IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR202113 MARCH 30, 2021

IHCP to cover CPT codes 93985 and 93986, mass reprocess or mass adjust claims

Effective immediately, the Indiana Health Coverage Programs (IHCP) will cover the following Current Procedural Terminology (CPT®[1]) codes:

- Code 93985 – *Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study*
- Code 93986 – *Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete unilateral study*

Coverage applies retroactively to fee-for-service (FFS) professional claims (*CMS-1500* form or electronic equivalent) and outpatient claims (*UB-04* form or electronic equivalent) with dates of service (DOS) on or after **January 1, 2020**. Coverage applies to all Traditional Medicaid and other IHCP programs that include full Medicaid State Plan benefits. These procedure codes may not be covered under IHCP plans with limited benefits.

Note: CPT codes 93985 and 93986 were crosswalked from Healthcare Common Procedure Coding System (HCPCS) code G0365, which had been covered but was end dated December 31, 2019.

The following reimbursement information applies to CPT codes 93985 and 93986:

- Pricing:
  - Professional (physician): Resource-based relative value scale (RBRVS)
  - Outpatient: Maximum fee
- Prior authorization (PA): None required
- Billing guidance: Standard billing guidance applies

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

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This coverage will be reflected in the next regular update to the *Outpatient Fee Schedule* and the *Professional Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

The IHCP identified a claim-processing issue that affects FFS claims for CPT codes 93985 and 93986 with DOS on or after January 1, 2020. Claims or claim details billed for these codes may have denied for one of the following explanation of benefits (EOB):

- EOB 4013 – *This procedure code is not covered for this date of service*
- EOB 4801 – *Procedure code not covered for benefit plan*

Claims processed during the indicated time frame that denied for EOB 4013 or EOB 4801 will be mass reprocessed or mass adjusted, as appropriate. Providers should see the reprocessed or adjusted claims on Remittance Advices (RAs) beginning May 5, 2021, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims) or 52 (mass replacements non-check related).

Beginning immediately, providers may submit claims for these codes with DOS on or after January 1, 2020, if not previously submitted. Claims submitted beyond the original filing limit must include a copy of this banner page as an attachment and must be submitted within 180 days of the banner page's publication date.

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IHCP to cover CPT codes 27130 and 33858 in the outpatient setting, mass reprocess or mass adjust claims

Effective immediately, the Indiana Health Coverage Programs (IHCP) will update the claim-processing system for coverage of the Current Procedural Terminology (CPT®[1]) codes in Table 1 in the outpatient setting. Coverage applies retroactively to outpatient claims with dates of service (DOS) on or after **January 1, 2020**, and to all Traditional Medicaid and other IHCP programs that include full Medicaid State Plan benefits. These procedure codes may not be covered under IHCP plans with limited benefits.

The following reimbursement information applies:

- Pricing: See Table 1
- Prior authorization (PA): None required
- Billing guidance: Standard guidance applies

Table 1 – Procedure codes reimbursable in the outpatient setting, effective retroactively for DOS on or after January 1, 2020

Procedure code	Description	Pricing
27130	Replacement of thigh bone and hip joint prosthesis	*Ambulatory Surgical Center (ASC) indicator: M
33858	Repair of ascending aorta with graft on heart-lung machine, for separation of wall of aorta (dissection)	Manual: 10% of billed charges

**For the rates that apply to ASC indicators (codes), see the Outpatient Fee Schedule.*

continued

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.

This coverage will be reflected in the next regular update to the *Outpatient Fee Schedule*, accessible from the [IHCP Fee Schedules] page at in.gov/medicaid/providers.

The IHCP identified a claim-processing issue that affects FFS claims for the CPT codes in Table 1. Claims with DOS on or after January 1, 2020, may have denied incorrectly with the following explanation of benefits (EOB):

- EOB 4014 – *Claim being reviewed for pricing*
- EOB 4108 – *There is no ASC on file for this procedure code. Please verify that the appropriate outpatient surgery code was billed.*

Claims or claim details processed during the indicated time frame for the codes in Table 1 will be mass reprocessed or mass adjusted, as appropriate. Providers should see adjusted claims on Remittance Advices (RAs) beginning May 12, 2021, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims) or 52 (mass replacements non-check related).

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HCPCS code B4187 pricing update

Effective April 30, 2021, the Indiana Health Coverage Programs (IHCP) will update the pricing for Healthcare Common Procedure Coding System (HCPCS) code B4187 – *Omegaven, 10 grams lipids*. Pricing for this HCPCS code is changing from manual pricing to maximum fee pricing, with a rate of $13.58. This change applies to fee-for-service (FFS) professional claims (*CMS-1500* form or electronic equivalent) with dates of service (DOS) on or after April 30, 2021. Additionally, claims for this code will no longer require submission of an attachment that documents the manufacturer's suggested retail price (MSRP) or cost invoice.

This reimbursement 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.

This change will be reflected in the next regular update to the *Professional Fee Schedule*, accessible from the [IHCP Fee Schedules] page at in.gov/medicaid/providers, and to the *Procedure Codes That Require Attachments*, available from the [Code Sets] page.

IHCP to link procedure codes for outpatient observation stays to revenue code 762, accept resubmitted claims

Effective immediately, the Indiana Health Coverage Programs (IHCP) will update the claim-processing system to link the procedure codes for outpatient observation stays in Table 2 to revenue code 762 – *Specialty Services - Observation Hours*. These linkages apply retroactively to outpatient claims with dates of service (DOS) on or after **July 1, 2020**.

Table 2 – Procedure codes linked to revenue code 762, effective retroactively for DOS on or after July 1, 2020

Procedure code	Description
99224	Subsequent observation care, typically 15 minutes per day
99225	Subsequent observation care, typically 25 minutes per day
99226	Subsequent observation care, typically 35 minutes per day

This change will be reflected in the next regular update to the *Outpatient Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

Beginning immediately, providers may bill a code in Table 2 and revenue code 762 together, as appropriate. Additionally, providers may resubmit fee-for-service (FFS) outpatient claims for these procedure codes during the indicated time frame that denied with explanation of benefits (EOB) 0520 – *Invalid revenue code and procedure code combination - please verify and resubmit*. Claims resubmitted beyond the original filing limit must include a copy of this banner page as an attachment and must be submitted within 180 days of the banner page's publication date.

Professional Fee Schedule update for HCPCS code R0075

The Indiana Health Coverage Programs (IHCP) has updated the *Professional Fee Schedule* to display reimbursement rate information for Healthcare Common Procedure Coding System (HCPCS) procedure code R0075 – *Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen*, with the processing modifiers in Table 3.

This information will be reflected in the next regular update to *Professional Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

Coverage and reimbursement have not changed and no claims are affected by this update to the fee schedule.

Table 3 – Update to Professional Fee Schedule for procedure code R0075 with modifiers

Modifier	Description
UN	Two patients served
UP	Three patients served
UQ	Four patients served
UR	Five patients served
US	Six or more patients served

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