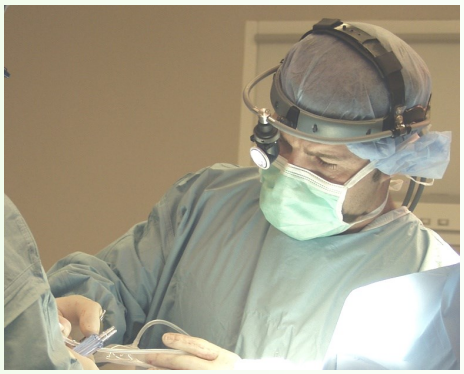
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202131 AUGUST 3, 2021

IHCP to cover HCPCS codes G2170 and G2171

Effective September 3, 2021, the Indiana Health Coverage Programs (IHCP) will cover the following Healthcare Common Procedure Coding System (HCPCS) codes for surgical procedures, percutaneous arteriovenous fistula creation (AVF):

- G2170 – *Percutaneous arteriovenous fistula creation (AVF), direct, any site, by tissue approximation using thermal resistance energy, and secondary procedures to redirect blood flow (e.g., transluminal balloon angioplasty, coil embolization) when performed, and includes all imaging and radiologic guidance, supervision and interpretation, when performed*
- G2171 – *Percutaneous arteriovenous fistula creation (AVF), direct, any site, using magnetic-guided arterial and venous catheters and radiofrequency energy, including flow-directing procedures (e.g., vascular coil embolization with radiologic supervision and interpretation, when performed) and fistulogram(s), angiography, venography, and/or ultrasound, with radiologic supervision and interpretation, when performed*



Coverage applies to fee-for-service (FFS) 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 September 3, 2021. Coverage applies to all Traditional Medicaid and other IHCP programs that include full Medicaid State Plan benefits. These procedure codes may not be covered under IHCP plans with limited benefits.

The following reimbursement information applies:

- Pricing:
  - ⇒ Professional (physician): 90% of billed charges
  - ⇒ Outpatient: Maximum fee
- Prior authorization (PA): None required
- Billing guidance: Standard billing guidance applies.

continued

MORE IN THIS ISSUE

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 change 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.

Reimbursement update for COVID-19 treatment code Q0247 (Sotrovimab)

The Indiana Health Coverage Programs (IHCP) covers Healthcare Common Procedure Coding System (HCPCS) code Q0247 – *Injection, sotrovimab, 500 mg*, as announced in *Bulletin BT202156*. As also stated in *BT202156*, code Q0247 had not yet been assigned pricing. (All other billing guidance in the bulletin for code Q0247 was complete and remains unchanged.)

Effective June 21, 2021, the maximum fee for procedure code Q0247 is $2,205. This pricing applies retroactively to fee-for-service (FFS) professional claims (*CMS-1500* claim form or electronic equivalent) and institutional claims (*UB-04* claim form or electronic equivalent) with dates of service (DOS) on or after **June 21, 2021**.

This pricing 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 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.

FFS claims or claim details for Q0247 with DOS from June 21, 2021, through July 27, 2021, may have denied incorrectly with explanation of benefits (EOB) 4014 – *Claim being reviewed for pricing*.

The claim-processing system has been updated. Beginning immediately, providers may resubmit FFS claims for code Q0247 during the indicated time frame that may have denied incorrectly with EOB 4014, 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.

IHCP revises Hospital Assessment Fee adjustment factor for inpatient psychiatric LOC rate

Effective August 1, 2021, the Indiana Health Coverage Programs (IHCP) revised the Hospital Assessment Fee (HAF) adjustment factors used for outpatient reimbursement and inpatient diagnosis-related group (DRG) reimbursement for eligible hospitals, as announced in *Banner Page BR202129*. The revised HAF adjustment factors apply within the fee-for-service (FFS) and managed care delivery systems, including reimbursement under the Healthy Indiana Plan (HIP), Hoosier Care Connect and Hoosier Healthwise programs.

Effective August 1, 2021, the inpatient psychiatric level-of-care (LOC) factor of 2.2 given in *BR202129* is changing to 3.0. This change applies retroactively to claims with dates of service (DOS) on or after **August 1, 2021**.

All other guidance in *BR202129* remains unchanged.

IHCP to allow CLIA certificate of waiver for CPT codes 87637 and 87811, accept resubmitted claims

Procedure codes associated with laboratory testing are regulated under the Clinical Laboratory Improvement Amendments (CLIA). The Indiana Health Coverage Programs (IHCP) policy requires compliance with the Centers for Medicare & Medicaid Services (CMS) recommendations regarding CLIA regulations under all IHCP programs, whether managed care or fee-for-service (FFS).

Effective immediately, the *Core*MMIS claim-processing system has been updated for the following Current Procedural Terminology (CPT®[1]) codes:

- 87637 – *Infectious agent detection by nucleic acid (dna or rna); severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), influenza virus types a and b, and respiratory syncytial virus, multiplex amplified probe technique*
- 87811– *Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19])*

Procedure codes 87637 and 87811 were considered CLIA-waived tests as of Oct. 6, 2020. Claims for these codes with dates of service (DOS) on or after Oct. 6, 2020, will be billable by laboratories that have a valid CLIA certificate of waiver. The FFS claim-processing system has been updated to classify CPT codes 87637 and 87811 as CLIA-waived tests. This change applies retroactively to claims with DOS on or after **Oct. 6, 2020**.

