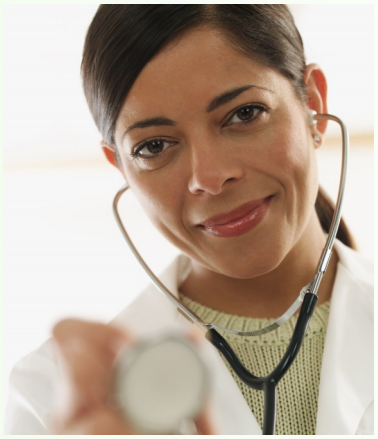
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201939 SEPTEMBER 24, 2019

IHCP to cover HCPCS code C9041



Effective October 24, 2019, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code C9041 – *Injection, coagulation factor Xa (recombinant), inactivated (Andexxa), 10 mg*. Coverage for this physician-administered drug (PAD) applies to all IHCP programs, subject to limitations established for certain benefit packages, and to claims with dates of service (DOS) on or after October 24, 2019.

The following reimbursement information applies:

- Pricing: Manually priced
- Prior authorization (PA): None required
- Billing guidance:
  - Must be billed with the National Drug Code (NDC) of the product administered
  - Separate reimbursement is allowed under revenue code 636 – *Drugs requiring detailed coding for separate reimbursement in an outpatient setting*. For reimbursement consideration, providers may bill the procedure code and the revenue code together, as appropriate.
  - Separate reimbursement is allowed outside the all-inclusive inpatient hospital diagnosis-related group (DRG) payment.

continued

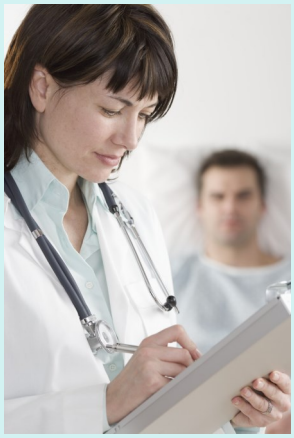
MORE IN THIS ISSUE

- All claims for procedure code C9041 will be processed as fee-for-service (FFS) claims, including claims for members enrolled in the Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise managed care programs. This action is referred to as a "carve-out" from managed care. See the *Claim Submission and Processing* provider reference module at in.gov/medicaid/providers for information about the FFS claim submission process, including timely filing requirements.

This information will be reflected in the next regular update to the *Procedure Codes That Require NDCs*, the *Revenue Codes Linked to Specific Procedure Codes*, and the *Physician-Administered Drugs Carved out Of Managed Care and Reimbursable Outside the Inpatient DRG* code tables on the *Code Sets* web page, and in the next regular update to the *Professional Fee Schedule* and the *Outpatient Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

Please direct questions about FFS medical claims to DXC by calling toll-free 1-800-457-4584. Questions regarding other claims for members in HIP, Hoosier Care Connect, and Hoosier Healthwise should be referred to the managed care entity (MCE) with which the member is enrolled.

IHCP to mass void or mass adjust claims for ABA therapy services



The Indiana Health Coverage Programs (IHCP) revised billing guidance for applied behavioral analysis (ABA) therapy services, as announced in *IHCP Bulletin BT201867 and Banner Page BR201915*. To facilitate the transition process to new procedure codes, the IHCP honored prior authorizations (PAs) issued before January 1, 2019, and reimbursed claims for the procedure code and modifier combinations in Table 1 for dates of service (DOS) through June 30, 2019. However, in error, the claim-processing system was not updated to end date the codes as previously announced.

Effective immediately, the procedure code and modifier combinations in Table 1 will no longer be reimbursed for claims with DOS on or after **July 1, 2019**. Instead, providers should use the new codes identified in *BR201915* for reimbursement of ABA therapy services.

The claim-processing system has been corrected. Claims with the procedure codes in Table 1 will be mass voided or mass adjusted, as appropriate. Providers should see voided or adjusted claims on Remittance Advices (RAs) beginning October 24, 2019, with internal control numbers (ICNs)/Claim IDs that begin with 56 (mass void request or single claim void) or 52 (mass replacement non-check related). For a claim that was overpaid, the net difference will appear as an accounts receivable. The accounts receivable will be recouped at 100% from future claims paid to the respective provider number.

