IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201948 NOVEMBER 26, 2019

Providers may resubmit outpatient claims billed with ICD-10 diagnosis code K35.80 that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects fee-for-service (FFS) outpatient claims billed with ICD-10 Clinical Modification (ICD-10-CM) diagnosis code K35.80 – *Unspecified acute appendicitis*, with dates of service (DOS) on or after February 13, 2017, when *Core*MMIS was implemented. Claims billed with code K35.80 may have denied incorrectly with explanation of benefits (EOB) 2006 – *Diagnosis code billed is not covered for the member's benefit plan.*

The claim-processing system has been corrected. Beginning immediately, providers may resubmit FFS outpatient claims billed with diagnosis code K35.80, which previously denied with EOB 2006 during the indicated time frame, for reimbursement consideration. This correction applies retroactively to claims with DOS on or after **February 13, 2017**. Claims resubmitted beyond the timely filing limit must include a copy of this banner page as an attachment.

Note: Claims with DOS before January 1, 2019, must be resubmitted within 1 year of the banner page's publication date. Claims with DOS on or after January 1, 2019, must be resubmitted within 180 days of the banner page's publication date.

IHCP to remove gender restriction on ICD-10 diagnosis code Z79.890 and accept resubmitted claims

Effective immediately, the Indiana Health Coverage Programs (IHCP) will remove the female-only gender restriction from coverage of ICD-10 Clinical Modification (ICD-10-CM) diagnosis code Z79.890 – *Hormone replacement therapy*. Other existing reimbursement guidelines for code Z79.890 remain unchanged.

Removal of the gender restriction applies retroactively to fee-for-service (FFS) claims with dates of service (DOS) on or after the effective date of the code, **October 1, 2015**. Claims billed with diagnosis code Z79.890 denied with either of the following explanation of benefits (EOB):

- EOB 4028 – *Diagnosis code not compatible with member's gender. Please verify and resubmit.*
- EOB 4031 – *Diagnosis given not compatible with member's gender. Please verify and resubmit.*

continued

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Beginning immediately, providers may resubmit FFS claims with diagnosis code Z79.890, which previously denied for EOB 4028 or EOB 4031 during the indicated time frame, for reimbursement consideration. Each claim resubmitted beyond the timely filing limit must include a copy of this banner page as an attachment.

Note: Claims with DOS before January 1, 2019, must be resubmitted within 1 year of the banner page's publication date. Claims with DOS on or after January 1, 2019, must be resubmitted within 180 days of the banner page's publication date.

IHCP clarifies VFC and private stock vaccine reimbursement, effective January 1, 2020

Effective January 1, 2020, as the Indiana Health Coverage Programs (IHCP) announced in *Bulletin* BT201960, the IHCP is changing reimbursement for Vaccines for Children (VFC) and private stock vaccines as clarified in this article.

Additionally, the IHCP is explaining guidance for providers that administer vaccines and bill the claims for IHCP members who have both Medicaid and private primary insurance.

Note: These updates will not change the billing instructions. For more information about billing claims for the VFC administration fee, see the Injections, Vaccines, and Other Physician-Administered Drugs provider reference module.

Administration fee

Effective for claims with dates of service (DOS) on or after January 1, 2020, the IHCP reimbursement for administering VFC vaccine will increase to $15 per dose for members in the fee-for-service (FFS) and managed care delivery systems. Providers should continue to bill the appropriate procedure code (Current Procedural Terminology [CPT®[1]] codes 90471-90474) with modifier SL – *State supplied vaccine*. For DOS beginning January 1, 2020, the VFC administration fee will be a maximum of $15 (payment is made at whichever is lower - $15 or the submitted charge). As a reminder, for a VFC vaccine administered during the course of an office visit, providers may bill the VFC vaccine administration procedure code/modifier combination in addition to the evaluation and management (E/M) procedure code.

Private stock vaccines

Effective for claims with DOS on or after January 1, 2020, the IHCP will not reimburse for a non-VFC vaccine (referred to as private stock vaccine) for children under 19 years of age. The CPT codes for these vaccines are in Table 1; this change does not affect covered vaccines that are not part of the VFC program. This update applies to members in the FFS and managed care delivery systems.

Providers that are not currently enrolled in the VFC program are encouraged to enroll, ensuring that members do not experience a disruption in care.

