IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201846 NOVEMBER 13, 2018

IHCP revises policy regarding outpatient mental health services limitations for certain procedure codes

The Indiana Health Coverage Programs (IHCP) outpatient mental health services policy identifies Current Procedural Terminology (CPT®[1]) codes that, in combination, are subject to limitations. In *Banner Page* BR201809, the IHCP removed the CPT codes in Table 1 from the limitation of 20 units per member, per provider, per rolling 12-month period for outpatient mental health services, effective March 27, 2018.

The IHCP is revising its policy to also remove the codes in Table 1 from two additional limitations associated with outpatient mental health/substance abuse services:

- Reimbursement is limited to 30 visits for outpatient mental health/substance abuse services per member per calendar year without prior authorization.
- Reimbursement is limited to 50 visits maximum for outpatient mental health/substance abuse services per member, per calendar year, with prior authorization.

Note the previous limitation is related to services per provider; the limitations above are not. Removal of these procedure codes from the two additional limitations applies retroactively to dates of service (DOS) on or after **March 27, 2018.**

Table 1– Codes not included in the outpatient mental health/substance abuse limitations, effective for DOS on or after March 27, 2018

Procedure code	Description
96151	Health and behavior re-assessment each 15 minutes
96152	Health and behavior intervention, individual each 15 minutes
96153	Health and behavior intervention, group each 15 minutes
96154	Health and behavior intervention, family and patient each 15 minutes
96155	Health and behavior intervention, family each 15 minutes

Because these procedure codes were previously included in limitation calculations, claims or claim line items for these codes and possibly other outpatient mental health/substance abuse services for DOS on or after March 27, 2018, may have denied for one of the following explanation of benefits (EOB), but might now pay:

continued

- EOB 6120 – *Reimbursement is limited to 30 visits for outpatient mental health/substance abuse services per recipient per calendar year without prior authorization. This recipient has received the maximum number allowable*.
- EOB 6121 – *Reimbursement is limited to 50 visits maximum for outpatient mental health/substance abuse services per recipient, per calendar year, with prior authorization. This recipient has received the maximum number allowable.*

All claims or claim details that denied for EOB 6120 or 6121 for the affected DOS will be mass adjusted or mass reprocessed, as appropriate. Providers should see the mass adjusted or mass reprocessed claims on Remittance Advices (RAs) beginning December, 13, 2018, with 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.

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

IHCP reminds providers of the 180-day timely filing limit for FFS claims

As announced in *Indiana Health Coverage Programs (IHCP) Bulletin* BT201829, effective January 1, 2019, the timely filing limit on claims for services rendered through the fee-for-service (FFS) delivery system will be 180 calendar days from the date of service (DOS). The 180-day timely filing limit will apply to claims with DOS on or after January 1, 2019. For inpatient claims, the 180-day limit will be based on the member's date of discharge.

The 180-day filing limit will also apply to claims submitted to managed care entities (MCEs) from providers not under contract with the MCE, for services rendered to members enrolled with the MCE. For providers contracted with MCEs, the 90-day filing limit will still apply.

The current 1-year timely filing limit will continue to apply to claims with DOS or dates of discharge on or before December 31, 2018. The circumstances to exclude, extend, or waive the timely filing limit remain unchanged. For details, please refer to *IHCP Bulletin BT201829*.

IHCP reminds providers of cost-sharing obligation limit for Medicaid members

As published in *Indiana Health Coverage Programs (IHCP) Bulletin* BT201639, federal regulations limit cost-sharing obligations for Medicaid members to no more than 5% of a family's total countable household income. Cost-sharing charges include contributions, premiums, deductibles, copayments, and other Medicaid-related charges. The IHCP applies this limit based on calendar quarters.

Effective September 1, 2017, the IHCP began systematically monitoring members who had met their established quarterly cost-sharing obligations. Claims processed after a member's copayment obligation was met in any given quarter no longer had copayments deducted. This claim-processing change was applied retroactively to claims processed on or after **July 5, 2016**.

