

# IHCP *banner page*

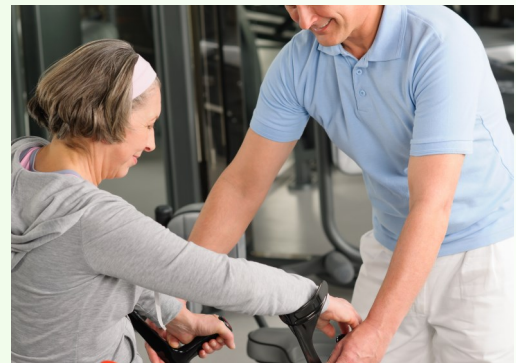
INDIANA HEALTH COVERAGE PROGRAMS

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## IHCP clarifies PA and billing for therapy services rendered in outpatient facility setting

The Indiana Health Coverage Programs (IHCP) is clarifying existing policy regarding the prior authorization (PA) and billing information for therapy services rendered in an outpatient facility setting. PA requests for occupational therapy, physical therapy, respiratory therapy and speech pathology services in an outpatient facility setting must include the applicable procedure codes for the services being rendered, including modifiers when appropriate. When billing for the service, the appropriate revenue code, procedure code and any applicable modifiers should be included on the outpatient institutional claim (*UB-04* claim form, Provider Healthcare Portal institutional claim or 837I electronic transaction).



Additionally, for certain occupational therapy and physical therapy services, the usage of modifier GO or GP on the claim must match the modifier usage on the PA. This guidance was originally announced in *IHCP Banner Page [BR202017](#)* for professional claims. This article clarifies that the same guidance also applies to outpatient facility claims. For a current list of services to which this requirement applies, see the *Physical and Occupational Therapy Procedure Codes That Require a Modifier Match (GO or GP) on Authorization Request and Claim* table on *Therapy Services Codes*, accessible from the [Code Sets](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).

The IHCP reimburses outpatient therapy claims at a flat, statewide fee based on revenue code only. For rate information, see the Revenue Codes tab of the Outpatient Fee Schedule, available from the [IHCP Fee Schedules](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).

The following PA and billing guidance applies for occupational therapy, physical therapy, respiratory therapy and speech pathology services rendered in an outpatient facility setting:

- Providers must list the procedure code (and appropriate modifier, if applicable) on the PA request.
- Providers must list the procedure code (with the appropriate modifier, if applicable) and revenue code on the outpatient claim.

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- [IHCP launches Quick Hits on-demand video series](#)
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- The outpatient claim will be denied due to lack of PA if the authorized procedure code is not listed on the claim.
- For designated occupational and physical therapy services, the outpatient claim will be denied due to lack of PA if the modifier usage (GO, GP or no modifier) does not match the usage on the PA.

This PA, billing and reimbursement information applies to services delivered under the fee-for-service (FFS) delivery system. Questions about PA, billing and reimbursement under the FFS delivery system should be directed to Gainwell Technologies at 800-457-4584. Individual managed care entities (MCEs) establish and publish PA, billing and reimbursement criteria within the managed care delivery system. Questions about managed care services should be directed to the MCE with which the member is enrolled.

## IHCP launches Quick Hits on-demand video series

Over the past few years, Indiana Health Coverage Programs (IHCP) providers have been requesting communication efforts be expanded to short on-demand videos for recurring topics and questions. The IHCP listened to these requests and has launched a new video series called *IHCP Quick Hits*. *IHCP Quick Hits* will offer valuable information to providers in five minutes or less and will be available on the [IHCP Quick Hits](#) page, in the Provider Education section of the Indiana Medicaid for Providers website at [in.gov/medicaid/providers](http://in.gov/medicaid/providers). Be sure to check out currently available Quick Hits videos like “Box 33” and “EVV.” Stay tuned for more videos!

## IHCP updates certain dialysis codes included on the LTC DME Per Diem Table

The Indiana Health Coverage Programs (IHCP) is updating procedure codes for services that are included in the renal dialysis composite rate from the Long-Term Care (LTC) Durable Medical Equipment (DME) Per Diem Table.

This action follows review of the IHCP [Renal Dialysis Services](#) provider reference module, where the Office of Medicaid Policy and Planning (OMPP) noted that dialysis sessions are reimbursed at a composite rate that includes overhead costs, personnel services, administrative services, equipment and supplies, end-stage renal disease (ESRD)-related laboratory tests, and certain drugs and biologics. The LTC facility should not incur costs related to the dialysis codes on the LTC DME Per Diem Table, because the dialysis provider would be incurring these costs and receiving reimbursement for them through the dialysis composite rate.

Effective immediately, the procedure codes listed in [Table 1](#) will no longer appear on the LTC DME Per Diem Table, accessible from the [Long-Term Care DME Per Diem Table](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers). These codes will remain on the table of procedure codes that are included in the renal dialysis composite rate, on *Renal Dialysis Services Codes*, accessible from the [Code Sets](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).

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Table 1 – Procedure codes removed from the LTC DME Per Diem Table

Procedure codes	Description
A4653	Peritoneal dialysis catheter anchoring device, belt, each
A4714	Treated water (deionized, distilled, or reverse osmosis) for peritoneal dialysis, per gallon
E1610	Deionizer water purification system, for hemodialysis
E1615	Deionizer water purification system, for hemodialysis
E1625	Water softening system, for hemodialysis
E1629	Tablo hemodialysis system for the billable dialysis service
E1634	Peritoneal dialysis clamps, each

**QUESTIONS?**

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

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