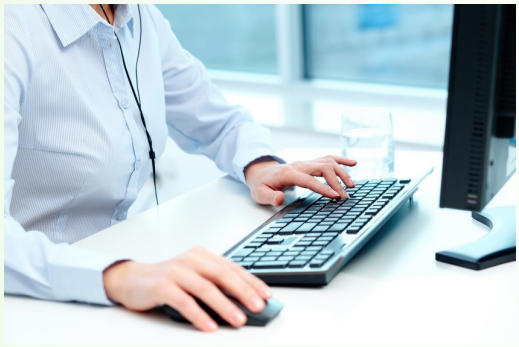
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202143 OCTOBER 26, 2021

FSSA hosts MLTSS webinar Nov. 2



The Family and Social Services Administration (FSSA) will host a webinar on Nov. 2, 2021, to provide an overview of Managed Long Term Services and Supports (MLTSS). For information on MLTSS visit the Long Term Services and Supports Reform webpage at in.gov/fssa/long-term-services-and-supports-reform. The webinar will cover both the national perspective along with key concepts for long-term services and supports (LTSS) providers. FSSA contractor, ADvancing States, will lead the webinar. ADvancing States has extensive expertise in MLTSS programs.

During the webinar, there will be an opportunity to ask questions and give feedback. Providers will have a chance to share which MLTSS topics are most important to them. FSSA will use information from the question, answer and feedback portion of the webinar to develop a series of LTSS provider educational webinars to prepare for the transition to MLTSS in 2024.

Webinar information:

- Date: Tuesday, Nov. 2, 2021
- Time: 3 p.m. Eastern Time
- Zoom Room link: nasuad.zoom.us

Speaker:

- ADvancing States

On the day of the webinar, please log in for attendance using the Zoom link above. The audio will be voice-over-internet, so participants will need to use speakers or headphones to hear the presentation.

Certain procedure codes no longer inpatient-only, reimbursement of claims that denied

Effective immediately, the Indiana Health Coverage Programs (IHCP) will update the claim-processing system (*Core*MMIS) for pricing on the outpatient services shown in Table 1. The Current Procedural Terminology (CPT®[1]) codes for the services were previously identified as Inpatient-Only (IPO) on the IHCP Outpatient Fee Schedule. To better align reimbursement of outpatient services with nationwide standards, the IHCP follows medically unlikely edits (MUEs) for Medicaid services.

continued

Effective immediately for dates of service (DOS) on or after **July 1, 2021**, the codes in Table 1 are no longer IPO and are reimbursable in the outpatient setting. Pricing for the procedure codes in Table 1 for outpatient services is retroactively effective for claims with DOS on or after July 1, 2021, and will reimburse a percentage of billed charges.

Table 1 – Procedure codes with manual pricing reimbursable in the outpatient setting, effective retroactively for claims with DOS on or after July 1, 2021

Procedure code	Description	Manual pricing (percentage of billed amount)
19364	Reconstruction of breast with free flap	20%
31230	Removal of nasal sinus and eye bone	10%
32820	Reconstruction of the chest wall after injury	10%
32905	Removal of infected area of chest cavity	10%
32906	Removal of infected area in chest cavity and closure of abnormal drainage tract	10%
33050	Removal of cyst or growth from sac that covers the heart	10%
33261	Destruction of tissue and reconstruction of right lower heart on heart-lung machine	10%
33310	Incision, exploration, and removal of foreign body of upper or lower heart chamber	10%
33315	Incision, exploration, and removal of foreign body of upper or lower heart chamber on heart-lung machine	10%
33477	Implantation of heart valve (pulmonary) to lungs, accessed through the skin	10%
33542	Partial removal of heart muscle	10%
33620	Placement of bands around the right and left pulmonary (lung) arteries, hybrid approach	10%
33622	Reconstruction of complex cardiac defects	10%
33681	Closure of congenital single opening in wall between lower heart chambers	10%
33684	Closure of congenital single opening in wall between lower heart chambers and release of valve tissue	10%
33688	Closure and reinforcement of congenital opening in wall between lower heart chambers	10%
33788	Reimplantation of abnormal pulmonary (lung) artery to heart	10%
33917	Repair of narrowing of pulmonary (lung) artery on heart-lung machine	10%
33924	Disconnection of blood vessel shunt system used to repair a congenital heart defect	10%
35132	Repair of diseased or ruptured bulging (aneurysm) artery of groin	10%
35142	Repair of diseased or ruptured bulging (aneurysm) artery of upper thigh	10%
38765	Removal of lymph nodes at groin and pelvis, superficial	10%
39000	Drainage, biopsy, or removal of foreign body of chest cavity, cervical	10%
39010	Drainage, biopsy, or removal of foreign body of chest cavity, transthoracic, with sternotomy	10%

continued

Table 1 – Procedure codes with manual pricing reimbursable in the outpatient setting, effective retroactively for claims with DOS on or after July 1, 2021 (continued)

Procedure code	Description	Manual pricing (percentage of billed amount)
43635	Partial removal of stomach with severing of vagus nerve	15%
43640	Severing of vagus nerve to stomach	15%
43641	Repair of stomach outlet muscle and severing of vagus nerve	15%
44050	Incisional repair of twisted or herniated small bowel	15%
47711	Removal of growth from bile duct external to liver	15%
47712	Removal of growth from bile duct within liver	15%
47715	Removal of gallbladder cyst	15%
49000	Exploration of abdomen and abdominal organs	15%
57540	Removal of remaining cervix through the abdomen	10%
59620	Cesarean delivery after vaginal delivery attempt due to prior cesarean delivery	10%
69535	Removal of temporal bone of ear	15%
69554	Removal of growth of external ear	15%

This change to pricing 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 fee-for service (FFS) outpatient claims for the procedure codes in Table 1, for claims with DOS from July 1, 2021, through Oct. 25, 2021. Claims or claim details for these procedure codes may have denied, and will be mass reprocessed or mass adjusted, as appropriate. Providers should see reprocessed or adjusted claims on Remittance Advices (RAs) beginning Dec. 1, 2021, with internal control numbers (ICNs) / Claim IDs that begin with 80 (reprocessed denied claim) or 52 (mass replacements non-check related).

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.

QUESTIONS?

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

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from the *Banner Pages* page of the IHCP provider website at in.gov/medicaid/providers.

TO PRINT

A printer-friendly version of this publication, in black and white and without photos, is available for your convenience.

SIGN UP FOR IHCP EMAIL NOTIFICATIONS

To receive email notices of IHCP publications, subscribe by clicking the blue subscription envelope or sign up from the IHCP provider website at in.gov/medicaid/providers.