IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR201743 OCTOBER 24, 2017

IHCP assigns maximum-fee pricing to CPT codes 77065, 77066, and 77067

Effective November 24, 2017, the Indiana Health Coverage Programs (IHCP) will assign maximum-fee pricing to the Current Procedural Terminology (CPT®[1]) codes in Table 1. The maximum-fee pricing amount for each code is noted in the table. This pricing applies retroactively to outpatient services with dates of service (DOS) on or after **January 1, 2017**.

Table 1 – Maximum-fee pricing assigned to outpatient services codes, effective for DOS on or after January 1, 2017

Code	Description	Payment Amount
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	$65.56
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	$83.89
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	$69.28

Beginning November 24, 2017, providers may resubmit fee-for-service (FFS) outpatient claims for CPT codes 77065, 77066, and 77067 for the affected DOS that previously denied for explanation of benefits (EOB) 4014 – *Claim being reviewed for pricing* for reimbursement consideration. 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. Specific guidance regarding similarly affected managed care claims will be issued directly by the managed care entities (MCE).

This pricing change will be reflected in the next regular update to the *Outpatient Fee Schedule* at indianamedicaid.com.

IHCP to mass adjust or mass reprocess claims for HCPCS code H0035 that denied incorrectly

The Indiana Health Coverage Programs (IHCP) identified a claim-processing issue that affects fee-for-service partial hospitalization claims for Healthcare Common Procedure Coding System (HCPCS) code H0035 – *Mental Health Partial Hospitalization, treatment, less than 24 hours*, for dates of service (DOS) on or after February 13, 2017. Claims denied incorrectly with explanation of benefits (EOB) 4013 – *This procedure is not covered for this date of service*.

The claim-processing system has been corrected. Claims or claim detail for procedure code H0035 for the affected DOS that denied for EOB 4013 will be mass adjusted or mass reprocessed.

continued

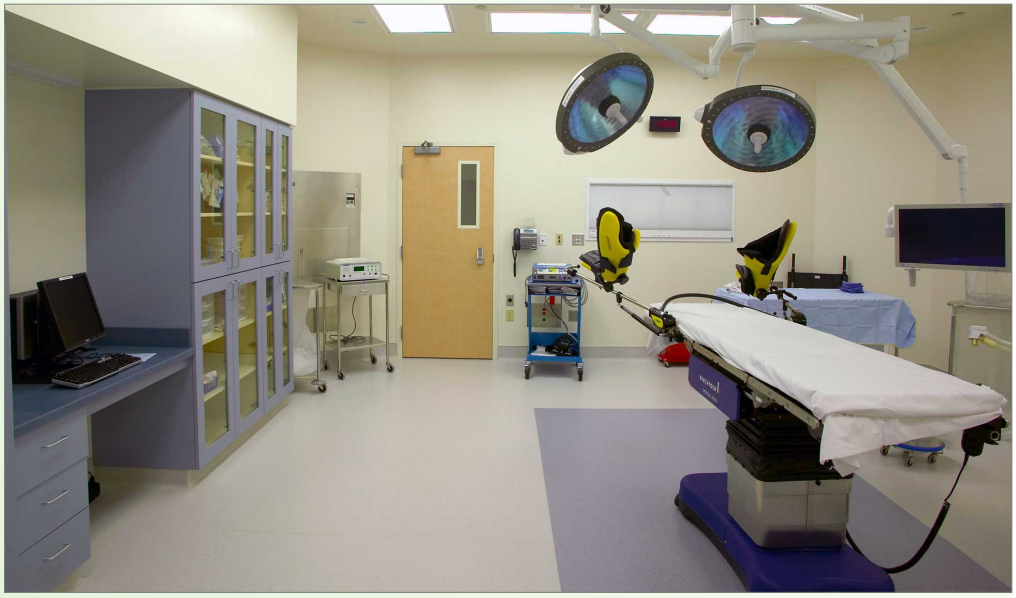
Providers should see claims affected by this issue on Remittance Advices (RAs) beginning November 28, 2017. These claims will be identified by internal control numbers (ICNs)/Claim IDs that begin with 52 (mass replacement non-check related) and 80 (reprocessed denied claims). For claims that were underpaid, the net difference will be paid and reflected on the RA.

IHCP links CPT code 0474T to revenue code 940 and updates pricing

Effective November 24, 2017, the Indiana Health Coverage Programs (IHCP) will update the pricing for Current Procedural Terminology (CPT®[1]) code 0474T – *Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space.* Pricing for code 0474T will change from Ambulatory Surgery Center (ASC) pricing to maximum-fee pricing. The IHCP will adopt Medicare's maximum-fee rate. This pricing change applies retroactively to outpatient claims with dates of service (DOS) on or after **July 1, 2017**.

Additionally, effective November 24, 2017, the IHCP will link CPT code 0474T to revenue code 940 – *Other Therapeutic Services.* This linkage applies retroactively to outpatient claims with dates of service (DOS) on or after **July 1, 2017**.

For reimbursement consideration, beginning November 24, 2017, providers may bill CPT code 0474T and revenue code 940 together, as appropriate. Fee-for-service (FFS) 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.



Fee-for-service claims or claims detail with DOS on or after July 1, 2017, that previously denied for explanation of benefits (EOB) 0520 – *Invalid revenue code and procedure code combination*, will be mass adjusted or mass reprocessed. Mass adjusted and mass reprocessed claims will begin appearing on the November 28, 2017, Remittance Advice (RA) and will be identified with internal control numbers (ICNs)/Claim IDs that begin with region codes 56 (mass void request or single claim void) or 80 (reprocessed denied claims). For claims that were underpaid, the net difference will be paid and reflected on the RA.

The pricing change will be reflected in the next regular update to the *Outpatient Fee Schedule*. The revenue code linkages will be reflected in updates to the *Revenue Codes Linked to Specific Procedure Codes* table, accessible through the Code Sets web page at indianamedicaid.com.

IHCP to update outpatient reimbursement methodology for cardiology revenue codes

Effective December 1, 2017, the Indiana Health Coverage Programs (IHCP) will update the outpatient reimbursement methodology from stand-alone services to treatment room services for the following revenue codes:

- 480 – *Cardiology – General Classification*
- 481 – *Cardiology – Cardiac Catheter Lab*
- 482 – *Cardiology – Stress Test*
- 489 – *Cardiology – Other Cardiology*

The change in methodology from stand-alone services to treatment room services applies to outpatient claims with dates of service (DOS) on or after December 1, 2017.

Providers should continue to bill outpatient services for these revenue codes as before. The IHCP outpatient methodology allows reimbursement for a treatment room at a flat statewide rate per date of service (DOS). The flat rates of revenue codes 480, 481, 482, and 489 remain unchanged.

Treatment room services reported with surgical procedure codes that have an ambulatory surgical center (ASC) rate on file will pay the ASC rate of the procedure code. Two surgical services are reimbursed per date of service. The highest reimbursing ASC rate will be reimbursed at 100% of the allowed amount, and the second highest reimbursing ASC rate at 50%.

Additional information about the IHCP outpatient payment methodology can be found in the *Outpatient Hospital and Ambulatory Surgical Center Services* provider reference module available at indianamedicaid.com. The *Revenue Codes* table and the *Outpatient Payment Methodologies* table accessible via the Code Sets page at indianamedicaid.com will be updated to reflect these changes

QUESTIONS?

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