IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201913 MARCH 26, 2019

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

The Indiana Health Coverage Programs (IHCP) previously announced in *IHCP Banner Page BR201838*, 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. The IHCP has identified additional claims for those services during the same time frame for which claims or claim details billed for the 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 described 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 May 1, 2019, 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 reminds providers of reimbursement guidelines for infusion services; restriction will be implemented in *Core*MMIS

The Indiana Health Coverage Programs (IHCP) continues to allow separate reimbursement for infusions performed during the same encounter as a treatment room service in the outpatient setting.

As before, the procedure codes for infusion services in Table 1 may be reimbursed separately from the treatment room revenue codes in Table 2, with the same date of service (DOS), **if** the infusion procedure code is billed with revenue code 260 – *IV Therapy - General* on a separate claim detail line from the treatment room revenue code.

Effective May 1, 2019, the IHCP will enhance the *Core*MMIS claim-processing system so that any procedure code not in Table 1, even if it is billed with revenue code 260 and for a service performed during the same encounter as a treatment room service, will systematically deny with explanation of benefits (EOB) 4090 – *Payment for 250, 251, 252, 257, 259, 270-279 drug and supply revenue codes and infusions are included in the treatment room reimbursement.*

continued

Table 1 – Infusion procedure codes (if billed with revenue code 260) that may be billed separately from treatment room revenue codes

Procedure code	Description
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
96361	Intravenous infusion, hydration; each additional hour
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion
96369	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)
96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour
96371	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s)

Table 2 – Treatment room revenue code series

Revenue code series	Description (header only)
45x	Emergency Room
48x	Cardiology
51x	Clinic
52x	Freestanding Clinic
70x	Cast Room
71x	Recovery Room
72x	Labor Room/Delivery
76x	Specialty Services

Reimbursement information applies to services delivered under the fee-for-service (FFS) delivery system. Individual managed care entities (MCEs) establish and publish reimbursement information within the managed care delivery system. Questions about managed care should be directed to the MCE with which the member is enrolled.

continued

For more information about billing and reimbursement for infusion services in the outpatient setting, see the *Outpatient Facility Services* provider reference module. The outpatient payment methodology for revenue code 260 is a flat rate, as indicated in the *Revenue Codes* table, which is accessible from the *Code Sets* web page at in.gov/medicaid/providers.

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