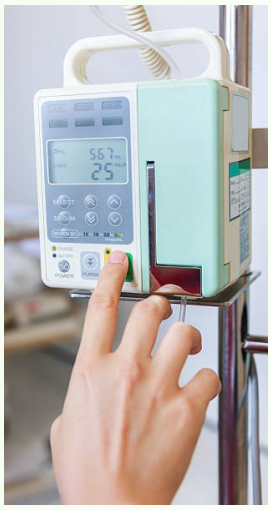
IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR202132 AUGUST 10, 2021

IHCP to cover HCPCS code G0498 (chemotherapy infusion pump)

Effective Sept. 10, 2021, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code G0498 – *Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/clinic setting using office/clinic pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/clinic, includes follow up office/clinic visit at the conclusion of the infusion.*

Coverage 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 Sept. 10, 2021. 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:
  - ⇒ Professional: 90% of billed charges
  - ⇒ Outpatient: Maximum fee
- Prior authorization (PA): None required
- Billing guidance: Standard billing guidance applies.

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.

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.

MORE IN THIS ISSUE

- IHCP applies ASC pricing to certain outpatient surgical services no longer IPO, accepts resubmitted claims
- IHCP reminds FQHC and RHC providers to bill for one unit of code T1015 on a claim

IHCP applies ASC pricing to certain outpatient surgical services no longer IPO, accepts resubmitted claims

Effective immediately, the Indiana Health Coverage Programs (IHCP) is updating the claim-processing system (*Core*MMIS) for pricing on the Current Procedural Terminology (CPT®[1]) codes in Table 1 (below) for outpatient services. This change better aligns IHCP reimbursement of outpatient services with nationwide standards; the IHCP follows National Correct Coding Initiative (NCCI) medically unlikely edits (MUEs) for Medicaid services.

Note: An MUE for a procedure code is the maximum number of units of service under most circumstances allowable by the same provider for the same beneficiary on the same date of service (DOS). For more information about MUEs and other NCCI edits, see the National Correct Coding Initiative provider reference module at in.gov/medicaid/providers.

The procedure codes in Table 1 are no longer inpatient-only (IPO), as previously identified in the IHCP *Outpatient Fee Schedule*. Beginning immediately, providers may submit fee-for-service (FFS) outpatient claims (*UB-04* form or electronic equivalent) for the codes in Table 1 with an ambulatory surgical center (ASC) pricing indicator as shown in the table. The rates associated with ASC pricing indicators are listed in the *ASC Code/Rate* table, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

Pricing for the procedure codes in Table 1 for outpatient services is effective retroactively for FFS claims with DOS on or after **Jan. 1, 2021**.

Note: Inpatient claims for the codes in Table 1 will continue to be reimbursed using the diagnosis-related group (DRG) methodology as described in the Inpatient Hospital Services provider reference module at in.gov/medicaid/providers.

Table 1 – Procedure codes with ASC pricing reimbursable in the outpatient setting, effective retroactively for claims with DOS on or after Jan. 1, 2021

Procedure code	Description	ASC pricing indicator
21705	Removal of neck muscle and extra rib at neck with release of nerves	G
35372	Removal of blood clot and portion of artery of upper thigh artery, deep	G
35800	Exploration of neck for postsurgical bleeding, blood clot, or infection	G
37182	Insertion of shunts to bypass blood flow to liver using imaging guidance	M
37617	Tying of major artery of the abdomen	H
38562	Removal of pelvic or aortic lymph nodes	M
43840	Suture of perforated ulcer, wound, or injury of stomach or upper small bowel	G
44300	Insertion of small bowel tube, open procedure	8
44314	Reconstruction of small bowel opening	G
44345	Reconstruction of large bowel opening, complicated	H
44346	Revision of large bowel opening and hernia repair	H
44602	Suture of small bowel for perforated ulcer, pouch, wound, injury or rupture	H

continued

Table 1 – Procedure codes with ASC pricing reimbursable in the outpatient setting, effective retroactively for claims with DOS on or after Jan. 1, 2021 (continued)

