IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201832 JUNE 29, 2018

July 2018 quarterly HCPCS code updates announced

The Indiana Health Coverage Programs (IHCP) has reviewed the Healthcare Common Procedure Coding System (HCPCS) code updates effective July 1, 2018, per the Centers for Medicare & Medicaid Services (CMS), to determine coverage and billing guidelines.

- Table 1 provides a list of the new codes contained in the quarterly update, along with code descriptions, program coverage determinations, prior authorization (PA) requirements, National Drug Code (NDC) requirements, and any special billing instructions. For reimbursement consideration, covered codes may be billed for dates of service (DOS) on or after July 1, 2018.
- Table 2 identifies newly covered codes from Table 1 for which separate reimbursement is allowed when billed with revenue code 636 – *Drugs requiring detailed coding for separate reimbursement in an outpatient setting*. For reimbursement consideration, providers may bill these procedure codes and the revenue code together, as appropriate, for DOS on or after July 1, 2018.
- Table 3 identifies one deleted code included in the quarterly update, along with the alternate code consideration. The code deletion is effective for DOS on or after July 1, 2018. The alternate code noted is a new code, which is included in Table 1 with coverage determinations noted.
- Table 4 identifies one new modifier included in the quarterly update for DOS on or after July 1, 2018.
- Table 5 identifies two newly covered codes from Table 1 that are being carved out from managed care. The IHCP will process PA and claims for these procedure codes through the fee-for-service (FFS) delivery system for all IHCP members, including those in Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise. In addition, these procedure codes can be reimbursed separately from the all-inclusive inpatient hospital diagnosis-related group (DRG) payment when delivered in an inpatient setting. Both the managed care carve-out and separate reimbursement outside the DRG apply to DOS on or after July 1, 2018.

Additional coverage parameters

Providers should be aware of the following coverage parameters regarding certain covered codes included in the July HCPCS update:

- **HCPCS code C9030**

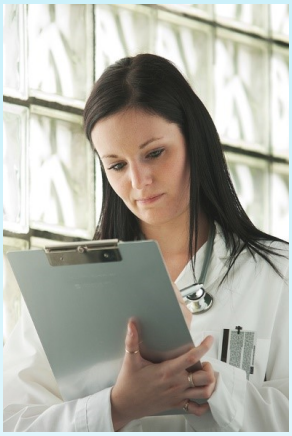
  Aliqopa (copanlisib) requires PA and may be considered medically necessary when ***all*** the following criteria are met:

  - Member is age 18 years of age or older.
  - Member has a diagnosis of follicular lymphoma.
  - Member has relapsed, refractory, or progressive disease.
  - Member has received at least two prior systemic therapies.
  - Member will be using Aliqopa as monotherapy.

Aliqopa (copanlisib) therapy is not considered medically necessary for members who have experienced disease progression while on or following a PI3K inhibitor (for example, idelalisib, copanlisib).

This agent may be approved in 6-month durations or as determined through clinical review. The quantity limit is three 60 mg vials per 28 days. The recommended dose is 60 mg administered as a 1-hour intravenous infusion on Days 1, 8, and 15 of a 28-day treatment cycle on an intermittent schedule (3 weeks on and 1 week off) with continued treatment until disease progression or unacceptable toxicity.

- **HCPCS code C9031**



Lutathera (lutetium Lu 177 dotatate) requires PA and may be considered medically necessary when ***all*** the following criteria are met:

  - Member is age 18 years of age or older.
  - Member has a diagnosis of unresectable, locally advanced, or metastatic gastroenteropancreatic neuroendocrine tumor (GEP-NET).
  - Member has somatostatin receptor-based imaging documenting somatostatin receptor-positive GEP-NET.
  - Member has received long-acting somatostatin analog (SSA) therapy (that is, Somatuline Depot OR Sandostatin LAR) for a duration of at least 12 weeks.
  - Member has not received a prior course of therapy with Lutathera (that is, maximum of 4 doses at intervals of at least 8 weeks).

