IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202045 NOVEMBER 10, 2020

IHCP to cover CPT code 90694

Effective December 10, 2020, the Indiana Health Coverage Programs (IHCP) will cover Current Procedural Terminology (CPT®[1]) code 90694 – *Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, for injection into muscle, 0.5 ml dosage*.

Coverage for this physician-administered drug (PAD) applies to professional claims (*CMS-1500* form or electronic equivalent) with dates of service (DOS) on or after December 10, 2020. Coverage applies to all Traditional Medicaid and other IHCP programs that include full Medicaid State Plan benefits. This procedure code may not be covered under IHCP plans with limited benefits.

The following reimbursement information applies:

- Pricing: Maximum fee of $55.53
- Prior authorization (PA): None required
- Billing guidance: This code is not separately reimbursable in the outpatient setting.

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 *Professional Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

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IHCP to cover HCPCS code J9118

Effective December 10, 2020, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code J9118 – *Injection, calaspargase pegol-mknl, 10 units*.

Coverage for this physician-administered drug (PAD) applies to professional claims (*CMS-1500* form or electronic equivalent) and outpatient claims (*UB-04* form or electronic equivalent) with dates of service (DOS) on or after December 10, 2020. Coverage applies to all Traditional Medicaid and other IHCP programs that include full Medicaid State Plan benefits. This procedure code may not be covered under IHCP plans with limited benefits.

The following reimbursement information applies:

- Pricing: Maximum fee of $67.20
- Prior authorization (PA): None required
- 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.

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, and in the *Procedure Codes That Require NDCs* and the *Revenue Codes with Special Procedure Code Linkages* code tables, available from the *Code Sets* web page.

IHCP to mass adjust claims for nursing facility $115 per resident daily add-on that paid incorrectly

The Indiana Health Coverage Programs (IHCP) announced in *Banner Page BR202021* that nursing facilities (NFs) could qualify for reimbursement of a temporary $115 per resident daily add-on. To be eligible, NFs needed to attest to being *COVID-19 Ready* and bill claims for COVID-19 positive residents with the correct diagnosis code. For more information, see *BR202021*. Reimbursement for the additional $115 payment per COVID-19 positive IHCP member was effective from May 1, 2020, through August 31, 2020, with a lifetime maximum of 21 days per resident.

continued

The IHCP has identified a claim-processing issue that affects claims for the temporary $115 per resident daily add-on. The claim-processing system did not apply the $115 add-on when the member had a cost-sharing amount due on the same claim.

The claim-processing system has been corrected. Affected claims processed during the indicated time frame that paid incorrectly will be mass adjusted. Providers should see the adjusted claims on Remittance Advices (RAs) beginning December 16, 2020, with internal control numbers (ICNs)/Claim IDs that begin with 52 (mass replacement non-check related). For claims that were underpaid, the net difference will be paid and reflected on the RA.

IHCP to revise rates for select clinical laboratory services based on 2021 Medicare rates

In compliance with *Section 1903(i)(7)* of the *Social Security Act*, Medicaid reimbursement for individual clinical laboratory procedures cannot exceed the Medicare rate of reimbursement. For this reason, in accordance with the clinical laboratory reimbursement methodology set out in Title 405 of *Indiana Administrative Code (IAC) 5-18-1* and in the approved Indiana Medicaid State Plan (Attachment 4.19-B, page 1c), the Indiana Health Coverage Programs (IHCP) will adopt the 2021 Medicare rates for any clinical laboratory procedure code for which the IHCP's current reimbursement rate exceeds the 2021 Medicare rate. These rate changes will be effective for dates of service (DOS) on or after January 1, 2021, and will be reflected in the *Professional Fee Schedule* and the *Outpatient Fee Schedule*, accessible from the *IHCP Fee Schedules* web page at in.gov/medicaid/providers.

The 2021 Medicare Clinical Laboratory Fee Schedule will be available on the Centers for Medicare & Medicaid Services (CMS) website at cms.gov.

Countdown to EVV implementation for personal care providers: T-minus 7 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.

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 requirement 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.

QUESTIONS?

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