Questions and Answers

Follow up from question #6 (03/09/2012)

1. **For OMPP**: Will the State please give us the status to the Single Eligibility System? When should we expect this system that was to be up and running (by Indiana code) 01/01/2012 to be effective. HB 1171 IC 12-15-1-21?

   **HP Response**: Web interchange is the single eligibility system. There have been some instances of eligibility not being communicated right away from the plans regarding PMP information, but as long as the appropriate plan is identified; even if there is no PMP assigned the identified plan is responsible for the claim. The plans do continue to ask that if there is any question regarding the information that web interchange displays, the provider please check their web portals, otherwise web interchange is the single line of eligibility.

   Will OMPP please read the above question and advise the target date they have planned to start following HB 1171 that became effective 01/01/2012?

   **OMPP Response**: OMPP is working with our MCE contractors to review the current policy and HB 1171 to determine what adjustments to current stated policy needs to be made. OMPP will notify ISMA before the next coalition meeting with any changes made.

Follow up from question #8 (03/09/2012)

2. **For HP**: Can you please give detailed instructions on the billing procedure when a patient has Medicaid secondary to a high deductible HRA/HAS account?

   **HP Response**: When payments are received by Providers from a member’s Health Reimbursement Account (HRA), after Medicaid has paid the claim, providers should apply the HRA payment to the claim and reimburse Medicaid since under federal law Medicaid is the payer of last resort. Rights to third party payments for member medical expenses are assigned to the IHCP; if, however, the third party payment to a provider is from an employee funded (wholly or in part) HSA, because there is no responsibility on the part of the member to pay commercial co-insurance or deductibles, (whether from the member's pocket or from the member's HSA), then it seems there should be no billing of/responsibility of the member’s HSA to pay the co-insurance or deductibles and therefore there are no rights to payment that are assigned to the IHCP. OMPP would have to weigh in on this.

   Will OMPP please read the above response and provide a detailed example of each scenario? **OMPP Response**: OMPP has been working with ISMA to assist with a Policy Consideration Request that would address this very issue. OMPP has received this formal policy request and will work with ISMA during this policy review phase. When completed ISMA will update at our next coalition meeting.

3. For each MCE, please provide information as to when providers need referrals and how the provider should obtain that referral. This should include all lines of business including the HIP plans? For MDwise will this be the same for Care Select and Advantage?

   **MHS Response**: MHS Referral Authorizations: MHS has provided guidelines below, but suggests that interested parties refer to the Provider Manual at www.mhsindiana.com.

   Primary Medical Providers (PMP): Referrals to a contracted specialist do not require a referral from MHS for an initial or recurring office visit, unless the service otherwise requires authorization. The PMP and specialist office may communicate directly for any needed referrals.
Referrals to non-contracted specialist require a referral authorization from MSH for initial and ongoing treatment specialist: Contracted and non-contracted specialist should call for authorization for any procedure or test that the specialist decides is necessary after seeing the patient in the office.

**Anthem Response:** HIP & HHW - All providers, except the PMP to which the member is assigned, require a referral from the member’s PMP. The provider requesting the referral should contact the assigned PMP, and all referrals should be documented in the member’s chart. Some services are excluded from the PMP referral requirement. These are:

- If no PMP is identified for the member.
- If one physician is on call or covering for another. In this case, the billing provider must complete Box 17b of the CMS-1500 claim form to receive reimbursement.
- If the provider is in the same provider group, or has the same tax ID or NPI as the referring physician, and is an approved provider type.
- Services that were provided after hours (codes 99050 & 99051).
- Emergency services (services performed in place of service 23).
- Family Planning services.
- Diagnostic specialties such as lab and X-ray services.
- Anesthesia claims.
- Professional Inpatient claims.
- OB/GYN claims
- If the billing or referring physician is any of the following: A Federally Qualified Health Center, an Indian Health Provider or an Urgent Care Center.
- Self-referrals: Members may self-refer for certain services—some services for both Hoosier Healthwise and HIP, some for Hoosier Healthwise only—that are provided by an Indiana Health Coverage Program (IHCP) qualified provider. These include, but are not limited to:
  - Psychiatric services
  - Family Planning services
  - Emergency services
  - Diabetes self-management services
  - Behavioral health services

Please refer to the Provider Bulletin dated December 11, 2011 for additional information.

