IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR202323 JUNE 6, 2023

IHCP reminds providers of Kepro transition and announces additional Atrezzo Provider Portal benefits

As previously announced in *Indiana Health Coverage Programs (IHCP) Bulletin* BT202301, Kepro will be the new fee-for-service (FFS) prior authorization and utilization management (PA-UM) contractor for IHCP nonpharmacy services. Kepro will assume PA-UM responsibilities beginning July 1, 2023. Kepro will work with current IHCP contractors to ensure that PA-UM responsibilities are carried out seamlessly and with no interruption of services.

With this transition on July 1, 2023, Kepro will be adjudicating all concurrent reviews, continued stay requests and other updates to existing prior authorization (PA) requests that had been processed by Gainwell. To ensure appropriate review of these FFS PA update requests, providers should include the Gainwell PA number in the notes section of the authorization update request submitted to Kepro.

Kepro is excited to share another feature of its Atrezzo Provider Portal. After the transition, Kepro will be working with the Office of Medicaid Policy and Planning (OMPP) to determine possible services that could be auto-approved. Auto-approval rules for specific services will allow providers to submit a request for that service, and if the defined rules or criteria were met, an authorization approval would be delivered nearly instantaneously upon submission of the request.

Remember that after the transition, all existing FFS PA authorizations will be honored until all approved units have been used or length-of-stay dates have been exhausted. No action will be needed by members or providers to ensure this continuity. Furthermore, for renewal or continuation of authorization for home health and therapy (physical, occupational, speech) services, requests received from July 1, 2023, through Sept. 30, 2023, will be honored for at least 180 days at the same service level, provided the requests also meet administrative requirements.

Finally, providers can sign up now for upcoming Atrezzo Provider Portal training sessions (see *IHCP Bulletin* BT202339). Providers and administrators need only attend one training session but may attend more than one if they would like to hear the information again. After all the training sessions have taken place, recordings of the training sessions will be available to watch anytime through the Kepro website, which will be live June 12, 2023.

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IHCP removing unit limit from psychiatric procedure codes 90785 and 90840 and clarifies use of 90785

Effective July 6, 2023, the Indiana Health Coverage Programs (IHCP) will be changing coverage for the Current Procedural Terminology (CPT®[1]) codes in Table 1, including removing them from the group of psychiatric services that are limited, collectively, to 20 units per provider per 12-month period without prior authorization.

Table 1 – CPT codes that will no longer count toward the psychiatric service limit of 20 units per provider per year, effective for DOS on or after July 6, 2023

Procedure code	Description
90785	Psychiatric services complicated by communication factor
90840	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)

CPT code 90785 is an add-on code, reported in addition to the code for a primary psychiatric service. It is reported when the patient being treated has certain factors that increase the complexity of treatment rendered. These qualifying factors are limited to the following:

- The need to manage disruptive communication that complicated the delivery of treatment
- Complications involving the implementation of a treatment plan due to caregiver behavioral or emotional interference
- Evidence of a sentinel event with subsequent disclosure to a third party and discussion and/or reporting to the patient(s)
- Use of play equipment or translator to enable communication when a barrier exists

Providers may report CPT code 90785 with the following services, when the complexity of the service is increased due to one of the preceding qualifying factors:

- Psychiatric evaluation services (90791–90792)
- Psychotherapy services (90832–90834, 90836–90838)
- Group psychotherapy (90853)

CPT code 90785 should **not** be reported without providing psychotherapy or with any of the following:

- Psychotherapy for crisis (90839–90840)
- Psychological and neuropsychological testing (96130–96134, 96136–96139, 96146)
- Adaptive behavior assessment/treatment services (97151–97158, 0362T, 0373T)

continued

When reported with an applicable psychiatric service code, CPT code 90785 includes certain additional communication and activities that might be provided in conjunction with the underlying service, as follows:

- Includes communication with:
  - Emotionally charged or dissonant family members
  - Patients wanting others present during visit (such as family member or translator)
  - Patients with impaired or undeveloped verbal skills
  - Patients with third parties responsible for their care (such as parents or guardians)
  - Third-party involvement (such as schools, probation and parole officers, or child protective agencies)

- Includes one or more of the following activities:
  - Discussion of sentinel event demanding third-party involvement (such as abuse or neglect reported to state agency)
  - Interference by caregiver's behavior or emotional state to understand and assist in treatment plan
  - Managing discordant communication complicating care among participating members (such as arguing or reactivity)
  - Nonverbal communication methods (such as toys, other devices or translator) to eliminate communication barriers

This reimbursement and billing information applies to services delivered under the FFS delivery system. IHCP managed care entities (MCEs) are also expected to remove unit-limit PA for the listed CPT codes if PA was previously required.

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

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