IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201917 APRIL 23, 2019

IHCP updates NCCI medically unlikely edits for hospitals

The Indiana Health Coverage Programs (IHCP) will update the *Core*MMIS claim-processing system logic for National Correct Coding Initiative (NCCI) edits, in order to allow certain services to bypass the Practitioner Medically Unlikely Edits (MUEs) when billed by hospitals.

Effective May 23, 2019, and retroactive to **January 1, 2018**, the IHCP will allow the following hospital provider specialties to bypass the NCCI edits when billing for physician-administered drugs (PADs) reimbursable outside the Diagnosis-Related Group (DRG).

- 010 - Acute Care
- 011 - Psychiatric Facility
- 012 - Rehabilitation
- 013 - Long Term Acute Care

Procedure codes for the PADs reimbursable outside the DRG are published in the *Physician-Administered Drugs Carved Out of Managed Care and Reimbursable Outside the Inpatient Diagnosis-Related Group* code table, accessible from the Codes Set page at in.gov/medicaid/providers.

Note: This system update for NCCI MUEs that do not apply to the hospital services previously described follows guidance published by the Centers for Medicare & Medicaid Services (CMS). According to CMS, the edits do not apply to Medicaid claims from inpatient and residential facilities, such as services to inpatients provided by hospitals. For more information, see the Medicaid NCCI guidance manual at medicaid.gov.

The NCCI MUEs applied by the claim-processing system may have caused claims or claim details to deny for explanation of benefits (EOB) 4183 – *Units of service on the claim exceed the medically unlikely edit (MUE) allowed per date of service. Go to www.medicaid.gov/medicaid/program-integrity/ncci for information regarding maximum number of units of service allowed for the service billed.*

Beginning May 23, 2019, providers may resubmit or adjust affected claims with dates of service (DOS) on or after January 1, 2018, as appropriate, for reimbursement consideration. Providers may resubmit original claims that denied.

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A provider that believes a claim was reimbursed incorrectly may submit an adjusted, replacement claim.To submit a replacement claim, the provider must first void the original claim. The replacement claim must include the same attachments as were submitted with the original claim. A claim (the original or an adjusted replacement) resubmitted beyond the timely filing limit must include a copy of this banner page as an attachment.

Note: Claims with DOS before January 1, 2019, must be resubmitted within 1 year of the banner page's publication date. Claims with DOS on or after January 1, 2019, must be resubmitted within 180 days of the banner page's publication date.

IHCP will mass reprocess certain medical claims submitted on paper forms that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain professional claims with third-party liability (TPL) (not including crossover claims) submitted on the *CMS-1500* paper form and processed from February 13, 2017, through March 31, 2019. In error, the claim-processing system applied an edit (net balancing) to these claims, which may have denied incorrectly for explanation of benefits (EOB) 0509 – *This claim was submitted with an incomplete or invalid net charge. The estimated amount due must equal the total of all line item charges, less any TPL amount, patient paid (non-covered) charges, and/or any patient liability amount. Please verify and resubmit.*

The claim-processing system has been corrected. Claims processed during the indicated time frame that previously denied in error for EOB 0509 will be mass reprocessed. Providers should see the reprocessed claims on Remittance Advices (RAs) beginning May 22, 2019, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims).

IHCP corrects procedure codes allowable for vision services published in *Banner Page BR201915*

The Indiana Health Coverage Programs (IHCP) has identified an error published in *IHCP Banner Page* BR201915, in the article titled, *IHCP to correct vision code sets, and reprocess or adjust vision services claims that denied incorrectly.* In error, Table 1 identified Current Procedure Terminology (CPT®[1]) codes 66820 and 66821 as allowable for billing by provider specialty 180 (optometrist). Because these services are surgical in nature, they are outside of an optometrist's scope of practice.

Accordingly, procedure codes 66820 and 66821 are **not** allowable for billing by the optometrist provider specialty. Claims or claim details that denied for these codes will not be reprocessed or mass adjusted as described in *BR201915*.

The corrected information will be reflected in the *Vision Services Codes* table, accessible from the *Code Sets* page at in.gov/medicaid/providers.

The other information in the article about procedure codes for vision services is accurate.

[1]*CPT copyright 2019 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

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