IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201545 NOVEMBER 10, 2015

IHCP will mass adjust nursing facility claims that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified an eligibility issue that affected certain claims billed for long-term care (LTC) facility residents whose level of care (LOC) status had not yet been entered into the claims processing system. LTC claims for affected members processed between April 1, 2015, and October 28, 2015, may have inappropriately denied with an explanation of benefits (EOB) 2042 – *Member enrolled in HIP or Hoosier Care Connect.*

LTC facility residents without an LOC status in the system, who would otherwise have been eligible for HIP or Hoosier Care Connect, were systematically enrolled into those programs. LTC services, other than short-term stays less than 30 days in duration, are not included in the scope of benefits provided to members in HIP or Hoosier Care Connect, thus resulting in the claim denials.

Program eligibility and LOC information has been corrected in the system for the affected members. Accordingly, these members are appropriately enrolled in the fee-for-service Traditional Medicaid program, which includes coverage of LTC services. Claims processed during the indicated time frame that previously denied for EOB 2042 will be mass adjusted. Providers should begin to see the adjusted claims on Remittance Advices (RAs) beginning December 15, 2015, with internal control numbers (ICNs) that begin with 56 (mass adjusted).

IHCP will mass adjust claims for HCPCS code J9070 that paid incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claims processing issue that affects certain claims with dates of service (DOS) from July 1, 2015, to October 31, 2015. Fee-for-service claims billed with Healthcare Common Procedure Coding System (HCPCS) code J9070 – *Cyclophosphamide, 100 mg* may have paid inappropriately due to incorrect pricing.

The claims processing system has been corrected. Claims processed for HCPCS code J9070 with dates of service (DOS) between July 1, 2015, and October 31, 2015, will be mass adjusted. Providers should begin to see the adjusted claims on

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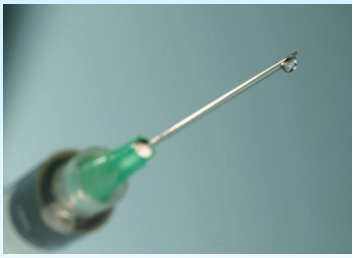
Remittance Advices (RAs) beginning November 10, 2015, with internal control numbers (ICNs) that begin with 56 (mass adjusted). For claims that were underpaid, the net difference will be paid and reflected on the RA.

Pricing information for J9070 will be updated in the next monthly update to the provider Fee Schedule at indianamedicaid.com.

Pricing and billing guidelines updated for HCPCS S0164



Effective December 16, 2015, the Indiana Health Coverage Programs (IHCP) will update the pricing for Healthcare Common Procedure Coding System (HCPCS) code S0164 – *Injection, pantoprazole sodium, 40 mg*. The pricing for this procedure code is changing from manual pricing to maximum fee pricing. In addition, claims for S0164 will require a valid National Drug Code (NDC) to be considered for reimbursement. These changes apply retroactively to dates of service (DOS) on or after **July 1, 2015**.

Beginning December 16, 2015, providers may resubmit claims for reimbursement consideration for HCPCS code S0164 with a DOS on or after July 1, 2015, that denied with EOB 6000 — *Manual pricing required*. Resubmitted claims must include the NDC code. Claims resubmitted 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.

These changes will be reflected in the next monthly update to the *Procedure Codes that Require National Drug Codes (NDCs)* on the Code Sets web page and the Fee Schedule at indianamedicaid.com.

Prior authorization is now required for CDT code D7960

Effective December 10, 2015, the Indiana Health Coverage Programs (IHCP) will require prior authorization (PA) when providers bill for Current Dental Terminology (CDT®[1]) code D7960 – *Frenulectomy – Also known as frenectomy or frenotomy – separate procedure not incidental to another*. This change applies to dates of service (DOS) on or after December 10, 2015.

This PA requirement applies to services delivered under the fee-for-service (FFS) delivery system. Questions regarding FFS PA should be directed to ADVANTAGE Health Solutions[SM] at 1-800-269-5720. Individual managed care entities (MCEs) establish and publish PA criteria within the risk-based managed care (RBMC) delivery system. Questions regarding RBMC PA should be directed to the MCE with which the member is enrolled.

Prior authorization information for D7960 will be revised in the next monthly update to the provider Fee Schedule at indianamedicaid.com.

IHCP to update rates and billing guidance for certain P-codes

Effective January 1, 2016, the Indiana Health Coverage Programs (IHCP) will update the rates for the Healthcare Common Procedure Coding System (HCPCS) codes in Table 1. Updates will be consistent with the IHCP physician-administered drug reimbursement methodology. In addition, claims for these HCPCS codes will require a valid National Drug Code (NDC) to be considered for reimbursement. These rate and billing changes apply to fee-for-service claims with dates of service (DOS) on or after January 1, 2016.

Table 1 – HCPCS codes with rate updates effective for DOS on or after January 1, 2016

Procedure Code	Description
P9041	Infusion, albumin (human), 5%, 50 ml
P9043	Infusion, plasma protein fraction (human), 5%, 50 ml
P9045	Infusion, albumin (human), 5%, 250 ml
P9046	Infusion, albumin (human), 25%, 20 ml
P9047	Infusion, albumin (human), 25%, 50 ml
P9048	Infusion, plasma protein fraction (human), 5%, 250 ml

These changes will be reflected in the next monthly update to the *Procedure Codes that Require National Drug Codes (NDCs)* on the Code Sets web page and the Fee Schedule at indianamedicaid.com.

IHCP will mass reprocess and mass adjust claims for routine foot care that denied incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claims processing issue that affects claims with dates of service (DOS) on or after October 1, 2015, processed from October 1 through November 4, 2015. Fee-for-service (FFS) claims for routine foot care billed with the ICD-10 codes indicated in the Medical Policy Manual were incorrectly denied with explanation of benefits (EOB) 9100 – *Routine foot care limited to specific diagnoses.*

The claims processing system has been corrected. Claims with DOS on or after October 1, 2015, and processed during the indicated time frame that previously denied for EOB 9100 will be mass adjusted or mass reprocessed. Providers should begin to see the adjusted or reprocessed claims on Remittance Advices (RAs) dated November 17, 2015, with internal control numbers (ICNs) that begin with region code 56 (mass adjusted) or 80 (mass reprocessed).

QUESTIONS?

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