IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR201833 AUGUST 14, 2018

IHCP to mass reprocess or mass adjust transportation services claims that adjudicated incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain fee-for-service (FFS) claims for transportation services processed on or after February 13, 2017. Claim details billed for transportation services with the diagnosis codes in Table 1 may have inappropriately denied for explanation of benefits (EOB) 6803 – *Prior authorization required for transportation services in excess of the allowed number minus exemptions.* Members on renal dialysis and members residing in nursing homes are exempt from the 20 one-way trip limitation.

Table 1 –Diagnosis code associated with transportation claims that will be reprocessed or adjusted

Procedure code	Description
Z02.89	Encounter for other administrative examinations – Nursing home resident
Z49.01	Encounter for fitting and adjustment of extracorporeal dialysis catheter
Z49.31	Encounter for adequacy testing for hemodialysis
Z49.32	Encounter for adequacy testing for peritoneal dialysis

The claim-processing system has been corrected. Claims with claim details for transportation services with the diagnosis codes in Table 1 processed during the indicated time frame that previously denied for EOB 6803 will be mass reprocessed or mass adjusted. Providers should see the reprocessed or adjusted claims on Remittance Advices (RAs) beginning September 19, 2018, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims) or 52 (mass replacement non-check related). For claims that were underpaid, the net difference will be paid and reflected on the RAs.

MORE IN THIS ISSUE

IHCP implements claim-processing edit to enforce reimbursement limitations on clubhouse psychosocial rehabilitation services

As announced in *IHCP Bulletin* BT201618, effective May 1, 2016, the Indiana Health Coverage Programs (IHCP) covers psychosocial rehabilitation as a Medicaid Rehabilitation Option (MRO) service. The following reimbursement limitations and billing requirements for psychosocial rehabilitation services were outlined in the bulletin:

- Service packages are limited to members with an Needs and Strengths Assessment (ANSA) level of need (LON) of 3, 4, 5, or 5A.
- Services must be billed with Healthcare Common Procedure Coding System (HCPCS) code H2017 HW – *Psychosocial rehabilitation services, per 15 min.*
- Services are limited to 1,820 units (one unit equals 15 minutes) per each 180-day period of a member's MRO eligibility.
- Services are limited to 32 units per day.
- The service is not reimbursable when billed on the same date of service (DOS) as H2012 HW HB U1 – *Adult Intensive Rehabilitative Services (AIRS).*
- H2014 HW – *Skills Training and Development* is limited to 8 units (2 hours) when billed on the same DOS as H2017 HW.
- Services must be billed using the *CMS-1500* professional claim form, or an 837P electronic transaction.
- The rendering provider identified on the claim must be the clubhouse psychosocial rehabilitation provider with provider specialty 613.

Effective September 14, 2018, the IHCP will implement a new audit function in *Core*MMIS to enforce the reimbursement limit for H2014 HW *to* 8 units (2 hours) when billed on the same DOS as H2017 HW.

Claims processed on or after September 14, 2018, with details containing services for H2014 HW or H2017 HW for the same DOS, will be subject to this audit as follows:

- If a claim for H2017 HW was previously adjudicated and a subsequent claim for H2014 HW is submitted for the same DOS, the subsequent claim will deny if the number of units billed for H2014 HW is greater than 8 units. The Remittance Advice (RA) will indicate explanation of benefits (EOB) 6376 – *H2014 HW is not payable with a quantity billed greater than 8 units, when H2017 HW has been paid in history for the same member by any provider*.
- If a claim for H2014 HW was previously adjudicated and a subsequent claim for H2017 HW is submitted for the same DOS, the IHCP will recoup payments previously made for H2014 HW if the number of units previously billed was greater than 8 units. The RA will indicate EOB 6377 – *H2017 HW is being paid and the previously paid similar service, H2014 HW, will be recouped*.

IHCP to mass reprocess or mass adjust certain claims that denied incorrectly for exceeding PA units

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects claims for certain services requiring prior authorization (PA) that were processed from February 13, 2017, through July 15, 2018. Units of service billed by school corporations and First Steps providers during these dates were systematically deducted from members' prior authorized units in error. This error caused claims from other providers as well as subsequent claims from school corporations and First Steps providers to deny inappropriately for explanation of benefits (EOB) 3000 – *Payment for this service has been denied or cutback due to units billed exceeding the units prior authorized*.

The claim-processing system has been corrected. Claims processed during the timeframe indicated that denied for EOB 3000 will be mass reprocessed or mass adjusted. Providers should see the reprocessed or adjusted claims on Remittance Advices (RAs) beginning September 18, 2018, with internal control numbers (ICNs)/ Claim IDs that begin with 80 (reprocessed denied claim) or 52 (mass replacement non-check related). For claims that were underpaid, the net difference will be paid and reflected on the RAs.

IHCP enhances Portal to allow submission of electronic dental PA requests

Effective August 30, 2018, the Indiana Health Coverage Programs (IHCP) Provider Healthcare Portal (Portal) will be enhanced to allow providers to submit all information associated with a dental prior authorization (PA) request via the Portal rather than completing the *IHCP Prior Review and Authorization Dental Request Form* and submitting it as an attachment to the electronic request.

On the *Care Management Create Authorization* page of the Portal, the *Dental Request Form* will automatically display when one of the following service types is selected:

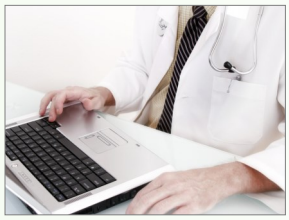
- Adjunctive dental services
- Dental accident
- Dental care
- Dental crowns
- Diagnostic dental
- Endodontics
- Maxillofacial prosthetics
- Oral surgery
- Orthodontics
- Periodontics
- Prosthodontics
- Restorative

The *electronic Dental Request Form* will require providers to enter the same information as is required on the paper *IHCP Prior Review and Authorization Dental Request* form. Providers will also be required to include the same attachments with the electronic dental PA submission as are required with the paper form.

Although providers will be able to submit dental PA requests and attachments via the Portal, the paper *IHCP Prior Review and Authorization Dental Request* form and the associated attachments will still be accepted via fax and mail.

For additional information about requesting PA electronically through the Portal, please refer to the *Prior Authorization* and the *Provider Healthcare Portal* provider reference modules at indianamedicaid.com.

Additional information to be required when providers revalidate enrollments on the Portal



Effective August 30, 2018, providers revalidating their Indiana Health Coverage Programs (IHCP) enrollments through the Provider Healthcare Portal (Portal) will be required to re-enter information that previously had been pre-populated on revalidation submissions. Providers should be prepared to provide the following information for enrollment revalidations:

- All providers will be required to re-enter all disclosure information at the time of revalidation.
- All group providers will be required to verify every rendering provider's status with the group and remove any rendering providers no longer active at the service location that is revalidating.
- All group providers will be required to include a newly signed rendering provider agreement for each rendering provider that remains active at the service location that is revalidating.

QUESTIONS?

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