IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201935 AUGUST 27, 2019

IHCP to correct for overpayment of medical paper claims submitted with TPL/Medicare attachment forms

Paper medical claims (*CMS-1500*), as reminded in Indiana Health Coverage Programs (IHCP) *Banner Page* BR201914, must be submitted with a special attachment form that contains required third-party liability (TPL) and Medicare information at the detail-level.

The IHCP has identified a claim-processing issue that affected certain fee-for-service (FFS) claims processed from February 13, 2017, through August 15, 2019. Paper medical claims submitted with the *TPL/Medicare Special Attachment Form* may have overpaid inappropriately when the primary insurance made a payment.

The claim-processing system has been corrected. Claims processed during the indicated time frame that overpaid will be corrected. Providers should see the original claim voided on Remittance Advices (RAs) beginning October 2, 2019, and a new claim with internal control numbers (ICNs) or Claim IDs that begin with 10 (paper claims with no attachments) or 11 (paper claims with attachments). For a claim that 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.

Note: Providers are encouraged to use either an 837 electronic transaction or the IHCP Provider Healthcare Portal for submitting claims that require detail-level Medicare or other TPL information.

IHCP clarifies coverage qualifications for partial hospitalization

To qualify for partial hospitalization services, Indiana Health Coverage Programs (IHCP) members must have a diagnosed or suspected behavioral health condition (mental health illness or substance use disorder [SUD]) **and** one of the following:

- A short-term deficit in daily functioning
- An assessment of the member indicating a high probability of serious deterioration of the member's general medical or behavioral health

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Coverage for partial hospitalization services applies to all IHCP programs subject to limitations established for certain benefit packages.

Reimbursement information applies to outpatient services rendered in the fee-for-service (FFS) and the managed care service delivery systems. Some expectations apply to outpatient pricing for the Healthy Indiana Plan (HIP). Prior authorization (PA) and billing guidance apply to services delivered under the FSS delivery system. Questions about FFS PA should be directed to Cooperative Managed Care Services (CMCS) at 1-800-269-5720. Individual managed care entities (MCEs) establish and publish PA and billing guidance within the managed care delivery system. Questions about managed care guidance should be directed to the MCE with which the member is enrolled.

IHCP to update the anesthesia code sets

Effective October 1, 2019, the Indiana Health Coverage Programs (IHCP) will revise billing guidance for the anesthesia and certified registered nurse anesthetists (CRNAs) Current Procedural Terminology (CPT®[1]) codes.

Procedure codes that require the AA modifier when billed for anesthesia services

- Effective October 1, 2019, the IHCP will no longer require modifier AA – *Anesthesia services performed personally by an anesthesiologist* to be billed with certain codes. This update applies to fee-for-service (FFS) claims with dates of service (DOS) **retroactive to January 1, 2019**. The *Anesthesia Services Codes, Procedure Codes That Require the AA Modifier When Billed for Anesthesia Services,* will be considered obsolete and removed from the anesthesia code sets. Providers are expected to continue use of the modifier, as appropriate, per standard coding guidance.

  Note: The Anesthesia Services Codes tables are accessible from the Code Sets page at in.gov/medicaid/providers.

- Effective October 1, 2019, the CPT codes listed in Table 1 (see next page) will no longer require modifier AA to be considered an allowable CRNA service. The AA modifier will be removed from the anesthesia code set for CRNAs for DOS **retroactive to January 1, 2019**.

- The IHCP identified a claim-processing issue affecting FFS claims for anesthesia services with DOS on or after January 1, 2019. Claims or claim details for the procedure codes in Table 1 of the *Anesthesia Services Codes,* accessible from the *Code Sets* page, that were not billed with modifier AA may have denied.

  The claim-processing system has been corrected. This correction applies retroactively to claims with DOS on or after **January 1, 2019**, that denied incorrectly. Claims will be mass reprocessed or mass adjusted, as appropriate. Providers should see reprocessed or adjusted claims on Remittance Advices (RAs) beginning October 9, 2019, with internal control numbers (ICNs) or Claim IDs that begin with 80 (reprocessed denied claims) or 52 (mass replacement non-check related). For claims that were underpaid, the net difference will be paid and reflected on the RA.

- Effective October 1, 2019, the IHCP will no longer cover FFS claims for CPT code 99116 – *Anesthesia complicated by lowering total body temperature*. Previously, this code was covered only when billed with modifier AA. Claim details for DOS on or after October 1, 2019, will deny if billed with CPT code 99116.

continued

Procedure code set for certified registered nurse anesthetists

- The CPT codes in Table 2 were accurately included in the published code set for the for the CRNA provider specialty. However, in error, these procedure codes were **not** included in the claim-processing system as allowable for billing by this specialty. This issue affects anesthesia services in Table 2 that may have denied inappropriately. Claims that denied or claims that paid with a denied detail will be mass adjusted or reprocessed for DOS on or after January 1, 2019. Providers should see the reprocessed or adjusted claims on provider Remittance Advices (RAs) beginning October 9, 2019, with Claim IDs/ICNs 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.
- The CPT codes listed in Table 3 were correctly added to the *Core*MMIS claim-processing system, however, were **not** added to the anesthesia code set as allowable for billing by provider specialty 094 (CRNA). Providers may begin submitting or resubmitting claims with these codes on or after October 1, 2019, for DOS on or after January 1, 2019. Claims submitted beyond the 180-day timely filing limit must include a copy of this banner page.
- Effective October 1, 2019, CPT code 76937 – *Ultrasound guidance for accessing into blood vessel,* will no longer be billable by CRNAs. Claim details will deny for CPT code 76937 performed by CRNAs for DOS on or after October 1, 2019.
- These updates will be reflected on the *Anesthesia Services Codes Table 2 – Procedure Codes Set for Certified Registered Anesthetists (CRNAs) (Specialty 094).*

This billing information applies to services delivered under the FFS delivery system. Individual managed care entities (MCEs) establish and publish reimbursement, prior authorization (PA), and billing criteria within the managed care delivery system. Questions about managed care billing should be directed to the MCE with which the member is enrolled.

