IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR202119 MAY 11, 2021

IHCP to mass reprocess claims for certain behavioral health services that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects fee-for-service (FFS) claims submitted by the following behavioral health provider specialties. Claims with dates of service (DOS) from December 1, 2020, through March 16, 2021, for IHCP members who are dually eligible (Medicare and Medicaid) may have denied incorrectly with explanation of benefits (EOB) 2502 – *This member is covered by Medicare Part B or Medicare D; therefore, you must first file claims with Medicare. If already submitted to Medicare, please submit your EOMB.*

- 619 – Licensed Marriage and Family Therapist (LMFT)
- 620 – Licensed Mental Health Counselor (LMHC)
- 621 – Licensed Clinical Addiction Counselor (LCAC)

The claim-processing system has been corrected. Claims submitted by the provider specialties named above and during the indicated time frame that denied for EOB 2502 will be mass reprocessed. Providers should see the reprocessed claims on Remittance Advices (RAs) beginning June 16, 2021, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims).

MORE IN THIS ISSUE

IHCP to mass reprocess claims for FQHC services that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects fee-for-service (FFS) claims submitted by federally qualified health centers (FQHCs) with dates of service (DOS) from February 13, 2017, through February 28, 2021. Claims from *different* FQHC providers for the same IHCP member on the same DOS may have denied incorrectly with explanation of benefits (EOB) 5001 – *This is a duplicate of another claim*.

The claim-processing system has been corrected. An updated "exact duplicate" audit in the system will identify claims submitted by different FQHCs providers for the same member on the same DOS. Affected claims during the indicated time frame that denied for EOB 5001 will be mass reprocessed. Providers should see the reprocessed claims on Remittance Advices (RAs) beginning June 16, 2021, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims).

Providers may resubmit, or void and replace claims for FSW service A9279 U7 U5 UA

The Indiana Health Coverage Programs (IHCP) identified a claim-processing issue that affects certain fee-for-service (FFS) claims for the Division of Disability and Rehabilitative Services (DDRS) Bureau of Developmental Disabilities Services (BDDS) Family Supports Waiver (FSW) code and modifier combination A9279 U7 U5 UA – *Remote Supports, 1 Participant.* Claims or claim details with dates of service (DOS) from January 1, 2020, through March 31, 2021, for this service may have denied incorrectly with explanation of benefits (EOB) 4209 – *No matching pricing segment for the procedure/modifier combination billed on the CMS 1500 form*.

The claim-processing system has been corrected. Beginning immediately, providers may resubmit FFS claims for code and modifier combination A9279 U7 U5 UA during the indicated time frame that denied with EOB 4209. Providers that believe a claim underpaid (detail line denied) may submit a replacement claim for reimbursement consideration. To submit a replacement claim, providers must first void the original claim. The replacement claim must include the same attachments (if any) as were submitted with the original claim.

Claims resubmitted, or voided and replaced 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 will add noncovered CPT code 0011M to fee schedules

The Indiana Health Coverage Programs (IHCP) will update the *Outpatient Fee Schedule* and the *Professional Fee Schedule* to include the noncovered Current Procedural Terminology (CPT®[1]) code 0011M – *Oncology, prostate cancer, mRNA expression assay of 12 genes (10 content and 2 housekeeping), RT-PCR test utilizing blood plasma and urine, algorithms to predict high-grade prostate cancer risk*, to align with the claim-processing system (*Core*MMIS).

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.

