Chapter 13: Utilization Review
# Chapter 13: Revision History

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Section 1: Introduction

General Information

Utilization review activities required by the Indiana Health Coverage Programs (IHCP) are accomplished through a series of monitoring systems developed to ensure that services are reasonable, medically necessary, and of optimum quality and quantity.

Members and providers are subject to utilization review. Utilization control procedures safeguard against the following situations:

• Unnecessary care and services
• Inappropriate services or poor quality of service monitored in accordance with IHCP guidelines
• Inappropriate payments as defined by the Office of Medicaid Policy and Planning (OMPP)

Utilization Review Focus

Utilization review activities ensure the efficient and cost-effective administration of the IHCP by monitoring the following items:

• Billing and coding practices
• Diagnosis-related group (DRG) validations
• Documentation
• Medical necessity
• Misuse and overuse
• Other administrative findings
• Quality of care
• Reasonableness of prior authorization (PA)

Claims Analysis and Recovery

The Claims Analysis and Recovery (CAR) staff reviews claims data at the systems level. The process determines aberrant billing patterns and inappropriate reimbursements that may occur across a specific provider type and specialty. When a potential issue is discovered, the CAR staff performs thorough research and conducts payment studies to determine if overpayment of services occurred. When identified, the CAR staff may request that a provider submit medical or other records, including X-rays, to fully explain why services were rendered and billed to the IHCP. This documentation must be sufficient to fully disclose the extent of the services provided. See Indiana Administrative Code (IAC) 405 IAC 1-5-1 for a list of items that, at minimum, should be included in documentation.

Providers must maintain medical records and other documentation for a period of seven years from the date of service. A failure to provide medical records or other records when requested may constitute an abuse of IHCP policy and a violation of applicable federal law.

Inappropriately reimbursed IHCP funds are recouped based on these payment studies.
Managed Care Considerations

Care Select

Members and providers enrolled in Care Select are subject to all applicable procedures described in this chapter.

Risk-Based Managed Care

Review and monitoring guidelines for providers enrolled with a managed care organization (MCO) in the risk-based managed care (RBMC) delivery system other than carve-out services are handled by the MCO in which the provider is enrolled. Each MCO may establish and communicate its own criteria. Questions about review and monitoring guidelines for providers enrolled in the RBMC delivery system should be directed to the MCO in which the provider is enrolled. Chapter 1 includes MCO contact information and information about carved-out services.

IHCP Provider and Member Concern Line

Healthcare abuse and fraud hurts everyone. The State relies on the healthcare provider community to actively participate in detecting and deterring IHCP abuse and fraud. If abusive or fraudulent activities are suspected, providers are encouraged to call the IHCP Provider and Member Concern Line or FSSA Fraud Hotline at 1-800-446-1993.

IHCP members are also encouraged to report potential member or provider fraud. If abuse or fraudulent activities regarding IHCP members are suspected, a member’s eligibility may result in potential placement of utilization monitoring through the Right Choices Program (RCP). Below is the list of Right Choices Program administrators:

- ADVANTAGE Health Solutions
  - Care Select – 1-800-784-3981
  - Traditional Medicaid – 1-800-784-3981
- Anthem
  - Hoosier Healthwise – 1-866-902-1690 Option 3
  - Healthy Indiana Plan (HIP) – 1-866-902-1690 Option 3
- Managed Health Services
  - Hoosier Healthwise – 1-877-647-4848
- MDwise
  - Care Select – 1-866-440-2449
  - Hoosier Healthwise – 1-866-902-1690 Option 31-800-356-1204
  - HIP – 1-866-902-1690 Option 31-877-822-7196
Section 2: Abuse and Fraud

General Information

This section outlines utilization review activities and provides the reporting procedures to be followed if Indiana Health Coverage Programs (IHCP) abuse or fraud is suspected or discovered.

Federal Requirements

*Title XIX of the Social Security Act, Sections 1902 and 1903*, and regulations found in 42 CFR 456, mandate that utilization review of IHCP services ensures that services rendered are necessary and of optimum quality and quantity.

These federal regulations also require that the IHCP agency be able to identify and, if warranted, refer cases of suspected abuse or fraud to the Indiana Attorney General’s Medicaid Fraud Control Unit (MFCU) for investigation and prosecution. Utilization review guards against unnecessary medical care and services, and it ensures that payments are appropriate according to the coverage policies established by the IHCP.

Utilization Monitoring

The OMPP Program Integrity team exists to ensure that correct payments are made to legitimate providers for appropriate and reasonable services to eligible Medicaid members. Through the receipt of provider or public complaints that are initiated through the IHCP Provider and Member Concern Line or the Surveillance and Utilization Review (SUR) process, its role is to investigate both medical and pharmacy providers identified as potentially abusing services that are reimbursed by the IHCP.

Individuals, such as Medicaid members or employees of a provider, may contact the IHCP Provider and Member Concern Line with issues of suspected fraud and abuse. These issues are referred to the OMPP Program Integrity team for documentation, preliminary investigation, and tracking. Research of claim history is conducted through the Medicaid Management Information System (MMIS) or other managed care entity (MCE) databases to determine type and volume of alleged abuse.

If the allegations of the referral are substantiated, through the OMPP Program Integrity team’s review, they are referred to the appropriate entity for further investigation and appropriate action. The OMPP Program Integrity team refers issues and coordinates efforts with the State of Indiana Medicaid Fraud Control Unit (MFCU), the State, and county and local law enforcement agencies, and initiates referrals to SUR management staff for potential case assignment. The MFCU will discern whether the referrals initiated by the OMPP Program Integrity team will require further investigation for potential criminal or civil prosecution. The MFCU will advise the OMPP Program Integrity team of the necessity to place a provider on hold within 10 business days. A hold is defined as the request that neither the OMPP Program Integrity team nor the OMPP contracted staff initiate audit-related contacts with the identified provider without receiving prior approval from MFCU.

The IFSSA contracted vendor performs concurrent, desk, and on-site pharmacy audits of Indiana Medicaid pharmacy providers. During these reviews, claims are examined for data entry and billing errors as well as adherence to program policies and procedures. Providers with suspicious billing behavior are referred to MFCU for investigation.
Provider Utilization Review

IHCP Abuse Defined

The term *abuse* describes incidents or practices of IHCP providers that, although not usually considered fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices. These practices can result in unnecessary costs to the IHCP, improper payment, or payment for services that fail to meet recognized standards of care or are medically unnecessary. The following are some examples of abuse:

- Billing and receiving payment from an IHCP member for the difference between the provider charge and the IHCP reimbursement for the service
- Billing the IHCP at a higher fee than for private pay patients
- Submitting claims for services not medically necessary in relation to a member’s diagnosis
- Excessive charges for services or supplies
- Violation of any of the provisions of the provider agreement

IHCP Fraud Defined

*Fraud* is an intentional deception or misrepresentation made by the provider or member, which could result in an unauthorized benefit, such as an improper payment being made to an IHCP provider. Some examples of fraud are listed below:

- Altering a member’s medical records to generate fraudulent payments
- Billing for *group* visits, such as a provider billing for several members of the same family in one visit, although only one family member was seen or provided medically necessary services
- Billing for services or supplies that were not rendered or provided
- Misrepresenting services provided (for example, billing a covered procedure code and providing a noncovered service)
- Soliciting, offering, or receiving a kickback, bribe, or rebate
- Submitting claim forms that have been altered or manipulated to obtain higher reimbursement

Review Process Outcomes

All providers and members are subject to review, fraud referral, and administrative sanctions.

Providers and members are notified in writing about the results of any utilization review that has resulted in administrative action. The written notification outlines the administrative action anticipated and includes appeal procedures.

