IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201724 JUNE 13, 2017

IHCP issues new billing guidance for partial hospitalization services for managed care programs

The Indiana Health Coverage Programs (IHCP) currently covers partial hospitalization (PHP) services. Coverage applies to all IHCP programs subject to limitations established by certain benefit plans. Providers billing for PHP services rendered under the managed care service delivery system must follow different billing guidelines than those issued under the fee-for-service (FFS) delivery system.

When billing managed care entities (MCEs) for PHP services, providers should use the claim type most appropriate for their provider type, as follows:

- Facility providers must file a *UB-04* claim and bill Healthcare Common Procedure Coding System (HCPCS) code H0035 - *Mental Health Partial Hospitalization, treatment, less than 24 hours* with one of the following revenue codes:
  - 912 – *Behavioral Health Treatments/Services-Extension of 090X-Partial Hospitalization-Less Intensive*
  - 913 – *Behavioral Health Treatments/Services-Extension of 090X-Partial Hospitalization-Intensive*
- Professional billers must file a *CMS 1500* claim and should contact the appropriate MCE for billing guidance.

The reimbursement rate for PHP services billed on a *UB-04* is $219.86 per day. For hospital billers, this rate is exempt from the hospital assessment fee (HAF) add-on payments. However, if the hospital is otherwise eligible for the HAF add-on payments, the rate is also exempt from the 3% rate reduction currently in effect for outpatient hospital services.

This billing guidance is effective retroactively to dates of service (DOS) on or after **July 1, 2016**. Providers with claims for PHP services that were denied by MCEs should immediately resubmit their claims to the applicable MCE using the appropriate claim type and following the billing guidance above. Claims resubmitted after the timely filing limit should include a copy of this publication as an attachment and should be resubmitted within 90 days of publication.

Prior authorization (PA) requirements for PHP services is unchanged by this billing guidance. Questions about this billing guidance or about specific claims should be referred to the MCE with which the member is enrolled.

continued

IHCP reminds providers to include the member's ICD-10 diagnosis code on update requests to approved MRO benefit packages

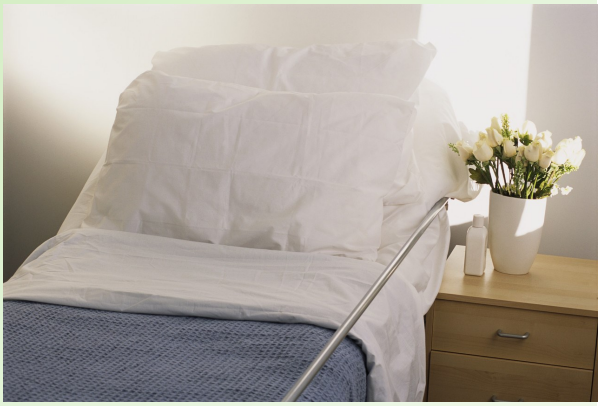
When submitting a *System Update* request to modify an existing approved Medicaid Rehabilitation Option (MRO) benefit package for a member, the provider should include the member's primary ICD-10 diagnosis code on the request. This is necessary for requests submitted via the Portal as well as those submitted on the paper request form. The ICD-10 diagnosis code is not currently stored in *Core*MMIS, but is needed to process modification requests. Update requests that do not include the ICD-10 diagnosis code will be delayed. Requests received without the primary diagnosis code could be suspended for up to 30 days until the provider submits this information. Including the diagnosis code on the initial *System Update* request will help prevent delays in processing.

Providers may resubmit claims for CPT code 99292 that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim processing issue that affects fee-for-service (FFS) claims billed for Current Procedural Terminology (CPT®[1]) 99292 – *Critical care, Evaluation and management of the critically ill or critically injured patient, each additional 20 minutes*.

Claim detail lines may have inappropriately denied with one of the following explanations of benefits (EOB):

- Claims processed before February 13, 2017, in Indiana*AIM* may have denied for EOB 4190 – *Add-on codes not payable when base code not billed*.
- Claims processed on or after February 13, 2017, in *Core*MMIS may have been denied with EOB 6390 – *Add-on codes are performed in addition to the primary service or procedure, and must never be reported as a stand-alone code.*



This issue affects claims retroactive to dates of service (DOS) on or after **January 1, 2016**.

A billing exception exists that should allow payment for CPT code 99292 billed by one provider if another provider of the **same specialty** in the **same group practice** billed for CPT code 99291 *"Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* on the same DOS. In those instances, the claim for CPT code 99292 should adjudicate and not deny for the EOBs indicated.

The claim processing system has been corrected to allow this exception. Beginning July 13, 2017, providers may resubmit claims for CPT 99292 that denied appropriately for EOB codes 4190 or 6390, for reimbursement consideration. Claims resubmitted beyond the original one-year filing limit must include a copy of this banner page as an attachment and must be filed within one year of the publication date.

QUESTIONS?

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

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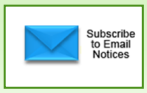

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