IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202142 OCTOBER 19, 2021

Sandata to host webinar for alternative EVV vendors

The *21st Century Cures Act* directs Medicaid programs to require personal care service and home health service providers to use an electronic visit verification (EVV) system to document services rendered. See *Indiana Health Coverage Programs (IHCP) Bulletin* BT201855 for more information.

Personal care services were required to use an EVV system by Jan. 1, 2021. Home health services will still be required to use an EVV system by Jan. 1, 2023.

The IHCP is partnering with Sandata to host a live webinar on alternative EVV vendors. The purpose of this webinar is to provide a general overview of the Sandata system and to answer presubmitted questions. The webinar will not be used to address open provider tickets. Webinar event information is as follows:

- Date: Nov. 10, 2021
- Time: 12 p.m. (noon) Eastern Time

To participate in the webinar on Nov. 10, providers should register before the event. To register, use the following link: FSSA Alternative EVV Vendor Webinar Registration.

The registration tool may be used to submit questions directly to Sandata prior to the webinar. If the question requires additional detail, please submit them before the webinar to EVV@fssa.in.gov.

Outpatient Fee Schedule correction for A4555 and E0766

Effective Oct. 29, 2020, as announced in *Indiana Health Coverage Programs (IHCP) Banner Page* BR202039, the following codes are covered:

- A4555 – *Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only*
- E0766 – *Electrical stimulation device used for cancer treatment, includes all accessories, any type*

continued

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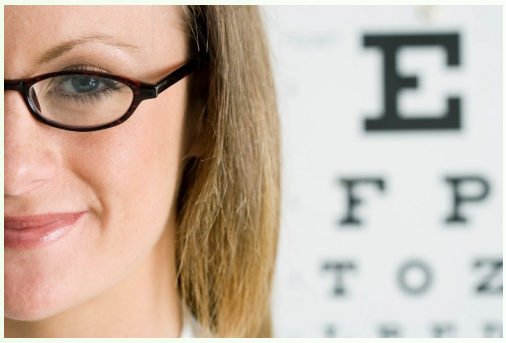
The Outpatient Fee Schedule was not updated to reflect the coverage of these codes. Both codes are separately reimbursable in the outpatient setting.

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.

Reimbursement, prior authorization (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.

IHCP removes prior authorization requirement for developmental testing codes 96112 and 96113



Effective immediately, the Indiana Health Coverage Programs (IHCP) will no longer require prior authorization (PA) for Current Procedural Terminology (CPT®[1]) developmental testing codes 96112 – *Developmental test administration, first hour* and 96113 – *Developmental test administration, additional 30 minutes*. This change applies to all IHCP programs for dates of service (DOS) on or after Oct. 19, 2021.

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

This PA and billing guidance apply to services delivered under the fee-for-service (FFS) delivery system. Individual managed care entities (MCEs) establish and publish PA and billing guidance within the managed care delivery system. Questions about managed care guidance 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 updates Outpatient Fee Schedule-prior authorization

The Indiana Health Coverage Programs (IHCP) recently reviewed the Outpatient Fee Schedule and discovered discrepancies regarding prior authorization (PA). The codes in Tables 1 and 2 require PA when billed as outpatient claims, but the Outpatient Fee Schedule indicates that PA is not required.

continued

Per *IHCP Bulletin* BT201866, the code in Table 1 requires PA when billed on outpatient claims for dates of service (DOS) on or after Jan. 1, 2019. The Outpatient Fee Schedule has indicated that PA is not required.

Table 1 – Code that requires PA on outpatient claims for DOS on or after Jan. 1, 2019

Procedure code	Description
A9513	Lutetium lu 177, dotatate, therapeutic, 1 millicurie

As stated in the *Hearing Services* provider reference module at in.gov/medicaid/providers and *Indiana Administrative Code 405 IAC 5-19-13*, PA is required for the purchase of hearing aids. The Outpatient Fee Schedule has indicated that PA is not required.

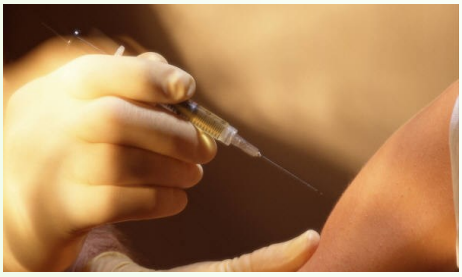
Table 2 – Codes for hearing aids that require PA on outpatient claims

Procedure code	Description
V5050	Hearing aid, monaural, in the ear
V5060	Hearing aid, monaural, behind the ear
V5140	Binaural, behind the ear
V5256	Hearing aid, digital, monaural, ite
V5257	Hearing aid, digital, monaural, bte
V5260	Hearing aid, digital, binaural, ite
V5261	Hearing aid, digital, binaural, bte

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.