The state of Indiana MFCU is responsible for investigating suspected cases of IHCP fraud. Such an investigation could result in a felony or misdemeanor criminal conviction. Providers under investigation by the MFCU are not identified until court action is filed in a county, state, or federal court.

The MFCU can also refer cases of providers convicted of IHCP fraud to the Department of Health and Human Services (DHHS) for civil monetary penalties under the *Federal Civil Monetary Law* of the *Social Security Act.*
Federal Exclusion

The Office of Inspector General (OIG) has the authority to exclude from participation in Medicare, Medicaid, and other federal healthcare programs individuals or entities that have been convicted of fraud. If an individual or entity is excluded from participation, this exclusion applies to all States and all federal healthcare programs. Any provider excluded by the OIG is not permitted to participate in the IHCP or other federal healthcare programs. The OIG publishes names of excluded individuals and entities. Access this list from the OIG Web site at http://www.oig.hhs.gov/fraud/exclusions.asp.

The following is from the Health and Human Services (HHS) OIG Special Advisory Bulletin: The Effect of Exclusion from Participation in Federal Health Care Programs (September 1999), C. Exclusion from Federal Health Care Programs, available on the OIG Web site at http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/effected.htm.

Any items and services furnished by an excluded individual or entity are not reimbursable under Federal health care programs [including Medicaid]. In addition, any items and services furnished at the medical direction or prescription of an excluded physician are not reimbursable when the individual or entity furnishing the services either knows or should know of the exclusion. This prohibition applies even when the Federal payment itself is made to another provider, practitioner, or supplier that is not excluded.

The prohibition against Federal program payment for items or services furnished by excluded individuals or entities also extends to payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Federal program beneficiaries. This prohibition continues to apply to an individual even if he or she changes from one health care profession to another while excluded. In addition, no Federal program payment may be made to cover an excluded individual's salary, expenses, or fringe benefits, regardless of whether they provide direct patient care.

The following are examples of some of the types of items or services that are reimbursed by federal healthcare programs, which when provided by excluded parties, violate OIG exclusions. These examples are not a complete list; however, the examples indicate reasons why IHCP providers must screen potential employees and review all current employees for OIG exclusion. These examples are excerpted from the HHS OIG Special Advisory Bulletin: The Effect of Exclusion from Participation in Federal Health Care Programs (September 1999) available on the OIG Web site at http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/effected.htm:

- Services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency, or physician practice, if such services [provided] are reimbursed directly or indirectly by a federal healthcare program.
- Services performed by excluded pharmacists or others (such as pharmacy technicians) who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by any federal healthcare program.
- Services performed by excluded ambulance drivers, dispatchers or other employees involved in providing transportation reimbursed by a federal healthcare program.
- Services performed for (members) by excluded individuals who sell, deliver, or refill orders for medical devices or equipment being reimbursed by a federal healthcare program.
- Services performed by excluded social workers who are employed by healthcare entities to provide services to (members), and whose services are reimbursed, directly or indirectly, by a federal healthcare program.
- Administrative services, including the processing of claims for payment, performed by an excluded individual.
Services performed by an excluded administrator, billing agent, accountant, claims processor, or utilization reviewer that are related to and reimbursed, directly or indirectly, by a federal healthcare program.

Items or services provided to a (member) by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a federal healthcare program.

Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of (members) and reimbursed, directly or indirectly, by a federal healthcare program.

Providers are encouraged to check all current and future employees, subcontractors, and agency staff for possible exclusion from participation in federal health programs. Failure to verify this information may result in recoupment, fines, and exclusion from federal health programs, including the IHCP. Knowing submission of false claims in violation of the exclusion provisions may be prosecuted in state or federal court. Providers must ensure that they maintain and follow written internal procedures for compliance with federal exclusion guidelines. Providers are advised to self-report any violation of the Federal Exclusion policy to the Medicaid Fraud Control Unit (MFCU) by calling 1-800-382-5516.

Employee Education about False Claims Recovery

The Deficit Reduction Act of 2005 (DRA) amended the Social Security Act with important requirements related to Medicaid program integrity. Under Chapter 3 of the DRA, entitled “Eliminating Fraud, Waste and Abuse,” the U.S. Congress enacted provisions regarding the “Employee Education About False Claims Recovery” (Section 6032) and the Medicaid Integrity Program (MIP) (Section 6034). Medicaid program integrity influenced the False Claims Act (FCA) and Section 6032 of the DRA, which established Section 1902(a)(68) of the Social Security Act.

In a broad sense, Medicaid program integrity works to ensure that all aspects of the Medicaid program are strong and functioning well. To this end, the new DRA requirements direct the Centers for Medicare & Medicaid Services (CMS) to improve methods to detect and prevent fraud, waste, and abuse in federal healthcare programs.

Under the MIP, the CMS is statutorily required to develop a five-year comprehensive Medicaid integrity plan. This information is available, along with other information about combating Medicaid fraud, waste, and abuse at http://www.cms.hhs.gov/MedicaidGenInfo/.

“Employee Education About False Claims Recovery” establishes an entity’s requirements for compliance. Section 1902(a)(68) of the Social Security Act reads as follows:

“A State plan for medical assistance must provide that any entity that receives or makes annual payments under the [Medicaid] State plan of at least five million dollars ($5,000,000) as a condition of receiving such payments shall –

(A) establish written policies for all employees of the entity (including management) and of any contractor or agent of the entity, that provide detailed information about

a) the False Claims Act established by sections 3729 through 3733 of Title 31 of the United States Code,  
b) administrative remedies for false claims and statements established under chapter 38 of title 31,United States Code,  
c) any State laws pertaining to civil or criminal penalties for false claims and statements, and  
d) whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f)).
(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

An entity is not required to create an employee handbook if one does not already exist. No template of policy language is being furnished to entity as this detail should clearly relate to the entity’s specific practices.”

Requirements for State

Section 6032 further identifies duties of the State to conduct reviews to assess provider compliance. The OMPP, or its contractors, will conduct reviews annually of selected entities. The reviews will include collection and examination of the entities' policies and procedures regarding the education it provides to employees, management, officers, and contractors or agents as set out in items (A) through (C) above. This federal legislation became effective January 1, 2007.

Upon request by the OMPP or its contractors, entities will provide a copy of the policies and procedures for review purposes.

Upon request by the OMPP or its contractors, entities will provide a copy of the employee handbook, if one exists, for review purposes.

Consequences of Noncompliance for Healthcare Entities

If an entity is found not to be in compliance with any part of the requirements noted above regarding the False Claims Act and section 1902(a)(68) of the Social Security Act, entities are required to submit to the OMPP a corrective action plan within 60 calendar days.

The corrective action plan will describe the actions and methods the entity will follow to ensure that the entity comes into compliance. If an entity is required to submit a corrective action plan and does not do so within 60 days, the State may withhold payment to the entity until a corrective action plan is received. The corrective action plan will designate a contact person within the entity responsible for communicating plan implementation details with the OMPP.

Reporting Avenues

The utilization review process assists the Office of Medicaid Policy and Planning (OMPP) in making important policy decisions. In addition, utilization review activities can identify areas of policy that require clarification or change. It is a valuable tool in shaping policy guidelines to ensure services are provided in an efficient and effective manner.

Any information related to IHCP abuse or fraud should be reported to the appropriate authorities. Suspected cases of abuse or fraud should be reported to the following:

IHCP Provider and Member Concern Line
(317) 234-7598 or 1-800-457-4515

Surveillance and Utilization Review (SUR)
402 W. Washington Street, E442, MS58
Indianapolis, IN 46204
Section 3: Provider Utilization Review Process

General Information

The Indiana Health Coverage Programs (IHCP) Surveillance and Utilization Review (SUR) Department identifies areas of noncompliance and misunderstanding related to IHCP billing, benefits, and reimbursement. This department reports information to the IHCP provider community through IHCP provider publications, such as bulletins, newsletters, and banner pages. To keep informed of current communications and policy updates, providers must enroll in the IHCP’s Email Notifications at: http://www.indianamedicaid.com/ihcp/mailing_list/default.asp. Providers that are already enrolled should verify that their e-mail addresses are correct.

