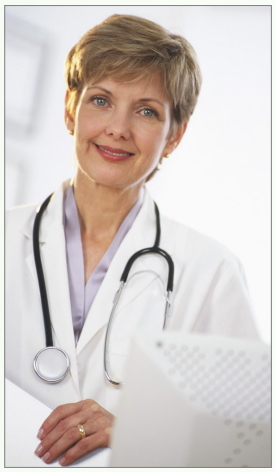
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201845 NOVEMBER 6, 2018

Clarification regarding physician-administered drugs carved out of managed care



As stated in Indiana Health Coverage Programs (IHCP) *Bulletin* BT201812, certain physician-administered drugs (PADs) are carved out of managed care and are paid through the fee-for-service (FFS) delivery system for all IHCP members. The list of procedure codes for PADs carved out of managed care is posted for reference in the *Physician-Administered Drugs Carved Out of Managed Care and Reimbursable Outside the Inpatient DRG* table on the *Code Sets* page at indianamedicaid.com. The currently posted table became effective July 1, 2018; additions or deletions of PADs are announced in IHCP provider bulletins.

To clarify, only the PAD procedure code is carved out of managed care. All other services associated with the drug (for example, laboratory testing, administration of the drug, inpatient stay during which the drug is administered) are the responsibility of the managed care entity (MCE) with which the member is enrolled. If prior authorization (PA) is required for any of these services, the PA must be obtained through the MCE.

If a PAD carved out of managed care requires PA, the PA must be obtained through Cooperative Managed Care Services (CMCS). This requirement applies to all IHCP members – PA should not be requested through the member's managed care entity (MCE) for carved-out drugs.

Note: An exception currently exists regarding PA for procedure code Q2041 – *Axicabtagene ciloleucel, up to 200 million autologous anti-CD19 CAR T Cells, including leukapheresis and dose preparation procedures, per infusion*. For managed care members, providers should contact the MCE regarding PA for the hospital stay associated with the infusion for code Q2041. If the MCE approves PA for the hospital stay, the MCE will coordinate the process to obtain PA for the drug. This alternate PA process is a temporary work-around specifically for Q2041.

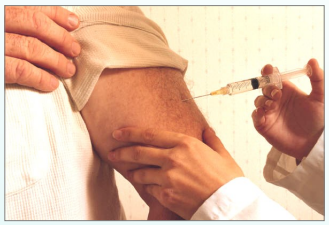
CMS updates NCCI medically unlikely edits for HCPCS code J1726 Makena

The Indiana Health Coverage Programs (IHCP) announces that effective January 1, 2019, the Centers for Medicare & Medicaid Services (CMS) will update the National Correct Coding Initiative (NCCI) Practitioner Medically Unlikely Edit (MUE) for Healthcare Common Procedure Coding System (HCPCS) code J1726 – *Injection, hydroxyprogesterone caproate (Makena), 10 mg.* The MUE update will increase the maximum allowed units per date of service (DOS) from 25 units to 28 units. The CMS update is retroactive to DOS on or after **January 1, 2018**.

continued

MORE IN THIS ISSUE

Beginning January 1, 2019, providers may resubmit fee-for-service (FFS) claims that previously denied for explanation of benefits (EOB) 4183 – *Units of service on the claim exceed the medically unlikely edit (MUE) allowed per date of service* for reimbursement consideration. Claims resubmitted beyond the original 1-year filing limit must include a copy of this banner page as an attachment and must be filed within 1 year of the publication date.



Individual managed care entities (MCEs) establish and publish billing guidance within the managed care delivery system. Questions about managed care claims should be directed to the MCE with which the member is enrolled.

IHCP to mass reprocess or mass adjust professional claims that adjudicated incorrectly in *Core*MMIS

The Indiana Health Coverage Programs (IHCP) continues to evaluate claims processed through the *Core*MMIS system to make certain all claims have adjudicated correctly. The IHCP has identified claim-processing issues that affect fee-for-service (FFS) claims for certain procedure code/modifier combinations. With the implementation of *Core*MMIS, claims or claim details for the procedure code/modifier combinations in Table 1 may have denied inappropriately for one of the following explanation of benefit (EOB) codes:

- EOB 4014 – *Claim being reviewed for pricing*
- EOB 4013 – *This procedure code is not covered for this date of service*
- EOB 4218 – *Service billed is not allowed on this claim type*

Details of the issues with each procedure code/modifier combination are outlined in Table 1. The issues affected claims processed on or after February 13, 2017.

