IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202146 NOVEMBER 16, 2021

IEP-related nursing services rate remains unchanged for calendar year 2022

The Indiana Health Coverage Programs (IHCP) provides coverage for nursing services rendered by a registered nurse (RN) who is employed by or under contract with an IHCP-enrolled school corporation provider. Covered services must be medically necessary, as ordered by a physician and provided in accordance with an IHCP-enrolled student's Individualized Education Program (IEP).

Pursuant to the Indiana Medicaid State Plan, the annual reimbursement rate for Current Procedural Terminology (CPT®[1]) code and modifiers 99600 TD TM – *IEP-related nursing services, per 15 minutes* is calculated based on the most recent home health cost reports required from all home health providers billing the IHCP for services. As stated in *IHCP Bulletin* BT201904, home health agencies are no longer required to submit cost reports because the reports are no longer used to set home health reimbursement rates. The current home health rates will remain in effect until revisions to the reimbursement rules are promulgated.

For this reason, the rate for IEP-related nursing services for calendar year 2022 will remain unchanged from the calendar year 2021 rate. Accordingly, for claims with dates of service (DOS) from Jan. 1, 2022, through Dec. 31, 2022, the maximum reimbursement rate for CPT code and modifiers 99600 TD TM is $10.87 per 15 minutes. Coverage policy and billing instructions published in the *School Corporation Services* provider reference module remain the same. Pricing for the 2022 calendar year will be reflected in the Professional Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

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IHCP adds prosthetic device coverage for HCPCS codes L8701 and L8702

Effective Dec. 16, 2021, the Indiana Health Coverage Programs (IHCP) adds coverage of myoelectric upper limb prosthetics for Healthcare Common Procedure Coding System (HCPCS) codes:

- L8701 – *Powered upper extremity range of motion assist device, elbow, wrist, hand with single or double upright(s), includes microprocessor, sensors, all components, and accessories, custom fabricated*
- L8702 – *Powered upper extremity range of motion assist device, elbow, wrist, hand, finger, single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated.*

Coverage applies to fee-for-service (FFS) 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 Dec. 16, 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.

Coverage and prior authorization requirements

The IHCP reimburses for prosthetic devices only when the device is ordered in writing by a physician, optometrist or dentist.

The IHCP does not cover prosthetic devices dispensed for purely cosmetic reasons. Coverage for prosthetic devices requires prior authorization (PA) for medical necessity. After the basic prosthesis is approved, all customizing features are exempt from PA.

Myoelectric upper limb prosthetic components meet the definition of medical necessity when ***all*** the following criteria are met:

- Patient is age 2 years or older.
- Upper extremity prosthesis is needed.
- Patient is a suitable candidate for myoelectric prosthesis, as indicated by ***all*** the following:
  - Unilateral transhumeral or transradial (forearm) deficiency
  - Able and willing to participate in myoelectric prosthesis training
  - Able to tolerate weight of prosthesis
  - Adequate cognitive ability to operate myoelectric prosthesis
  - Remaining proximal arm musculature containing minimum microvolt threshold to operate myoelectric prosthesis
  - No surrounding environment that precludes use of myoelectric prosthesis (such as excessive moisture or dust)
  - No underlying neuromuscular disease

continued

- Provider or team of experts with appropriate expertise in patient's condition has evaluated patient and recommended prosthesis.
- Standard body-powered prosthesis cannot be used or has insufficient functionality to assist patient with performance of activities of daily living.

Reimbursement

Pricing: 75% of manufacturer's suggested retail price (MSRP) or 120% of the cost invoice

Prior authorization: Required

Billing guidance:

- Allowable for provider specialties *250 – Durable Medical Equipment (DME)/Medical Supply Dealer* and *251 – Home Medical Equipment (HME)*
- Reimbursable in the outpatient setting when billed in conjunction with revenue code 274 – Prosthetic/Orthotic Devices
- Claims must include an attachment of the MSRP or cost invoice.

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

The changes will also be reflected in the following code table documents on the *Code Sets* page accessible from I n.gov/medicaid/providers:

- *Durable and Home Medical Equipment and Supplies Codes*
- *Procedure Codes That Require Attachments*
- *Revenue Codes With Special Procedure Code Linkages*

Individual managed care entities (MCEs) establish and publish reimbursement and billing criteria within the managed care delivery system. Questions about managed care billing and PA should be directed to the MCE in which the member is enrolled.

IHCP to add 66821 to optometry services code set

Effective Dec. 16, 2021, the Indiana Health Coverage Programs (IHCP) will update the optometry services code set, Covered Procedure Codes for Optometrists (Specialty 180), to include Current Procedural Terminology (CPT) procedure code 66821 – *Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (1 or more stages)*.

This change applies to fee-for-service (FFS) claims with dates of service (DOS) on or after Dec. 16, 2021.

continued

Reimbursement and billing guidelines for the procedure codes in the optometry services code set remain unchanged and are subject to current policies, edits and audits. 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.

These additional codes will be reflected in the next regular update to *Vision Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

IHCP updates pricing for certain procedure codes in the outpatient setting, effective immediately

The codes in Table 1 have been separately reimbursable in the outpatient setting. However, the information in the Outpatient Fee Schedule was incomplete. In addition to the information in the Outpatient Fee Schedule, the additional reimbursement information in Table 1 also applies immediately for dates of service (DOS) on or after the date shown in Table 1.

Table 1- Additional outpatient reimbursement methodologies for DOS on or after date listed

Procedure code	Description	Reimbursement added	Effective date
10005	Fine needle aspiration of first lesion using ultrasound guidance	ASC 4	April 1, 2021
50436	Enlargement of existing opening into urinary tract accessed through skin using imaging guidance	Max fee $1,739.75	Jan. 1, 2019
50437	Enlargement of existing opening into urinary tract accessed through skin and creation of new access into urine collecting system of kidney, using imaging guidance	Max fee $2,926.86	Jan. 1, 2019
0540T	Administration of blood-derived T white blood cells (T lymphocytes) for chimeric antigen receptor T-cell therapy	ASC B (this code does not pay a max fee)	Jan. 1, 2019

The code in Table 2 has not been separately reimbursed in the outpatient setting. Effective immediately for DOS on or after Jan. 1, 2021, the code in Table 2 is separately reimbursable as shown.

Table 2-Code separately reimbursable in the outpatient setting for DOS on or after Jan 1, 2021

Procedure code	Description	Reimbursement added	Effective date
C9770	Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent	ASC H	Jan. 1, 2021

continued

The IHCP identified a claim-processing issue that affects fee-for-service (FFS) outpatient claims for the procedure codes in Tables 1 and 2. Claims for codes in Tables 1 and 2 with DOS on or the dates in the tables may have denied with explanation of benefits (EOB) 4014 – *Claim being reviewed for pricing* or EOB 4108 – *There is no ASC on file for this procedure code. Please verify that the appropriate outpatient surgery code was billed*. Beginning immediately, providers may resubmit FFS outpatient claims for the procedure codes in Tables 1 and 2 during the indicated time frames that denied with EOB 4014 or 4108, for reimbursement consideration. 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, prior authorization (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 pricing 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.

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