IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202126 JUNE 29, 2021

IHCP to mass reprocess or mass adjust claims for optometrist services that denied incorrectly

The Indiana Health Coverage Programs (IHCP) identified a claim-processing issue that affects fee-for-service (FFS) professional claims for optometrist services with dates of service (DOS) from October 1, 2020, through June 7, 2021. Claims or claim details submitted by optometrists (provider type code 18) for Current Procedural Terminology (CPT®[1]) code 65205 – *Removal of foreign body in external eye, conjunctiva* may have denied incorrectly with explanation of benefits (EOB) 4801 – *Procedure code not covered for benefit plan*.

The claim-processing system has been corrected. Claims processed during the indicated time frame that denied incorrectly for EOB 4801 will be mass reprocessed or mass adjusted, as appropriate. Providers should see reprocessed or adjusted claims on Remittance Advices (RAs) beginning August 4, 2021, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims) or 52 (mass replacements non-check related).

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IHCP to update processing of FQHC and RHC encounter claims, beginning July 1, 2021

Effective July 1, 2021, federally qualified health center (FQHC) and rural health clinic (RHC) medical wraparound (supplemental) payments will be systematically processed weekly by Gainwell Technologies, and displayed on providers' weekly Remittance Advices (RAs). See *Indiana Health Coverage Programs (IHCP) Bulletin* BT202144 for the original announcement with details.

To support this change, new explanation of benefits (EOB) codes, place of service (POS) codes and accounts receivable (A/R) reason codes will be added to the claim-processing system (Core Medicaid Management Information System [*Core*MMIS]) for FQHC and RHC encounter claims.

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EOB codes

Effective July 1, 2021, fee-for-service (FFS) professional claims for FQHC and RHC encounters will be subject to claim-processing system edits. Claims that do not meet criteria will deny with one of the EOB codes in Table 1.

Table 1 – EOB codes for which FQHC/RHC medical services on professional claims may deny, effective for DOS on or after July 1, 2021

EOB code	Description
4121	T1015 must be billed with a valid CPT/HCPCS code
4124	The CPT/HCPCS code billed is not a valid encounter
4173	The CPT/HCPCS code billed is not payable according to the PPS reimbursement methodology
6096	The CPT/HCPCS code billed is not payable according to the PPS reimbursement methodology

For reference, the EOB codes, POS codes and A/R reason codes given in *BT202144* are duplicated below.

Table 2 – New EOB codes for FQHC/RHC medical services on professional claims, effective for DOS on or after July 1, 2021

EOB code	Description	Additional information
3370	Sum of all payors amount is zero for the COB field for the encounter claim. Please verify and resubmit.	EOB identifies denied RQHC/RHC encounter claims where the sum of all payers' amount is zero or blank in the Coordination of Benefits (COB) table segment.
3371	The service submitted for the FQHC/RHC encounter claim is not payable when billed with a Notice of Pregnancy (NOP).	EOB identifies denied encounter claims reported with T1015 and NOP procedure code/modifier 99354 TH.
3372	Calculated wraparound payment amount is zero.	EOB identifies FQHC/RHC encounter claims where the difference between the provider-specific rate and the sum of all payers' amount.

POS codes

Effective July 1, 2021, the following POS codes will be included as allowable for valid FQHC and RHC encounter claims:

- 02 – Telehealth
- 03 – School
- 04 – Homeless Shelter

A/R reason codes

Effective July 1, 2021, the new A/R reason codes in Table 3 will be used in processing wraparound payments.

continued

Table 3 – New A/R reason codes for FQHC/RHC medical services

A/R reason code	Description	Additional information
8681	A/R – Result of a wraparound payment adjustment	Identifies a wraparound payment adjustment deducted from future payments resulting from a void/replacement encounter claim
8682	A/R – Manual setup (wraparound payment)	Identifies a manually setup wraparound payment adjustment deducted from future payments

IHCP updates provider self-disclosure process and requirements

The Indiana Health Coverage Programs (IHCP) has updated the self-disclosure protocol for providers reporting Medicaid and Children's Health Insurance Program (CHIP) fee-for-service (FFS) overpayments. This change applies to overpayments identified on or after June 1, 2021.

As before under existing federal law, a provider that identifies an overpayment must report the overpayment and return the entire amount to a Medicaid program within 60 days after the overpayment is reported. When an overpayment has been identified, providers (third party or staff that bills for a claim) are required to complete the *Voluntary Self-Disclosure of Provider Overpayments* packet and submit it for review. Providers must ensure that contact information is up-to-date and accurate because all communication will be sent to the person(s) identified in the packet.

