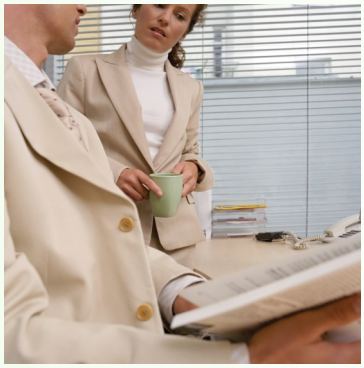
IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR202224 JUNE 14, 2022

IHCP updates documentation requirements for sterilization services, revises code set



For any procedure that is performed specifically to sterilize a member, the provider is obligated to obtain informed consent as described in the *Family Planning Services* provider reference module at in.gov/medicaid/providers. The Indiana Health Coverage Programs (IHCP) reimburses for sterilizations and related services only when a valid *Consent for Sterilization* form accompanies all claims connected with the service, unless one of the following exceptions applies:

- The patient was already sterile prior to the procedure.
- The patient is not rendered sterile by the procedure (for example, because the procedure was performed unilaterally rather than bilaterally).
- The provider renders a patient sterile as a result of an illness or injury, when prior acknowledgement was not possible.

The IHCP is amending requirements for documenting the preceding exceptions. Effective for dates of service (DOS) on or after July 14, 2022, if a valid *Consent for Sterilization* form is not included with the claim, the provider must attach either an operative report or a statement attesting that one of the preceding exceptions apply. The following information should be included:

- Patient name
- Explanation of the exception
- Physician signature

These documentation requirements amend information previously announced in *IHCP Banner Pages* *BR202124* and *BR202214*.

Additionally, the IHCP is revising the list of codes for which a sterilization consent form or documentation of a qualifying exception is always required. Effective for DOS on or after July 14, 2022, the codes in Table 1 will no longer automatically require a *Consent for Sterilization* form because these codes, on their own, are not sterilization related.

These policies apply to all fee-for-service and managed care programs.

This information will be updated in *Procedure Codes That Require Attachments*, accessible from the *Code Sets* page, and in the next regular revision of the *Family Planning Services* provider reference module.

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Table 1 – Procedure codes that no longer require Consent for Sterilization form

Procedure code	Description
55550	Laparoscopy, surgical, with ligation of spermatic veins for varicocele
58673	Laparoscopy, surgical; with salpingostomy (salpingoneostomy)
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral;
58943	Oophorectomy, partial or total, unilateral or bilateral; for ovarian, tubal or primary peritoneal malignancy, with para-aortic and pelvic lymph node biopsies, peritoneal washings, peritoneal biopsies, diaphragmatic assessments, with or without salpingectomy(s), with or without omentectomy
58950	Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy;
58952	Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with radical dissection for debulking (ie, radical excision or destruction, intra-abdominal or retroperitoneal tumors)

Note: The Consent for Sterilization form should not be used for hysterectomy procedures. If a service in the sterilization code set is performed due to a medically necessary hysterectomy, an informed consent and acknowledgement statement for hysterectomies should be used, instead. Providers are reminded that the IHCP covers only medically necessary hysterectomies performed to treat an illness or injury. For more information about hysterectomies, see the Obstetrical and Gynecological Services provider reference module.

IHCP to mass adjust or mass reprocess claims for CPT codes 91132 and 91133

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain fee-for-service (FFS) claims for the following Current Procedural Terminology (CPT©[1]) codes:

- 91132 – Recording and interpretation of stomach electrical activity
- 91133 – Recording and interpretation of stomach electrical activity with drug administration

The claim-processing system has been updated to allow modifier 26 – Professional component or modifier TC – Technical component for these codes, retroactive to **Feb. 1, 2017**. Claims submitted before June 1, 2022, may have denied incorrectly with explanation of benefits (EOB) 4033 – *The modifier used is not compatible with the procedure code billed. Please verify and resubmit.*

continued

The claim-processing system has been corrected and claims will be mass adjusted or reprocessed. Providers should see adjusted/reprocessed claims on Remittance Advices (RAs) beginning July 27, 2022, with internal control numbers (ICNs)/ Claim IDs beginning with 52 (mass replacements non-check related) or 80 (reprocessed denied claims).

IHCP corrects rates for HCPCS codes J1650, J9017, J9263 and Q0161

The Indiana Health Coverage Programs (IHCP) is revising the reimbursement rates for the Healthcare Common Procedure Coding System (HCPCS) codes in Table 2, effective retroactively to dates of service (DOS) on or after **Jan. 1, 2022**. Claims for these codes with DOS on or after **Jan. 1, 2022,** may have underpaid. The claim-processing system has been corrected to reflect the maximum-fee rates listed in Table 2 for the DOS indicated.

Table 2 – Procedure codes with revised reimbursement rates

Procedure code	Description	Maximum fee	Date applicable
J1650	Injection, enoxaparin sodium, 10 mg	$1.05	1/1/2022
J9017	Injection, arsenic trioxide, 1 mg	$15.33	1/1/2022
J9263	Injection, oxaliplatin, 0.5 mg	$0.06	1/1/2022
Q0161	Chlorpromazine hydrochloride, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	$0.10	1/1/2022 to 3/31/2022
		$0.09	4/1/2022 and onward

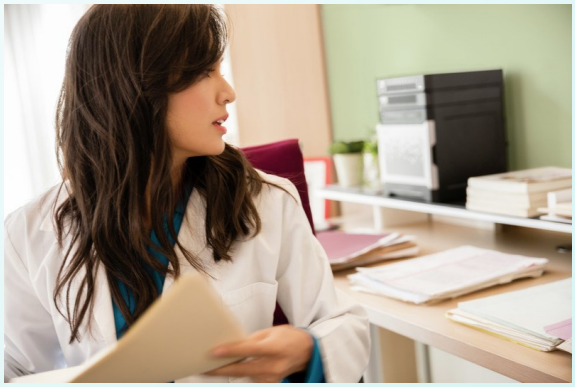
Gainwell will mass reprocess or mass adjust impacted fee-for-service (FFS) claims submitted. Providers should see reprocessed or adjusted claims on Remittance Advices (RAs) beginning July 20, 2022, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claim) or 52 (mass replacements non-check related).

Reimbursement, PA and billing information apply to services delivered under the 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 Outpatient Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

IHCP advises long-term care providers of issue with June 2022 patient liabilities

The Indiana Health Coverage Programs (IHCP) discovered a system issue in the Indiana Eligibility Determination Services System (IEDSS) that prevented Social Security income from being included in the formation of patient liabilities for approximately 12,000 members for the month of June 2022. June 2022 liabilities will not be corrected, following the Timely Notice of Adverse Action policy outlined in section 2232.00.00 of the *Indiana Health Coverage Program Policy Manual*, which indicates that recipients must be given timely, advance written notice of any adverse action.



Patient liability amounts have been corrected to the appropriate amount beginning in July 2022. Notices have been sent to members affected by this issue.

Reimbursement for dates of service (DOS) in June 2022 will reflect the patient liability amount listed in *Core*MMIS.

QUESTIONS?

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