IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR201814 APRIL 3, 2018

IHCP to cover CPT code 90682

Effective May 3, 2018, the Indiana Health Coverage Programs (IHCP) will cover Current Procedural Terminology (CPT®[1]) code 90682 – *Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use)*. The Food and Drug Administration (FDA) approved the product Flublok Quadrivalent for this code, in October 2016 for patients 18 years of age and older. Coverage applies to all IHCP programs, subject to limitations established for certain benefit plans. Coverage applies to dates of service (DOS) on or after May 3, 2018.

The following reimbursement information applies:

- Pricing: Maximum fee of $46.31
- Prior authorization (PA): None required
- Billing guidance: See the *Injections, Vaccines, and Other Physician-Administered Drugs* provider reference module at indianamedicaid.com for billing procedures.

This coverage information will be reflected in the next regular update to the *Professional Fee Schedule* at indianamedicaid.com.

Reimbursement, PA, and billing information apply 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 managed care delivery system. Questions about managed care billing and PA should be directed to the MCE with which the member is enrolled.

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IHCP to cover CPT Code 81528

Effective May 3, 2018, the Indiana Health Coverage Programs (IHCP) will cover Current Procedural Terminology (CPT®[1]) code 81528 – *Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result (Cologuard).* Coverage is limited to once every 3 years for individuals ages 50 through 75, and applies to dates of service (DOS) on or after May 3, 2018.

continued

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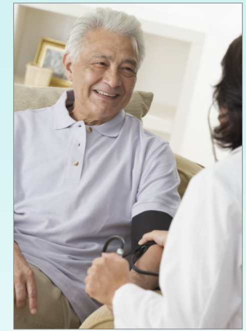

The following reimbursement information applies.

- Pricing: Max fee of $508.87
- Prior authorization (PA): None required
- Billing guidance: Standard billing guidance applies

This coverage information will be reflected in the next regular update to the *Outpatient Fee Schedule* and the *Professional Fee Schedule* at indianamedicaid.com.

Reimbursement, PA, and billing information apply 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 managed care delivery system. Questions about managed care billing and PA should be directed to the MCE with which the member is enrolled.

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New dental provider training now available

The Indiana Health Coverage Programs (IHCP) is making web-based Program Integrity Provider Education Training available to all providers. Each training focuses on specific IHCP services and/or provider specialties, and covers topics such as documentation requirements, billing guidelines, and other program integrity-related and audit-related issues. These training presentations are intended to supplement the provider reference modules and other IHCP-published provider reference materials.

The newest Program Integrity Provider Education Training titled, Dental Provider Documentation Requirements and Billing Guidelines is now available. The training is designed specifically for dental providers that bill through the fee-for-service (FFS) delivery system, although any dental provider may take the web-based training and find it helpful.

In this course, providers will learn how to appropriately document and bill for medically necessary dental services. By the end of the course, providers should be able to:

- Define the different types of covered dental services
- Determine when prior authorization is required for dental services
- Describe the general requirements and best practices for billing dental services
- Define the coverage, limitations, and billing requirements for common dental services.

To access the training, navigate to the *Program Integrity Provider Education Trainin*g page at indianamedicaid.com. Other training topics are listed below. Watch upcoming IHCP provider publications for announcements when trainings under development become available.

- *Non-Emergency Transportation Documentation Requirements and Billing Guidelines*
- *Ambulance Transportation Documentation Requirements and Billing Guidelines*
- *Program Integrity Audit Process* (under development)

IHCP revises periodontal maintenance policy

The Indiana Health Coverage Programs (IHCP) currently covers periodontal maintenance (D4910 – *Periodontal maintenance*) only when at least one unit of the following qualifying dental services had been rendered prior:

- D4341 – *Periodontal scaling and root planing – four or more teeth per quadrant*
- D4342 – *Periodontal scaling and root planing – one to three teeth per quadrant*

Further, there must be at least six months between the date of service (DOS) for the first qualifying service and the DOS for periodontal maintenance.

Effective May 3, 2018, the IHCP will revise its coverage policy to include the Current Dental Terminology (CDT®[1]) codes in Table 1 as qualifying dental codes to allow subsequent reimbursement for periodontal maintenance.