The updated self-disclosure packet and guidance are available on the *Protocol for Voluntary Self-Disclosure of Provider Overpayments* webpage at in.gov/medicaid/providers.

Changes to the provider self-disclosure process and requirements include the following:

- A new validation process now ensures that providers reimburse the IHCP for the correct overpayment amount. This process will not begin until the IHCP receives a completed self-disclosure overpayment packet. The process verifies that the correct claims were submitted, they were not adjusted or audited, and the correct overpayment was reported.
- The self-disclosure packet was updated and condensed to capture the most important and necessary information.
- Providers are no longer required to submit payment with the self-disclosure packet. The IHCP must first review the provider's completed packet and validate the overpayment amount.
- Before making any payment (as advised in the self-disclosure packet), the provider should wait for a letter that confirms the total amount owed. If the submitted packet is complete and accurate, and depending on the number of claims to be validated, the confirmation letter is mailed typically within 14 business days.
- The *Protocol for Voluntary Self-Disclosure of Provider Overpayments* page is up-to-date.
- The IHCP will return incomplete packets, which could lead to referral for an audit. (Previously, the IHCP attempted to obtain information missing from incomplete packets with limited success.)
- For any questions or concerns about self-disclosure protocol, please contact the State:

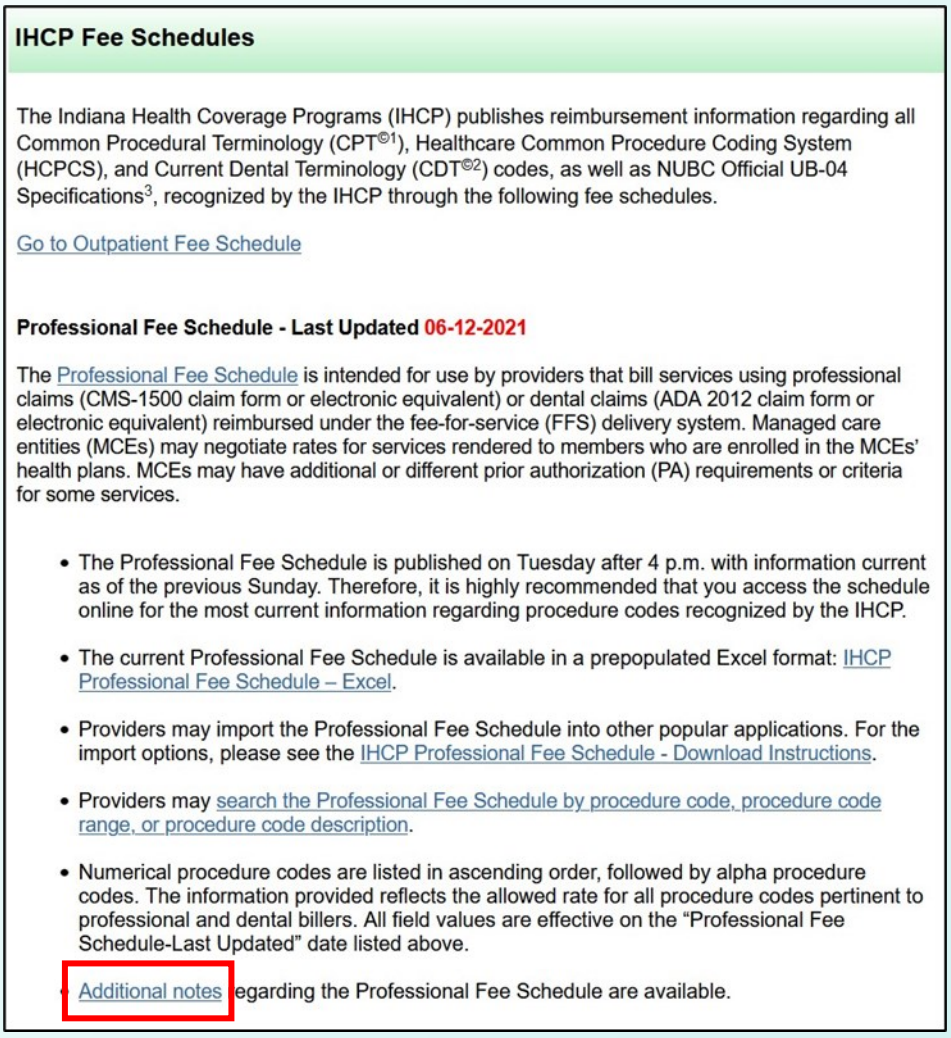
  800-457-4515, option 2
  Email: Program.Integrity@fssa.in.gov

