IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR202037 SEPTEMBER 15, 2020

IHCP updates reimbursement rate for HCPCS code C9803, mass adjusts claims that paid incorrectly

Effective retroactively March 1, 2020, the Indiana Health Coverage Programs (IHCP) is revising the outpatient reimbursement rate for Healthcare Common Procedure Coding System (HCPCS) code C9803 - *Hospital outpatient clinic visit specimen collection for Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source*. This update is to align with pricing from the Centers for Medicare & Medicaid Services (CMS), and replaces the rate published in *IHCP Bulletin* *BT202061*. The other information in *BT202061*, including billing guidance, remains unchanged. The following maximum rate applies **retroactively** to outpatient claims for code C9803 with dates of service (DOS) on or after March 1, 2020.

Updated pricing: **Maximum fee of $22.99**

Affected outpatient claims for code C9803 with DOS from March 1, 2020, through September 3, 2020, that paid incorrectly will be mass adjusted as indicated on Remittance Advices (RAs), with internal control numbers (ICNs)/Claim IDs that begin with 52 (mass replacements non-check related).

This information 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.

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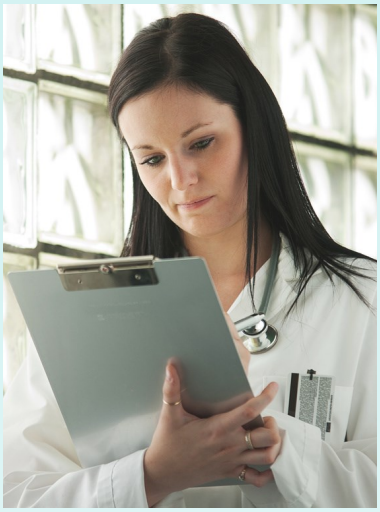
IHCP to mass reprocess or mass adjust professional claims for PET scan services that denied inappropriately



The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects professional fee-for-service (FFS) claims for Positron Emission Tomography (PET) scan procedures with dates of service (DOS) from February 7, 2020, through August 13, 2020. Claims or claim details for the PET scan procedure codes in Table 1 may have denied inappropriately for one of the following explanation of benefits (EOB):

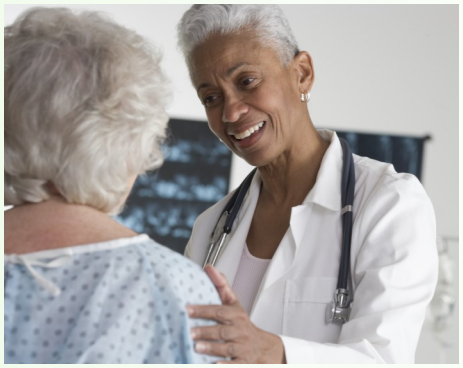
- EOB 6280 – *PET scan procedures refractory seizures limited to diagnosis codes.*
- EOB 6282 – *PET scan imaging for myocardial perfusion is limited to specific diagnosis codes.*
- EOB 6288 – *PET scan imaging (breast cancer, whole body or regional for neck and head cancer) are limited to specific diagnosis codes.*

The claim-processing system has been corrected. Claims during the indicated time frame that denied inappropriately for one of the EOBs above will be mass reprocessed or mass adjusted, as appropriate. Providers should see the reprocessed or adjusted claims on Remittance Advices (RAs) beginning October 14, 2020, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims) or 52 (mass replacements non-check related).

Table 1 – PET scan procedure codes that may have denied inappropriately for claims with DOS from February 7, 2020, through August 13, 2020

Procedure code	Description
78459	Single nuclear medicine study of heart muscle with metabolic evaluation
78491	Single nuclear medicine study of blood flow in heart muscle
78492	Multiple nuclear medicine studies of blood flow in heart muscle at rest and with stress
78608	Nuclear medicine study brain with metabolic evaluation
78609	Nuclear medicine study brain with blood circulation evaluation
78811	Nuclear medicine study limited area
78812	Nuclear medicine imaging from skull base to mid-thigh
78813	Nuclear medicine imaging whole body
78814	Nuclear medicine study with CT imaging
78815	Nuclear medicine study with CT imaging skull base to mid-thigh
78816	Nuclear medicine study with CT imaging whole body

Providers may resubmit professional claims for procedure code C9132 that denied incorrectly



The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects fee-for-service (FFS) professional claims for procedure code C9132 – *Prothrombin complex concentrate (human), Kcentra, per i.u. of factor IX activity*, processed from May 1, 2018, through July 15, 2020. Claims submitted for this physician-administered drug (PAD) for IHCP members enrolled in the Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise managed care programs may have denied incorrectly with explanation of benefits (EOB) 2017 – *The member is enrolled in the risk based managed care portion of the Hoosier Healthwise Program or has been identified as a member of the Hoosier Care Connect Program. The member must seek care from the appropriate managed care entity.*

The claim-processing system has been corrected. Beginning immediately, providers may resubmit claims for procedure code C9132 that previously denied for EOB 2017 during the indicated time frame, for reimbursement consideration. Claims resubmitted beyond the original filing limit must include a copy of this banner page as an attachment.