Lutathera (lutetium Lu 177 dotatate) therapy is not considered medically necessary for experimental/investigational use for indications not supported by CMS-recognized compendia or acceptable peer-reviewed literature.

- **HCPCS code C9032**

Voretigene neparvovec-rzyl (Luxturna) is proven and/or medically necessary for the treatment of inherited retinal dystrophies (IRD) caused by mutations in the retinal pigment epithelium-specific protein 65kDa (RPE65) gene in members who meet ***all*** the following criteria:

  - Member is greater than 12 months of age.
  - Diagnosis is made of a confirmed biallelic RPE65 mutation-associated retinal dystrophy (for example, Leber's congenital amaurosis [LCA], Retinitis pigmentosa [RP] Early Onset Severe Retinal Dystrophy [EOSRD], and so on).
  - Genetic testing documents biallelic mutations of the RPE65 gene.
  - Sufficient viable retinal cells as determined by optical coherence tomography (OCT) confirm an area of retina within the posterior pole of >100 µm thickness.
  - Luxturna is prescribed and will be administered by ophthalmologist or retinal surgeon with experience providing subretinal injections.
  - Member has not previously received RPE65 gene therapy in intended eye.

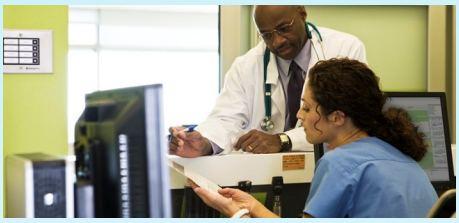
- **HCPCS code Q5105**

Coverage applies to the administration of epoetin in the treatment of end-stage renal disease (ESRD).

- **HCPCS codes Q9991 and Q9992**

  Buprenorphine extended-release (sublocade) requires PA. This agent may be considered medically necessary when ***all*** the following criteria are met:

  - Member must be 18 years of age or older.
  - Member must have initiated opioid use disorder treatment on a transmucosal buprenorphine-containing product delivering the equivalent of 8 mg to 24 mg buprenorphine daily, for a minimum of 7 days.
  - Physician must meet all qualifications to prescribe buprenorphine/naloxone or buprenorphine (federal, State, and local).
  - Member must have a diagnosis of opiate dependence/addiction (at prescriber's office or verified from prior rehab/detox).
  - Physician must verify that the risks of using buprenorphine with alcohol or benzodiazepines have been explained to the member.
  - Physician must verify that there are no untreated or unstable psychiatric conditions that would interfere with buprenorphine/naloxone or buprenorphine compliance.



  - If member is pregnant, physician must verify that the choice of buprenorphine injection over alternatives has been explained to the member or verify that documentation supporting the member is unable to use an alternative medication was submitted to the obstetrician's office.
  - Physician must provide documentation of the member's referral to or active involvement in formal counseling with a licensed behavioral health provider; must also indicate the name of the behavioral health provider and where the member is receiving counseling.
  - Dose of sublocade is less than or equal to 300 mg per month.

- **HCPCS code Q9995**

  IHCP Bulletin *BT201812* instructed providers to bill J7199 when administering Hemlibra, because there was no specific HCPCS code for this drug. For DOS on or after July 1, 2018, Hemlibra must be billed using HCPCS code Q9995 – *Injection, emicizumab-kxwh, 0.5 mg*. Claims for Hemlibra (per the NDC code on the claim) using HCPCS code J7199 will be denied for DOS on or after July 1, 2018. *BT201812* further indicated Hemlibra is carved out from managed care and also reimbursable outside the diagnosis-related group (DRG). These parameters continue to apply.

For more information

The codes in this quarterly update have been added to the Indiana *Core*MMIS claim-processing system. Coverage and reimbursement information will be reflected in the next regular update to the IHCP Fee Schedules, as appropriate, and to the affected code tables on the *Code Sets* page at indianamedicaid.com. The standard global billing procedures and edits apply unless otherwise noted.

