February 7, 2020

Recent KMAP Policy Changes

- Revisions to Abortion Procedures – Effective with claims processed on and after November 1, 2019, ICD-10 codes 10D17Z9, 10D17ZZ, 10D18Z9, 10D18ZZ, 0UDB7ZZ and 0UDB8ZZ will be removed from a group of procedures considered abortion procedures. DXC and the MCO's will identify and reprocess any inappropriately denied claims. KMAP bulletin pending.

- Expanded Coverage for Hydroxyprogesterone Caproate - Effective with the dates of service on or after November 1, 2019, Hydroxyprogesterone Caproate can be administered to pregnant women using HCPCS code J1726. This drug may be billed via both the pharmacy and medical benefit plans. KMAP bulletin pending.

- Occurrence Code 55 and Patient Status Code - Effective with dates of service on and after November 1, 2019, when a Patient Discharge Status Code of 20 (expired), 40 (expired at home), 41 (expired in a medical facility) or 42 (expired-place unknown) is billed without an Occurrence Code 55 (Date of Death), the claim will be denied. Aetna and Sunflower are already compliant. DXC and United will implement 11/1. KMAP bulletin pending.

- Coverage of Bariatric Surgery Procedures in Accordance with Inpatient, Outpatient and Ambulatory Surgical CMS Payment Status Indicators – Effective with September 15, 2019 service dates, KMAP will align Medicaid coverage locations with the current CMS payment status indicators (inpatient only, outpatient only). Additionally, ICD-10 procedure 0DB64Z3 will be a covered procedure. Reference KMAP bulletin 19125.

- Appropriate Billing of C-Series HCPCS Codes - Effective with November 1, 2019 service dates, "C" Codes (currently in the range of C1713 – C9899) will only be allowed by outpatient facilities. This section of codes reports drug, biological and device codes that must be used by OPPS hospitals, Non-OPPS hospitals, Critical Access Hospitals (CAHs) and Indian Health Hospitals. These codes can only be reported for facility services. Billing of C-codes is not a guarantee of coverage or payment status. Reference KMAP bulletin 19163.

- 2019 Update to Medicare Guidelines for Unacceptable Principal Diagnosis Codes – Effective with October 1, 2019 service dates, Kansas Medicaid has adopted code list changes as noted in the Definitions of Medicare Code Edits v37. When submitting claims for payment, providers must use an acceptable ICD-10 CM principal diagnosis code. Reference KMAP bulletin 19155.

- Coverage of Diagnostic and Screening Mammography - Effective with December 1, 2019 service dates, 3D Digital Breast Tomosynthesis (DBT) will be a covered service.
  A radiological mammogram is a covered diagnostic test under the following conditions:
  • A patient has distinct signs and symptoms for which a mammogram is indicted;
  • A patient has a history of breast cancer; or
  • A patient is asymptomatic, but on the basis of the patient's history and other factors the physician considers significant, the physician's judgement is that a mammogram is appropriate. Reference KMAP bulletin 19177.

- External Independent Third-Party Review - Effective with denials issued by Aetna, Sunflower or United Healthcare to providers on and after January 1, 2020, providers are entitled to request an external independent third-party review (EITPR) of the MCO's provider appeal decision. The EITPR will be available to KanCare providers who have received a denial by an MCO of authorization of a new healthcare service to an MCO member or a denial of a claim for reimbursement to the provider for a healthcare service to an MCO member. Documentation reviewed by the external reviewer will be limited to documentation submitted by the provider in the MCO's appeal process, along with medical necessity criteria applied in the appeal decision for denials of a healthcare service. Reference KMAP bulletin 19178.

- Newborn Hearing Screening Billing under Newborn DRG - Effective January 1, 2020, inpatient reimbursement for newborn hearing screening CPT codes 92586 and 92587 is included in the Newborn DRG and these codes are not allowed for POS 21. CPT/HCPCS codes for hearing screening cannot be billed for dates on or during the date span of the delivery hospital stay. Follow-up screening for newborns who fail their initial hearing screening may be billed using CPT/HCPCS codes. Follow-up screens may be billed only if they occur on dates of service outside of the date span for the delivery hospital admission. Reference KMAP bulletin 19186.

- MCO PAR Provider Contract Termination - Effective January 1, 2020, MCOs will begin sending PAR contracts term notices for any provider that has not obtained a KMAP ID. MCOs must validate the provider has no existing KMAP ID tied to their NPI and must obtain permission from KDHE prior to terminating a PAR contract for no KMAP ID. This is limited to any provider with no claim activity in the past 6 months. Reference KMAP bulletin 19214.

- Effective with January 1, 2020 discharge dates, the following updates were made:
  DRG Weights and Rates (Reference KMAP bulletin 19212)
  New DRG Grouper version 37 (Reference KMAP bulletin 19225)
  Cost Adjustment Factor for Critical Access Hospitals

Upcoming KMAP Policy Changes

- Diabetes Self-Management Training – Effective with July 1, 2020 service dates, KMAP will cover DSMT, which is a preventive outpatient service for persons diagnosed with diabetes. An accredited outpatient DSMT program includes education on self-monitoring of blood glucose, diet and exercise, and an insulin treatment plan developed specifically for the patient who is insulin dependent and motivates patients to use the skills for

successful self-management of diabetes. DSMT services minimizes the occurrence of disease disability through instruction and maintaining the health and well-being of the patient.

- Coverage for Low Dose Lung CT - Effective with July 1, 2020 service dates, codes G0296 (Counseling visit to discuss need for lung cancer screening using low dose CT (LDCT) scan) and G0297 (Low dose CT scan for lung cancer screening) will be covered by KMAP with Prior Authorization (PA) for the Fee-for-Service (FFS) population. Individuals must meet specific criteria to have these services covered every 12 months. KMAP bulletin pending.

- Coverage Guidance and Rate Change for CPT Codes 81229 and 81243 – Effective with July 1, 2020 service dates, the following rates will apply to cytogenic microarray (CMA) testing: 81229 - $986.00 and 81243 - $112.67. A suspected diagnosis of Global Developmental Delay or Fragile X is appropriate to bill with these codes. These tests are considered the standard of care when genetic conditions are suspected and supported by clinical examination. Genetic counseling is not required.