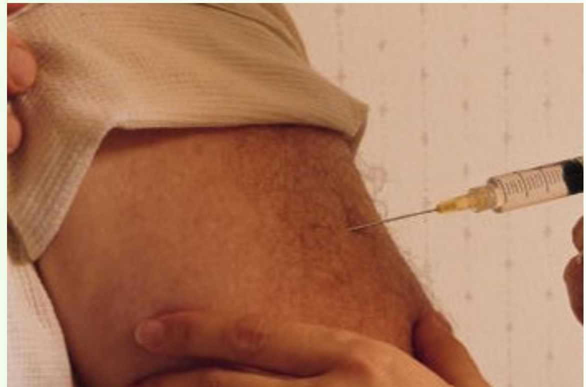
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202138 SEPTEMBER 21, 2021

IHCP to cover HCPCS code C9047



Effective Oct. 22, 2021, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code C9047 – *Injection, caplacizumab-yhdp, 1 mg*.

Coverage for this physician-administered drug (PAD) applies to professional claims (*CMS-1500* form or electronic equivalent) and outpatient claims (*UB-04* form or electronic equivalent) with dates of service (DOS) on or after Oct. 22, 2021. Coverage applies to all Traditional Medicaid and other IHCP programs that include full Medicaid State Plan benefits. This procedure code may not be covered under IHCP plans with limited benefits.

The following reimbursement information applies:

- Pricing: Maximum fee of $696.82
- 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. It will also be updated in the *Procedure Codes That Require NDCs* and the *Revenue Codes with Special Procedure Code Linkages* code tables, available from the Code Sets page at in.gov/medicaid/providers.

MORE IN THIS ISSUE

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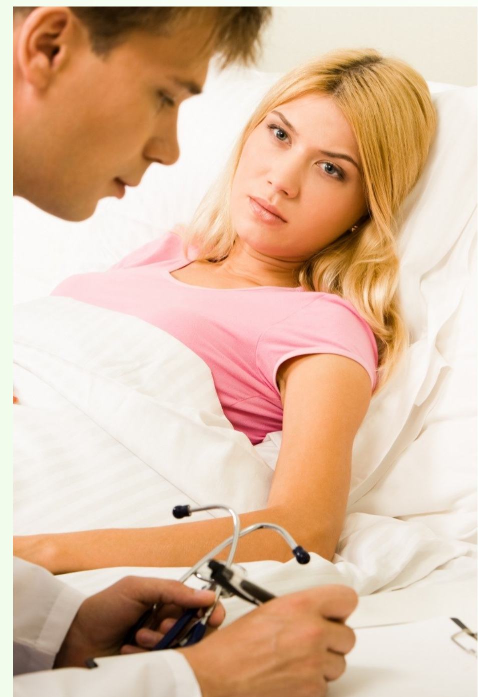
New EOB for HMS adjustments

The Indiana Health Coverage Programs (IHCP) created new explanation of benefits (EOB) code 8238 – *Recoupment due to identification of TPL or Medicare benefits under the HMS disallowance process effective* for fee-for-service (FFS) claims processed on or after October 1, 2021.

The *Code of Federal Regulations 42 CFR §433 Subpart D* requires Medicaid to bill potential third-party liability (TPL) insurers to ensure that Medicaid is the payer of last resort. HMS identifies and adjusts IHCP paid claims where the member has Medicare or TPL coverage at the time the Medicaid claim was paid. The new EOB 8238 will identify these adjustments on the provider Remittance Advice (RA).

For additional information about the HMS Disallowance Project, see *IHCP Bulletin* BT202117.

Prior authorization no longer required for outpatient claims for CPT 94668



Effective Oct. 21, 2021, the Indiana Health Coverage Programs (IHCP) will no longer require prior authorization (PA) on institutional claims for Current Procedural Terminology (CPT®[1]) code 94668 – *Manual maneuvers to chest wall to assist movement of lung secretions*. This change applies to all IHCP programs for dates of service (DOS) on or after Oct. 21, 2021.

This change will be reflected in the next regular update to the Outpatient Fee Schedule, accessible from the IHCP Fee Schedules page at in.gov/medicaid/providers.

This reimbursement information applies to services delivered under the fee-for-service (FFS) delivery system, as well as to certain services delivered under the managed care delivery system. For some services, managed care entities (MCEs) may establish and publish different reimbursement, PA and billing criteria. Questions should be directed to the MCE with which the member is enrolled.

[1]*CPT copyright 2021 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

IHCP reminds providers of medical record documentation general requirements and best practices

The Office of Medicaid Policy and Planning (OMPP) Program Integrity Unit found several errors following the Payment Error Rate Measurement (PERM) revenue year (RY) 2021 audit, due to a lack of provider document retention. Indiana Health Coverage Programs (IHCP) providers are aware of the importance of proper documentation as it enables the continuity of care for members between healthcare professionals, and it helps providers comply with federal and state laws. The OMPP Program Integrity Unit is providing the following information to avoid similar errors in future federal audits and to help providers create and maintain proper records.

In accordance with *Indiana Administrative Code* *405 IAC 1-1.4-2*, all IHCP providers shall maintain medical and other records of services provided to IHCP members for a period of seven years from the date of service. These records must be of sufficient quality to fully disclose and document the extent of services rendered. Records must be documented at the time services are provided or rendered, and prior to submitting the associated claim for reimbursement. For more information on the timeliness of documentation please see *IHCP Banner Page* BR201915.

Medical record documentation requirements

Medical record documentation should meet IHCP rules and include:

- The identity of the member the service is being rendered to
- The identity of the provider rendering or ordering service
- The date the service was rendered or ordered
- Diagnosis of the medical condition of the member that is receiving services
- Active treatment, including the physician's progress notes as to the ongoing evaluations to assess progress and redefine goals
- Medical necessity and justification for the treatment and clinical rationale
- The location where services were rendered
- The signatures or initials of the rendering or ordering provider and the providers employees rendering services, per IHCP policy
- A detailed statement describing services rendered, including duration of services rendered
- X-rays, mammograms, electrocardiograms, ultrasounds and other electronic imaging records
- Fully disclosed and documented extent of the services provided to the Medicaid member

Information must be documented at the time the services are provided or rendered, and prior to the associated claim submission.

continued

Best practices

The OMPP Program Integrity Unit is providing the following best practices as recommendations based on findings and issues noted from prior audits:

- Make sure documentation is complete, concise, accurate and legible.
- Make sure documentation is signed and dated.
- Make sure documentation supports the appropriate procedure codes, diagnoses codes, modifiers and units, per IHCP policy.
- Make sure documentation reflects all member and provider information.
- Make sure documentation reflects a qualified billing and rendering provider.
- Document services during the encounter or as soon as practicable after the encounter.
- Develop and implement a medical record documentation policy if there is not one in place.
- Regularly check the medical record documentation policy to make sure that it complies with federal and state regulations.
- Regularly audit your medical records.
- With electronic health records (EHRs), you may need to take some extra cautions:
  - Make sure all notes have a date and time stamp.
  - Recognize each visit as a standalone record and ensure documentation reflects the level of service provided.
  - Create policies and procedures to ensure documentation integrity.

Additional service-specific documentation requirements are specified in IHCP provider reference modules, as well as in IHCP provider bulletins and banner pages, the *IAC*, and statutes. Modules, bulletins and banner pages are available on the *Provider Reference Materials* page at in.gov/medicaid/providers.

QUESTIONS?

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