The provider is well positioned to help stop IHCP abuse and reverse trends related to misuse and overuse of services and inappropriate billing practices.

The following are some suggestions to help eliminate healthcare abuse and fraud:

• Providers that rely on billing services and other consultants should carefully monitor how IHCP is being billed for services. Regardless of who submits the forms, providers are legally responsible for claims filed on their behalf.

• To avoid overpayments being included in subsequent SUR reviews, providers should request claim adjustments as soon as overpayments are identified by internal audit procedures. Adjusting claims or returning overpayments does not eliminate audit liability for the error that existed when SUR identified the claim for review and notification of an audit was sent to the provider. SUR will include the net overpayment amount in the extrapolation process for audits completed via sample.

Medical and Financial Record Retention

Providers must maintain medical records of sufficient quality to fully disclose and document the extent of services rendered for a period of seven years. This requirement is further addressed in 405 IAC 1-5-1. A claim form is not considered sufficient documentation. At minimum, records must include the following information:

• Identification of the individual to whom service is rendered

• Identification of the provider or provider’s employee and position rendering the service

• Date of service

• Diagnosis, excluding transportation and dental providers

• Narrative description of services rendered

• Location of service

• Amount charged for the service

Additional requirements are specified in this manual, IHCP provider bulletins, newsletters, banner pages, the Indiana Administrative Code (IAC), and statutes. In many cases, written evidence of physician involvement and personal patient evaluation that documents the acute medical need is required. Some services, such as therapy, home health, or mental health services, require a plan of treatment and evidence of ongoing evaluation.
Provider Utilization Review

Selection Criteria for Provider Utilization Review

Providers are selected for review based on a comparison of their individual service provision with a peer group of similar specialty. The goals of the required utilization control are to identify providers whose practice patterns are aberrant when compared to their peers, provide necessary education to help the provider achieve IHCP compliance, and recover IHCP overpayments. An analysis of utilization review data is completed by trained SUR review staff.

Record Review Criteria

The following criteria are used when reviewing records:

- The medical record or documentation must support the services billed.
- Services must be covered IHCP benefits.
- Services must be medically reasonable and necessary, as indicated by the documentation in the medical record.
- Services must be billed in the quantities ordered and documented, as indicated by the documentation in the medical record.
- Services must be specifically identified on the provider’s itemized statements or the charge tickets maintained by the provider.
- Services must be billed to the IHCP only after other medical insurance resources have been exhausted.
- Services must be billed in accordance with established IHCP policy.
- The physician must order services in writing, as indicated by the documentation in the medical record.

Utilization Review Procedures

Providers are selected for review based on the Office of Medicaid Policy and Planning (OMPP) audit plan. SUR procedures include the following five levels:

- Level I – Identification, review, and analysis of the Provider Summary Profile, focusing on the exceptions to determine whether there is a pattern of aberrant IHCP activity related to services billed and paid, as compared with the class or peer group.
- Level II – Review of all available documentation, such as history and claim detail, to determine, identify, and document patterns of aberrant activity. This detailed analysis is documented in a written report, with appropriate recommendations for presentation to the medical staff.
- Level III – Presentation of review analysis to SUR management for consideration, recommendation, and approval of action. Following this presentation, the case report is logged and forwarded to the Medicaid Fraud Control Unit (MFCU) for review before SUR takes any action. This procedure has been established to guarantee the confidentiality of any Indiana Attorney General’s MFCU investigations and allows the MFCU to determine whether a joint on-site review of the aberrant provider is beneficial to the investigation. If the MFCU does not have an investigation pending or in progress on the provider, notification is given to SUR to proceed with the recommended actions.
• Level IV – Initiation and completion of all approved recommendations, including the following actions:
  – Case closure
  – Educational contact
  – Provider Self Audit Selection, Medical record review (audit), or on-site review
  – Prepayment review
  – Recoupment
  – Referral of suspected cases of abuse and fraud to the appropriate investigative entity

• Level V – Case closure.

Provider Utilization Review Results

Utilization review of an IHCP provider can result in one or more of the following actions depending on the review findings:

• Closure of the case because aberrant practices were not confirmed
• Formal request for further documentation from the provider
• Educational contact by letter or in person to correct minor infractions
• On-site or in-house review of supporting documentation
• Recoupment of improper reimbursements due to incorrect billing, insufficient or missing documentation, or lack of medical necessity for services rendered
• Prepayment review of IHCP claims because of serious billing errors that show consistent lack of knowledge of IHCP rules, or lack of desire to abide by those rules
• Referral to the OMPP for possible administrative sanctions for continuing noncompliance
• Referral to the MFCU for further investigation and possible criminal or civil prosecution

On-site Reviews

On-site reviews are recommended and performed in the following instances:

• Analysis of the statistical claim data documentation available to the reviewer during the desk review process does not support the necessity of the services claimed.
• Services are not consistent with IHCP guidelines.

On-site provider reviews may be conducted using a statistically valid random sample (SVRS) of the provider claims or a focused sample, which may be an SVRS, concentrating on one or more specific issues. When the review is performed on a statistically valid random sample of claims, the findings can be extrapolated to the total claim population for recovering overpayments.

For example, during an on-site review, $2,000 was identified as inappropriate IHCP payment in an SVRS of 100 claims. The total population for the review time period was 350 claims. To reach the extrapolated overpayment, the actual overpayment is divided by the number of claims in the random sample and then multiplied by the total claims in the population: $2,000/100 x 350 = $7,000.

The SUR Department typically confirms scheduled reviews by certified mail subsequent to telephone scheduling. Audits may be conducted unannounced or with limited notice based on concerns in the identification and/or development of the case. Providers are notified in writing of the results of the review and any corresponding actions.
To maintain privacy and provider accountability for record security, the SUR Department allows a representative of the provider’s office to be present during the on-site audit of the records. However, the following conditions apply:

- Provider office staff can remain with the audit team only to ensure security and physical integrity of the records. This is an option for providers, not a requirement.
- Provider office staff can serve as a resource to the audit team by answering questions raised by the audit team or by retrieving missing documentation, when requested.
- Provider office staff will not be involved in the audit process and should not attempt to interfere with the record review process.
- Providers are reminded that audit findings at the point of record review are preliminary and, therefore, no argument or challenges are appropriate.

If a provider’s record security procedures would preclude SUR auditors from reviewing original records without provider staff present, the provider may exercise one of the following options when notified of an upcoming SUR audit:

- Appoint a staff member to remain present during the on-site audit of records to ensure the security of original medical records.
- Provide copies of the medical record to be reviewed during the on-site audit, with original medical records being available for SUR audit staff to review as requested.

The provider is not required to exercise one of these options. Providers may continue to allow SUR auditors to review the original medical records. Any copies can be made at the time of the audit. As an alternative to an on-site audit, SUR may conduct a medical record audit by requesting copies of records be sent to the SUR Department.

Costs for copies of medical records will not be absorbed by the OMPP or the SUR Department.

**Educational Focus**

The main focus of provider utilization reviews, including medical record reviews and on-site reviews, is to evaluate utilization and recover overpayments. One aspect of resolution of inappropriate provider utilization is provider education. Education can include the following:

- A letter from IHCP detailing the inappropriate action
- A visit by an HP provider field representative
- A visit by IHCP SUR to explain program guidelines related to medical necessity and intensity and appropriateness of service or to assist with administrative aspects of the program.

