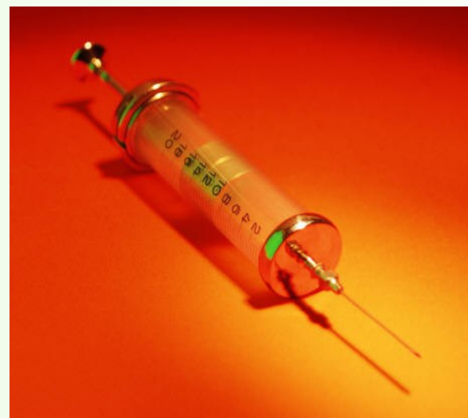
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202232 AUGUST 9, 2022

# IHCP to cover HCPCS code 90759

*Note: This article corrects the article posted in IHCP Banner Page BR202231.*



Effective immediately, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code 90759 – *Injection, Hepatitis B vaccine, 10 mcg.*

Coverage applies to all IHCP programs, subject to limitations established for certain benefit packages, and for 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 **July 1, 2022**.

The following reimbursement information applies:

- Pricing:
  - Ages 19 years of age and over: Maximum fee of $67.99.
  - Ages 18 years of age and under: $0 as covered under the Vaccines for Children (VFC) program. For information on VFC billing, see the *Injections, Vaccines and Other Physician-Administered Drugs* provider reference module at in.gov/medicaid/providers.
- Prior authorization (PA): None required.
- Billing guidance:
  - 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.
  - Excluded from copayment for Healthy Indiana Plan and Presumptive Eligibility-Adult.

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 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.

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# IHCP reminds providers of plan of care requirements following RY21 PERM audit

The Centers for Medicare & Medicaid Services (CMS) Payment Error Rate Measurement (PERM) review year 2021 (RY21) audit identified several errors due to a lack of documentation maintenance. Specifically, many errors were due to missing or incomplete Plans of Care. Indiana Health Coverage Programs (IHCP) providers should be aware of the importance of proper documentation, as it enables the continuity of care for members between healthcare professionals and helps providers stay in compliance with federal and state laws. The Office of Medicaid Policy and Planning (OMPP) Program Integrity staff is providing the following information to avoid similar errors in future federal audits and to help providers create and maintain proper records.

### Plan of care requirements

A Plan of Care must be developed within 14 days of admission to an inpatient behavioral health facility. The Plan of Care is developed following a diagnostic evaluation and must include the following components:

- Treatment objectives and goals, including an integrated program of appropriate therapies, activities and experiences designed to meet the objectives
- A post-discharge plan and a plan for coordination of inpatient services with partial discharge plans, including appropriate services in the member's community to ensure continuity of care when patients return to their family and community upon discharge

For members 22 years old or older, the attending or staff physician must develop and submit a Plan of Care within 14 days of the admission date and must update the plan at least every 90 days. For members 21 years old and younger, a physician and interdisciplinary team must develop and submit a Plan of Care within 14 days of the admission date and review the plan at least every 30 days.

### Best practices for plans of care

The following are suggested best practices for completion and maintenance of a Plan of Care:

The plan is complete, concise, accurate and legible.

- The plan identifies the name, title and qualifications of all professionals involved in the creation of the plan.
- The plan is stored in the appropriate area where all staff can locate the plan upon request.
- The plan includes information on the member and member's parents, legal guardians or others to whose care or custody the member will be released following discharge.
- The plan is updated and reviewed as required.

Additional service-specific requirements are specified in *IHCP provider reference modules*, as well as in IHCP provider bulletins and banner pages, the *Indiana Administrative Code*, and statutes. Providers can visit the [Provider References] page at in.gov/medicaid/providers, for more information.

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