IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT2024181 NOVEMBER 14, 2024

IHCP reminds providers not to bill Medicaid members, with some exceptions

Following numerous questions from the provider community, the Office of Medicaid Policy and Planning (OMPP) Program Integrity section is reminding Indiana Health Coverage Programs (IHCP) providers that federal and state regulations prohibit providers from charging an IHCP member, or the family of the member, for any amount not paid for an IHCP-covered service following a reimbursement determination by the IHCP. This reminder applies to providers in both the fee-for-service (FFS) and managed care delivery systems. There are some exceptions, as described in this bulletin.

As a condition of the provider's participation in the IHCP, the provider must accept the IHCP's determination of payment as payment in full, whether the IHCP is the primary or secondary payer. If the provider disagrees with the IHCP determination of payment, the provider's right of recourse is limited to an adjustment request, administrative review and appeal, as provided in *Indiana Administrative Code 405 IAC 1-1-3*. Violation of this section constitutes grounds for termination of the provider agreement and decertification of the provider, at the option of the Indiana Family and Social Services Administration (FSSA).

Providers are also bound by a provision in the *IHCP Rendering Provider Agreement* that no member or family of a member may be billed in excess of the amount paid by the IHCP for covered services, and agree to the following:

> *To accept as payment in full the amounts determined by FSSA or its fiscal agent, in accordance with the federal and state statutes and regulations as the appropriate payment for IHCP covered services provided to members. Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for IHCP covered services, excluding any co-payment permitted by law.*

Exceptions that allow billing IHCP members

The following exceptions pertain to all IHCP members, regardless of their eligibility category or program.

An IHCP provider may bill a member for noncovered services only when these conditions are met:

- The member must understand, ***before*** receiving the service, that the service is not covered under the IHCP and that the member is responsible for the service charges.

- The provider must maintain documentation in the member's file that clearly demonstrates that the member voluntarily chose to receive the service, knowing it was not covered by the IHCP. The IHCP does not provide forms used for this purpose. A provider may use a waiver form to document such notification; however, a waiver form is not required. If used, forms are subject to the following:
  - If a waiver form is used to document that a member has been informed that a service is noncovered, the waiver must not include conditional language such as "if the service is not covered by the IHCP, or not authorized by the member's primary medical provider (PMP), the member is responsible for payment." This language appears to circumvent the need for the provider to verify eligibility or seek PMP authorization or prior authorization (PA) as needed.
  - A generic consent form is not acceptable unless it identifies the specific procedure to be performed, and the member signs the consent before receiving the service. If written statements are used, the statements must not contain conditional language such as, "If an IHCP service is not covered…."
  - Obtaining a signed waiver will not prevent the IHCP from investigating the facts alleged in the waiver.

Additional conditions for billing members apply based on circumstances, and adhere to federal regulations and Indiana code as noted:

- If the member has a PMP and wishes to receive services from a non-IHCP provider, the PMP must inform the member before services are rendered that the services will not be covered and may include an additional out-of-pocket expense.
- The service to be rendered must be determined to be noncovered by the IHCP. For example, the member has exceeded the program limitations for a particular service or PA for the service was denied.
- The covered or noncovered status of embellishments or enhancements to basic services can be considered separately from the basic service only if a separate procedure code, revenue code or National Drug Code (NDC) exists:
  - If a separate code exists, a noncovered embellishment may be billed to the member and the basic charge billed to the IHCP.
  - If a separate code does not exist, the service, in its entirety, is considered covered or noncovered.
  - *Example:* Because no separate procedure code exists for embellishments to a standard pair of eyeglass frames, it is not allowable for the IHCP to be billed for the basic frames and for the member to be billed for additional charges. The entire charge for embellished frames is noncovered by the IHCP in accordance with the IAC guidance for covered services.

- If after the provider takes appropriate action to ascertain and identify a responsible payer for a service, there is no indication that the member has coverage under any IHCP program. This means:
  - The provider may bill the member if the member failed to advise the provider of Medicaid eligibility.
  - If the provider is notified of the member's Medicaid eligibility within the 180-day timely filing limit, the IHCP must be billed for the covered service. Any monies that were collected by the IHCP provider from the IHCP member must be reimbursed in full to the member immediately.

    Note: For information about claim filing limits, see the [Claim Submission and Processing](#) provider reference module at in.gov/medicaid/providers.
  - Documentation must be maintained in the file to establish that the member was billed, or information was requested within the timely filing limit.
- The provider may bill the amount credited to the member's waiver liability as identified on the remittance advice (RA), following the final adjudication of the claim.
- The service is not covered by the member's benefit plan, such as services not related to family planning for Family Planning Eligibility Program members, or nonemergency transportation services for Package E – Emergency Services Only members. A waiver is not required.

- The service required PA, but the authorization was denied by the IHCP.
- Services exceed a benefit limit when PA is not available to receive additional services.
- A hospital may bill a member for services if the hospital's utilization review (UR) committee, in accordance with *Code of Federal Regulations* [42 CFR 482.30](#), makes a determination that a continued stay is not medically necessary. The determination must comply with the requirements of *42 CFR 482.30 (d)(1)*, which states:
  - The determination that a continued stay is not *medically necessary*:
    - May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified in [42 CFR 482.12(c)](#), concur with the determination or fail to present their views when afforded the opportunity.
    - Must be made by at least two members of the UR committee in all other cases.
    - Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner or practitioners responsible for care of the patient, as specified in *42 CFR 482.12(c)*, and afford the practitioner or practitioners the opportunity to present their views.

- If the UR committee decides that admission to, or continued stay in, the hospital is not medically necessary, the committee must give written notification no later than two business days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for care of the patient, as specified in *42 CFR 482.12(c)*. Additionally:
  - Before billing the patient, the provider must notify the patient or the patient's healthcare representative in writing that the patient will be responsible for the cost of services provided after the date of the notice.
  - Providers should consult with their attorneys or other advisors about any questions concerning their responsibilities in the UR process.

Missed appointments

IHCP providers may not charge IHCP members for missed appointments. This policy is based on the reasoning that a missed appointment is not a distinct reimbursable service, but a part of the provider's overall costs of doing business. Additionally, according to *405 IAC 5-25-2*, the IHCP will not reimburse a physician for missed appointments.

Copies or transfers of medical records

IHCP providers are not permitted to charge members for copies or transfers of medical records, including mailing costs. IHCP reimbursement for services is intended to cover certain overhead costs. Providers do not receive additional reimbursement from the state or authorized agents for the state, for any cost associated with medical record duplications or medical record transfers, except for members in the Medical Review Team (MRT) benefit plan. The IHCP considers physicians who charge Medicaid patients for copying or transferring medical records to be in violation of federal regulation and their *IHCP Rendering Provider Agreement*.

For more information

For more information about billing Medicaid members, see the *Provider and Member Utilization Review* and the *Provider Enrollment* provider reference modules at in.gov/medicaid/providers.

QUESTIONS?

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