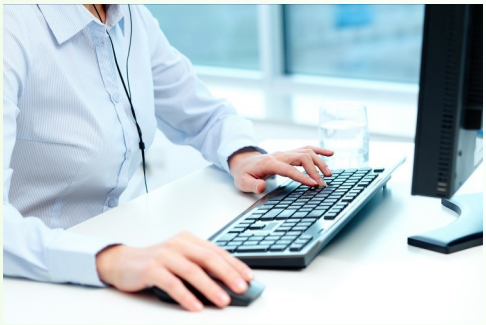
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202145 NOVEMBER 9, 2021

IHCP modifies EVV to remove unauthorized services exception

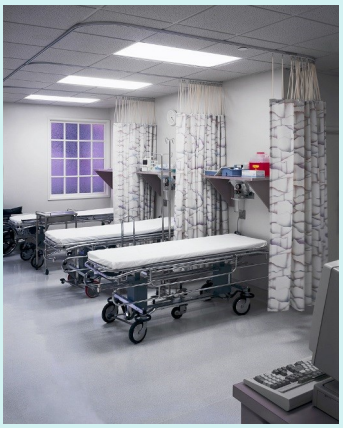


The *21st Century Cures Act* directs Medicaid programs to require personal care service and home health service providers to use an electronic visit verification (EVV) system to document services rendered. See *Indiana Health Coverage Programs (IHCP) Bulletin* BT201855 for additional information. The implementation date for requiring the use of an EVV system for personal care services was delayed to Jan. 1, 2021. The implementation date for requiring the use of an EVV system for home health services remains Jan. 1, 2023.

Effective for EVV records submitted on or after Nov. 3, 2021, the IHCP will remove the EVV record exception for unauthorized service. This change impacts the Sandata state-sponsored EVV system, as well as alternate or third-party EVV systems. This change means that EVV records will no longer need to be modified when the authorization information is not included on the EVV record. Providers are reminded that only services authorized through a member's level of care will be reimbursed.

Note: Sandata users can find information about EVV record exceptions in the Agency Provider Participant Guide, accessible through the Sandata portal on the Sandata website at sandata.zendesk.com.

Inpatient DRG claim denials



The Indiana Health Coverage Programs (IHCP) has identified an issue that affects fee-for-service (FFS) inpatient diagnosis-related group (DRG) claims that processed from Sept. 23, 2021, to Sept. 28, 2021.

Claims may have denied in error for explanation of benefits (EOB) 4099 – *Pricing being reviewed*.

The claim-processing system has been corrected. Claims that denied incorrectly for EOB 4099 will be mass reprocessed. Providers should see reprocessed claims on Remittance Advices (RAs) beginning immediately, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims).

MORE IN THIS ISSUE

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IHCP to update reimbursement for HCPCS codes S0145, S0190 and S0191

Effective Dec. 10, 2021, the Indiana Health Coverage Programs (IHCP) will update reimbursement for the following Healthcare Common Procedure Coding System (HCPCS) codes:

- S0145 – *Injection, pegylated interferon alfa-2a, 180 mcg per ml*
- S0190 – *Mifepristone, oral, 200 mg*
- S0191 – *Misoprostol, oral, 200 mcg*

The reimbursement information below applies to professional claims (*CMS-1500* claim form or electronic equivalent) and outpatient claims (*UB-04* claim form or electronic equivalent) with dates of service (DOS) on or after **Dec. 10, 2021**.

The following reimbursement information applies:

S0145

- Pricing: Maximum fee of $1,072.56
- 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.

S0190

- Pricing: Maximum fee of $70.35
- Billing guidance:
  - Must be billed with the 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.

S0191

- Pricing: Maximum fee of $0.88
- Billing guidance:
  - Must be billed with the NDC of the product administered.
  - Not separately reimbursable in the outpatient setting.

continued

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.

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*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Changes to reimbursement for eligible out-of-state children's hospitals

In accordance with *House Enrolled Act* (*HEA*) *1305*, the Indiana Health Coverage Programs (IHCP) will reimburse inpatient hospital and outpatient hospital services provided by eligible out-of-state children's hospitals at 130% of the Medicaid reimbursement rate. For inpatient claims, the increase does not apply to the capital per-diem, medical education per-diem (if applicable) or the outlier payment (if applicable). For outpatient claims, the increase does not apply to clinical laboratory codes, details billed with revenue code 274 – *Medical/Surgical Supplies and Devices – Prosthetic/Orthotic Devices*, or details billed with revenue code 636 – *Pharmacy (extension of 025X) – Drugs Requiring Detailed Coding*. This change is effective for inpatient hospital services with discharge dates on or after July 1, 2021, through June 30, 2023, and outpatient hospital services with "from" dates of service (DOS) on or after **July 1, 2021**, through **June 30, 2023**. A new explanation of benefits (EOB) code 9046 – *Out of State Children's Hospital additional payment* will be used to identify fee-for-service (FFS) claim details that are reimbursed at the increased reimbursement amount.