Procedure code	Description	ASC pricing indicator
49010	Exploration behind abdominal cavity	H
49255	Removal of lining covering abdominal organs	H
51840	Suture of bladder neck to vaginal wall and pubic bone with bladder canal suspension	G
56630	Partial removal of external female genitals, partial	G
61624	Occlusion of abnormal artery, accessed through the skin	M

Additionally, the CPT codes in Table 2 (below) continue to use ASC pricing indicators to determine pricing. These codes are not IPO. In error, the IHCP *Outpatient Fee Schedule* identified the procedure codes in Table 2 as both IPO and reimbursable with ASC pricing for claims with DOS on or after Jan. 1, 2021. Claims processed correctly with ASC pricing and no claims were affected.

Table 2 – Procedure codes with ASC pricing reimbursable in the outpatient setting, effective retroactively for claims with DOS on or after Jan. 1, 2021

Procedure code	Description	ASC pricing indicator
20955	Bone graft at lower leg with microvascular connection	G
20956	Bone graft of pelvic bone with microvascular connection	G
20957	Bone graft of foot bone with microvascular connection	G
20962	Bone graft with microvascular connection	G
20969	Placement of skin and bone flap with microvascular connection	G
20970	Placement of skin and bone flap to pelvic bone with microvascular connection	G

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

The IHCP identified a claim-processing issue that affects FFS outpatient claims for the procedure codes in Table 1 with DOS on or after Jan. 1, 2021. Claims or claim details for these codes may have denied with explanation of benefits (EOB) 4108 – *There is no ASC on file for this procedure code. Please verify that the appropriate outpatient surgery code was billed.*

The claim-processing system has been updated. Beginning immediately, providers may resubmit FFS outpatient claims for the procedure codes in Table 1 during the indicated time frame that denied with EOB 4108. 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.

continued

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.

IHCP reminds FQHC and RHC providers to bill for one unit of code T1015 on a claim

The Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) is clarifying for federally qualified health center (FQHC) and rural health clinic (RHC) providers how to bill units for Healthcare Common Procedure Coding System (HCPCS) encounter code T1015 – *Clinic visit/encounter, all-inclusive*.

For claims in the fee-for-service (FFS) delivery system, the FQHC or RHC provider should bill for ***one*** unit of code T1015 on the claim. Additionally, as clarified in *IHCP Banner Page BR202010*, the IHCP allows reimbursement of only one encounter code T1015, per billing provider, per day, unless the primary diagnosis code differs for each additional encounter.

For claims in the managed care delivery system, such as claims for members in the Hoosier Care Connect, Hoosier Healthwise, or Healthy Indiana Plan (HIP) plan, the provider should bill the managed care entity (MCE) for ***one*** unit of code T1015 on the claim. If a claim is submitted with more than ***one*** unit, reimbursement of the "wrap" payment will be delayed because only one unit is allowed per member, per day, per diagnosis code.

Note: Providers may recognize the "wrap" payment as the supplemental payment that providers receive. In the current reimbursement process, it is the difference between the PPS (prospective payment system) rate and the sum of all payers.

For any questions about submitting claims for code T1015, email IHCP reimbursement at FSSA.IHCPReimbursement@fssa.IN.gov. Please make sure that any email containing protected health information (PHI) is sent via secure email.

QUESTIONS?

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

TO PRINT

A printer-friendly version of this publication, in black and white and without photos, is available for your convenience.

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from the *Banner Pages* page of the IHCP provider website at in.gov/medicaid/providers.

SIGN UP FOR IHCP EMAIL NOTIFICATIONS

To receive email notices of IHCP publications, subscribe by clicking the blue subscription envelope or sign up from the IHCP provider website at in.gov/medicaid/providers.