Note: More information about the VFC program can be found on the Vaccines for Children Information for Providers page at in.gov/isdh. Or, call 1-800-701-0704.

continued

Members with Medicaid and private primary insurance

Providers have two different options for administering vaccines and billing claims for IHCP members who are under age 19 and have both Medicaid and private primary insurance that covers the vaccine.

The *Vaccines for Children Operations Guide*, published by the Centers for Disease Control and Prevention (CDC), mentions that children with primary insurance may be eligible for the VFC program as follows:

> *Some children may have a private primary health insurance plan with Medicaid as their secondary insurance. These children are considered VFC-eligible because of their Medicaid enrollment. However, their parents are not required to participate in the VFC program.*

The provider and parent should choose one of the following options, depending on the most cost-effective for the family. The parent of a child with Medicaid as secondary insurance should never be billed for a vaccine or an administration fee.

Option 1: The provider can administer a VFC vaccine and bill Medicaid for the administration fee.

In most healthcare situations, Medicaid is considered the "payer of last resort." This means that claims must be filed with and rejected by all other insurers before Medicaid will consider payment for the service.

This is not true of the vaccine administration fee for Medicaid-eligible VFC children. Medicaid must reimburse the administration fee to the VFC program-enrolled provider, because vaccinations are a component of the Medicaid Early Periodic Screening, Diagnostic, and Treatment (EPSDT) program. However, after a claim is submitted to Medicaid, the State Medicaid agency may seek reimbursement for the administration fee from the primary insurer.

Considerations regarding this option:

- It is the easiest way for a provider to use VFC vaccines and bill Medicaid for the administration fee. (VFC program-enrolled providers get the vaccines free.)
- There are no out-of-pocket costs to the parent for the vaccine or the administration fee.

Option 2: The provider can administer a private stock vaccine and bill the primary insurance carrier for both the cost of the vaccine and the administration fee.

If the primary insurer reimburses less than Medicaid for the vaccine administration fee, the provider can bill Medicaid for the balance, up to the amount Medicaid reimburses for the administration fee.

If the primary insurer denies payment of a vaccine and the administration fee, such as in cases where a deductible must be met, the provider may replace the privately purchased vaccine with VFC vaccine and bill Medicaid for the administration fee. The provider must document this replacement using the following form at in.gov/isdh.

Consideration regarding this option:

- The provider may be reimbursed a higher dollar amount for administering private stock vaccine, and billing both the vaccine and the administration fee to the primary insurer.

continued

Because the IHCP will no longer reimburse private stock vaccine claims with DOS on or after January 1, 2020, for the procedure codes in Table 1 for members under age 19, providers that choose option 2 will not be eligible for Medicaid reimbursement for the vaccine (beyond the reimbursement from the member's primary insurer). When providers administer private stock vaccine, reimbursement for the vaccine administration continues to be included in the reimbursement of in-office visits.

This change 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.

Table 1 – Procedure codes for vaccines in the VFC program that will not be reimbursed for members under age 19, effective for DOS on or after January 1, 2020

Procedure code	Description
90620	Vaccine for meningococcus for injection into muscle
90621	Vaccine for meningococcus for injection into muscle
90632	Vaccine for Hepatitis A injection into muscle, adult dosage
90633	Vaccine for Hepatitis A (2 dose schedule) injection into muscle, pediatric or adolescent dosage
90636	Vaccine for Hepatitis A and Hepatitis B injection into muscle, adult dosage
90647	Vaccine for Hemophilus influenza B (3 dose schedule) injection into muscle
90648	Vaccine for Hemophilus influenza B (4 dose schedule) injection into muscle
90651	Vaccine for human papilloma virus (3 dose schedule) injection into muscle
90670	Pneumococcal vaccine for injection into muscle
90672	Vaccine for influenza for nasal administration
90674	Vaccine for influenza for administration into muscle, 0.5 ml dosage
90680	Vaccine for Rotavirus (3 dose schedule) for oral administration
90681	Vaccine for Rotavirus (2 dose schedule) for oral administration
90685	Vaccine for influenza for administration into muscle, 0.25 ml dosage
90686	Vaccine for influenza for administration into muscle, 0.5 ml dosage
90687	Vaccine for influenza for administration into muscle, 0.25 ml dosage
90688	Vaccine for influenza for administration into muscle, 0.5 ml dosage
90696	Vaccine for diphtheria, tetanus toxoids, acellular pertussis (whooping cough), and polio for injection into muscle, patient 4 through 6 years of age
90698	Vaccine for diphtheria, tetanus toxoids, acellular pertussis (whooping cough), haemophilus influenza type B, and polio for injection into muscle
90700	Vaccine for diphtheria, tetanus, and acellular pertussis (whooping cough) injection into muscle, child younger than 7 years
90702	Vaccine for diphtheria and tetanus toxoids injection into muscle, patient younger than 7 years of age

