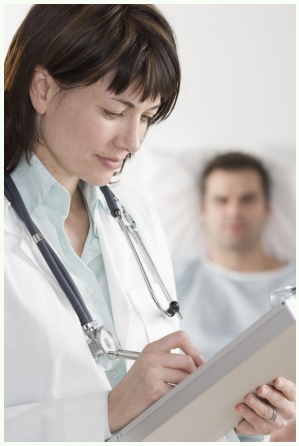
# IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202123 JUNE 8, 2021

## IHCP clarifies coverage of IOT services rendered by licensed behavioral health professionals, accepts resubmitted claims

The Indiana Health Coverage Programs (IHCP) previously announced in *Bulletin* BT2020108 that the following licensed behavioral health professionals are eligible to enroll directly with the IHCP. These professionals were added as provider specialties under IHCP provider type 11 – *Behavioral Health Provider*:



- 616 – *Licensed Psychologist*
- 617 – *Licensed Independent Practice School Psychologist*
- 618 – *Licensed Clinical Social Worker (LCSW)*
- 619 – *Licensed Marriage and Family Therapist (LMFT)*
- 620 – *Licensed Mental Health Counselor (LMHC)*
- 621 – *Licensed Clinical Addiction Counselor (LCAC)*

Covered procedure codes for these behavioral health provider specialties were listed in *Bulletin* BT2020122. However, that bulletin in error omitted the following Healthcare Common Procedure Coding System (HCPCS) codes that are covered:

- *H0015 – Alcohol and or drug services*
- *S9480 – Intensive outpatient psychiatric services*

Fee-for-service (FFS) professional claims submitted by these provider specialties (named above) for procedure codes H0015 or S9480 with DOS on or after November 1, 2020, may have denied incorrectly with explanation of benefits (EOB) 1012 – *Service and or modifier billed not payable for your provider type/specialty.*

The claim-processing system has been corrected to reimburse FFS claims submitted by these provider specialties for codes H0015 and S9480. Effective retroactively for claims with dates of service (DOS) on or after **November 1, 2020**, these specialties will be reimbursed for procedure codes H0015 and S9480 based on previous guidance in bulletins BT201929 and BT202082. As stated in those bulletins, these provider specialties are authorized to provide intensive outpatient treatment (IOT) services.

*continued*

**MORE IN THIS ISSUE**

Beginning immediately, providers may resubmit FFS claims for codes H0015 or S9480 during the indicated time frame that denied with EOB 1012, 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.

Questions about FFS billing should be directed to Gainwell Technologies at 800-457-4584.

Individual managed care entities (MCEs) establish and publish reimbursement, prior authorization (PA) and billing criteria within the managed care delivery system. Questions about billing, PA and resubmitting claims within the managed care delivery system should be directed to the MCE with which the member is enrolled.

This information will be reflected in the next regular update to the *Mental Health and Addiction Services Codes* document, accessible from the *Code Sets* page at in.gov/medicaid/providers.

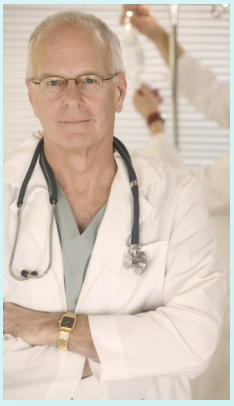
# Providers may resubmit outpatient crossover claims for HCPCS codes C9761 and C9769 that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain fee-for-service (FFS) outpatient crossover claims for dually eligible IHCP members, submitted for the Healthcare Common Procedure Coding System (HCPCS) codes in Table 1. Claims or claim details for the HCPCS codes in Table 1 with dates of service (DOS) on or after October 1, 2020, may have denied inappropriately with explanation of benefits (EOB) 4801 – *Procedure code not covered for benefit plan*.

*Table 1 – Procedure codes that may have denied incorrectly for outpatient crossover claims with DOS on or after October 1, 2020*

| Procedure code | Description |
|---|---|
| C9761 | Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy, and ureteral catheterization for steerable vacuum aspiration of the kidney, collecting system, ureter, bladder, and urethra if applicable |
| C9769 | Cystourethroscopy, with insertion of temporary prostatic implant/stent with fixation/anchor and incisional struts |

The claim-processing system has been corrected. Beginning immediately, providers may resubmit FFS claims for procedure code C9761 or C9769 denied with EOB 4801 during the indicated time frame, for reimbursement consideration. Providers that believe a claim underpaid (detail line denied) may submit a replacement claim. To submit a replacement claim, providers must first void the original claim. The replacement claim must include the same attachments (if any) submitted with the original claim. Claims resubmitted, or voided and replaced, beyond the original filing limit must include a copy of this banner page as an attachment and must be resubmitted within 180 days of the banner page's publication date.



# IHCP links procedure codes to revenue code 260

Effective retroactively to February 13, 2017, the Indiana Health Coverage Programs (IHCP) linked the procedure codes in Table 2 to Revenue Code 260 – *IV Therapy – General*. The codes were previously included in the *Core*MMIS claim processing system. However, providers were not notified of the codes' linkage to revenue code 260.

This linkage applies retroactively to outpatient claims with dates of service (DOS) on or after February 13, 2017, when *Core*MMIS was implemented. Beginning immediately, providers may bill the procedure codes in Table 2 and revenue code 260 together as appropriate, for reimbursement consideration. No previous claims were affected.

Reimbursement and billing information applies to services delivered under the fee-for-service (FFS) delivery system. Individual managed care entities (MCEs) establish and publish reimbursement 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 linkage will be reflected in the next regular update to the *Revenue Codes with Special Procedure Code Linkages* code tables document, accessible from the *Code Sets* webpage at in.gov/medicaid/providers.

*Table 2 – Procedure codes linked to revenue code 260, effective retroactively for claims with DOS on or after February 13, 2017*

| Procedure code | Description |
|---|---|
| 96372 | Injection beneath the skin or into muscle for therapy, diagnosis, or prevention |
| 96373 | Injection into artery for therapy, diagnosis or prevention |
| 96374 | Injection of drug or substance into a vein for therapy, diagnosis, or prevention |
| 96375 | Injection of different drug or substance into a vein for therapy, diagnosis, or prevention |
| 96521 | Refilling and maintenance of portable pump |
| 96522 | Refilling and maintenance of implantable pump or reservoir for drug delivery |
| 96523 | Irrigation of implanted venous access drug delivery device |
| Q0081 | Infusion therapy, using other than chemotherapeutic drugs, per visit |

# IHCP updates *Professional Fee Schedule* for CPT codes reported with modifier 53

The Indiana Health Coverage Programs (IHCP) has updated the *Professional Fee Schedule* to remove reimbursement rate information for the Current Procedural Terminology (CPT®[1]) codes in Table 3 reported with modifier 53 – *Discontinued procedure*.

This updated information is reflected in the *Professional Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers. Coverage and reimbursement for these codes have not changed and no claims are affected.

*continued*

*Table 3 – Reimbursement rates removed from CPT codes reported with modifier 53*

| Procedure code | Description |
|---|---|
| 44388 | Diagnostic examination of large bowel using an endoscope inserted through surgically created opening into large bowel from body wall (colostomy) |
| 45378 | Diagnostic examination of the colon (large bowel) using an endoscope (colonoscopy); high risk |

Reimbursement and billing information applies to services delivered under the fee-for-service (FFS) delivery system. Individual managed care entities (MCEs) establish and publish reimbursement 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?

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