**Recoupment**

Incorrect reimbursements are considered overpayments, regardless of how they occurred. Recoupment of excess payments results when the payments are identified during the utilization review process. Problems identified by utilization review can also result in a review of the provider’s IHCP billing practices either through a medical records review conducted by OMPP Program Integrity staff or an on-site review. Excessive payments to a provider that are discovered during any review may necessitate a request for a refund.
Prepayment Review

Depending on the severity of the identified problems, the educational contact, letter, on-site visit, referral received, or other SUR identified concern can result in a review of future claims prior to payment. A SUR reviewer develops the parameters for prepayment review according to the documented pattern of problems. The review provides additional information to help the provider understand the scope of benefits by correlating billing practices and IHCP policy. Prepayment review of claims is not a sanction and is not subject to appeal.

As part of the prepayment review process, providers are required to send supporting documentation for each claim submission. The documentation is used to determine the medical necessity of the services rendered and to verify services billed. The option to submit electronic claims is available; however, these claims continue to follow the prepayment review adjudication process.

Note: Claims submitted for services not consistent with IHCP policy can be denied or cut back in accordance with the established policies.

Prepayment review is implemented for a minimum period of six months. Providers are reviewed on a periodic basis and will be considered for removal from prepayment review only when they achieve compliance with all IHCP policy and guidelines. The SUR Department performs a follow-up review to monitor continued compliance typically after the initial six-month period of Prepayment Review (PPR) and then at subsequent intervals of six months to one year when claim activity continues.

When a provider has not complied with the educational approaches mentioned above, including prepayment review, the SUR Department forwards documentation to the OMPP for administrative sanctions. The following are examples of administrative sanctions:

- Temporary suspension of the provider from the IHCP for a specified period of time
- Permanent removal of provider certification for participation in the program, or decertification

Provider On-site Review Process

Retrospective Review Process

The SUR Department conducts retrospective reviews of all IHCP providers to evaluate and objectively document patterns of healthcare provided to members in all healthcare settings. All IHCP providers are subject to ongoing SUR activities. Based on paid claim information, the SUR Department establishes statistical profiles for provider peer class groups to monitor the delivery and receipt of medical services. Analyzing and comparing providers with peer groups can identify misuse and aberrant practices.

The objectives for all the SUR reviews are as follows:

- Assist in identifying and correcting documentation and billing pattern problems for all IHCP providers
- Assist the OMPP in developing clear and consistent medical policies
- Assess quality of care
- Determine whether services provided and billed are consistent with IHCP guidelines
- Educate the provider about any problems identified, when appropriate
- Identify and initiate recovery of overpayment refund amounts due
Perform utilization review activities that evaluate medical services for appropriateness, reasonableness, and necessity

• Verify billed services
• Recover inappropriate IHCP payments
• Refer suspected cases of abuse and fraud to the appropriate investigative entity

The purpose and scope of the retrospective review process does not authorize or allow credit for underpayments. If providers identify underpayments, they may submit claim adjustments as appropriate to obtain additional payment as provided by applicable law.

Case development and documentation are accomplished by thorough research and review of the following types of items:

• SUR reports
• Claim samples
• Case files and prior reviews for background information
• Current regulations and laws pertinent to the review
• Medical records review
• Referrals

The SUR Department may review records on-site at the provider’s place of business or in the SUR Department. At the conclusion of the review, the reviewer summarizes the results and notes the recommended disposition of the case.
Section 4: Member Utilization Review Process

General Information

Member utilization review identifies members who use Indiana Health Coverage Programs (IHCP) services more extensively than their peers. The Right Choices Program (RCP) is designed to provide high-intensity member education, care coordination, and utilization management to eligible Hoosier Healthwise, Care Select, Healthy Indiana Plan (HIP), and Traditional Medicaid members identified as overusing or abusing services.

Multiple vendors administer the RCP according to consistent policies established by the OMPP. Therefore, providers must verify member eligibility to determine the appropriate member health plan assignment and RCP status. Please refer to Chapter 2 for member eligibility information.

Selection Criteria

Any form of overuse or misuse of services may identify a member for potential inclusion in the RCP. Members may be selected for review based on their utilization. Reviews can also be initiated due to referrals of potential overuse or abuse from various sources, such as providers and other agencies. Common referral reasons for the program include the member being treated by several physicians for the same or similar medical condition, purchasing the same or similar medications from several different pharmacies, or frequently using the hospital emergency department for services that are not considered an emergency.

Once a member is identified for review, the RCP administrator completes a Member Summary Worksheet to determine if the member is truly a candidate for the program. Members who score higher than the threshold limits specified in the utilization criteria are sent for clinical review. The clinical reviewer then determines whether the member should be placed in the RCP.

Once the member is selected for the RCP, an Initial Notification Letter is sent to the member by the RCP administrator to notify the member that he or she has been chosen for the RCP. The RCP guidelines and member’s appeal rights are explained in the letter. The member has 10 calendar days from the date the letter was sent to respond with the selection of RCP providers within the RCP administrator’s designated network. The member selects one primary medical provider (PMP), one pharmacy, and one hospital in the RCP administrator’s network to provide non-emergency services. Requiring the member to receive services from only limited providers controls the use of services and promotes better management of the member’s care through coordination of service delivery.

Once selections have been made, the Provider Assignment Letter is sent to the member. Providers are also notified by mail of the selections and given a summary of responsibilities as the lock-in provider. If the member is currently under the care of a specialist, the PMP must make the referral to the specialist and send a copy of the referral to the RCP administrator. The RCP administrator’s medical director may authorize a one-time referral in the event that the PMP is unable to be reached. The member has 30 calendar days from the receipt of the Initial Notification Letter to appeal his or her enrollment into the RCP. Member appeals are reviewed by the administrative law judge (ALJ); in the case of the managed care organizations (MCOs), the appeal is reviewed by the MCO’s appeals panel.

RCP members are placed on the program for two to five years. Thirty to 60 calendar days prior to the projected end of the member’s enrollment in the program, the RCP administrator’s staff reviews the member’s case to determine the outcome of performance in the program. The RCP administrator’s staff convenes a multidisciplinary Exit Care Conference to evaluate the member’s readiness for
removal from the program and to assess any therapeutic situations or circumstances that may be present and have the potential to contribute to the member’s return to inappropriate utilization once removed from the program. Persons participating in the conference may include but are not limited to the following:

- Member’s RCP care/case manager
- Primary lock-in physician or designee
- Primary lock-in pharmacy staff or designee
- RCP administrator’s Pharmacy director or medical director
- Pharmacy director or medical director

**Identification of Right Choices Program Members**

The provider is responsible for checking the status of IHCP member eligibility prior to rendering services. While verifying eligibility, providers can confirm the member’s RCP status. The IHCP reimburses only the providers to whom the member is restricted unless a referral is on file at the RCP administrator in which the member is assigned, or if the service is for an emergency condition. If the member receives nonemergency services from providers that are not locked-in, the IHCP does not reimburse the services. RCP status is available through eligibility verification from the following options:

- Automated Voice Response (AVR) system
- Omni point-of-sale device
- Web interChange
- Electronic 270/271 interactive or batch transactions

If no restrictions are listed, the member is not restricted to any specific provider. If the eligibility response indicated “locked-in” status, the member is restricted to receiving specific types of services only from the specific providers indicated. *Chapter 3* provides expanded information about the eligibility verification options.

**Note:** Claims for nonemergency services rendered by a provider not assigned or referred to an RCP member are denied.

The provider types to which members are most often restricted are physicians, pharmacies, and hospitals. A member can be restricted to other provider types if such action is warranted.