IHCP updates *Professional Fee Schedule* for physician interpretation of laboratory codes

The Indiana Health Coverage Programs (IHCP) is updating the *Professional Fee Schedule* and the associated *Additional Notes*, accessible from the *IHCP Fee Schedules* webpage at in.gov/medicaid/providers, for the Current Procedural Terminology (CPT®[2]) laboratory codes in Table 4. The updates will provide more information about reimbursement for these codes.

In the *Professional Fee Schedule*, an asterisk in the Notes column next to a procedure code will indicate that additional notes are available and should be consulted regarding reimbursement of the code. To view the additional notes, go to the *IHCP Fee Schedules* page, click **View Professional Fee Schedule**, accept the agreement by choosing **Accept**, and click **Additional Notes**. See Figure 1 for the link to additional notes.

Figure 1 – Additional Notes



IHCP Fee Schedules

The Indiana Health Coverage Programs (IHCP) publishes reimbursement information regarding all Common Procedural Terminology (CPT©[1]), Healthcare Common Procedure Coding System (HCPCS), and Current Dental Terminology (CDT©[2]) codes, as well as NUBC Official UB-04 Specifications[3], recognized by the IHCP through the following fee schedules.

Go to Outpatient Fee Schedule

Professional Fee Schedule - Last Updated 06-12-2021

The Professional Fee Schedule is intended for use by providers that bill services using professional claims (CMS-1500 claim form or electronic equivalent) or dental claims (ADA 2012 claim form or electronic equivalent) reimbursed under the fee-for-service (FFS) delivery system. Managed care entities (MCEs) may negotiate rates for services rendered to members who are enrolled in the MCEs' health plans. MCEs may have additional or different prior authorization (PA) requirements or criteria for some services.

- The Professional Fee Schedule is published on Tuesday after 4 p.m. with information current as of the previous Sunday. Therefore, it is highly recommended that you access the schedule online for the most current information regarding procedure codes recognized by the IHCP.
- The current Professional Fee Schedule is available in a prepopulated Excel format: IHCP Professional Fee Schedule – Excel.
- Providers may import the Professional Fee Schedule into other popular applications. For the import options, please see the IHCP Professional Fee Schedule - Download Instructions.
- Providers may search the Professional Fee Schedule by procedure code, procedure code range, or procedure code description.
- Numerical procedure codes are listed in ascending order, followed by alpha procedure codes. The information provided reflects the allowed rate for all procedure codes pertinent to professional and dental billers. All field values are effective on the "Professional Fee Schedule-Last Updated" date listed above.
- Additional notes egarding the Professional Fee Schedule are available.

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Additionally, claims for the codes in Table 4 reported with an informational modifier to identify the facility component, but without the pricing type modifier 26 – *Professional component*, will be reimbursed at maximum fee. This update does not affect pricing or how claims are processed, and is informational only.

The additional information for the codes in Table 4 will be reflected in the next regular update to the *Professional Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers, and in the *Additional Notes*.

Table 4 – Procedure codes added to Additional Notes of IHCP Professional Fee Schedule

Procedure code	Description
83020	Hemoglobin analysis and measurement, electrophoresis
84165	Protein measurement, serum
84166	Protein measurement, body fluid
84181	Protein measurement
84182	Protein measurement, immunological probe for band identification
85390	Coagulation function screening test with interpretation and report
85576	Platelet aggregation function test
86255	Screening test for antibody to noninfectious agent
86256	Measurement of antibody to noninfectious agent
86320	Immunologic analysis technique on serum
86325	Immunologic analysis technique on body fluid
86327	Immunologic analysis technique, crossed
86334	Immunologic analysis technique on serum (immunofixation)
86335	Immunologic analysis technique on body fluid, other fluids with concentration
87164	Dark field microscopic examination for organism, includes specimen collection
87207	Special stain for inclusion bodies or parasites
88371	Protein analysis of tissue with interpretation and report
88372	Protein analysis of tissue by western blot, with interpretation and report
89060	Crystal identification from tissue or body fluid

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