Reimbursement and PA information apply to services delivered under the FFS delivery system. Questions about FFS PA should be directed to Cooperative Managed Care Services (CMCS) at 1-800-269-5720. Individual MCEs establish and publish reimbursement, PA, and billing information within the managed care delivery system. Questions about managed care reimbursement, PA, and billing should be directed to the MCE with which the member is enrolled.

The July 2018 HCPCS code updates are available for download from the CMS website at cms.gov. They are also posted on the American Medical Association website at ama-assn.org.

Table 1 – New HCPCS codes, effective for DOS on or after July 1, 2018

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
0505T	Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion	Noncovered	N/A	N/A	N/A
0506T	Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report	Noncovered	N/A	N/A	N/A
0507T	Near-infrared dual imaging (ie, simultaneous reflective and trans-illuminated light) of meibomian glands, unilateral or bilateral, with interpretation and report	Noncovered	N/A	N/A	N/A
0508T	Pulse-echo ultrasound bone density measurement resulting in indicator of axial bone mineral density, tibia	Noncovered	N/A	N/A	N/A
C9030	Injection, copanlisib, 1 mg	Covered	Yes	Yes	See Table 2
C9031	Lutetium Lu 177, dotatate, therapeutic, 1 mCi	Covered	Yes	Yes	See Table 2
C9032	Injection, voretigene neparvovec-rzyl, 1 billion vector genome	Covered	Yes	Yes	See Table 2 and Table 5
Q5105	Injection, epoetin alfa, biosimilar, (Retacrit) (for ESRD on dialysis), 100 units	Covered	No	Yes	See Table 2
Q5106	Injection, epoetin alfa, biosimilar, (Retacrit) (for non-ESRD use), 1000 units	Covered	No	Yes	No
Q9991	Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg	Covered	Yes	Yes	See Table 2
Q9992	Injection, buprenorphine extended-release (sublocade), greater than 100 mg	Covered	Yes	Yes	See Table 2
Q9993	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	Covered	No	Yes	No
Q9994	In-line cartridge containing digestive enzyme(s) for enteral feeding, each	Noncovered	N/A	N/A	N/A
Q9995	Injection, emicizumab-kxwh, 0.5 mg	Covered	No	Yes	See Table 2 and Table 5

* "Covered" indicates the service described for the code is covered, subject to limitations established for certain benefit packages.
"Noncovered" indicates that the IHCP does not cover the service described for the code.

Table 2 – Newly covered codes for which separate reimbursement is allowed when billed with revenue code 636, effective for DOS on or after July 1, 2018

Procedure code	Description
C9030	Injection, copanlisib, 1 mg
C9031	Lutetium Lu 177, dotatate, therapeutic, 1 mCi
C9032	Injection, voretigene neparvovec-rzyl, 1 billion vector genome
Q5105	Injection, epoetin alfa, biosimilar, (Retacrit) (for ESRD on dialysis), 100 units
Q9991	Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg
Q9992	Injection, buprenorphine extended-release (sublocade), greater than 100 mg
Q9995	Injection, emicizumab-kxwh, 0.5 mg

Table 3 – Discontinued code with alternate code consideration, effective for DOS on or after July 1, 2018

Procedure code	Description	Alternative code
C9469	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	Q9993

Table 4 – Newly covered modifier, effective for DOS on or after July 1, 2018

Procedure code	Description
QQ	Ordering professional consulted a qualified Clinical Decision Support Mechanism (CDSM) for this service and the related data was provided to the furnishing professional

Table 5 – Newly covered codes for which reimbursement is carved out from managed care and reimbursement allowed outside the DRG, effective for DOS on or after July 1, 2018

Procedure code	Description
C9032	Injection, voretigene neparvovec-rzyl, 1 billion vector genome
Q9995	Injection, emicizumab-kxwh, 0.5 mg

QUESTIONS?

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