IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202013 MARCH 31, 2020

IHCP to cover HCPCS code Q5116

Effective May 1, 2020, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code Q5116 – *Injection, trastuzumab-qyyp, biosimilar, (Trazimera), 10 mg*.

Coverage for this physician administered drug (PAD) applies to all IHCP programs, subject to limitations established for certain benefit packages, and for professional claims (*CMS-1500* form or electronic equivalent) and institutional claims (*UB-04* form or electronic equivalent) with dates of service (DOS) on or after May 1, 2020.

The following reimbursement information applies:

- Pricing: Maximum fee of $84.78
- Prior authorization (PA): None required
- Billing guidance:
  - Must be billed with the National Drug Code (NDC) of the product administered.
  - 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.

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.

This information will be reflected in the next regular update to the *Outpatient Fee Schedule* and the *Professional Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers, and to the *Procedure Codes That Require National Drug Codes (NDCs)* and the *Revenue Codes with Special Procedure Code Linkages* code tables, available from the *Code Sets* web page.

MORE IN THIS ISSUE

- IHCP to revise billing guidance for HCPCS code T4544, and accept resubmitted claims
- IHCP mass reprocesses and mass adjusts claims for ABA services that denied incorrectly
- IHCP to include CPT code 0514T for optometrist services
- IHCP amends alternate EVV solution specifications and reminds providers about establishing the data interface
- Countdown to EVV implementation for personal care providers: T-minus 39 weeks

IHCP to revise billing guidance for HCPCS code T4544, and accept resubmitted claims

Effective May 1, 2020, fee-for-service (FFS) claims submitted by IHCP-contracted incontinence vendors (J&B Medical Supply Company and Binson's Home Health Care Centers) will no longer require prior authorization (PA) for Healthcare Common Procedure Coding System (HCPCS) code T4544 – *Adult sized disposable, protective, disposable underwear/ pull on, above extra-large*.

The IHCP continues to require FFS Medicaid members to order HCPCS code T4544 from contracted providers J&B Medical and Binson's Home Health Care, as described in the *Durable and Home Medical Equipment and Supplies* provider reference module at in.gov/medicaid/providers. There is no change to existing billing guidance for noncontracted providers of incontinence supplies.

Effective May 1, 2020, IHCP-contracted providers should bill for HCPCS code T4544 using the following usual and customary charge (UCC) rates, for reimbursement consideration. These rates apply retroactively to claims for code T4544 with dates of service (DOS) on or after February 1, 2020.

- J&B Medical Supply Company: $0.90 per unit
- Binson's Home Health Care Centers: $1.05 per unit

Noncontracted vendors and other caregivers should encourage members who request the product (code T4544) to contact one of the two contracted vendors to obtain supplies. IHCP members with Medicare or other third-party insurance must follow the guidelines of their primary insurance plan to receive reimbursement for incontinence supplies. For more information, see the *Durable and Home Medical Equipment and Supplies* provider reference module.

Contact information for IHCP-contracted providers of incontinence supplies follows:

- J&B Medical Supply Company
  jandbmedical.com
  Telephone: 1-866-674-5850
- Binson's Home Health Care Centers
  binsons.com
  Telephone: 1-888-217-9610

Reimbursement, PA, and billing information applies to services delivered under the 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.

IHCP to accept resubmitted claims from contracted providers

The IHCP identified a claim-processing issue that affects certain FFS claims submitted by IHCP-contracted providers for HCPCS code T4544 with DOS on or after February 1, 2020. Claims billed for code T4544 may have denied inappropriately with explanation of benefits (EOB) 3001 – *Dates of service not on the P.A. master file*.

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Beginning May 1, 2020, contracted providers may resubmit FFS claims for HCPCS code T4544 that previously denied for EOB 3001, for reimbursement consideration. This applies retroactively to claims with DOS on or after February 1, 2020. Claims resubmitted beyond the original filing limit must include a copy of this banner page as an attachment and must be resubmitted within 180 days of the banner page's publication date.

These changes 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.

IHCP mass reprocesses and mass adjusts claims for ABA services that denied incorrectly

The Indiana Health Coverage Programs (IHCP) announced in *Banner Page* BR201950 that a claim processing issue was identified for certain fee-for-service (FFS) claims for applied behavioral analysis (ABA) therapy services, with dates of service (DOS) from January 1, 2019, through November 21, 2019. Claims billed for the following Current Procedural Terminology (CPT®[1]) procedure codes may have denied incorrectly for explanation of benefits (EOB) 4013 – *This procedure code is not covered for this date of service*:

- 0362T – *Behavioral Identification Supporting Assessment*
- 0373T – *Adaptive Behavior Treatment with Protocol Modification*

The IHCP continues to process affected claims. Claims or claim details processed during the indicated time frame that previously denied for EOB 4013 will be mass reprocessed or mass adjusted, as appropriate. Providers should see reprocessed or adjusted claims on Remittance Advices (RAs) beginning May 6, 2020, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims) or 52 (mass replacement non-check related). For claims that were underpaid, the net difference will be paid and reflected on the RA.

