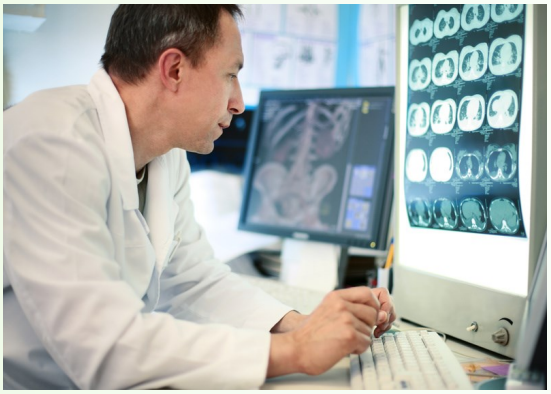
IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR202108 FEBRUARY 23, 2021

IHCP to mass reprocess outpatient claims for surgical services that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim processing issue that affects certain outpatient fee-for-service (FFS) claims for surgical services processed from January 1, 2020, through February 4, 2021. Claims billed for the Current Procedural Terminology (CPT®[1]) codes in Table 1 may have denied incorrectly for one of the following explanation of benefits (EOB):

- 4108 – *There is no ASC on file for this procedure code. Please verify that the appropriate outpatient surgery code was billed.*
- 4218 – *Service billed is not allowed on this claim type.*



The claim-processing system has been corrected. Claims processed during the indicated time frame that denied incorrectly for EOB 4108 or EOB 4218 will be mass reprocessed. Providers should see the reprocessed claims on Remittance Advices (RAs) beginning on March 31, 2021, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims).

This information will be reflected in the next regular update to the *Outpatient Fee Schedule*, including the ambulatory surgical center (ASC) codes for billing, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

Table 1 – Procedure codes that may have denied inappropriately for outpatient claims, processed from January 1, 2020, through February 4, 2021

Procedure code	Description
62328	Declotting infusion of implanted central venous access device or catheter
62329	Therapeutic spinal tap of lower spine using imaging guidance
64451	Injection of anesthetic agent and/or steroid into nerves supplying joint between spine and pelvis using imaging guidance
64454	Injection of anesthetic agent and/or steroid into genicular nerve branches of knee using imaging guidance

continued

Table 1 – Procedure codes that may have denied inappropriately for outpatient claims, processed from January 1, 2020, through February 4, 2021 (continued)

Procedure code	Description
64624	Destruction of genicular nerve branches of knee by injection using imaging guidance
64625	Radiofrequency destruction of nerves supplying joint between spine and pelvis using imaging guidance

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FSSA seeks public comment on HCBS settings that require heightened scrutiny

The Indiana Family and Social Services Administration (FSSA) is seeking public comment on Home and Community Based Services (HCBS) settings, in accordance with Code of Federal Regulations 42 CFR Sections *441.301(c)(4)* and *441.710*, respectively. The public comment period is on behalf of the Division of Aging (DA), the Division of Mental Health and Addiction (DMHA), and the Division of Disability and Rehabilitative Services (DDRS).

Indiana will publish the settings for public review in the Heightened scrutiny evidence packets section of the *Statewide Transition Plan* web page at in.gov/fssa/da/projects. The FSSA's Office of Medicaid Policy and Planning (OMPP) would like HCBS members, providers, and stakeholders to provide input on these settings, which are isolative in nature for members and so require heightened scrutiny.

The public comment period is from **March 1, 2021, through March 31, 2021**.

Requests for paper copies of the HCBS settings for comment, and feedback on the settings, are welcome via email or written correspondence.

- Email: HCBSrulecomments@fssa.in.gov.
- U.S. mail:
  State of Indiana FSSA/OMPP
  Attn: HCBS Final Rule – BreAnn Teague, Director of Government Affairs
  State Plan and Waivers
  402 W. Washington St., Rm. W374 MS - 07
  Indianapolis, IN 46204-2739

Background information

HCBS settings presumed to be institutional

On March 17, 2014, the Centers for Medicare & Medicaid (CMS) published final regulations in the Federal Register,

continued

implementing new requirements for Medicaid's HCBS programs, furnished either through a *1915(c)* waiver or a *1915(i)* State plan option. The federal rule establishes the qualities that demonstrate the setting is a home and community-based setting and does not have the characteristics of an institution.

The federal rule provides a transition period for the State to evaluate the settings where individuals live and receive Medicaid waiver services, to ensure the settings meet the required qualities of HCBS. The State may work with settings that do not fully meet the final HCBS rule definition to develop a plan to bring settings into compliance.

CMS heightened scrutiny review

Certain types of settings are identified by the federal regulation as presumed to be institutional. This includes the following settings:

- Setting located within a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment
- Building on the grounds of, or adjacent to, a public institution or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS

For settings that do not have the required HCBS characteristics, States should submit evidence to CMS requesting a heightened scrutiny review. The request must include sufficient evidence to demonstrate the setting as not having the effect of isolating individuals receiving Medicaid HCBS from the broader community, and evidence that a public comment period was held to obtain public input on the identified setting.

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