IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR202111 MARCH 16, 2021

Billing and reimbursement updates for COVID-19 laboratory testing codes, claims that paid incorrectly

Rate decrease for HCPCS codes U0003 and U0004

In compliance with *Section 1903(i)(7)* of the *Social Security Act*, Medicaid reimbursement for individual clinical laboratory procedures cannot exceed the Medicare rate of reimbursement. For this reason, the Indiana Health Coverage Programs (IHCP) will adopt the 2021 Medicare rate for any clinical laboratory procedure code for which the IHCP's current reimbursement rate exceeds the 2021 Medicare rate. As announced in *IHCP Banner Page* BR202045, these changes are effective for dates of service (DOS) on or after January 1, 2021.

As a result of changes to the Medicare reimbursement rates, IHCP Medicaid reimbursement of the following Healthcare Common Procedure Coding System (HCPCS) codes associated with coronavirus disease 2019 (COVID-19) testing will decrease from a maximum fee of $100.00 to $75.00, effective retroactively for professional and outpatient claims with DOS on or after January 1, 2021:

- U0003 – *Infectious agent detection by nucleic acid (DNA or RNA); Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R*
- U0004 – *2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R*

Note: Revenue code linkages for COVID-19 laboratory test procedure codes are no longer manually maintained by the State. Fee-for-service (FFS) revenue code linkages for these procedure codes will follow the Office of Medicaid Policy and Planning (OMPP) uniform billing (UB) Editor. For codes U0003 and U0004, the manual linkage to revenue code 300 ended on June 30, 2020.

Claims for codes U0003 and U0004 that paid incorrectly

The IHCP identified a claim-processing issue that affects FFS professional and outpatient claims for procedure codes U0003 and U0004, with DOS on or after January 1, 2021. Claims or claim details may have paid incorrectly.

The claim-processing system has been updated with the new rate. Claims processed during the indicated time frame for codes U0003 and U0004 will be mass adjusted, as appropriate. Providers should see adjusted claims on Remittance Advices (RAs) beginning April 21, 2021, with internal control numbers (ICNs)/Claim IDs that begin with 52 (mass replacements non-check related).

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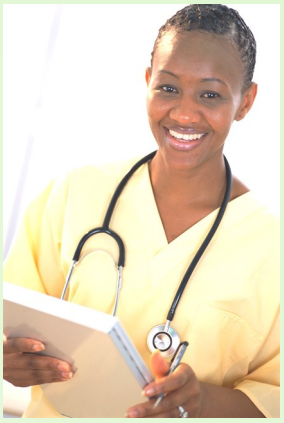
Claims for codes U0003 and U0004 that paid incorrectly (continued)



If a claim was overpaid, the net difference will appear as an accounts receivable on the RA. The accounts receivable will be recouped at 100% from future claims paid to the respective provider number.

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.

Add-on payment using HCPCS code U0005

Effective January 1, 2021, the Centers for Medicare & Medicaid Services (CMS) released HCPCS code U0005 – *Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, CDC or non-CDC, making use of high throughput technologies, completed within two calendar days from date and time of specimen collection.*

Code U0005 is intended to serve as an add-on payment for codes U0003 and U0004 and may be billed when all the following criteria have been met:

- Laboratories must complete the COVID-19 Clinical Diagnostic Laboratory Test (CDLT) in 2 calendar days or less from the date of specimen collection.
- The majority of the laboratory's COVID-19 CDLTs were performed using high throughput technology in the previous calendar month and were completed in 2 calendar days or less for all their patients.

The IHCP follows the standard written rules and guidance from CMS for billing U0005 and other high throughput COVID-19 testing codes.

Note: For more information, see section D of COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing at cms.gov.

