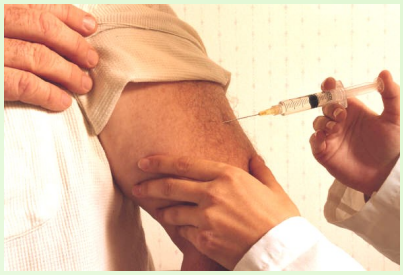
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201946 NOVEMBER 12, 2019

IHCP to cover HCPCS code Q5107 (Mvasi)

Effective December 13, 2019, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code Q5107 – *Injection, bevacizumab-awwb, biosimilar mvasi,10 mg*. Coverage for this physician-administered drug (PAD) applies to all IHCP programs, subject to limitations established for certain benefit plans, and for professional (*CMS-1500* form or electronic equivalent) and institutional (*UB-04* form or electronic equivalent) claims with dates of service (DOS) on or after December 13, 2019.

The following reimbursement information applies:



- Pricing: Maximum fee of $71.13
- Prior authorization (PA): None required
- Billing guidance:
  - Must be billed with the National Drug Code (NDC) of the product administered
  - Separate reimbursement is allowed with revenue code 636 – *Pharmacy (extension of 025X) – Drugs Requiring Detailed Coding.* For reimbursement consideration, providers may bill the procedure code and the revenue code together, as appropriate.

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

Note: This reimbursement information applies to outpatient services rendered under the fee-for-service (FFS) and managed care delivery systems.

This change will be reflected in the next regular update to the *Outpatient Fee Schedule* and the *Professional Fee Schedule,* accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers, and in the *Procedure Codes That Require National Drug Codes (NDCs)*, accessible from the *Code Sets* web page. The revenue code linkage will be updated in the *Revenue Codes with Special Procedure Code Linkages*, also available on the web page.

MORE IN THIS ISSUE

Pricing updated for HCPCS code B4100 on professional claims

Effective December 12, 2019, the Indiana Health Coverage Programs (IHCP) will update the pricing for Healthcare Common Procedure Coding System (HCPCS) code B4100 – *Food thickener, administered orally, per ounce*. This change applies to fee-for-service (FFS) claims with dates of service (DOS) on or after December 12, 2019.

The pricing for code B4100 is changing from maximum-fee pricing to manual pricing. The IHCP will reimburse code B4100 at 75% of the manufacturer's suggested retail price (MSRP) or 120% of the cost invoice when the code is billed on a professional claim (*CMS-1500* form or electronic equivalent). Outpatient reimbursement will remain unchanged. Providers will need to submit either an MSRP or cost invoice with the claim for reimbursement consideration.

This reimbursement information applies to services delivered under the 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.

These changes 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, and in the *Procedure Codes That Require Attachments* code table, accessible from the *Code Sets* web page.

IHCP reminds providers of limit on reimbursement for infusion services in an outpatient setting

The Indiana Health Coverage Programs (IHCP) continues to allow separate reimbursement for infusions performed during the same encounter as a treatment room service in an outpatient setting. However, as previously described in *IHCP Banner Page BR201913*, reimbursement will be limited to services billed appropriately using the procedure codes in Table 1.

Effective immediately, any Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®[1]) code other than one identified in Table 1, and reported with revenue code 260 – *IV therapy – general classification* for a procedure performed during the same encounter as a treatment room service, will systematically deny with explanation of benefits (EOB) 4090 – *Payment for 250, 251, 252, 257, 259, 270-279 drug and supply revenue codes and infusions are included in the treatment room reimbursement.*

Table 1 – Infusion procedure codes allowed for separate reimbursement

Procedure code	Description
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)

continued

Table 1 – Infusion procedure codes allowed for separate reimbursement (continued)

Procedure code	Description
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)
96369	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)
96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96371	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)

Reimbursement of the infusion procedure codes in Table 1 is allowed in the outpatient setting when they are billed with revenue code 260. Separate reimbursement is allowed for the procedure codes in Table 1 when they are reported with revenue code 260 for the same date of service (DOS) as a treatment room revenue code in Table 2.

Table 2 – Treatment room revenue code series

Revenue code series	Description (header only)
45x	Emergency Room
48x	Cardiology
51x	Clinic
52x	Freestanding Clinic
70x	Cast Room
71x	Recovery Room
72x	Labor Room/Delivery
76x	(Specialty Services) Treatment or Observation Room

This reimbursement information applies to outpatient services delivered under the fee-for-service (FFS) and managed care delivery systems.

continued

For more information about billing and reimbursement for infusion services in the outpatient setting, see the *Outpatient Facility Services* provider reference module. The outpatient payment methodology for revenue code 260 is a flat rate, as indicated in the *Revenue Codes* table, which is accessible from the *Code Sets* web page at in.gov/medicaid/providers.

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