IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202203 JANUARY 18, 2022

IHCP updates pricing for CPT 49215 code no longer inpatient-only, claims may be resubmitted

Effective immediately, the Indiana Health Coverage Programs (IHCP) will update the claim-processing system (*Core*MMIS) for pricing of Current Procedural Terminology (CPT®[1]) code 49215 – *Removal of growth of pelvis or sacrum*. CPT code 49215 was 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.

Effective immediately for dates of service (DOS) on or after **July 1, 2021**, CPT code 49215 is no longer IPO and is reimbursable in the outpatient setting. Pricing for CPT code 49215 for outpatient services is retroactively effective for claims with DOS on or after **July 1, 2021,** and will reimburse at 15% of billed charges.

Claims for CPT code 49215 with DOS on or after **July 1, 2021**, may have denied with explanation of benefits (EOB) 4014 – *Claim being reviewed for pricing* or EOB 4108 – *There is no ASC on file for this procedure code. Please verify that the appropriate outpatient surgery code was billed.* Beginning immediately, providers may resubmit fee-for-service (FFS) outpatient claims for CPT code 49215 during the indicated time frame that denied with EOB 4014 or 4108 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 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.

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.

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IHCP to allow CLIA certificate of waiver for CPT codes 87400, 87420 and 87430, accepts resubmitted claims

Procedure codes associated with laboratory testing are regulated under the Clinical Laboratory Improvement Amendments (CLIA). The Indiana Health Coverage Programs (IHCP) policy requires compliance with the Centers for Medicare & Medicaid Services (CMS) recommendations regarding CLIA regulations under all IHCP programs, whether managed care or fee-for-service (FFS).

Effective immediately, the *Core*MMIS claim-processing system has been updated for the following Current Procedural Terminology (CPT) codes:

- 87400 – *Detection test by immunoassay technique for Influenza virus, A or B*
- 87420 – *Detection test by immunoassay technique for respiratory syncytial virus (RSV)*
- 87430 – *Detection test by immunoassay technique for Strep (Streptococcus, group A)*

Procedure codes 87400, 87420 and 87430 were considered CLIA-waived tests as of Oct. 6, 2020. Claims for these codes with dates of service (DOS) on or after **Oct. 6, 2020**, will be billable by laboratories that have a valid CLIA certificate of waiver. The FFS claim-processing system has been updated to classify CPT codes 87400, 87420 and 87430 as CLIA-waived tests. This change applies retroactively to claims with DOS on or after **Oct. 6, 2020**.

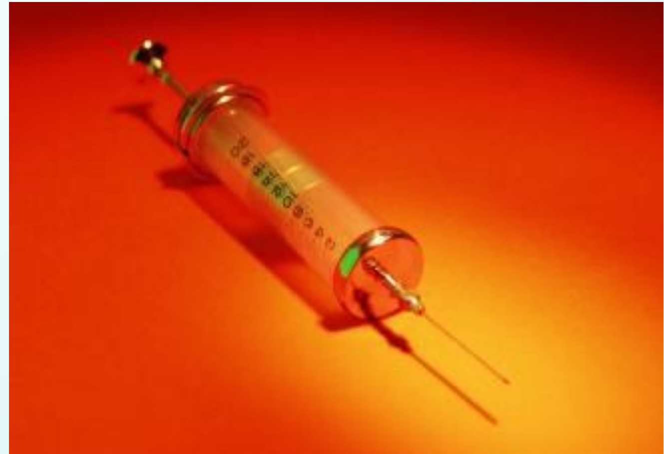
FFS claims billed for procedure codes 87400, 87420 or 87430 by providers with valid CLIA certificates of waiver may have denied inappropriately with explanation of benefits (EOB) 4207 – *Effective CLIA number not on file for dates of service billed*.

Beginning immediately, laboratory providers may resubmit claims for codes 87400, 87420 and 87430 with DOS on or after **Oct. 6, 2020**, that denied for EOB 4207, for reimbursement consideration. Claims must be resubmitted within 180 days of this banner page's publication date. Claims resubmitted beyond the original filing limit must include a copy of this banner page as an attachment.

Reimbursement, prior authorization (PA) and billing information applies to services delivered under the 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.

IHCP corrects rate for HCPCS code J0741

Effective retroactively to Oct. 1, 2021, the Indiana Health Coverage Programs (IHCP) is revising the reimbursement rate for Healthcare Common Procedure Coding System (HCPCS) code J0741 – *Injection, cabotegravir and rilpivirine, 2mg/3mg*, with dates of service (DOS) on or after **Oct. 1, 2021**. Claims for this code may have underpaid.



The claim-processing system has been corrected. The following maximum rate applies retroactively for HCPCS code J0741 with DOS on or after **Oct. 1, 2021.**

Updated pricing: Maximum fee of $20.79

Providers that believe an affected claim was reimbursed incorrectly must first void the original claim and then submit a new replacement claim. 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.

Reimbursement, PA and billing information applies to services delivered under the fee-for-service (FFS) delivery system. Individual 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.

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

IHCP to mass adjust DME claims that adjudicated incorrectly in *Core*MMIS

The Indiana Health Coverage Programs (IHCP) has identified claim-processing issues that affects certain fee-for-service (FFS) claims with region code 52 – *Mass replacement non-check related* or claims with region code 64 – *Spenddown EOB auto-initiated mass replacements*. FFS claims that were impacted posted with an explanation of benefits (EOB) code 6065 – *DME total rental not to exceed purchase amt (dtl).* The incorrect payment may have applied to claims submitted between Feb. 13, 2017, and Jan. 18, 2022.

The claim-processing system has been corrected and claims will be mass adjusted. Providers should see adjusted claims on Remittance Advices (RAs) beginning Feb. 22, 2022, with internal control numbers (ICNs)/Claim IDs that begin with 52 (mass replacements non-check related).

IHCP reminds providers to use the most accurate procedure and diagnosis code

Following a recent review of claims data, the Office of Medicaid Policy and Planning (OMPP) Program Integrity (PI) staff reminds Indiana Health Coverage Program (IHCP) providers to use the most accurate and specific diagnosis code on their claims.

Providers are responsible for selecting the diagnosis and procedure code that best describes the reason for the encounter and the service provided. Providers may not use a code from a covered diagnosis or procedure code list if a more specific or appropriate code exists, but is not covered by the IHCP. Providers will be subject to all current and applicable IHCP edits, audits and policies. Providers must bill only for services they are licensed and certified to perform under applicable federal and state laws and regulations, and IHCP rules and policies.

The IHCP uses the International Classification of Diseases, Tenth Revision (ICD-10); Current Procedural Terminology (CPT); Healthcare Common Procedure Coding System (HCPCS) and Current Dental Terminology (CDT®[2]). Please note that codes from these resources are subject to change based on annual and quarterly review processes and IHCP policy changes. Providers are strongly encouraged to review all applicable coding guidelines.

To help providers choose the most appropriate procedure and diagnosis code, the IHCP maintains several code documents for provider reference. These documents are posted on the *Code Sets* page at in.gov/medicaid/providers. These codes include:

- Codes necessary for billing and claim processing
- Codes billable for certain types of services and by certain provider types or specialties
- Codes related to specific coverage policies for certain members and programs

For additional information on billing and reimbursement, refer to the *IHCP Provider Reference Modules* page, for general as well as service- and provider-specific information. In addition, providers should always monitor all IHCP bulletins and banner page articles for future coding information and clarification of billing practices. These items are available on the *News, Bulletins and Banner Pages* page at in.gov/medicaid/providers.

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