IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201713 MARCH 28, 2017

IHCP to cover HCPCS code Q5102

Effective April 28, 2017, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code Q5102 – *Injection, infliximab, biosimilar, 10 mg*. Coverage applies to all IHCP programs, subject to limitations established for certain benefit packages. Coverage applies retroactively to dates of service (DOS) on or after **October 18, 2016**.

Beginning April 28, 2017, providers may submit claims for HCPCS code Q5102 for dates of service on or after **October 18, 2016**. Fee-for-service (FFS) claims submitted 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.

The following reimbursement information applies:

Pricing: Maximum fee of $99.36

Prior authorization (PA): No

Billing guidance:

- National Drug Code (NDC) required
- Separate reimbursement is allowed under revenue code 636 – *Drugs requiring detailed coding for separate reimbursement in an outpatient setting*. For reimbursement consideration, providers may bill the procedure code and the revenue code together, as appropriate.

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

These changes will be reflected in the *Procedure Codes That Require National Drug Codes* code table on the *Code Sets* web page at indianamedicaid.com. Information will also be reflected in the next weekly update to the *Fee Schedule* at indianamedicaid.com.

MORE IN THIS ISSUE

IHCP will no longer cover chemistry and toxicology tests

Effective April 28, 2017, the Indiana Health Coverage Programs (IHCP) will no longer cover the Healthcare Common Procedure Coding System (HCPCS) codes in Table 1. This change applies to all IHCP programs for dates of service (DOS) on or after April 28, 2017.

Table 1 – HCPCS codes no longer covered by the IHCP effective for DOS on or after April 28, 2017

HCPCS code	Description
P2028	Cephalin floculation, blood
P2029	Congo red, blood
P2031	Hair analysis (excluding arsenic)
P2033	Thymol turbidity, blood
P2038	Mucoprotein, blood (seromucoid) (medical necessity procedure)

This change will be reflected in the next weekly update to the provider *Fee Schedule* at indianamedicaid.com.

IHCP will no longer cover HCPCS code S3000

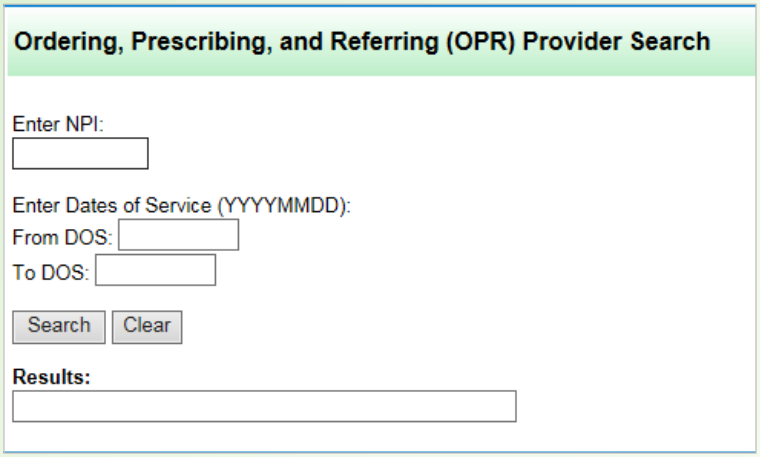
Effective April 28, 2017, the Indiana Health Coverage Programs (IHCP) will no longer cover Healthcare Common Procedure Coding System (HCPCS) code S3000 – *Diabetic Indicator; retinal eye exam, dilated, bilateral*. This change applies to all IHCP programs for dates of service (DOS) on or after April 28, 2017.

This change will be reflected in the next weekly update to the provider *Fee Schedule* at indianamedicaid.com.

OPR Search Tool now available

Indiana Health Coverage Programs (IHCP) providers that render services to Medicaid members must verify IHCP enrollment of the ordering, prescribing, or referring (OPR) provider before service or supplies are rendered. Since the transition to *Core*MMIS, a comprehensive OPR Search Tool has not been available.

The OPR Search Tool is now available on indianamedicaid.com. Providers can access the tool from the quick links on the Home page or from the *Ordering, Prescribing, and Referring Providers* web page at indianamedicaid.com.



IHCP revises maximum facility reimbursement rates for birthing centers

As announced in the November 29, 2011, *Indiana Health Coverage Programs* (*IHCP) Bulletin* BT201158, the IHCP allows birthing centers to enroll as Medicaid providers, effective January 1, 2012. Enrollment requirements are outlined for quick reference under provider type 08 – *Clinic* and provider specialty code 088 – *Birthing center* on the *IHCP Provider Enrollment Type and Specialty Matrix* at indianamedicaid.com.