Note: Claims with dates of service (DOS) before January 1, 2019, must be resubmitted within 1 year of the banner page's publication date. Claims with DOS on or after January 1, 2019, must be resubmitted within 180 days of the banner page's publication date.

Providers may resubmit FSW claims for day habilitation services that denied inappropriately

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects Family Supports Waiver (FSW) claims for the day habilitation services in Table 2. Claims with dates of service (DOS) from August 1, 2020, through August 14, 2020, may have denied inappropriately with one of the following explanation of benefits (EOB):

- EOB 4021 – *Procedure code is not covered for the dates of service for the program billed. Please verify and resubmit.*
- EOB 4033 – *The modifier used is not compatible with the procedure code billed. Please verify and resubmit.*
- EOB 4801 – *Procedure code not covered for benefit plan.*

The claim-processing system has been corrected. Beginning immediately, providers may resubmit claims for the day habilitation services in Table 2 that previously denied for EOB 4021, 4033, or 4801 during the indicated time frame, for reimbursement consideration. 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.

continued

Table 2 – FSW services that may have denied inappropriately for claims with DOS from August 1, 2020, through August 14, 2020

Service	Procedure code	Modifier 1	Modifier 2	Modifier 3
Day Habilitation, Small Group 2:1, 3:1, 4:1	T2020	U7	U5	U2
Day Habilitation, Medium Group 5:1, 6:1, 7:1, 8:1, 9:1, 10:1	T2020	U7	U5	UA
Day Habilitation, Large Group 11:1, 12:1, 13:1, 14:1, 15:1, 16:1	T2020	U7	U5	UB

Pricing updated for HCPCS codes E2216, E2217, and E2218

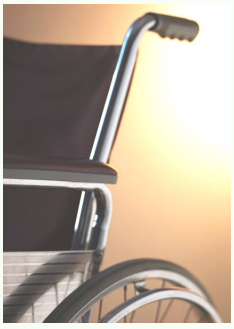
Effective October 15, 2020, the Indiana Health Coverage Programs (IHCP) will update the pricing for the Healthcare Common Procedure Coding System (HCPCS) codes in Table 3. Pricing for these HCPCS codes is changing from manual pricing to maximum-fee pricing. This change applies to fee-for-service (FFS) professional claims with dates of service (DOS) on or after October 15, 2020. Additionally, claims for these codes will no longer require being submitted with an attachment of the manufacturer's suggested retail price (MSRP) or cost invoice.

Table 3 – HCPCS codes updated from manual pricing to maximum-fee pricing, effective for DOS on or after October 15, 2020

Procedure code	Description	Maximum fee (with modifier *NU or **RR)
E2216	Manual wheelchair accessory, foam filled propulsion tire, any size, each	NU: $47.22 RR: $4.72
E2217	Manual wheelchair accessory, foam filled caster tire, any size, each	NU: $41.79 RR: $4.18
E2218	Manual wheelchair accessory, foam propulsion tire, any size, each	NU: $47.22 RR: $4.72

*NU = New equipment

**RR = Rental

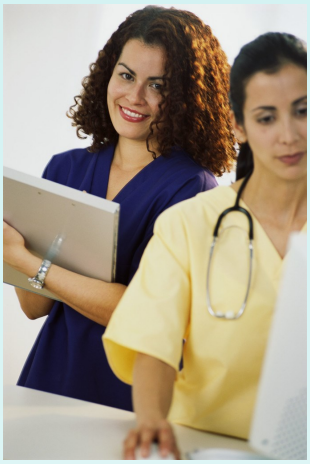


This reimbursement information applies to services delivered under the FFS delivery system. Individual managed care entities (MCEs) establish and publish reimbursement, prior authorization (PA), and billing criteria within the managed care delivery system. Questions about managed care billing should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

These changes 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.

continued

IHCP to revise pricing for certain "unspecified" procedure codes billed on professional claims



Effective October 15, 2020, the Indiana Health Coverage Programs (IHCP) will update pricing for the "unspecified" Current Procedural Terminology (CPT®[1]) codes in Table 4 and the Current Dental Terminology (CDT®[2]) procedure code in Table 5, from maximum fee to a percentage of billed charges as shown in the tables.