These changes will be reflected in the *Anesthesia Services Codes* tables, accessible from the *Code Sets* page at in.gov/medicaid/providers. Information will also be reflected in the next regular update to the *Professional Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

[1]*CPT copyright 2019 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Table 1 – HCPCS codes that no longer require modifier AA for CRNAs, effective January 1, 2019

Procedure code	Description
36555	Insertion of central venous catheter for infusion, patient younger than 5 years
36556	Insertion of central venous catheter for infusion, patient 5 years or older
36620	Insertion of arterial catheter for blood sampling or infusion, accessed through the skin
36625	Insertion of arterial catheter for blood sampling or infusion

continued

Table 2 – Procedure codes that incorrectly denied when billed by a CRNA, effective January 1, 2019

Procedure code	Description
93503	Insertion of catheter into right upper heart chamber and pulmonary (lung) artery for monitoring purposes
20551	Injections of tendon attachment to bone
20600	Aspiration and/or injection of small joint or joint capsule
20605	Aspiration and/or injection of medium joint or joint capsule
20610	Aspiration and/or injection of large joint or joint capsule
27096	Injection procedure into sacroiliac joint for anesthetic or steroid
31500	Emergent insertion of breathing tube into windpipe cartilage using an endoscope
36010	Introduction of catheter into the upper or lower major vein (vena cava)
36011	Insertion of catheter into vein
36012	Insertion of catheter into vein
36013	Insertion of catheter into right heart or main pulmonary (lung) artery
36014	Insertion of catheter into left or right pulmonary (lung) artery
36015	Insertion of catheter into an artery of a lobe of the lung
36400	Insertion of needle into upper leg or neck vein, patient younger than 3 years
36405	Insertion of needle into scalp vein, patient younger than 3 years
36406	Insertion of needle into vein, patient younger than 3 years
36410	Insertion of needle into vein, patient 3 years or older
36415	Insertion of needle into vein for collection of blood sample
36420	Incision of vein for insertion of needle or catheter, patient younger than 1 year
36425	Incision of vein for insertion of needle or catheter, patient age 1 or over
36510	Insertion of catheter into vein of navel, newborn
36600	Arterial puncture withdrawal of blood for diagnosis
36660	Insertion of catheter into an artery in navel, newborn
36680	Insertion of needle for infusion into bone
61790	Stereotactic creation of lesion of cranial nerve, accessed through the skin
62263	Injection or mechanical removal of spinal canal scar tissue, percutaneous procedure, accessed through the skin, multiple sessions over 2 or more days
62264	Injection or mechanical removal of spinal canal scar tissue, percutaneous procedure, accessed through the skin, multiple sessions in 1 day
62273	Injection of blood or blood clot into spinal canal

continued

Table 2 – Procedure codes that incorrectly denied when billed by a CRNA, effective January 1, 2019 (continued)

Procedure code	Description
62280	Injection of substance into spinal canal to destroy nerve tissue
62281	Injection of spinal canal to destroy nerve
62282	Injection of spinal canal to destroy nerve
64600	Destruction of trigeminal (facial) nerve branch
64605	Destruction of trigeminal (facial) nerve branch
64610	Destruction of trigeminal (facial) nerve branch under X-ray monitoring
64630	Destruction of pudendal (external genital) nerve
64680	Injection of agent to destroy abdominal sympathetic nerve bundle

Table 3 – Procedure codes to be added to procedure code set for CRNAs, effective January 1, 2019

Procedure code	Description
20526	Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")
62290	Injection procedure for discography, each level; lumbar
62291	Injection procedure for discography, each level; cervical or thoracic
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
64455	Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s)

continued

Table 3 – Procedure codes to be added to procedure code set for CRNAs, effective January 1, 2019 (continued)

Procedure code	Description
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s)
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
72285	Discography, cervical or thoracic, radiological supervision and interpretation
72295	Discography, lumbar, radiological supervision and interpretation
73040	Radiologic examination, shoulder, arthrography, radiological supervision and interpretation
73525	Radiologic examination, hip, arthrography, radiological supervision and interpretation
99151	Moderate sedation services 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; initial 15 minutes of intraservice time, patient younger than 5 years of age
99152	Moderate sedation services 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; initial 15 minutes of intraservice time, patient age 5 years or older
99153	Moderate sedation services 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 intraservice time
99155	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age
99156	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older
99157	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intraservice time

IHCP postpones Portal enhancement for allowing certain out-of-state providers to perform telemedicine services

The Indiana Health Coverage Programs (IHCP) previously announced in *IHCP Bulletin* BT201940, that effective August 29, 2019, the Provider Healthcare Portal (Portal) would allow certain out-of-state providers to perform telemedicine services without fulfilling the out-of-state prior authorization (PA) requirement.

The IHCP is postponing the effective date and will later announce a new date. Please watch future IHCP publications.

For more information about this coming change, refer to the bulletin.

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