IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201433 AUGUST 19, 2014

BPHC procedure codes denied in error

Behavioral & Primary Healthcare Coordination (BPHC) claims submitted between June 1, 2014, and August 11, 2014, with the following Healthcare Common Procedure Coding System (HCPCS) codes were denied in error:

- T1016 UC – *Case management, each 15 minutes; Behavioral & Primary Healthcare Coordination*
- T1016 UC U3 – *Case management, each 15 minutes; Behavioral & Primary Healthcare Coordination; Community health worker and/or certified recovery specialist*

Claims for services rendered by community health workers and/or certified recovery specialists were mistakenly denied for the following explanation of benefits (EOB) codes:

- 2500 – *This recipient is covered by Medicare part A; therefore, you must first file claims with Medicare* [code used for claims without an attachment]
- 2501 – *This recipient is covered by Medicare part A; therefore, you must first file claims with Medicare* [code used for claims with an attachment]
- 2504 – *Recipient is covered by private insurance which must be billed prior to Medicaid*

Corrections have been made to Indiana*AIM*. Providers may resubmit claims for HCPCS codes T1016 UC and T1016 UC U3 that denied for EOB codes 2500, 2501, and 2504 between June 1, 2014, and August 11, 2014, for reimbursement consideration.

EHR Incentive Program Medicare payment adjustments

Beginning January 1, 2015, payment adjustments will be applied to Medicare eligible professionals (EPs) who are not meaningful users of Certified Electronic Health Record (EHR) Technology under the Medicare Electronic Health Records (EHR) Incentive Program. Please note that EPs who participate only in the Indiana Medicaid EHR Incentive Program and do not bill Medicare are not subject to these payment adjustments. EPs who can participate in the Medicare or the Indiana Medicaid EHR Incentive Programs will be subject to the payment adjustments unless they are meaningful users as specified by the Centers for Medicare & Medicaid Services (CMS).

EPs must attest to 90 days of meaningful use by October 1, 2014

To avoid payment adjustments, EPs who are first demonstrating meaningful use in

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2014 must demonstrate meaningful use for a 90-day reporting period in 2014. **The 90-day reporting period must occur within the first nine months of calendar year 2014, and EPs that fall into this category must attest to meaningful use no later than October 1, 2014, to avoid the payment adjustments. Provider attestations must be completed and submitted to the Medical Assistance Provider Incentive Repository (MAPIR) by October 1, 2014**. For example, if a provider attested to adoption, implementation, or upgrade (AIU) in 2013, that EP must attest to 90 days of meaningful use in 2014 by October 1, 2014, to avoid a Medicare payment penalty for 2015.

Please note – EPs attesting to adoption, implementation, or upgrade (AIU) with the Medicaid EHR Incentive Program will not be exempt from the Medicare payment adjustments.

For more detail, see the Payment Adjustments & Hardship Exceptions Tipsheet for Eligible Professionals on the CMS website at cms.gov. If you have further questions, please contact the Indiana Medicaid EHR Incentive Program Customer Service at (317) 488-5137 or 1-855-856-9563.

The IHCP to process Medicare Replacement Plan copayments for crossover claims effective September 24, 2014

The Centers for Medicare & Medicaid Services (CMS) has advised that the terms *coinsurance* and *copayment* are interchangeable with respect to original Medicare and Medicare Replacement Plan cost sharing. As such, effective **September 24, 2014**, the Indiana Health Coverage Programs (IHCP) will treat Medicare Replacement Plan copayments in the same manner as original Medicare coinsurance. Going forward, anywhere the IHCP uses the term *coinsurance* – for example, eligibility verification response, Remittance Advices, the *IHCP Provider Manual*, and so on – the term *coinsurance* will be interpreted to mean original Medicare *coinsurance* and/or Medicare Replacement Plan *copayment*.

The IHCP provides reimbursement for Medicare crossover claims only when the service is also covered by the IHCP and the Medicaid-allowed amount is greater than the amount paid by Medicare. If the Medicaid-allowed amount is greater than the Medicare Replacement Plan-paid amount, the IHCP reimburses the lesser of the coinsurance/copayment and deductible or the difference between the Medicaid-allowed amount and the Medicare Replacement Plan-paid amount.

