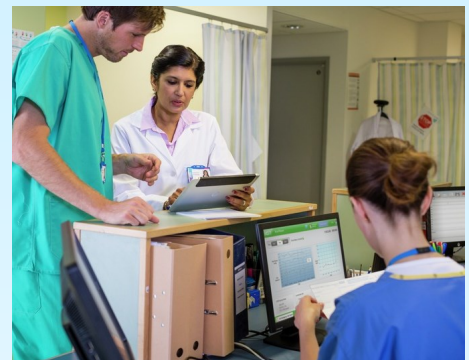
INDIANA HEALTH COVERAGE PROGRAMS BR201441 OCTOBER 14, 2014

## The IHCP reminds providers of reimbursement policies and billing guidelines for treatment room revenue codes

The Indiana Health Coverage Programs (IHCP) reminds providers of certain reimbursement policies and billing guidelines in place for billing treatment room revenue codes (RCs). This policy is not new; for details, see [Chapter 8: Billing Instructions](#) of the *IHCP Provider Manual* at indianamedicaid.com.

### Treatment room revenue codes billed with surgical procedure codes

Revenue codes for treatment rooms (such as 45X, 51X, 52X, 70X, 72X, and 76X) are defined as surgical revenue codes when billed with a surgical Current Procedural Terminology (CPT<sup>®1</sup>) or Healthcare Common Procedure Coding System (HCPCS) procedure code. When claims are billed this way, the IHCP reimburses these revenue codes at the appropriate ambulatory surgical center (ASC) rate. If no surgical procedure is performed, the provider must bill the treatment room revenue code without a CPT or HCPCS procedure code. In these instances, the IHCP reimburses the service at the treatment room flat rate.



### Administration of therapeutic and diagnostic injections

Administration of therapeutic and diagnostic injections, including the administration of infusions and vaccines, are required to be billed with the revenue code for the treatment room where the injection was administered (such as an operating room – 360, emergency room – 450, or clinic – 510). Reimbursement for the administration of injections and infusions is considered when establishing treatment room rates; therefore, administration of the injection or infusion is typically not separately reimbursable, unless otherwise specified by the IHCP. If a patient was treated and received only an injection or infusion service, the provider will be reimbursed the flat rate of the appropriately billed treatment room revenue code.

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#### RC 92X and 94X series

The IHCP does not reimburse for revenue codes in the 92X – *Other Diagnostic Services* and 94X – *Other Therapeutic Services* series. Claims billing these revenue codes are denied with explanation of benefits (EOB) code 4107 – *Revenue code is not appropriate or not covered for the type of service being provided.*

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## Claims denied for transgender members due to sex identification

The Indiana Health Coverage Programs (IHCP) has been made aware of claim denials for transgender members due to sex-versus-procedure or sex-versus-diagnosis edits in the IndianaAIM claims processing system. The claims may have denied with one of the following explanation of benefits (EOB) codes related to such edits:

- 4028 – *Diagnosis vs sex restriction per detail, Diagnosis code not compatible with recipient's sex, please verify and resubmit the claim.*
- 4031 – *Diagnosis vs sex restriction per header level, Diagnosis given not compatible with recipient's sex, please verify and resubmit the claim.*
- 4035 – *Procedure code vs sex restriction, procedure code billed not compatible with the recipient's sex, please verify and resubmit.*

Effective November 13, 2014, claims with dates of service on or after September 1, 2013, that denied for one of these EOB codes may be resubmitted for reimbursement consideration, along with a copy of this banner page and supporting medical documentation showing that the member is transgender. In order for claims to bypass timely filing limits, the claim must be submitted within one year of publication of this banner. Appropriate medical documentation includes:

- Medical records showing that the procedure performed is consistent with the member's transgender status
- A statement of medical necessity based on the patient's biological status

The supporting documentation will be reviewed by the Medical Review Team for appropriateness of the services for the member.

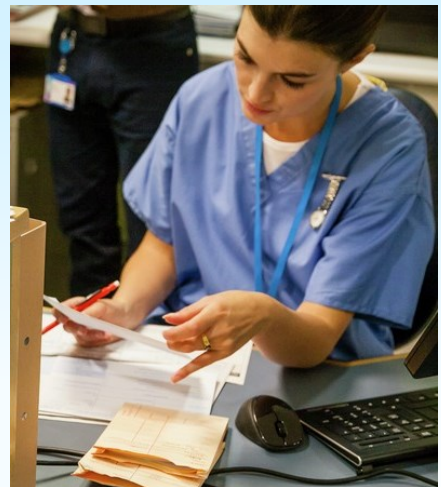
## CPT codes 92607 and 92608 linked to revenue code 444

Effective November 15, 2014, the Indiana Health Coverage Programs (IHCP) will link the following Current Procedural Terminology (CPT) codes to revenue code 444 – *Speech Therapy-Language Pathology-Evaluation or Reevaluation*:

- 92607 – *Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour*
- 92608 – *Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure).*

These linkages apply retroactively to dates of service (DOS) on or after **July 1, 2014**. Beginning November 15, 2014, for reimbursement consideration, providers may bill CPT codes 92607 and 92608 with revenue code 444, as appropriate.

Claims with DOS on or after July 1, 2014, that previously denied for explanation of benefits (EOB) 520 – *Invalid revenue code/procedure code combination* may be resubmitted for processing.



**QUESTIONS?**

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