IHCP banner page

INDIANA HEALTH COVERAGE PROGRAMS BR201838 SEPTEMBER 18, 2018

IHCP to mass reprocess or mass adjust professional claims that denied inappropriately

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain professional fee-for-service (FFS) claims processed from June 5, 2018, through July 23, 2018. Claims or claim details billed for the procedure codes in Table 1 may have denied inappropriately for one of the following explanation of benefits (EOB):

- EOB 2502 – *This member covered by Medicare Part B or Medicare D; therefore, you must first file the claims with Medicare. If already submitted to Medicare, please submit your EOMB.*
- EOB 2505 – *This member covered by private insurance, which must be billed prior to Medicaid*.

Table 1 – Procedure codes that may have denied inappropriately for claims processed from June 5, 2018, through July 23, 2018

Procedure code	Description
T1016 TC	Case management, each 15 minutes
97161	Evaluation of physical therapy, typically 20 minutes
97162	Evaluation of physical therapy, typically 30 minutes
97163	Evaluation of physical therapy, typically 45 minutes
H0010	Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient)

The claim-processing system has been corrected. Claims processed during the indicated time frame that denied in full or that included line items that denied for EOB 2502 or EOB 2505 will be mass reprocessed or mass adjusted, as appropriate. Providers should see the reprocessed or adjusted claims on Remittance Advices (RAs) beginning October 24, 2018, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claim) or 52 (mass replacements non-check related). For claims that were underpaid, the net difference will be paid and reflected on the RAs.

MORE IN THIS ISSUE

IHCP to mass reprocess or mass adjust claims for services that denied inappropriately

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects fee-for-service (FFS) claims for a number of procedure codes, including codes for transportation, durable medical equipment (DME), and other services, that processed from May 30, 2018, through June 4, 2018. Claims or claim details billed for these procedure codes may have denied inappropriately for one of the following explanation of benefits (EOB):

- EOB 2502 – *This member covered by Medicare Part B or Medicare D; therefore, you must first file the claims with Medicare. If already submitted to Medicare, please submit your EOMB.*
- EOB 2505 – *This member covered by private insurance, which must be billed prior to Medicaid*.

The claim-processing system has been corrected. Claims processed during the indicated time frame for the identified procedure codes that denied in full or that included line items that denied for EOB 2502 or EOB 2505 will be mass reprocessed or mass adjusted, as appropriate. Providers should see the reprocessed or adjusted claims on Remittance Advices (RAs) beginning October 24, 2018, with internal control numbers (ICNs)/ Claim IDs that begin with 80 (reprocessed denied claim) or 52 (mass replacements non-check related). For claims that were underpaid, the net difference will be paid and reflected on the RAs.

IHCP eligibility verification systems to include tooth sealant information to support dental benefit limits

Effective October 1, 2018, Indiana Health Coverage Programs (IHCP) eligibility verification systems will include information regarding the limitation on Current Dental Terminology (CDT®[1]) code D1351 – *Dental sealant per tooth,* to one sealant per tooth per lifetime along with other benefit limitations that apply to a member. Responses to a provider's eligibility verification request via the IHCP Provider Healthcare Portal (Portal), 270/271 electronic transactions, and the Interactive Voice Response (IVR) system will include the tooth numbers that have been previously sealed for that member. See Figure 1 for a screen shot of how this information will display under the Limit Details panel of the Portal when a provider is verifying a member's eligibility. Similar information will be returned when the provider verifies eligibility and benefit limits using 270/271 transactions or the IVR system.

Figure 1 – Screen shot of limit details regarding tooth sealants as displayed in the IHCP Portal

Limit Details

The Dollar Limits and Service Limits may not reflect recent claims.

Service Limits	Limit	Remaining
6225 ONE SEALANT PER TOOTH PER LIFETIME - Sealant applied	3, 14, 19, 30	-

[1]*CDT copyright 2018 American Dental Association. All rights reserved. CDT is a registered trademark of the American Dental Association.*

Procedure codes reimbursable in the outpatient setting and linked to revenue code 636

Effective October 18, 2018, the Indiana Health Coverage Programs (IHCP) will allow reimbursement for the procedure codes in Table 2 in the outpatient setting. This will apply to outpatient services rendered under the fee-for-service (FFS) and managed care delivery systems for dates of service (DOS) on or after October 18, 2018.

The IHCP will link the procedure codes in Table 2 to revenue code 636 – *Pharmacy-Extension of 025X-Drugs Requiring Detailed Coding.* Beginning October 18, 2018, providers may bill the procedure codes in Table 2 together with revenue code 636, as appropriate, for reimbursement consideration. The codes in Table 2 will be priced with a maximum fee rate. Some exceptions apply to outpatient pricing for Healthy Indiana Plan (HIP). Questions about outpatient pricing for HIP members should be directed to the managed care entity (MCE) with which the member is enrolled.

These changes will be reflected in the next regular update to the *Outpatient Fee Schedule* at indianamedicaid.com. The revenue code linkage will be reflected in the *Revenue Codes Linked to Specific Procedure Codes* table on the Code Sets web page of the website.

Table 2 – Procedure codes reimbursable in the outpatient setting and linked to revenue code 636, effective for DOS on or after October 18, 2018

Procedure code	Description
90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use
90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
C9497	Loxapine, inhalation powder, 10 mg
J0350	Injection, anistreplase, per 30 units
J0395	Injection, arbutamine HCl, 1 mg
J0600	Injection, edetate calcium disodium, up to 1,000 mg
J0800	Injection, corticotropin, up to 40 units
J1212	Injection, DMSO, dimethyl sulfoxide, 50%, 50 ml
J1430	Injection, ethanolamine oleate, 100 mg
J1438	Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J1560	Injection, gamma globulin, intramuscular, over 10 cc
J1830	Injection interferon beta-1b, 0.25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J1945	Injection, lepirudin, 50 mg

continued

Table 2 – Procedure codes reimbursable in the outpatient setting and linked to revenue code 636, effective for DOS on or after October 18, 2018 (continued)

Procedure code	Description
J2504	Injection, pegademase bovine, 25 IU
J2760	Injection, phentolamine mesylate, up to 5 mg
J2993	Injection, reteplase, 18.1 mg
J3305	Injection, trimetrexate glucuronate, per 25 mg
J7296	Levonorgestrel-releasing intrauterine contraceptive system, (kyleena), 19.5 mg
J7297	Levonorgestrel-releasing intrauterine contraceptive system, 52mg, 3 year duration
J7298	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration
J7300	Intrauterine copper contraceptive
J7301	Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg
J7310	Ganciclovir, 4.5 mg, long-acting implant
J7327	Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose
J7330	Autologous cultured chondrocytes, implant
J7501	Azathioprine, parenteral, 100 mg
J7504	Lymphocyte immune globulin, antithymocyte globulin, equine, parenteral, 250 mg
J7505	Muromonab-CD3, parenteral, 5 mg
J7511	Lymphocyte immune globulin, antithymocyte globulin, rabbit, parenteral, 25 mg
J7513	Daclizumab, parenteral, 25 mg
J7525	Tacrolimus, parenteral, 5 mg
J9216	Injection, interferon, gamma 1-b, 3 million units

QUESTIONS?

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

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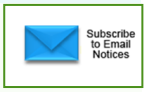

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