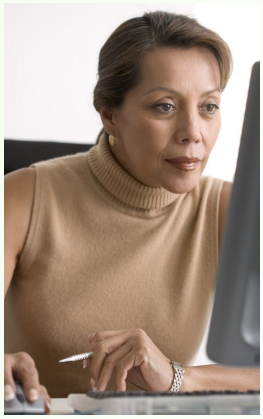
FFS claims billed for procedure codes 87637 or 87811 by providers with valid CLIA certificates of waiver may have denied inappropriately with explanation of benefits (EOB) 4207 – *Effective CLIA number not on file for dates of service billed.*

Beginning immediately, laboratory providers may resubmit claims for codes 87637 and 87811 with DOS on or after **Oct. 6, 2020**, that denied for EOB 4207, for reimbursement consideration. Claims resubmitted beyond the original filing limit must include a copy of this banner page as an attachment. Claims must be resubmitted within 180 days of this banner page's publication date.

Reimbursement, prior authorization (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 corrects *Outpatient Fee Schedule* for certain laboratory, drug and vaccine procedure codes rates

The Indiana Health Coverage Programs (IHCP) identified incorrect reimbursement rates in the fee-for-service (FFS) *Outpatient Fee Schedule* for the procedure codes in Table 1 and Table 2 below.



However, the reimbursement rates for these procedure codes were correct in the *Core*MMIS claim-processing system and clams processed correctly. Coverage and reimbursement for the procedure codes in Table 1 and Table 2 have not changed and no FFS claims are affected by this update to the fee schedule.

The correct rates, along with their effective dates, apply to the following Current Procedural Terminology (CPT®[1]) codes for laboratory services in Table 1, and to the procedure codes for drugs and vaccines in Table 2.

Table 1 – Laboratory procedure codes with correct rates and effective dates

Procedure code	Description	Correct rate ($)	Rate effective date
80424	Glucagon tolerance panel	50.50	Jan. 1, 2020
81309	Gene analysis (partner and localizer of BRCA2) targeted sequence analysis	274.83	Jan. 1, 2020
83605	Assay of lactic acid	11.57	Jan. 1, 2020
83615	Lactate dehydrogenase (LD) (LDH)	6.04	Jan. 1, 2020
83625	Assay of LDH enzymes	12.79	Jan. 1, 2020
83918	Organic acids total quant	22.39	Jan. 1, 2015
87428	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19]) and influenza virus types A and B	63.59	Nov. 10, 2020
87449	Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; multiple step method, not otherwise specified, each organism	11.98	Jan. 1, 2020
87501	infectious agent detection by nucleic acid (DNA or RNA); influenza virus, reverse transcription and amplified probe technique, each type or subtype	51.31	Jan. 1, 2020
87507	Detection test for digestive tract pathogen -IADNA-DNA/RNA Probe TQ 12-25	416.78	Jan. 1, 2020
88262	Chromosome analysis 15-20	125.49	Jan. 1, 2020
88274	Cytogenetics 25-99	42.38	Jan. 1, 2019

continued

Table 2 – Drug and vaccine procedure codes with correct rates and effective dates

Procedure code	Description	Correct rate ($)	Rate effective date
90376	Rabies immune globulin, heat-treated (RIg-HT), human, for intramuscular and/or subcutaneous use	430.76	Jan. 1, 2021
90675	Rabies vaccine, for intramuscular use	379.04	April 1, 2021
90750	Shingrix (zoster vaccine recombinant, adjuvanted)	170.11	April 1, 2021
J0888	Injection, epoetin beta, 1 microgram, (for non-ESRD use)	3.03	July 1, 2019
J1110	Injection, dihydroergotamine mesylate, per 1 mg	79.58	July 1, 2020
J2350	Injection, ocrelizumab, 1 mg	58.58	April 1, 2021
J7402	Mometasone sinus sinuva	10.67	April 1, 2021
J8521	Capecitabine, oral, 500 mg	0.53	July 1, 2020

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The corrections to rates 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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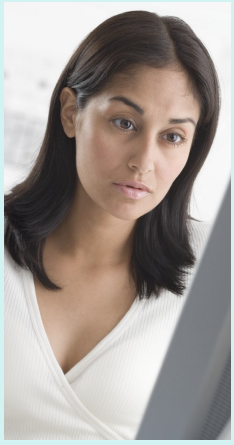
IHCP corrects *Outpatient Fee Schedule* for CPT codes 92274, 93985 and 93986



The following Current Procedural Terminology (CPT®[1]) codes are covered for fee-for-service (FFS) claims with dates of service (DOS) on or after January 1, 2021, as announced in Indiana Health Coverage Programs (IHCP) *Banner Page* *BR202113*:

- 93985 – *Ultrasound scan of blood flow in extremity on both sides of body for preoperative assessment of blood vessel for dialysis access*
- 93986 – *Ultrasound scan of blood flow in extremity on one side for preoperative assessment of blood vessel for dialysis access*

As stated in *BR202113*, both codes are covered in the outpatient setting. The reimbursement information for these codes in the *Outpatient Fee Schedule* contains an error, indicating that these two codes are not covered. However, as announced in *BR202113*, CPT codes 93985 and 93986 *are* covered and will be reimbursed according to the pricing and other information in the *Outpatient Fee Schedule*.

continued

Additionally, CPT code 92274 – *Multifocal recording of retinal electrical responses to external stimuli with interpretation and report*, was missing from the *Outpatient Fee Schedule*. Code 92274 continues to be covered for FFS outpatient claims with DOS on or after January 1, 2019. This procedure code is reimbursable when billed on an institutional claim (*UB-04* claim form or electronic equivalent). Regarding CPT codes 93985, 93986 and 92274, there are no changes to coverage or reimbursement and no FFS claims are affected by the corrections to the *Outpatient Fee Schedule*. The procedure is reimbursed at the nationally-linked revenue code's flat rate.

These corrections 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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