IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202036 SEPTEMBER 8, 2020

IHCP to cover HCPCS code Q5121

Effective October 8, 2020, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code Q5121 – *Injection, infliximab-axxq, biosimilar, (AVSOLA), 10 mg*.

Coverage for this physician-administered drug (PAD) 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 October 8, 2020.

The following reimbursement information applies:

- Pricing: Maximum fee of $52.50
- 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.

continued

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This information 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 to mass reprocess or mass adjust claims for HCPCS code J2469 that denied incorrectly

The Indiana Health Coverage Programs (IHCP) identified a claim-processing issue that affects certain fee-for-service (FFS) claims for Healthcare Common Procedure Coding System (HCPCS) code J2469 – *Injection, palonosetron HCl, 25 mcg* billed with National Drug Code (NDC) 63323-067-321. Claims with dates of service (DOS) from September 7, 2018, through September 8, 2020, may have denied incorrectly with explanation of benefits (EOB) 4300 – *Invalid NDC to procedure code combination*.

The claim-processing system has been corrected. Claims or claim details processed during the indicated time frame for J2469 that denied for EOB 4300 will be mass reprocessed or mass adjusted, as appropriate. Providers should see reprocessed or adjusted claims on Remittance Advices (RAs) beginning October 14, 2020, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claim) or 52 (mass replacements non-check related).

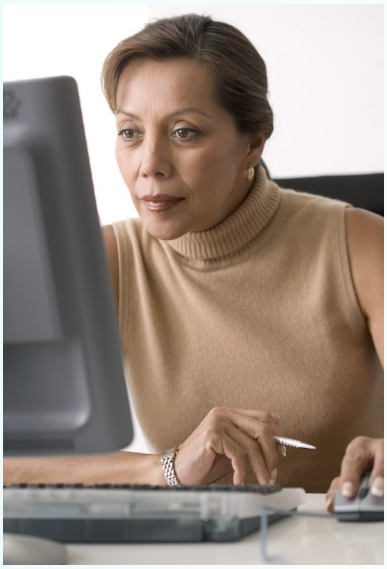
IHCP to mass adjust claims for hospital inpatient services that paid incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain fee-for-service (FFS) claims for inpatient services rendered by Hospital Assessment Fee (HAF)-eligible hospitals. The claim-processing system did not apply the correct HAF amount to inpatient claims that were reimbursed with an All-Patient Refined (APR) Diagnosis-Related Group (DRG). This includes claims with patient dates of discharge on or after August 1, 2020, and claims before August 1, 2020, that may have processed incorrectly following the IHCP selection of APR-DRG version 36, effective August 1, 2020.

For more information about the DRG grouper and inpatient hospital reimbursement rates, see *IHCP Bulletins BT202059 and BT202077*.

The claim-processing system has been corrected. Claims processed during the indicated time frame that applied the incorrect HAF rate will be mass adjusted. Providers should see the adjusted claims on Remittance Advices (RAs) beginning October 7, 2020, with internal control numbers (ICNs)/Claim IDs that begin with 52 (mass replacement non-check related). If a claim 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.

IHCP clarifies age range restrictions on procedure and diagnosis codes



Effective October 8, 2020, the Indiana Health Coverage Programs (IHCP) will use the following age ranges for reimbursement of procedure and diagnosis codes that contain an age range in the code description, unless specified otherwise in the description:

- Newborn/neonate/neonatal: 0-28 days
- Infant: 0-364 days
- Pediatric/child: 0-19 years
- Adult: 15-999 years
- Pregnancy related: 10-60 years

Where to find age restrictions

For procedure codes that are covered under the fee-for-service (FFS) delivery system, age restrictions will appear in the next scheduled update to the *Professional Fee schedule*. If a procedure code description does not list an age range, there are no age limits on the procedure code.

Claim processing

Claims for procedure codes with age restrictions that do not correspond with the member's age will deny with explanation of benefits (EOB) 4034 – *Service billed not compatible with member's age. Please verify and resubmit*.

Examples of claims for procedure codes with age restrictions

The following examples illustrate how age restrictions apply.