Effective April 30, 2017, the maximum facility reimbursement rates for the services provided by IHCP-enrolled birthing centers are shown in Table 2. These maximum rates apply retroactively to dates of service (DOS) on or after **January 1, 2017.** Birthing centers are advised to submit claims for the affected DOS after April 30, 2017.

Table 2 – Maximum facility reimbursement rates for birthing centers effective for DOS on or after January 1, 2017

Service	Revenue code	Procedure code	Maximum reimbursement rate
Vaginal delivery	724	None	$1,652.98
Labor occurring but not resulting in a delivery	724	S4005	$488.57 (ASC 3)

Billing guidelines for birthing centers were outlined in the February 14, 2012, *IHCP Bulletin* BT201206. These guidelines remain unchanged. As a reminder, birthing center providers must include the taxonomy code 261QB0400X (birthing) in field locator 81CCa of the *UB-04* claim form (or similar field on its electronic equivalent). Additionally, birthing center services must be billed using place-of-service code 25 (birthing center).

Pricing updated for HCPCS codes A6450 and A6451

Effective April 28, 2017, the Indiana Health Coverage Programs (IHCP) will update the pricing for the Healthcare Common Procedure Coding System (HCPCS) codes in Table 3. The pricing for these HCPCS codes is changing from manual pricing to maximum-fee pricing. This change applies to fee-for-service (FFS) claims with dates of service (DOS) on or after April 28, 2017.

Table 3 – HCPCS codes updated from manual pricing to maximum-fee pricing effective for DOS on or after April 28, 2017

HCPCS code	Description
A6450	Light compression bandage, elastic, knitted/woven, width not greater than or equal to 5 in., per yard
A6451	Moderate compression bandage, elastic, knitted/woven, load resistance or 1.25 to 1.34 ft. lbs. at 50% maximum stretch, width not greater than or equal to 3 in. and less than 5 in. per yard

Note: These procedure codes are priced per yard.

This billing information applies to services delivered under the fee-for-service (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 next weekly update to the *Fee Schedule* at indianamedicaid.com.

Prior authorization is now required for CPT code 69930

Effective April 28, 2017, The Indiana Health Coverage Programs (IHCP) will require prior authorization (PA) for Current Procedural Terminology (CPT®[1]) 69930 – *Cochlear Device Implantation*. This requirement applies to dates of service (DOS) on or after April 28, 2017. Billing guidance remains unchanged.

Cochlear implants will be authorized only if they are medically necessary, and objective evidence of significant benefit to the member is documented. Indications for coverage of cochlear implants include the following:

- The treatment of bilateral pre- or post-linguistic, sensorineural, moderate-to-profound hearing loss in individuals who demonstrate limited benefit from amplification.
- Post-linguistically deafened adults must demonstrate test scores of less than or equal to 40% on sentence recognition scores from tape-recorded tests in the patient's best listening condition.
- The treatment of children ages 1 through 17, if there is a demonstrated ability to improve on age-appropriate, closed-set word identification tasks with amplification.

Coverage is provided only for those patients who meet all the following selection guidelines:

- Diagnosis of bilateral moderate-to-profound sensorineural hearing impairment (HI) with limited benefit from appropriate hearing (or vibrotactile) aids
- Cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation
- Freedom from middle-ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system
- No contraindications to surgery
- The device must be used in accordance with U.S. Food and Drug Administration (FDA)-approved labeling

The PA requirement applies to services delivered under the fee-for-service (FFS) delivery system. Questions regarding 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 criteria within the managed care delivery system. Questions about managed care PA should be directed to the MCE with which the member is enrolled.

This change will be reflected in the next weekly update to the provider *Fee Schedule* at indianamedicaid.com.

Providers should no longer bill certain DME procedure codes with the NU modifier

Effective April 28, 2017, the Indiana Health Coverage Programs (IHCP) is revising billing guidance for the durable medical equipment (DME) Healthcare Common Procedure Coding System (HCPCS) codes in Table 4. Fee-for-service (FFS) claims for these HCPCS codes should no longer include the NU – *New DME* modifier. This change applies retroactively to claims with dates of service (DOS) on or after **July 1, 2016**.