Reimbursement, prior authorization (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.

IHCP announces procedure code links to revenue code 260



Effective retroactively, the Indiana Health Coverage Programs (IHCP) linked the procedure codes in Table 3 to revenue code 260 – *IV Therapy – General.* The codes were previously included in the *Core*MMIS claim-processing system. However, providers were not notified of the codes' linkage to revenue code 260. The IHCP follows national coding guidelines and the procedure codes linked to revenue code 260 follow the Office of Medicaid Policy and Planning (OMPP) uniform billing (UB) Editor.

continued

This linkage applies retroactively to outpatient claims with dates of service (DOS) on or after the date in Table 3. Beginning immediately, providers may bill the procedure codes in Table 3 and revenue code 260 together as appropriate, for reimbursement consideration. No previous fee-for-service (FFS) claims were affected.

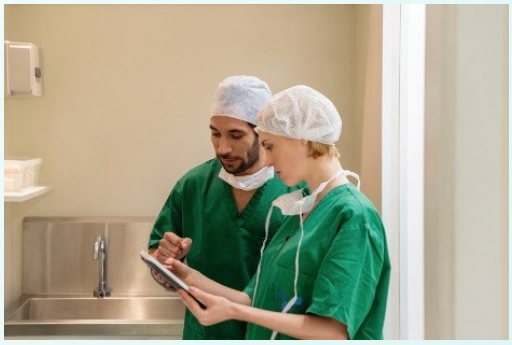
This linkage will be reflected in the next regular update to the *Revenue Codes with Special Procedure Code Linkages*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Reimbursement and billing information applies to services delivered under the FFS delivery system. Individual managed care entities (MCEs) establish and publish reimbursement 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.

Table 3 – Procedure codes linked to revenue code 260, effective retroactively for claims with DOS on or after date indicated

Procedure code	Description	Effective date
J1745	Injection, infliximab, excludes biosimilar, 10 mg	April 1, 2021
M0240	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring, subsequent repeat doses	Oct. 1, 2021
M0241	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency, subsequent repeat doses	Oct. 1, 2021
M0243	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring	April 1, 2021
M0245	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring	July 1, 2021
M0247	Intravenous infusion, sotrovimab, includes infusion and post administration monitoring	Oct. 1, 2021
M0248	Intravenous infusion, sotrovimab, includes infusion and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency	Oct. 1, 2021
M0249	Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, first dose	Oct. 1, 2021
M0250	Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, second dose	Oct. 1, 2021

Certain procedure codes now inpatient only, no longer reimbursable in outpatient setting



To better align reimbursement of outpatient services with nationwide standards, the Indiana Health Coverage Programs (IHCP) follows medically unlikely edits (MUEs) for Medicaid services. Procedure codes with a Medicaid Outpatient Hospital Services MUE of 0 are considered inpatient only (IPO) by the IHCP and are not separately reimbursable in the outpatient setting.

Some organ acquisition procedure codes listed in *IHCP Banner Page* BR201939 as reimbursable in the outpatient setting have MUEs of 0. Therefore, they are IPO codes.

The procedure codes in Table 4 are also IPO because the MUEs for the codes are 0.

Table 4 – Organ acquisition procedure codes that are IPO

Procedure code	Description
32855	Preparation of one lung from a cadaver
32856	Preparation of two cadaver lungs for transplantation
33930	Harvest of donor heart and lung
33933	Preparation of donor heart and lung for transplantation
33940	Obtaining donor cadaver heart
33944	Preparation of donor heart for transplantation
44132	Removal of donor small bowel, open procedure
44133	Partial removal of donor small bowel for transplantation, open procedure
44715	Preparation of donor small bowel for transplantation
44720	Reconstruction of donor small bowel for transplantation venous connection
44721	Reconstruction of donor small bowel for transplantation arterial connection
47133	Removal of donor liver
48551	Preparation of donor pancreas for transplantation
48552	Preparation of donor pancreas for transplantation, each
50300	Removal of donor kidney
50320	Removal of donor kidney, open procedure
50323	Preparation of donor kidney for transplantation
50325	Preparation of donor kidney for transplantation, open or endoscopic procedure

continued

Table 4 – Organ acquisition procedure codes that are IPO (continued)

