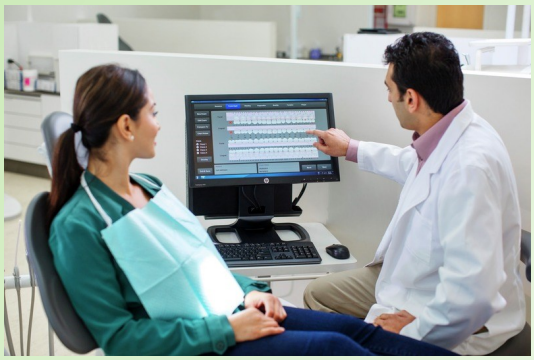
# IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201526 JUNE 30, 2015

## IHCP to cover HCPCS code D4910



Effective August 1, 2015, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code D4910 – *Periodontal maintenance*. Coverage applies to all IHCP programs except for the Healthy Indiana Plan (HIP), subject to limitations established for certain benefit packages. Coverage applies to dates of service (DOS) on or after August 1, 2015.

The following reimbursement information applies:

**Pricing**: Maximum fee of $153.00

**Prior authorization (PA)**: None

**Billing Guidance**: The IHCP provides coverage for periodontal maintenance with the following restrictions:

- At least one unit of either D4341 – *Periodontal scaling and root planing, four or more teeth per quadrant,* or D4342 – *Periodontal scaling and root planing, one to three teeth per quadrant*, has been billed. There must be at least six months between the first DOS for D4341 or D4342 and the first DOS for periodontal maintenance.
- Coverage is limited to once every six months for members 3 through 20 years of age or for institutionalized members.
- Coverage is limited to once every 12 months for members 21 years of age and older.
- Providers are not allowed to bill for HCPCS code D1120 – *Prophylaxis, child* or D1110 – *Prophylaxis, adult* for members receiving periodontal maintenance. There must be at least six months between a DOS billed for periodontal maintenance and prophylaxis for individuals under the age of 21, or for institutional members; and 12 months between a DOS billed for periodontal maintenance and prophylaxis for individuals aged 21 and older.

These changes will be reflected in the next monthly update to the Fee Schedule at indianamedicaid.com. Reimbursement and PA information applies to services delivered under the fee-for-service (FFS) delivery system. Individual managed care entities (MCEs) establish and publish reimbursement, PA, and billing criteria within the risk-based managed care (RBMC) delivery system. Questions about RBMC-PA should be directed to the MCE with which the member is enrolled.

**MORE IN THIS ISSUE**

## Changes to Indiana law affect IHCP pharmacy reimbursement of methadone

Effective July 1, 2015, Indiana Code *IC 12-15-35.5-7.5* (called for in *Senate Enrolled Act 464*) allows Medicaid reimbursement for methadone on a pharmacy claim if the drug is prescribed for the treatment of pain or pain management. Accordingly, the Indiana Health Coverage Programs (IHCP) will reimburse pharmacy claims for methadone for dates of service (DOS) on or after July 1, 2015, only under the following conditions:

- The drug must be prescribed for the treatment of pain or pain management
- The daily dosage cannot exceed 60 milligrams without prior authorization (PA)
- A daily dosage greater than 60 milligrams requires PA based on proof of medical necessity

This change in pharmacy coverage applies to fee-for-service (FFS) and risk-based managed care (RBMC) IHCP programs, subject to limitations established for certain benefit packages.

## IHCP to include additional diagnosis codes for coverage of PET scans

Effective August 1, 2015, the Indiana Health Coverage Programs (IHCP) will include additional diagnosis codes under its coverage policy of Positron Emission Tomography (PET) scans. The additional diagnosis codes are listed in Table 1. This change applies to all IHCP programs with the exception of the Healthy Indiana Plan (HIP), subject to limitations established for certain benefit packages. The change applies retroactively for dates of service (DOS) on or after **May 1, 2015** and will be reflected in updates to the *Medical Policy Manual* at indianamedicaid.com.

Beginning August 1, 2015, fee-for-service (FFS) claims for PET scans performed on or after May 1, 2015, with these diagnosis codes, can be submitted for reimbursement consideration. Claims for DOS on or after May 1, 2015 that denied for explanation of benefits (EOB) 4204 – *Invalid diagnosis for procedure code/modifier combination* may be resubmitted for reimbursement consideration. Claims submitted beyond the one-year timely filing limit must include a copy of this BR page as an attachment and must be filed within one year of the publication date.

Individual managed care entities (MCEs) establish and publish reimbursement and billing guidance within the risk-based managed care (RBMC) delivery system. Related questions should be directed to the MCE with which the member is enrolled.