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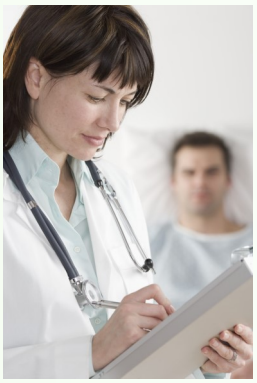
IHCP to allow modifier HE to bypass NCCI Procedure-to-Procedure edits, mass reprocess or mass adjust claims



The Indiana Health Coverage Programs (IHCP) is revising billing guidance for newly enrolled behavioral health professionals. The previous guidance, published in *IHCP Bulletin* BT2020122, stated that *"because these practitioners are now eligible for enrollment, the midlevel modifier will no longer override applicable National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits."* That guidance became effective for claims with dates of service (DOS) on or after January 1, 2021. However, that guidance mistakenly neglected other behavioral health specialties eligible to provide outpatient mental health services, such as those under Title 405 of the *Indiana Administrative Code* (IAC) 5-20-8(2)(F). Persons who hold master's degrees in social work, marital and family therapy, or mental health counseling, but do not possess the necessary qualifications to independently enroll, must continue to bill under their supervising practitioner using modifier HE.

Effective retroactively to **January 1, 2021**, the IHCP will once again authorize modifier HE to bypass National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) editing as described in the *IHCP Banner Page* BR201912 article called, *IHCP clarifies billing for psychotherapy, evaluation, and management services on the same day*.

Reimbursement, prior authorization (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.

The IHCP identified a claim-processing issue that affects FFS claims submitted with modifier HE for DOS from January 1, 2021, through June 11, 2021. Claims or claim details submitted with modifier HE may have denied with one of the following explanation of benefits (EOB):

- EOB 6396 – *This service is not payable with another service on the same date of service due to National Correct Coding Initiative.*
- EOB 6399 – *A previously paid service is being recouped per National Correct Coding Initiative (NCCI) processing of another service on the same date of service by the same provider.*

Claims processed during the indicated time frame that denied for EOB 6396 or EOB 6399 will be mass reprocessed or mass adjusted, as appropriate. Providers should see the reprocessed or adjusted claims on Remittance Advices (RAs) beginning June 22, 2021, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims) or 52 (mass replacements non-check related).

IHCP to cover CPT code 50590 in the outpatient setting, accept resubmitted claims

Effective immediately, the Indiana Health Coverage Programs (IHCP) will cover the Current Procedural Terminology (CPT®[1]) code 50590 – *Lithotripsy, extracorporeal shock wave* in the outpatient setting. Coverage applies retroactively to outpatient claims with dates of service (DOS) on or after **July 1, 2020,** and to all Traditional Medicaid and other IHCP programs that include full Medicaid State Plan benefits.

continued

This procedure code may not be covered under IHCP plans with limited benefits.

The following reimbursement information applies:

- Pricing: Ambulatory Surgical Center (ASC) indicator H
- Prior authorization (PA): None required
- Billing guidance: Standard guidance applies

Reimbursement, PA, and billing information apply 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.

This coverage 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 affects FFS claims for code 50590 with DOS on or after July 1, 2020. Claims or claim details may have denied incorrectly with one of the following explanation of benefits (EOB):

- EOB 4014 – *Claim being reviewed for pricing*
- EOB 4108 – *There is no ASC on file for this procedure code. Please verify that the appropriate outpatient surgery code was billed.*

The claim-processing system has been corrected. Beginning immediately, providers may resubmit FFS claims for procedure code 50590 during the indicated time frame that may have denied incorrectly with EOB 4014 or EOB 4108, 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 updates pricing on outpatient procedure codes that were previously inpatient-only, applies NCCI MUE

Effective retroactively to **January 1, 2021**, the Indiana Health Coverage Programs (IHCP) is updating pricing on procedure codes for outpatient services identified as inpatient-only (IPO) on the IHCP *Outpatient Fee Schedule*. Additionally, the IHCP will apply National Correct Coding Initiative (NCCI) medically unlikely edits (MUEs) to those procedure codes to better align IHCP reimbursement of Medicaid services with nationwide standards. This change applies retroactively to fee-for-service (FFS) claims with dates of service (DOS) on or after January 1, 2021.

Note: An MUE for a procedure code is the maximum number of units of service under most circumstances allowable by the same provider for the same beneficiary on the same date of service. For more information about MUEs and other NCCI edits, see the National Correct Coding Initiative provider reference module at in.gov/medicaid/providers.