RCP members include those eligible Hoosier Healthwise, *Care Select*, HIP, and Traditional Medicaid members. Members in both RCP and *Care Select* must follow guidelines for both programs, such as using the lock-in providers that have obtained certification codes from the primary medical provider. The MCOs monitor utilization for RBMC members and should be contacted directly to report utilization or billing issues.
Providers may refer questions about RCP members to the following numbers and addresses:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Address</th>
<th>Phone Numbers</th>
<th>Fax Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADVANTAGE Health Solutions – Care Select and Traditional Medicaid</td>
<td>P.O. Box 40789 Indianapolis, IN 46240-0789</td>
<td>1-800-784-3981 1-800-689-2759</td>
<td></td>
</tr>
<tr>
<td>Anthem – Hoosier Healthwise and HIP</td>
<td>P.O. Box 6144 Indianapolis, IN 46209-6144</td>
<td>1-866-902-1690 Option 3 1-866-387-2959</td>
<td></td>
</tr>
<tr>
<td>Managed Health Services – Hoosier Healthwise</td>
<td>1099 N. Meridian Street, Suite 400 Indianapolis, IN 46204-4287</td>
<td>1-877-647-4848 1-866-753-7240</td>
<td></td>
</tr>
<tr>
<td>MDwise – Care Select</td>
<td>P.O. Box 44214 Indianapolis, IN 46244-0214</td>
<td>1-800-440-2449 1-866-440-2449</td>
<td>(317) 822-7519</td>
</tr>
<tr>
<td>MDwise – Hoosier Healthwise</td>
<td>P.O. Box 441423 Indianapolis, IN 46244-1423</td>
<td>1-800-356-1204 929-5530</td>
<td></td>
</tr>
<tr>
<td>MDwise – HIP</td>
<td>P.O. Box 44236 Indianapolis, IN 46244-0236</td>
<td>1-877-822-7196 822-7192</td>
<td></td>
</tr>
</tbody>
</table>

**Primary Lock-in Physician Responsibilities in the RCP**

Physicians will be notified of new RCP enrollment for a particular member through the Lock-in Physician Notification letter generated by the member’s RCP administrator.

By participating in a care coordination team, a primary lock-in physician (the PMP) is better able to manage a member’s care and coordinate service delivery. One physician is aware of all of the member’s treatments and medications, which reduces the potential for adverse health outcomes and contradictory medical treatments. The goal of the PMP’s intervention is to improve the member’s care and health outcomes. It is also anticipated that there will be a reduction in inappropriate utilization of pharmacy and other health services, which could harm the member and create unnecessary and wasteful program expenditures.

**Referrals and Additional Lock-in Providers**

The PMP must use referrals if the RCP member requires evaluation or treatment by a specialist or another doctor. The purpose of the referral is to assure that the PMP has authorized the visit to the referral provider. The referral should be sent to the RCP administrator to assure that claims from referral providers will be processed for payment. Referral physicians that treat lock-in members are still responsible for checking Medicaid eligibility and should not treat the member if the PMP’s referral has not been obtained. In addition, if a member pays cash (and a provider receives cash) for any Medicaid-covered service, it is considered a fraudulent activity by both the member and the provider.

If the referral physician would like to refer the member to a third physician, the PMP must also sign the referral and send to the RCP administrator before the provider will be added to the member’s lock-in list. Additionally, each referral must include the following information:

- IHCP member’s name
- IHCP member’s recipient identification number (RID)
• First and last name of the referring physician (the second physician)
• First and last name of the referral physician (the third physician)
• New rendering provider’s National Provider Identifier (NPI) and the group that the rendering provider is linked to
• Date of the referral
• Date(s) of service for which the referral is valid
  – If no time period is specified on the referral, the referral will be approved for up to one year depending on the type of provider being added.
  – The start date of the referral will be the date indicated on the referral unless an alternate start date is specified by the PMP on the referral.
  – A second hospital or pharmacy may be added for the dates of service only.
• PMP’s manual or electronic signature
  – Signatures of office staff for the physician are unacceptable.

If the PMP has not sent a referral to the RCP administrator for a member, and the PMP is not available to write a referral, temporary physician coverage may be approved by the RCP administrator.

It is encouraged for PMPs to provide referrals for all Medicaid services, including self-referral services, to ensure that any prescriptions written by the providers will be reimbursed appropriately at the pharmacy. While referrals are not required for all self-referral services, this process will provide for better coordination of care among providers, assist members in obtaining their prescriptions from self-referral providers, and will enable the pharmacy claim to be reimbursed.

For additional information on coordination of care with pharmacies and hospitals, please refer to Primary Lock-In Pharmacy Responsibilities in the RCP and Primary Lock-in Hospital Responsibilities in the RCP.

The provider may opt to terminate a member’s care for specific reasons outlined in the provider’s internal office policies and the administrator’s provider manuals, such as noncompliance with treatment recommendations and abusiveness to office staff. If this situation should transpire for a RCP member, the following should occur:

• The provider should give a letter to the member, with 30 days notice, stating that the member’s care (by the provider) is being terminated.
• A copy of this letter should be mailed or faxed to the RCP administrator with any applicable reassignment request forms. The RCP administrator’s designated staff will work with the member to select another provider to replace the physician terminating care.
• Referrals made by the terminating provider will expire 30 calendar days after RCP administrator’s receipt of the dismissal. Upon approval from the administrator’s medical director, the expiration date may be extended under the following extenuating circumstances:
  – New provider is unable to see member within 30 calendar days.
  – RCP member eligibility terminates during the process of changing the PMP and the member is auto-assigned to dismissing provider.

Primary Lock-in Pharmacy Responsibilities in the RCP

When a member selects or is assigned to a particular pharmacy location as the primary lock-in pharmacy, the pharmacy providers will be notified through the Provider Notification Letter generated and sent by the RCP administrator. If the pharmacy is also part of a corporation, a letter will also be addressed to the pharmacy’s corporate headquarters.
In addition, the Provider Notification Letter will delineate the primary lock-in pharmacy’s roles and responsibilities in managing prescription medications for RCP members, list the authorized lock-in prescribers for the RCP member, and provide contact information for the RCP administrator.

The primary lock-in pharmacy must fill prescriptions from the primary lock-in physician (the PMP) and any referred prescribers authorized by the PMP only. If the claim denies for an invalid prescriber identification, the pharmacy should contact the RCP administrator to confirm whether the prescription is written by an authorized lock-in prescriber. The primary lock-in pharmacy should not fill prescriptions written by non-lock-in prescribers unless the PMP’s referral has been obtained. The primary lock-in pharmacy may fill any legal prescription, but Indiana Medicaid will not reimburse claims for prescriptions that are not written by the PMP or a referred prescriber. If the primary lock-in pharmacy has changed the NPI number from a non-lock-in provider to the lock-in prescriber without a valid referral, the reimbursement for the claim will be subject to recoupment by the State, and the action will be subject to a Medicaid fraud investigation. It is also considered an act of Medicaid fraud for a Medicaid member to pay cash or a pharmacy provider to receive cash for services to which he or she is entitled under Medicaid.

**Obtaining / Documenting Primary Lock-in Physician Authorization for Denied Prescriptions**

If an RCP member presents a prescription for which the claim is denied because it is from a prescriber that is not the PMP or a valid referral, the primary lock-in pharmacy may contact the PMP by telephone or facsimile to determine whether he or she wishes to authorize the prescription. All prescriptions authorized in this manner shall be documented as an oral prescription from the PMP, and the claim must be resubmitted as a prescription from the PMP.

