IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201938 SEPTEMBER 17, 2019

CPT codes 77048 and 77049 reimbursable in the outpatient setting

Effective October 17, 2019, the Indiana Health Coverage Programs (IHCP) will allow reimbursement of the following Current Procedural Terminology (CPT®[1]) codes in the outpatient setting:

- 77048 – *MRI of one breast with and without contrast*
- 77049 – *MRI of both breasts with and without contrast*

These procedure codes will be manually priced at 15% of billed charges.

This change will apply to outpatient services rendered under the fee-for-service (FFS) delivery system for dates of service (DOS) on or after October 17, 2019. Individual managed care entities (MCEs) establish and publish reimbursement information within the managed care delivery system. Questions about managed care guidance should be directed to the MCE with which the member is enrolled.

This change 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.

[1]*CPT copyright 2019 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

IHCP to apply claim-processing limit on reimbursement of injection services

Effective October 31, 2019, the Indiana Health Coverage Programs (IHCP) will apply the following limit in the claim-processing system to the reimbursement of outpatient claims for injection procedure codes billed on the same day as certain treatment room revenue codes.

The IHCP will not reimburse for an injection administration procedure code in Table 1 billed for the same date of service (DOS) as a treatment room revenue code in Table 2, if the revenue code was already reimbursed for that DOS. This limit includes codes billed on the same or different claims, and by the same or different providers. (The restriction applies vice versa as well, to a treatment room revenue code in Table 2 billed on the same DOS as a procedure code in Table 1 that was already paid.)

Beginning October 31, 2019, outpatient claims for the procedures and treatment room revenue codes billed on the same DOS (as described above) will deny for explanation of benefits (EOB) 6404 – *Treatment room services and Injection/administration service procedures are not allowed on the same date of service.*

continued

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Table 1 – Procedure codes for injection services with reimbursement limit applied, effective October 31, 2019

Procedure code	Description
90460	Administration of first vaccine or toxoid component through 18 years of age with counseling
90461	Administration of vaccine or toxoid component through 18 years of age with counseling
90465	Immunization administration younger than 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; first injection (single or combination vaccine/toxoid), per day
90468	Immunization administration younger than age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; each additional administration (single or combination vaccine/ toxoid), per day (list separately in addition to code for primary procedure)
90470	H1N1 immunization administration (intramuscular, intranasal), including counseling when performed
90471	Administration of 1 vaccine
90472	Administration of vaccine
90473	Administration of 1 nasal or oral vaccine
90474	Administration of nasal or oral vaccine
96372	Injection beneath the skin or into muscle for therapy, diagnosis, or prevention
96373	Injection into artery for therapy, diagnosis, or prevention
96374	Injection of drug or substance into a vein for therapy, diagnosis, or prevention
96375	Injection of different drug or substance into a vein for therapy, diagnosis, or prevention
96376	Injection of drug or substance into a vein for therapy, diagnosis, or prevention, in a facility

Table 2 – Treatment room revenue codes with reimbursement limit applied, effective October 31, 2019

Treatment room revenue codes (families)	General descriptions
450 451 456 459 480-483 489	Emergency room (450, 451, 456, 459), Cardiology (480-483, 489)
510-517 519-521 523 529	Clinic (510-517, 519), Freestanding clinic (520-521, 523, 529)
700 710 720 721 724 760-762	Cast room (700), Recovery room (710), Labor room/delivery (720, 721, 724), Specialty services (760-762)
900 907 914-916 918	Behavioral health treatments

Note: For more information about billing and reimbursement of injection services, see the Claim Submission and Processing, the Outpatient Facility Services, and the Injections, Vaccines, and Other-Physician Administered Drugs provider reference modules at in.gov/medicaid/providers.

IHCP amends the qualifier required in certain fields of *CMS-1500* claim form for atypical providers

Effective October 10, 2019, atypical (nonhealthcare) providers submitting paper *CMS-1500* claim forms to the Indiana Health Coverage Programs (IHCP) should use the G2 qualifier in the following form fields and discontinue use of the 1D qualifier:

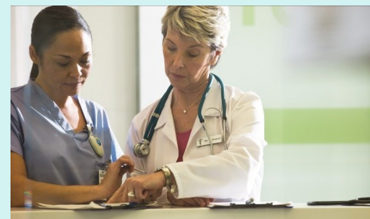
- 17a [ID NUMBER OF REFERRING PROVIDER, ORDERING PROVIDER, OR OTHER SOURCE]
  The qualifier must be in the first box of 17a, indicating what the number reported in the second box (shaded) of 17a represents. Atypical providers should report the IHCP Provider ID in the second box of 17a.

  G2 is the qualifier that applies to the IHCP Provider ID for the atypical nonhealthcare provider. The Provider ID includes nine numeric characters and one alpha character for the service location or a blank.
- 24I ID. QUAL
  Enter the qualifier indicating what the rendering provider number reported in the shaded area of 24J represents. Required, if applicable.

