IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201524 JUNE 16, 2015

IHCP to cover HCPCS code E2321-RR

Effective August 1, 2015, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) code E2321-RR – *Power wheelchair interface* as a durable medical equipment (DME) rental. Coverage applies to all IHCP programs, subject to limitations established for certain benefit packages.

Coverage applies retroactively to fee-for-service (FFS) claims with dates of service (DOS) on or after **July 1, 2014**. Beginning August 1, 2015, claims that previously denied with explanation of benefits (EOB) 4209 – *Invalid procedure code/modifier combination* may be resubmitted for reimbursement consideration. Claims resubmitted beyond the one-year timely filing limit must include a copy of this banner page as an attachment and must be filed within one year of the publication date.

The following reimbursement information applies:

- Pricing: Max fee of $152.04
- Prior authorization (PA): None required
- Building guidance: The modifier RR must be used for rental DME; see *Chapter 8* of the IHCP Provider Manual for general billing procedures.

These changes will be reflected in the next monthly update to the provider *Fee Schedule* at indianamedicaid.com. Reimbursement, PA, and billing information apply to services delivered under the FFS delivery system. Individual managed care entities (MCEs) establish and publish reimbursement, PA, and billing criteria within the risk-based managed care (RBMC) delivery system. Questions about RBMC PA should be directed to the MCE with which the member is enrolled.

Clarification and guidance regarding the IHCP's policy to bypass the 24-hour rule for inpatient-only codes

Indiana Health Coverage Programs (IHCP) Banner Page BR201515, dated April 14, 2015, announced implementation of a change to the 24-hour rule for inpatient services, effective May 15, 2015. Under this new reimbursement policy, the 24-hour rule is bypassed to allow procedure codes determined by Medicare as "inpatient-only" to be reimbursed as inpatient services when the service is delivered in an inpatient setting to a patient discharged or expired within 24 hours of admission.

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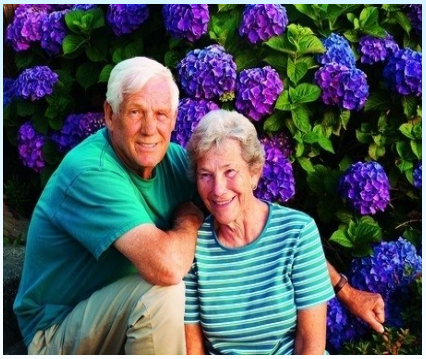
The change applied retroactively to dates of service (DOS) on or after **July 1, 2014**. A list of the affected codes is posted on the *Code Sets* page at indianamedicaid.com. This banner page provides additional clarification and guidance regarding the interim billing instructions outlined in *BR201515*.

When submitting the initial outpatient claim, providers should bill *only* the affected code – the surgical code determined "inpatient-only" that bypasses the 24-hour rule. After receiving a denial of the outpatient claim, when submitting the request for Administrative Review along with an inpatient claim, the provider should bill *all* services provided to the member on the DOS of the surgical procedure. Adhering to this guidance ensures that providers do not receive duplicate payments, which would be subject to recoupment.

Additionally, the instructions outlined in *BR201515* indicate that providers should include documentation that supports the service was performed in an inpatient setting along with their request for Administrative Review. Such documentation should include an inpatient order from the member's medical record indicating the member was admitted before the procedure was performed. The documentation should also indicate that the member was either discharged or had expired within 24 hours of admittance. The IHCP considers submission of these medical records sufficient documentation.

As a reminder, the affected procedure codes remain non-reimbursable when performed in the outpatient setting.

IHCP will mass adjust Hoosier Care Connect claims that paid incorrectly



The Indiana Health Coverage Programs (IHCP) has identified a claims processing system issue that affects Hoosier Care Connect claims processed from April 1, 2015, through April 30, 2015. During this time frame, certain professional and dental claim details for Hoosier Care Connect members may have inappropriately paid for services or specialties not covered under Hoosier Care Connect.

The claims processing system has been corrected. Affected claims will be mass adjusted. Providers will see the adjusted claims on Remittance Advice (RA) statements beginning July 21, 2015, with internal control numbers (ICNs) that begin with 56 (mass adjusted). 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 adjust certain medical and outpatient claims subject to NCCI editing

The Indiana Health Coverage Programs (IHCP) has determined that certain medical and outpatient claims with dates of service (DOS) on or after October 1, 2013, subject to National Correct Coding Initiative (NCCI) Column I and Column II edits, require adjustment. NCCI editing rules generally do not allow payment for both Column I and Column II codes on the same DOS.

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Affected claims will be mass adjusted. The mass adjustment will apply to medical and outpatient claims with DOS on or after October 1, 2013, for scenarios in which a Column I code was billed and reimbursed *after* the provider had already received payment for a Column II code for the same DOS. During the mass adjustment process, the IHCP will recoup provider payments for the Column II code.

Providers will see the adjusted claims on Remittance Advices (RAs) beginning July 21, 2015, identified with internal control numbers (ICNs) that begin with 56 (mass adjusted). If a claim was overpaid, the net difference will appear as an accounts receivable. The accounts receivable will be recouped at 100% from future claims paid to the respective provider number. Providers disputing the outcome of the mass adjustment should follow the NCCI Administrative Review process outlined in *Chapter 10* of the IHCP Provider Manual.

QUESTIONS?

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