

IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS

BR202050

DECEMBER 15, 2020

IHCP to cover HCPCS code B4105

Effective January 15, 2021, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code B4105 – *In-line cartridge containing digestive enzyme(s) for enteral feeding, each*.

Coverage 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 January 15, 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: Manually priced at 75% of submitted manufacturer's suggested retail price (MSRP) or 120% of submitted cost invoice
- Prior Authorization (PA): Required

PA is required for all digestive enzyme cartridges for use with enteral tube feeding. For IHCP approval and coverage of initial requests up to 3 months, all the following criteria must be met:

- Diagnosis of cystic fibrosis and exocrine pancreatic insufficiency (EPI)
- Evidence of failed standard pancreatic enzyme therapy (defined as not meeting target weight gain for a minimum period of 6 weeks)



continued

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- Requires nightly continuous tube feedings through gastrostomy tube no less than three times weekly to achieve goal caloric intake
- For the initial PA or extensions of initial PA, providers must include additional documentation to support medical necessity of the following orders:
 - The need for special nutrients
 - The need for a pump; see the *Parenteral and Enteral Nutrition Pumps for Home Infusion* section of the [Durable and Home Medical Equipment and Supplies](#) provider reference module at in.gov/medicaid/providers.

■ Billing guidance:

- Allowable for provider specialty 250 – *Durable Medical Equipment (DME)/Medical Supply Dealer*
- Reimbursable in the outpatient setting
- Professional claims must include an attachment of the MSRP or cost invoice.

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 coverage will be reflected in the next regular update to the *Professional Fee Schedule* and the *Outpatient Fee Schedule*, accessible from the [IHCP Fee Schedules](#) web page at in.gov/medicaid/providers. This information will also be reflected in the *Durable and Home Medical Equipment and Supplies Codes* and the *Procedure Codes That Require Attachments*, available from the [Code Sets](#) page.

IHCP to mass reprocess or mass adjust inpatient claims for certain ICD-10 procedure codes that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects fee-for-service (FFS) inpatient claims for the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) codes in Table 1, with dates of service (DOS) from October 1, 2020, through November 2, 2020. Claims for these procedure codes may have denied incorrectly for explanation of benefits (EOB) 4067 – *ICD Proc Code not effective for DOS (HDR)*.

The claim-processing system has been corrected. Claims or claim details processed during the indicated time frame for the ICD-10 procedure codes in [Table 1](#) that denied for EOB 4067 will be mass reprocessed or mass adjusted, as appropriate. Providers should see reprocessed or adjusted claims on Remittance Advices (RAs) beginning January 20, 2021, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims) or 52 (mass replacements non-check related).



continued

Table 1 – ICD-10 procedure codes that denied inappropriately for claims with DOS from October 1, 2020 through November 2, 2020

| Procedure code | Description |
|-----------------------|--|
| XW013F5 | Introduce New Tech Therap in Subcu, Perc, New Tech 5 |
| XW033E5 | Introduce Remdesivir in Periph Vein, Perc, New Tech 5 |
| XW033F5 | Introduce New Tech Therap in Periph Vein, Perc, New Tech 5 |
| XW033G5 | Introduce Sarilumab in Periph Vein, Perc, New Tech 5 |
| XW033H5 | Introduce Tocilizumab in Periph Vein, Perc, New Tech 5 |
| XW043E5 | Introduce Remdesivir in Central Vein, Perc, New Tech 5 |
| XW043F5 | Introduce New Tech Therap in Central Vein, Perc, New Tech 5 |
| XW043G5 | Introduce Sarilumab in Central Vein, Perc, New Tech 5 |
| XW043H5 | Introduce Tocilizumab in Central Vein, Perc, New Tech 5 |
| XW0DXF5 | Introduce New Tech Therap in Mouth/Phar, Extern, New Tech 5 |
| XW13325 | Transfuse Convalesc Plasma in Periph Vein, Perc, New Tech 5 |
| XW14325 | Transfuse Convalesc Plasma in Central Vein, Perc, New Tech 5 |

IHCP to mass reprocess or mass adjust professional claims for certain medical supplies that denied inappropriately

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects professional claims for the Healthcare Common Procedure Coding System (HCPCS) codes in Table 2. Claims processed from February 13, 2017, through October 28, 2020, may have denied inappropriately for explanation of benefit (EOB) 4013 – *This procedure code is not covered for this date of service.*

The claim-processing system has been corrected. Claims or claim details processed during the indicated time frame for the codes in Table 2 that denied incorrectly with EOB 4013 will be mass reprocessed or mass adjusted as appropriate. Providers should see the reprocessed or adjusted claims on Remittance Advices (RAs) beginning December 30, 2020, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims) or 52 (mass replacements non-check related).

