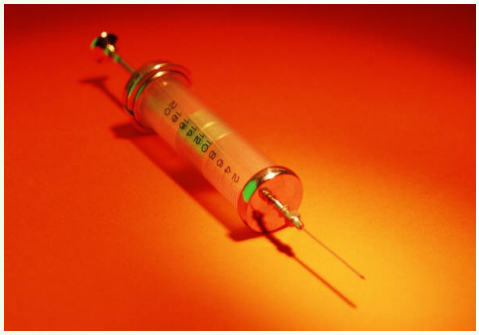
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202149 DECEMBER 7, 2021

IHCP to mass reprocess or mass adjust claims for HCPCS Code 90621 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 90621 – *Vaccine for meningococcus lipoprotein for injection into muscle, 2 or 3 dose schedule* when billed with a National Drug Code (NDC).

Claims with dates of service (DOS) from **July 1, 2021**, through **Nov. 10, 2021**, may have denied incorrectly with explanation of benefits (EOB) 4300 – *Invalid NDC to procedure code combination*.

The claim-processing system has been corrected. Claims or claim details processed during the indicated time frame for 90621 that denied for EOB 4300 will be mass reprocessed or mass adjusted, as appropriate. Providers should see reprocessed or adjusted claims on Remittance Advices (RAs) beginning Jan. 12, 2022, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claim) or 52 (mass replacements non-check related).

IHCP to host live webinar on clinical documentation practices for proper payment

The Indiana Health Coverage Programs (IHCP) will host a live webinar for registered nurses (RNs), advanced practice nurses (APRN), licensed practical nurses (LPNs), dentists, physicians, chiropractors, physical therapists (PTs), occupational therapists (OTs), compliance personnel and coders to present principles for clinical documentation and review the Subjective, Objective, Assessment, Plan (SOAP) format for what to include in a note during the clinician-patient encounter.

The webinar will also discuss best practices for effective clinical documentation to ensure proper payment, such as using self-check questions when finalizing a note. Providers will be able to ask questions via a chat feature during the webinar.

Attendees who attend the live event via their web browser will earn Continued Education (CE) credits. Registration is required.

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Webinar information:

- Date: Thursday, Dec. 16, 2021
- Time: 11 a.m. – noon Eastern Time
- Registration dates: Dec. 7, 2021, to Dec. 16, 2021

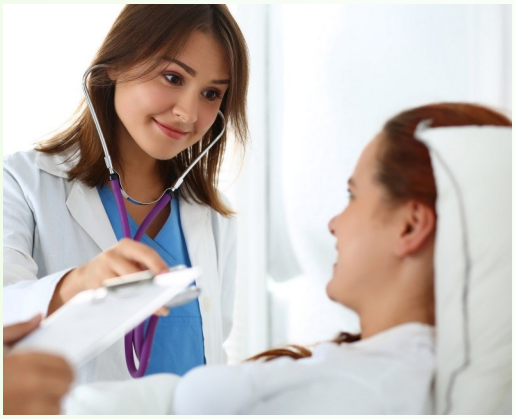
Speakers:

- Office of Medicaid Policy and Planning (OMPP): Amelia Hilliker, JD, Director, Program Integrity
- Deloitte/Facilitator: Dr. Barton Bishop, PT, DPT, SCS, CSCS, PMP, Program Manager
- Deloitte: Leslie Slater, RHIA, CCDS, CIC, CRC, Clinical Review Lead
- Deloitte: Patricia Hansrote, BS-RN, CCS, CCM, Clinical Review Lead

Look for a new banner page coming soon on how to participate.

For those who cannot attend on Dec. 16, a recording of the webinar will be posted to the Program Integrity Provider Education Training web page at in.gov/medicaid/providers/provider-education.

IHCP updates Inpatient Hospital Services Code Set



As stated in the *Inpatient Hospital Services* module, inpatient claims with stays less than 24 hours that do not meet the neonatal diagnosis -related group (DRG) exception criteria will deny with explanation of benefits (EOB) 0501 – *The discharge date is within 24 hours of the admit date/time,* and will be required to be billed as outpatient claims.

However, the Indiana Health Coverage Programs (IHCP) bypasses this 24-hour rule to allow certain procedure codes designated as inpatient-only (IPO) to be reimbursed as inpatient services when the service is delivered in an inpatient setting to a patient discharged or expired within 24 hours of admission. The list of Healthcare Common Procedure Coding System (HCPCS) and Current Procedure Terminology (CPT®[1]) codes to which this exception applies is listed in the *Procedure Codes Payable as an Inpatient Service When Delivered in an Inpatient Setting for Stays Less Than 24 Hours* table in *Inpatient Hospital Services* code set, available on the *Codes Sets* page at in.gov/medicaid/providers.

For more information on inpatient stays less than 24 hours, see the *Inpatient Hospital Services* module, available on the *IHCP Provider Reference Modules* web page at in.gov/medicaid/providers.

Several codes in Table 1 are no longer IPO codes. Because these codes are no longer considered IPO, when billing these codes for inpatient stays of less than 24 hours, the codes should be billed as an outpatient service for discharge dates on or after Jan. 1, 2021. The *Inpatient Hospital Services* Codes Set will be updated to reflect this change.

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continued

Table 1 – Procedure codes no longer considered IPO codes and will be removed from Table 2 in the Inpatient Hospital Services module, effective for dates of service (DOS) on or after January 1, 2021

Procedure code	Description
20661	Application of halo, including removal; cranial
21347	Open treatment of nasomaxillary complex fracture (Lefort II type); requiring multiple open approaches
22595	Arthrodesis, posterior technique, atlas-axis (C1-C2) with bone graft and/or internal fixation
22600	Arthrodesis, posterior technique, cervical below C2 segment, local bone or bone allograft
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (list separately in addition to code for primary procedure)
22846	Anterior instrumentation; 4 to 7 vertebral segments (list separately in addition to code for primary procedure)
22850	Removal of posterior nonsegmental instrumentation (eg, Harrington rod)
22852	Removal of posterior segmental instrumentation
22855	Removal of anterior instrumentation
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement [eg, total shoulder])
27268	Closed treatment of femoral fracture, proximal end, head; with manipulation
27280	Arthrodesis, sacroiliac joint (including obtaining graft)
27445	Arthroplasty, knee, total; prosthetic (eg, Walldius type)
27535	Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed

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

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