IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202017 APRIL 28, 2020

IHCP to mass adjust outpatient and outpatient crossover claims for hospital services that paid incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain fee-for-service (FFS) outpatient and outpatient crossover claims for services rendered by Hospital Assessment Fee (HAF)-eligible hospitals, processed from November 27, 2019, through February 12, 2020. Claims did not process correctly when the IHCP member had any type of copayment amount applied.

HAF eligible hospitals are in-state acute care hospitals licensed under *Indiana Code IC 16-21-2* and freestanding psychiatric hospitals licensed under *IC 12-25*.

As explained in the *Hospital Assessment Fee* provider reference module at in.gov/medicaid/providers, the following hospitals are ***not*** eligible for participation in the HAF program:

- Long-term acute care (LTAC) hospitals
- State-owned hospitals
- Hospitals operated by the federal government
- Freestanding rehabilitation hospitals
- Out-of-state hospitals

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If a HAF-participating hospital becomes ineligible for the HAF program, or if an IHCP-enrolled hospital that was previously ineligible for the HAF program becomes eligible (including newly enrolling hospitals), the hospital must notify the Indiana Family and Social Services Administration (FSSA) of the change within 30 days.

The claim-processing system has been corrected. Affected claims processed during the indicated time frame that paid incorrectly will be mass adjusted. Providers should see the adjusted claims on Remittance Advices (RAs) beginning June 3, 2020, with internal control numbers (ICNs)/Claim IDs that begin with 52 (mass replacement non-check related). If a claim was overpaid, the net difference will appear as an accounts receivable. The accounts receivable will be recouped at 100% from future claims paid to the respective provider number.

IHCP COVID-19 Response: IHCP increases nursing facility reimbursement rates by 4.2%, and mass adjusts claims

In response to the coronavirus disease 2019 (COVID-19), the Indiana Family and Social Services Administration (FSSA) increased Medicaid reimbursement rates by 4.2% for all Indiana nursing facilities, effective March 1, 2020.

Fee-for-service (FFS) claims submitted by nursing facility providers with dates of service (DOS) from March 1, 2020, through March 31, 2020, will be mass adjusted retroactively for the rate increase. Claims submitted for DOS from April 1, 2020, through June 30, 2020, will be revised in accordance with the normal case mix quarterly update, and will then be increased by 4.2%.

Letters about the rates for March and April will be mailed to nursing facility providers that are not registered on the Myers and Stauffer portal. Additionally, the letters are available on the Myers and Stauffer portal, accessible from the website at mslc.com.

Claims processed during the indicated time frames that paid without factoring the 4.2% increase will be mass adjusted. Providers should see adjusted claims on Remittance Advices (RAs) beginning April 29, 2020, with internal control numbers (ICNs)/Claim IDs that begin with 52 (mass replacement non-check related).

IHCP COVID-19 Response: IHCP reimburses for certain laboratory tests and accepts resubmitted claims

Procedure codes associated with laboratory testing are regulated under the Clinical Laboratory Improvement Amendment (CLIA). Indiana Health Coverage Programs (IHCP) policy requires compliance with the Centers for Medicare & Medicaid Services (CMS) recommendations regarding CLIA regulations for all IHCP programs, whether services are delivered under the fee-for-service (FFS) system or managed care. This update applies to both FFS and managed care.

Effective retroactively for professional and institutional claims with dates of service (DOS) on or after March 20, 2020, the IHCP will reimburse for the following procedure codes, with some restrictions, billed by laboratories with a CLIA certificate of waiver for coronavirus disease 2019 (COVID-19) laboratory testing:

- 87635 – *Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique*

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- U0002 – *2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC*

While some COVID-19 tests can be performed by laboratories with a CLIA certificate of waiver, at this time however, most laboratory tests billed for procedure codes 87635 or U0002 are not approved for these types of laboratories. A list of the U.S. Food and Drug Administration (FDA)-approved COVID-19 tests and the level of CLIA certification required for each test kit can be found on the *Emergency Use Authorizations* web page at fda.gov/medical-devices. Providers should refer to the table titled, *Test Kit Manufacturers and Commercial Laboratories Table*, which lists test kits by manufacturer. Only tests with an Authorized Setting(s) of **W** are allowed to be performed by laboratories with a CLIA certificate of waiver.

The IHCP identified a claim-processing issue that affects certain claims submitted by laboratory providers that currently have a CLIA certificate of waiver, for procedure codes 87635 and U0002 with DOS on or after March 20, 2020. Claims billed for these codes may have denied inappropriately with explanation of benefits (EOB) 4207 – *Effective claim number not on file for dates of service billed*.

Beginning immediately, laboratory providers that are authorized to perform COVID-19 testing as described may resubmit claims for codes 87635 and U0002 that previously denied for EOB 4207, for reimbursement consideration. This applies retroactively to claims with DOS on or after March 20, 2020. Claims resubmitted beyond the original filing limit must include a copy of this banner page as an attachment. Claims must be resubmitted within 180 days of this banner page's publication date.

IHCP notifies providers that claim-processing system will require highest level of specificity for ICD-10-CM codes

Effective July 1, 2020, the Indiana Health Coverage Programs (IHCP) will update the *Core*MMIS claim-processing system to enforce the requirement that claim submissions with International Classification of Diseases, Tenth Revision (ICD-10) Clinical Modification (CM) diagnostic codes use the highest level of specificity to describe those codes. The system edit to enforce the ICD-10-CM coding specificity will be placed on a post and pay status until July 1, 2020, when this edit will begin actively denying claims. Affected claims for dates of service (DOS) on or after July 1, 2020, will deny if any ICD-10-CM diagnosis codes do not contain the highest level of specificity.