This information will be reflected in the next regular update to the *Professional Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

continued

Table 1 – Procedure codes and modifier combinations no longer covered for ABA therapy, effective for DOS on or after July 1, 2019

Procedure code and modifier	Description
96150 U1	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment; ABA Therapy Assessment provided by BCBA, BCBA-D, or HSPP
96150 U2	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment; ABA Therapy Assessment provided by BCaBA
96151 U1	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment; ABA Therapy Re-assessment provided by BCBA, BCBA-D, or HSPP
96151 U2	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment; ABA Therapy Re-assessment provided by BCaBA
96152 U1	Health and behavior intervention, each 15 minutes, face-to-face; individual; ABA Therapy provided by BCBA, BCBA-D, or HSPP
96152 U2	Health and behavior intervention, each 15 minutes, face-to-face; individual; ABA Therapy provided by BCaBA
96152 U3	Health and behavior intervention, each 15 minutes, face-to-face; individual; ABA Therapy provided by RBT
96153 U1	Health and behavior intervention, each 15 minutes, face-to-face; group; ABA Therapy provided by BCBA, BCBA-D, or HSPP
96153 U2	Health and behavior intervention, each 15 minutes, face-to-face; group; ABA Therapy provided by BCaBA
96153 U3	Health and behavior intervention, each 15 minutes, face-to-face; group; ABA Therapy provided by RBT
96154 U1	Health and behavior intervention, each 15 minutes, face-to-face; family with patient present; ABA Therapy provided by BCBA, BCBA-D, or HSPP
96154 U2	Health and behavior intervention, each 15 minutes, face-to-face; family with patient present; ABA Therapy provided by BCaBA
96154 U3	Health and behavior intervention, each 15 minutes, face-to-face; family with patient present; ABA Therapy provided by RBT
96155 U1	Health and behavior intervention, each 15 minutes, face-to-face; family without patient present; ABA Therapy provided by BCBA, BCBA-D, or HSPP
96155 U2	Health and behavior intervention, each 15 minutes, face-to-face; family without patient present; ABA Therapy provided by BCaBA
96155 U3	Health and behavior intervention, each 15 minutes, face-to-face; family without patient present; ABA Therapy provided by RBT

IHCP to mass adjust certain claims for physician-administered drug procedures that paid inappropriately

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain physician and physician crossover claims processed from February 13, 2017, through September 22, 2019, for physician-administered drugs (PAD) services.

Certain claim details may have paid inappropriately because a claim-processing audit was not applied. Claim details should have denied for explanation of benefits (EOB) 5000 – *This is a duplicate of another claim,* when any of the following criteria applied:

- Current claim detail has the same or overlapping date of service (DOS) as a previously processed claim detail.
- The procedure code and National Drug Code (NDC) are the same as a previously processed claim detail.
- At least one modifier on the claim detail is the same as for a previously processed detail, or modifiers are absent from both details.
- A procedure is rendered by different rendering providers for the same member.

Note: If every detail line on a claim met a criteria (above), the entire claim should have denied.

The claim-processing system has been corrected. Claims during the indicated time frame will be mass adjusted. Providers should see the adjusted claims on Remittance Advices (RAs) beginning October 25, 2019, with internal control numbers (ICNs)/Claims IDs that begin with 52 (mass replacement non-check related). If a claim was overpaid, the net difference appears as an accounts receivable. The accounts receivable will be recouped at 100% from future claims paid to the respective provider number.

IHCP to allow reimbursement of acquisition of body components in the outpatient setting

Effective October 24, 2019, the Indiana Health Coverage Programs (IHCP) will allow reimbursement of the revenue codes in Table 2 for services related to the acquisition of body components in the outpatient setting.