Table 1 – Additional CDT codes which allow subsequent reimbursement for periodontal maintenance, effective for dates of service (DOS) on or after May 3, 2018

Dental Code	Description
D4210	Gingivectomy or gingivoplasty, four or more contiguous teeth or tooth bounded spaces per quadrant
D4211	Gingivectomy or gingivoplasty, one to three contiguous teeth or tooth bounded spaces per quadrant
D4240	Gingival flap procedure, including root planing four or more contiguous teeth or tooth bounded spaces per quadrant
D4241	Gingival flap procedure, including root planing one to three contiguous teeth or tooth bounded spaces per quadrant
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant

If a fee-for-service (FFS) claim for D4910 denies with explanation of benefits (EOB) 6305 – *Periodontal maintenance (D4910) not allowed without a periodontal service paid in history,* and a qualifying service was performed before the member's enrollment, providers may request an administrative review of the claim's adjudication. The review request should include medical and/or dental records verifying that a qualifying service was performed before the member was enrolled and that the service was rendered at least 6 months before the DOS of the periodontal maintenance.

For information about requesting the administrative review of a claim, providers should refer to the Claim Administrative Review and Appeals provider reference module at indianamedicaid.com. The *Indiana Health Coverage Programs Administrative Review Request* form is located on the Forms page at indianamedicaid.com.

[1] *CDT copyright 2018 American Dental Association. All rights reserved. CDT is a registered trademark of the American Dental Association.*

IHCP to mass adjust inpatient claims that did not have HAF or ICD-10-PCS codes applied appropriately

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects fee-for-service (FFS) inpatient claims that may not have had Hospital Assessment Fee (HAF) adjustments or ICD-10 Procedure Coding System (ICD-10-PCS) codes applied appropriately. Inpatient claims billed by HAF-eligible providers did not have HAF adjustments applied as appropriate, which may have resulted in incorrect payments. Inpatient claims with ICD-10-PCS codes had the codes removed in error which may have resulted in reimbursement at an incorrect diagnosis-related group (DRG) rate.

The system has been corrected. Affected inpatient claims for dates of service (DOS) on or after February 13, 2017, will be mass adjusted. Providers should see the adjusted claims on Remittance Advices (RAs) beginning May 9, 2018, with internal control numbers (ICNs)/Claim IDs that begin with 52 (mass replacement non-check related). For claims that were underpaid, the net difference will be paid and reflected on the RA. 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.

IHCP to mass adjust or mass reprocess certain claims that adjudicated incorrectly in *Core*MMIS

The Indiana Health Coverage Programs (IHCP) continues to evaluate claims processed through the *Core*MMIS system to make certain all claims have adjudicated correctly. The IHCP has identified some claim-processing issues that affect a variety of Current Procedural Terminology (CPT®[1]) codes, Healthcare Common Procedure Coding System (HCPCS) codes, revenue codes, and explanation of benefits (EOB) codes for fee-for-service (FFS) claims. Details of the issues as well as the affected codes, claim processing dates, and types of claims affected appear in the following tables:

- Table 2 –This table lists procedure codes for which claims or claim details may have denied incorrectly.
- Table 3 – This table lists procedure codes for which claims or claim details may have paid incorrectly.
- Table 4 – This table lists revenue codes for which claims may have denied incorrectly.
- Table 5 – This table lists explanation of benefit (EOB) codes that were set incorrectly in the system to deny claims rather than to suspend claims for manual review.

These claim-processing issues have been corrected. Affected claims that may have processed incorrectly will be mass adjusted or mass reprocessed, as appropriate. Providers should begin to see the adjusted or reprocessed claims on Remittance Advices (RAs) beginning May 9, 2018. These claims will be identified by internal control numbers (ICNs)/ Claim IDs that begin with 52 (mass replacement non-check related) or 80 (reprocessed denied claims). For claims that were underpaid, the net difference will be paid and reflected on the RA. If a claim was overpaid, the net difference will appear as an accounts receivable. The accounts receivable will be recouped at 100% from future claims paid to the respective provider number.

continued

Table 2 – Procedure codes for which claims may have denied incorrectly

Procedure Code	Modifier	Processed Dates	Affected Claim Type
96377	62	2/13/17-3/28/18	Professional Claims
90710	N/A*	2/13/17-3/27/18	Professional Claims
G0659 P0973 P9100	N/A	2/13/17-2/7/18	Professional Claims
H2032	U7 U5	2/13/17-1/26/18	Waiver Claims
T2016	U7 U5	2/13/17-1/26/18	Waiver Claims
T2016	U7 U5 TG	2/13/17-1/26/18	Waiver Claims
64897 64902	62	2/13/17-1/24/18	Professional Claims
D9222 D9239	N/A	2/13/17-1/24/18	Dental Claims
A9597 A9598	N/A	2/13/17-11/22/17	Professional Claims
T2002	U7 U5	2/13/17-11/17/17	Waiver Claims
T2002	U7 U5 U2	2/13/17-11/17/17	Waiver Claims
T2002	U7 U5 U3	2/13/17-11/17/17	Waiver Claims
36903 36906 36908 36909	N/A	2/13/17-11/10/17	Outpatient Claims
50549	N/A	2/13/17-11/10/17	Outpatient Claims
92607	N/A	2/13/17-11/10/17	Professional Claims
C9733	N/A	2/13/17-11/10/17	Professional Claims and Outpatient Claims
J1890 Q9965 Q9966 Q9967	N/A	2/13/17-11/10/17	Outpatient Claims
90989 90993	N/A	2/13/17-10/18/17	Professional Claims
96549	N/A	2/13/17-10/18/17	Outpatient Claims
A9279	U7 U5 U2	2/13/17-10/11/17	Waiver Claims
A9279	U7 U5 U3	2/13/17-10/11/17	Waiver Claims
A9279	U7 U5 U4	2/13/17-10/11/17	Waiver Claims

