IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201612 MARCH 22, 2016

IHCP to mass-adjust hospice claims to apply FFY 2016 rates

The hospice rates for federal fiscal year (FFY) 2016 were announced in Indiana Health Coverage Programs (IHCP) *Bulletin* BT201573. These rates apply to hospice claims with dates of service (DOS) from October 1, 2015, through September 30, 2016, inclusive. The IHCP claims processing system was not updated with FFY 2016 hospice rates until January 28, 2016. As a result, hospice claims for DOS on or after October 1, 2015, that processed before the system updates were incorrectly paid at FFY 2015 rates.

The IHCP will mass-adjust affected hospice claims to apply the FFY 2016 rates beginning the week of April 18, 2016. Providers should begin seeing the adjust claims on Remittance Advices (RAs) on April 26, 2016, with internal control numbers (ICN) that begin with 56 (mass-adjusted). For claims that were underpaid, the net difference will be paid and reflected on the RA. 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.

These adjustments will be made only to apply the FFY 2016 hospice *per diem* rates. Adjustments to apply the new payment methodology for routine home care (RHC) hospice services and the new Service Intensity Add-on (SIA) payment will occur at a later date.

The mass adjustment will apply to hospice revenue codes billed for Medicaid *per diem* payments including 651, 652, 653, 654, 655, and 656. Revenue codes not associated with a Medicaid hospice *per diem* payment will not be included in the mass adjustment, as follows:

- 180 – *General leave of absence*
- 183 – *Nursing facility bed hold for hospice therapeutic leave days*
- 185 – *Nursing facility bed hold policy for hospitalization for services unrelated to the terminal illness of the hospice member*
- 657 – *Hospice direct care physician services*
- 659 – *Medicare/Medicaid dually eligible nursing facility members only*. (This code is billed for room and board only for dually eligible members in nursing homes; Medicare is responsible for the hospice *per diem*.)

MORE IN THIS ISSUE

IHCP will mass-reprocess or mass-adjust certain home health claims that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claims processing issue that affects certain home health claims involving initial speech therapy evaluations for dates of service (DOS) on or after January 1, 2014. Per national coding guidelines, Current Procedural Terminology (CPT®[1]) code 92506 – *Evaluation of speech, language, voice, communication, and/or auditory processing* was end-dated as of December 31, 2013, and replaced with the codes in Table 1 effective January 1, 2014.

Table 1 – Initial speech therapy evaluation codes replacing CPT 92506 effective for DOS on or after January 1, 2014

Procedure Code	Description
92521	Evaluation of speech fluency (eg, stuttering, cluttering)
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance

[1] *CPT copyright 2015 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Pricing updates for the replacement codes were not made in the claims processing system, causing home health claims billed for these codes to inappropriately deny with an explanation of benefits (EOB) 4104 – *No pricing segment on file.* A maximum fee of $62.80 has been assigned to each of the four codes in Table 1 retroactive to DOS on or after January 1, 2014. The claims processing system will be updated accordingly. Home health claims with DOS on or after January 1, 2014, for the procedure codes in Table 1 that denied for EOB 4104 will be mass reprocessed or mass adjusted (if paid with a denied detail line). Providers should see the reprocessed/adjusted claims on Remittance Advices (RAs) beginning May 17, 2016, with internal control numbers (ICNs) that begin with 56 (mass adjusted) or 80 (mass reprocessed). For claims that were underpaid, the net difference will be paid and reflected on the RA. Pricing information will be updated in the next monthly update to the provider *Fee Schedule* at indianamedicaid.com.

IHCP clarifies the dental benefit period for HIP members

Healthy Indiana Plan (HIP) dental benefit limits are calculated within a member's "benefit period." A member's benefit period depends on when the member enrolls in the HIP program. Once an individual is enrolled in HIP, the 12-month benefit period begins. A benefit period can begin in any month of the year, but will always start on the first day of a month and end on the last day of a month. For example, a member who begins coverage under HIP in April 2016 would have a benefit period of April 1, 2016, through March 31, 2017; a new benefit period would begin

continued

April 1, 2017. Dental benefit limitations renew with each new benefit period. Within any benefit period, eligibility for dental benefits is also contingent on the member's HIP eligibility for a specific date of service.

Providers can determine a member's benefit period and any dental benefits already utilized in a given benefit period by contacting the HIP Dental Benefit Manager, DentaQuest, by telephone at 1-855-453-5286 or online via the DentaQuest web portal.

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