The claim-processing issues have been corrected. Affected claims that may have processed incorrectly will be mass reprocessed or mass adjusted as appropriate. Providers should begin to see the adjusted or reprocessed claims on Remittance Advices (RAs) beginning December 12, 2018. These claims will be identified by internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claim) or 52 (mass replacement non-check related). For claims that were underpaid, the net difference will be paid and reflected on the RA. The changes identified in Table 1 will be reflected in the next regular update to the *Professional Fee Schedule* at indianamedicaid.com.

Table 1 – Procedure code/modifier combinations for which professional claims or claim details may have denied inappropriately on or after February 13, 2017

Type of service	Procedure code	Modifier	System error related to procedure code/modifier combination
Medical Supplies	A4253	U1	Coverage of combination end dated in error; claims or claim details denied inappropriately for EOB 4014 or 4218
DME	E0465	MS	Coverage of combination end dated in error for claim type B (crossover claims); crossover claims or claim details denied inappropriately for EOB 4013

continued

Table 1 – Procedure code/modifier combinations for which professional claims or claim details may have denied inappropriately on or after February 13, 2017 (continued)

Type of service	Procedure code	Modifier	System error related to procedure code/modifier combination
DME	E0466	MS	Coverage of combination end dated in error for claim type B (crossover claims); crossover claims or claim details denied inappropriately for EOB 4013
DME	E0620	RR	Coverage of combination not accurately reflected in the system; claims or claim details denied inappropriately for EOB 4013, 4014, or 4218
DME	E1634	No modifier	Coverage of procedure code (no modifier) end dated in error; claims or claim details denied inappropriately for EOB 4013
DME	E1818	RR MS	Coverage of combinations not accurately reflected in system for claim type B (crossover claims); crossover claims or claim details denied inappropriately for EOB 4218
DME	K0843	RR	Coverage of combination not accurately reflected in system for claim type M (medical claims); medical claims or claim details denied inappropriately for EOB 4218
Waiver	S5165	U7 U7 U8 U7 NU	Coverage for combinations end dated in error; claims or claim details denied inappropriately for EOB 4013

The IHCP identified additional issues with how coverage of the DME and medical supply procedure code/modifier combinations in Table 2 are reflected in the *Professional Fee Schedule*. Although *Core*MMIS processed claims for these combinations correctly, the fee schedule did not reflect coverage information accurately. Details of the issues with each procedure code/modifier combination are outlined in the table. The changes identified in Table 2 will be reflected in the next regular update to the *Professional Fee Schedule* at indianamedicaid.com.

Table 2 – DME and medical supply procedure code/modifier combinations for which coverage information has been corrected on the Professional Fee Schedule

Procedure code	Modifier	***Professional Fee Schedule* correction**
A4253	NU UI NU	NU modifier not applicable with procedure code; code combinations removed from fee schedule
E0154	NU	NU modifier not applicable with procedure code; code combination removed from fee schedule
E0607	RR	RR modifier allowable with procedure code; code combination added to fee schedule
E0607	NU U1 NU	NU modifier not applicable with procedure code; code combinations removed from fee schedule
E0936	RR	RR modifier required with procedure code; code combination added to fee schedule
E0936	NU	NU modifier not applicable with procedure code; code combinations removed from fee schedule

continued

Table 2 – DME and medical supply procedure code/modifier combinations for which coverage information has been corrected on the Professional Fee Schedule (continued)

Procedure code	Modifier	*Professional Fee Schedule* correction
E0953	NU RR MS	NU, RR, or MS modifier required with procedure code; code combinations added to fee schedule
E0954	NU RR MS	NU, RR, or MS modifier required with procedure code; code combinations added to fee schedule
E1634	NU	NU modifier not applicable with procedure code; code combination removed from fee schedule
K0098	NU RR MS	NU, RR, or MS modifier required with procedure code; code combinations added to fee schedule
Q0490	NU	NU modifier not applicable with procedure code; code combination removed from fee schedule

QUESTIONS?

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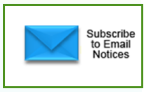

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