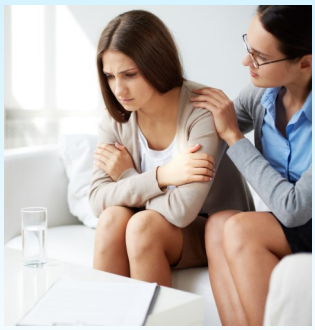
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201641 OCTOBER 11, 2016

IHCP will mass-adjust or mass-reprocess claims for crisis intervention services for DOS on or after February 1, 2015



Indiana Health Coverage Programs (IHCP) *Banner Page* BR201634 indicated that the fee-for-service claims processing system had incorrectly denied Healthy Indiana Plan (HIP) and Hoosier Care Connect member claims for crisis intervention services. *BR201634* also indicated that the affected claims, billed with procedure code H2011 HW – *Crisis intervention service, per 15 minutes,* would be mass adjusted or mass reprocessed retroactive to dates of service (DOS) on or after July 1, 2015.

The IHCP has determined that mass adjustments or mass reprocessing will be extended retroactively to claims with DOS on or after **February 1, 2015.** Accordingly, all HIP and Hoosier Care Connect claims for H2011 HW for DOS February 1, 2015, through June 30, 2015, that denied inappropriately will be mass adjusted or mass reprocessed. Providers should expect to see affected claims on their Remittance Advices (RAs) beginning October 18, 2016, with internal control numbers (ICNs) that begin with 56 (mass adjusted) or 80 (mass reprocessed).

Refer to *Banner Page* BR201634 for reference purposes. For more information on crisis intervention, please see the *Medicaid Rehabilitation Option Services* provider reference module at indianamedicaid.com.

IHCP corrects ICD-10 eligible MRO diagnosis codes

The Indiana Health Coverage Programs (IHCP) is correcting the International Classification of Diseases, Tenth Revision (ICD-10) diagnosis codes eligible for Medicaid Rehabilitation Option (MRO) announced in *BT201653*, as follows:

- The IHCP is adding F42.2 – *Mixed obsessional thoughts and acts* as an eligible MRO diagnosis code for both adults (Adult Needs and Strengths Assessment, or ANSA) and children or adolescents (Child and Adolescent Needs and Strengths, CANS). This change is effective immediately, retroactive to dates of service (DOS) on or after **October 1, 2016**.
- The IHCP is removing F42.8 – *Other obsessive compulsive disorder* as an eligible MRO diagnosis code for both ANSA and CANS. This change is effective for DOS on or after November 10, 2016.

These ICD-10 code changes also apply to the Adult Mental Health Habilitation (AMHH) and the Behavioral and Primary Healthcare Coordination (BPHC) programs. These changes will be reflected in updates to the respective diagnosis code tables for MRO, AMHH, and BPHC located on the *Code Sets* page at indianamedicaid.com.

MORE IN THIS ISSUE

IHCP will mass-adjust outpatient claims that inappropriately paid for HCPCS code 81220

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain outpatient claims with dates of service (DOS) on or after July 1, 2015. Fee-for-service outpatient claims billed with Healthcare Common Procedure Coding System (HCPCS) code 81220 – *CFTR (Cystic Fibrosis Transmembrane Conductance Regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ ACOG guidelines)* may have paid without the required prior authorization (PA). Affected claims would have indicated explanation of benefits (EOB) 3001 – *Dates of service not on the P.A. Master File* on the provider's Remittance Advice (RA).

The claim-processing issue has been resolved. Claims for the affected DOS will be mass-adjusted. Providers should begin seeing the adjusted claims on their RA statements beginning November 8, 2016, with internal control numbers (ICNs) that begin with 56 (mass adjusted). For claims that were overpaid, the net difference appears as an accounts receivable. The accounts receivable will be recouped at 100% from future claims paid to the respective provider number.

IHCP will mass-adjust certain outpatient claims that inappropriately paid

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain outpatient claims with dates of service (DOS) on or after July 1, 2015. Fee-for-service outpatient claims billed with revenue codes 420 – *Physical therapy*, 430 – *Occupational therapy*, and 440 – *Speech language pathology* may have paid without the required prior authorization (PA). Affected claims would have indicated explanation of benefits (EOB) 3001—*Dates of service no on the P.A. Master File* on the provider's remittance Advice (RA).

The claim-processing issue has been resolved. Claims for the affected DOS that will be mass adjusted. Providers should begin seeing the adjusted claims on their RA statements beginning November 8, 2016, with internal control numbers (ICNs) that begin with 56 (mass adjusted). For claims that were overpaid, the net difference appears as an accounts receivable. The accounts receivable will be recouped at 100% from future claims paid to the respective provider number.

IHCP encourages providers to review reporting processes for submitting lead screening information

The Indiana Health Coverage Programs (IHCP), in collaboration with the Indiana State Department of Health (ISDH), reminds providers of the importance of reporting complete blood lead testing data to reference laboratories to assist in surveillance and case management activities. As outlined in *IHCP Banner Page* BR201640, it is a federal requirement for all children enrolled in Medicaid to be screened for lead toxicity and for all results to be reported to the ISDH.

Indiana Administrative Code 410 IAC 29-3-1 states that the person who examines blood for the presence of lead must report the results of the examination to the ISDH no later than one week after the exam. The report must include at least the following information.

With respect to the individual whose blood is examined:

- Full name
- Date of birth
- Gender
- Full address, including street address, city, state, and ZIP Code
- County of residence
- Race and ethnicity
- Parent's or guardian's name and phone number, where applicable

With respect to the examination:

- The date the blood was analyzed
- The type of blood test performed: capillary or venous
- The normal limits for the test
- The results of the test
- The interpretation of the results of the test

This reporting includes results that are analyzed in a laboratory or by using a portable blood lead analyzer. While the person who analyzes the sample is responsible by state law to report the results, healthcare providers that submit specimens for analysis have an ethical obligation to provide the required information for submission.

Recent data extrapolated from the ISDH surveillance system indicates that many healthcare providers/laboratories are not reporting important demographic information needed for surveillance and case management activities. The top four missing required data elements are:

- Full address, including street address, city, state, and ZIP Code
- Blood specimen sample type
- Guardian name
- Gender of the patient

To ensure that laboratories are able to report all the required data elements to the ISDH, all IHCP providers are encouraged to review their processes for submitting lead screening laboratory samples to ensure the information submitted with the samples is complete and accurate. Providers are asked to revise their processes as needed, so that the reporting requirement can be met.

The ISDH, after proper notice, may fine an entity up to $1,500 (*IC 16-41-39.4-3*) per blood lead sample if the required information is not accurately reported in a timely manner. If you have any questions regarding the reporting requirements or would like more information, please contact the Indiana Lead and Healthy Homes Program (ILHHP) at (317) 233-7177.

QUESTIONS?

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

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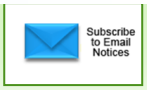

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