continued

Table 1 – Procedure codes for vaccines in the VFC program that will not be reimbursed for members under age 19, effective for DOS on or after January 1, 2020 (continued)

Procedure code	Description
90707	Vaccine for measles, mumps, and rubella (German measles) injection beneath skin
90710	Vaccine for measles, mumps, rubella (German measles), and varicella (chicken pox) injection beneath skin
90713	Vaccine for polio injection beneath the skin or into muscle
90714	Vaccine for tetanus and diphtheria toxoids injection into muscle, patient 7 years or older
90715	Vaccine for tetanus, diphtheria toxoids and acellular pertussis (whooping cough) for injection into muscle, patient 7 years or older
90716	Vaccine for varicella (chicken pox) injection beneath skin
90723	Vaccine for diphtheria, tetanus toxoids, acellular pertussis (whooping cough), Hepatitis B, and polio for injection into muscle
90732	Vaccine for pneumococcal polysaccharide for injection beneath the skin or into muscle, patient 2 years or older
90733	Vaccine for meningococcus for injection beneath skin
90734	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diphtheria toxoid carrier (MENACWY-D) or CRM197 carrier (MENACWY-CRM), for intramuscular use
90739	Vaccine for Hepatitis B adult dosage (2 dose schedule) injection into muscle
90744	Vaccine for Hepatitis B (3 dose schedule) for injection into muscle, pediatric and adolescent patients
90746	Vaccine for Hepatitis B adult dosage (3 dose schedule) injection into muscle
90756	Vaccine for influenza for injection into muscle

IHCP to update *Core*MMIS to capture fields present on standard national claim forms

Effective January 1, 2020, the Indiana Health Coverage Programs (IHCP) will update the *Core*MMIS claim-processing system to capture the data submitted in all fields present on the national *CMS-1500* and *UB-04* claim forms. The data submitted in these fields will be captured on the *CMS-1500, UB-04,* IHCP Provider Healthcare Portal, and 837 transaction types listed in Table 2. The field descriptions in Table 3 and Table 4 apply to the IHCP guidelines only and are not intended to replace instructions issued by the National Uniform Claim Committee (NUCC).

Note: The NUCC instruction manual can be found at nucc.org.

continued

Effective January 1, 2020, the IHCP will edit *CMS-1500* claims for the Pregnancy indicator in field 24H - *EPSDT Family Plan* and date in field 14 - *Date of Current Illness, Injury, or Pregnancy (LMP)*. Claims with a pregnancy indicator and no last menstrual period (LMP) date will post and pay with explanation of benefits (EOB) 0957 – *LMP date missing*.

Table 2 – Claim form fields captured in CoreMMIS, effective January 1, 2020

Form locator	Field	Transaction method	837 transaction
10d	CLAIM CODES	Paper *CMS-1500* (02/12) Provider Healthcare Portal 837P (Professional) electronic transaction	Loop 2300, HI segment
11b	OTHER CLAIM ID	Paper *CMS-1500* (02/12) Provider Healthcare Portal 837P (Professional) electronic transaction	Loop 2010 BA, REF segment
19	ADDITIONAL CLAIM INFORMATION	Paper *CMS-1500* (02/12)	Loop 2300, NTE segment
48	NON-COVERED CHARGES	Paper *UB-04* (*CMS-1450*) Provider Healthcare Portal (This field is new to the Portal.) 837I (Institutional) electronic transaction	Loop 2400, SV207 segment
72	EXTERNAL CAUSE OF INJURY (ECI)	Paper *UB-04* (*CMS-1450*) Provider Healthcare Portal 837I (Institutional) electronic transaction	Loop 2300, HI segment

