IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201737 SEPTEMBER 12, 2017

*Core*MMIS corrected to properly adjudicate certain neonate inpatient claims

With the implementation of *Core*MMIS, the Indiana Health Coverage Programs (IHCP) identified that the system was not properly adjudicating fee-for-service (FFS) inpatient claims for neonates that expired within one day of birth. These claims inappropriately denied with explanation of benefit (EOB) 0501 – *The discharge date is within 24 hours of the admit date/time*. A special batch process was required as a work-around for these claims to adjudicate properly.

The *Core*MMIS system has been corrected to allow providers to submit FFS inpatient claims for neonates that expire within one day of birth, through the normal claims submission processes. A special batch is no longer required. This change applies retroactively to dates of service (DOS) on or after **August 30, 2017**.

These claims have been assigned a neonatal All-Patient Refined Diagnosis-Related Group (APR DRG) grouper within the range of 580 through 640. Claims should indicate a patient status code of 20 – *Expired (died),* and the member's date of birth should be entered as the admit date. Claims meeting this criteria will be reimbursed appropriately through the DRG inpatient pricing methodology. Inpatient claims with stays less than 24 hours that do not meet the neonatal DRG exception criteria will continue to deny with EOB 0501 and be required to be billed as outpatient claims.

IHCP to cover HCPCS code C9489

Effective October 12, 2017, the Indiana Health Coverage Programs (IHCP) will cover Healthcare Common Procedure Coding System (HCPCS) C9489 – *Injection, nusinersen, 0.1mg*. The U.S. Food and Drug Administration (FDA) approved Spinraza (nusinersen) in December, 2016. Coverage applies to all IHCP programs, subject to limitations established for certain benefit plans. Coverage applies to dates of service (DOS) on or after October 12, 2017.

The following reimbursement information applies:

- Pricing: Max Fee
- Prior authorization (PA): Yes

continued

MORE IN THIS ISSUE

- Billing guidance:
  - National Drug Code (NDC) required
  - Procedure code linked to revenue code 636 – *Drugs Requiring Detailed Coding*
  - Spinraza (nusinersen) may be billed on a professional claim (*CMS-1500*) or an institutional claim (*UB-04*).

PA requires documentation of medical necessity. Spinraza (nusinersen) is considered medically necessary for the treatment of spinal muscular atrophy (SMA) in individuals who meet *both* criteria A and B:

A. Documentation of confirmatory diagnosis by *one* of the following:

- SMA diagnostic test results confirming zero copies of SMN1
- Molecular genetic testing of 5q SMA for *any* of the following:
  - Homozygous gene deletion
  - Homozygous conversion mutation
  - Compound heterozygote

B. Documentation of *one* of the following:

- Genetic testing confirming no more than two copies of SMN2
- SMA-associated symptoms before six months of age

  Note: If the member has more than 2 copies of SMN2, but has point mutations on SMN 2 exon 7, treatment would be considered medically necessary.

Continuation of treatment with nusinersen beyond six months after the initiation of therapy, and every six months thereafter, is considered medically necessary for the treatment of spinal muscular atrophy when individuals meet *both* criteria A and B:

A. When *initial therapy* was determined to meet the above criteria

B. When there is documentation of clinically significant improvement in spinal muscular atrophy-associated symptoms (for example, progression, stabilization, or decreased decline in motor function) compared to the predicted natural history trajectory of the disease

Coverage information will be updated in the *Procedure Codes That Require NDCs* and the *Revenue Codes Linked to Specific Procedure Codes* code tables on the *Code Sets* web page, and in the next regular updates to the *Professional Fee Schedule* and *Outpatient Fee Schedule* at indianamedicaid.com.

Reimbursement, PA, and billing information apply to services delivered under the fee-for-service (FFS) delivery system. Questions about FFS PA should be directed to Cooperative Managed Care Services (CMCS) at 1-800-269-5720. Individual managed care entities (MCEs) establish and publish reimbursement, PA, and billing criteria within the managed care delivery system. Questions about managed care billing guidance and PA, should be directed to the MCE with which the member is enrolled.

IHCP to mass adjust or mass reprocess certain dental claims that denied for EOB 4211

The Indiana Health Coverage Programs (IHCP) identified a claims processing issue that affects dental claims for certain services billed for a primary, or deciduous, tooth that denied inappropriately with explanation of benefits (EOB) 4211 – *The tooth number billed is not valid with the procedure*.

The issue affects claims submitted with any of the following Current Dental Terminology (CDT®[1]) codes retroactive to dates of service (DOS) on or after **July 20, 2017**:

- D2140 Amalgam – one surface, primary or permanent
- D2150 Amalgam – two surfaces, primary or permanent
- D2160 Amalgam – three surfaces, primary or permanent
- D2161 Amalgam – four or more surfaces, primary or permanent

This issue has been corrected. Claims for the affected procedure codes and DOS indicated that denied for EOB 4211, will be mass adjusted or mass reprocessed.

Providers should see adjusted or reprocessed claims on their remittance advices (RAs) beginning October 12, 2017. These claims will be identified by internal control numbers (ICNs)/Claim IDs that begin with 52 (mass replacement non-check related) and 80 (reprocessed denied claims). For clams that were underpaid, the net difference will be paid and reflected on the RA.

