IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202010 MARCH 10, 2020

IHCP to extend 3% reduction in reimbursement for hospital services, and mass adjust claims that paid incorrectly

As previously announced in Indiana Health Coverage Programs (IHCP) *Bulletin* BT201747, the IHCP implemented a 3% reduction in reimbursement for inpatient and outpatient hospital services, effective January 1, 2014, through June 30, 2019. This reimbursement reduction will be extended through June 30, 2021.

For fee-for-service (FFS) claims with dates of service (DOS) from July 1, 2019, through June 30, 2021, reimbursement for inpatient and inpatient crossover claims continue to be reduced by 3%. Inpatient hospital claims will process through the diagnosis-related group (DRG) grouper. DRG payments, capital payments, medical education payments (if applicable), and outlier payments (if applicable) will be calculated as usual. The total calculated payment amount will be reduced before subtracting any applicable third-party liability (TPL) payments.

The allowed amount for each detail line of outpatient and outpatient crossover claims will be calculated using the current reimbursement methodology. The allowed amount for each line item on the outpatient claim will be reduced at the detail level. TPL will be subtracted from the total allowed amount of the claim.

As before, these reductions are not applicable for state-operated psychiatric hospitals. Disproportionate share hospital (DSH) payments and hospital upper payment limit (UPL) payments are not subject to the reimbursement reduction. For hospitals participating in the Hospital Assessment Fee (HAF), the 3% inpatient and outpatient hospital reimbursement reductions will not apply while the HAF is in effect, except for the reduction for outpatient laboratory services.

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The IHCP has identified a claim-processing issue that affects certain FFS claims for hospital services processed from July 1, 2019, through February 26, 2020. The claim-processing system did not reduce payments by 3% as expected and overpaid claims.

The claim-processing system has been corrected. 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 April 15, 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 clarifies reimbursement of FQHC and RHC claims for HCPCS code T1015, and will mass reprocess claims

The Indiana Health Coverage Programs (IHCP) allows reimbursement of only one federally qualified health center (FQHC) Healthcare Common Procedure Coding System (HCPCS) encounter code T1015 – *Clinic visit/encounter, all-inclusive* per IHCP member, per billing provider, per day, ***unless*** the primary diagnosis code differs for each additional encounter. Multiple encounter claims from an FQHC or rural health clinic (RHC) for a member on the same date of service (DOS) that do not include a different primary diagnosis code are denied for explanation of benefits EOB 5000 or 5001 – *This is a duplicate of another claim*.

The IHCP has identified a claim-processing issue that affects certain claims billed for encounter code T1015 and processed from February 13, 2017, through February 20, 2020. Claims for the same member, by the same provider, for the same DOS, and with *different* primary diagnosis codes denied inappropriately for EOB 5001. The claims described should have paid because they had different primary diagnosis codes.

The claim-processing system has been corrected. Claims billed for code T1015 during the indicated time frame that denied inappropriately for EOB 5001 will be mass reprocessed. Providers should see reprocessed claims on Remittance Advices (RAs) beginning April 15, 2020, with internal control numbers (ICNs)/claim IDs that begin with 80 (reprocessed denied claims).

Note: Billing modifier U8 – Medicaid level of care 8, as defined by each state, with encounter code T1015 will cause the claim to deny and not bypass duplicate auditing.

IHCP to require prior authorization for certain outpatient services

The Indiana Health Coverage Programs (IHCP) identified seven procedure codes with inconsistencies in prior authorization (PA) requirements across the medical and outpatient contracts. The procedure codes in Table 1 were identified as requiring PA in the medical contract, but not in the outpatient contract. To align the two contracts, the IHCP will require PA for billing the codes in Table 1 for outpatient services, effective April 10, 2020.

Table 1 – Prior authorization required for outpatient services, effective April 10, 2020

Procedure code	Description
22856	Insertion of artificial upper spine disc, anterior approach
81439	Test for detecting genes associated with inherited disease of heart muscle
81504	Genetic profiling on oncology biopsy lesions
97164	Re-evaluation of physical therapy, typically 20 minutes
97168	Re-evaluation of occupational therapy established plan of care, typically 30 minutes
C9739	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants
C9740	Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants

Note: None of the IHCP member criteria for PA for these codes has changed from the medical contract and outpatient services will use the same PA criteria.

