IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201536 SEPTEMBER 8, 2015

IHCP to correct pricing for laboratory codes G0103 and G0434 and mass adjust claims that paid incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claims processing issue that affects certain fee-for-service claims with dates of service (DOS) from January 1, 2013, through December 31, 2013. Claims billed during that time frame for the following Healthcare Common Procedure Coding System (HCPCS) codes may have overpaid due to incorrect rates on file.

- G0103 – *Prostate cancer screening; prostate specific antigen test (PSA)*
- G0434 – *Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter*

Pursuant to *Section 1903(i)(7)* of the *Social Security Act*, Medicaid reimbursement for individual clinical laboratory procedures cannot exceed the Medicare rate of reimbursement. The rates applied to claims for G0103 and G0434 with DOS from January 1, 2013, through December 31, 2013, did not comply with this requirement. The claims processing system has been corrected with accurate pricing for this time frame.

Claims for G0103 and G0434 with the DOS indicated will be mass adjusted. Providers should begin to see the adjusted claims on Remittance Advices (RAs) beginning November 1, 2015, with internal control numbers (ICN) that begin with 56 (mass adjusted). If a claim was overpaid, the net difference appears as an accounts receivable. The accounts receivable will be recouped at 100% from future claims paid to the respective provider number.

CPT code 11900 linked to provider specialty 180 – Optometrist

Effective October 9, 2015, the Indiana Health Coverage Programs (IHCP) will link Current Procedural Terminology (CPT®[1]) code 11900—*Injection, intralesional up to and including 7 lesions* to provider specialty 180 – Optometrist. This linkage applies to fee-for-service claims with dates of service (DOS) on or after October 9, 2015.

This change will be reflected in the next monthly update to the Code Sets at indianamedicaid.com. The standard billing guidelines outlined in Chapter 8 of the *IHCP Provider Manual* apply.

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MORE IN THIS ISSUE

Providers can assist in correcting Presumptive Eligibility MCE plan assignment errors

Individuals enrolling in the Indiana Health Coverage Programs (IHCP) via the Presumptive Eligibility (PE) process, who are eligible under the PE Adult aid category, are required to select a managed care entity (MCE) plan during the PE application process. It was recently discovered that member selections made from August 12, 2015, through August 25, 2015, may have been erroneously overridden by the system's auto-assignment logic. As a result, the information reflected in the IHCP Eligibility Verification System (EVS) may reflect an MCE plan other than the one selected by the member.

Affected members will be allowed to change MCE plan assignments. Changes will be made retroactive to members' PE enrollment date. If a member presents a PE approval letter with an MCE assignment different from what is reflected in the EVS, the provider can assist the member in having the error corrected in the following ways.

- The provider can fax a copy of the letter showing the original plan selection to HP Provider Relations at (317) 488-5020. Provider Relations will coordinate the appropriate change.
- Providers can direct members to call the enrollment broker, Maximus, at 877-438-4479 to change their plan. Maximus will coordinate the appropriate change.

IHCP to update pricing for certain anesthesiology codes and mass adjust claims that paid incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claims processing issue that affects certain fee-for-service anesthesiology claims with dates of service (DOS) on or after February 1, 2015. Claims for the Current Procedural Terminology (CPT®[1]) codes in Table 1 on the following page may have paid inappropriately due to incorrect rates on file.

Effective October 9, 2015, the rates for the affected codes will be updated. Claims for these codes with dates of service from February 1, 2015, through October 8, 2015, will be mass adjusted. Providers should begin to see the adjusted claims on Remittance Advices (RAs) dated October 27, 2015, with internal control numbers (ICNs) that begin with 56 (mass adjusted). For claims that were underpaid, the net difference will be paid and reflected on the RA. If a claim was overpaid, the net different appears as an accounts receivable. The accounts receivable will be recouped at 100% from future claims paid to the respective provider number.

Pricing information will be updated in the next monthly update to the provider Fee Schedule at indianamedicaid.com.

continued

Table 1 – Anesthesiology CPT codes that may have paid incorrectly due to incorrect rates on file for DOS from February 1, 2015 through October 8, 2015

CPT Code	Description
36555 AA	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age
36556 AA	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older
36557 AA	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; younger than 5 years of age
36558 AA	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years and older
36560 AA	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age
36561 AA	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older
36563 AA	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump
36565 AA	Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; without subcutaneous port or pump (eg, Tesio type catheter)
36566 AA	Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; with subcutaneous port(s)
36568 AA	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; younger than 5 years of age
36569 AA	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years and older
36570 AA	Insertion of peripherally inserted central venous catheter access device, with subcutaneous port; younger than 5 years of age
36571 AA	Insertion of peripherally inserted central venous catheter access device, with subcutaneous port; age 5 years or older
36575 AA	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site
36576 AA	Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site
36578 AA	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site
36580 AA	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
36581 AA	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
36582 AA	Replacement, complete, of a tunneled centrally inserted central venous device, with subcutaneous port, through same venous access

continued

Table 1 – Anesthesiology CPT codes that may have paid incorrectly due to incorrect rates on file for DOS from February 1, 2015 through October 8, 2015 (continued)

CPT Code	Description
36583 AA	Replacement, complete, of a tunneled centrally inserted central venous device, with subcutaneous pump, through same venous access
36584 AA	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump through same venous access
36585 AA	Replacement, complete, of a peripherally inserted central venous device with subcutaneous port, through same venous access
36589 AA	Removal of tunneled central venous catheter, without subcutaneous port or pump
36590 AA	Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion
36595 AA	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access
36596 AA	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen
36597 AA	Repositioning of previously placed central venous catheter under fluoroscopic guidance
36620 AA	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous
36625 AA	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); cutdown
93503 AA	Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes
99183 AA	Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session

QUESTIONS?

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