Questions and Answers from the 2021 IHCP Roadshow Panel Discussion:
Hospital and Physician Group

The Indiana Health Coverage Programs (IHCP) hosted a panel discussion on Tuesday, May 4, 2021, for hospital and physician group providers as part of the 2021 IHCP Roadshow. This document provides a summary of the questions and answers discussed during the panel.

What is the process for submitting a request to cover a new service or change an existing policy at OMPP?

The Office of Medicaid Policy and Planning (OMPP) has a specific process for members, providers or other interested parties that would like to submit requests for policy consideration. A policy consideration request may seek to add coverage for specific medical codes, revise a provider code set or revise a current medical policy.

On May 28, 2021, the OMPP introduced a new process for submitting policy consideration requests. Please review *IHCP Bulletin* *BT202139* for details.

Policy determinations can frequently be made within several weeks; however, more complex requests may require additional time.

After a determination has been made, the requester will receive an email with the attached determination. If the request has been approved, the requester will be notified that the request is moving through the implementation process. If the request has been denied, the requester will receive an explanation for the decision. A denied request may be submitted for a new consideration following a period of 18 months from the date of the decision or upon release of new studies that would support the request.

What criteria is used to determine if medical necessity or coverage is established for service?

The IHCP uses nationally recognized criteria to determine medical necessity and appropriateness of inpatient hospital, rehabilitation and skilled nursing facility admissions. Sources of criteria include but are not limited to:

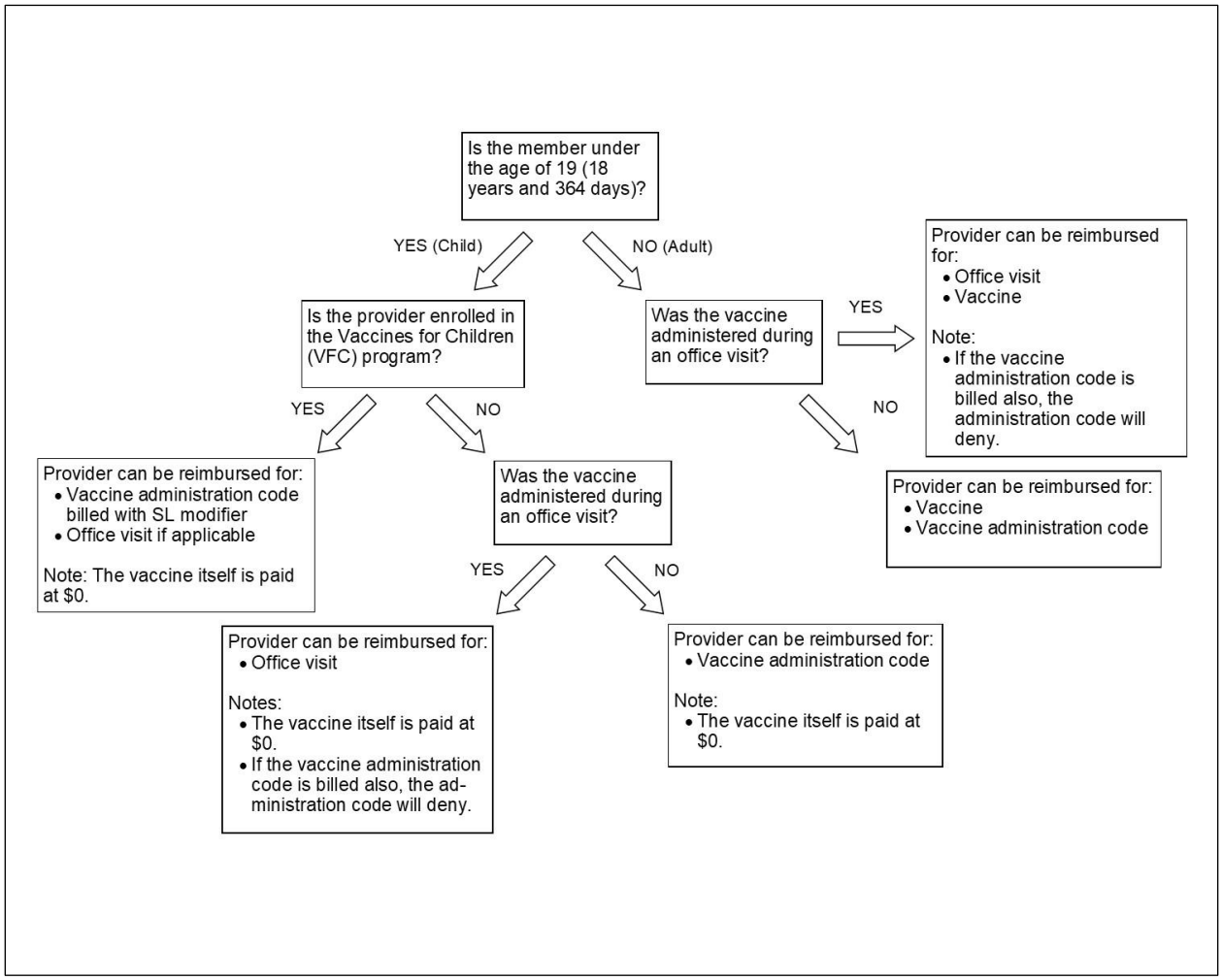
- State and federal legislation
- Medicare and other Centers for Medicare & Medicaid Services (CMS) policies
- Nationally recognized guidelines as assessed by Milliman Care Guidelines Health and InterQual
- Professional standards and association recommendations from entities such as the American College of Obstetricians and Gynecologists (ACOG) and American Dental Association (ADA)
- Food and Drug Administration (FDA) recommendations
- Other state Medicaid programs
- Journal articles and research studies

