IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202235 AUGUST 30, 2022

IHCP clarifies age-range restrictions for Z00.00

Effective Sept. 30, 2022, the Indiana Health Coverage Programs (IHCP) will update the age restrictions in the Core Medicaid Management Information System (*Core*MMIS) claim-processing system for reimbursement of claims submitted with diagnosis code Z00.00 – *Encounter for general adult medical examination without abnormal findings* for members ages 15 and older. These age restrictions are consistent with Medicare guidelines.

The allowable age range will apply to fee-for-service (FFS) claims with dates of service (DOS) on or after Sept. 30, 2022. 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.

IHCP corrects rate for HCPCS codes M0222 and M0223

Effective immediately for dates of service (DOS) on or after Feb. 11, 2022, the Indiana Health Coverage Programs (IHCP) is revising the reimbursement rate for the following Healthcare Common Procedure Coding System (HCPCS) codes:

- M0222 – *Intravenous injection, bebtelovimab, includes injection and post administration monitoring*
- M0223 – *Intravenous injection, bebtelovimab, includes 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]*

Claims for these codes may have underpaid.

The claim-processing system has been corrected. The following maximum rate applies retroactively for HCPCS codes M0222 and M0023 for DOS on or after Feb. 11, 2022.

Updated pricing:

- M0222 – **Maximum fee of $314.46**
- M0223 – **Maximum fee of $493.75**

continued

Providers that believe an affected claim was reimbursed incorrectly must first void the original claim and then submit a new claim. 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.

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, prior authorization (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 Professional Fee Schedule and the Outpatient Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 800-457-4584.

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