50327	Preparation of donor kidney for transplantation, venous connection
50328	Preparation of donor kidney for transplantation, arterial connection
50329	Preparation of donor kidney for transplantation, ureteral connection

Table 5 – Additional procedure codes that are IPO

Procedure code	Description
0554T	Bone strength and fracture risk assessment: retrieval and transmission of CT scan data, assessment of bone strength and fracture risk and bone mineral density, interpretation and report
0557T	Bone strength and fracture risk assessment: interpretation and report
0582T	High-energy water vapor heat destruction of malignant prostate tissue, including imaging and needle guidance
A4255	Platforms for home blood glucose monitor, 50 per box
A4257	Replacement lens shield cartridge for use with laser skin piercing device, each
C2637	Brachytherapy source, non-stranded, ytterbium-169, per source

This reimbursement information applies to services delivered under the fee-for-service (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 Outpatient Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

Sum of all payors added to remittance advice on FQHC/RHC professional claims

The Indiana Health Coverage Programs (IHCP) has updated the provider remittance advice (RA) for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) claims to include a new field for the sum of all payors. This field displays Managed Care payments and Third Party Liability (TPL) information at the detail level on a claim-by-claim basis. Additionally, a total of the sum of all payors will display on the RA. Effective Oct. 13, 2021, providers began to see the Sum of All Payors on the RA as seen in Figure 1.

Figure 1

REPORT: CRA-WPPY-R
RA#: XXXXXXX
PAYER: TXIX

INDIANA CORE MMIS
INDIANA TITLE XIX
PROVIDER REMITTANCE ADVICE
WRAP PAYMENTS EXPENDITURES

DATE: MM/DD/YYYY
PAGE: XXX

PROVIDER NAME
PROVIDER ADDRESS
CITY, STATE ZIP-ZIP FOUR

PAYEE ID XXXXXXXXXA MCD
NPI XXXXXXXXXX
PAYMENT NUMBER XXXXXXXXX
PAYMENT DATE MM/DD/YYYY

MEMBER NO.	--ICN--	PATIENT NO.	MCE ID	SERVICE DATES FROM TO	BILLED AMT	SUM OF ALL PAYORS AMT	WRAP AMT	TRANSACTION NUMBER
XXXXXXXXXX99	7021XXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXX	MMDDYY MMDDYY	9,999,999.99	9,999,999.99	9,999,999.99	9999999999
XXXXXXXXXX99	7021XXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXX	MMDDYY MMDDYY	9,999,999.99	9,999,999.99	9,999,999.99	9999999999
XXXXXXXXXX99	7021XXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXX	MMDDYY MMDDYY	9,999,999.99	9,999,999.99	9,999,999.99	9999999999
XXXXXXXXXX99	7021XXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXX	MMDDYY MMDDYY	9,999,999.99	9,999,999.99	9,999,999.99	9999999999
			TOTAL WRAP PAYMENT SERVICES PAID:		99,999,999.99	99,999,999.99	99,999,999.99	

TOTAL NO. PAID: 9,999,999

REPORT: CRA-WPAD-R
RA#: 2188629
PAYER: TXIX

INDIANA CORE MMIS
INDIANA TITLE XIX
PROVIDER REMITTANCE ADVICE
WRAP PAYMENTS ADJUSTMENTS

DATE: MM/DD/YYYY
PAGE: XXX

PROVIDER NAME
PROVIDER ADDRESS
CITY, STATE ZIP-ZIP FOUR

PAYEE ID XXXXXXXXXA MCD
NPI XXXXXXXXXX
PAYMENT NUMBER XXXXXXXXX
PAYMENT DATE MM/DD/YYYY

MEMBER NO.	--ICN--	PATIENT NO.	MCE ID	SERVICE DATES FROM TO	BILLED AMT	SUM OF ALL PAYORS AMT	WRAP AMT	TRANSACTION NUMBER
XXXXXXXXXX99	7021XXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	MMDDYY MMDDYY	9,999,999.99	9,999,999.99	9,999,999.99	999999999
XXXXXXXXXX99	7021XXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	MMDDYY MMDDYY	9,999,999.99	9,999,999.99	9,999,999.99	999999999
XXXXXXXXXX99	7021XXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	MMDDYY MMDDYY	9,999,999.99	9,999,999.99	9,999,999.99	999999999
XXXXXXXXXX99	7021XXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	MMDDYY MMDDYY	9,999,999.99	9,999,999.99	9,999,999.99	999999999
						TOTAL WRAP PAYMENT SERVICES ADJ:	99,999,999.99	

TOTAL NO. ADJ: 9,999,999

QUESTIONS?

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