Table 3 – CMS-1500 claim form field descriptions

Form locator	Field description
10d	**CLAIM CODES** – The claim codes identify additional information about the patient's condition on the claim. When reporting more than one code, enter three blank spaces and then the next code. This field allows for the entry of 19 characters. Optional.
11b	**OTHER CLAIM ID** – The Other Claim ID identifies additional information about another claim payer source. This field allows for the entry of 2 characters to the left of the vertical, dotted line and 28 characters to the right of the dotted line. Optional.
14	**Date of Current Illness, Injury, or Pregnancy (LMP)** – The date of current illness, injury, or pregnancy (LMP) should be entered using the applicable qualifier. This information should be reported to the right of the vertical, dotted line. This information should be entered as 2 digits under MM, 2 digits under DD and 4 digits under YYYY and then the 3 characters to the right of the vertical, dotted line for the qualifier. **Required, if applicable.**
19	**ADDITIONAL CLAIM INFORMATION** – This field is being used as a notes section for information such as partial sterilization (see the *Claim Submission and Processing* provider reference module) or third-party liability (TPL) 90 day no response. This field is limited to 80 characters. The additional claim information is the functional equivalent of the claim note section on the 837P and Portal claim submissions. Optional.

continued

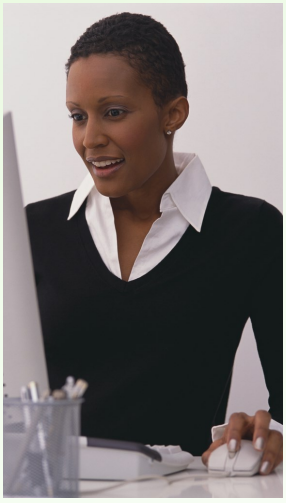
Table 3 – CMS-1500 claim form field descriptions (continued)

Form locator	Field description
24H	**EPSDT/Family Plan** – Reporting of EPSDT and family planning services. EPSDT may be reported using the National Uniform Claim Committee (NUCC) two-character codes. Family planning should be reported with a "Y" for yes in the unshaded area of the field. **Required, if applicable.**

Table 4 – UB-04 claim form field descriptions

Form locator	Field description
48	**NON-COVERED CHARGES** – Reflects noncovered charge amounts. Optional
72	**ECI** – If applicable, use the appropriate external cause of injury (ECI) diagnosis codes provided at the time of admission, as stated by the physician. ECI codes indicate the external cause of injury, poisoning, or adverse effect. Up to three ECI codes may be entered. The IHCP does not require a present on admission (POA) indicator in the ECI field. If a POA indicator is entered in this field, it will be ignored and not used for diagnosis-related group (DRG) grouping. Optional. *Note: Claims submitted with an invalid ECI code will be denied for EOB 4060 – The E-code billed is not a valid ICD code.*

New Program Integrity provider training available – *Renal Dialysis Services Billing Guidelines*



The Indiana Health Coverage Programs (IHCP) is making web-based Program Integrity provider education training available to all IHCP providers. These training presentations are intended to supplement the provider reference modules and other IHCP-published provider reference materials.

The latest Program Integrity provider education training titled, *Renal Dialysis Services Billing Guidelines*, is now available. The purpose of this training is to explain how to document and bill for medically necessary dialysis services within the fee-for-service (FFS) delivery system.

By the end of the course, providers should be able to:

- Identify which services are covered in the composite rate for renal dialysis.
- Understand the billing guidelines for renal dialysis services, equipment and supplies, laboratory tests, and drugs and biologicals.
- Apply the billing guidelines for physician and transportation services for members on renal dialysis.

To access the training, navigate to the *Program Integrity Provider Education Training* page at in.gov/medicaid/providers.

continued

Other training topics posted on the web page are listed below. Watch upcoming IHCP provider publications for announcements about other trainings that become available.

- *Non-Emergency Transportation Documentation Requirements and Billing Guidelines*
- *Ambulance Transportation Documentation Requirements and Billing Guidelines*
- *Dental Provider Documentation Requirements and Billing Guidelines*
- *Program Integrity Audit Process Overview*
- *Program Integrity Self-Disclosure Protocol*
- *Behavioral Health and ABA Documentation Guidelines*
- *Indiana FADS Secure Portal Tutorial*
- *Random Sampling and Extrapolation Process*

QUESTIONS?

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

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