*Table 1 – Diagnosis codes added under coverage policy of PET scans for DOS on or after May 1, 2015*

| Diagnosis Code | Description |
|---|---|
| 157.9 | Malignant neoplasm of the pancreas, part unspecified |
| 163.8 | Malignant neoplasm of the pleura of the other specified sites of pleura |
| 180.9 | Malignant neoplasm of cervix uteri, unspecified site |
| 203.00 | Multiple myeloma, without mention of having achieved remission |
| 518.89 | Other disease of lung, not elsewhere classified |
| 785.6 | Enlargement of lymph nodes |

## IHCP will mass adjust claims for HCPCS codes that denied incorrectly for NDC coding

The Indiana Health Coverage Programs (IHCP) has identified a claims processing issue that affects certain claims processed with dates of service (DOS) from January 1, 2015, through May 19, 2015, that require a National Drug Code (NDC). Claim details billed for the Healthcare Common Procedure Coding System (HCPCS) codes in Table 2 may have inappropriately denied with explanation of benefits (EOB) 4300 – *Invalid NDC to procedure code combination,* even though NDCs were correctly included on the claim forms.

*Table 2 – HCPCS codes potentially denied inappropriately for EOB 4300 for DOS from January 1, 2015, through May 19, 2015*

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| A9606 | J1322 | J1439 | J2704 | J3145 | J7181 | J7200 | J7201 | J9267 |

The codes in Table 2 have now been linked to the appropriate NDC codes in the claims processing system. Claims processed during the indicated time frame with detail lines that previously denied for EOB 4300 will be mass adjusted. Providers should begin to see the adjusted claims on Remittance Advices (RAs) dated August 4, 2015, with internal control numbers (ICNs) that begin with 56 – mass adjusted.

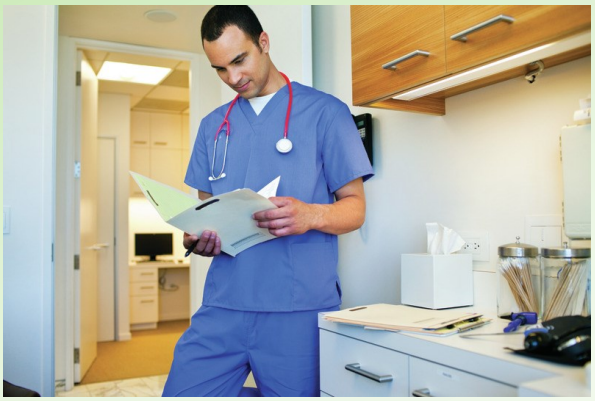
## Selected CPT codes no longer linked to revenue code 921

Effective August 1, 2015, the Indiana Health Coverage Programs (IHCP) will no longer link the Current Procedural Terminology (CPT®[1]) codes in Table 3 to revenue code 921 – *Other diagnostic services, peripheral vascular lab*. These linkage changes are consistent with national coding guidelines and apply to fee-for-service (FFS) claims for dates of service (DOS) on or after date August 1, 2015. Claims billing the CPT codes in Table 3 with revenue code 921 for DOS on or after August 1, 2015 will deny.

*Table 3 – Codes no longer linked to revenue code 921 for DOS on or after August 1, 2015*

| Code | Description |
|---|---|
| 93799 | Unlisted cardiovascular service or procedure |
| 93886 | Transcranial Doppler study of the intracranial arteries; complete study |
| 93888 | Transcranial Doppler study of the intracranial arteries; limited studies |
| 93930 | Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study |
| 93970 | Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study |
| 93971 | Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study |
| 93975 | Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study |

## HCPCS code J7327 no longer linked to revenue code 636



In Indiana Health Coverage Programs (IHCP) Bulletin *BT201501*, dated January 6, 2015, Healthcare Common Procedure Coding System (HCPCS) code J7327 – *Hyaluronan or derivative, MONOVISC, for intra-articular injection, per dose* was incorrectly listed as billable with revenue code 636 – *Drugs requiring detailed coding for separate reimbursement in the outpatient setting*.

Effective August 1, 2015, HCPCS code J7327 will no longer be linked to revenue code 636 and no longer be separately reimbursable in the outpatient setting. This change applies to fee-for-service (FFS) claims for dates of service (DOS) on or after August 1, 2015. Claims with DOS before August 1, 2015, will be unaffected.

