IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202322 MAY 30, 2023

IHCP adds coverage for genetic testing codes 81338 and 81364

Effective June 30, 2023, the Indiana Health Coverage Programs (IHCP) will be adding coverage for the following Current Procedural Terminology (CPT®[1]) codes in Table 1 for gene analysis.

Table 1 – Procedure codes for gene analysis, effective for dates of service on or after June 30, 2023

Procedure code	Description	Pricing
81338	MPL (MPL proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; common variants (eg, W515A, W515K, W515L, W515R)	$150.33
81364	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence	$324.58

Coverage applies to Traditional Medicaid and other IHCP programs that include full Medicaid benefits; the service may not be covered under IHCP plans with limited benefits.

Prior authorization (PA) is required for the genetic tests in Table 1 to be reimbursed.

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.

IHCP announces COVID-19-related updates to the pharmacy benefit

The Indiana Health Coverage Programs (IHCP) announces changes to the pharmacy benefit in response to the expiration of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) on May 11, 2023.

Cost-sharing

As established in *IHCP Bulletin* BT202044, copayments for all pharmacy claims have been waived since April 1, 2020, as a result of the COVID-19 PHE. Cost-sharing for COVID-19 vaccines, treatments and testing will continue to be waived for

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all Food and Drug Administration (FDA)-authorized and approved products billed through the pharmacy benefit until Sept. 30, 2024, the last day of the first calendar quarter that begins one year after the last day of the emergency period.

Applicable COVID-19 treatments include those for acute infection as well as post-COVID-19 conditions as diagnosed by an IHCP-enrolled provider. In addition, until Sept. 30, 2024, cost-sharing for the treatment of a condition that could seriously complicate COVID-19 infection, as determined by an IHCP-enrolled provider, will be waived for the period in which the member is experiencing COVID-19 infection. Removal of the cost-share obligation from pharmacy claims for the treatment of post-COVID-19 conditions and conditions that could seriously complicate an acute COVID-19 infection will require entry, at point of sale (POS), of an active diagnosis code issued by an IHCP-enrolled prescriber. See Table 2 for Optum Rx POS National Council for Prescription Drug Programs (NCPDP) clinical segment pharmacy claim-processing guidance for cost-share removal.

*Table 2 – NCPDP clinical segment cost-sharing removal instructions for post-COVID-19 and COVID-19-complicating conditions**

Field	NCPDP field name	Value
491-VE	Diagnosis Code Count	Count of diagnosis occurrence (maximum of five)
492-WE	Diagnosis Code Qualifier	ØØ = Not Specified Ø1 = International Classification of Diseases (ICD9) Ø2 = International Classification of Diseases-1Ø-Clinical Modifications (ICD-1Ø-CM)
424-DO	Diagnosis Code	Applicable COVID-19 ICD-10 diagnosis code

**Pharmacy claims for which POS intervention was performed to remove cost sharing will be subject to audit.*

COVID-19 vaccination reimbursement will continue to be “carved out” of managed care benefits, as established in *BT2020127*. Pharmacy claims for COVID-19 treatments and testing should be submitted to the managed care entity (MCE) with which the member is enrolled.

PREP Act

The IHCP will comply with the Health and Human Services (HHS) COVID-19 Public Readiness and Emergency Preparedness (PREP) Act declarations and authorizations until the HHS Secretary ends this provision. This includes all active amendments to the declaration with respect to the providers that are considered qualified to prescribe, dispense, administer, deliver and/or distribute COVID-19 vaccines, treatments and testing.

Reimbursement

IHCP-enrolled pharmacies should continue to submit ingredient cost of $0 or $0.01 for products obtained free charge from the government strategic stockpile.

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Beginning July 1, 2023, the IHCP will update at-home COVID-19 test kit reimbursement to that consistent with other supplies and devices that currently process through the pharmacy benefit at POS. With this reimbursement methodology, IHCP-enrolled pharmacies are reimbursed the cost of the product with no additional dispensing fee. For dates of service on or after July 1, 2023, the IHCP will reimburse IHCP-enrolled pharmacies the cost of at-home COVID-19 test kits without an added dispensing fee.