Age restriction in years

A procedure code that has an age restriction in years is allowable until the end of the year shown in the code description. For example, a code that has an age limit of 0-1 year is allowable through the day before the member turns 2 years old. If the member was born on August 2, 2019, a claim for a code having an age restriction of 0-1 year and with date of service (DOS) on or after August 2, 2021, will deny with EOB 4034.

Age restriction in months

A procedure code that has an age limit in months is allowable until the end of the month shown in the code description. For example, a code that has an age restriction of 0-6 months is allowable through the day before the member turns 7 months of age. If the member was born on August 2, 2019, a claim for a code having an age restriction of 0-6 months and with DOS on or after March 2, 2020, will deny with EOB 4034.

continued

Age restriction in days

A procedure code that has an age restriction in days is allowable until the end of the day shown in the code description. For example, a code that has an age restriction of 0-28 days is allowable for the member from birth until the member is 28 days old. Claims for the code will deny once the member is 29 days or older. If the member was born on August 2, 2019, a claim for a code having an age restriction of 0-28 days and with DOS on or after August 31, 2019, will deny with EOB 4034.

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.

IHCP to revise age restrictions on certain procedure codes

Effective October 8, 2020, the Indiana Health Coverage Programs (IHCP) will update the age restrictions on the procedure codes in Table 1. The allowable age ranges shown in the table will be updated in the *Core*MMIS claim-processing system, and will apply to fee-for-service (FFS) claims with dates of service (DOS) on or after October 8, 2020.

Reimbursement and billing information applies to services delivered under the FFS delivery system. Individual managed care entities (MCEs) establish and publish reimbursement 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 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, and to the *Anesthesia Services Codes*, accessible from the *Code Sets* page.

Table 1 – Procedure codes with updated age restrictions, effective for claims with DOS on or after October 8, 2020

Procedure code	Description	Allowable age range
00326	Anesth larynx/trach < 1 yr	0-364 days
00561	Anesth heart surg <1 yr	0-364 days
00834	Anesth hernia repair < 1 yr	0-364 days
00836	Anesth hernia repair preemie	0-6 months
36420	Vein access cutdown < 1 yr	0-364 days
46070	Incision of anal septum	0-364 days
46700	Repair of anal stricture	15-999 years
46705	Repair of anal stricture	0-364 days
46750	Repair of anal sphincter	15-999 years
46751	Repair of anal sphincter	0-19 years
46760	Repair of anal sphincter	15-999 years
46761	Repair of anal sphincter	15-999 years

continued

Table 1 – Procedure codes with updated age restrictions, effective for claims with DOS on or after October 8, 2020 (continued)

Procedure code	Description	Allowable age range
49491	Rpr hern preemie reduc	0-6 months
49492	Rpr ing hern premie blocked	0-6 months
49495	Rpr ing hernia baby reduc	0-5 months
49496	Rpr ing hernia baby blocked	0-5 months
49500	Rpr ing hernia init reduce	6-59 months
49501	Rpr ing hernia init blocked	6-59 months
49580	Rpr umbil hern reduc < 5 yr	0-4 years
49582	Rpr umbil hern block < 5 yr	0-4 years
53020	Incision of urethra	1-999 years
53025	Incision of urethra	0-364 days
54001	Slitting of prepuce	Age restriction will be removed
54160	Circumcision neonate	0-28 days
54161	Circum 28 days or older	Age restriction will be removed
59412	Antepartum manipulation	10-60 years
59414	Deliver placenta	10-60 years
59425	Antepartum care only	10-60 years
59426	Antepartum care only	10-60 years
59430	Care after delivery	10-60 years
59612	Vbac delivery only	10-60 years
59620	Attempted vbac delivery only	10-60 years
67229	Tr retinal les preterm inf	0-364 days
73592	X-ray exam of leg infant	0-364 days
76010	X-ray nose to rectum	0-19 years
76706	Us abdl aorta screen aaa	65-999 years
76885	Us exam infant hips dynamic	0-364 days
76886	Us exam infant hips static	0-364 days
80081	Obstetric panel	10-60 years
83664	Lamellar bdy fetal lung	10-60 years
94772	Breath recording infant	0-364 days
99170	Anogenital exam child w imag	0-19 years
99381	Init pm e/m new pat infant	0-364 days

continued

Table 1 – Procedure codes with updated age restrictions, effective for claims with DOS on or after October 8, 2020 (continued)

