IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202042 OCTOBER 20, 2020

IHCP to allow CPT 92549 as reimbursable for provider specialty 200 – Audiologist

Effective November 20, 2020, the Indiana Health Coverage Programs (IHCP) will allow reimbursement of claims by provider specialty 200 – Audiologist for Current Procedure Terminology (CPT®[1]) code 92549 – *Computerized dynamic post-urography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (MCT) and adaptation test (ADT)*. This change applies to all IHCP programs, subject to limitations established for certain benefit packages, retroactively to claims with dates of service (DOS) on or after **January 1, 2020**.

Beginning November 20, 2020, providers may submit claims for code 92549 with DOS on or after January 1, 2020, for reimbursement consideration. Claims submitted beyond the original 180 day filing limit must include a copy of this banner page as an attachment and must be filed within 180 days of the publication date.

This change will be reflected in the next regular update to the *Hearing Services Codes* for audiologists (specialty 200), accessible from the *Code Sets* web 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.*

IHCP to mass reprocess MRT claims for procedure codes that denied inappropriately

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects fee-for-service (FFS) professional claims for Medical Review Team (MRT) procedure codes, with dates of service (DOS) from June 2, 2017, through September 4, 2020. Claims for the procedure codes in Table 1 may have denied inappropriately for explanation of benefits (EOB) 4021 – *Procedure code is not covered for the dates of service for the program billed. Please verify and resubmit*.

continued

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The claim-processing system has been corrected. Claims processed during the indicated time frame that denied inappropriately for EOB 4021 will be mass reprocessed.

Providers should see the reprocessed claims on Remittance Advices (RAs) beginning October 21, 2020, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims).

Table 1 – MRT procedure codes that denied inappropriately for claims with DOS from June 2, 2017, through September 4, 2020

Procedure code	Modifier	Description
72081	SE	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (e.g., scoliosis evaluation); 1 view
73501	SE	Radiologic examination, hip unilateral, with pelvis when performed; 1 view
73502	SE	Radiologic examination, hip unilateral, with pelvis when performed; 2-3 views
73503	SE	Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views
73521	SE	Radiologic examination, hips, bilateral, with pelvis when performed; 2 views
73522	SE	Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views
73552	SE	Radiologic examination, femur; minimum 2 views
73560	SE	Radiologic examination, knee; 1 or 2 views
76700	SE	Ultrasound, abdominal, real time with image documentation; complete
82803	SE	Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation)
85027	SE	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
99203	SE	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 components: a detailed history; a detailed examination; medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family needs. Usually, the presenting problem(s) are moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99204	SE	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity; counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 45 minutes are spent face to face with the patient and/or family.
99205	SE	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patients and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.

continued

Table 1 – MRT procedure codes that denied inappropriately for claims with DOS from June 2, 2017, through September 4, 2020 (continued)

Procedure code	Modifier	Description
99213	SE	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity; counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face to face with the patient and/or family.
99214	SE	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians. Other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face o-face with the patient and/or family.
99215	SE	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

Providers can submit meaningful use attestations for Program Year 2020, beginning November 2, 2020

The Indiana Health Coverage Programs (IHCP) participates in the federal Promoting Interoperability (PI) Program to provide incentives for eligible professionals and hospitals to adopt, implement, upgrade (AIU), or demonstrate meaningful use (MU) of certified electronic health records (EHR) technology.

Beginning November 2, 2020, the Indiana Medicaid Promoting Interoperability Program will accept Program Year 2020 MU attestations from eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs). Providers can submit attestations using the Medical Assistance Provider Incentive Repository (MAPIR) payment system through the IHCP Provider Healthcare Portal (Portal).

The last day to submit Program Year 2020 attestations is Monday, March 1, 2021.

Note: The Indiana Medicaid Promoting Interoperability (PI) Program was formerly known as the Electronic Health Records Incentive Program.

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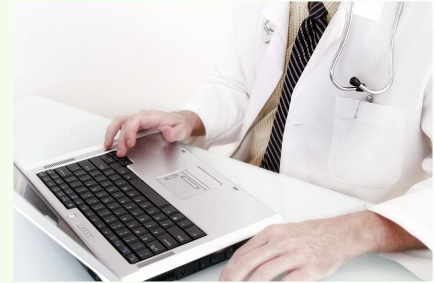
For additional information:



- Registering and attesting through the MAPIR system (via the Portal):
  - See the user guides on the *Registering for the Indiana Medicaid Promoting Interoperability Program* web page at in.gov/medicaid/providers.
  - Contact Indiana Medicaid Promoting Interoperability Program/MAPIR Customer Service at 1-855-856-9563 or MedicaidHealthIT@fssa.in.gov.
- Promoting the Centers for Medicare & Medicaid Services (CMS) interoperability final rule, objectives and measures, clinical quality measures (CQMs), and any other programmatic concerns – Contact the Purdue Healthcare Advisors Indiana Medicaid Promoting Interoperability Programs Help Desk at 1-844-742-4668 or INMedicaidMUHelp@purdue.edu.
- General information and updates – Visit the *Indiana Medicaid Promoting Interoperability Program* page at in.gov/medicaid/providers.

