IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201823 JUNE 5, 2018

IHCP identifies system issues with processing outpatient claims for certain revenue codes

The Indiana Health Coverage Programs (IHCP) continues to evaluate claims processed through the *Core*MMIS system to ensure all claims have adjudicated correctly. Issues were identified with the adjudication of fee-for-service (FFS) outpatient claims for the revenue codes in Table 1. In error, claims for these revenue codes paid incorrectly or denied inappropriately for explanation of benefits (EOB) 4014 – *Claim being reviewed for pricing.* The affected claims were processed on or after February 13, 2017, when the *Core*MMIS system was implemented.

The identified issues in *Core*MMIS have been corrected. Affected claims will be mass adjusted or mass reprocessed, as appropriate. Providers should see the adjusted or reprocessed claims on Remittance Advices (RAs) beginning July 5, 2018. These claims will be identified by internal control numbers (ICNs)/Claim IDs that begin with 52 (mass replacement non-check related) or 80 (reprocessed denied claims). For claims that were underpaid, the net difference will be paid and reflected on the RA.

Table 1 – Revenue Codes for which claims processed incorrectly in CoreMMIS on or after February 13, 2017

Revenue Code	Description	Outpatient Payment Disposition	Outpatient Unit Restrictions	Other Outpatient Billing Limitations
262	IV Therapy – IV Therapy/Pharmacy Services	Flat Rate – 18.90	1/day/provider	Stand-alone – May be billed alone or with treatment room.
263	IV Therapy – IV Therapy/Drug/Supply Delivery	Flat Rate – 18.90	1/day/provider	Stand-alone – May be billed alone or with treatment room.
264	IV Therapy – IV Therapy/Supplies	Flat Rate – 18.90	1/day/provider	Stand-alone – May be billed alone or with treatment room.
514	Clinic – OB/GYN Clinic	Flat Rate – 40.80 / ASC – Procedure	1/day/provider OR surgery	Treatment room – Either two surgeries per day per provider (highest paying at 100%, second highest at 50%), OR one flat rate per day and add-on RCs and stand -alone RCs should pay for that date of service.
616	Magnetic Resonance Technology – MRA – Lower Extremities	Procedure Code	None	Stand-alone – May be billed alone or with treatment room.

continued

Table 1 – Revenue Codes for which claims processed incorrectly in CoreMMIS on or after February 13, 2017 (continued)

Revenue Code	Description	Outpatient Payment Disposition	Outpatient Unit Restrictions	Other Outpatient Billing Limitations
618	Magnetic Resonance Technology – MRA – Other	Procedure Code	None	Stand-alone – May be billed alone or with treatment room.
943	Other Therapeutic Services (see also 095X, an extension of 094X) – Cardiac Rehabilitation	Flat Rate – 61.61	1/day/provider	Stand-alone – May be billed alone or with treatment room.

The revenue codes in Table 2 are invalid codes. *Core*MMIS has been corrected to reflect this status. No claims will be affected by this correction.

Table 2 – Invalid Revenue Codes corrected in CoreMMIS

Revenue Code	Description
709	Cast Room – Other
749	EEG – Other
759	Gastrointestinal (GI) Services – Other

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