**Primary Lock-In Physician Authorization for Denied Schedule II Prescriptions**

If an emergency exists, as defined by 856 Indiana Administrative Code (IAC) 2-6-7(e), and the PMP orally authorizes a prescription for a Schedule II controlled substance after a written prescription from a non-lock-in prescriber is denied, the primary lock-in pharmacy shall document the oral prescription and may dispense and submit a claim for an emergency supply per 856 IAC 2-6-7. As required by this rule, the prescriber must provide a written prescription for the emergency quantity to the dispensing primary lock-in pharmacy within seven business days after authorizing the emergency oral prescription. The member should then see the PMP to obtain a new written prescription for further supplies of the Schedule II prescription. No claim may be paid by Indiana Medicaid for an oral prescription for a Schedule II unless an emergency exists under 856 IAC 2-6-7, as the dispensing of such a prescription is prohibited.

**Primary Lock-in Physician Internal Referrals**

For pharmacy claims to be appropriately processed for an RCP member, the prescription must be issued by the PMP or a valid referring prescriber, and be presented at the primary lock-in pharmacy. A physician within the same practice group as the PMP is not a valid referring physician, unless a valid referral from the PMP is on file with the RCP administrator.

**Primary Lock-in Physician Referrals to Secondary Pharmacies**

If the primary lock-in pharmacy indicates that it does not have a specific medication for a specific date of service, a second pharmacy may be added to the member’s lock-in list for that date of service only. Prior to doing so, the RCP administrator must verify that the primary lock-in pharmacy does not have the medication, and verify that the second pharmacy does. The secondary pharmacy will be added for
specific dates of service only, and the RCP administrator will notify the PMP that the secondary pharmacy was added for those dates.

If the member is transferred to a long-term care (LTC) facility during his or her RCP enrollment period, the member’s primary lock-in pharmacy will be changed to the one contracted by the LTC facility. When the member leaves LTC, the member’s primary lock-in pharmacy will return to the original pharmacy.

For additional information on coordination of care with physicians and hospitals, please refer to Primary Lock-in Physician Responsibilities in the RCP and Primary Lock-in Hospital Responsibilities in the RCP.

**Primary Lock-in Hospital Responsibilities in the RCP**

**Selection of Primary Lock-in Hospital**

The primary lock-in hospital will be notified of lock-in status through the Hospital Provider Notification letter, which will be sent upon receipt of the RCP member’s selection by the RCP administrator. The primary lock-in hospital should be a full-service hospital and one where the PMP has been issued admitting privileges.

**Role of the Primary Lock-in Hospital**

The primary lock-in hospital is responsible for ensuring that the RCP member is obtaining appropriate inpatient and outpatient services, including those rendered in the ER setting. If a member is found to be using the ER to obtain non-emergent services, the member’s PMP and RCP administrator should be notified. The hospital is strongly encouraged to educate the member on appropriate utilization of the ER, and encourage him or her to see the assigned PMP for non-emergent services. The RCP administrator will also provide education on the appropriate use of the ER.

**Hospital Services**

If the primary lock-in hospital is not the desired hospital for a specific inpatient or outpatient service, the PMP may refer the member to a second hospital or facility and request that it be added to the member’s lock-in list. The secondary hospital will only be added for the dates of service or time span specified by the PMP upon approval by the RCP administrator.

**Services Provided in the Emergency Room**

For Care Select and Traditional Medicaid RCP members, a referral is not necessary for services provided in the emergency room. However, only services rendered for medical emergency conditions are reimbursed for HHW and HIP members in an ER setting. Once the RCP member has been stabilized, approval from the PMP must be obtained for further treatment. The lock-in hospital should notify the PMP whenever a member is treated in the ER.

Non-emergent services rendered in the ER will not be covered for HHW and HIP members. In this case, the hospital should refer the member to his or her PMP, educate the member on appropriate ER use, and notify the member’s PMP of the visit.
Prescriptions upon Discharge from Hospital

If discharge prescriptions are being written for the RCP member to be filled at the primary lock-in pharmacy, the hospital should contact the member’s PMP prior to discharge to obtain a referral for the discharge physician to be added to the member’s lock-in list for a specified timeframe. If an emergency supply of discharge medications are provided by the hospital pharmacy to the RCP member upon discharge, claims for the prescriptions will not be reimbursed by Indiana Medicaid unless there is an emergency indicator on the pharmacy claim and the PMP has made a valid referral for the discharge physician to be added to the member’s lock-in list for the specified timeframe.

For additional information on coordination of care with physicians and pharmacies, please refer to Primary Lock-in Physician Responsibilities in the RCP and Primary Lock-in Pharmacy Responsibilities in the RCP.

Carved-Out and Self-Referral Services

Certain services are not typically included in the coordination by the RCP and can still be accessed by the member on a self-referral basis. These services would not require a written referral unless the member is going to receive prescriptions from the provider. If the provider writes a prescription that will be dispensed at a pharmacy, a referral is necessary for the prescription claim to be paid. Services that do not require a written referral, if no prescriptions will be written, include the following:

- Behavioral health
- Chiropractic services
- Dental services
- Diabetes self-management training services
- Family planning services
- HIV/AIDS targeted case management services
- Home health care
- Hospice
- Podiatric services
- Transportation
- Vision care (except surgery)
- Waiver services

If a member has shown misuse in one of the areas listed above, a restriction to one provider in that specialty may be implemented.

Note: MDwise often requires selection and lock-in for behavioral health providers and dental services. MDwise requires these additional lock-in selections because these services are highly likely to generate prescriptions, especially for controlled substances.

Provider Termination

The provider may opt to terminate a member’s care for specific reasons outlined in the provider’s internal office policies and the RCP administrator’s provider manuals, such as noncompliance with...
treatment recommendations and abusiveness to office staff. If this situation should transpire for an RCP member, the following should occur:

- The provider should give a letter to the member, with 30 calendar days’ notice, stating that the member’s care is being terminated.

- A copy of this letter should be mailed or faxed to the RCP administrator with any applicable reassignment request forms. The RCP administrator’s designated staff will work with the member to select another provider to replace the physician terminating care.

- Referrals made by the terminating provider will expire 30 calendar days after RCP administrator’s receipt of the dismissal. Upon approval from the administrator’s medical director, the expiration date may be extended under the following extenuating circumstances:
  - New provider unable to see member within 30 calendar days
  - RCP member eligibility terminates during the process of changing the PMP and the member is auto-assigned to dismissing provider

**Member Initiating PMP Change**

If the RCP member initiates the PMP change, a new PMP may be selected only in one or more of the following conditions:

- Access to Care
- Continuity of Care
- Quality of Care or Service

If the member is assigned because of failure to respond to his or her initial notification, the member will be allowed to change primary lock-in providers one time during his or her tenure in the RCP. Members will be required to submit a written request to the RCP administrator detailing the reason(s) for the requested change(s). If there is a change in the member’s lock-in providers, he or she will receive a letter with the new providers’ information. The new lock-in providers will also receive a letter.

**Emergency Services**

The IHCP reimburses any provider for emergency services if the RCP member’s case is related to a true emergency. Emergency services are services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in one or more of the following situations:

- Placing the patient’s health in jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any body organ or part

For more information, see *Primary Lock-in Hospital Responsibilities in the RCP*.

Note: See Chapter 8: Billing Instructions for emergency diagnosis codes.

**Billing for Services Rendered to Right Choices Program Members**

A major factor in the success of the RCP is timely and appropriate claims adjudication. Specific procedures on proper claims submission for Care Select and Traditional Medicaid, as well as all
pharmacy claims, can be found in Chapter 8: Billing Instructions. For Hoosier Healthwise and HIP members, claims submission procedure can be found within the applicable RCP administrator’s provider manual. Claims for RCP members may suspend or deny if all claims processing guidelines have not been followed. The following claims processing guidelines are specific to RCP members.

### Referral Physicians

- The referral physician must receive from the member’s PMP a referral authorizing the member’s care for the initial service. The referral physician must confirm that the member was not referred through other means, such as the member’s self-referral.

