IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202003 JANUARY 21, 2020

IHCP to cover HCPCS codes Q5114, and Q5115

Effective February 21, 2020, the Indiana Health Coverage Programs (IHCP) will cover the following Healthcare Common Procedure Coding System (HCPCS) codes:

- Q5114 – *Injection, trastuzumab-dkst, biosimilar, (Ogivri), 10 mg*
- Q5115 – *Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg*

Coverage for these physician administered drugs (PADs) applies to all IHCP programs, subject to limitations established for certain benefit packages, and for professional claims (*CMS-1500* form or electronic equivalent) and outpatient claims (*UB-04* form or electronic equivalent) with dates of service (DOS) on or after February 21, 2020.

The following reimbursement information applies to both procedure codes:

- Pricing: Maximum fee
  - Q5114: $92.43
  - Q5115: $88.78
- Prior authorization (PA): None required
- Billing guidance:
  - Must be billed with the National Drug Code (NDC) of the product administered
  - Separate reimbursement in the outpatient setting is allowed under 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.

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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 NDCs* and the *Revenue Codes with Special Procedure Code Linkages* code tables, available from the *Code Sets* web page.

IHCP removes age restriction on adult day services for A&D and TBI waivers, accepts resubmitted claims

Effective immediately, the Indiana Health Coverage Programs (IHCP) is removing the age restriction on certain adult day services (ADS) for the Aged and Disabled (A&D) and Traumatic Brain Injury (TBI) waivers under the Home and Community-Based Services (HCBS) programs. Services billed for either of the following Healthcare Common Procedure Coding System (HCPCS) codes in combination with modifier U7 *and* modifier U1, U2, *or* U3, previously were restricted to IHCP members ages 18 and older:

- S5100 – *Day care services, adult; per 15 minutes*
- S5101 – *Day care services, adult; per half day*

However, when ADS services are billed as follows, the age restriction *no longer* applies:

- TBI waiver – code S5100 or code S5101 billed with modifier U7 *and* modifier U1, U2, *or* U3
- A&D waiver – code S5100 billed with modifier U7 *and* modifier U1, U2, *or* U3

Note: For A&D waivers, the existing age restriction continues to apply to ADS services billed for code S5101 with the modifiers described.

Removal of the age restriction on the code/modifier combinations indicated applies retroactively to fee-for-service (FFS) claims with dates of service (DOS) on or after **January 1, 2019**. Claims billed for those code/modifier combinations may have denied for explanation of benefits (EOB) 4034 – *Service billed not compatible with the members age. Please verify and resubmit.*

Effective immediately, providers may resubmit FFS claims for the code/modifier combinations during the time frame indicated that denied for EOB 4034, for reimbursement consideration. Claims resubmitted beyond the timely filing limit must include a copy of this banner page as an attachment and must be filed within 180 days of the banner page's publication date.

IHCP assigns maximum fee pricing to CPT codes for outpatient services, accepts resubmitted claims

Effective immediately, the Indiana Health Coverage Programs (IHCP) will update pricing for reimbursement of outpatient services billed with the Current Procedural Terminology (CPT®[1]) codes in Table 1. These codes will now have maximum fee pricing (see Table 1), and ambulatory surgical center (ASC) pricing (indicator 3) will be removed. This change to reimbursement applies to services rendered in the outpatient setting, retroactively for claims with dates of service (DOS) on or after **January 1, 2019**.

continued

Table 1 – CPT codes assigned maximum fee pricing for outpatient services, effective for DOS on or after January 1, 2019

Procedure code	Description	Maximum fee
10005	Fine needle aspiration of first lesion using ultrasound guidance	$579.34
10007	Fine needle aspiration of first lesion using fluoroscopice guidance	$579.34
10009	Fine needle aspiration of first lesion using CT guidance	$579.34
10011	Fine needle aspiration of first lesion using MR guidance	$579.34

Reimbursement and 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.

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.

The IHCP identified a claim-processing issue that affected FFS claims for the codes in Table 1 with ASC pricing, with DOS on or after January 1, 2019. Claims or claim details billed for outpatient services with these codes may have denied inappropriately for explanation of benefits (EOB) 4014 – *No pricing segment on file*.

The claim-processing system has been corrected. Effective immediately, providers may resubmit FFS claims for the indicated codes and DOS that previously denied for EOB 4014, for reimbursement consideration. Claims resubmitted beyond the filing limit must include a copy of this banner page as an attachment and must be filed within 180 days of the banner page's publication date.

[1]CPT copyright 2020 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

IHCP to mass reprocess claims for skilled nursing facility services that may have denied incorrectly

The Indiana Health Coverage Programs (IHCP) has reviewed coverage for members eligible through the Presumptive Eligibility Adult (PE Adult) benefit plan, and identified a claim-processing error that affects claims for skilled nursing facility (SNF) services processed on or after November 26, 2019. Claims billed for these services for eligible members may have adjudicated incorrectly and denied for explanation of benefits (EOB) 2033 – *Invalid claim type for the program billed.*

The claim-processing system has been corrected. Claims billed for the described services and during the indicated time frame that denied for EOB 2033 will be mass reprocessed. Providers should see reprocessed claims on Remittance Advices (RAs) beginning January 22, 2020, with internal control numbers (ICNs)/claim IDs that begin with 80 (reprocessed denied claims).

FSSA to host provider meeting on January 24, including information on new Medicaid waiver for SMI

The Indiana Family and Social Services Administration (FSSA) received federal approval for a Medicaid waiver that will offer improved access to a full continuum of care for thousands of Hoosiers suffering from serious mental illness (SMI), as recently announced in *Indiana Health Coverage Programs (IHCP) Bulletin* [BT202003](BT202003).

As part of continuing efforts to build awareness for this new waiver, the Division of Mental Health and Addiction (DMHA) and the Office of Medicaid Policy and Planning (OMPP) will host a meeting for mental health providers to discuss, among other topics, the SMI waiver's approval and its impact on behavioral health treatment in the state.

The date, time, and location for this meeting are as follows:

- Date: January 24, 2020
- Time: 9:30 a.m. – 4 p.m. EST
- Location:
  Indiana Government Center South
  Conference room 22
  302 W. Washington St.
  Indianapolis, IN 46204

Providers who wish to attend the meeting in person must register in advance on the *Event Scheduler* at ddrsprovider.fssa/events.

For providers who cannot attend the meeting and wish to participate via the live webinar, here's how:

1. Go to https://Indiana.adobeconnect.com/dmha to sign in to the webinar.

2. Ensure that Guest is selected, type your name, and click **Enter Room**.

3. The webinar provides audio over the internet, so be sure that your speakers or headphones are connected to enable you to hear the presentation.

Notes:

- Before the webinar, you can test your connection by clicking the following link: https://indiana.adobeconnect.com/common/help/en/support/meeting_test.htm.
- This test will prompt you for any updates or add-ins that your computer needs to join the webinar.
- Please do not log in to the webinar using Citrix or a virtual private network (VPN), because these services will not be able to play back audio.
- If multiple individuals from your organization will join, please join from the same location if possible to save webinar slots for others.
- The webinar spans the entire meeting and includes more topics than the Medicaid waiver for SMI.

QUESTIONS?

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