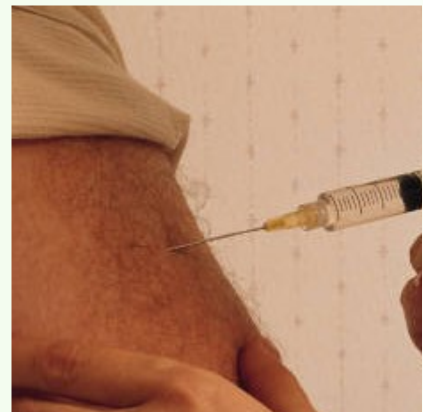
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202144 NOVEMBER 2, 2021

Providers may resubmit claims for HCPCS code J2182 that denied incorrectly



The Indiana Health Coverage Programs (IHCP) identified a claim-processing issue that affects certain fee-for-service (FFS) claims for Healthcare Common Procedure Coding System (HCPCS) code J2182 – *Injection, mepolizumab, 1 mg*, billed with any of the following National Drug Codes (NDCs):

- 00173-089-201
- 00173-089-242
- 00173-089-261

Claims with dates of service (DOS) from **Jan. 1, 2020**, through **Nov. 2, 2021**, may have denied incorrectly with explanation of benefits (EOB) 4300 – *Invalid NDC to procedure code combination*.

The claim-processing system has been corrected. Effective immediately, providers may resubmit FFS claims for HCPCS code J2182 billed with any of the NDCs listed above during the indicated time frame that may have denied incorrectly, 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.

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.

IHCP follows national guidelines for revenue codes 761 and 762

Indiana Health Coverage Programs (IHCP) Banner Page BR202113 stated that the Current Procedural Terminology (CPT®[1]) codes in Table 1 could be billed with revenue code 762 – *Specialty Services – Observation Hours.*

The revenue code linkage for these procedure codes follows the Office of Medicaid Policy and Planning (OMPP) universal billing (UB) editor and can update quarterly.

continued

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For dates of service (DOS) July 1, 2020, through March 31, 2021, the codes could be billed with revenue code 762. For DOS on or after **April 1, 2021**, these procedure codes can be billed with revenue code 761 – *Specialty Services – Treatment Room*.

Table 1 - Procedure codes with updated revenue code linkages, effective retroactively for DOS on or after April 1, 2021

Procedure code	Description
99224	Subsequent observation care, typically 15 minutes per day
99225	Subsequent observation care, typically 25 minutes per day
99226	Subsequent observation care, typically 35 minutes per day

For DOS on or after **April 1, 2021**, fee-for-service (FFS) claims for these codes follow national coding guidelines for revenue code linkages.

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.

[1]*CPT copyright 2021 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

IHCP to remove prior authorization for 99473 and 99474

Effective Dec. 2, 2021, the Indiana Health Coverage Programs (IHCP) will remove prior authorization (PA) requirements for two Current Procedural Terminology (CPT) codes for self-measured blood pressure using a device validated for clinical accuracy.

The coverage for the two codes in Table 2 was first published in *IHCP Bulletin* *BT201978* and currently require PA for IHCP reimbursement.

Table 2 – CPT codes for self-measured blood pressure

Code	Description
99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
99474	Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient

continued

Reimbursement, PA and billing information apply to services delivered under the fee-for-service (FFS) delivery system. Questions about FFS PA should be directed to Gainwell Technologies at 800-457-4584, option 7.

This information will be reflected in the next regular update to the Professional Fee Schedule and Outpatient Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

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

IHCP to update maximum number of units of service for CPT codes 11103, 11105 and 11107

Effective Jan. 1, 2019, Current Procedural Terminology (CPT) codes 11103, 11105 and 11107 for the "biopsy of skin lesion[s]" currently have unit restrictions of one unit per day per provider per member in fee-for-service (FFS) Medicaid.

However, CPT codes 11103, 11105 and 11107 are for “each separate/additional” skin lesion, and with current Indiana Health Coverage Programs (IHCP) billing rules a provider cannot receive reimbursement for more than one unit of any of these three codes on the same day of service. This is not in accordance with the Medically Unlikely Edits (MUEs) that the Medicaid National Correct Coding Initiative (NCCI) Program uses for these codes.