This change will apply to outpatient services rendered under the fee-for-service (FFS) delivery system for claims with dates of service on or after October 24, 2019. Providers may bill using the revenue codes in Table 2 for reimbursement consideration. Individual managed care entities (MCEs) establish and publish reimbursement information within the managed care delivery system. Questions about managed care guidance should be directed to the MCE with which the member is enrolled.

This change will be reflected in the next regular update to the *Outpatient Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers, and in the *Revenue Codes* table, accessible from the *Code Sets* page on the website.

continued

Table 2 – Acquisition of body components revenue codes reimbursable in the outpatient setting, effective October 24, 2019

Revenue code	Description
810	Acquisition of Body Components-General
811	Acquisition of Body Components-Living Donor
812	Acquisition of Body Components-Cadaver Donor
813	Acquisition of Body Components-Unknown Donor
814	Acquisition of Body Components-Unsuccessful Organ Search-Donor Bank Charges
819	Acquisition of Body Components-Other Donor

IHCP to update reimbursement of certain organ acquisition services in the outpatient setting

Effective October 24, 2019, the Indiana Health Coverage Programs (IHCP) will update the reimbursement methodology for the Current Procedural Terminology (CPT®[1]) codes and Healthcare Common Procedure Coding System (HCPCS) codes in Table 3. Providers may bill these codes as outpatient services for dates of service (DOS) on or after October 24, 2019, and will be reimbursed at a percentage of the amount they bill (see Table 3).

This change will be reflected in the next regular update to the *Outpatient Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

Table 3 – Procedure codes that will reimburse for a percentage of the amount billed, effective October 24, 2019

Procedure code	Description	Percentage of amount billed
32855	Preparation of one lung from a cadaver	10%
32856	Preparation of two cadaver lungs for transplantation	10%
33930	Harvest of donor heart and lung	10%
33933	Preparation of donor heart and lung for transplantation	10%
33940	Obtaining donor cadaver heart	10%
33944	Preparation of donor heart for transplantation	10%
38205	Collection of donor stem cells for transplantation	10%
38206	Collection of stem cells for transplantation	10%
38230	Harvest of donor bone marrow for transplantation	10%
38232	Harvest of patient bone marrow for transplantation	10%
44132	Removal of donor small bowel, open procedure	15%

continued

Table 3 – Procedure codes that will reimburse for a percentage of the amount billed, effective October 24, 2019 (continued)

Procedure code	Description	Percentage of amount billed
44133	Partial removal of donor small bowel for transplantation, open procedure	15%
44715	Preparation of donor small bowel for transplantation	15%
44720	Reconstruction of donor small bowel for transplantation	15%
44721	Reconstruction of donor small bowel for transplantation	15%
47133	Removal of donor liver	15%
47140	Partial removal of donor liver left segment	15%
47141	Removal of donor liver left lobe	15%
47142	Removal of donor liver right lobe	15%
47143	Preparation of donor liver for transplantation	15%
47144	Preparation of donor liver for transplantation	15%
47145	Preparation of donor liver for transplantation	15%
47146	Preparation of donor liver for transplantation	15%
47147	Preparation of donor liver for transplantation	15%
48551	Preparation of donor pancreas for transplantation	15%
48552	Preparation of donor pancreas for transplantation	15%
50300	Removal of donor kidney	10%
50320	Removal of donor kidney, open procedure	10%
50323	Preparation of donor kidney for transplantation	10%
50325	Preparation of donor kidney for transplantation, open or endoscopic procedure	10%
50327	Preparation of donor kidney for transplantation	10%
50328	Preparation of donor kidney for transplantation	10%
50329	Preparation of donor kidney for transplantation	10%
0537T	Harvesting of blood-derived T white blood cells (T lymphocytes) for chimeric antigen receptor T-cell therapy, per day	90%
0538T	Preparation of blood-derived T white blood cells (T lymphocytes) for transportation for chimeric antigen receptor T-cell therapy	90%
0539T	Receipt and preparation of blood-derived T white blood cells (T lymphocytes) for chimeric antigen receptor T-cell therapy	90%
V2785	Processing, preserving and transporting corneal tissue	90%
V2790	Amniotic membrane for surgical reconstruction, per procedure	90%

PE approval letters to include HIPAA notification and resources

Effective September 30, 2019, the Indiana Health Coverage Programs (IHCP) will begin appending the *Health Insurance Portability and Accountability Act* (HIPAA) notification to the Presumptive Eligibility (PE) approval notices for individuals approved for PE. Because an individual's data may be shared to provide him or her proper coverage and pay claims, this HIPAA notice should be given to each individual at the time of approval.

