IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201630 JULY 26, 2016

HIP members may temporarily have concurrent Medicare coverage

In some circumstances, a member's Medicare coverage may temporarily overlap with that member's Healthy Indiana Plan (HIP) coverage. Some members may gain Medicare coverage while on HIP by attaining the age of 65 or by qualifying for Medicare based on a Social Security Administration (SSA) determination. In other instances, Medicare benefits may be approved with a retroactive effective date, leading to an overlap in HIP and Medicare coverage.

The process to terminate the member's HIP benefits begins after notice of the dual coverage is received by the IHCP. Federal policy requires that a member be notified prior to the termination of any benefits. Accordingly, Web interChange may correctly reflect that a member is eligible for both HIP and Medicare benefits.

If a member has dual coverage, HIP is the secondary payer. Medicaid, as always, is the payer of last resort, including for those insured under Medicare. As with all third-party liability, Medicare must be billed first, and a copy of the Medicare explanation of benefits (EOB) must be submitted with the HIP claim to the appropriate managed care entity (MCE).

IHCP billing guidance and information is available in the *Third Party Liability* provider reference module. Contact the respective MCEs for HIP billing information. Please see the current IHCP Quick Reference Guide posted at indianamedicaid.com for current HIP contact information.

Reimbursement updated for HCPCS code A4264

Effective September 1, 2016, the Indiana Health Coverage Programs (IHCP) will update the reimbursement for Healthcare Common Procedure Coding System (HCPCS) code A4264 – *Permanent implantable contraceptive intratubal occlusion device(s) and delivery system*.

Reimbursement for A4264 will continue to be manually priced; however, consistent with IHCP durable medical equipment (DME) reimbursement methodology, the IHCP will reimburse 120% of the amount listed on the cost invoice. HCPCS code A4264 will no longer have a maximum reimbursement of $1,700. These reimbursement changes apply to fee-for-service claims with dates of service (DOS) on or after September 1, 2016.

continued

The billing instructions for HCPCS code A4264, as shown in Table 1, remain unchanged.

Table 1 – Billing instructions for HCPCS code A4264

Provider	Claim Type	Code for Procedure and Device	Additional Billing Requirements
Outpatient hospital or ASC	*UB-04*	■ Bill the procedure using CPT code 58565, with appropriate revenue code.	■ Print "**Essure sterilization**" in the body of the claim form or on the accompanying invoice. ■ Submit a manufacturer's cost invoice with the claim to support the cost of the Essure device. ■ Submit a valid, signed *Consent for Sterilization* form with the claim. ■ Enter ICD-10 diagnosis code Z30.2 – *Encounter for sterilization* as the primary diagnosis on the claim.
	CMS-1500 Bill for the device under the professional or DME provider number.	■ Bill the device using HCPCS code A4264. ■ Include a cost invoice with the claim.	
Physician	*CMS-1500*	■ Bill the procedure using CPT code 58565.	
		■ Bill the device on a separate line, using HCPCS code A4264. ■ Include a cost invoice with the claim	

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-577-1278.

SIGN UP FOR IHCP EMAIL NOTIFICATIONS

To receive email notices of IHCP publications, subscribe by clicking the blue subscription envelope here or on the pages of indianamedicaid.com.

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from indianamedicaid.com.

TO PRINT

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