As a result, the IHCP will remove the one unit per day per provider per member restriction codes 11103, 11105 and 11107. Instead, the IHCP will follow Medicaid MUEs established for the codes in Table 3.

Table 3 – CPT codes for the “biopsy of skin lesion[s]”

Code	Description	Maximum number of units
11103	Tangential biopsy of skin (for example, shave, scoop, saucerize, curette); each separate/additional lesion (List separately in addition to code for primary procedure)	Six units per member, per provider, per date of service
11105	Punch biopsy of skin (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)	Three units per member, per provider, per date of service
11107	Incisional biopsy of skin (for example, wedge) (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)	Two units per member, per provider, per date of service

continued

The claim-processing system has been updated. Claims for dates of service (DOS) on or after **Jan. 1, 2019,** will be mass adjusted. Providers should see adjusted claims on Remittance Advices (RA) beginning Dec. 8, 2021, with internal control numbers (ICNs)/Claim IDs that begin with 52 (mass replacements non-check related).

Reimbursement and billing information applies to services delivered under the 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.

For information regarding NCCI, including MUEs, please visit the NCCI webpage on the Centers for Medicare & Medicaid Services (CMS) website at cms.gov. IHCP billing guidance and information can be found in the *National Correct Coding Initiative* provider reference module at in.gov/medicaid/providers.

Assisted Living temporary rate adjustment, effective Jan. 1, 2022 through June 30, 2022

The Division of Aging (DA) and the Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) are announcing that rates for Assisted Living for the Aged and Disabled (A&D) Waiver and the Traumatic Brain Injury (TBI) Waiver will be temporarily adjusted. To assure that the full state fiscal year 2022 budget allocation for Assisted Living providers is spent in a manner that optimizes federal match dollars, a temporary rate adjustment is being implemented for the period of Jan. 1, 2022, through June 30, 2022. This temporary rate adjustment has been approved by the Centers for Medicare & Medicaid Services (CMS). Table 4 shows the temporary changes to the rates and Table 5 shows the rates after the temporary adjustment.

Table 4 - Assisted Living temporary changes effective Jan. 1, 2022 through June 30, 2022

Service	Proc code	Mod 1	Mod 2	Mod 3	Current rate	New rate	Note
Assisted Living, Lvl 1	T2031	U7	U1		$75.35	$78.82	Daily
Assisted Living, Lvl 2	T2031	U7	U2		$83.68	$87.53	Daily
Assisted Living, Lvl 3	T2031	U7	U3		$96.85	$101.31	Daily
Assisted Living, Lvl 1	T2031	U7	U1	UA	$2237.90	$2340.96	Monthly
Assisted Living, Lvl 2	T2031	U7	U2	UA	$2485.30	$2599.65	Monthly
Assisted Living, Lvl 3	T2031	U7	U3	UA	$2876.45	$3008.91	Monthly

continued

Table 5 – Assisted Living rates, effective July 1 2022

Service	Proc code	Mod 1	Mod 2	Mod 3	Current rate	New rate	Note
Assisted Living, Lvl 1	T2031	U7	U1		$78.82	$75.35	Daily
Assisted Living, Lvl 2	T2031	U7	U2		$87.53	$83.68	Daily
Assisted Living, Lvl 3	T2031	U7	U3		$101.30	$96.85	Daily
Assisted Living, Lvl 1	T2031	U7	U1	UA	$2,340.96	$2,237.90	Monthly
Assisted Living, Lvl 2	T2031	U7	U2	UA	$2,599.65	$2,485.30	Monthly
Assisted Living, Lvl 3	T2031	U7	U3	UA	$3,008.91	$2,876.45	Monthly

Questions or concerns should be directed to the FSSA Indiana Health Coverage Programs (IHCP) reimbursement mailbox: FSSA.IHCPReimbursement@fssa.in.gov.

Please be sure to send communications containing protected health information (PHI) to this mailbox via secure email.

QUESTIONS?

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

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