Agenda

• Healthy Indiana Plan (HIP) 2.0
• Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
• Early Elective Delivery
• Timely Filing
• Electronic Health Records (EHR)
• Adult Needs and Strengths Assessment (ANSA)
• Reminder
• Did You Know?
• Helpful Tools
Objectives

To provide updates and opportunity for enhanced knowledge of changes occurring in the IHCP
Healthy Indiana Plan (HIP) 2.0
**BT201426 – Proposal to expand HIP**

- Provide coverage for uninsured Hoosiers
- Create incentives for Hoosiers to transition from public assistance to stable employment
- Promote personal responsibility and decision-making in healthcare
- Maintain and strengthen the POWER Account
  - Increase amount from $1,100 to $2,500
- Enhanced benefits such as dental and vision coverage

For additional information regarding the new HIP 2.0 plan, please visit the HIP Documents and Resources page on the FSSA website at in.gov/fssa.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
EPSDT

**BT201427 – EPSDT Screening Components**

Effective July 14, 2014:

- The IHCP requires documentation of body mass index (BMI) as part of the EPSDT nutritional assessment for all members age 2 and older
  - BMI documentation is a required activity as a component of EPSDT periodic screening services
  - Nutritional assessment now requires the provider to calculate BMI for the member and document the BMI in the member’s chart
  - Nutritional assessment, based on the child’s health history, physical exam including oral dental exam, growth pattern, and appropriate blood work, are required at each EPSDT visit
EPSDT

**BT201427 – EPSDT Screening Components**

- Periodic screenings by an EPSDT screening provider, in accordance with the EPSDT periodicity schedule, include the following:
  - A comprehensive health and developmental history, including assessment of physical and mental health development
  - A comprehensive unclothed physical exam
  - A nutritional assessment
  - A developmental assessment
  - Appropriate vision and hearing testing
  - Dental screening
  - Health education, including anticipatory guidance

For more information about the EPSDT program, please see the [HealthWatch/EPSDT Provider Manual](https://indianamedicaid.com) at indianamedicaid.com.
Early Elective Delivery Policy
Early Elective Delivery Policy

BT201421

The Indiana State Department of Health (ISDH) has identified reducing Indiana’s infant mortality rate as a top priority for the state of Indiana.

- Indiana currently ranks 45th in the nation for infant mortality
  - Eight of every 1,000 children die before their first birthday

- Infant mortality is a multifactorial health problem, and improving Indiana’s infant mortality rate will require a multifaceted approach
  - One of these approaches is to reduce elective deliveries before 39 weeks of gestation

To align with the ISDH’s initiative, the IHCP implemented a nonpayment policy for early elective deliveries (EEDs) effective July 1, 2014. Deliveries that are not medically indicated prior to 39 weeks and 0 days, known as EEDs, are noncovered for dates of service on or after July 1, 2014.
Early Elective Delivery Policy

*BT201421*

- Deliveries that occur before 39 weeks due to spontaneous labor or as the result of a medically indicated induction or cesarean section will continue to be covered.

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### Approved medical indications for a medically necessary delivery prior to 39 weeks and 0 days

