IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201721 MAY 23, 2017

IHCP addresses issues with MRO, AMHH, BPHC, and CMHW benefit packages

With the implementation of *Core*MMIS, the Indiana Health Coverage Programs (IHCP) is aware of various challenges associated with member benefit packages for Medicaid Rehabilitation Option (MRO), Adult Mental Health Habilitation (AMHH), Behavioral and Primary Healthcare Coordination (BPHC), and Child Mental Health Wraparound (CMHW) services. The following outlines the current status of the identified issues.

MRO, AMHH, BPHC, and CMHW benefit packages not being created for members with approved services

- *MRO services*: This issue has been resolved for MRO members – both current and future. The files to create the accurate MRO benefit packages for current members have been reprocessed and should be visible in the Provider Healthcare Portal (Portal).
- *AMHH, BPHC, and CMHW services*: This issue has been resolved for AMHH, BPHC, and CMHW newly enrolling members moving forward; however, the IHCP is working with the Division of Mental Health and Addiction (DMHA) to create accurate benefit packages for members whose files were previously denied. Once completed, the package updates will be visible in the Portal. In addition, providers will receive error-and-response files when the records for the previously denied packages are reprocessed.

MRO and BPHC benefit package effective and end dates not in line with approved dates, due to errors in converting prior authorization (PA) files

- *MRO and BPHC services*: This issue has been resolved. Adjustments have been made to benefit package effective and end dates, and correct information should be visible in the Portal. This issue did not impact AMHH or CMHW benefit packages.

MRO, AMHH, BPHC, and CMHW benefit packages were created incorrectly when member's eligibility was end-dated and then reinstated, resulting in overlapping PAs

- *CMHW services*: Updates to the claim-processing system for CMHW members are pending. Please monitor future IHCP publications for an update on the policy for CMHW services when a member's Medicaid has been end-dated and reinstated.

continued

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- *MRO, AMHH, and BPHC services*: Updates to *Core*MMIS have been applied so that, moving forward, the system will accurately create benefit packages for MRO, AMHH, and BPHC services when a member's Medicaid eligibility has been reinstated. However, the IHCP continues to work with the DMHA to correct benefit packages for members whose files were originally rejected due to the system issues and overlapping PAs.

  Records received from the DMHA that were originally rejected will be reprocessed to create the appropriate benefit packages. The IHCP will evaluate and address claim issues on a case-by-case basis for benefit packages that have been reprocessed. Once completed, the package updates will be visible in the Portal. After the rejected records have been reprocessed, an error-and-response report will be generated and sent to providers.

  Providers should be aware that a new MRO package processing system error code has been created to prevent duplication of packages. The new error code, 1676 – *MRO PA already exists for all/part of the service dates*, will appear on the error report should an existing PA already exist for all or part of the service dates.

Watch future IHCP provider publications for additional updates on issues that remain outstanding.

IHCP will mass reprocess or mass adjust claims for psychiatric therapy services that may have inappropriately adjudicated

The Indiana Health Coverage Programs (IHCP) has identified a claims processing issue that affects claims for certain therapy services processed through *Core*MMIS. The system erroneously applied the 20 per calendar year limitation for psychiatric services to claims for the applied behavior analysis (ABA) therapy codes listed in Table 1 that were billed with modifiers U1, U2, or U3. Because the system included ABA therapy services when calculating the limitation, claims for other psychiatric services were also affected. Claims for ABA therapy, as well as claims for other psychiatric services, may have been denied inappropriately for explanation of benefits (EOB) 6900 – *Psychiatric services in excess of 20 per rolling calendar year require an approved prior authorization.*

Table 1 – ABA therapy codes billed with modifiers U1, U2, or U3 that may have denied adjudicated incorrectly

CPT codes	Description
96150	Health and behavior assessment each 15 minutes
96151	Health and behavior re-assessment each 15 minutes
96152	Health and behavior intervention, individual each 15 minutes
96153	Health and behavior intervention, group each 15 minutes
96154	Health and behavior intervention, family and patient each 15 minutes
96155	Health and behavior intervention, family each 15 minutes

The claims processing system has been corrected. All claims for the ABA therapy services in Table 1 processed in *Core*MMIS will be voided and mass reprocessed to remove the claims from the limitation edit. After these claims are correctly adjudicated, other claims that denied for EOB 6900 will be mass adjusted or mass reprocessed for proper adjudication. Providers should begin to see the reprocessed claims on Remittance Advices (RAs) beginning June 13, 2017, with internal control numbers (ICNs) that begin with 50 (paper single claim replacement), 52 (mass replacement non-check replacement), and 80 (reprocessed denied claims). For claims that were underpaid, the net difference will be paid and reflected on the RA.

Effective January 1, 2018, paper claims must be submitted on NUCC red claim forms

Effective January 1, 2018, paper claims submitted to the Indiana Health Coverage Programs (IHCP) must be on the official red claim forms developed by the National Uniform Claim Committee (NUCC). The IHCP will no longer accept black-and-white copies. This change applies to the *CMS-1500* claim form 1500 (02-12) and the *UB-04 CMS-1450*. This change does not apply to dental claims submitted on the approved American Dental Association (ADA) claim form.

The IHCP retains electronic images of all paper claims submitted, and the red claim forms allow for optical character recognition (OCR), which enables the claim-processing system to read the characters submitted on the claim form for quicker processing with fewer keying errors. Further, for proper imaging and processing, paper claims should not contain highlights or color marks, and liquid paper correction fluid (Wite-Out®) should not be used. Paper claims should not have any writing outside the approved fields.

Claims for services must be legible and submitted on the correct form for the type of service billed. Claims that are not submitted on the correct form will be returned to providers without being processed. If a claim is returned, you must refile the claim on the correct red claim form. Timely filing requirements will apply to resubmitted claims.

Providers may purchase these NUCC red claim forms from a variety of vendors, the U.S. Government Publishing Office, or the U.S. Government Bookstore.

IHCP is addressing system issues with batch 270/271 eligibility transactions

With the implementation of *Core*MMIS, the Indiana Health Coverage Programs (IHCP) has identified some situations in which eligibility inquiries sent using batch 270 transactions may not be receiving 271 batch responses. These issues affect only electronic eligibility inquiries for a small percentage of Medicaid members. They do not affect eligibility inquiries performed via the Provider Healthcare Portal or the Interactive Voice Response (IVR) system.

The IHCP anticipates resolution of the 270/271 batch issues on May 24, 2017. The IHCP is communicating directly with trading partners in this regard. Providers should consult with their vendors or send questions about this publication to INXIXTradingPartner@hpe.com.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-457-4584.

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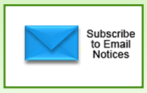

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