  G2 is the qualifier that applies to the IHCP Provider ID for atypical, nonhealthcare providers.
- 33b BILLING PROVIDER
  If the billing provider is an atypical provider, enter the qualifier G2 and the billing provider's IHCP Provider ID.

PERM review process and requests for provider medical records

The Payment Error Rate Measurement (PERM) program is designed to measure improper payments in the Medicaid program and Children's Health Insurance Program (CHIP). The *Improper Payments Information Act (IPIA) of 2002*, amended by the *Improper Payments Elimination and Recovery Act of 2010 (IPERA)* and the *Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA)*, requires the heads of federal agencies to perform the following oversight activities for the programs they administer:



- Conduct annual review of programs
- Identify those that may be susceptible to significant improper payments
- Estimate the amount of improper payments
- Submit those estimates to Congress
- Submit a report on corrective actions the agency is taking to reduce improper payments

Medicaid and CHIP are reviewed separately in three areas:

- Fee-for-service (FFS) claims
- Managed care claims
- Program eligibility

continued

Three federal contractors share responsibilities to conduct a review of the Medicaid and CHIP FFS and managed care claims. Responsibilities are divided as follows:

- Statistical contractor (SC) – Responsible for selection of claim sample and conducting the calculation of the claim error rates; current SC contractor is The Lewin Group.
- Review contractor (RC) – Responsible for the collection of medical policies and for conducting the medical reviews and claim adjudication reviews; current RC contractor is AdvanceMed.
- Eligibility review contractor (ERC) – Responsible for performing eligibility reviews and providing eligibility data to support the RC data processing review; current ERC contractor is Booz Allen Hamilton.

AdvanceMed, the PERM RC for Review Year 2021 (RY2021), will conduct reviews of selected Medicaid and CHIP claims to determine if claims were paid correctly. Payments made July 1, 2019 through June 30, 2020 will be reviewed in RY2021. When a claim is selected in the sample for a service rendered to a Medicaid or CHIP member, the RC contacts the provider directly for a copy of the provider's medical records to support the medical review of the claim.

Before requesting records, AdvanceMed verifies providers' contact information. To assist with facilitating this verification, it is *crucial* that provider enrollment with the Indiana Health Coverage Programs (IHCP) is up-to-date. Providers can view and update their enrollment information using the Provider Maintenance link in the IHCP Provider Healthcare Portal, accessible from the home page at in.gov/medicaid/providers.

The initial letter request packet to be sent to providers will include:

- Centers for Medicare & Medicaid Services (CMS) letter (authority to request records)
- PERM fax cover sheet with specific list of requested documentation (unique to each claim category)
- Claim summary data for the specific claim sampled
- Medical record submission options and instructions

After receipt of the initial letter request packet, the provider must submit supporting medical records within 75 calendar days. AdvanceMed and/or State staff will follow up with the provider at regular intervals to ensure that the requested information is submitted on time. Patient authorization to release documentation is not required and providers will not receive reimbursement for responding to a PERM request for medical records.

Past studies have shown that the principal cause of errors during the medical review have been insufficient documentation or not submitting documentation for review. Sending incomplete documentation and not sending documentation are errors that can easily be prevented. Accordingly, the Indiana Family and Social Services Administration (FSSA) requests that providers submit complete information before the 75-day deadline. Any documentation requested from providers that is not received timely by the RC for review is considered an error against the State's Medicaid or CHIP program. For any incomplete documentation requests made by the RC, providers are given 14 calendar days to send the required documentation.

Note: If federal financial participation (FFP) is disallowed for a claim, or a portion of the claim, that amount is recouped from the provider.

continued

Protected health information concerns

Providers should submit documentation using the methods described by AdvanceMed. Understandably, providers are concerned with maintaining the privacy of patient information. Remember that providers are required by Section 1902 (a)(27) of the *Social Security Act* to retain records necessary to disclose the extent of services provided to individuals claimed by the provider for rendering services. Additionally, the collection and review of protected health information (PHI) contained in individual-level medical records for payment review purposes is permissible by the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* and in accordance with *Code of Federal Regulations Title 45, parts 160 and 164*.

Contact information

Communication with the RC (AdvanceMed) and the State Office of Medicaid Policy and Planning (OMPP) PERM Team is encouraged. AdvanceMed gives its contact information directly to providers.

The State OMPP PERM Team can be reached at:

FSSA Office of Medicaid Policy and Planning
Indiana Medicaid PERM Project
402 W. Washington St., Room W374
Indianapolis, IN 46204
Telephone: 1-800-457-4515, Option 8
Email: PERM@fssa.in.gov

IHCP reminds providers about IHCP members' MCE choice and process

The Indiana Health Coverage Programs (IHCP) is reminding providers that IHCP members should select a managed care entity (MCE) during their full application, and if later needed, may request to disenroll following the required process.

Most IHCP members receive services through the managed care delivery system. Under managed care, members are enrolled in a health plan with an MCE. Choosing a health plan is a personal decision, which is emphasized by the State's Medicaid member enrollment during the MCE selection process. Each MCE maintains its own provider network, provider services unit, and member services unit for the health plans they offer.