## CPT codes 77061 and 77062 linked to revenue code 614

Effective August 1, 2015, the Indiana Health Coverage Programs (IHCP) will link the following Current Procedural Terminology (CPT) codes to revenue code 614 – *Magnetic resonance technology-MRI-other*:

- 77061 – *Digital breast tomosynthesis; unilateral*
- 77062 – *Digital breast tomosynthesis; bilateral*

These linkages follow national coding guidelines. Linkages will apply retroactively to fee-for-service (FFS) claims with dates of service (DOS) on or after **January 1, 2015**.

For reimbursement consideration, beginning August 1, 2015, providers may bill CPT code 77061 or 77062 and revenue code 614 together, as appropriate. Claims with DOS on or after January 1, 2015, that previously denied with explanation of benefits (EOB) 520 – *Invalid revenue code and procedure code combination* or EOB 4107 – *Revenue code is not appropriate/covered for service; Revenue group invalid* may be resubmitted. Claims beyond the original one-year filing limit must include a copy of this banner page as an attachment and must be filed within one year of the publication date.

## Certain CPT codes linked to revenue codes 920/929/940

Effective August 1, 2015, the Indiana Health Coverage Programs (IHCP) will link certain Current Procedural Terminology (CPT) codes to one or more of the following diagnostic and therapeutic revenue codes for reimbursement consideration:

- 920 – *Other Diagnostic Services – General*
- 929 – *Other Diagnostic Service – Other Diagnostic Service*
- 940 – *Other Therapeutic Service – General*

*continued*

Table 4 lists the affected CPT codes and the revenue codes linked to each. These linkages apply retroactively to fee-for-service (FFS) claims with dates of service (DOS) on or after **July 1, 2015**. For reimbursement consideration, beginning August 1, 2015, providers may bill the CPT codes listed in Table 4 together with the relevant revenue code 920, 929, or 940, as appropriate. Claims submitted beyond the original one-year timely filing limit must include a copy of this banner page as an attachment and must be filed within one year of the publication date.

Providers may bill these revenue codes only with the corresponding CPT codes listed in the tables. Claims billing these revenue codes with any other CPT codes will be denied.

*Table 4 – CPT codes linked to revenue codes 920, 929, or 940 for DOS on or after July 1, 2015*

| Code | Description | Revenue Code Linkages |
|---|---|---|
| 92542 | Positional nystagmus test, minimum of 4 positions, with recording | 920, 929 |
| 92543 | Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording | 920, 929 |
| 92546 | Sinusoidal vertical axis rotational testing | 920, 929 |
| 92548 | Computerized dynamic posturography | 920, 929 |
| 93886 | Transcranial Doppler study of the intracranial arteries; complete study | 920, 929 |
| 93888 | Transcranial Doppler study of the intracranial arteries; limited study | 920, 929 |
| 93890 | Transcranial Doppler study of the intracranial arteries; vasoreactivity study | 920, 929 |
| 93892 | Transcranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection | 920, 929 |
| 93893 | Transcranial Doppler study of the intracranial arteries; emboli detection with intravenous microbubble injection | 920, 929 |
| 93930 | Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study | 929 |
| 93970 | Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study | 929 |
| 93971 | Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study | 929 |
| 93975 | Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study | 929 |
| 93998 | Unlisted noninvasive vascular diagnostic study | 920, 929 |
| 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 | 920, 929 |

*Table 4 – CPT codes linked to revenue codes 920, 929, or 940 for DOS on or after July 1, 2015 (continued)*

| Code | Description | Revenue Code Linkages |
|---|---|---|
| 95782 | Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist | 920, 929 |
| 95783 | Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist | 920, 929 |
| 95857 | Cholinesterase inhibitor challenge test for myasthenia gravis | 920, 929 |
| 95933 | Orbicularis oculi (blink) reflex, by electrodiagnostic testing | 920, 929 |
| 95970 | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurement | 920, 929 |
| 95971 | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurement | 920, 929 |
| 95972 | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurement | 920, 929 |
| 95974 | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurement | 920, 929 |
| 95978 | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse | 920, 929 |
| 95981 | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator | 920, 929 |
| 95982 | Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator | 920, 929 |

*Table 4 – CPT codes linked to revenue codes 920, 929, or 940 for DOS on or after July 1, 2015 (continued)*

| Code | Description | Revenue Code Linkages |
|---|---|---|
| 96000 | Comprehensive computer-based motion analysis by video-taping and 3D kinematics | 920, 929 |
| 96001 | Comprehensive computer-based motion analysis by video-taping and 3D kinematics; with dynamic plantar pressure measurements during walking | 920, 929 |
| 97610 | Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day | 940 |

**QUESTIONS?**

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