continued

Table 2 – Procedure codes for which claims may have denied incorrectly (continued)

Procedure Code	Modifier	Processed Dates	Affected Claim Type
A9279	U7 U5 UA	2/13/17-10/11/17	Waiver Claims
C1779	N/A	2/13/17-10/11/17	Hospital Services Billed on Professional Claims
H2020	U7 U5 U1	2/13/17-10/11/17	Waiver Claims
H2020	U7 U5 U2	2/13/17-10/11/17	Waiver Claims
84449	N/A	2/13/17-10/5/17	Professional Claims and Outpatient Claims
85576	N/A	2/13/17-9/21/17	Professional Claims
92585	26	2/13/17-9/21/17	Professional Claims
96151	U1	2/13/17-9/21/17	Professional Claims
96151	N/A	2/13/17-9/12/17	Professional Claims
A6540	N/A	2/13/17-9/8/17	Professional Claims
90680	N/A	2/13/17-9/1/17	Professional Claims and Outpatient Claims
96040	N/A	2/13/17-8/15/17	Professional Claims and Outpatient Claims
77520 77522 77523 77525	N/A	2/13/17-8/11/17	Professional Claims
90620 90621	N/A	2/13/17-8/11/17	Professional Claims and Outpatient Claims
S5165	U7 NU	2/13/17-8/11/17	Waiver Claims
S5165	U7 U8	2/13/17-8/11/17	Waiver Claims
T2016	U7 U5 U3	2/13/17-8/11/17	Waiver Claims
81001 81002 97161 97162 97163 97164	N/A	2/13/17-8/4/17	Chiropractor Claims
T2029	U7 U8 U5	2/13/17-8/1/17	Waiver Claims
J1322 J1439 J2274 J2704	N/A	2/13/17-7/21/17	Professional Claims
92587 92588	TC or 26	2/13/17-7/14/17	Professional Claims
77301	N/A	2/13/17-7/11/17	Professional Claims
97760 97761	N/A	2/13/17-7/6/17	Professional Claims

continued

Table 2 – Procedure codes for which claims may have denied incorrectly (continued)

Procedure Code	Modifier	Processed Dates	Affected Claim Type
40899 45398 47133 48160	N/A	2/13/17-6/20/17	Professional Claims
72080 76497 77065 77066 77067	TC or 26	2/13/17-6/20/17	Professional Claims
76496 77402 77407	N/A	2/13/17-6/20/17	Professional Claims
78699	TC	2/13/17-6/20/17	Professional Claims
Q4152	N/A	2/13/17-4/28/17	Professional Claims and Outpatient Claims
S5165	U7 U8	2/13/17-4/28/17	Waiver Claims
T2033	U7 U5	2/13/17-4/28/17	Waiver Claims
T1005	U7 U5 TD	2/13/17-3/29/17	Waiver Claims
S5140	U7 U3	2/13/17-3/28/17	Waiver Claims
T2003	U7	2/13/17-3/28/17	Waiver Claims
T2015	U7 U5 UD	2/13/17-3/28/17	Waiver Claims
92516	80, 81, 82 or AS	2/13/17-3/24/17	Professional Claims
59409 59514 59612 59620	UA UB UC with 62, 80, 81, 82 or AS	2/13/17-3/11/17	Professional Claims
J7320	N/A	2/13/17-3/3/17	Professional Claims and Outpatient Claims
59409 59514 59612 59620 59425 59426	N/A	2/13/17-2/28/17	Professional Claims
S5165	U7	2/13/17-2/28/17	Waiver Claims
T2015	U7 U5 UA	2/13/17-2/20/17	Waiver Claims