When a provider administers a vaccine, under what circumstances is it appropriate to bill a code for evaluation and management, vaccine administration and/or the vaccine? How does this guidance change for providers that participate in the Vaccines for Children program?

Reimbursement for vaccine administration is included in the evaluation and management (E/M) code allowed amount. Separate reimbursement for vaccine administration is allowed when the administration is the only service billed by the practitioner on that date of service.

The following flowchart illustrates the IHCP's general guidance for billing and administering vaccines. Please note the billing and reimbursement methodology depends on the source of the vaccine stock, the age of a patient, whether the provider participates in the Vaccines for Children (VFC) program, and whether the vaccine was administered during an office visit.

IHCP Vaccine Billing and Administration Process



Providers can review the IHCP *Injections, Vaccines and Other Physician-Administered Drugs* provider reference module for more information.

What services are covered by HIP Maternity?

The *HIP Maternity* benefit plan for pregnant Healthy Indiana Plan (HIP) members offers all the benefits under the State Plan with no cost-sharing obligations. During a member's pregnancy and 60-day postpartum period, *HIP Maternity* offers enhanced coverage including vision, dental and chiropractic services; nonemergency transportation; and enhanced smoking cessation services.

After the 60-day period, members will be transferred to *HIP Basic*. To switch to *HIP Plus*, the member will need to make a Personal and Wellness Responsibility (POWER) Account contribution within 60 days of receiving *HIP Basic* benefits. Members with income over the federal poverty level who do not pay for *HIP Plus* will lose eligibility for *HIP Basic* after 60 days. To change the status of their eligibility, members must contact the Division of Family Resources (DFR).

How should providers bill for Notification of Pregnancy to align with the new NCCI requirements?

For Notification of Pregnancy (NOP) claims, bill using Current Procedural Terminology (CPT) code 99354 with modifier TH:

- 99354 – *Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service, first hour (list separately)*
- TH – *Obstetrical treatment/services, prenatal or postpartum*

The date of service on the NOP claim should be the date the provider completed the risk assessment during a visit with the pregnant member.

After the May 4, 2021, panel discussion, the IHCP received clarification from the CMS that managed care entities (MCEs) can continue to bypass the National Correct Coding Initiative (NCCI) edit for an NOP service (99354 TH) billed for the same date as an evaluation and management (E/M) service (99202–99215).

Providers may continue to submit the NOP form through the IHCP Provider Healthcare Portal and to submit claims to the member's MCE, as outlined in the IHCP's *Obstetrical and Gynecological Services* provider reference module.

What steps does the IHCP recommend to providers verifying eligibility, particularly when the member does not disclose their third-party liability (TPL) coverage on the date of service?

Per IHCP policy, a provider must verify eligibility at each date of service prior to rendering services. The IHCP acknowledges that sometimes a member's eligibility is not up to date in the IHCP Provider Healthcare Portal, or that a member may not disclose accurate information when a provider verifies eligibility.

If a Member ID (also known as RID) is not known, eligibility can be verified using the member name, date of birth and/or Social Security number.

Scenario 1: When a member has other insurance, an IHCP provider must submit claims to the other insurance carrier before submitting them to the IHCP. The other insurance carrier will pay or deny the claim, and the provider will receive a written response on an explanation of benefits (EOB) from the other carrier. If a third-party insurance carrier fails to respond within 90 days of the billing date, the provider can submit the claim to the IHCP for payment consideration.

The IHCP's 90 Day Provision for Coordination of Benefits Billing policy, as well as information about certain exceptions where cost-avoidance may be bypassed, can be found in the *Third-Party Liability* provider reference module.

Scenario 2: When an IHCP provider is unaware that the patient was eligible for Medicaid at the time services were rendered, and certain conditions are met, the Family and Social Services Administration (FSSA) will review the claim to determine if good faith efforts were made to prevent the need for retroactive enrollment or submit claims in a timely manner. The following conditions must be met:

- The provider's records document that the patient refused or was physically unable to provide their Medicaid number.
- The provider can substantiate that reimbursement was continually pursued from the patient until Medicaid eligibility was discovered.
- The provider billed the IHCP or otherwise contacted the IHCP in writing regarding the situation within 60 days of the date Medicaid eligibility was discovered.

The IHCP's policy for how to submit claims for filing-limit waiver requests can be found in the *Claim Processing and Submission* provider reference module.

