IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201758 AUGUST 29, 2017

Copay-exempt claims to be reprocessed

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, IHCP members who have met their established quarterly cost-sharing obligations will not be required to pay copayments for the remainder of that quarter. Accordingly, claims for a member processed after a member's copayment obligation is met in any given quarter will no longer have copayments deducted. This claim-processing change will be applied retroactively to claims processed on or after **July 5, 2016**.

Providers can 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 – 270/271 transactions, IHCP Provider Healthcare Portal (Portal), or the Interactive Voice Response (IVR) system. If a copayment is due, a dollar amount will be indicated for the services to which a copayment applies. In the Portal this information will display within the Benefit Details screen (see Figure 1). If no copayment is due, no copayment fields will display under the Benefit Details screen (See Figure 2).

Figure 1 – Eligibility verification display on the Portal indicating copayments apply for certain services on the specified DOS

Eligibility Verification Request

* Indicates a required field.
Enter the member information. If Member ID is not known, enter SSN and Birth Date, or Last Name, First Name, and Birth Date.

Member ID | Last Name | First Name
SSN | Birth Date
*Effective From 08/22/2017 | Effective To 08/22/2017

Submit | Reset

Coverage Details for from 08/22/2017 to 08/22/2017

Member ID | Birth Date | Expand All | Collapse All
Verification Response ID

Benefit Details

Coverage	Description	Effective Date	End Date
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	08/22/2017	08/22/2017
Medical Review Team	Medical Review Team procedure codes only	08/22/2017	08/22/2017

Coverage	Copayments	Amount
Full Medicaid	Medically Related Transportation	$2.00
Full Medicaid	Hospital - Outpatient	$3.00

Managed Care Assignment Details

Demographic Details

Figure 2 – Eligibility verification display on the Portal indicating no copayments apply on the specified DOS – no copayment fields under Benefit Details

Eligibility Verification Request

* Indicates a required field.
Enter the member information. If Member ID is not known, enter SSN and Birth Date, or Last Name, First Name, and Birth Date.

Member ID | Last Name | First Name
SSN | Birth Date
*Effective From 08/24/2017 | Effective To 08/24/2017

Submit Reset

Coverage Details for from 08/24/2017 to 08/24/2017

Member ID | Birth Date | Expand All | Collapse All
Verification Response ID

Benefit Details

Coverage	Description	Effective Date	End Date
Community Integration and Habilitation HCBS Waiver	Authorized Community Integration and Habilitation Waiver services found in the Notice of Action (NOA)	08/24/2017	08/24/2017
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	08/24/2017	08/24/2017
Qualified Medicare Beneficiary	Qualified Medicare Beneficiary - Members for whom co-insurance and deductibles are paid as well as Medicare Part B premiums	08/24/2017	08/24/2017

Other Insurance Details

Demographic Details

Fee-for-service (FFS) claims submitted and processed on or after July 5, 2016, will be reprocessed to determine if copayments were deducted from claims after a member's cost-sharing obligation was met. Any claim that had a copayment amount deducted inappropriately will be mass-adjusted and the copayment amount refunded to the provider. The IHCP will identify affected claims and adjust the payments accordingly; providers do not need to take any action to initiate reprocessing.

Providers should see adjusted claims on Remittance Advices (RAs) beginning the week of October 2. These claims will be identified by internal control numbers (ICNs)/Claim IDs that begin with 52 (mass adjustment). Copayment refunds will be paid and reflected on the RA. If a copayment is refunded, the provider must determine if a similar refund is due to the IHCP member and is responsible for refunding the member the collected copayment amount.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-457-4584.

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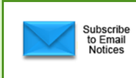

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