Indiana health coverage applicants have an opportunity to select an MCE on the application, but if the applicant does not select an MCE, the applicant will be auto-assigned according to the State's methodology. In accordance with *Code of Federal Regulations 42 CFR 438.10 (e)*, the State's enrollment broker, Maximus, provides potential members with general information about the basic features of managed care and information specific to each MCE operating in the potential member's service area.

IHCP member opportunities to change MCE

Although an MCE may be auto-assigned, State contractual requirements allow members additional opportunities to select a new MCE by contacting Maximus at 1-866-963-7383.

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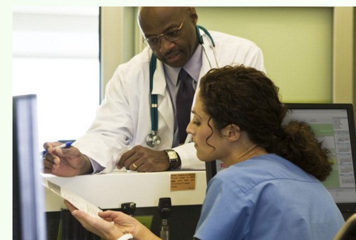

A Hoosier Healthwise or Hoosier Care Connect member may change his or her MCE selection during the first 90 days or during the annual redetermination period. A Healthy Indiana Plan (HIP) member may change his or her MCE selection any time before making the first Personal Wellness and Responsibility (POWER) Account contribution, or within 60 days of assignment to an MCE, whichever comes first. A HIP member may also change MCEs during open enrollment each year. Open enrollment occurs November 1 through December 15, for the next benefit year.

Members may change MCEs any time outside the redetermination and enrollment periods for all programs for *just cause*, according to *Code of Federal Regulations 42 CFR 438.56*. Members may change their MCE selection at any time during the 12-month benefit period for *just cause*. The reasons include, but are not limited to:

- Receiving poor quality care
- Failure of the MCE to provide covered services
- Failure of the MCE to comply with established standards of medical care administration
- Lack of access to providers experienced in dealing with the member's healthcare needs
- Significant language or cultural barriers
- Corrective action levied against the MCE by the State
- Limited access to a primary care clinic or other health services within reasonable proximity to the member's residence
- A determination that another MCE's formulary is more consistent with the new member's existing healthcare needs
- Lack of access to medically necessary services covered under the MCE's contract within the state
- Services not covered by the MCE for moral or religious objections
- Related services required to be performed at the same time, but not available within the MCE's network (and the member's primary medical provider (PMP) or another provider determines that receiving the services separately would subject the member to unnecessary risk)
- Disenrollment of the member's PMP from the member's current MCE and enrolling with another MCE (in this circumstance, the member can change plans to follow his or her PMP to the new MCE)
- Other circumstances determined by the State or its designee, that constitute poor quality healthcare coverage

IHCP member disenrollment process

IHCP members must follow the membership termination process for submitting *just cause* disenrollment requests to the MCE and Maximus.

The process for a member to disenroll from an MCE is as follows:

1) Members are required to attempt to resolve concerns with their MCE and exhaust the MCE's internal grievance and appeal process before requesting an MCE change.

continued

2) The MCE will provide the enrollment broker's contact information and explain that the member must contact the enrollment broker to complete the *just cause* disenrollment. This information must include how to obtain the enrollment broker's standardized form for requesting an MCE change.
3) Members must submit a formal request to change MCE for *just cause* to the enrollment broker (Maximus) verbally or in writing, after exhausting the MCE's internal grievance and appeal process. If the member chooses to make the request verbally
    a) The Maximus helpline representative will determine whether the member is in their 90-day free change period. If the member is in the 90-day change period, the MCE change request will be processed.
    b) If the member is not in the 90-day free change period, the helpline representative will explain that members may not change MCEs until the end of the member's 12-month enrollment period. If the member has expressed a complaint that relates to a *just cause* reason for changing MCEs, or if the member persists in his or her desire to change MCEs, the *just cause* reasons will be explained and the member will be asked if he or she would like to submit a request to change MCEs for *just cause*.
        i) If the member indicates "yes," the helpline representative must start to process the request, as long as sufficient information is collected over the phone.
        ii) The helpline representative will complete the MCE Change form over the phone, or mail it to the member for completion.
4) If the member has already filed a grievance with their MCE prior to contacting the enrollment broker, the helpline representative will request a copy of the member's grievance record from the MCE. The MCE will be expected to respond to the enrollment broker's request within 3 business days of receiving the MCE change form.
    a) In forwarding the grievance record to the enrollment broker, the MCE must include a form summarizing the actions taken, including the content of the grievance and resolution.
    b) The enrollment broker will then determine whether the member's request should be approved or denied, within 7 business days.
5) After making its final decision and obtaining approval from the Office of Medicaid Policy and Planning (OMPP), the enrollment broker will proceed, depending on whether the request was denied or approved:
    a) Denied: The enrollment broker will notify the member of the denial. A form letter will be sent to the member describing the reason for the denial and information about how to file an appeal with Indiana Family and Social Services (FSSA) Hearing and Appeals.
    b) Approved: The enrollment broker will notify the member in writing and explain that the member will be disenrolled from his or her current MCE, and enrolled with his or her newly selected MCE. The enrollment broker will also notify the OMPP.

QUESTIONS?

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

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