IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201919 MARCH 28, 2019

April 2019 quarterly HCPCS codes updates announced

The Indiana Health Coverage Programs (IHCP) has reviewed the Healthcare Common Procedure Coding System (HCPCS) code updates effective April 1, 2019, per the Centers for Medicare & Medicaid Services (CMS), to determine coverage and billing guidelines.

- Table 1 provides a list of new codes contained in the quarterly update, along with code descriptions, program coverage, 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 April 1, 2019.
- Table 2 provides new HCPCS codes from Table 1 released as a part of the April 2019 second quarter update for which outpatient reimbursement information has yet to be determined. The IHCP will issue a publication after the final coverage determinations have been completed.

Providers should be aware of the following PA criteria regarding certain covered codes included in the April 2019 quarterly HCPCS update:

- **HCPCS code C9044**
  - PA for cemiplimab-rwlc (Libtayo) requires one of the following criteria to be met:
    - Patient has a diagnosis of metastatic cutaneous squamous cell carcinoma.
    - Patient has locally advanced cutaneous squamous cell carcinoma and is not a candidate for curative surgery or curative radiation.
  - PA limit is 6 months.
- **HCPCS code C9045**
  - PA for moxetumomab pasudotox-tdfk (Lumoxiti) requires both the following criteria to be met:
    - Patient has a diagnosis of relapsed or refractory hairy cell leukemia (HCL).
    - Patient has failed at least two prior systemic therapies, including treatment with a purine nucleoside analog (PNA).
  - PA limit is 6 months.

Table 1 – New HCPCS codes, effective for DOS on or after April 1, 2019

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
C9040	Injection, fremanezumab-vfrm, 1mg	Covered for all programs	No	Yes	TBD
C9041	Injection, coagulation factor Xa (recombinant), inactivated (andexxa), 10 mg	Noncovered	N/A	N/A	N/A
C9042	Injection, bendamustine hcl (belrapzo), 1 mg	Noncovered	N/A	N/A	N/A
C9043	Injection, levoleucovorin, 1 mg	Covered for all programs	No	Yes	TBD
C9044	Injection, cemiplimab-rwlc, 1 mg	Covered for all programs	Yes	Yes	TBD
C9045	Injection, moxetumomab pasudotox-tdfk, 0.01 mg	Covered for all programs	Yes	Yes	TBD
C9046	Cocaine hydrochloride nasal solution for topical administration, 1 mg	Covered for all programs	No	Yes	TBD
C9141	Injection, factor viii, (antihemophilic factor, recombinant), pegylated-aucl (jivi), 1 i.u.	Covered for all programs	No	Yes	TBD
G2001	Brief (20 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Noncovered	N/A	N/A	N/A
G2002	Limited (30 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Noncovered	N/A	N/A	N/A
G2003	Moderate (45 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Noncovered	N/A	N/A	N/A
G2004	Comprehensive (60 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Noncovered	N/A	N/A	N/A

* "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 1 – New HCPCS codes, effective for DOS on or after April 1, 2019 (Continued)

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G2005	Extensive (75 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Noncovered	N/A	N/A	N/A
G2006	Brief (20 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Noncovered	N/A	N/A	N/A
G2007	Limited (30 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Noncovered	N/A	N/A	N/A
G2008	Moderate (45 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Noncovered	N/A	N/A	N/A
G2009	Comprehensive (60 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Noncovered	N/A	N/A	N/A
G2013	Extensive (75 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Noncovered	N/A	N/A	N/A

* "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 1 – New HCPCS codes, effective for DOS on or after April 1, 2019 (Continued)

Procedure code	Description	Program coverage*	Prior authorization required	NDC required	Special billing information
G2014	Limited (30 minutes) care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.)	Noncovered	N/A	N/A	N/A
G2015	Comprehensive (60 mins) home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/ or nursing facility within 90 days following discharge from an inpatient facility.)	Noncovered	N/A	N/A	N/A

* "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 HCPCS codes for which outpatient reimbursement information has yet to be determined

Procedure code	Description
C9040	Injection, fremanezumab-vfrm, 1mg
C9043	Injection, levoleucovorin, 1 mg
C9044	Injection, cemiplimab-rwlc, 1 mg
C9045	Injection, moxetumomab pasudotox-tdfk, 0.01 mg
C9046	Cocaine hydrochloride nasal solution for topical administration, 1 mg
C9141	Injection, factor viii, (antihemophilic factor, recombinant), pegylated-aucl (jivi), 1 i.u.

Note: Procedure code C9141 will be carved out of managed care as well as the diagnosis-related group (DRG). The Physician-Administered Drugs Carved Out of Managed Care and Reimbursable outside the Inpatient DRG will be updated.

The codes in the 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 in.gov/medicaid/providers. The standard global billing procedure and edits apply unless otherwise noted. Reimbursement and PA information applies to services delivered under the fee-for-service (FFS) delivery system. Questions about FFS PA should be directed to Cooperative Managed Care Services (CMCS) at 1-800-269-5720. Individual managed care entities (MCE) 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 April 2019 HCPCS code updates are available for download from the CMS website at cms.gov. The code updates are also posted on the American Medical Association website at ama-assn.org.

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