- The PMP must provide the RCP administrator with a written referral with the referral physician’s NPI, as outlined previously in the Primary Lock-In Physician Responsibilities in the RCP section. The referral physician is encouraged to request a copy of the written referral from the PMP; however, this is not necessary. The appearance of the referral physician’s information on the member’s eligibility verification in Web interChange for the date of service allows for payment. Referral providers may elect to print the Web interChange eligibility verification and retain for billing purposes.

- If the referral physician writes a prescription, it is recommended that a copy of the written referral or member’s eligibility verification from Web interChange accompany the prescription to the primary lock-in pharmacy. If the RCP administrator has not yet added the written referral to the Web interChange, the pharmacy should contact the RCP administrator to verify validity and entry of the referral. If the pharmacy is unable to contact the RCP administrator, such as in an after-hours situation, the pharmacist is encouraged to use his or her judgment as to whether the medication in need is of an emergent nature. If the pharmacist does make such a determination, the pharmacist should submit the pharmacy claim with an emergency indicator and dispense a 72-hour supply.

- After the RCP administrator adds a provider to a member’s lock-in table, the provider files the claim in the usual manner. The member’s PMP lock-in provider taxonomy code and ZZ qualifier must be in field 17a. A taxonomy code is only required to make a one-to-one match. The PMP NPI must be reported in field 17b of the CMS-1500 claim form. If the provider is part of a group, the group also needs to be added to the member’s lock-in table.

### Non-IHCP and Out-of-state Physicians

Out-of-state (OOS) generic provider numbers will not bypass the lock-in list or be accepted as a valid lock-in provider number for an RCP member; therefore, all out-of-state physicians must have an IHCP provider number to be a covered provider for the RCP. If the physician is out-of-state, the RCP administrator will determine whether the physician has an IHCP provider number.

- If the physician has an IHCP provider number, he or she may be considered a covered provider for an RCP member in the event that the referral or use of service is deemed valid by the RCP administrator.

- If the out-of-state physician does not have an IHCP provider number, the physician is not a covered provider for the RCP.

The primary lock-in hospital and other acute care facilities can file claims as they would for any non-RCP member, only if the facility’s IHCP number is on the member’s lock-in list.

A hospital that is the member’s primary lock-in hospital can file claims in the same manner followed for non-RCP members because the hospital’s provider number is on the member’s RCP lock-in table. A hospital that is not the member’s primary lock-in hospital must file claims with the lock-in physician’s NPI in Box 78 of the UB-04 claim form. For hospitals billing physician services on the CMS-1500 claim form, please refer to the instructions in the Referral Physicians section.
Pharmacies (for all IHCP programs)

- The prescription must be written by the PMP lock-in provider or a valid referral doctor and be presented at the lock-in pharmacy. Claims can be submitted through point-of-sale (POS). If an RCP member presents a prescription at the lock-in pharmacy from a prescriber that is not the primary lock-in provider or a valid referral provider, the claim will be denied. If an RCP member presents a prescription to a pharmacy that is not on the member’s lock-in list, the claim will be denied.

- If the claim denies for an invalid prescriber identification, the pharmacy should contact the RCP administrator to confirm whether the prescription is written by an authorized lock-in prescriber. The pharmacy should not fill prescriptions written by nonlock-in prescribers until the primary lock-in prescriber’s referral has been obtained. The primary lock-in pharmacy may fill any legal prescription, but Indiana Medicaid will not reimburse claims for prescriptions that are not written by the primary lock-in prescriber or a referred prescriber. Please refer to the appropriate Hoosier Healthwise or HIP manuals for claims submission and processing guidelines.

See Primary Lock-In Pharmacy Responsibilities in the RCP.

Note: It is important to remember that the IHCP does not reimburse providers for services unless these guidelines are followed. For more information on billing IHCP members, refer to Chapter 4, Section 5.
Section 5: Utilization Review Trends

General Information

Utilization review activities identify common areas of Indiana Health Coverage Programs (IHCP) misuse, overuse, abusive practice patterns, and potential fraud. This section reports these trend areas to assist providers with practice management procedures.

Sections 1900 and 1903 of Title XIX of the Social Security Act 42 CFR 456 mandate that utilization reviews of IHCP services take place to ensure that services rendered are necessary and of optimum quality and quantity. These federal regulations also allow the IHCP to identify and refer cases of suspected fraud and abuse of the IHCP for investigation and prosecution, if warranted. Utilization review is a safeguard against unnecessary care and services and ensures that payments are appropriate according to policies established by the IHCP. A comprehensive description of IHCP utilization review is also included in this chapter, in Section 2: Abuse and Fraud.

General Trend Areas

Common trends include, but are not limited to, the following situations:

- Billing and receiving payment from a member for IHCP-covered services
- Billing for medically unnecessary services not supported by the diagnoses documented
- Billing for services outside the scope of practice of the enrolled provider specialty
- Billing generic procedure codes when procedure codes specific to the services rendered are available
- Billing IHCP members more than private pay patients
- Billing inaccurate units of service
- Maintaining inadequate or incomplete documentation to support the services billed
- Noncompliance with published Indiana Administrative Code (IAC) regulations
- Unbundling globally billed charges, such as surgical, laboratory, radiology, and dental services
- Charging IHCP members for missed appointments
- Charging IHCP members for transfer or copies of medical records
- Manipulating service procedure codes for reimbursement

Surveillance and Utilization Review

The Surveillance and Utilization Review (SUR) Department receives several hundred telephone calls monthly. The majority of these calls are requests for information. The following are two common areas for which SUR receives inquiries:

- Billing of IHCP members
- Provider or member inquiries
**Member Right Choices Program**

Member utilization review identifies members using IHCP services more extensively than their peers. When the utilization review process identifies a member who is being treated by several physicians, purchasing the same medication from several different pharmacies, or frequently using the hospital emergency department for services that are not considered an emergency, the member can be assigned to the Right Choices Program (RCP).

The RCP is a program in which a member is assigned to one primary medical provider (PMP), one pharmacy, and one hospital. These providers coordinate the member’s medical services in a manner that is in the best interest of the member.

RCP members can be identified using eligibility verification performed by Automated Voice Response (AVR), electronic 270/271 transactions, Web interChange, or Omni. These mechanisms also identify the names of the IHCP lock-in providers to which the RCP member is assigned.

**Billing IHCP Members**

IHCP providers are prohibited from charging a member, or the family of the member, for any amount not paid as billed for a covered IHCP service. Acceptance of payment in full is a condition of participation in the IHCP.

An IHCP provider can bill a member only when the following conditions have been met:

- The service rendered must be determined to be noncovered by the IHCP.
- The member has exceeded the program limitations for a particular service; for example, the services were denied prior authorization (PA).
- 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 charges associated with the service.
- The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that the IHCP did not cover the service.

For more information on billing IHCP members, refer to Chapter 4, Section 5.

If the member has a PMP and wishes to receive services from a non-IHCP provider, the PMP must inform the member that services will not be covered and may include an additional out-of-pocket expense.

In summary, a provider can bill a member only when the above criteria are fully met. 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...”
Section 6: Utilization Review Administrative Review and Appeal Process

General Information

Overpayments to providers, identified during SUR reviews, are recovered by the authority of 405 IAC 1-1-5. Such recouped overpayments may be due to one or more of the following:

- Amount paid for such services has been or can be paid from other sources, such as Medicare, private insurance, or a trust fund.
- Overpayment resulted from an inaccurate description of services or an inaccurate usage of procedure codes.
- Overpayment resulted from duplicate billing.
- Overpayment resulted from services or materials determined not medically reasonable or necessary.
- Overpayment resulted from the provider’s itemization of services rather than submission of one bill for a related group of services provided to a member, or global billing, as set out in the Indiana Health Coverage Programs (IHCP) medical policy.
- Overpayment to the provider resulted from any other reason not specified in this subsection.
- Paid claim that arose out of any act or practice prohibited by law or by rules of the Office of Medicaid Policy and Planning (OMPP).
- Service paid for was provided to a person who was not eligible for IHCP at the time of the provision of the service.
- Services paid for were not documented by the provider as required by 405 IAC 1-5-1.
- Services were provided to someone other than the member in whose name the claim was made and paid.

