IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202006 FEBRUARY 11, 2020

PERM FY 2017 federal audit findings and requirements to maintain records

Following the Payment Error Rate Measurement (PERM) fiscal year (FY) 2017 federal audit, a number of errors were discovered because providers failed to retain medical records.

As part of the corrective action plan to avoid similar errors in future audits, the Office of Medicaid Policy and Planning (OMPP) Program Integrity team is reminding providers of requirements under Title 405 of the *Indiana Administrative Code* (IAC), which were announced in *Indiana Health Coverage Programs (IHCP) Bulletin* *BT201914* that described amendments to the code.

Because the code amendments included the 180-day timely filing limit for services rendered through the fee-for-service (FFS) delivery system, providers may wish to review *BT201914* and the reminder in *IHCP Banner Page* *BR201915*.

In accordance with *405 IAC 1-1.4-2 Medical records*, all IHCP providers shall maintain *medical and other records of services* provided to IHCP members for a period of 7 years from the date of service (DOS). These records must be of sufficient quality to fully disclose and document the extent of services rendered. Records must be documented at the time services are provided or rendered, and prior to submitting the associated claim for reimbursement.

Providers whose reimbursement is determined by the IHCP shall maintain *financial records* for a period of at least 3 years following submission of financial data to the IHCP. A provider shall disclose this financial data when the information is to be used during the rate determination process, as well as during audit proceedings.

Regarding the requirements to maintain records of services, a copy of a claim form submitted by the provider for reimbursement is not sufficient documentation by itself. Providers must maintain records that are independent of claims for reimbursement. These records shall include, at a minimum, the following information and documentation:

- The identity of the individual to whom service was rendered
- The identity, including dated signature or initials, of the provider rendering the service

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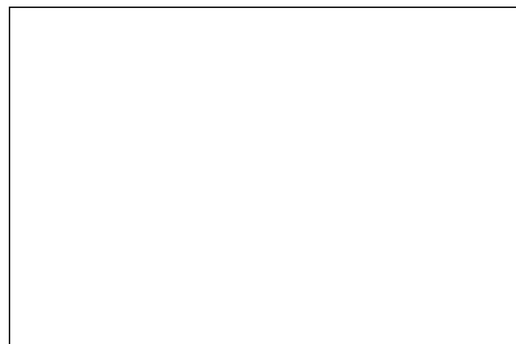
- The identity, including dated signature or initials, and position of the provider's employee rendering the service, if applicable
- The date on which the service was rendered
- The diagnosis of the medical condition of the individual to whom service was rendered, relevant to physicians and dentists only
- A detailed statement describing services rendered, including duration of services rendered
- The location at which services were rendered
- The amount claimed through Medicaid for each specific service rendered
- Written evidence of physician involvement, including signature or initials, and personal patient evaluation to document the acute medical needs
- When required under Medicaid rules, physician progress notes as to the medical necessity and effectiveness of treatment and ongoing evaluations to assess progress and redefine goals
- X-rays, mammograms, electrocardiograms, ultrasounds, and other electronic imaging records



Upon request, IHCP providers must fully disclose all medical, financial, and other records maintained. Requests may come from, but are not limited to, the following entities (or their contractors):

- Office of Medicaid Policy and Planning (OMPP)
- Indiana Family and Social Services Administration (FSSA) Audit Services
- Indiana Medicaid Fraud Control Unit
- Centers for Medicare & Medicaid Services (CMS)
- Office of Inspector General
- U.S. Department of Health and Human Services

Failure to provide such records when requested may constitute an abuse of IHCP policy, a violation of federal law, and of the provider agreement.

Additional service-specific documentation requirements are in the IHCP provider reference modules, accessible from the *IHCP Provider Reference Modules* page at in.gov/medicaid/providers. Other sources include the IAC, Indiana statutes, and announcements in IHCP bulletins and banner pages available from the *IHCP Providers* home page.

For an overview of PERM and reporting year (RY) 2021, view the webinar, *Payment Error Rate Measurement (PERM)*.

Changes to the process for faxing prior authorization requests and supporting documents

The Indiana Health Coverage Programs (IHCP) is amending the process that providers use to fax prior authorization (PA) requests and supporting documents for services delivered under the fee-for-service (FFS) delivery system. Providers who choose to fax PA requests should follow these changes.

Effective February 25, 2020, each faxed submission must:

- Contain only one PA request or modification of an existing request, for one IHCP member, per provider
- Not exceed 999 pages, including supporting documents

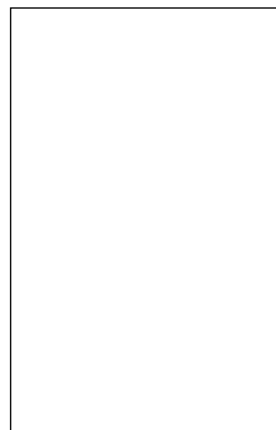
The IHCP will not accept multiple PA requests (batched) within the same faxed submission or single requests that exceed 999 pages.

A submission of more than 999 pages must be sent via mail or the Portal. For more information about mailing paper submissions, refer to the *Prior Authorization* provider reference module at in.gov/medicaid/providers. For details about using the Portal and including attachments, see the *Provider Healthcare Portal* module, also on the website.

Note: Portal attachments have a size limit of 5 MB each. Valid file types for upload include: .bmp, .gif, .jpg, .jpeg, .pdf, .png, .tif, and .tiff.

For general information about PA, including how PA is handled under the FFS and managed care delivery systems, visit the *Prior Authorization* page at in.gov/medicaid/providers.

IHCP reminds providers of new prior authorization customer service line via the IVR system



The Indiana Health Coverage Programs (IHCP) recently completed an enhancement to the Interactive Voice Response (IVR) system to accommodate provider inquiries about prior authorization (PA) requests for services delivered under the fee-for-service (FFS) delivery system.

Providers can now call the IHCP customer service line at 1-800-457-4584, and follow the prompts to speak with a PA representative for assistance with an initial or updated PA request.

At the provider main menu, providers should choose option 7 (PA), and based on the type of PA inquiry, can select the most appropriate prompt.

Note: With this enhancement, some of the prompts and selections will have changed.

Individual managed care entities (MCEs) establish and publish PA criteria within the managed care delivery system. Questions about managed care PA should be directed to the MCE with which the member is enrolled.

IHCP corrects limit on daily rate billing for assisted living services under code T2031

The Indiana Health Coverage Programs (IHCP) recently published a rate increase and methodology change for services provided under the Division of Aging (DA) Aged and Disabled (A&D) and Traumatic Brain Injury (TBI) waivers, effective February 1, 2020.

IHCP Bulletin *BT202006* incorrectly stated that for assisted living (AL) services under code T2031, billing for daily rates is limited to 29 times (units) per month.

Correction: The daily rate will have a monetary limit equivalent to the monthly rate billed at the same level of service. The billing methodology remains unchanged.

QUESTIONS?

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

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from the *Banner Pages* page of the IHCP provider website at in.gov/medicaid/providers.

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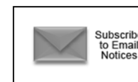

IHCP LISTENS

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