Table 2 – Procedure codes that may have denied inappropriately for claims processed from February 13, 2017, through October 28, 2020

| Procedure code | Description |
|-----------------------|---|
| A4435 | Ostomy pouch, drainable, high output, with extended wear barrier (one-piece system), with or without filter, each |
| A5056 | Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each |
| A5083 | Continent device, stoma absorptive cover for continent stoma |

Providers may resubmit claims for FSW and MFP-FSW services that denied incorrectly

The Indiana Health Coverage Programs (IHCP) identified a claim-processing issue that affects fee-for-service (FFS) claims for the Family Supports Waiver (FSW) and Money Follows the Person Family Supports Waiver (MFP-FSW) procedure code and modifier combinations in Table 3 for claims with dates of service (DOS) from July 16, 2020, through October 13, 2020. Claim details for these services may have denied incorrectly with explanation of benefits (EOB) 4021 – *Procedure code is not covered for the dates of service for the program billed. Please verify and resubmit.*



The claim-processing system has been corrected. Beginning immediately, providers may resubmit FFS claims for the procedure code and modifier combinations in Table 3 processed during the indicated time frame that may have denied incorrectly with EOB 4021, for reimbursement consideration. Claims resubmitted beyond the original filing limit must include a copy of this banner page as an attachment and must be submitted within 180 days of the banner page’s publication date.

As announced in *IHCP Bulletin BT202083*, the services were added to FSW, effective for claims with DOS on or after July 16, 2020. These changes are reflected in the *Professional Fee Schedule*, accessible from the [IHCP Fee Schedules](#) page at in.gov/medicaid/providers.

Table 3 – Procedure codes for FSW and MFP-FSW services that may have denied inappropriately for claims with DOS from July 16, 2020, through October 13, 2020

| Service | Code | Modifiers |
|--------------------------------------|-------|-----------|
| Environmental Modification, Install | S5165 | U7 U5 NU |
| Environmental Modification, Maintain | S5165 | U7 U5 U8 |
| Remote Supports, 1 Participant | A9279 | U7 U5 UA |
| Remote Supports, 2 Participants | A9279 | U7 U5 U2 |
| Remote Supports, 3 Participants | A9279 | U7 U5 U3 |
| Remote Supports, 4 Participants | A9279 | U7 U5 U4 |

Certain procedure codes no longer inpatient-only, reimbursement of claims that denied

Effective January 20, 2021, the Indiana Health Coverage Programs (IHCP) will update the claim-processing system (CoreMMIS) for pricing on the outpatient services in [Table 4](#) and [Table 5](#) below. The Current Procedural Terminology (CPT^{®1}) codes for the services were previously identified as Inpatient-Only (IPO) on the *IHCP Outpatient Fee Schedule*. In order to better align reimbursement of outpatient services with nationwide standards, the IHCP will follow Medically Unlikely Edits (MUEs) for Medicaid services.

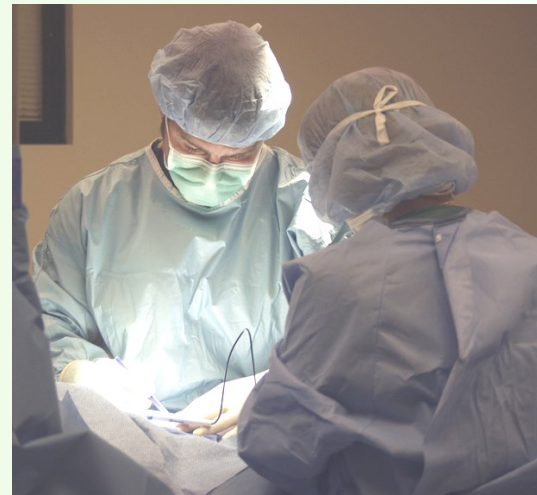
continued

Pricing for the procedure codes in Table 4 and [Table 5](#) for outpatient services is retroactively effective for claims with dates of service (DOS) on or after **January 1, 2020**.

This banner page article supersedes previously published guidance, and revises guidance in the *Inpatient Hospital Services* provider reference module, accessible from in.gov/medicaid/providers.

The IHCP identified a claim-processing issue that affects fee-for-service (FFS) outpatient claims for the procedure codes in Tables 4 and 5, for claims with DOS on or after January 1, 2020. Claims or claim details for the codes may have denied for one of the following explanation of benefits (EOB):

- 4013 – This procedure code is not covered for this date of service
- 4801– Procedure code not covered for benefit plan



The claim-processing system has been updated. Claims processed during the indicated time frame for the codes that denied for EOB 4013 or EOB 4801 will be mass reprocessed or mass adjusted, as appropriate. Providers should see reprocessed or adjusted claims on Remittance Advices (RAs) beginning February 3, 2021, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claim) or 52 (mass replacements non-check related).

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.

This information 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.

