IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201450 DECEMBER 16, 2014

ACA increase in reimbursement for primary care services ends December 31, 2014

As stated in *Indiana Health Coverage Programs (IHCP) Provider Bulletins BT201247* and *BT201302*, *Section 1202* of the *Affordable Care Act* (ACA) required a temporary increase in Medicaid payments for qualifying primary care services provided by qualifying physicians for dates of service (DOS) in calendar years (CYs) 2013 and 2014. The federally funded, temporary rate increase was authorized only for these two calendar years. This temporary increase will end December 31, 2014, and the Medicaid rate structures will return to preexisting levels for DOS on or after January 1, 2015.

Consistent with previous quarterly payments, qualifying physicians will receive the fourth-quarter 2014 ACA primary care physician (PCP) quarterly supplemental payments approximately 6-8 weeks after the end of the quarter, or approximately mid- to late February 2015. To accommodate the one-year IHCP fee-for-service (FFS) timely claims filing limit, a final settlement payment will be made for each year of the program. The final settlement payment for claims with DOS in CY2013 will be paid in the first half of 2015, and the final settlement payment for claims with DOS in CY2014 will be paid in the first half of 2016. The actual date for both final settlement payments will be communicated in future IHCP provider communications.

Changes in billing instructions

BT201247 issued billing instructions for the time period when ACA PCP rate increases applied. Some of these billing instructions will be continued, and others will end with the conclusion of the ACA PCP rate increase. Specific instructions follow.

Billing by individually enrolled nurse practitioners

BT201247 stated that, to qualify for the increased PCP rates under the ACA, individually enrolled nurse practitioners were required to bill the IHCP using the SA modifier and the rendering (supervising) physician's National Provider Identifier (NPI) in field 24J of the *CMS-1500* claim form. **Effective for DOS on or after January 1, 2015, individually enrolled nurse practitioners may resume billing using their own NPIs in field 24J of the *CMS-1500* claim form**.

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Claims for Vaccine for Children (VFC) vaccines

BT201247 instructed providers using VFC-provided vaccines to bill the IHCP for the VFC vaccine administration fee by billing V20.2 as the primary diagnosis, the procedure code of the specific vaccine administered with a billed amount of $0.00, and the appropriate vaccine administration code with the SL modifier. A list of appropriate administration procedure codes is provided in Table 1. The allowed amount per claim for the administration of a VFC vaccine was set at $8.00.

Table 1 – VFC-provided vaccine administration procedure codes

Procedure Code	Code Description
90471 SL	*Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid); VFC vaccine administration*
90472 SL	*Each additional vaccine (single or combination vaccine/toxoid); VFC vaccine administration*
90473 SL	*Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/ toxoid); VFC vaccine administration*
90474 SL	*Each additional vaccine (single or combination vaccine/toxoid); VFC vaccine administration*

The IHCP will continue to follow these billing instructions for DOS on or after January 1, 2015. Providers should continue to bill the preceding vaccine administration codes with the SL modifier for VFC vaccines with a billed amount of $8.00 and the procedure code of the specific vaccine administered with a billed amount of $0.00.

Providers are reminded it is federally prohibited to bill an amount greater than $0.00 for vaccines provided through the VFC program. Claims for VFC vaccines with billed amounts of $0.00 will continue to receive denial notices with Explanation of Benefit (EOB) code 268 – *Billed amount missing*. Although providers receive this denial, providers should continue to bill these claims as instructed and not rebill the IHCP with a different billed amount.

Claims for non-VFC vaccines

BT201247 instructed providers billing for non-VFC vaccines to bill the IHCP for the most appropriate vaccine administration code from those listed in Table 2.

Table 2 – Non-VFC vaccine administration procedure codes

Procedure Code	Code Description
90471	*Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)*
90472	*Each additional vaccine (single or combination vaccine/toxoid)*
90473	*Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/ toxoid)*
90474	*Each additional vaccine (single or combination vaccine/toxoid)*

The IHCP will continue to follow these billing instructions for DOS on or after January 1, 2015. Providers should continue to bill the preceding vaccine administration codes for non-VFC vaccines. Reimbursement for the vaccine administration continues to be included in the evaluation and management (E/M) code-allowed amount. Therefore, if an

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E/M service code is billed with the same DOS as an office-administered vaccination, providers will not be separately reimbursed for the vaccine administration code. Separate reimbursement for the vaccine administration is allowed when the administration of the drug is the only service billed by the practitioner. Additionally, if more than one vaccine is administered on the same DOS and no E/M code is billed, providers may bill an administration fee for each injection using the appropriate vaccine administration code.

The IHCP to mass adjust claims for NCCI edits

The Indiana Health Coverage Programs (IHCP) was delayed in implementing the third-quarter National Correct Coding Initiative (NCCI) edits. The NCCI edits have now been implemented. The IHCP will mass adjust claims with dates of service from July 1, 2014, through September 30, 2014, originally processed during the same period of time. The adjustments will take several weeks to complete. Providers will begin to see these adjustments on the December 23, 2014, Remittance Advice (RA) statement.

The IHCP clarifies its reimbursement policy for neonatal transfers between hospitals

The Indiana Health Coverage Programs (IHCP) clarifies its reimbursement policy for neonatal transfers paid using diagnosis-related groups (DRGs):

- DRG 639 – *Neonate, transferred less than 5 days old, born here*
- DRG 640 – *Neonate, transferred less than 5 days old, not born here*

Claims grouping to DRG 639 or DRG 640 are exempt from the special payment policies applied to other hospital transfer cases using the DRG payment methodology. Because DRG 639 and DRG 640 include only transfer cases, the transferring hospital is reimbursed at the full DRG rate instead of a prorated DRG daily rate. Additionally, when the neonate returns to a hospital from which he or she was previously transferred at less than five days old, the hospital is not required to combine the original admission stay and the subsequent return stay for billing purposes. All hospital transfers are subject to retrospective review to ensure appropriate billing and payment.

Chapter 7 of the *IHCP Provider Manual* provides detailed information about the special payment policies applied to other transfers, as well as the exemption for neonatal transfers. See *Chapter 8* of the manual for guidance on billing transfers. The *IHCP Provider Manual* is on the Manuals page at indianamedicaid.com.

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