IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201447 NOVEMBER 25, 2014

PA criteria revised for HCPCS codes E0470 and E0471 for members with hypoventilation syndrome

Effective January 1, 2015, the Indiana Health Coverage Programs (IHCP) will revise the prior authorization (PA) criteria for coverage of the following Healthcare Common Procedure Coding System (HCPCS) codes for individuals with hypoventilation syndrome:

- E0470 – *Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask*
- E0471 – *Respiratory assist device, bi-level pressure capability, with backup rate feature, used with noninvasive interface, e.g., nasal or facial mask*

The new PA criteria for HCPCS code E0470 are as follows:

- An initial arterial blood gas $PaCO_2$, done while awake and breathing, indicates the member's prescribed FIO_2 is greater than or equal to 45 mm Hg; AND
- Spirometry shows an FEV1/FVC of greater than or equal to 70% and an FEV1 of greater than or equal to 50% of predicted, with either:
  - An initial arterial blood gas $PaCO_2$, done during sleep or immediately upon awakening and breathing, indicating the member's prescribed FIO_2 worsened greater than or equal to 7 mm Hg, compared to the original result of the initial $PaCO_2$ done while awake and breathing; OR
  - A facility-based PSG demonstrating oxygen saturation of less than or equal to 88% for greater than or equal to five minutes of nocturnal recording time that is not caused by obstructive upper-airway events
- For members under the age of 19, appropriate noninvasive testing (such as capillary blood gas and end-tidal CO_2 tests) may be substituted for an arterial blood gas $PaCO_2$ test.

The new PA criteria for HCPCS code E0471 are as follows:

- A device as defined by HCPCS code E0470 is being used; AND

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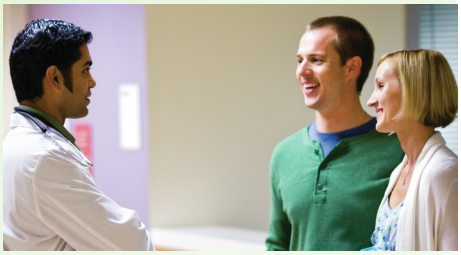
- Spirometry shows an FEV1/FVC of greater than or equal to 70% and an FEV1 of greater than or equal to 50% of predicted, with either:
  - An arterial blood gas $PaCO_2$, done while awake and breathing, indicating the member's prescribed FIO_2, worsened greater than or equal to 7 mm Hg compared to the $PaCO_2$ result, qualifying the member for the E0470 device; OR
  - A facility-based PSG demonstrating oxygen saturation of less than or equal to 88% for greater than or equal to five minutes of nocturnal recording time that is not caused by obstructive upper-airway events while using a device as defined by HCPCS code E0470.

These PA changes apply to dates of service (DOS) on or after January 1, 2015, for services delivered under the fee-for-service (FFS) delivery system. Questions regarding FFS PA should be directed to ADVANTAGE Health Solutions℠ at 1-800-269-5720. Individual managed care entities (MCEs) establish and publish PA criteria within the risk-based managed care (RBMC) delivery system. Questions regarding RBMC PA should be directed to the MCE under which the member is enrolled.

The IHCP to revise billing guidance for Essure implant device

The Indiana Health Coverage Programs (IHCP) continues to cover the Essure implant device as a sterilization option; however, billing for the device is being revised. Effective January 1, 2015, Healthcare Common Procedure Coding System (HCPCS) code A9900 – *Miscellaneous DME Supply, accessory, and/or service component of another HCPCS code* will be noncovered and should no longer be used for billing hysteroscopic sterilizations with the Essure implant device. For reimbursement consideration, providers must bill the Essure implant device using HCPCS code A4264 – *Permanent implantable contraceptive intratubal occlusion device(s) and delivery system.* This code is limited to once per lifetime, per member.

The coverage change for HCPCS code A9900 applies to dates of service (DOS) on or after January 1, 2015, for all IHCP programs, including the Family Planning Eligibility Program. All other policies regarding coverage of sterilizations and sterilization-related procedures are unaffected and remain in effect. The revised billing guidance applies to fee-for-service claims with dates of service (DOS) on or after January 1, 2015. All other guidance related to billing for the Essure implant device are unaffected and remain in effect. These changes will be reflected in the next monthly update to the IHCP Fee Schedule at indianamedicaid.com. The Family Planning Eligibility Program code set will be revised to reflect this change. See *Chapter 8* of the *IHCP Provider Manual* for other billing information.



As a reminder, the implant procedure can be performed by a medical doctor (MD) or by a doctor of osteopathy (DO) trained in the procedure, and can be performed in the office, at an outpatient hospital facility, or in an ambulatory surgical center (ASC). Providers must adhere to the billing instructions in Table 1 on the following page to receive reimbursement.

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Table 1 – Billing instructions for the hysteroscopic sterilization procedure with Essure implant device effective for DOS on or after January 1, 2015

Provider	Claim Type	Bill for the Procedure and the Supply	Additional Billing Requirements
Outpatient hospital or ASC	*UB-04*	CPT code 58565 with appropriate revenue code	■ Print "Essure Sterilization" in the body of the claim form or on the accompanying invoice ■ Submit a manufacturer's cost invoice with the claim to support the cost of the Essure device. The IHCP reimburses 130% of the amount listed on the cost invoice up to a maximum of $1,700 ■ Submit a valid, signed Sterilization Consent Form with the claim ■ Enter **ICD code V252** – **Sterilization** as the primary diagnosis on the claim
	CMS-1500 – Bill for the device under the professional or durable medical equipment (DME) provider number	Bill the device using HCPCS code A4264; include a cost invoice with the claim to support the actual cost of the device	
Physician	*CMS-1500*	CPT code 58565	
		Bill the device on a separate line using HCPCS code A4264; include a cost invoice	

The IHCP to adopt 2015 Medicare rates for select clinical laboratory services

Pursuant to *Section 1903(i)(7)* of the *Social Security Act*, Medicaid reimbursement for individual clinical laboratory procedures cannot exceed the Medicare rate of reimbursement. Therefore, in accordance with the clinical laboratory reimbursement methodology set out in *405 IAC 5-18-1* and in the approved Indiana Medicaid State Plan (Attachment 4.19B, page 2), the Indiana Health Coverage Programs (IHCP) will adopt the 2015 Medicare rates for any clinical laboratory procedure code for which the IHCP's current reimbursement rate exceeds the 2015 Medicare rate. The 2015 Medicare clinical laboratory fee schedule is available on the Centers for Medicare & Medicaid Services (CMS) website at cms.gov. Providers will be notified after the updated prices have been added to Indiana*AIM*. The rate changes will be effective for dates of service on or after January 1, 2015.

New Indiana EHR Incentive Program Attestation Deadline for Eligible Hospitals is December 31, 2014

To align with CMS' recent announcement of its intention to extend the attestation deadline for Eligible Hospitals (EHs), the Indiana Medicaid EHR Incentive Program is extending the deadline for **Eligible Hospitals** from **November 30, 2014,** to **December 31, 2014**. This extension allows more time for hospitals to submit their meaningful use data and receive incentive payments for the 2014 program year. More information will be posted at the *Indiana Medicaid EHR Incentive Program* page at indianamedicaid.com as it becomes available. If you have questions, please contact the Indiana Medicaid EHR Incentive Program Customer Service at 1-855-856-9563, or email MedicaidHealthIT@fssa.in.gov.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-577-1278.

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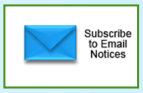

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