This change in reimbursement applies to both FFS and managed care claims.

Eligible out-of-state children's hospitals are children's hospitals located in a state bordering Indiana. In addition, the out-of-state children's hospital must be a freestanding general acute care hospital, or a facility located within a freestanding general acute care hospital that complies with one of the following:

1) Is designated by the Medicare program as a children's hospital

2) Furnishes inpatient and outpatient healthcare services to patients who are predominantly individuals younger than 19 years of age

continued

The IHCP has identified the following children's hospitals that are eligible to receive reimbursement under *HEA 1305.*

- Ann & Robert Lurie Children's Hospital
- Children's Hospital of Michigan
- Cincinnati Children's Hospital Medical Center
- La Rabida Children's Hospital
- Nationwide Children's Hospital
- Norton Children's Hospital
- Norton Women's & Children's Hospital
- Shriners Hospitals for Children
- University of Chicago - Comer Children's Hospital

If a hospital meets the requirements of *HEA 1305* and has not been contacted by the IHCP, please contact Myers and Stauffer via email at INHospital@mslc.com. If a hospital does not meet the requirements of *HEA 1305*, the hospital is not eligible for this payment program.

FFS claims with DOS of July 1, 2021, through Dec. 15, 2021, will be mass adjusted to apply the increased reimbursement. Mass adjusted claims will appear on Remittance Advice (RAs) beginning on or after Dec. 29, 2021, and will be identified with internal control numbers (ICNs)/Claim IDs that begin with 52 (mass replacements non-check related). Managed care claims will be mass adjusted. The timing of the mass adjustment will vary by MCE.

This rate increase is subject to approval from the Centers for Medicare & Medicaid Services (CMS).

IHCP adds coverage for CPT codes 90619 and 90697, effective Oct. 27, 2021

As recommended in CMS' 2021 Immunization Schedules, Indiana Health Coverage Programs (IHCP) members under 19 years of age can currently receive both the Menquadfi (MenACWY-TT) and Vaxelis (DTaP-IPV-Hib-HepB) vaccines as part of the federal Vaccines for Children (VFC) program. However, the codes associated with Menquadfi (Current Procedural Terminology [CPT®[1]] 90619) and Vaxelis (CPT code 90697) were not listed as covered services in the Professional Fee Schedule and the Outpatient Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

To create greater coverage alignment with the VFC program, the IHCP is adding coverage of CPT codes 90619 and 90697, effective Oct. 27, 2021.

For more coverage and reimbursement information, see Table 1.

continued

Table 1 – Coverage and reimbursement specifications for codes 90619 and 90697

Procedure code	Description	Coverage information
90619	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY-TT), for intramuscular use	• Covered under VFC program for children aged 2-18 years ⇒ For information on VFC billing, please see the *Injections, Vaccines and Other Physician-Administered Drugs* provider reference module • Covered under the IHCP for members aged 19 years and older ⇒ Max fee: $147.71 ⇒ Separate billing in 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.
90697	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use	• Covered under VFC program for children aged 6 weeks through 4 years ⇒ For information on VFC billing, see the *Injections, Vaccines and Other Physician-Administered Drugs* provider reference module • Not covered under the IHCP for members aged 5 years and older

Reimbursement and billing information applies to services delivered under the fee-for-service (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.

This pricing information 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.

Applicable updates will also be made to Revenue Codes with Special Procedure Code Linkages, accessible from the *Code Sets* page at in.gov/medicaid/providers.

VFC is a federal program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. Children who are eligible for VFC are entitled to receive all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). Children 18 years old and younger who are enrolled in Medicaid are eligible to receive vaccines through the VFC program. The IHCP encourages providers to enroll in the VFC program, which is administered by the Indiana Department of Health (IDOH). For more information about the VFC program, contact the IDOH Indiana Immunization Program at 800-701-0704.

QUESTIONS?

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