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Table 4 – Procedure codes with manual pricing reimbursable in the outpatient setting, effective retroactively for claims with DOS on or after January 1, 2020

| Procedure code | Description | Manual pricing (percentage of billed amount) |
|----------------|--|--|
| 21602 | Removal of tumor from chest wall including ribs with plastic reconstruction | 10% |
| 21603 | Removal of tumor from chest wall including ribs with plastic reconstruction and removal of lymph nodes from chest cavity | 10% |
| 22634 | Fusion of lower spine bones with removal of disc, posterior or posterolateral approach | 10% |

continued

Table 4 – Procedure codes with manual pricing reimbursable in the outpatient setting, effective retroactively for claims with DOS on or after January 1, 2020 (continued)

| Procedure code | Description | Manual pricing (percentage of billed amount) |
|-----------------------|--|---|
| 33017 | Drainage of heart sac with insertion of catheter accessed through skin, using fluoroscopy and/or ultrasound guidance imaging guidance, in patient 6 years or older | 10% |
| 33018 | Drainage of heart sac with insertion of catheter accessed through skin, using fluoroscopy and/or ultrasound guidance imaging guidance, in patient 5 years or older or any age with congenital heart defect | 10% |
| 33019 | Drainage of heart sac with insertion of catheter accessed through skin, using imaging guidance, using CT imaging guidance | 10% |
| 33858 | Repair of ascending aorta with graft on heart-lung machine, for separation of wall of aorta (dissection) | 10% |
| 33859 | Repair of ascending aorta with graft on heart-lung machine, for disease other than separation of wall of aorta (dissection) | 10% |
| 33871 | Repair of transverse arch of aorta with graft on heart-lung machine | 10% |
| 34717 | Repair of groin artery on one side with graft inserted through artery, performed at same time as repair of aorta | 10% |
| 34718 | Repair of groin artery on one side with graft inserted through artery, performed at same time as repair of aorta | 10% |
| 35702 | Exploration of artery of arm | 10% |
| 35703 | Exploration of artery of leg | 10% |
| 49013 | Exploration and packing of wound in pelvic region | 15% |
| 49014 | Re-exploration of wound in pelvic region with removal of wound packing and repacking, if necessary | 15% |

Table 5 – Procedure codes with ambulatory surgical center (ASC) pricing reimbursable in the outpatient setting, effective retroactively for claims with DOS on or after January 1, 2020

| Procedure code | Description | ASC pricing code |
|-----------------------|--|-------------------------|
| 22633 | Fusion of lower spine bones with removal of disc, posterior or posterolateral approach | M |
| 27130 | Replacement of thigh bone and hip joint prosthesis | M |
| 30801 | Destruction of soft tissue of nasal passages | 8 |
| 63265 | Removal of upper spine bone and growth | G |
| 63266 | Removal of middle spine bone and growth | G |
| 63267 | Removal of lower spine bone and growth | G |
| 63268 | Removal of sacral spine bone and growth | G |

IHCP to update mileage rate for HCPCS code A0090

Effective immediately, the Indiana Health Coverage Programs (IHCP) will update the mileage rate for Healthcare Common Procedure Coding System (HCPCS) code A0090 – *Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest*. The rate is increasing from \$0.38 per mile to \$0.39 per mile, retroactive to March 1, 2020, and is being updated in the claim-processing system (CoreMMIS) and the *IHCP Professional Fee Schedule*. The mileage rate for code A0090 is tied to the mileage rate State employees receive, and the Indiana Department of Administration (IDOA) increased the mileage reimbursement for State employees to \$0.39, effective March 1, 2020.



As a reminder, IHCP members served via the fee-for-service (FFS) delivery system receive nonemergency transportation (NEMT) services brokered through Southeastrans. There are no changes to the reimbursement rate by Southeastrans.

Within the managed care delivery system, individual managed care entities (MCEs) establish their own coverage criteria, prior authorization (PA) requirements, billing procedures, and reimbursement methodologies. For questions about services covered under the managed care delivery system, providers should contact the member’s MCE or refer to the MCE provider manual.

The change is to reflect the updated rate by the IDOA on the *Professional Fee Schedule*, accessible from the [IHCP Fee Schedules](#) page at in.gov/medicaid/providers.

IHCP will add noncovered procedure codes to Professional Fee Schedule

The Indiana Health Coverage Programs (IHCP) will update the *Professional Fee Schedule* to include the noncovered Healthcare Common Procedure Coding System (HCPCS) codes and Current Procedural Terminology (CPT^{®1}) codes in Table 6, to align with the claim-processing system (CoreMMIS).

This information 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.