This change to pricing 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.

continued

This change also revises the guidance about IHCP reimbursement of IPO procedure codes published in the *Inpatient Hospital Services* provider reference module at in.gov/medicaid/providers. The module will be revised accordingly during its next regular update.

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.

The IHCP identified a claim-processing issue that affects FFS claims for inpatient services with DOS from January 1, 2021, through May 11, 2021. Claims or claim details for the procedure codes described above may have denied, and will be mass reprocessed or mass adjusted, as appropriate. Providers should see reprocessed or adjusted claims on Remittance Advices (RAs) beginning June 15, 2021, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claim) or 52 (mass replacements non-check related).

IHCP revises age restriction on HCPCS codes M0239 and M0243, accepts resubmitted claims

Effective immediately, the Indiana Health Coverage Programs (IHCP) is changing the age restriction from 18 years of age and older to 12 years of age and older, on the following Healthcare Common Procedure Coding System (HCPCS) codes:

- M0239 – *Intravenous infusion, bamlanivimab-xxxx, includes infusion and post administration monitoring*
- M0243 – *Intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring*

This change applies retroactively to fee-for-service (FFS) professional claims (*CMS-1500* form or electronic equivalent) and institutional claims (*UB-04* form or electronic equivalent) with the following dates of service (DOS):

- M0239 – November 9, 2020
- M0243 – November 21, 2020

Beginning immediately, providers may bill HCPCS codes M0239 and M0243 for IHCP members ages 12 years of age and older, for claims with DOS on or after those dates.

The dates align with the U.S. Food and Drug Administration (FDA) authorization to use these procedure codes for treating coronavirus disease 2019 (COVID-19), as given in two corresponding Emergency Use Authorization (EUA) letters.

FFS claims for these procedure codes with DOS on or after the dates they were authorized for use may have denied with explanation of benefits (EOB) 4034 – *Service billed not compatible with member's age. Please verify and resubmit*.

Beginning immediately, providers may resubmit FFS claims for these codes during the indicated time frames that denied with EOB 4034, 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.

This revision to the age restriction 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 end dates coverage for HCPCS codes Q0239 and M0239 (Bamlanivimab)

Effective retroactively to **April 16, 2021**, the Indiana Health Coverage Programs (IHCP) end dated coverage of the following Healthcare Common Procedure Coding System (HCPCS) codes:

- Q0239 – *Injection, bamlanivimab-xxxx, 700 mg*
- M0239 – *Intravenous infusion, bamlanivimab-xxxx, includes infusion and post administration monitoring*

The IHCP will continue reimbursement of claims for those codes for dates of service (DOS) from November 10, 2020, through April 15, 2021.

On April 16, 2021, the U.S. Food and Drug Administration (FDA) revoked the Emergency Use Authorization (EUA) for Bamlanivimab because of a sustained increase in coronavirus disease 2019 (COVID-19) viral variants in the U.S. that are resistant to this antibody therapy. The FDA determined that the known and potential benefits of Bamlanivimab no longer outweigh the known and potential risks.

The FDA indicates that alternative monoclonal antibody therapies remain appropriate for treating COVID-19 patients; and healthcare providers may continue to administer the following authorized therapies. (Currently, there are no changes to coverage for these procedure codes.)

- Therapy – Casirivimab and Imdevimab:
  - Q0243 – *Injection, casirivimab and imdevimab, 2400 mg*
  - M0243 – *Intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring*
- Therapy – Bamlanivimab and Etesevimab:
  - Q0245 – *Injection, bamlanivimab and etesevimab, 2100 mg*
  - M0245 – *Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring*

For more information about therapies, see the following fact sheets at fda.gov, and the web page on the Centers for Medicare & Medicaid Services (CMS) website:

- *Fact Sheet for Health Care Providers EUA of Casirivimab and Imdevimab*, Section 15, Antiviral Resistance
- *Fact Sheet for Health Care Providers EUA of Bamlanivimab and Etesevimab*, Section 15, Antiviral Resistance
- *Monoclonal Antibody COVID-19 Infusion* web page at cms.gov

This reimbursement and billing information applies to services delivered under the fee for service (FFS) delivery system. Questions about FFS billing and reimbursement should be directed to Gainwell Technologies. 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.

