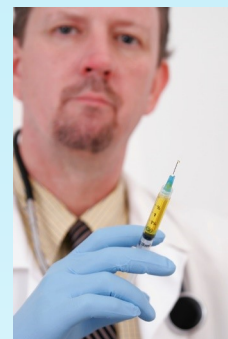


# IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS    BT202170    AUGUST 17, 2021

## IHCP covers additional COVID-19 treatment codes M0249, M0250 and Q0249

The Indiana Health Coverage Programs (IHCP) has received additional Healthcare Common Procedure Coding System (HCPCS) procedure code updates and code description revisions from the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA) for the treatment of the coronavirus disease 2019 (COVID-19). Effective for dates of service (DOS) on or after **June 24, 2021**, the IHCP covers three new COVID-19 codes listed in Table 1.



The following reimbursement information applies to all three codes listed in Table 1:

- Prior authorization (PA): None required
- Billing guidance: 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.
- Age restriction: Age 2 years and older

*Table 1 – New COVID-19 codes related to treatment of COVID-19, effective for DOS on or after June 24, 2021*

Procedure code	Description	Program coverage*	NDC required	Reimbursement information
M0249	Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with COVID-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, first dose	Covered	No	<i>Professional Claim:</i> \$403.66  <i>Outpatient Claim:</i> \$450.50
M0250	Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with COVID-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, second dose	Covered	No	<i>Professional Claim:</i> \$403.66  <i>Outpatient Claim:</i> \$450.50
Q0249	Injection, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with COVID-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, 1 mg	Covered	Yes	<i>Professional Claim:</i> \$6.05  <i>Outpatient Claim:</i> \$6.05

\* "Covered" indicates that the service is covered under Traditional Medicaid and other IHCP programs that include full Medicaid State Plan benefits; the service may not be covered under IHCP plans with limited benefits.

Providers have 90 days from the date of this publication for managed care claim submission, or 180 days from the date of publication for FFS claim submission, to bypass timely filing limits. Providers should include a copy of this bulletin (first page only) when submitting claims beyond the standard filing limit.

This information will be reflected in updates to the *Procedure Codes That Require NDCs* and the *Revenue Codes Linked to Specific Procedure Codes* on the [Code Sets](#) page. Updates will also be made to the Professional Fee Schedule and the Outpatient Fee Schedule, accessible from the [IHCP Fee Schedules](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).



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.

**QUESTIONS?**

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