IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201508 FEBRUARY 24, 2015

IHCP to cover CPT code 81270

Effective April 1, 2015, the Indiana Health Coverage Programs (IHCP) will cover Current Procedural Terminology (CPT ®[1]) code 81270 – *JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p. Val617Phe (V617F) variant*. Coverage applies to all IHCP programs, subject to limitations established for certain benefit packages. Coverage applies to dates of service on or after April 1, 2015. The following reimbursement information applies:

Pricing: Laboratory fee

Prior authorization: Prior authorization (PA) is required. Providers should use the criteria set in the IHCP Genetic Testing policy included in the *Medical Policy Manual* at indianamedicaid.com.

Billing Guidance: See *Chapter 8* of the *IHCP Provider Manual* for billing procedures.

These changes will be reflected in the next monthly update to the provider *Fee Schedule* at indianamedicaid.com. Reimbursement, PA, and billing information apply to services delivered under the fee-for-service (FFS) delivery system. Questions about FFS PA should be directed to ADVANTAGE Health Solutions[SM] at 1-800-269-5720. Individual managed care entities (MCEs) establish and publish reimbursement, PA, and billing criteria within the risk-based managed care (RBMC) delivery system. Questions about RBMC PA should be directed to the MCE with which the member is enrolled.

[1] *CPT copyright 2013 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

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Prior authorization is no longer required for CPT code 94664

Effective April 1, 2015, the Indiana Health Coverage Programs (IHCP) will no longer require prior authorization (PA) when providers bill for Current Procedural Terminology (CPT) code 94664 – *Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device*. This change applies to dates of service on or after April 1, 2015.

This PA requirement change applies to services delivered under the fee-for-service (FFS) delivery system. Questions about 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 (RMBC) delivery system. Questions about RBMC PA should be directed to the MCE with which the member is enrolled.

This change will be reflected in the next monthly update to the *Fee Schedule* at indianamedicaid.com.

Patient residence required on pharmacy claims effective April 1, 2015

Effective April 1, 2015, the Indiana Health Coverage Programs (IHCP) will require mandatory completion of the Patient Residence (384-4X) field on all pharmacy claims for IHCP members. A value of "1 = Home," previously not used by the IHCP, has been added to pages 1–3 of the *Companion Guide for the NCPDP Version D.0 Transaction Payer Sheet effective 4/1/15* accessible via the Pharmacy Services quick link at indianamedicaid. The value of "0 = Not Specified" will no longer be accepted as a valid value on a pharmacy claim. For dates of service (DOS) on or after April 1, 2015, pharmacy claims will reject if the Patient Residence field is blank or contains an invalid entry. See the Table 1 for a list of valid values for the Patient Residence field.

Table 1 – Valid values for Patient Residence (field 384-4X) for DOS on or after April 1, 2015

Value	Description
1	Home
2	Skilled Nursing Facility
3	Nursing Facility
4	Assisted Living Facility
5	Custodial Care Facility
6	Group Home
7	Inpatient Psychiatric Facility
9	Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID)
11	Hospice
12	Psychiatric Residential Treatment Facility
13	Comprehensive Inpatient Rehabilitation Facility

The Patient Residence field is used by pharmacies to communicate to the IHCP whether a member is a resident of a long-term care (LTC) facility. Patient residence values drive the following:

- Number of allowable dispensing fees when a member is in an LTC facility
- Nonassessment of copays when a member is in an LTC facility
- Adjudication of claims for services that are reimbursed *per diem* in an LTC facility and not separately billable to the IHCP
- Appropriate retro-Drug Utilization Review (DUR) screening

It is the responsibility of the pharmacist or pharmacy dispensing the prescription or adjudicating the claim to ensure that the Patient Residence field is populated correctly. The use of this field in claims adjudication is subject to pharmacy audit.

Please direct questions about this article to the Catamaran Clinical and Technical Help Desk by calling toll-free 1-855-577-6317.