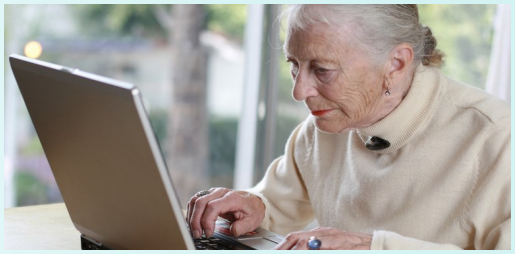
This information will be reflected in the next regular update to the *Outpatient Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

FSSA clarifies billing process for assisted living facility services

The Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) and the Division of Aging (DA) are clarifying changes to the billing process for assisted living facility (ALF) services, effective February 1, 2020. For more information, see Indiana Health Coverage Programs (IHCP*) Bulletin* BT202006. These changes now allow providers of ALF services to bill monthly.

When an ALF provider bills for the monthly rate, the provider should enter 1 unit and include modifier UA. The provider must also include a date of service (DOS) for which the member was physically in the facility, to get paid for the monthly rate. The provider should not use span dates when billing the monthly rate. One DOS is all that is necessary on the claim. As long as the member has not had a break in stay of more than 30 consecutive days, the provider is allowed to bill monthly. If the member exceeds the limit of 30 consecutive days out of the facility, or is voluntarily discharged from the ALF and transfers to another ALF, a skilled nursing facility (SNF), or home, then daily billing is required for the original ALF (and the new ALF, if applicable). See the following examples.

continued



Example 1: The ALF provider normally bills monthly. During the month, their resident Mary discharged to the hospital on February 13, 2020, with plans to return to the ALF. She was at the hospital for 4 days and then discharged to a SNF. Mary remained in the SNF for 14 days. While in the SNF, Mary's family decided to move her to another ALF and she discharged from the SNF. On the date of discharge from the SNF (March 2, 2020), Mary's family informed her ALF provider that she would not be returning and that they wanted her to go to a different ALF.

In this scenario, the original ALF provider would need to bill daily only for the days that Mary was in the facility. If the ALF provider had already submitted monthly billing for Mary, the provider would need to void the original claim and rebill the claim for only the DOS that Mary was in their facility. The new ALF provider would also need to bill the first month using the daily method.

Example 2: The ALF provider normally bills monthly. During the month, their resident Mary discharged to the hospital on February 13, 2020, with plans to return to the ALF. She was in the hospital for 4 days and then discharged to a SNF for 7 days. She returned to the ALF on February 24, 2020. The ALF can still bill the monthly rate for the entire month because Mary was not out of the ALF for 30 consecutive days. The ALF provider would need to choose a single DOS from February 1, 2020, through February 12, 2020, OR from February 24, 2020, through February 29, 2020. The provider can bill for one date in the date range, for 1 unit (for example, From Date of Service [FDOS] February 2, 2020 – To Date of Service [TDOS] February 2, 2020), and bill for T2031 U7 U1 (or U2, U3) and UA for 1 unit.

*Note: The modifiers determine the reimbursement rate, and the level of care (LOC) for the member. Providers receive a notice of action (NOA) via mail and email before the member is admitted to the facility (and whenever there are changes to the NOA). The NOA lists the procedure code and basic modifiers, as well as the total dollar amount that the provider may bill. The NOA does not list modifier UA for monthly billing. However, the provider **may** choose monthly billing instead of daily.*

Example 3: The ALF provider normally bills monthly. During the month, their resident Mary discharged to the hospital on February 3, 2020. Mary remained in the hospital for 10 days and then discharged to a SNF for 21 days. She returned to the ALF on March 5, 2020. In this scenario, Mary was out of the facility for more than 30 consecutive days. The ALF would need to bill daily only for the days that Mary was in the facility during February. If the monthly billing had already been completed for February, then the ALF would need to void the original claim and rebill for only February 1, 2020, through February 2, 2020.

*Note: The NOA will **not** list the **UA** modifier. The NOA will list the daily rate as previously. However, the maximum dollar amount will equal the monthly rate amounts for each level of care (LOC). If your ALF chooses to continue to bill for the daily rate, **29.7** is the maximum number of days that you will be able to bill in any given month. Look for corrected NOAs to be sent out in the next couple of weeks. After corrections have been made to the NOAs, then DXC Technology will reprocess claims that were billed daily for February 2020.*

Please direct any questions or concerns to the FSSA IHCP reimbursement mailbox. **Be sure to send all communications to this mailbox via secure email:** FSSA.IHCPReimbursement@fssa.IN.gov.