Claims for add-on payment

If a provider met the criteria (above) for billing code U0005 with a claim for procedure code U0003 or U0004 with DOS on or after January 1, 2021, the provider may choose to adjust the original claim by voiding the original and submitting a replacement. CMS guidance states that U0005 must be billed on the same claim as U0003 or U0004. The replacement claim must include the same attachments (if any) as were submitted with the original claim. Providers have 180 days from the date of this banner page publication to adjust claims. Replacement claims submitted beyond the original 180 day filing limit must include a copy of this banner page as an attachment and must be filed within 180 days of the publication date.

Note: For more about adjusting claims, see the Claim Adjustments Voids and Replacements provider reference module, accessible from the *IHCP Provider Reference Modules* web page at in.gov/medicaid/providers.

This billing information applies to services delivered under the FFS delivery system. Individual managed care entities (MCEs) establish and publish reimbursement, prior authorization (PA), and billing criteria within the managed care delivery system. Questions about managed care billing should be directed to the MCE with which the member is enrolled.

IHCP reminds providers not to bill Medicaid members, with some exceptions

Following numerous questions from the provider community, the Office of Medicaid Policy and Planning (OMPP) Program Integrity section is reminding Indiana Health Coverage Programs (IHCP) providers that federal and State regulations prohibit providers from charging an IHCP member, or the family of the member, for any amount not paid for an IHCP-covered service following a reimbursement determination by the IHCP. This reminder applies to providers in both the fee-for-service (FFS) and managed care delivery systems. There are some exceptions, as described below.

As a condition of the provider's participation in the IHCP, the provider must accept the IHCP's determination of payment as payment in full, whether the IHCP is the primary or secondary payer. If the provider disagrees with the Medicaid determination of payment, the provider's right of recourse is limited to an adjustment request, administrative review, and appeal, as provided in Title 405 of the *Indiana Administrative Code (IAC) 1.1-3*. Violation of this section constitutes grounds for termination of the provider agreement and decertification of the provider, at the option of the Indiana Family and Social Services Administration (FSSA).

Providers are also bound by a provision in the *IHCP Rendering Provider Agreement* that no member or family of a member may be billed in excess of the amount paid by the IHCP for covered services, and agree to the following:

> *To accept as payment in full the amounts determined by FSSA or its fiscal agent, in accordance with the federal and state statutes and regulations as the appropriate payment for IHCP covered services provided to members. Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for IHCP covered services, excluding any co-payment permitted by law.*

Exceptions that allow for billing IHCP members

The following exceptions pertain to all IHCP members, regardless of their eligibility category or program.

An IHCP provider may bill a member for noncovered services only when these conditions are met:

- The member must understand, before receiving the service, that the service is not covered under the IHCP and that the member is responsible for the service charges.
- The provider must maintain documentation in the member's file that clearly demonstrates that the member voluntarily chose to receive the service, knowing it was not covered by the IHCP. A provider may use a *waiver* form to document such notification; however, a waiver form is not required. Forms are subject to the following:
    - If a waiver form is used to document that a member has been informed that a service is noncovered, the waiver must not include conditional language such as "if the service is not covered by the IHCP, or not authorized by the member's primary medical provider (PMP), the member is responsible for payment." This language appears to circumvent the need for the provider to verify eligibility or seek PMP authorization or prior authorization (PA) as needed.

continued

Exceptions that allow for billing IHCP members (continued)

- A generic consent form is not acceptable unless it identifies the specific procedure to be performed and the member signs the consent before receiving the service. If written statements are used, the statements must not contain conditional language such as, "If an IHCP service is not covered…."
- Obtaining a signed waiver will not prevent the IHCP from investigating the facts alleged in the waiver.

