IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT2025125 AUGUST 28, 2025

Electronic claim submission process updated for dually eligible members with no or exhausted Part A benefits

The Indiana Health Coverage Programs (IHCP) updated the claim submission process on May 28, 2025, for fee-for-service (FFS) members with both Medicare and Medicaid coverage (dually eligible members) without Medicare Part A or exhausted Medicare Part A benefits, as identified by the member's Medicare plan. This change allows for electronic claim submissions. This bulletin updates the information that was announced in *IHCP Bulletin* BT202528.

This update applies to inpatient acute care services and includes Medicare benefits without Part A or exhausted Part A prior to or during an inpatient stay. Benefits are exhausted when a member has used all their available benefit days for a given period. The reimbursement policies remain the same.

IHCP Provider Healthcare Portal (IHCP Portal) and electronic (837I) claim transactions for inpatient acute care services must be submitted with the following information, as applicable:

- Medicare Part A benefits exhausted **without** Medicare Part B benefits
  - ⇒ Adjustment reason code (ARC) 119 – Benefit maximum for this time period or occurrence has been reached
  - ⇒ Claim filing indicator of MA
  - ⇒ Medicare Part A paid amount = 0
- Medicare Part A benefits exhausted **with** Medicare Part B benefits (see *Billing instructions for Medicare Part A benefits exhausted with Medicare Part B benefits*)
  - ⇒ ARC 119
  - ⇒ Claim filing indicator of MA
  - ⇒ Medicare Part A paid amount = 0

  AND
  - ⇒ Claim filing indicator of MB
  - ⇒ Medicare Part B paid amount
- No Medicare Part A benefits **with** Medicare Part B benefits
  - ⇒ Claim filing indicator of MB
  - ⇒ Medicare Part B paid amount

Billing instructions for Medicare Part A benefits exhausted with Medicare Part B benefits

The billing instructions included in the *Benefits Exhausted Prior to Inpatient Admission* subsection of the *Inpatient Hospital Services* provider reference module no longer apply.

For billing Medicare Part A benefits exhausted **with** Medicare Part B benefits, the following instructions apply:

- For the 837I electronic transaction, two Other Payer Name loops are required, one each for Medicare Part A and Medicare Part B:
  - ⇒ Medicare information should be transmitted at the header level in the following loop IDs:
    - ♦ 2320 – *Other subscriber information* and in sub-loop 2330A – *Other subscriber name*
    - ♦ 2330B – *Other payer name* (*Note that the corresponding NM109 segments [Other payer ID] will need to be different per 2330B loop entry.*)
  - ⇒ When applicable, detail information can be submitted in Loop 2430 – *Line adjudication information*.
  - ⇒ For further information, see the *837I Companion Guide, accessible from the IHCP Companion Guides* webpage at in.gov/medicaid/provider. The *837I Implementation Guide* is available through the X12 website.
- For claims submitted on the IHCP Portal:
  - ⇒ After selecting the **Include Other Insurance** box, enter the carrier information, including the total paid amount, in the *Other Insurance Details* panel.
  - ⇒ The Carrier Name and Carrier ID should be different for Medicare Part A and Medicare Part B submissions.
  - ⇒ For more information on billing institutional claims on the IHCP Portal, see the *Claim Submission and Processing* module.

For more information

The information in this bulletin applies to FFS claims. Questions about FFS billing and reimbursement should be directed to Gainwell Technologies Customer Assistance at 800-457-4584 or your Provider Relations consultant.

Within the managed care delivery system, individual managed care entities (MCEs) establish and publish reimbursement and billing criteria. Questions about managed care claims should be directed to the MCE with which the member is enrolled.

QUESTIONS?

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

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