Letters that will include the notice:

- ELG-HPEH-O – HPE Adult Approval Letter
- ELG-HPEB-O – HPE Former Foster Care Approval Letter
- ELG-HPEI-O – HPE Infant Approval Letter
- ELG-HPEF-O – HPE Family Planning Approval Letter
- ELG-HPPC-O – HPE Parent Caretaker Approval Letter
- ELG-HPIC-O – HPE Prisoner Inpatient Care Approval Letter
- ELG-HPEP-O – HPE Pregnancy Approval Letter
- ELG-PEPA-O – Presumptive Eligibility Acceptance Letter
- ELG-HPEC-O – HPE Child Approval Letter

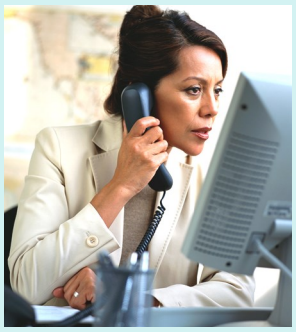
In addition to the standard HIPAA information, the letters for pregnant women – HPE Pregnancy Approval Letter, Presumptive Eligibility Acceptance Letter, and HPE Child Approval Letter (only if the child is under 19 and pregnant) – will contain the following to provide the member with additional resources:

> *"Because you are pregnant, there are many additional resources for you. The State Department of Health may call you to talk about these resources. Your caller ID will show "Indiana State Department of Health." Or you can call MOMS Helpline at 1-844-MCH-MOMS (1-844-624-6667) to find resources available near you."*

IHCP will collect origination and destination address information from encounter claims

Effective September 26, 2019, the Indiana Health Coverage Programs (IHCP) will begin collecting origination and destination address information from transportation encounter claims received from managed care entities (MCEs) and Southeastrans. Transportation origination address information will be captured from header loop 2310E and detail loop 2420G of the 837P electronic transaction. The destination address will be captured from header loop 2310F and detail loop 2420H of the 837P electronic transaction. These addresses will only be passed through *Core*MMIS, the claim-processing system, to the Enterprise Data Warehouse (EDW). The addresses will not be made visible in the *Core*MMIS user interface or in the IHCP Provider Healthcare Portal.

IHCP reminds providers of provider agreement during enrollment



The Indiana Health Coverage Programs (IHCP) has recently changed its enrollment policy to extend the application submission time from 30 days to 90 days from the date the *IHCP Provider Agreement* or the *IHCP Rendering Provider Agreement* is signed. Applications with provider agreements that are received beyond the 90 days will not be accepted and a new agreement will need to be submitted with updated signatures.

A signed and dated provider agreement must be submitted when a provider is enrolling for the first time in the IHCP, enrolling a new service location, revalidating their enrollment with the IHCP, or reporting a change of ownership.

The provider agreement must be signed by an owner or authorized official of the business who is directly or ultimately responsible for operating the business and is listed on the application in the *Individuals with an Ownership or Control Interest and Managing Individuals* section. If the person named as the delegated administrator is not reported as having ownership or controlling interest, he or she cannot sign the agreement.

Portal enhancement for allowing certain out-of-state providers to perform telemedicine services

The Indiana Health Coverage Programs (IHCP) previously announced in *IHCP Bulletin BT201940*, that the Provider Healthcare Portal (Portal) would allow certain out-of-state providers to perform telemedicine services without fulfilling the out-of-state prior authorization (PA) requirement. Effective September 26, 2019, this enhancement will be available in the Portal.

For more information about this coming change, refer to the bulletin.

QUESTIONS?

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