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Table 6 – Noncovered procedure codes to be included in the Professional Fee Schedule

| Procedure code | Description |
|----------------|--|
| 0101T | High energy shock wave therapy of musculoskeletal system |
| 0394T | High dose rate electronic brachytherapy |
| 0395T | High dose rate electronic brachytherapy |
| 10040 | Acne surgery |
| 54411 | Removal and replacement of infected components of inflatable penile prosthesis |

continued

Table 6 – Noncovered procedure codes to be included in the Professional Fee Schedule (continued)

| Procedure code | Description |
|----------------|--|
| 54417 | Removal and replacement of infected non-inflatable penile prosthesis |
| 89320 | Semen evaluation volume, sperm count, motility and analysis |
| 99360 | Prolonged physician standby service, each 30 minutes |
| 99500 | Home visit for assessment and monitoring of pregnancy, fetal heart rate and diabetes status |
| 99503 | Home visit for respiratory therapy care |
| 99505 | Home visit for care of large bowel or bladder opening |
| 99506 | Home visit for injections into a muscle |
| 99507 | Home visit for care and maintenance of catheters |
| 99510 | Home visit for individual, family, or marriage counseling |
| 99511 | Home visit for impacted stool management and enema administration |
| A0160 | Non-emergency transportation: per mile - case worker or social worker |
| D2951 | Pin retention-per tooth, in addition to restoration |
| G0498 | Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/ clinic setting using office/clinic pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/clinic, includes follow up office/clinic visit at the conclusion of the infusion |
| G8882 | Sentinel lymph node biopsy procedure not performed, reason not given |
| G9361 | Medical indication for induction [documentation of reason(s) for elective delivery (c-section) or early induction (e.g., hemorrhage and placental complications, hypertension, preeclampsia and eclampsia, rupture of membranes-premature or prolonged, maternal conditions complicating pregnancy/delivery, fetal conditions complicating pregnancy/delivery, late pregnancy, prior uterine surgery, or participation in clinical trial)] |
| S8265 | Haberman feeder for cleft lip/palate |

IHCP to update case management code T1016 billed with modifier HH as noncovered

Effective January 15, 2021, the Indiana Health Coverage Programs (IHCP) will update the claim-processing system (CoreMMIS) to make the following code and modifier combination noncovered: Healthcare Common Procedure Coding System (HCPCS) code T1016 – *Case management, each 15 minutes when billed with modifier HH – Integrated mental health/substance abuse program*. This change is to align with IHCP policy.

No previous claims for the code and modifier combination T1016 HH are affected by this update.



This revision 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.

Sandata EVV webinar (virtual training) sessions available January 2021

The *21st Century Cures Act* directs state Medicaid programs to require personal care service and home health service providers to use an Electronic Visit Verification (EVV) system to document the services rendered. For more information and resources, see the [Electronic Visit Verification](https://www.in.gov/medicaid/providers) web page at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers).

Required training

Enrolled providers are required to complete EVV training before receiving their Sandata EVV Portal Welcome Kits, which will include their EVV login credentials. Each provider or agency will enroll no more than two representatives per IHCP Provider ID to attend a training session. Training will be completed using the train-the-trainer (TTT) approach (model) so that those attending training can then train other EVV Portal administrators and caregivers within their organizations. It is expected that one of the training representatives will be an EVV administrator.

Because of the current public health emergency for the coronavirus disease 2019 (COVID-19), instructor-led classroom sessions are not available. However, webinar (virtual training) sessions will be available in January 2021 as shown in [Table 7](#).



Readiness

Providers are strongly encouraged to review the checklist in *Indiana Health Coverage Programs (IHCP) Bulletin BT201942* in preparation for implementing an EVV system.

Note: The federal requirement for providers of personal services to use an EVV system for documenting services rendered was changed to January 1, 2021, after the bulletin was published. Personal care services providers and agencies should complete all steps outlined in [BT201942](#) before January 1, 2021.

Registration

To register for a webinar session, follow the steps in the Indiana Family and Social Services Administration (FSSA) *EVV Agency Provider Training Registration Quick Reference Guide (QRG)* located on the [Electronic Visit Verification Training](#) page at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers). Providers are encouraged to register early because webinar class sizes are limited, and sessions are expected to fill quickly.

EVV webinar sessions dates and times

Each webinar session will consist of 2 hours of training each day, for 3 consecutive days, allowing for some flexibility around providers' schedules. Providers will be required to complete **all** three days of webinar sessions before receiving their welcome kits.

See [Table 7](#) for training session dates and times. Each session is limited to 100 attendees, so please register early to reserve your training.

continued

Table 7 – EVV webinar (virtual training) sessions

| Date (3 consecutive days) | Eastern Time |
|---------------------------|-----------------|
| January 12 – 14, 2021 | 1 p.m. – 3 p.m. |
| January 26 – 28, 2021 | 1 p.m. – 3 p.m. |

More information

More information will be available in future IHCP communications. For any immediate concerns or questions, please email <mailto:mEVV@fssa.in.gov>.

QUESTIONS?

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

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