IHCP reminds providers to respond to PERM RY2024 record requests

The Indiana Health Coverage Programs (IHCP) announced in *IHCP Banner Page* BR202247, the Review Year 2024 (RY2024) Centers for Medicare & Medicaid Services (CMS) Payment Error Rate Measurement (PERM) would start in the fall of 2022. The review cycle for RY2024 will review payments made July 1, 2022 – June 30, 2023. The IHCP reminds providers of their responsibility to respond to medical record (MR) requests promptly and completely. Only providers that have a claim selected in the sample for a service rendered to a Medicaid or Children's Health Insurance Program (CHIP) recipient will receive MR requests. The review contractor (RC), Empower AI, will contact the provider directly for a copy of the provider's medical records to support the medical review of the claim.

If the RC does not receive documentation requested from providers before the deadline, it is considered an error against the state's Medicaid or CHIP program. State staff will follow up with the provider at regular intervals to ensure the requested information is submitted on time.

If federal financial participation (FFP) is disallowed for a claim, or a portion of the claim, due to a lack of records from the provider, that amount will be recouped from the provider.

Contact information

The Family and Social Services Administration (FSSA) encourages providers to communicate with the RC and the Office of Medicaid Policy and Planning (OMPP) PERM Team. The state of Indiana OMPP PERM team can be reached at:

FSSA Office of Medicaid Policy and Planning

Indiana Medicaid PERM Project

402 W. Washington St. Room W374

Indianapolis, IN 46204

Email: PERM@fssa.in.gov

Kepro hospice authorization process reminders and Atrezzo Provider Portal features

As previously announced in *Indiana Health Coverage Programs (IHCP) Bulletin* BT202301, Kepro will be the new fee-for-service (FFS) prior authorization and utilization management (PA-UM) contractor for the IHCP nonpharmacy services. Kepro will assume PA-UM responsibilities beginning July 1, 2023. Kepro will work with current IHCP vendors to ensure PA-UM responsibilities are carried out seamlessly and with no interruption of services.

As the new IHCP FFS PA-UM contractor, Kepro will assume the responsibilities of authorization for Hoosier Healthwise members who want to enroll in hospice. In line with the current process, Hoosier Healthwise members must disenroll from managed care prior to receiving hospice benefits, and they will become eligible for hospice care the day after disenrollment from managed care.

Beginning July 1, 2023, to initiate the hospice authorization process, the hospice provider should send the completed *Medicaid Hospice Election* form, accessible from the *Forms* page at in.gov/medicaid/providers, to Kepro via fax at **800-261-2774**. It is imperative that hospice providers indicate "Hospice Member Disenrollment from Managed Care" on the cover page of the fax. After submitting the fax, hospice providers should call Kepro PA-UM at **866-725-9991** to confirm that Kepro received the fax. This practice ensures that the disenrollment of the hospice member from managed care is completed in a timely manner and prioritized within Kepro's overall workflow.

On receipt of the hospice enrollment information, Kepro will contact Maximus, the IHCP's managed care program enrollment broker, either on the same day or the next business day if the fax is received after business hours. The hospice provider may start billing the IHCP the day after the individual is disenrolled from managed care. Hospice providers are encouraged to communicate with Kepro to make certain Kepro has contacted Maximus by 4 p.m. Eastern Time that same day to disenroll the member from managed care. Coordination by 4 p.m. allows ample time for Maximus to process the disenrollment on the same day.

The corresponding *Medicaid Hospice Physician Certification* form and *Medicaid Hospice Plan of Care* form, accessible from the *Forms* page at in.gov/medicaid/providers, must be sent to Kepro within 10 business days of the date of hospice enrollment, as outlined in *Indiana Administrative Code 405 IAC 5-34-4*, to ensure the request is timely. These forms can be faxed to Kepro at 800-261-2774 or submitted via the Atrezzo Provider Portal at https://portal.kepro.com.

Kepro is excited to share more features of its Atrezzo Provider Portal:

- Providers can configure the portal to send an email (without personal health information) to the submitter upon an authorization request's status changing. This notification lets the provider know the status of their request has been updated by prompting them to log in to the Atrezzo Provider Portal for further information.
- Providers can also manage and track requests that have been submitted or are pending submission.
- Requests are saved automatically and users can view any unsubmitted requests on their home screen so that they can follow up appropriately.

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All existing FFS PA-UM requests will be honored until all approved units have been used or length-of-stay dates have been exhausted. No action will be needed by members or providers to ensure this continuity. Furthermore, for renewal or continuation of authorization for home health and therapy (physical, occupational, speech) services, requests received from July 1, 2023, through Sept. 30, 2023, will be honored for at least 180 days at the same service level, provided the requests also meet administrative requirements.

QUESTIONS?

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

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