IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202034 AUGUST 25, 2020

IHCP to mass reprocess or mass adjust school corporation claims for NEMT services

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain fee-for-service (FFS) claims for nonemergency medical transportation (NEMT) services submitted by specialty 120 (school corporation) providers, processed from April 21, 2020, through August 5, 2020. Claims for the procedure codes in Table 1 may have denied incorrectly for explanation of benefits (EOB) 2017 – *The member is enrolled in the risk based managed care portion of the Hoosier Healthwise program or has been identified as a member of the Hoosier Care Connect program. The member must seek care from the appropriate managed care entity*.

Table 1 – Procedure codes that may have denied incorrectly for claims processed from April 21, 2020, through August 5, 2020

Procedure code	Description
A0130	Non-emergency transportation: wheelchair van
A0425	Ground mileage, per statute mile
T2001	Non-emergency transportation; patient attendant/escort
T2003	Non-emergency transportation; encounter/trip
T2004	Non-emergency transport; commercial carrier, multi-pass

The claim-processing system has been corrected. Claims for the identified codes processed during the indicated time frame that denied incorrectly for EOB 2017 will be mass reprocessed or mass adjusted, as appropriate. Providers should see the reprocessed or adjusted claims on Remittance Advices (RAs) beginning September 30, 2020, with internal control numbers (ICNs)/Claim IDs that begin with 80 (reprocessed denied claims) or 52 (mass replacements non-check related).

MORE IN THIS ISSUE

IHCP to mass adjust claims for assisted living services that paid incorrectly

The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects claims for assisted living (AL) services with dates of service (DOS) from February 1, 2020, through February 29, 2020. The initial notice of actions (NOAs) for the new monthly rates effective February 1, 2020, and sent to AL providers contained errors. However, the Office of Medicaid Policy and Planning (OMPP) and the Division of Aging (DA) have corrected the NOAs and all AL providers should have received the corrected ones. The corrected NOAs align with the rate changes announced in *IHCP Bulletin* *BT202006* and published again in Table 2 below for reference purposes. There were no changes to monthly AL rates and coverage as given in *BT202006*.

Table 2 – Monthly assisted living service rates and coverage, effective February 1, 2020

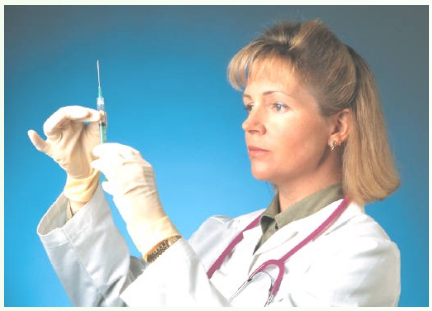
Service	Code	Mod 1	Mod 2	Mod 3	Dsc Pro Modified	Rate
Assisted Living – Level 1 Monthly	T2031	U7	U1	UA	U7=Waiver U1=Level 1 UA=Monthly	$2,153.84
Assisted Living – Level 2 Monthly	T2031	U7	U2	UA	U7=Waiver U2=Level 2 UA=Monthly	$2,391.44
Assisted Living – Level 3 Monthly	T2031	U7	U3	UA	U7=Waiver U3=Level 3 UA=Monthly	$2,768.04

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 on September 30, 2020, with internal control numbers (ICNs)/ Claim IDs that begin with 52 (mass replacements 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.

For any questions or concerns, please contact OMPP via the reimbursement mailbox, FSSA.IHCPReimbursement@fssa.IN.gov.

For more information about NOAs and billing, see the *Division of Aging Home and Community-Based Services Waivers* provider reference module at in.gov/medicaid/providers.

Providers may resubmit professional claims for HCPCS code C9055 that denied incorrectly



The Indiana Health Coverage Programs (IHCP) has identified a claim-processing issue that affects certain fee-for-service (FFS) professional claims with dates of service (DOS) from July 1, 2020, through August 7, 2020. Claims or claim detail lines billed for Healthcare Common Procedure Coding System (HCPCS) code C9055 – *Injection, brexanolone, 1mg* may have denied inappropriately with one of the following explanation of benefits (EOB):

- EOB 4218 – *Service billed is not covered for this claim type*
- EOB 4014 – *Claim being reviewed for pricing*

The claim-processing system has been corrected. Beginning immediately, providers may resubmit claims for procedure code C9055 that previously denied for EOB 4218 or EOB 4014 during the indicated time frame, for reimbursement consideration. Claims resubmitted beyond the original timely filing limit must be resubmitted within 180 days of the publication date and include a copy of this banner page as an attachment.

IHCP COVID-19 Response: IHCP clarifies billing for nursing facility resident daily add-on, and mass adjusts claims

Effective retroactively May 1, 2020, in response to the coronavirus disease 2019 (COVID-19) and as announced in *Indiana Health Coverage Programs (IHCP) Banner Page* BR202021, nursing facility (NF) providers that attest to being *COVID-19 Ready* are eligible for a temporary $115 per resident daily add-on for each resident who tests positive for COVID-19.

Providers will receive the temporary $115 add-on rate per day, for each day up to 21 days per member that the provider attested to being *COVID-19 Ready*. The add-on is limited to a member lifetime total of 21 days.