**MDwise Response:** For Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) non-Right Choices (RCP) members, in network primary medical providers (PMPs) do not need to complete a referral to refer a member for medically necessary specialist services. PMPs should document the medical necessity reason for the specialty referral and refer the member to an in-network specialty provider. Providers can view a list of in-network specialists using the provider directory at [www.mdwise.org](http://www.mdwise.org) or by contacting the member's MDwise delivery system. In network providers should keep in mind that certain services (i.e. surgical) may require a prior authorization from the MDwise delivery system and a list of services that require prior authorization for HHW and HIP is located at [http://www.mdwise.org/hoosierhealthwise/providers/forms.html](http://www.mdwise.org/hoosierhealthwise/providers/forms.html). Providers can contact the appropriate delivery system medical management department using the MDwise Quick Contact Guide located at [http://www.mdwise.org/docs/provider-quickcontact.pdf](http://www.mdwise.org/docs/provider-quickcontact.pdf).

An out-of-network specialty referral ALWAYS requires a PA from the member's delivery system PRIOR to that out-of-network provider rendering non-emergent services in provider's office setting. Out-of-network providers must contact the appropriate MDwise delivery system using the MDwise Quick Contact Guide located at [http://www.mdwise.org/docs/provider-quickcontact.pdf](http://www.mdwise.org/docs/provider-quickcontact.pdf).

MDwise Care Select operates under a different referral requirement than MDwise HHW and HIP. Effective with dates of service January 1, 2011 and on, the Indiana Care Select Program discontinued the use of certification codes. Per BT201043, the Indiana Health Coverage Programs (IHCP) prefers the member's PMP continue to serve as the member's medical home and to recommend to the member any medically necessary specialty
services in order to manage the member's health needs. The PMP should document the medical necessity for the specialty service referral and that member can be referred to any IHCP enrolled specialty provider statewide.

For MDwise HHW, HIP, and Care Select RCP members, there is a requirement that the RCP member's PMP write a referral to a specialty provider for a non-emergent service. This would include any self-referred service that may require a prescription. RCP PMPs must document the need for the specialty service and write a referral to send to the specialist the PMP is referring the RCP member to. The written referral must have the following information:

1) The PMP must write the referral on the PMP’s letterhead or prescription pad.
2) The PMP must date and sign the referral.
3) The referral must include the member’s name and member id.
4) The referral must include the specialist's first and last name, and NPI.
5) The PMP should list the period for which the referral is valid. If no time period is specified on the referral, the referral will be applied for the maximum 1 year allowable.
6) It is preferred that a reason for the referral also be communicated for care management support.

4. For HP, Pregnant patient with HIP. We have always billed traditional Medicaid until the time-consuming switch to Medicaid from HIP occurs. We currently have a patient who is pregnant, HIP eligible, that of course HIP won’t pay for but now traditional Medicaid is telling us that first trimester care, correctly coded and billed, on a date for which the patient is HIP eligible, is not a covered service. We are getting a run-around on the phone. If there is a new procedure we should have been notified. If there is not a new procedure we should be paid. What is up?

**HP Response:** The process has not changed. Claims with dates of service during the transition from HIP to Hoosier Healthwise are paid by HP however those claims need to be processed by working with your provider Relations Field Representative for special handling. The HP Customer assistance team will be educated further on this process to ensure that they give providers the correct information.

5. For Anthem, will you please go over the Coverage of Emergency Room Services for both HIP and Hoosier Healthwise Members?

**Anthem Response:** HIP & HHW - Anthem uses the prudent layperson standard for determination of payment. The list of diagnosis codes considered emergency conditions is available on the My Anthem website. If a claim is not billed with an emergent diagnosis it will be paid at the triage rate. If you feel that a member had an emergent condition and it paid the triage rate you may dispute the claim by submitting medical records. Any claims with a triage diagnosis submitted without medical records will be paid at the triage rate.

6. For each MCE and HP, what type of documentation do you expect to see in the patients chart in order for the provider to bill for smoking cessation?

**HP Response:** Ordering and rendering practitioners must maintain sufficient documentation of respective functions to substantiate the medical necessity of the service rendered and to substantiate the provision of the service itself; this requirement is consistent with existing IHCP policies and regulations.

**Anthem Response:** Anthem would expect to see evidence of smoking and a desire to quit in the member's chart.

**MHS Response:** MHS Patient Chart for Smoking Cessation: MHS expects documentation in the medical record that is consistent with how a provider would document any other medical service and/or consultation. Documentation should comply with professional practice standards and state and federal requirements. For example, on members 10 years and older, providers should make appropriate notations concerning use of tobacco, alcohol, and substance use.

**MDwise Response:** As with any IHCP covered service, there should be sufficient documentation included in the member’s medical record to justify the medical necessity for the service being provided. 405 IAC 5-1-5(d) states that documentation in the medical records maintained by the provider must substantiate the medical necessity for the procedure or service and the code selected or description given by the provider. This is subject to post-payment audit and review.