<table>
<thead>
<tr>
<th>Maternal Indications</th>
<th>Fetal Indications</th>
<th>Obstetric Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiphospholipid Syndrome</td>
<td>ABO Isoimmunization</td>
<td>Abruptio Placenta</td>
</tr>
<tr>
<td>Chronic Hypertension</td>
<td>Abnormal Fetal Heart Rate</td>
<td>Abruption</td>
</tr>
<tr>
<td>Cardiovascular Diseases</td>
<td>Chorioamnionitis</td>
<td>Antepartum Hemorrhage/Bleeding</td>
</tr>
<tr>
<td>Chronic Pulmonary Disease</td>
<td>Congenital Heart Defect/Heart Disease</td>
<td>Chronic Hypertension with Super Imposed Preeclampsia</td>
</tr>
<tr>
<td>Coagulopathy Defect</td>
<td>Fetal Abnormality</td>
<td>Chorioamnionitis</td>
</tr>
<tr>
<td>Coagulopathy Disorders</td>
<td>Fetal Chromosomal Anomaly</td>
<td>Gestational Diabetes</td>
</tr>
<tr>
<td>Congenital Heart Defect/Heart Disease</td>
<td>Fetal CNS Anomaly</td>
<td>Gestational Hypertension</td>
</tr>
<tr>
<td>Current Cancer</td>
<td>Fetal Damage due to Disease</td>
<td>Hypertensive Disorder</td>
</tr>
<tr>
<td>Condition</td>
<td>Cause</td>
<td>Complication</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>Fetal Damage due to Drugs</td>
<td>Maternal/Fetal Hemorrhage</td>
</tr>
<tr>
<td>Epilepsy/Seizure Disorder</td>
<td>Fetal Damage due to Radiation</td>
<td>Mild Pre-eclampsia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe Pre-eclampsia/HELLP/Eclampsia</td>
</tr>
<tr>
<td>Gastroenteric Diseases/Disorders</td>
<td>Fetal Damage due to Virus</td>
<td>Multiple Gestation/Multiple Gestation with Loss</td>
</tr>
<tr>
<td>Hematological Disorder</td>
<td>Fetal Demise-Singleton</td>
<td>Oligohydramnios</td>
</tr>
<tr>
<td>HIV; Asymptomatic HIV Infection Status</td>
<td>Fetal Distress</td>
<td>Placenta Previa</td>
</tr>
<tr>
<td>Hypertension Non-Specified</td>
<td>Fetal/Maternal Hemorrhage</td>
<td>Placental Previa Hemorrhage</td>
</tr>
<tr>
<td>Liver Disease</td>
<td>Intrauterine Growth Restriction</td>
<td>Polyhydramnios</td>
</tr>
<tr>
<td>Maternal/Fetal Hemorrhage</td>
<td>Non-Reassuring Fetal Antepartum Testing</td>
<td>Premature Rupture of Membranes</td>
</tr>
<tr>
<td>Previous Stillborn</td>
<td>RH Isoimmunization</td>
<td>Prolonged Rupture of Membranes</td>
</tr>
<tr>
<td>Prior Classical Cesarean Delivery</td>
<td></td>
<td>Ruptured Membranes</td>
</tr>
<tr>
<td>Prior Myomectomy Entering Endometrial Cavity</td>
<td></td>
<td>Unstable Lie; Multiple Gestation with Malpresentation</td>
</tr>
<tr>
<td>Renal Disease</td>
<td></td>
<td>Vasa Previa</td>
</tr>
</tbody>
</table>
Early Elective Delivery Policy

Billing Guidelines – CMS-1500

Dates of service on or after July 1, 2014, require modifiers when billing fee-for-service (FFS) claims with Current Procedural Terminology (CPT®) delivery codes 59409, 59514, 59612, and 59620

- **UB** – *Medically necessary delivery prior to 39 weeks of gestation:* Delivery resulting from:
  - Members presenting in labor and subsequently delivering before 39 weeks of gestation
  - Inductions or cesarean sections that meet the IHCP’s approved medical indications for a medically necessary delivery prior to 39 weeks and 0 days
    - Documentation of the gestational age of the fetus and the medical indication for an early delivery must be completed and maintained in the member’s file
    - Suggested forms for documentation are the ACOG Patient Safety Checklists on the ACOG website at acog.org or the IPQIC Scheduling form on the ISDH website at in.gov/isdh
- **UC** – *Delivery at 39 weeks of gestation or later:* Delivery at 39 weeks of gestation or later regardless of method (induction, cesarean section, or spontaneous labor)
- **UA** – *Nonmedically necessary delivery prior to 39 weeks of gestation:* Deliveries at less than 39 weeks of gestation that do not meet the IHCP’s stated guidelines for approved medically necessary delivery
Early Elective Delivery Policy