Additional conditions for billing members apply based on circumstances, and adhere to federal regulations and Indiana code as noted:

- If the member has a PMP and wishes to receive services from a non-IHCP provider, the PMP must inform the member before services are rendered that the services will not be covered and may include an additional out-of-pocket expense.
- The service to be rendered must be determined to be noncovered by the IHCP. For example, the member has exceeded the program limitations for a particular service or PA for the service was denied.
- The covered or noncovered status of embellishments or enhancements to basic services can be considered separately from the basic service only if a separate procedure, revenue, or National Drug Code (NDC) exists:
  - If a separate code exists, a noncovered embellishment may be billed to the member and the basic charge billed to the IHCP.
  - If a separate code does not exist, the service, in its entirety, is considered covered or noncovered.
  - Example: Because no separate procedure exists for embellishments to a standard pair of eyeglass frames, it is not allowable for the IHCP to be billed for the basic frames and for the member to be billed for additional charges. The entire charge for embellished frames is noncovered by the IHCP in accordance with the IAC guidance for covered services.
- If after the provider takes appropriate action to ascertain and identify a responsible payer for a service, there is no indication that the member has coverage under any IHCP program. This means:
  - The provider may bill the member if the member failed to advise the provider of Medicaid eligibility.
  - If the provider is notified of the member's Medicaid eligibility within the 180 day timely filing limit, the IHCP must be billed for the covered service. Any monies that were collected by the IHCP provider from the IHCP member must be reimbursed in full to the member immediately.

    Note: For information about claim filing limits, see the Claim Submission and Processing provider reference module at in.gov/medicaid/providers.
  - Documentation must be maintained in the file to establish that the member was billed or information was requested within the timely filing limit.
- The provider may bill the amount credited to the member's waiver liability as identified on the Remittance Advice (RA), following the final adjudication of the claim.

continued

Exceptions that allow for billing IHCP members (continued)

- The service is not covered by the member's benefit plan, such as services not related to family planning for Family Planning Eligibility Program members, or nonemergency transportation services for Package E – Emergency Services Only members. A waiver is not required.
- The service required PA but the authorization was denied by the IHCP.
- Services exceed a benefit limit when PA is not available to receive additional services.
- A hospital may bill a member for services if the hospital's utilization review (UR) committee, in accordance with *Code of Federal Regulations* 42 CFR 482.30, makes a determination that a continued stay is not medically necessary. The determination must comply with the requirements of *42 CFR 482.30(d)(1)*, which states:

  - The determination that a continued stay is not medically necessary:
    - May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified in 42 CFR 482.12(c), concur with the determination or fail to present their views when afforded the opportunity; and
    - Must be made by at least two members of the UR committee in all other cases.
  - Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner or practitioners responsible for care of the patient, as specified in *42 CFR 482.12(c)*, and afford the practitioner or practitioners the opportunity to present their views.
- If the UR committee decides that admission to, or continued stay in, the hospital is not medically necessary, the committee must give written notification no later than 2 business days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for care of the patient, as specified in *42 CFR 482.12(c)*. Additionally:
  - Before billing the patient, the provider must notify the patient or his or her healthcare representative in writing that the patient will be responsible for the cost of services provided after the date of the notice.
  - Providers should consult with their attorneys or other advisors about any questions concerning their responsibilities in the UR process.

Missed appointments

IHCP providers may not charge IHCP members for missed appointments. This policy is based on the reasoning that a missed appointment is not a distinct reimbursable service, but a part of the provider's overall costs of doing business. Additionally, according to 405 IAC 5-25-2, the IHCP will not reimburse a physician for missed appointments.

continued

Copies or transfers of medical records

IHCP providers are not permitted to charge members for copies or transfers of medical records, including mailing costs. IHCP reimbursement for services is intended to cover certain overhead costs. Providers do not receive additional reimbursement from the State or authorized agents for the State, for any cost associated with medical record duplications or medical record transfers, except for members in the Medical Review Team (MRT) benefit plan. The IHCP considers a physician who charges Medicaid patients for copying or transferring medical records to be in violation of federal regulation and his or her *IHCP Rendering Provider Agreement*.

For more information about billing Medicaid members, see the *Provider and Member Utilization Review* and the *Provider Enrollment* provider reference modules at in.gov/medicaid/providers.

QUESTIONS?

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

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