IHCP to host IHCP Live webinar about emergency services, March 24, 2020

The Indiana Health Coverage Programs (IHCP) will host a live webinar for all IHCP providers, to discuss changes to claim processing requirements for managed care entity (MCE) emergency services. The changes are due to the State's *Emergency Department Autopay List* that will be implemented on April 1, 2020, as announced in *IHCP Bulletin* *BT202009*. The webinar will also review some key points in the *Emergency Services* provider reference module, which is accessible from in.gov/medicaid/providers.

Members of the Provider Relations section and the Quality and Outcomes section from the Office of Medicaid Policy and Planning (OMPP) will facilitate discussion. Providers will be able to ask questions via a chat feature.

- **Date: March 24, 2020**
- **Time: 11 a.m. Eastern Time**

Here's how to participate:

1. Go to https://indiana.adobeconnect.com/state to sign in to the webinar.

2. Ensure that Guest is selected, type your name, and click **Enter Room**.

3. The webinar provides audio over the internet, so be sure that your speakers or headphones are connected to enable you to listen to the presentation.

Notes:

- Before the webinar, you can test your connection by clicking the following link: https://indiana.adobeconnect.com/common/help/en/support/meeting_test.htm.

  This test will prompt you for any updates or add-ins that your computer needs to join the webinar.

- Please do not log in to the webinar using Citrix or a virtual private network (VPN), because these services will not be able to play back audio.

- If multiple individuals from your organization will join, please join from the same location if possible to save webinar slots for others.

For those who cannot attend the webinar, a recording of the webinar will be posted later on the *IHCP Live* web page at in.gov/medicaid/providers.

Sign up now for the 2020 IHCP Roadshow

The Indiana Health Coverage Programs (IHCP) invites providers to attend the free IHCP Roadshow at various locations around the state, from April 21, 2020, through May 22, 2020. Each of the eleven Roadshow workshops will start at 9 a.m. and end at 3:45 p.m. local time. See Table 2 for specific locations and dates.

Roadshow sessions will include updates and new information from the Indiana Family and Social Services Administration (FSSA), each managed care entity (MCE), and DXC Technology. The roadshow will also feature a Q&A panel, which will address providers' questions that were submitted to IHCPlistens@fssa.IN.gov before February 28, 2020.

Each Roadshow will feature the same sessions, as described below. Session presentations will be posted on the *2020 IHCP Roadshow* page at in.gov/medicaid/providers in advance of the workshop dates. If desired, providers can print copies of the presentations for reference. **Paper copies of the presentations will not be provided onsite.**

Session Descriptions

- **FSSA – Updates** (9 a.m. – 9:45 a.m.)

  Hear the latest on the IHCP's strategic direction and initiatives, directly from the State.

- **DXC Technology – Fee-for-service Provider Updates** (10 a.m. – 10:30 a.m.)

  Find out about recent updates for providers and what is happening at DXC.

- **Anthem – Availity – Appeals and the Interactive Care Reviewer** (10:45 a.m. – 11:15 a.m.)

  Learn about the appeals process in Availity, including reconsideration and claim payment appeals, how to check status, filter your disputes, and view decisions. Anthem will also go over requesting prior authorization (PA) via the Interactive Care Reviewer (ICR), explaining how to submit requests for both inpatient and outpatient services, behavioral health, and update requests.

- **MDwise – Updates and Reminders** (11:30 a.m. – noon)

  Get updates and reminders pertaining to billing, PA, behavioral health, chiropractic services, and quality.

- **MHS – Tips, Updates and Reminders** (1 p.m. – 1:30 p.m.)

  Gather tips for resolving claim issues, presented by Managed Health Services (MHS), and hear about enhancements to the MHS Secure Web Portal, new procedures, and reminders regarding PA.

- **CareSource – Quality, Claims and Network Updates** (1:45 p.m. – 2:15 p.m.)

  Join your CareSource Provider Engagement Specialist to learn about quality initiatives, including HEDIS measures and key performance outcomes, surveys, and resources. CareSource will also review access and availability standards, claim disputes, appeal time lines, and important network updates.

- **FSSA – IHCP Listens – Tips, Updates and Reminders** (2:30 p.m. – 3:00 p.m.)