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IHCP to include CPT code 0514T for optometrist services

Effective May 1, 2020, the Indiana Health Coverage Programs (IHCP) will include Current Procedural Terminology (CPT®[1]) code 0514T – *Intraoperative visual axis identification using patient fixation (list separately in addition to code for primary procedure)*, with the covered codes for provider specialty group 180 – Optometrist. This will apply to fee-for-service (FFS) claims for optometrist services with dates of service (DOS) on or after May 1, 2020.

For billing guidance, see the Vision Services provider reference module at in.gov/medicaid/providers.

This information will be reflected in the next regular update to the *Vision Services Codes*, accessible from the Code Sets web page at in.gov/medicaid/providers.

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IHCP amends alternate EVV solution specifications and reminds providers about establishing the data interface

The *21st Century Cures Act* directs states to require providers of personal care services and home health services to use an electronic visit verification (EVV) system to document services rendered. Previous Indiana Health Coverage Programs (IHCP) publications announced related details.

Note: Providers can find more information by searching from the News, Bulletins, and Banner Pages web page at in.gov/medicaid/providers.

The IHCP posted an updated addendum for the alternate EVV solutions specification. The addendum called, *Indiana Addendum for Alternate EVV Specifications*, is located on the *Electronic Visit Verification* page in the Alternate EVV System Specifications section.

Process for interfacing with Sandata EVV Aggregator

Many vendors already have an interface established with Sandata, but they will still need to actively ensure that the data they send over the interface matches what is required by the state of Indiana.

Providers who plan to use an alternate EVV vendor will need to start the process to establish their vendor's interface with the Sandata EVV Aggregator system. Start the process by sending an email to the FSSA EVV email address at EVV@fssa.in.gov and list the following:

- Subject: Request for EVV Vendor Certification [Vendor Name]
- Provider name
- Provider contact name and email address
- Vendor name
- Vendor contact name and email address

Overview of the process

- The provider sends an email to EVV@fssa.IN.gov and requests testing credentials on behalf of the provider's alternate EVV vendor.
- The FSSA forwards the email request to DXC Technology to begin the process of creating appropriate testing credentials for the vendor. DXC will forward the email to Sandata. The email also serves as notification to Sandata regarding the intent to have the interface developed.
- Prior to testing the interface, the alternate EVV vendor should complete the development and internal testing processes based on the *Alternate EVV Specifications* provided on the *Electronic Visit Verification* web page at in.gov/medicaid/providers.
- After the request is made to begin testing, Sandata supplies the vendor with guidance on the testing process.

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- For testing purposes, the vendor sends completed visit information at least daily to the Sandata Aggregator.
- As visit data is received, Sandata verifies that the visit data passes all IHCP rules, and will work with the vendor to resolve any issues.

The vendor will supply all changes to the visit along with the final completed visit details. As part of the future claim adjudication process, EVV data will need to be available to the Core Medicaid Management Information System (*Core*MMIS) and meet all Indiana-specified rules for the IHCP to reimburse for a claim. Visits are considered to be complete after the vendor supplies all required information for the visit and remediates all exceptions for the visit.

Transmission frequency

For optimal system performance, Sandata recommends that visits be sent in near real time. It is expected that information is sent as it is added, changed, or deleted in the alternate EVV data collection system, at least once per day. However, more frequent data submissions will benefit both the State and the provider.

Note: Rejection responses will be delivered on a separate application programming interface (API) call that is initiated by the vendor – in near real time.

More information

Additional information is available on the *Electronic Visit Verification* web page and in the *Electronic Visit Verification FAQs* document at in.gov/medicaid/providers. For any general questions or concerns about the EVV Program, email EVV@fssa.in.gov.

Countdown to EVV implementation for personal care providers: T-minus 39 weeks

As announced in previous Indiana Health Coverage Programs (IHCP) publications, the *21st Century Cures Act* directs states to require providers of personal care services and home health services to use an electronic visit verification (EVV) system to document services rendered.

Providers of personal care services have until **January 1, 2021**, to implement an EVV system for documenting services.

Please note that personal care providers not in compliance with the EVV mandate by January 1, 2021, will experience claims and reimbursement issues until they follow the federal mandate for successfully recording EVV visits.

More information is available on the *Electronic Visit Verification* web page and in the *Electronic Visit Verification FAQs* document at in.gov/medicaid/providers. For any general questions or concerns about the EVV Program, email EVV@fssa.in.gov.

QUESTIONS?

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