A recent review of claims submitted using ICD-10-CM codes revealed a high number of claims with the diagnosis codes missing the correct number of characters to be considered valid. Providers are strongly encouraged to review all applicable coding guidelines before the IHCP claim-processing system is updated to enforce the highest level of specificity requirement.

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Note: The IHCP adheres to the coding guidelines published in the AHA Coding Clinic for ICD, a publication of the American Hospital Association, Central Office, and to guidelines posted in the ICD-10-CM Official Guidelines for Coding and Reporting, available on the Centers for Disease Control and Prevention (CDC) website at cdc.gov.

Providers can reference the complete list of ICD-10-CM codes on the *2020 ICD-10-CM* page of the Centers for Medicare & Medicaid (CMS) website at cms.gov/medicare/coding, and can view *ICD-10-CM Official Guidelines for Coding and Reporting*. That publication recommends, among other coding guidelines, that providers use the highest level of specificity when billing diagnostic and procedure codes:

> *A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.*

Other useful resources include:

- Provider reference modules, some of which include service-specific coding requirements, and other materials found on the *Provider Reference Materials* web page at in.gov/medicaid/providers
- *Claim Submission and Processing* provider reference module
- IHCP provider bulletins and banner pages on the *News, Bulletins, and Banner Pages* web page
- Indiana Code (IC) on the State website at iga.in.gov/legislative
- Indiana Administrative Code (IAC) on the State website at in.gov/isdh

Until July 1, 2020, the claim-processing system will continue to reimburse for claims with ICD-10-CM diagnosis codes that do not meet the level of specificity requirement. However, providers will receive an error message on their Remittance Advices (RAs) for a code that does not meet the requirement. For claims with DOS on or after July 1, 2020, claims with invalid ICD-10-CM codes will deny for explanation of benefits (EOB) 0012 – *Invalid diagnosis or header code - please verify and resubmit*.

IHCP to amend PA and billing requirements for therapy services on professional claims

Effective May 28, 2020, the Indiana Health Coverage Programs (IHCP) will amend its prior authorization (PA) and billing requirements for the physical and occupational therapy services billed on professional claims with the procedure codes in Table 1. The IHCP is making this change to ensure that the service on the PA request matches the service billed on the claim. For professional claims (*CMS-1500* form or electronic equivalent) with dates of service (DOS) on or after May 28, 2020, billing for the procedure codes in Table 1 will require that the PA request *and* claim include the appropriate modifier with each code.

Note: For a PA that was approved before May 28, 2020, and is still in effect – the provider will not need to do a system update to end that PA and request a new one that complies with the new requirement.

The IHCP will compare the modifier on the PA request (modifier GO, GP, or no modifier) to the modifier billed on the claim for physical or occupational therapy provided in a professional setting (modifier GO, GP, or no modifier).

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If the physical therapy PA request includes modifier GP – *Services delivered under a physical therapy plan of care,* then modifier GP must be billed on the claim. If the occupational therapy PA request includes modifier GO – *Services delivered under an occupational therapy plan of care,* then modifier GO must be billed on the claim. Instances for which the procedure code modifier combinations on the PA and claim do not match will deny for explanation of benefits (EOB) 3001 – *Dates of service not on the P.A. master file*.

Table 1 – Physical and occupational therapy procedure codes with revised PA and billing requirements on professional claims, effective May 28, 2020

Procedure code	Description
97014	Application of electrical stimulation to 1 or more areas, unattended by physical therapist
97035	Application of ultrasound to 1 or more areas, each 15 minutes
97110	Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes
97112	Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes
97113	Water pool therapy with therapeutic exercises to 1 or more areas, each 15 minutes
97116	Walking training to 1 or more areas, each 15 minutes
97140	Manual (physical) therapy techniques to 1 or more regions, each 15 minutes
97530	Therapeutic activities to improve function, with one-on-one contact between patient and provider, each 15 minutes
97535	Self-care or home management training, each 15 minutes

IHCP delays implementing third-party liability cost avoidance on prenatal care claims

The Indiana Health Coverage Programs (IHCP) previously announced in *Bulletin BT202015* changes related to third-party liability (TPL) cost avoidance requirements for prenatal care services. The bulletin explained that effective for claims with dates of service (DOS) on or after May 1, 2020, the IHCP would begin cost avoiding claims for prenatal care services when the member has an available third-party liability (TPL) resource. This means the provider would be required to bill the TPL resource before billing the IHCP. Prenatal care services would no longer be exempt from TPL cost avoidance requirements.

However, the effective date for those changes is being delayed until further notice. See *BT202015* for more information about the changes being delayed and watch future IHCP announcements for an update.

Countdown to EVV implementation for personal care providers: T-minus 35 weeks

As announced in previous Indiana Health Coverage Programs (IHCP) publications, the *21st Century Cures Act* directs states to require providers of personal care services and home health services to use an electronic visit verification (EVV) system to document services rendered.

Providers of personal care services have until **January 1, 2021**, to implement an EVV system for documenting services.

Please note that personal care providers not in compliance with the EVV mandate by January 1, 2021, will experience claims and reimbursement issues until they follow the federal mandate for successfully recording EVV visits.

More information is available on the *Electronic Visit Verification* web page and in the *Electronic Visit Verification FAQs* document at in.gov/medicaid/providers. For any general questions or concerns about the EVV Program, email EVV@fssa.in.gov.

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