Billing for the temporary COVID-19 $115 per resident daily add-on

To qualify for reimbursement of the temporary $115 per resident daily add-on, the NF must attest to being an Indiana *COVID-19 Ready* facility as defined in BR202021. Additionally, claims for the resident daily add-on must meet all of the following criteria:

- Claims for COVID-19 positive residents must be submitted with International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) primary diagnosis code U07.1 – *2019-nCoV acute respiratory disease*
- Claims for COVID-19 positive days are on separate claims from **non**-COVID-19 days (see the following examples)
- The temporary $115 per resident daily add-on is limited to 21 days total for each resident

Example 1

A NF provider attested to being *COVID-19 Ready* on May 1, 2020. A member was diagnosed as COVID-19 positive on May 15. The provider previously submitted a claim for the NF daily rate for dates of service (DOS) May 1 through May 31. Primary diagnosis code U07.1 **was** **not** listed on the claim.

continued

Example 1 (continued)

The provider will need to void the original claim and submit two new claims – one claim for DOS May 1 through May 14 ***without*** primary diagnosis code U07.1 for the days the member was not COVID-19 positive, and a second claim for DOS May 15 through May 31 ***with*** primary diagnosis code U07.1 to match the member's COVID-19 positive days.

Note: A new claim submitted for the member's COVID-19 positive days without diagnosis code U07.1 will not be reimbursed for the temporary $115 per resident daily add-on.

Example 2

A provider attested to being *COVID-19 Ready* on May 1, 2020. A member was diagnosed as COVID-19 positive on May 15. The provider previously submitted a claim for the NF daily rate for DOS May 1 through May 31. Primary diagnosis code U07.1 **was** listed on the claim.

The provider should void the original claim and submit two new claims to avoid overpayment of the temporary $115 add-on for the member's non-COVID-19 days. One claim should be submitted for DOS May 1 through May 14 ***without*** primary diagnosis code U07.1, and a second claim for DOS May 15 through May 31 ***with*** primary diagnosis code U07.1 for the resident's COVID-19 positive days.

Example 3

A provider attested to being *COVID-19 Ready* on May 1. A member was diagnosed as COVID-19 positive on May 1. The provider previously submitted a claim for the NF daily rate for DOS May 1 through May 31. Primary diagnosis code U07.1 **was** listed on the claim.

The IHCP will adjust the claim and the provider will receive the temporary $115 add-on up to a member lifetime total of 21 days.

Claim processing for the temporary $115 per resident daily add-on

Depending on whether previously submitted claims with DOS on or after May 1, 2020, met the required NF *COVID-19 Ready* attestation and billing criteria described above, claims will be addressed as follows.

Claims during the indicated time frame, such as in example 3 above, will be mass adjusted for providers that attested as *COVID-19 Ready* and included primary diagnosis code U07.1 for only the member's COVID-19 positive days. Providers should begin to see adjusted claims on Remittance Advices (RAs) beginning September 29, 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.

Duration of temporary daily add-on rate

The temporary $115 per resident daily add-on is available for qualified providers retroactively to claims with DOS on or after May 1, 2020, and will remain in place until the end of the national public health emergency or August 31, 2020, whichever comes first.

IHCP updates *Core*MMIS and fee schedules for noncovered procedure codes

The Indiana Health Coverage Programs (IHCP) identified the active, noncovered Healthcare Common Procedure Coding System (HCPCS) codes in Table 3 as missing from the *Core*MMIS claim-processing system and the published IHCP fee schedules.

These codes have been included in *Core*MMIS, and will be reflected in the next regular updates to the *Professional Fee Schedule* and *Outpatient Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

Table 3 – Noncovered HCPCS codes updated in CoreMMIS

Procedure code	Description
G9574	Adult patients 18 years of age or older with major depression or dysthymia who did not reach remission at six months as demonstrated by a six month (+/-60 days) PHQ-9 or PHQ-9M score of less than five; either PHQ-9 or PHQ-9M score was not assessed or is greater than or equal to five
G9666	The highest fasting or direct LDL-C laboratory test result of 70-189 mg/dl in the measurement period or two years prior to the beginning of the measurement period
G9868	Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the next generation ACO model, less than 10 minutes
G9869	Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the next generation ACO model, 10-20 minutes
G9870	Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the next generation ACO model, 20 or more minutes

IHCP end dates certain noncovered procedure codes

The Indiana Health Coverage Programs (IHCP) has end dated the inactive Healthcare Common Procedure Coding System (HCPCS) codes in Table 4, to align the claim-processing system (*Core*MMIS) with national codes end dated in the past. These HCPCS codes were noncovered by the IHCP.

The claim-processing system has been corrected. These changes will be reflected in the next regular updates to the *Professional Fee Schedule* and *Outpatient Fee Schedule*, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

continued

Table 4 – End-dated noncovered procedure codes

Procedure code	Description
G0298	HIV antigen/antibody, combination assay, screening
G9668	Documentation of medical reason (s) for not currently being a statin therapy user or receive an order (prescription) for statin therapy (e.g., patient with adverse effect, allergy or intolerance to statin medication therapy, patients who have an active diagnosis of pregnancy or who are breastfeeding, patients who are receiving palliative care, patients with active liver disease or hepatic disease or insufficiency, patients with end stage renal disease (ESRD), and patients with diabetes who have a fasting or direct LDL-c laboratory test result < 70 mg/dl and are not taking statin therapy)
L0474	TLSO, triplanar control, rigid posterior frame with flexible soft apron anterior with multiple straps, closures and padding, extends from sacrococcygeal junction to scapula, lateral strength provided by pelvic, thoracic, and lateral frame pieces, rotational strength provided by subclavicular extensions, restricts gross trunk motion in the sagittal, coronal, and transverse planes, produces intracavitary pressure to reduce load on the intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment
Q3021	Injection, Hepatitis B vaccine, pediatric or adolescent, per dose
Q3022	Injection, Hepatitis B vaccine, adult, per dose
Q3023	Injection, Hepatitis B vaccine, immunosuppressed patients (including renal dialysis patients), per dose
S0832	Low-dose computer tomography for lung cancer screening
S9105	Evaluation by ocularist

QUESTIONS?

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