The IHCP recommends reviewing the third-party liability and claim-processing guidance from each managed care entity (MCE) for specific claim-submission guidelines.

How do providers navigate the IHCP Fee Schedules?

The Professional Fee Schedule and Outpatient Fee Schedule are accessible from the *IHCP Fee Schedules* webpage.

The Professional Fee Schedule should be used if the provider is going to be billing a professional claim (CMS-1500 claim form, IHCP Provider Healthcare Portal professional claim or 837P electronic transaction). The Professional Fee Schedule can be viewed in full online, or a search tool is available for looking up specific codes or code ranges. The Professional Fee Schedule can also be downloaded as a Microsoft Excel spreadsheet or as text files to be imported into other popular applications.

The Outpatient Fee Schedule is available only as a Microsoft Excel spreadsheet, so there is no specific lookup feature. Providers can search the spreadsheet using Ctrl+F to find a specific code. The Outpatient Fee Schedule document has multiple tabs with helpful information, and the actual fee schedule (by procedure code) is on tab 3.

Both fee schedules have prior authorization (PA) columns. "Y" means PA is required. A blank field or "N" means PA is not required. Some entries on the Professional Fee Schedule have an asterisk that links to additional notes for situations where the values may vary depending on certain factors.

The IHCP recognizes national coding guidelines for linked CPT and revenue codes. Special revenue code linkages are shown in tabs 6 through 14 of the Outpatient Fee Schedule.

Why do the IHCP and MCEs perform recoupments?

Medicaid programs are jointly funded between the state and the federal government. The Government Accountability Office (GAO) has included Medicaid on its list of high-risk programs since 2003, acknowledging that the size, complexity and diversity of Medicaid make the program particularly challenging to oversee at the federal level. Each state has been directed by the federal government to set up a method for pre- and post-payment audit of claims (*Section 1902(a)(37)* of the *Social Security Act* is one of the many federal requirements). The federal government also requires the State Plan to include requirements for identification, investigation and referral of fraud and abuse. It also requires methods to ensure that services reimbursed by Medicaid were actually furnished, and that the services were furnished to beneficiaries.

States do this through different ways. One such way in Indiana is the postpayment audit of claims. When fraud, waste or abuse is identified within the system, the state of Indiana is required to repay the federal share back to the federal government within one year of identification. The state requests repayment from providers so that it can repay the federal government back its share and stay in compliance with many federal requirements to recover the mispayments.

As MCEs have contracted with the state to provide Medicaid services, they also have agreed to monitor their system for fraud, waste and abuse. This same requirement is placed on them by the federal government, as well.

How do you notify providers of overpayments and what is the process providers should use to pay back MCEs or Gainwell?

Managed care entities (MCEs) and Gainwell Technologies (for fee-for-service [FFS] claims) request recoupments when claims are overpaid or paid in error. Some common reasons for a recoupment include errors in member or provider eligibility, services billed in error, duplicate claims, or identification of third-party liability (TPL).

Providers are notified of a recoupment by letter, which states the reason(s) for recoupment and action steps for providers. See the following table for information on how the recoupment process is handled by each MCE and by Gainwell.

Recoupment Processes

MCE or Gainwell	Response time/ time to auto-recoup	Options for payment
Anthem	65 days	Anthem requests providers follow the process outlined in the recoupment notification letter.
CareSource	60 days	Funds recovered from future Remittance Advices (RAs)
MDwise	90 days	Recoupments are obtained through future RAs or explanation of payments (EOPs) until the overpayment amount is satisfied
Managed Health Services (MHS)	60 days	Providers have an option to send a refund check or establish recoupment from future payment through a negative balance.

MCE or Gainwell	Response time/ time to auto-recoup	Options for payment
UnitedHealthcare	60 days	Providers have an option to send a refund check or request an offset against future claim payments.
Gainwell (FFS claims)	60 days	Providers have an option to send a refund check or request an offset against future claim payments. The recoupment process is managed by HMS.

Can a member see a credentialed primary medical provider (PMP) if the member is not assigned to that PMP on the date of service?

Anthem permits members to see any IHCP-enrolled Anthem provider as a primary medical provider (PMP).

CareSource allows its members to see any participating provider that is enrolled as a CareSource PMP. CareSource encourages offices to work with members in updating their assigned provider if they are rendering routine care to a member.

MDwise permits members to see a PMP other than the one to which they were assigned, but the service will not be reimbursed unless both the PMP that provided the service and the member's assigned PMP are all enrolled under the same IHCP group tax identification number (TIN) and National Provider Identifier (NPI).

MHS permits members to see an MHS PMP other than the one to which were assigned, but encourages members to see their assigned PMP if available. During the enrollment process, MHS uses the MHS provider portal to enroll and update the PMP panel information as requested by the provider.

UnitedHealthcare permits members to see an unassigned PMP. If members would like to change their PMP, they can call Member Services at 800-832-4643 and request a PMP change. Those changes are updated on the United Healthcare Community Care Portal within 24 hours of the PMP change.