Billing Guidelines – *UB-04*

- The following condition codes are required when billing for fee-for-service (FFS) obstetric delivery services
  - **81** – C-sections or inductions performed at less than 39 weeks’ gestation for medical necessity
  - **82** – C-sections or inductions performed at less than 39 weeks’ gestation electively
  - **83** – C-sections or inductions performed at 39 weeks’ gestation or greater

- Condition codes are to be placed in fields 18-24 of the *UB-04* claim form
Early Elective Delivery Policy

Billing Guidelines – UB-04

FFS does not cover CPT delivery codes 59410, 59515, 59614, and 59622; for additional information, see *Chapter 8: Billing Instructions of the IHCP Provider Manual*

This EED policy applies to all IHCP programs; billing information described in BT201421 applies to services delivered under the FFS delivery system.

For criteria within the risk-based managed care (RBMC) delivery systems, please see the MCEs’ policies for information regarding prior authorization, reimbursement, and billing for obstetric delivery services.
Timely Filing for Retroactive Coverage
Timely Filing for Retroactive Coverage and Billing Changes

BR201422

Current IHCP policy requires providers to file claims within one year from the date of service on all FFS claims

• Claims affected by retroactive coverage notices and reimbursement or billing changes are subject to a one-year filing limit based on the date of the publication in which the retroactive change is announced
• Claims filed beyond the original one-year filing limit due to retroactive IHCP changes must include a copy of the related provider publication (IHCP Bulletin or Banner Page) as an attachment

Chapter 10 of the IHCP Provider Manual provides additional information regarding timely filing and acceptable documentation required to waive the limit
Timely Filing for Retroactive Eligibility

IHCP Provider Manual, Chapter 8, Section 1

• Use claim notes when billing a claim that is past the filing limit, and the member was awarded retroactive eligibility
  – Claims must be submitted within one year of the eligibility determination date
  – Follow these steps to submit a claim:
    1. Complete the claim as you would normally, using Web interChange
    2. Click Notes in header of claim; and under Note Reference Code, type ADD
    3. In Note text, type: Member has retroactive eligibility. Please force timely filing
Timely Filing for Retroactive Eligibility

**Professional Claim**

* denotes a required field.

**Billing Information**

* NPI
* Legacy Provider ID
* Member ID
* Last Name

**Rendering Information**

* First Name
* Patient Name
* Rendering Provider
* Rendering NPI
* Referring Provider
* Referring NPI
* Signature Indicator
* Medical Record #

**Claim Note Information**

- Save and Close
- Cancel

**Header Notes**

**Note Reference Code**

**Note Text**

MEMBER HAS RETROACTIVE ELIGIBILITY - PLEASE FORCE TIMELY FILING
Timely Filing for Retroactive Eligibility
Electronic Health Records (EHR)
### EHR Incentive Program Documentation

**BR201422 – Eligible professionals**

#### Table 3 – Required documentation for the Indiana EHR Incentive Program in Program Year 2014

<table>
<thead>
<tr>
<th>Providers</th>
<th>Year 1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Acceptable documentation as proof of relationship between provider and EHR vendor *</td>
</tr>
<tr>
<td></td>
<td>2. Documentation from the Office of the National Coordinator for Health IT (ONC) showing proof of certified EHR technology. **</td>
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<td>3. The Indiana EHR pre-payment review team will request documentation supporting the provider’s current submission of patient volume for variances greater than 20%, as compared to the Medicaid Management Information System (MMIS).</td>
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## EHR Incentive Program Documentation

**BR201422 – Eligible hospitals**

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<th>Year 1</th>
<th>Years 2-6</th>
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</thead>
<tbody>
<tr>
<td>1. Medicare Cost Report spreadsheet</td>
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</table>
EHR Incentive Program Documentation
BR201422

Notes

* Acceptable documentation refers to the certified EHR technology by name and certification number, and includes financial and/or contractual commitment. Examples include the EHR contract, invoice, or receipt that includes provider name and point of contact; vendor name and point of contact; and CEHRT name, version, and ONC-issued CEHRT ID.