- Beginning April 28, 2017, providers should bill the HCPCS codes in Table 4 for DOS on or after July 1, 2016, **without** the NU modifier.
- Beginning April 28, 2017, claims for the affected HCPCS codes submitted **with** the NU modifier will deny for explanation of benefit (EOB) 4033 – *Invalid procedure code modifier combination.*

Providers who may have previously billed the HCPCS codes in Table 4 **without** the NU modifier for DOS on or after July 1, 2016, and received a denial for EOB 4033 may resubmit the claim (without the NU modifier) for reimbursement consideration. Claims resubmitted 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.

Table 4 – HCPCS codes that can no longer be billed with modifier NU effective for DOS on or after July 1, 2016

HCPCS code	Description
L3216	Orthopedic footwear, ladies shoe, depth inlay, each
L3221	Orthopedic footwear, mens shoe, depth inlay, each
L3222	Orthopedic footwear, mens shoe, hightop, depth inlay, each
Q0480	Driver for use with pneumatic ventricular assist device, replacement only
Q0481	Microprocessor control unit for use with electric ventricular assist device, replacement only
Q0482	Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only
Q0483	Monitor/display module for use with electric ventricular assist device, replacement only
Q0484	Monitor/display module for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0485	Monitor control cable for use with electric ventricular assist device, replacement only
Q0486	Monitor control cable for use with electric/pneumatic ventricular assist device, replacement only
Q0487	Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device, replacement only
Q0489	Power pack base for use with electric/pneumatic ventricular assist device, replacement only
Q0490	Emergency power source for use with electric ventricular assist device, replacement only
Q0491	Emergency power source for use with electric/pneumatic ventricular assist device, replacement only
Q0492	Emergency power supply cable for use with electric ventricular assist device, replacement only

continued

Table 4 – HCPCS codes that can no longer be billed with modifier NU effective for DOS on or after July 1, 2016 (continued)

HCPCS code	Description
Q0493	Emergency power supply cable for use with electric/pneumatic ventricular assist device, replacement only
Q0494	Emergency hand pump for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0495	Battery/power pack charger for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0496	Battery, other than lithium-ion, for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0497	Battery clips for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0498	Holster for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0499	Belt/vest/bag for use to carry external peripheral components of any type ventricular assist device, replacement only
Q0500	Filters for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0501	Shower cover for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0502	Mobility cart for pneumatic ventricular assist device, replacement only
Q0503	Battery for pneumatic ventricular assist device, replacement only, each
Q0504	Power adapter for pneumatic ventricular assist device, replacement only, vehicle type

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 *Durable and Home Medical Equipment and Supplies Codes* code table on the *Code Sets* web page at indianamedicaid.com. Information will also be reflected in the next weekly update to the provider *Fee Schedule* at indianamedicaid.com.

continued

Pricing updated for CDT codes D0251 and D1354

Effective April 28, 2017, the Indiana Health Coverage Programs (IHCP) will update the pricing for the Current Dental Terminology (CDT®[1]) codes in Table 5. The pricing for these CDT codes is changing from manual pricing to maximum-fee pricing. This change applies to fee-for-service (FFS) claims with dates of service (DOS) on or after April 28, 2017.

Table 5 – CDT codes updated from manual pricing to maximum-fee pricing effective for DOS on or after April 28, 2017

CDT code	Description
D0251	Extra-oral posterior dental radiographic image
D1354	Interim caries arresting medicament application

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 next weekly update to the *Fee Schedule* at indianamedicaid.com.

IHCP updates attachment requirements for various HCPCS codes

Effective April 28, 2017, the Indiana Health Coverage Programs (IHCP) will update the attachment requirements when providers bill the Healthcare Common Procedure Coding System (HCPCS) codes in Table 6. Although these procedure codes continue to be manually priced, claims for these codes will no longer require attachments. This change applies to fee-for-service (FFS) claims with dates of service (DOS) on or after April 28, 2017.

Table 6 – HCPCS codes that no longer require claim attachments for DOS on or after April 28, 2017

HCPCS code	Description
J7604	Acetylcysteine, inhalation solution, compounded product, administered through DME, unit dose form, per gram
J7632	Cromolyn sodium, inhalation solution, compounded product, administered through DME, unit dose form, per 10 mg
J7676	Pentamidine isethionate, inhalation solution, compounded product, administered through DME, unit dose form, per 300 mg
V5010	Assessment for hearing aid

continued

This billing information applies to services delivered under the fee-for-service (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 *Procedure Codes That Require Attachments* code table on the *Code Sets* web page at indianamedicaid.com. Information will also be reflected in the next weekly update to the provider *Fee Schedule* at indianamedicaid.com.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-457-4584.

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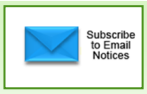

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