IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202021 MAY 26, 2020

IHCP to cover CPT code 44705

Effective June 26, 2020, the Indiana Health Coverage Programs (IHCP) will cover Current Procedural Terminology (CPT®[1]) 44705 – *Preparation of fecal microbiota for instillation, including assessment of donor specimen*. Coverage applies to all IHCP programs, subject to limitations established for certain benefit plans, for claims with dates of service (DOS) on or after June 26, 2020.

The following reimbursement information applies:

- Pricing: Resource-based relative value scale (RBRVS)
- Billing guidance: Standard billing guidance applies
- Prior authorization (PA): Required

PA for the coverage of fecal microbiota transplant is subject to all the following being met:

- There have been at least three episodes of recurrent clostridioides (clostridium) difficile infection confirmed by positive stool cultures.
- There has been a persistent episode that is refractory to appropriate antibiotic treatment protocol, including at least one regimen of pulsed vancomycin.
- If medical necessity dictates more frequent examination or care, documentation of medical necessity must be maintained in the provider's office. This documentation must be submitted with the subsequent PA request.

The IHCP encourages that this service be provided by a gastroenterologist.

Additionally, the procedure must be performed at a tertiary care center.

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.

continued

MORE IN THIS ISSUE

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

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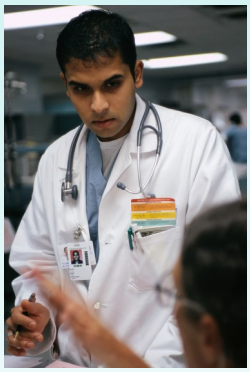
IHCP to mass adjust institutional claims that overpaid for medical education payments



The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects fee-for-service (FFS) institutional claims for hospital services processed from February 13, 2017, through March 6, 2020. The claim-processing system was incorrectly reimbursing 100% of medical education costs to providers that do not participate in the Hospital Assessment Fee (HAF) program.

Note: Institutional providers must continue to submit current CMS-2552 cost reports to remain qualified for medical education payments. For providers receiving medical education payments, adjustments in the payment rate are made based on changes in the full-time equivalent (FTE) count of interns and residents. Payment for medical education is provided only to hospitals that operate medical education programs. For more information about reimbursement of medical education costs, see the Inpatient Hospital Services provider reference module at in.gov/medicaid/providers.

The claim-processing system has been corrected. Claims processed during the indicated time frame that paid incorrectly will be mass adjusted to apply corrected medical education payments. Providers should see the adjusted claims on Remittance Advices (RAs) beginning on July 1, 2020, with internal control numbers (ICNs)/Claim IDs that begin with 52 (mass replacements non-check related). If a claim was overpaid, the net difference appears as an accounts receivable. The accounts receivable will be recouped at 100% from future claims paid to the respective provider number.

IHCP to mass reprocess institutional claims submitted via 837I electronic transaction that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects fee-for-service (FFS) institutional claims submitted electronically via 837I transaction with dates of service (DOS) from February 13, 2017, through May 13, 2020. Claims submitted through 837I transaction without the DOS included at the detail level may have denied incorrectly for explanation of benefits (EOB) 0236 – *The detail line, from date of service is missing. The correct format is mmddyy. Please provide and resubmit.*

The claim-processing system has been corrected. Institutional claims submitted via 837I transaction during the indicated time frame that denied for EOB 0236 will be mass reprocessed. Providers should see reprocessed claims on Remittance Advices (RAs) beginning on July 1, 2020, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims).

For information about electronic 837I transactions, see the *Electronic Data Interchange* provider reference module at in.gov/medicaid/providers, and *837I Health Care Claim; Institutional Transaction V3.6*, available from the *IHCP Companion Guides* page on the website.

IHCP COVID-19 Response: IHCP temporarily covers COVID-19 related services under family planning programs

Effective March 18, 2020, and to accommodate all Indiana Health Coverage Programs (IHCP) members who require testing for the coronavirus disease 2019 (COVID-19), the IHCP is temporarily adding services to the limited benefits under the Family Planning Eligibility and Presumptive Eligibility (PE) Family Planning programs, through the duration of the public health emergency. Temporary coverage of these services applies retroactively to fee-for-service (FFS) claims for the Current Procedural Terminology (CPT®[1]) codes in Table 1 with dates of service (DOS) on or after **March 18, 2020**.

Reimbursable services must be related to COVID-19 testing only. Providers should bill for a service with the appropriate International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) diagnosis code. For more information about billing for services related to COVID-19 testing, see *IHCP Bulletin* BT202048.

Procedure codes for new or established patient office or other outpatient visits (codes 99201-99205, and 99211-99215) do not require modifier FP if billed for the purposes of COVID-19 testing. To view these codes with descriptions, see *Family Planning Eligibility Program Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Note: As a reminder, code 71045 – Radiologic examination, chest; single view, may be used for billing services related to COVID-19 testing, as appropriate. This code is listed in the Family Planning Eligibility Program Codes.