This update will be reflected 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, and to *Revenue Codes with Special Procedure Code Linkages*, available from the *Code Sets* page.

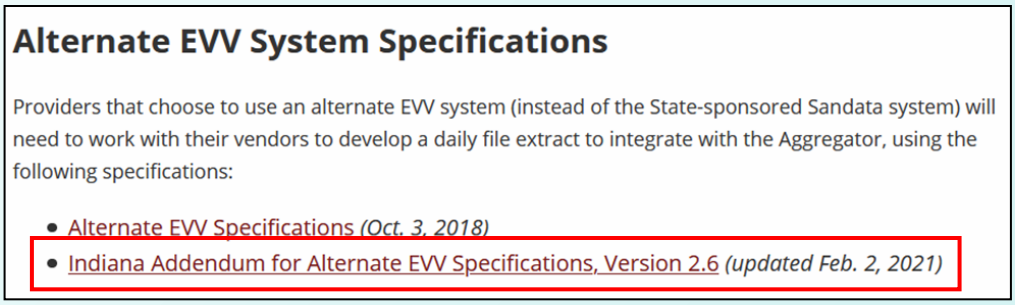
Updates to specifications for alternate EVV systems

The *21st Century Cures Act* directs Medicaid programs to require providers of personal care services and home health services to use an electronic visit verification (EVV) system to document services rendered. For more information, see the *Electronic Visit Verification* page, and reference the Indiana Health Coverage Programs (IHCP) bulletins and banner pages linked on that page. *IHCP Bulletin* BT201855 gives an overview.

The IHCP is using Sandata as the State-sponsored system for implementing federal EVV requirements. However, providers may choose to use an EVV system other than Sandata. Those providers will be required to export data from their alternate system to the Sandata "Aggregator" for integration with the IHCP claim-processing system (*Core*MMIS). The Aggregator will capture EVV data from both Sandata users and from users of alternate EVV systems.

Providers that choose to use an alternate EVV system (instead of the Sandata system) will need to work with their vendors to develop a daily file extract to integrate with the Aggregator. Vendors of alternate EVV systems can find the specifications needed for configuring their systems on the *Electronic Visit Verification* page, under Alternate EVV System Specifications.

Vendors can stay up-to-date on any changes to the EVV system specifications, which are published in an addendum available on the *Electronic Visit Verification* page. The most recent addendum (as of this banner page's publication date) was updated February 2, 2021.



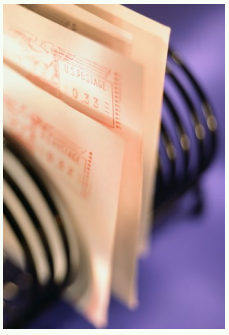
Alternate EVV System Specifications

Providers that choose to use an alternate EVV system (instead of the State-sponsored Sandata system) will need to work with their vendors to develop a daily file extract to integrate with the Aggregator, using the following specifications:

- Alternate EVV Specifications *(Oct. 3, 2018)*
- Indiana Addendum for Alternate EVV Specifications, Version 2.6 *(updated Feb. 2, 2021)*

Additionally, Sandata notifies providers and vendors on their email distribution list when updates to specifications are available.

Reminder of updated Gainwell Technologies post office mailing addresses



With the recent transition of DXC Technology to Gainwell Technologies, as announced in *Indiana Health Coverage Programs (IHCP) Banner Page* BR202042, providers and business entities should use the new Gainwell Technologies post office mailbox addresses that became effective February 1, 2021. Mail addressed to DXC will continue to be delivered to Gainwell Technologies through July 31, 2021. However, after that date mail addressed to DXC may be returned to the sender by the U.S. Postal Service carrier.

The new mailbox addresses are listed in the *IHCP Quick Reference Guide*, accessible from the *IHCP Quick Reference Guide* page at in.gov/medicaid/providers.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-457-4584.

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