IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT202412 FEBRUARY 6, 2024

IHCP changes FQHC/RHC billing guidance for crossover claims

Previously, federally qualified healthcare centers (FQHCs) and rural health clinics (RHCs) were instructed to include the T1015 encounter code on ***all*** professional claims with the exception of claims for services that are carved out of the prospective payment system (PPS). The Indiana Health Coverage Programs (IHCP) is changing the guidelines for submitting T1015 on Medicare crossover claims (that is, claims for Medicare-covered services where Medicare or a Medicare Advantage Plan is the primary payer).

Effective immediately, it is no longer a requirement for FQHCs and RHCs to include T1015 on Medicare crossover claims with dates of service on or after **July 1, 2021**. Crossover claims do not qualify for wrap payments. Therefore, there is no need to use the T1015 on these claims.

During the public health emergency (PHE), Healthy Indiana Plan (HIP) members who became eligible for Medicare during that time remained on the HIP program. HIP claims submitted to the managed care entities (MCEs) through May 2024 are also affected by this change. Any HIP Medicare or Medicare Advantage Plan coinsurance claims that denied for not having T1015 will need to be adjusted by the member's MCE.

QUESTIONS?

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