Medicare Replacement Plan crossover claims that were submitted with a copayment amount and denied between August 9, 2012, through September 24, 2014**,** with explanation of benefits (EOB) code 558 – *Coinsurance and deductible amount missing* must be resubmitted by providers. Claims beyond the original one-year filing limit must include a copy of this Banner Page as an attachment and must be filed within one year of the publication date. Instructions for rebilling these claims are as follows:

UB-04 paper claim form – Instructions for including copayment

Copayment to be entered in **Fields 39a-41d:**

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a						
b						
c						
d						

continue

VALUE CODES – Use these fields to identify Medicare Remittance Notice (MRN) or Medicare Replacement Plan information. The following value codes must be used along with the appropriate dollar or unit amounts for each. **Required, if applicable.**

- Value Code A1 – Medicare deductible amount
- Value Code A2 – Medicare coinsurance/copayment amount
- Value Code 06 – Medicare blood deductible amount
- Value Code 80 – IHCP covered days

CMS-1500 paper claim form – Instructions for including copayment

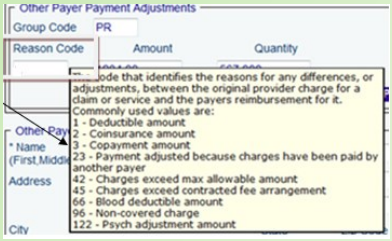
Copayment to be entered in **Field 22:**

Applicable for Medicare Part B crossover claims and Medicare Replacement Plan claims. For crossover claims, the combined total of the Medicare coinsurance/copayment, deductible, and psychiatric reduction must be reported on the left side of field 22 under the heading *Code*. The Medicare paid amount (actual dollars received from Medicare/Medicare Replacement Plan) must be reported in field 22 on the right side under the heading *Original Ref No*. **Required, if applicable.**

Web interChange institutional and professional crossover claims – Instructions for including copayment

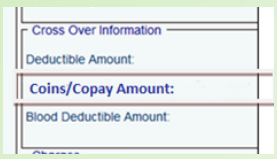
Claim submission – When entering *Other Payer Payment Adjustments* for institutional and professional crossover claims, use a reason code of *3* for copayment amounts. The copayment amount should be entered in the *Amount* field to the right of the *Reason Code* field.

Tip Help for the *Reason Code* field has been updated with the addition of *3 - Copayment Amount*.



Claim Inquiry

The copayment amount for crossover claims will be viewable under the crossover information section in the *Coins/Copay Amount* field.



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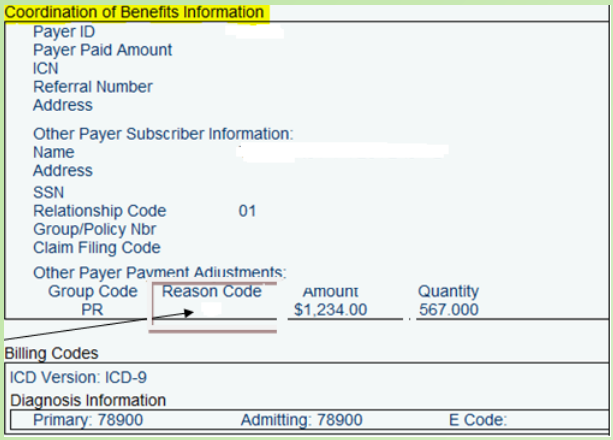
Claim Print

The copayment Reason Code of *3* and *Amount* for crossover claims will be viewable under the *Coordination of Benefits Information* section.



Web Help pages have been updated with instructions for entering copayments.

How electronic data interchange (EDI) 837I and 837P transactions will process copayment

On the 837P professional claim transaction, the copayment amount is reported at the service line level – Loop 2430 in the Claim Level Adjustment segment (CAS), Line Adjustment segment. For example:

- CAS01 = PR (patient responsibility)
- CAS02 = 3 (adjustment reason code for copayment amount)
- CAS03 = copayment amount

*Example: CAS*PR*3*1.75~*

On the 837I institutional claim transaction, the copayment amount is reported at the claim level – Loop 2320 or at the service line level – Loop 2430 in the CAS, Claim Level Adjustments segment. For example:

- CAS01 = PR (patient responsibility)
- CAS02 = 3 (adjustment reason code for copayment amount)
- CAS03 = copayment amount

*Example: CAS*PR*3*1.75~*

Please see the *837I* and *837P* *IHCP Companion Guides* at indianamedicaid.com for details.

QUESTIONS?

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