IHCP clarifies reimbursement policies and billing guidelines for the use of treatment room revenue codes when administering infusions

Indiana Health Coverage Programs (IHCP) Banner Page BR201441, dated October 14, 2014, incorrectly stated current IHCP policies and guidelines for the reimbursement and billing of treatment room codes when **administering infusions**. In error, BR201441 stated that the administration of infusions is required to be billed with the revenue code for the treatment room where the infusion was administered, and that the administration of infusions is not separately reimbursable. Contrary to the guidance provided in *BR201441*, the administration of infusions is treated differently from the administration of injections with respect to outpatient reimbursement and billing.

The reimbursement policies and billing guidelines for the **administration of infusions** are corrected as follows:

> Consistent with national coding guidelines that indicate infusion administration should be billed with revenue code 260 – *IV Therapy-General*, infusions are considered a stand-alone service by the IHCP. When performed in conjunction with other services in a treatment room, providers may bill the infusion administration code along with revenue code 260 on a separate line from the treatment room. When performing only an infusion, providers may bill only the administration code along with revenue code 260.

Language in BR201441 correctly stated the IHCP's reimbursement policy and billing guidelines regarding the **administration of therapeutic and diagnostic injections**, **including the administration of vaccines**, as follows:

> Administration of therapeutic and diagnostic injections, including the administration of vaccines, are required to be billed with the revenue code for the treatment room where the injection was administered (such as an operating room – 360, emergency room – 450, or clinic – 510). Reimbursement for the administration of injections is considered when establishing treatment room rates. Therefore, when providing other services in the treatment room setting, administration of the injection is not separately reimbursable. If a patient only receives an injection service, and no other service is provided, the provider is instructed to bill only the administration code using revenue code 260.

In addition, effective April 1, 2015, the IHCP will require that revenue code 260 always be billed with a procedure code for outpatient claims. This change applies to fee-for-service claims with dates of service (DOS) on or after April 1, 2015. As with all other services, reimbursement of infusion and injection administration is subject to post-payment review.

For additional information regarding stand-alone services and treatment room reimbursement, please see Chapter 8 of the *IHCP Provider Manual*.

Register now for first-quarter provider workshops

The Indiana Health Coverage Programs (IHCP) is offering one-day educational workshops to providers throughout the state during the month of March. This year, providers can attend workshops in Lawrenceburg, Scottsburg, and Richmond, as well as in traditional locations such as South Bend, East Chicago, Indianapolis, Evansville, and Fort Wayne. Workshop sessions include:

- **Reimbursement update, new Hospital Presumptive Eligibility (HPE) Adult Aid Category, and Healthy Indiana Plan (HIP) –** This session will include information regarding the following:
  - Fee-for-service (FFS) reimbursement update – HP will discuss when FFS reimbursement changes became effective and the impact to providers paid using the physician fee schedule.
  - New Hospital Presumptive Eligibility (HPE) Adult aid category – This session will discuss how this new aid category will integrate with the existing HPE process and the positive impact it will have for enrollees.
  - New Healthy Indiana Plan (HIP 2.0) – A representative from the Indiana Family and Social Services Administration (FSSA) will discuss the HIP expansion, including benefit plans, copayments, and the general impact of the program on members and providers. In addition, the three managed care entities (MCEs) – Anthem, MDwise, and MHS – will each have 45 minutes to discuss the individual details of their plans and answer providers' questions.
- **Hoosier Care Connect** – This session will include an overview of the Hoosier Care Connect program and its goals, identify members transitioning to Hoosier Care Connect, and explain how the program will affect newly eligible persons. The three managed care entities (MCEs) selected as Hoosier Care Connect vendors will each have 45 minutes to discuss the individual details of their plans and answer questions.

Session registration

Be sure to register early, as spaces fill up quickly. For more information, including dates and locations, see the *First-Quarter IHCP Provider Workshops* page at indianamedicaid.com. To register, visit the *Workshop Registration page* at indianamedicaid.com. The registration page provides instructions, including the Workshop Registration Tool Quick Reference. Online registrants receive immediate confirmation.

QUESTIONS?

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

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