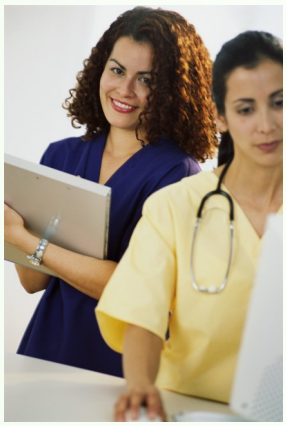
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202220 MAY 17, 2022

Duplicate payer IDs on electronic claim submissions



The Indiana Health Coverage Programs (IHCP) has identified an issue when 837 claim transactions are submitted with duplicate Medicare payer IDs on a single detail.

This issue caused a problem when loading the detail third-party liability (TPL) information, and claims may have had the incorrect payment information applied to the incorrect detail of the submitted claim.

The claim-processing system has been corrected and claims will be mass adjusted. Providers should see adjusted claims on Remittance Advices (RAs) beginning June 22, 2022, with internal control numbers (ICNs)/Claim IDs that begin with 52 (mass replacements non-check related).

IHCP to update rate for A0090 in *Core*MMIS

Effective immediately, the Indiana Health Coverage Programs (IHCP) will update the mileage rate displayed on the IHCP Professional Fee Schedule for Healthcare Common Procedure Coding System (HCPCS) code A0090 – *Non-emergency transportation, per mile – vehicle provided by individual (family member, self, neighbor) with vested interest*. The rate is increasing from $0.39 per mile to $0.42 per mile, retroactive to April 18, 2022. The mileage rate for code A0090 is tied to the mileage rate state employees receive, and the Indiana Department of Administration (IDOA) increased the mileage reimbursement for state employees to $0.42, effective April 18, 2022.

As a reminder, IHCP members served via the fee-for-service (FFS) delivery system receive nonemergency medical transportation (NEMT) services brokered through Southeastrans. There are no changes to the reimbursement rate by Southeastrans.

Within the managed care delivery system, individual managed care entities (MCEs) establish their own coverage criteria, prior authorization (PA) requirements, billing procedures and reimbursement methodologies. For questions about services covered under the managed care delivery system, providers should contact the member's MCE or refer to the MCE provider manual.

The change to reflect the updated IDOA rate will be reflected on the next regularly scheduled update of the Professional Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

MORE IN THIS ISSUE

IHCP adds codes to LTC DME

Indiana Health Coverage Programs (*IHCP) Bulletin* BT202227 announced new codes effective April 1, 2022. The IHCP has identified eight of these codes that are appropriate to be added to the durable medical equipment (DME) and supply codes included in the long-term care (LTC) facility per diem rate. Effective immediately and retroactive to dates of service (DOS) on or after April 1, 2022, the codes in Table 1 will not be separately reimbursable for LTC facility members.

This information will be reflected in the next regularly scheduled update of the *LTC DME Per Diem Table*, accessible from the *Long-Term Care DME Per Diem Table* page at in.gov/medicaid/providers.

Table 1 – DME and supply codes included in the LTC facility per diem rate

HCPCS code	Description
A2011	Supra SDRM, per square centimeter
A2012	Suprathel, per square centimeter
A2013	InnovaMatrix FS, per square centimeter
A4100	Skin substitute, FDA cleared as a device, not otherwise specified
E2102	Adjunctive continuous glucose monitor or receiver
K1031	Non-pneumatic compression controller without calibrated gradient pressure
K1032	Non-pneumatic sequential compression garment, full leg
K1033	Non-pneumatic sequential compression garment, half leg

IHCP excludes additional services from electronic visit verification requirement in 24-hour congregate settings

Effective for dates of service on or after June 1, 2022, the Indiana Health Coverage Programs (IHCP) will no longer require electronic visit verification (EVV) records for the personal care waiver services listed in Table 2 when they are performed in a 24-hour congregate setting. Providers are instructed to use the HQ modifier to indicate that services are being performed in a 24-hour congregate setting. For additional services to which this exemption applies, see *IHCP Bulletin* BT202205.

continued

Table 2 – Services where EVV records are no longer required during a 24-hour congregate setting

Procedure code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Unit
H0034	UB				Medication training and support; per 15 minutes; Adult Mental Health Habilitation; individual setting	15 min
H0034	UB	HR			Medication training and support; per 15 minutes; Adult Mental Health Habilitation; family/couple with member present	15 min
H0034	UB	HS			Medication training and support; per 15 minutes; Adult Mental Health Habilitation; family/couple without member present	15 min
H0034	UB	U1			Medication training and support; per 15 minutes; Adult Mental Health Habilitation; group setting	15 min
H0034	UB	U1	HR		Medication training and support; per 15 minutes; Adult Mental Health Habilitation; group setting, family/ couple with member present	15 min
H0034	UB	U1	HS		Medication training and support; per 15 minutes; Adult Mental Health Habilitation; group setting, family/ couple without member present	15 min
H2014	HA				Skills training and development; per 15 minutes; Child Mental Health Wraparound	15 min
H2014	UB				Skills training and development; per 15 minutes; Adult Mental Health Habilitation; individual setting	15 min
H2014	UB	HR			Skills training and development; per 15 minutes; Adult Mental Health Habilitation; family/couple with member present	15 min
H2014	UB	HS			Skills training and development; per 15 minutes; Adult Mental Health Habilitation; family/couple without member present	15 min
S5150	UB				Unskilled respite care; per 15 minutes; Adult Mental Health Habilitation	15 min
T1005	HA				Respite care services; per 15 minutes; Child Mental Health Wraparound	15 min

Electronic outpatient crossover claim denials for missing coinsurance and deductible

The Indiana Health Coverage Programs (IHCP) has identified an issue with electronic outpatient crossover claims denying for explanation of benefits (EOB) code 0558 - *Coinsurance and deductible amount is missing indicating that this is not a crossover claim*. This denial occurs when no amounts are submitted in the claim header for deductible, coinsurance or copayment.

This issue is being remedied and a publication with reprocessing information will be forthcoming.

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