Under Indiana Code (IC) IC 12-15-21-3(5), the amount of overcharges and overpayments are identified by means of a random or focused sample review. Random sample findings are subject to extrapolation.

Appeal Process

If the SUR Department identifies an overpayment as the result of a provider utilization review, the SUR Department sends the provider a preliminary findings letter outlining what was discovered in the review. The physician or the provider has the option to disagree with the findings by sending a letter to the SUR Department. If the SUR Department does not receive a response from the physician or provider disputing the preliminary findings within 45 calendar days, the SUR Department will send a Final Determination Letter requesting the overpayment. The Final Determination Letter contains information about appealing the identified overpayment. The provider may appeal the findings to the Office of the Secretary of Family and Social Services Administration (FSSA) within 60 calendar days of the receipt of the findings letter. A Statement of Issues must be filed in addition to the appeal. The Statement of Issues includes information about specific findings that the provider wishes to appeal, which includes, but is not limited to, identification of the findings being appealed and the reason the provider believes that the determination was in error, including any documentation to support that position or any rule or statute that the provider believes substantiates the appeal. The Statement of
Issues must be filed within 60 calendar days after the provider receives a determination of the findings or in conjunction with a timely appeal and comply with the regulations in 405 IAC 1-1.5-2. The provider must submit the appeals and Statement of Issues documentation to the following addresses:

Secretary, Indiana Family and Social Services Administration
In care of: Compliance Manager, OMPP
Office of Medicaid and Policy Planning
402 W. Washington Street, W382
Indianapolis, IN 46204

Surveillance and Utilization Review
Attn: Statement of Issues
402 W. Washington Street, E442, MS58
Indianapolis, IN 46204

Questions about this process should be directed to the Surveillance and Utilization Review (SUR) Department at 1-800-457-4515 or (317) 234-7598.

Nonhospital and Hospital Providers

Per IC 12-15-13-3, providers have 60 calendar days from receipt of the certified notification letter to respond in one of the following manners:

• Repay the amount of overpayment including interest and not appeal.
• Request a hearing and repay the amount identified. Interest does not continue to accrue during appeal.
• Appeal the overpayment audit findings and not repay the overpayment amount. Interest does continue to accrue during appeal.

If a hearing or appeal determines that the provider does not owe the money identified, but the provider has made reimbursement, the funds are returned. If the provider has elected not to repay prior to the hearing, but the appeal decision determines that the funds are owed, the provider pays the amount of the overpayment, including interest. The interest accrues from the date of the overpayment through the date of actual reimbursement.

Additionally, the OMPP or the SUR Department may enter into an agreement with a provider to repay any overpayment by having the overpayment and interest deducted from subsequent payments to the provider not to exceed a period of six months according to 405 IAC 1-1-5(g).

Informal Reconsideration by the SUR Department

In addition to the formal administrative appeal procedure, the OMPP, in conjunction with the SUR Department, offers providers an opportunity to resolve disagreements with overpayment determinations through an informal reconsideration process after the provider files an appeal to the OMPP.

This informal reconsideration occurs between the provider and the SUR Department. When the provider has submitted the Statement of Issues and request for appeal, the SUR Department conducts an informal reconsideration of the original audit. A reviewer other than the one who performed the original or initial review completes the informal reconsideration.

Further, for any appealed findings, the provider is strongly encouraged to submit copies of all requested medical records, charts, X-rays, notes, treatment plans, account information, billing records,
appointment logs, statements, and other documentation necessary to verify services were provided and billed in accordance with IHCP guidelines.

On receipt of the provider’s documentation and information, the SUR Department conducts its informal reconsideration of the appeal documentation and provides a written response to Statement of Issues. The SUR Department attempts to notify the provider of findings of the informal reconsideration 90 calendar days from the date of receipt of all documentation. The informal reconsideration provides an opportunity to resolve issues among the provider, the OMPP, and the SUR Department. The appeal process is ongoing during this informal reconsideration process; however, this does afford the provider an additional opportunity to resolve the overpayment determination or narrow the issues prior to continuing litigation with the OMPP before an administrative law judge (ALJ).
Section 7: Administrative Review and Appeal
Procedures for Providers on Prepayment Review

General Information

Claim reimbursement administrative review procedures are outlined in 405 IAC 1-1-3.

Provider appeals, including claim reimbursement appeals, are conducted in accordance with 405 IAC 1-1.5.

Procedures

If a provider disagrees with the Indiana Health Coverage Programs (IHCP) determination of payment, before filing an appeal with the State, the provider must first exhaust the administrative review process with the contractor as provided in 405 IAC 1-1-3 and outlined in this section.

Administrative Review

Prior to filing a claim administrative review request, the provider must exhaust routine measures to receive claim payment. The following information outlines the administrative review process:

1. On receipt of the claim denial, the provider must review the denial, make applicable corrections, and resubmit the claim through the routine claim-processing channels.

2. If the claim is paid and the provider disagrees with the reimbursement, the provider must submit an adjustment request with documentation stating why the provider disagrees with the reimbursement.

3. If the provider receives the same results, following the two previous initial administrative review steps, the provider can file a formal administrative review request.

4. The provider files a formal administrative review request by writing a letter stating the reason for disagreement with the denial or the amount of reimbursement. The provider must note Administrative Review clearly on the letter and attach all pertinent documentation. The formal administrative review request must be filed within seven calendar days of notification of claim payment or denial from HP.

5. The provider sends the package of information to the following address:
   Administrative Review – Prepayment Review (PPR)
   402 W. Washington Street, E442, MS58
   Indianapolis, IN 46204

6. On receipt of a claim administrative review, a PPR administrative review analyst reviews the administrative review request.
7. The analyst investigates the claim and works with other functional areas of HP and contractors to formulate a detailed response to the provider.

8. If the analyst confirms that the claim should be paid as the provider requests, appropriate action is taken, and the claim is resubmitted for processing.

**Administrative Review Responses**

A PPR administrative review analyst responds to all administrative reviews within 90 calendar days of receipt of the request, regardless of the decision to pay or deny the claim. Each denial decision is specific, detailed, and fully documented. If the administrative review response is unfavorable to the provider, the PPR administrative review analyst states the appeal rights and the time period during which appeal rights can be exercised for the response.

**Appeals**

Prior to filing a request for appeal, the provider must exhaust the formal administrative review process described previously. The provider must comply with any resubmissions or requests for additional documentation made by HP and must receive a receipt of a final written denial of the claim from HP. To preserve appeal rights, all of these steps must be followed.

If after the provider has exhausted all the procedures required for administrative review, the provider is still not satisfied with the determination, the provider can send a request for appeal, within 15 calendar days of receipt of the final administrative decision, to the following address:

**Indiana Family and Social Services Administration**
**Hearings and Appeals Section, MS-04**
**402 W. Washington St., Room W392**
**Indianapolis, IN 46204-2773**

Refer to 405 IAC 1-1.5 for appeal procedures.

The following is the appeal sequence and the applicable time limits:

1. An appeal request must be delivered to the Indiana Family and Social Services Administration (IFSSA) within 15 calendar days after receipt of an adverse administrative review decision notice on which the appeal is premised.

2. An administrative law judge’s adverse decision can be appealed by filing objections with the ultimate authority for the agency within 15 calendar days of receipt of the decision.

3. An appellant can file a petition for judicial review in accordance with IC 4-21.5-5 if the appellant is not satisfied with the agency review decision.
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