IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201616 APRIL 19, 2016

CPT code 87624 linked to revenue codes 300, 306, and 309

Effective May 19, 2016, the Indiana Health Coverage Programs (IHCP) will link Current Procedural Terminology (CPT®[1]) code 87624 – *Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), high-risk types* to the following revenue codes:

- 300 – *Laboratory-General*
- 306 – *Laboratory-bacteriology and microbiology*
- 309 – *Laboratory-other laboratory*

These linkages apply retroactively to fee-for-service claims with dates of service (DOS) on or after **October 1, 2015**.

For reimbursement consideration, beginning May 19, 2016, providers may bill CPT code 87624 and revenue codes 300, 306, or 309 together, as appropriate. Claims with DOS on or after October 1, 2015, that previously denied for explanation of benefits (EOB) 520 – *Invalid revenue code and procedure code combination* will be mass adjusted.

Mass adjusted claims will begin appearing on the June 7, 2016, Remittance Advice (RA) and will be identified with internal control numbers (ICNs) that begin with 56 (mass adjusted).

CPT code 22551 linked to revenue code 490

Effective May 19, 2016, the Indiana Health Coverage Programs (IHCP) will link Current Procedural Terminology (CPT®[1]) code 22551 – *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2* to revenue code 490 - *Ambulatory Surgical Care-General.*

This linkage applies retroactively to fee-for-service claims with dates of service (DOS) on or after **July 1, 2015.**

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For reimbursement consideration, beginning May 19, 2016, providers may bill CPT code 22551 and revenue code 490 together, as appropriate. Claims with DOS on or after July 1, 2015, that previously denied for explanation of benefits (EOB) 520 – *Invalid revenue code and procedure code combination* 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.

IHCP to end separate reimbursement for certain CPT codes in the outpatient setting

Effective May 19, 2016, the Indiana Health Coverage Programs (IHCP) will no longer separately reimburse the Current Procedural Terminology (CPT®[1]) codes in Table 1 when they are provided in the outpatient setting. Reimbursement for these CPT codes is included in the established payment for other outpatient services. This change affects outpatient billing on the *UB-04* or the 837I only. Professional billing for these codes on the *CMS-1500* or the 837P will not be affected. The change applies to fee-for-service (FFS) claims with dates of service (DOS) on or after May 19, 2016.

Table 1 – CPT codes no longer separately reimbursable in the outpatient setting for DOS on or after May 19, 2016

CPT Code	Description
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)
65757	Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)
77061	Digital breast tomosynthesis; unilateral
77062	Digital breast tomosynthesis; bilateral
99143	Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; younger than 5 years of age, first 30 minutes intra-service time
99144	Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; age 5 years or older, first 30 minutes intra-service time
99145	Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time (List separately in addition to code for primary service)

continued

Table 1 – CPT codes no longer separately reimbursable in the outpatient setting for DOS on or after May 19, 2016 (continued)

CPT Code	Description
99148	Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; younger than 5 years of age, first 30 minutes intra-service time
99149	Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; age 5 years or older, first 30 minutes intra-service time
99150	Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary service)
99177	Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with on-site analysis

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