IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201512 MARCH 24, 2015

Medical and Crossover Part B claims to be mass adjusted for overpayment

The Indiana Health Coverage Programs (IHCP) recently learned of a systems error that resulted in an overpayment to providers for Medical and Crossover B claims. Effective February 1, 2015, the IHCP updated the resource-based relative value scale (RBRVS) conversion factor as part of the physician rate increase implemented with approval of the HIP 2.0 waiver. Due to the system issue, overpayments were made on Medical and Crossover Part B claims impacted by RBRVS pricing that were processed between February 1, 2015 and March 11, 2015.

Beginning May 1, 2015, affected claims will be mass adjusted to correct the overpayment. Adjustments will begin appearing on Remittance Advices (RAs) dated May 5, 2015, and will be identified with internal control numbers (ICNs) that begin with region code 56 (mass adjusted).

Refer to PE approval letters as proof of temporary coverage

Presumptive eligibility (PE) allows qualifying individuals to receive temporary health coverage under the Indiana Health Coverage Programs (IHCP) until official eligibility can be determined by the Indiana Family and Social Services Administration (FSSA). This temporary eligibility allows members to gain access to services immediately and allows providers to be paid for services rendered. PE coverage is temporary and lasts for up to 60 days. To continue coverage, members are required to complete and submit an *Indiana Application for Health Coverage* and be found eligible.

Members who are found eligible through the PE process receive letters that serve as proof of coverage during their PE period. These members do not receive IHCP member identification cards. The letter clearly indicates the dates the member's PE period begins and ends, the member's recipient identification number (RID), and if applicable, the member's managed care entity (MCE). Please be aware that an original PE approval letter is sufficient to validate temporary coverage even if the member is not listed in the appropriate eligibility system. See the sample PE approval letter provided for your reference.

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continued

The State is aware that some members are presenting for pharmacy and other services before their PE status is visible to providers in the IHCP Eligibility Verification System or in the MCEs' pharmacy benefits manager (PBM) systems. This is a particular concern with point-of-sale pharmacy providers as it may take up to three days for members' eligibility to be visible in PBM systems. Pharmacy providers should contact the member's MCE regarding claims submission. The IHCP is working to develop better processes that will allow members' PE eligibility to be loaded into systems more quickly.

IHCP revises unit restrictions on CPT code 95018

Effective May 1, 2015, the Indiana Health Coverage Programs (IHCP) will revise the unit restrictions for Current Procedural Terminology (CPT®[1]) code 95018 – *Allergy Testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests.* The current restriction of one unit will be revised to a restriction of 19 units, which is in line with the national coding guidelines. This change applies to fee-for-service claims with dates of service (DOS) on or after May 1, 2015.

IHCP changes age range for CPT code 49491

Effective May 1, 2015, the Indiana Health Coverage Programs (IHCP) will expand the age range for Current Procedural Terminology (CPT) code 49491 – *Repair, initial inguinal hernia, preterm infant (less than 37 weeks gestation at birth), performed from birth to 50 weeks post-conception age, with or without hydrocelectomy; reducible*. Currently the age range for this code is from zero to four months of age. The age range will be expanded to from zero to seven months of age to accommodate members who are 50 weeks post-conception.

This change applies retroactively to fee-for-service claims with dates of service (DOS) on or after **January 1, 2015**. Beginning May 1, 2015, claims that denied for explanation of benefits (EOB) code 4034 – *Procedure code vs age restriction* may be resubmitted for reimbursement consideration. 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.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-577-1278.

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