IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR201930 JULY 23, 2019

IHCP to reimburse for revenue codes 390 and 391 billed as stand-alone services or with treatment rooms

Effective September 1, 2019, the Indiana Health Coverage Programs (IHCP) will reimburse for either revenue code in Table 1 billed as a stand-alone service, or billed in conjunction with a treatment room visit in the outpatient setting. This change will apply to claims for dates of service (DOS) on or after September 1, 2019. As before, the revenue code must be billed with an appropriate procedure code.

Table 1 – Revenue codes 390 and 391 reimbursable as stand-alone services, effective September 1, 2019

Revenue code	Description
390	Administration, processing and storage for blood and blood components – General
391	Administration, processing and storage for blood and blood components – Administration (e.g., transfusions)

Beginning September 1, 2019, providers may bill revenue codes 390 and 391 as stand-alone services in combination with appropriate procedure codes for reimbursement consideration.

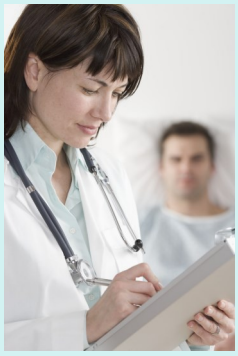
This billing information applies to services delivered under the fee-for-service (FFS) delivery system. Individual managed care entities (MCEs) establish and publish reimbursement, prior authorization (PA), and billing criteria within the managed care delivery system. Questions about managed care billing should be directed to the MCE with which the member is enrolled.

Note: This change will update the claim-processing system to match the currently published Revenue Codes table, accessible from the Code Sets page at in.gov/medicaid/providers, and the Outpatient Fee Schedule, accessible from the IHCP Fee Schedules page.

For more information about billing and reimbursement of revenue codes, see the *Claim Submission and Processing* provider reference module at in.gov/medicaid/providers. For more information about stand-alone services, see the *Outpatient Facility Services* module.

MORE IN THIS ISSUE

Physician-administered drugs carved out of managed care exempt from HAF payments, unless submitted as professional claims



The Indiana Health Coverage Programs (IHCP) announced in *Bulletin* BT201812 that claims for physician-administered drugs (PADs) carved out of managed care must be submitted to DXC Technology as professional claims (*CMS-1500* form or electronic equivalent). This information applies to all procedure codes in the *Physician-Administered Drugs Carved Out of Managed Care and Reimbursable Outside the Inpatient DRG* code table, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Effective August 23, 2019, claims and claim details for PADs carved out of managed care submitted as institutional claims (*UB-04* form or electronic equivalent) will *not* receive Hospital Assessment Fee (HAF) payments. Providers may bill for the PAD codes using the claim type most appropriate for the setting where the drug is administered (institutional or professional). However, as explained in *BT201812*, PADs should be billed as professional claims, through the fee-for-service (FFS) delivery system. Claims or claim details billed as professional claims will receive HAF payments.

Note: Healthcare Common Procedure Coding System (HCPCS) code J0221 – Injection, alglucosidase alfa, (Lumizyme), 10 mg, will be "carved out" of the Diagnosis-Related Group (DRG) and NOT managed care, as previously described in IHCP Banner Page BR201927. Code J0221 must be billed on a professional claim whether the member is enrolled in FFS or managed care, for reimbursement consideration and to receive the HAF.

IHCP establishes a Telemedicine Services Code Set

Effective August 23, 2019, the Indiana Health Coverage Programs (IHCP) will establish and publish a *Telemedicine Services Code Set*. This code set is not the result of a policy change, but will provide a published table of the procedure codes currently reimbursable as telemedicine services.

This new code set will apply to all IHCP programs. Reimbursement, prior authorization (PA), and billing information will apply to services rendered under the fee-for-service (FFS) delivery system. Questions about FFS PA should be directed to Cooperative Managed Care Services at 1-800-269-5720. Managed care entities (MCEs) establish and publish reimbursement, PA, and billing information within the managed care delivery system. Questions about managed care information should be directed to the MCE with which the member is enrolled.

When billing for telemedicine services, providers must use Place of Service (POS) code 02 – *the location where health services and health related services are provided or received, through a telecommunication system* AND modifier 95 – *Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system*. The POS code 02 describes services furnished via telemedicine.

The *Telemedicine Services Code Set* will be accessible from the *Code Sets* web page at in.gov/medicaid/providers. Code sets are subject to change based on annual and quarterly Healthcare Common Procedure Coding System (HCPCS) updates and policy changes. Changes to code sets are announced in IHCP provider publications.

For information about using telemedicine services, see the *Telemedicine and Telehealth Services* provider reference module at in.gov/medicaid/providers.

IHCP reminds providers that midlevel practitioners must bill using supervisor's NPI

The Indiana Health Coverage Programs (IHCP) does not enroll midlevel practitioners with their own National Provider Identifiers (NPIs). For this reason, a midlevel practitioner who provides services to an IHCP member must bill using his or her supervising practitioner's NPI in the Rendering field on a professional claim (*CMS-1500* form or electronic equivalent). In all settings, the IHCP considers the supervising practitioner as the individual who provides direct supervision over the midlevel practitioner, and who assumes final responsibility for a member's treatment plan.

Beginning September 1, 2019, all IHCP audit activity will enforce the requirement that midlevel practitioners bill for their services using their supervising practitioner's NPI. The supervising practitioner identified as the rendering provider on the professional claim must be the same person who directly supervised the midlevel practitioner. Midlevel practitioners are described in the *Medical Practitioner Reimbursement* provider reference module at in.gov/Medicaid/providers.

When the practitioner who normally supervises is not available, such as during an extended absence, an alternative enrolled provider can supply a supervising practitioner who is authorized by law to supervise midlevel practitioners. Midlevel practitioners should only have one such assigned alternative provider, which promotes consistency and continuity of patient care. The professional claim must clearly identify the name and role of the supervisor who signed the member's treatment plan.

IHCP revises date for including manually priced procedures in multiple surgery reimbursement reduction

The Indiana Health Coverage Programs (IHCP) previously announced in *IHCP Banner Page BR201916*, in the article titled, *IHCP to include manually priced procedures in multiple surgery reimbursement reduction, effective June 1, 2019,* that manually priced procedures would be included in the reimbursement methodology for multiple surgeries. The effective date of June 1, 2019, has changed to September 1, 2019.

For details about this coming change, see the article in *BR201916*.

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