** N/A (Not Applicable) indicates that no modifier applies.*

continued

Table 3 – Procedure codes for which claims may have paid incorrectly

Procedure Code	Modifier	Processed Dates	Affected Claim Type
S2083	N/A*	2/13/17-2/7/18	Outpatient Claims
33928 33929	N/A	2/13/17-1/9/18	Professional Claims
90756	N/A	2/13/17-1/9/18	Professional Claims
97127	80, 81, 82 or AS	2/13/17-1/9/18	Professional Claims
97760 97761	N/A	2/13/17-1/9/18	Professional Claims
0489T 0490T 0495T 0496T 0500T 0501T 0502T 0503T 0504T	80, 81, 82 or AS	2/13/17-1/9/18	Professional Claims
D5511	N/A	2/13/17-1/9/18	Dental Claims
41870 S2068	N/A	2/13/17-11/10/17	Outpatient Claims
50549 97607 97608	N/A	2/13/17-11/10/17	Outpatient Claims
93799	N/A	2/13/17-10/18/17	Outpatient Claims
S2117	N/A	2/13/17-10/18/17	Professional Claims
31634 36456	N/A	2/13/17-10/6/17	Outpatient Claims
G0499	N/A	2/13/17-10/5/17	Professional Claims
T4529	N/A	2/13/17-10/5/17	Professional Claims
81504	N/A	2/13/17-9/22/17	Professional Claims
L3257 L3260	N/A	2/13/17-9/21/17	Professional Claims
T1023	SE	2/13/17-9/12/17	Professional Claims
31632 31652 31653 36473 36903 36906 36908 36909	N/A	2/13/17-9/8/17	Outpatient Claims

continued

Table 3 – Procedure codes for which claims may have paid incorrectly (continued)

Procedure Code	Modifier	Processed Dates	Affected Claim Type
47532 47533 47534 47536 47538 47539 47540 47541 50430 50432 50433 50434 50693 50694 50695 92953 92961 92977 92986 92987 92990 94799 99170 0191T 0234T 0236T 0237T 0238T G0288 S2066 S2067 S2068 S2075 S2077 S2079 S2325	N/A	2/13/17-9/8/17	Outpatient Claims
S8121 S8185	N/A	2/13/17-9/8/17	Professional Claims
92601	N/A	2/13/17-8/4/17	Professional Claims
Q0505	N/A	2/13/17-8/4/17	Professional Claims
90648 C2644 J0129 J0561 J0743	N/A	2/13/17-7/14/17	Professional Claims and Outpatient Claims

continued

Table 3 – Procedure codes for which claims may have paid incorrectly (continued)

Procedure Code	Modifier	Processed Dates	Affected Claim Type
J1000 J1050 J1410 J1450 J1645 J1830 J2510 J2770 J3420 J3486 J7504 J7606 J9330	N/A	2/13/17-7/14/17	Professional Claims and Outpatient Claims
D3427	N/A	2/13/17-7/6/17	Dental Claims
J2920 J2930	N/A	2/13/17-6/29/17	Professional Claims and Outpatient Claims
78267 78268	N/A	2/13/17-6/20/17	Professional Claims
K0740 L3160	N/A	2/13/17-6/20/17	Professional Claims
90785 90940	N/A	2/13/17-3/10/17	Professional Claims and Outpatient Claims
99251 99252 99253 99254 99255	N/A	2/13/17-3/10/17	Professional Claims
59409 59425 59426 59514 59612 59620	N/A	2/13/17-2/28/17	Professional Claims
96120	N/A	1/1/17-2/12/17	Professional Claims

** N/A (Not Applicable) indicates that no modifier applies.*

Table 4 – Revenue codes for which claims may have adjudicated incorrectly

Revenue Code	Description	Processed Dates	Service Type
RC 710	Recovery room – general classification	2/13/17-10/11/17	Outpatient Claims
RC 924	Other diagnostic services – allergy test	2/13/17-9/1/17	Outpatient Claims

continued

Table 5 – EOB codes that reported for claims that denied in error rather than suspending for manual review

EOB Code	Description	Processed Dates	Affected Claim Type
4022	Claim denied for additional information. If the abortion was performed for therapeutic or other approved Indiana Health Coverage Program approved purposes, please resubmit the claim with a physician certification form and medical record documentation (H&P, discharge summary, op note).	2/13/17-4/10/17	Hospital Services Billed on Professional Claims
6382	Routine preoperative medical visits performed on the day of surgery are not separately payable. Documentation not present or not sufficient to justify care was of a non-routine nature.	2/13/17-4/10/17	Professional Claims
6383	Reimbursement reflects the difference between Indiana Health Coverage Programs allowable for the procedure billed and the amount paid for the component(s).	2/13/17-4/10/17	Professional Claims

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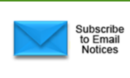

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