  Provide feedback about the State's provider engagement and outreach efforts.

continued

- **All – Question and Answer Panel** (3:15 p.m. – 3:45 p.m.)

  Hear answers to providers' questions that were submitted to IHCPlistens@fssa.IN.gov before February 28, 2020.

Note: Providers can use their smartphones to access online surveys and provide feedback on different sessions. For more information, see the video about using quick response (QR) codes on the Provider Education Opportunities web page at in.gov/medicaid/providers.

Workshop Registration

To register, visit the *Provider Education* page at in.gov/medicaid/providers. Click the **Workshop Registration** link to access the IHCP Workshop Registration Tool. Please note that you must register for each session you want to attend. Online confirmation is immediate. **Be sure to register early because workshops can fill up quickly**. Although registration is strongly encouraged, if you are unable to register, walk-ins will be allowed if space is available.

Table 2 – Dates and locations for 2020 IHCP Roadshow

Date	Location	Address
April 21, 2020	Valley Oaks Health Medical Arts Building Fourth Floor	415 N 26th Street Lafayette, Indiana
April 23, 2020	Deaconess Hospital Bernard Schnacke Auditorium	600 Mary Street Evansville, Indiana
April 24, 2020	Baptist Health Paris Health Education Center	1850 State Street New Albany, Indiana
April 28, 2020	Reid Hospital Lingle Auditorium	1100 Reid Parkway Richmond, Indiana
May 1, 2020	Indiana University Ball Hospital Auditorium	2401 W University Ave Muncie, Indiana
May 6, 2020	Terre Haute Regional Hospital A and B Meeting Room	3901 South Seventh Street Terre Haute, Indiana
May 11, 2020	Indiana University Health Methodist Hospital Petticrew Auditorium	1701 N Senate Boulevard Indianapolis, Indiana (Parking is $5)
May 15, 2020	Lutheran Hospital Kachmann Auditorium	7950 W Jefferson Boulevard Fort Wayne, Indiana
May 19, 2020	Columbus Regional Hospital Kroot Auditorium	2400 E 17th Street Columbus, Indiana
May 21, 2020	St. Catherine Hospital Professional Office Building Conference Room	4321 Fir Street East Chicago, Indiana
May 22, 2020	St. Joseph Regional Medical Center Lower Level Conference Room	5215 Holy Cross Parkway Mishawaka, Indiana

The IHCP looks forward to seeing everyone at the Roadshow!

IHCP reminds providers about HIP member benefit limitations on therapy services

The Indiana Health Coverage Programs (IHCP) is reminding providers of the following benefit limitations for Healthy Indiana Plan (HIP) members who receive physical, occupational, speech, respiratory, or cardiac therapy:

- *HIP Basic* members – Up to 60 combined units per benefit period
- *HIP Plus* members – Up to 75 combined units per benefit period
- *HIP State Plan* members – No combined units limitation (see note)

The IHCP reminds providers that it considers one unit to be one unit of a billable physical, occupational, speech, respiratory, or cardiac therapy procedure code. The benefit limitations apply across all enrolled IHCP providers who bill for these services, including chiropractors.

Note: The HIP State Plan covers a combined annual total of 50 units for services performed by a chiropractor. This coverage benefit is only for services performed by a chiropractor. Treatments by a physical therapist, occupational therapist, or speech therapist are not included in this benefit limit. The 50 units can be a combination of office visits, manipulation, and physical medicine treatments and therapies. Chiropractic office visits are limited to five per year (i.e., up to five of the 50 units can be office visits). Radiology, laboratory, diabetic education, and community health worker services on the chiropractic code set do not count towards this limit. This visit limit is assigned to the provider specialty level, so all physical medicine treatments and therapies, manipulations, and office visits performed by a chiropractor apply to this limit, even if for rehabilitation purposes, and not to any other benefit.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-457-4584.

IHCP LISTENS

Do you have feedback for the IHCP? Help us serve you better by giving thoughts and suggestions about our provider engagement at IHCPListens@fssa.in.gov. This inbox helps solicit input from the provider community about workshops, webinars, and other presentations made on behalf of the IHCP. Providers may also email this inbox with ideas for future workshops and presentations, and questions about policies and programs.

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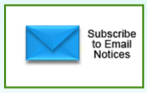

TO PRINT

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