Procedure code	Description	Allowable age range
99391	Per pm reeval est pat infant	0-364 days
99478	Ic lbw inf < 1500 gm subsq	0-364 days
99479	Ic lbw inf 1500-2500 g subsq	0-364 days
99480	Ic inf pbw 2501-5000 g subsq	0-364 days
0362T	Bhv id suprt assmt ea 15 min	0-20 years
0373T	Adapt bhv tx ea 15 min	0-20 years
0475T	Rec ftl car sgl 3 ch i&r	10-60 years
0476T	Rec ftl car sgl elec tr data	10-60 years
0477T	Rec ftl car sgl xrtj alys	10-60 years
0478T	Rec ftl car 3 ch rev i&r	10-60 years
D5952	Pediatric speech aid	0-19 years
L7007	Adult electric hand	15-999 years
L7008	Pediatric electric hand	0-19 years
L7009	Adult electric hook	15-999 years
Q4001	Cast sup body cast plaster	15-999 years
Q4002	Cast sup body cast fiberglas	15-999 years

IHCP to update age restrictions on ICD-10 diagnosis codes for body mass index

Effective October 8, 2020, the Indiana Health Coverage Programs (IHCP) will update age restrictions in the *Core*MMIS claim-processing system for reimbursement of claims submitted with the International Classification of Diseases-10-Clinical Modification (ICD-10-CM) diagnosis codes for body mass index (BMI). This policy change applies to Traditional Medicaid (fee-for-service) and all managed care benefit programs. The following age restrictions apply to claims with dates of service (DOS) on or after October 8, 2020:

- The IHCP will restrict adult diagnosis codes Z681-Z6845 to members 15 years of age and older.
- The IHCP will restrict pediatric diagnosis codes Z6851- Z6854 to members 2 through 19 years of age.

These age restrictions are consistent with Medicare guidelines.

Providers may resubmit claims for HCPCS code V2629 that denied inappropriately

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects fee-for-service (FFS) Durable Medical Equipment (DME) claims for Healthcare Common Procedure Coding System (HCPCS) code V2629 – *Prosthetic eye, other type* with dates of service (DOS) from January 1, 2019, through August 27, 2020. Claims or claim details submitted for V2629 may have denied inappropriately with explanation of benefits (EOB) 4013 – *This procedure code is not covered for this date of service*.

The claim-processing issue has been corrected. Beginning immediately, providers may resubmit FFS claims for HCPCS code V2629 that previously denied for EOB 4013 during the indicated time frame, for reimbursement consideration. Claims resubmitted beyond the original filing limit must include a copy of this banner page as an attachment and must be submitted within 180 days of the banner page's publication date.

IHCP to mass reprocess claims for TBI waiver services that denied inappropriately

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects fee-for-service (FFS) claims for the Traumatic Brain Injury (TBI) waiver category 2 adult day services in Table 3. Claims for the procedure code and modifier combinations in Table 3 with dates of service (DOS) from February 1, 2020, through August 27, 2020, may have denied inappropriately for explanation of benefits (EOB) 3930 – *Payment is not allowed for the rendering or billing provider type/specialty*.

Table 3 – TBI waiver adult day services that denied inappropriately for claims with DOS from February 1, 2020, through August 27, 2020

Procedure code	Modifier 1	Modifier 2	Service
S5100	U7	U1	Adult Day Service (Category 2) (Level 1)
S5100	U7	U2	Adult Day Service (Category 2) (Level 2)
S5100	U7	U3	Adult Day Service (Category 2) (Level 3)

The claim-processing system has been corrected. Claims for the services in Table 3 during the indicated time frame and that denied for EOB 3930 will be mass reprocessed. Providers should see the reprocessed claims on Remittance Advices (RAs) beginning October 14, 2020, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims).

QUESTIONS?

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