Corrections to rates and services for Family Supports Waiver

The Indiana Family and Social Service Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) and the Division of Disability and Rehabilitative Services (DDRS) recently published changes to rates and services for the Family Supports Waiver (FSW). Some of that information, announced in *Indiana Health Coverage Programs (IHCP) Bulletin BT202083*, was incorrect as described below. The implementation date of the changes remains July 16, 2020, as published in the bulletin.

Correction to service lifetime cap

The lifetime cap for the service in Table 2 below was incorrect in *BT202083* and had an incorrect rate applied in the claim -processing system. The cap was incorrectly published as $7,500 for FSW. The correct lifetime cap is $15,000.

Table 2 – Correct lifetime cap for service (Specialized Medical Equip/Supply, Install) under FSW, effective for DOS on or after July 16, 2020

Service	Code	Mod 1	Mod 2	Mod 3	Dsc Proc Modified	Rate	Notes
Specialized Medical Equip/Supply, Install	T2029	U7	U5	NU	U7=Waiver U5=DD NU=New DME	Individual	Lifetime cap = **$15,000 FSW**

Claim processing

The claim-processing system has been corrected. Beginning immediately, providers who believe a FSW claim for code T2029 with modifiers U7, U5, and NU with dates of service (DOS) on or after July 16, 2020, was reimbursed incorrectly may submit a replacement claim for reimbursement consideration.

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To submit a replacement claim, providers must first void the original claim. The replacement claim must include the same attachments (if any) as were submitted with the original claim. Replacement FSW claims submitted beyond the original 180 day filing limit must include a copy of this banner page as an attachment and must be filed within 180 days of the publication date.

Correction to rate and annual limit

- The service, *Equipment – Assess/Inspect/Train*, had an incorrect rate for the FSW identified in the bulletin. The correct rate is $17.99 per 15 minutes for both waivers, as shown in Table 3. The correct rate was applied in the claim-processing system and claims processed correctly.
- The service, *Transportation, Level 1* applies to the FSW (see Table 3). The bulletin did not include the annual limit for the FSW. This service has a rate of $5.25 per trip at 2 trips per day, with an annual limit of $2,625.

Table 3 – Correct rate and annual limit, effective for DOS on or after July 16, 2020

Service	Code	Mod 1	Mod 2	Mod 3	Dsc Proc Modified	Rate	Notes
Equipment – Assess/Inspect/Train	T1028	U7	U5	---	U7=Waiver U5=DD	**$17.99**	Per 15 minutes FSW
Transportation, Level 1	T2002	U7	U5	---	U7=Waiver U5=DD	$5.25	Per trip; 2 trips/day; **$2,625**/year **FSW**

Correction to service description

- The service, *Behavior Management, Basic* (with procedure code and modifier combination H0004, U7, U5, U2) was incorrectly named as *Psychological Therapy* in the bulletin. The correct description is, *Behavior Management, Basic*, as reflected in Table 4. There are no changes to the rates.

Table 4 – Correct service description, effective for DOS on or after July 16, 2020

Service	Code	Mod 1	Mod 2	Mod 3	Dsc Proc Modified
Behavior Management, Basic	H0004	U7	U5	U2	U7=Waiver U5=DD U2=Level 2

Providers can direct any questions or concerns to the IHCP reimbursement mailbox at FSSA.IHCPReimbursement@fssa.IN.gov.

DXC Technology U.S. State and Local Health and Human Services to become Gainwell Technologies

Effective October 1, 2020, DXC Technology entered into an agreement to sell the U.S. State and Local Health and Human Services business to Veritas Capital. The agreement with Veritas brings together a market leader in government health and human services technology with the leading investor in government and healthcare technology businesses. The creation of a new stand-alone company under Veritas is a significant opportunity for staff and customers.

The name of the new company is Gainwell Technologies. The name *Gainwell* embraces the commitment to improving the health outcomes in the U.S. by utilizing and developing innovative technology solutions and support to better assist our clients.

Moving forward, providers will see communications referring to Gainwell Technologies rather than DXC Technology.

Services to providers, the State, and businesses remain unaffected. There will be no changes to day-to-day services or personnel. Local business and account leadership teams remain intact.

QUESTIONS?

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

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