IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR202116 APRIL 20, 2021

IHCP revises pricing and billing guidance for HCPCS code P9603

Effective May 20, 2021, the Indiana Health Coverage Programs (IHCP) will update pricing for Healthcare Common Procedure Coding System (HCPCS) code P9603 – *Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated miles actually travelled*. Pricing for code P9603 will change from 90% of billed charges to a maximum fee of $1.01. This change applies to fee-for-service (FFS) 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 20, 2021.

As a result of this change to reimbursement, the IHCP is announcing new guidance on the correct use and billing of HCPCS code P9603. The new IHCP guidance, effective for claims with DOS on or after May 20, 2021, aligns with longstanding guidance from Medicare relating to P9603.

The travel allowance is intended to cover the provider's estimated travel costs for collecting a specimen, including the laboratory technician's salary and travel expenses. The per mile travel allowance is to be used in situations when the average trip to the patients' homes is farther than 20 miles round trip, and is to be prorated in situations when specimens are drawn from non-Medicaid members (patients) in the same trip. (See the examples below.) In no situation will the laboratory be reimbursed for billing more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

When one trip is made for multiple specimen collections (to a nursing home, for instance), the travel payment component is prorated based on the number of specimens collected in that trip, for both Medicaid and non-Medicaid members.

Examples for billing:

Example 1: A laboratory technician travels 60 miles round trip from the laboratory in a city to a remote rural location, and back to the laboratory to draw one Medicaid member's blood. The claim submitted should be for $60.60 (60 miles x $1.01 a mile), plus the specimen collection fee.

Example 2: A laboratory technician travels 40 miles from the laboratory to a Medicaid member's home to draw blood, next travels an additional 10 miles to a non-Medicaid member's home, and then travels 30 miles to return to the laboratory. The total miles traveled would be 80 miles. The claim submitted should be for half of the miles traveled or $40.40 (40 x $1.01), plus the specimen collection fee.

continued

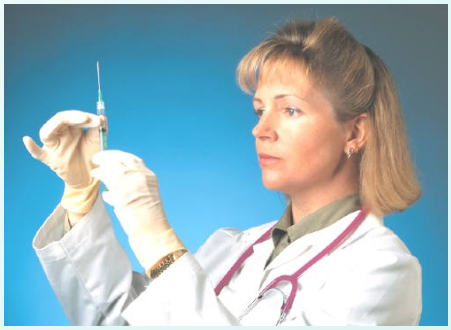
MORE IN THIS ISSUE

This 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.

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

IHCP updates reimbursement and billing guidance for HCPCS code J7169 (Andexxa)

Effective for claims with dates of service (DOS) on or after May 21, 2021, the Indiana Health Coverage Programs (IHCP) is revising its guidance for billing Healthcare Common Procedure Coding System (HCPCS) code J7169 – *Injection coagulation factor Xa (recombinant), inactivated-zhzo (Andexxa), 10 mg*. Andexxa is no longer classified as an antihemophilia agent, and coverage will no longer be carved out of managed care benefits or the inpatient diagnosis-related group (DRG).



All claims (through the member's medical or pharmacy benefit) and prior authorization (PA) for Andexxa, prescribed for or administered to members with managed care benefits, must be submitted to the member's managed care entity (MCE).

Medical benefit claims for Andexxa

The IHCP is revising reimbursement for HCPCS code J7169 (Andexxa). Because Andexxa is no longer considered an antihemophilia agent, the following reimbursement information replaces the previous information published in *IHCP Bulletin BT202084*. These changes apply to fee-for-service (FFS) professional claims (*CMS-1500* form or electronic equivalent) and outpatient claims (*UB-04* form or electronic equivalent) with (DOS) on or after May 21, 2021.

The following reimbursement information applies:

- Pricing: Maximum fee of $288.75
- 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.
  - Not carved out of managed care
  - Not carved out of the inpatient DRG

This information 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, and to the *Physician-Administered Drugs Carved Out of Managed Care and Reimbursable Outside the Inpatient DRG* code table, available from the *Code Sets* page.

continued

Pharmacy benefit claims for Andexxa

Andexxa point-of-sale (POS) pharmacy claim submissions for FFS members will remain unchanged. The FFS pharmacy benefit currently has no PA criteria. Andexxa PA requirements and POS pharmacy claim submissions for members with managed care benefits will follow the same processes used for drugs not carved out.

This reimbursement and PA 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 should be directed to the MCE with which the member is enrolled.

IHCP will add procedure codes to *Professional Fee Schedule*

Effective immediately, the Indiana Health Coverage Programs (IHCP) will update the *Professional Fee Schedule* to include the Healthcare Common Procedure Coding System (HCPCS) codes in Table 1, to align with the claim-processing system (*Core*MMIS). These codes are covered and have a reimbursement of $0.00 when billed on a professional claim (*CMS-1500* form or electronic equivalent).

The codes in Table 1 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 to be included in the Professional Fee Schedule, effective immediately

Procedure code	Description
C9352	Microporous collagen implantable tube (neuragen nerve guide), per centimeter length
C9353	Microporous collagen implantable slit tube (neurawrap nerve protector), per centimeter length
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch
C9601	Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)
C9602	Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch
C9603	Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)
C9604	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel
C9605	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (list separately in addition to code for primary procedure)

continued

Table 1 – Procedure codes to be included in the Professional Fee Schedule, effective immediately (continued)

Procedure code	Description
C9606	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel
C9607	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel
C9608	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure)
C9739	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants
C9740	Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants

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