** Proof must verify that the current CEHRT version meets program year requirements. A screen shot from the ONC website is acceptable proof.

*** Providers that report public health measures will receive confirmation of registration and/or submission from the ISDH, and should scan and upload this confirmation as documentation for the EHR attestation.

For questions regarding these documentation requirements or the Indiana EHR attestation process, please contact Indiana Medicaid EHR Customer Service via email at MedicaidHealthIT@fssa.in.gov or call 1-855-856-9563.

See the EHR Incentive Program FAQs web page at indianamedicaid.com
Adult Needs and Strengths Assessment (ANSA)
Time Frame for ANSA

BR2014220

• The Indiana Family and Social Services Administration (FSSA) requires that the ANSA be conducted for adults with behavioral health disorders:
  - Effective May 1, 2014, the time frame for completing and submitting the ANSA was extended from 30 days to 60 days to allow additional time for providers to complete the assessment, as well as the application process for programs that require an application
  - Programs affected include Medicaid Rehabilitation Option (MRO), Behavioral and Primary Healthcare Coordination (BPHC), and Adult Mental Health Habilitation (AMHH)

For questions or additional information, providers can email BPHCService@fssa.IN.gov.
Reminder
Medicare Replacement Plans

*Medicare Replacement Plan* must be written on the explanation of benefits (EOB) submitted with the claim when:

- The submitted services are *PAID* at -0- by the replacement plan
- The submitted services are *DENIED* by the replacement plan

**Third-party liability (TPL)**

The name of the TPL carrier on the EOB submitted with a claim, when required, must match the information on the member’s eligibility verification.
Did You Know?
IHCP Provider Newsletter Discontinued

After the May 2014 issue, the IHCP is no longer publishing the monthly IHCP Provider Newsletter

• The IHCP continues to keep providers informed of important news and information through IHCP Bulletins and the weekly IHCP Banner Page, as well as announcements and information posted to the provider website at indianamedicaid.com

• Providers are encouraged to sign up for automatic IHCP Email Notifications, so they will know when important information has posted to the website

• Subscribe using the blue subscription envelope on the pages of indianamedicaid.com, and follow the steps to create an email blast account

SUBSCRIBE TO EMAIL NOTICES
Provider Manuals Updated on Routine Basis

Revision History and Highlights are located in the beginning of the manual or specific chapter of the IHCP Provider Manual

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Reason for Revision</th>
<th>Completed By</th>
<th>Relations and Publications Units</th>
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<td>June 2009</td>
<td>Original Publication</td>
<td>Provider Relations and Publications Units</td>
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<td>July 2009</td>
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<td>July 14, 2011</td>
<td>Updated diagnosis codes in Table 6.1</td>
<td>HP Claims and Publications Units</td>
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<td>3.2</td>
<td>Policies and procedures as of August 1, 2011 Published: November 17, 2011</td>
<td>Semiannual update</td>
<td>HP Claims, Provider Relations, and Publications Units</td>
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Revision History

Library Reference Number: PRPR10004
Published: June 10, 2014
Policies and Procedures as of April 1, 2014
Version: 14.0
Helpful Tools
Helpful Tools

• IHCP website at [indianamedicaid.com](http://indianamedicaid.com)

• [IHCP Provider Manual](#)

• Electronic Solutions Service Desk
  - 1-877-877-5182 (toll-free)
  - inxixElectronicSolutions@hp.com

• Customer Assistance
  - 1-800-577-1278 (toll-free)
  - Provider Relations field consultant
  - [provider.indianamedicaid.com/contact-us/provider-relations-field-consultants.aspx](http://provider.indianamedicaid.com/contact-us/provider-relations-field-consultants.aspx)

• Written Correspondence
  - HP Provider Written Correspondence
    P. O. Box 7263
    Indianapolis, IN 46207-7263
Q&A