IHCP clarifies billing for services during the presumptive eligibility period

When submitting a claim to Indiana Health Coverage Programs (IHCP) for services rendered to members during their presumptive eligibility (PE) period, providers must use the correct member ID as follows:

- If the member has an IHCP member ID (from previous coverage) – use the member's IHCP member ID.
- If the member does not have an IHCP member ID (no previous coverage) – use the member's PE member ID:
  - Presumptive Eligibility for Pregnant Women (PEPW) members will have a PE ID with a 55x prefix.
  - Other PE members will have a PE ID with a 60x prefix.

Providers should use the eligibility verification system (EVS) – the Provider Healthcare Portal (Portal), Interactive Voice Response (IVR) system, or 270/271 electronic transactions – to determine the appropriate member ID to use.

Examples of billing scenarios:

- The member has PE coverage and had no previous IHCP coverage. The member will have PE member ID (beginning with 60x or 55x) in the EVS. During the PE period, the provider should bill using the member's PE member ID. If the member is determined eligible for IHCP coverage based on a full application, the member will be assigned an IHCP member ID. The PE member ID will be linked to the IHCP member ID in the EVS, and the provider should begin using the IHCP member ID for billing.
- The member has PE coverage and had previous IHCP coverage that is expired – the member's IHCP member ID is activated in the EVS. During the PE period, the provider should bill using the member's IHCP member ID. If the member is determined eligible for IHCP coverage based on a full application, the member will keep the same IHCP member ID in the EVS and the provider should continue to use it.

IHCP clarifies billing for PASRR and MRT services

The Indiana Health Coverage Programs (IHCP) announced in banner page *BR201717*, dated April 25, 2017, that with the implementation of *CoreMMIS*, Preadmission Screening Resident Review (PASRR) and Medical Review Team (MRT) member identification numbers were being revised to begin with the prefix 4xx and to no longer include members' Social Security numbers (SSNs).

To clarify, a PASRR or MRT identification number (with the 4xx prefix) is assigned only if the member does not have an existing IHCP member ID (RID) already in the system. This applies to members who have IHCP member IDs for current coverage or from previous coverage that is no longer in effect. When billing for PASRR or MRT services, providers should use the correct member ID as follows:

- If the member does not have an IHCP member ID, the assigned PASRR or MRT member ID (with 4xx prefix) should be used.
- If the member has an IHCP member ID (from current or previous coverage), the IHCP member ID should be used.

Providers should use the eligibility verification system (EVS) – the Provider Healthcare Portal (Portal), Interactive Voice Response (IVR) system, or 270/271 electronic transactions – to determine the appropriate member ID to use for billing purposes.

Examples of billing scenarios:

- The member is covered for PASRR services only and had no previous IHCP coverage – The member will have a PASRR member ID with a 4xx prefix in the EVS. The provider should bill for PASRR services using the member's PASRR ID.
- The member is covered for PASRR services only. However, the member had an IHCP member ID for previous coverage from 10 years ago – The member will have an IHCP member ID in the EVS. The provider should bill for PASRR services using the member's IHCP member ID.
- The member is covered for MRT services and also currently has full Medicaid coverage. The member will have an IHCP member ID in the EVS. The provider should bill for all services, including MRT services, using the member's IHCP member ID.

Place of Service Code field required for pharmacy claims

Effective October 15, 2017, the Indiana Health Coverage Programs (IHCP) will require the National Council for Prescription Drug Programs (NCPDP) Place of Service Code (field 307-C7), on all fee-for-service (FFS) pharmacy claims. This change applies to dates of service (DOS) on and after October 15, 2017.

Place of Service Codes specify the setting in which the member received pharmacy services. FFS claims submitted by providers with a non-valid or a null (missing) Place of Service Code will reject with the message *"missing or invalid (M/I) place of service code"*.

Please direct any questions about this billing guidance to the OptumRx Clinical and Technical Help Desk by calling toll-free 1-855-577-6317.

IHCP makes Applied Behavioral Analysis PA Checklist available

The Indiana Health Coverage Programs (IHCP) has developed an IHCP Applied Behavioral Analysis (ABA) Prior Authorization Checklist. Voluntary use of this tool should help providers prepare comprehensive requests for prior authorization (PA), for applied behavior analysis therapy, and reduce suspensions for requests for additional information. The checklist is relevant to PA information needed for both fee-for-service (FFS) and managed care ABA services. The checklist is available on the Forms page at indianamedicaid.com under the Prior Authorization section.

Questions about FFS PA should be directed to Cooperative Managed Care Services (CMCS) at 1-800-269-5720. Individual managed care entities (MCEs) establish and publish PA criteria within the managed care delivery system. Questions about managed care PA should be directed to the MCE with which the member is enrolled.

Marriott is accepting reservations for the 2017 IHCP Annual Provider Seminar

The Indiana Health Coverage Programs (IHCP) 2017 Annual Provider Seminar is fast approaching. This year's seminar is scheduled for October 17-19, 2017, at the Marriott Indianapolis East, 7202 E. 21st Street in Indianapolis.

Guest room reservations made on or before September 29, 2017, are available at a special rate of $133 plus tax per night. Reservations may be made online using the Marriott East website (preferred) or by telephone at (317) 352-1231 or 1-800-991-3346. Call before the deadline and indicate you are attending the Medicaid seminar to secure the special rate. Rooms at the discounted rate are booked on a first come, first serve basis, so don't delay.

Watch for an upcoming IHCP publication with more details about the annual seminar, including session descriptions, session times, and registration information. If you would like more information about the seminar before the descriptions are published or are unsure which day to attend, contact your DXC Technology, Anthem, MDwise, MHS, or CareSource Indiana provider representatives.

QUESTIONS?

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

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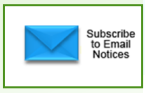

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