Table 1 – Temporarily covered CPT codes under the Family Planning Eligibility and PE Family Planning programs for services related to COVID-19 testing, effective March 18, 2020

Procedure code	Description
71046	X-ray of chest, 2 views
94760	Measurement of oxygen saturation in blood using ear or finger device
99281	Emergency department visit, self-limited or minor problem
99282	Emergency department visit, low to moderately severe problem
99283	Emergency department visit, moderately severe problem
99284	Emergency department visit, problem of high severity
99285	Emergency department visit, problem with significant threat to life or function
99341	New patient home visit, typically 20 minutes
99342	New patient home visit, typically 30 minutes
99343	New patient home visit, typically 45 minutes
99344	New patient home visit, typically 60 minutes
99345	New patient home visit, typically 75 minutes

continued

Table 1 – Temporarily covered CPT codes under the Family Planning Eligibility and PE Family Planning programs for services related to COVID-19 testing, effective March 18, 2020 (continued)

Procedure code	Description
99347	Established patient home visit, typically 15 minutes
99348	Established patient home visit, typically 25 minutes
99349	Established patient home visit, typically 40 minutes
99350	Established patient home visit, typically 60 minutes

IHCP accepts resubmitted claims

The IHCP has identified a claim-processing issue that affects FFS claims for the procedure codes in Table 1 with DOS on or after March 18, 2020. Claims or claim details billed for these temporarily covered codes for services related to COVID-19 testing may have denied previously for explanation of benefits (EOB) 4021 – *Procedure code is not covered for the dates of service for the program billed. Please verify and resubmit.*

Beginning immediately, providers may resubmit FFS claims for the codes in Table 1 during the indicated time frame that previously denied for EOB 4021, for reimbursement consideration. Claims resubmitted beyond the filing limit must include a copy of this banner page as an attachment and must be filed within 180 days of the banner page's publication date.

IHCP COVID-19 Response: Temporary reimbursement rates increase for *COVID-19 Ready* nursing facilities

Effective retroactively May 1, 2020, in response to the coronavirus disease 2019 (COVID-19), the Indiana Health Coverage Programs (IHCP) is implementing a temporary 2% increase in Medicaid reimbursement rates for Indiana nursing facilities (NFs) that are *COVID-19 Ready*. Readiness is based on the requirements described as follows.

Additionally, NF providers that attest to being *COVID-19 Ready* will be eligible for a temporary $115 per resident daily add-on for each resident who tests positive for COVID-19.

***COVID-19 Ready* 2% increase**

To qualify for the temporary 2% rate increase, NFs will need to follow and attest to these *COVID-19 Ready* requirements from the Indiana State Department of Health (ISDH):

- Follow ISDH guidelines for COVID-19 preparedness.
- Follow ISDH long-term care hospital transfer guidance or have developed a mutually agreed upon plan with local hospitals for admission and readmission of COVID-19 residents.

continued

***COVID-19 Ready* 2% increase (continued)**

- Follow ISDH communication guidelines.
- Accept COVID-19 admissions and transfers.
- Share complete COVID-19 status information with transportation providers serving residents.
- Follow ISDH reporting requirements for new COVID-19 cases and deaths involving residents and staff.

This temporary 2% rate increase will be calculated based on each facility's standard rates (before applying the 4.2% increase that was announced in *IHCP Banner Page* BR202017).

COVID-19 $115 per resident daily add-on

In order to qualify for the temporary $115 per resident daily add-on, the facility must meet **both** of the following:

- Qualify as a *COVID-19 Ready* facility
- Bill claims for COVID-19 positive residents with the primary International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis code of U07.1 – *2019-nCoV acute respiratory disease*

The $115 per resident daily add-on is limited to 21 days per resident.

Duration of temporary rate increase and add-on

The temporary 2% rate increase and the temporary $115 per resident per daily add-on will remain in place until the end of the National Public Health Emergency or August 31, 2020, whichever comes first.

Attestation process

Nursing facility providers that are *COVID-19 Ready* can attest using the ISDH EMResource system, **or** complete and sign the *Attestation Statement – COVID-19 Ready Providers* on the Myers and Stauffer website at mslc.com/indiana/announcements.

- Providers enrolled in the EMResource system can attest to being *COVID-19 Ready* by entering *yes* in the *LTC COVID Ready Facility Status* column.
- Providers can complete the *Attestation Statement – COVID-19 Ready Providers*, print, sign, scan, and email the form to Derris.Harrison@fssa.in.gov.

Countdown to EVV implementation for personal care providers: T-minus 31 weeks

As announced in previous Indiana Health Coverage Programs (IHCP) publications, the *21st Century Cures Act* directs states to require providers of personal care services and home health services to use an electronic visit verification (EVV) system to document services rendered.

continued

Providers of personal care services have until **January 1, 2021**, to implement an EVV system for documenting services.

Please note that personal care providers not in compliance with the EVV mandate by January 1, 2021, will experience claims and reimbursement issues until they follow the federal mandate for successfully recording EVV visits.

More information is available on the *Electronic Visit Verification* web page and in the *Electronic Visit Verification FAQs* document at in.gov/medicaid/providers. For any general questions or concerns about the EVV Program, email EVV@fssa.in.gov.

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