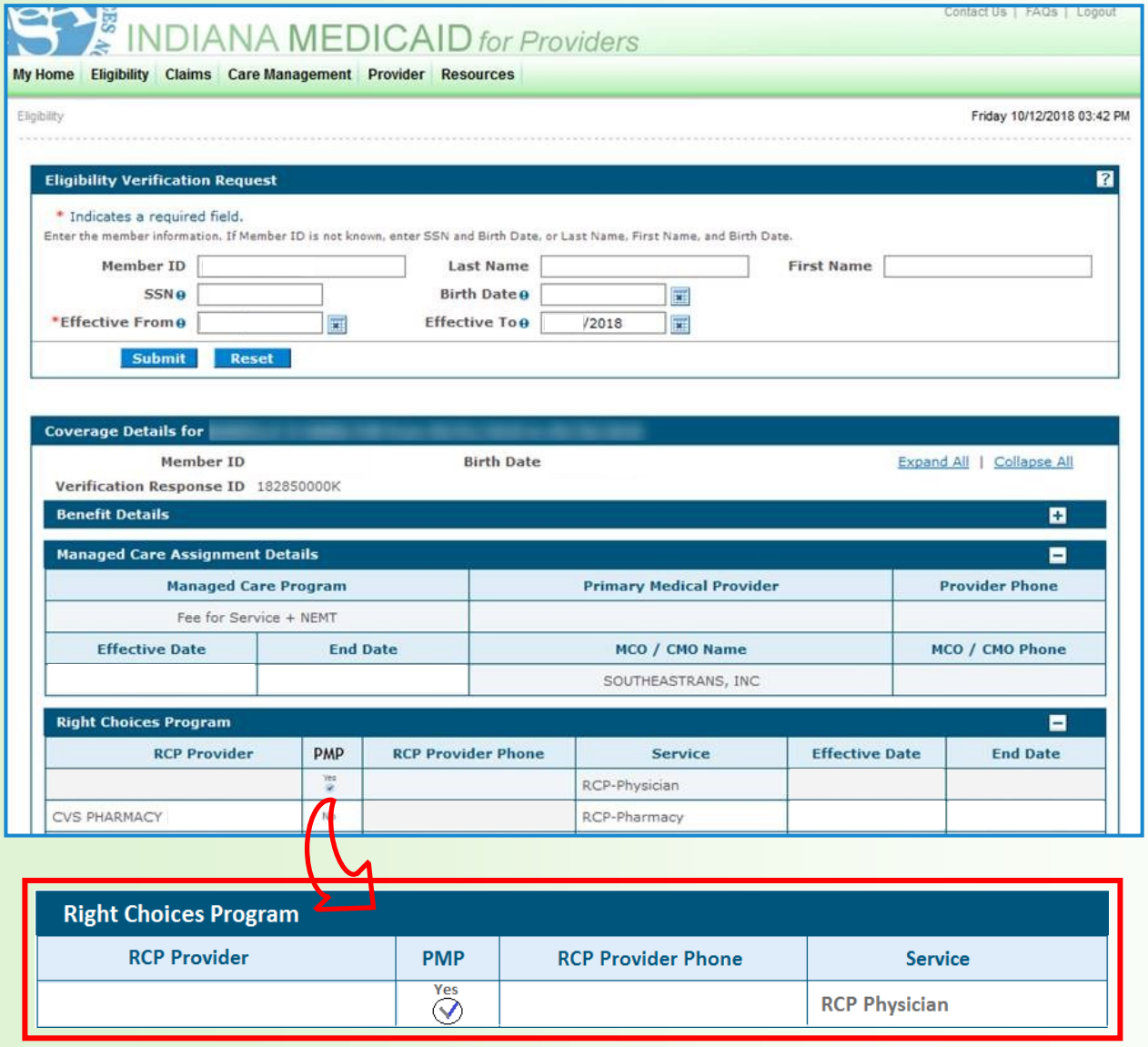
System enhancements are being implemented to more accurately calculate cost-sharing obligations for households with multiple members. Providers will continue to determine if a copayment should be collected from a member on a date of service (DOS) when verifying the member's eligibility through any of the Eligibility Verification System (EVS) options. Refer to *IHCP Bulletin* BT201758 or the *Member Eligibility and Benefit Coverage* provider reference module for more details and for a description of how copayment requirements display in the IHCP Provider Healthcare Portal.

Portal enhanced to display Right Choices Program PMP when verifying member eligibility

Effective November 29, 2018, Indiana Health Coverage Programs (IHCP) providers will be able to see a member's Right Choices Program (RCP) primary medical provider (PMP) when viewing that member's eligibility in the IHCP Provider Healthcare Portal (Portal).

The Portal allows providers to retrieve a member's benefit and coverage information through the *Eligibility Verification Request* page as explained in the *Provider Healthcare Portal* provider reference module at indianamedicaid.com. Previously, for a member assigned to the RCP, the member's RCP PMP did not display. Beginning November 29, 2018, the PMP will appear in the *Right Choices Program* panel as shown in Figure 1.

Figure 1 – Right Choices Program panel in the Portal displays member's PMP



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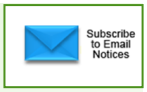

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