This change applies to fee-for-service (FFS) professional claims (*CMS-1500* form or electronic equivalent), and dental (*American Dental Association [ADA] 2012 Dental Claim Form* [or electronic equivalent]), effective for dates of service (DOS) on or after October 15, 2020. Other billing guidelines and reimbursement limitations remain unchanged.

Reimbursement, prior authorization (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.

This information 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.

[1]*CPT copyright 2020 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

[2]*CDT copyright 2020 American Dental Association. All rights reserved. CDT is a registered trademark of the American Dental Association.*

Table 4 – CPT codes that will pay a percentage of billed charges on professional claims, effective for DOS on or after October 15, 2020

Procedure code	Description	Amount reimbursed as a percentage of billed charges
19499	Breast procedure	20%
21299	Skull and face bone procedure	20%
21499	Musculoskeletal procedure on head	20%
22899	Spine procedure	20%
22999	Procedure on abdomen, muscle or bone	20%
25999	Lower arm or wrist procedure	20%
26989	Hand or finger procedure	20%
27299	Pelvis or hip joint procedure	20%

continued

Table 4 – CPT codes that will pay a percentage of billed charges on professional claims, effective for DOS on or after October 15, 2020 (continued)

Procedure code	Description	Amount reimbursed as a percentage of billed charges
29799	Casting or strapping procedure	20%
31599	Voice box procedure	20%
31899	Windpipe or lung airway procedure	20%
37799	Blood vessel procedure	20%
38999	Lymph node procedure	20%
40799	Lip procedure	20%
40899	Mouth procedure	20%
41599	Tongue or floor of mouth procedure	20%
41899	Relocation of mouth tissue to gum surface	20%
42699	Salivary gland or duct procedure	20%
42999	Throat, adenoids, or tonsils procedure	20%
43999	Stomach procedure	20%
44799	Small bowel procedure	20%
45999	Rectal procedure	20%
47399	Liver procedure	20%
47999	Bile duct procedure	20%
49999	Abdominal procedure	20%
53899	Urinary system procedure	35%
55899	Male genital system procedure	35%
64999	Nervous system procedure	20%
68899	Tear-producing drainage system procedure	20%
69799	Middle ear procedure	20%

Table 5 – CDT code that will pay a percentage of billed charges on dental claims, effective for DOS on or after October 15, 2020

Dental code	Description	Amount reimbursed as a percentage of billed charges
D1999	Unspecified preventive procedure, by report	90%

IHCP to host webinar about updates on EVV implementation, September 24, 2020

The Indiana Health Coverage Programs (IHCP) will host a town-hall style webinar on Thursday September 24, 2020, at 10:00 a.m. (Eastern Time) to give updates on the electronic visit verification (EVV) implementation and address providers' questions and concerns.

To participate in the webinar on September 24, go to https://Indiana.AdobeConnect.com/indiana to sign in. Ensure that Guest is selected, type your name, and click **Enter Room**.

Please note:

- The audio will be voice-over-internet, so participants will need to use speakers or headphones to hear the presentation.
- Prior to the webinar, participants can go to https://indiana.adobeconnect.com/common/help/en/support/meeting_test.htm to test the connection. The test will prompt the user for any updates or add-ins needed to participate in the webinar.
- Do not log in to the webinar using Citrix or a virtual private network (VPN) because these services will not be able to play back audio.
- If you wish to log in using your mobile device, download the Adobe Connect mobile app from your device's app store.

For those who cannot attend on September 24, a recording of the webinar will be posted later on the *IHCP Live* web page at in.gov/medicaid/providers.

Countdown to EVV implementation for personal care providers: T-minus 15 weeks

As announced in previous Indiana Health Coverage Programs (IHCP) publications, the *21st Century Cures Act* directs states to require providers of personal care services and home health services to use an electronic visit verification (EVV) system to document services rendered.

Providers of personal care services have until **January 1, 2021**, to implement an EVV system for documenting services.

Please note that personal care providers not in compliance with the EVV mandate by January 1, 2021, will experience claims and reimbursement issues until they follow the federal mandate for successfully recording EVV visits.

More information is available on the *Electronic Visit Verification* web page and in the *Electronic Visit Verification FAQs* document at in.gov/medicaid/providers. For any general questions or concerns about the EVV Program, email EVV@fssa.in.gov.

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