

ISMA Coalition Meeting

July 20, 2012

Questions and Answers

1. For OMPP: Since the eligibility issues started when the MCEs were required to assist the members in selecting their PMP rather than Maximus, can the state switch it back to become the responsibility of Maximus? We did not have these issues when Maximus was responsible for helping the member select the PMP.

OMPP Response: The primary goal of this contract was to integrate the HIP and HHW programs, creating a family health plan that results in a seamless experience for Hoosier families. These new contracts became effective Jan. 1, 2011. OMPP will continue to provide guidance to providers in understanding how members will select a health plan, what actions providers may need to take to remain in the program and to verify member eligibility. Switching this responsibility back to Maximus is not a possibility at this time. Please see Bulletin BT201038 for more detail. OMPP & the ISMA have agreed to meet to discuss this issue in greater detail.

2. For HP: If a referring doctor doesn't get revalidated for a specialist, does a claim get denied?

HP Response: Yes, the specialist's claims would deny if the referring provider does not revalidate and is terminated.

3. For HP: Is there a fee involved for revalidating?

HP Response: There is **no fee** when revalidating. Please refer to Bulletin BT201221 dated June 26, 2012.

4. For OMPP and all MCEs: Does Indiana Medicaid (including all MCEs) follow Medicare's incident-to guidelines?

HP Response: HP does follow the Medicare care incident to guidelines per the law, IAC 405 IAC 1-11.5-2 (8). HP published the guidelines for incident to in the IHCP provider manual in chapter 8 section 4 pages 8-300 and 8-301.

MHS Response: MHS follows incident-to guidelines.

Anthem HHW: Anthem follows incident to billing as described in the IHCP manual.

MDwise Response: Per the IHCP Provider Manual: Mid-Level Practitioner Services Coverage and Billing Procedures - The proper billing procedures for billing nurse practitioner and physician assistant services are as follows:

- Nurse practitioners – The IHCP reimburses independently practicing nurse practitioners at 75% of the rate on file. The nurse practitioner must enter his or her rendering NPI number in field 24J of the CMS-1500. The billing NPI must be entered in field 33a on the CMS-1500 claim form.

- Nurse practitioners not individually enrolled in the IHCP, and clinical nurse specialists employed by physicians in a physician-directed group or clinic, bill services with the SA modifier and the physician rendering NPI in fields 24J of the CMS-1500. The billing NPI must be entered in field 33a on the CMS-1500 claim form. The IHCP reimburses them at 100% of the Medicaid-allowed amount.
- Nurse practitioners with an individual LPI and NPI who are employed by a physician should bill using their rendering NPI in field 24J of the CMS-1500. The NPI must be entered in field 33a on the CMS-1500 claim form. The IHCP reimburses them at 100% of the Medicaid-allowed amount.
- Providers cannot bill separately for nurse practitioner services in outpatient and should include these services in the hospital outpatient reimbursement rate.
- Physician assistants –Providers should bill physician assistant services with the HN, bachelor’s degree or HO, master’s degree modifier applicable to the level of education of the physician assistant. The physician rendering NPI must be entered in field 24J of the CMS-1500. The physician billing NPI must be entered in field 33a on the CMS-1500 claim form. The IHCP reimburses them at 100% of the Medicaid-allowed amount.
- Physician assistants are not separately enrolled in the IHCP. However, when a physician assistant provides assistant surgeon services, the provider should use modifier AS instead of the HN or HO modifier. Reimbursement for the assistant at surgery is 20% of the rate on file.

Providers should place modifiers in field 24D, under the modifier heading on the -1500 claim form.

5. For all MCEs: Do all of the HIP plans follow incident-to guidelines? Since Indiana Medicaid does not enroll PAs, is direct supervision required for a PA to bill under the physician’s number?

MHS Response: MHS follows incident-to guidelines. The PA may bill incident-to under the practitioner’s NPI with the correct modifier. Requirements for “incident to” are:

- The services are commonly furnished in a physician’s office.
- The physician must have initially seen the patient and has an active part in the ongoing care of the patient.
- There is direct personal supervision by the physician of auxiliary personnel. Direct supervision in the office setting does not mean that the physician/non-physician must be present in the same room with his aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction while the aide is performing services.

Anthem HIP: Anthem follows incident to billing as described in the manual.

MDwise response: Yes. See answer to question 4.

6. For all MCEs: Does HIP cover CPT codes 97802, 97803 and 97804 (MNT) if done by a registered dietician billed under the supervision of a nurse practitioner since Medicaid doesn’t enroll dieticians? These codes are on the Medicaid fee schedule, so one would assume they can do this with Medicaid patients.

MHS Response: MHS covers these codes, which are listed on the Medicaid and Medicare fee schedule, if provider follows correct billing practices. MHS follows CPT guidelines, CMS and NCCI edits.

Anthem HIP: 97802, 97803, or 97804 MNT are not covered when billed by a physician, registered dietician/nutritionist or nurse practitioner.

MDwise response: The policy regarding supervision of dieticians in the IHCP provider manual is not clear at this time. Therefore, MDwise will follow the mid-level practitioner rule specified in question #4. These codes are covered for HIP when medically necessary and must be billed by a physician enrolled in the IHCP and modifier AE (registered dietician). If additional information about supervision of dieticians and billing becomes available, MDwise will review this new information for policy consideration.

7. For OMPP and all MCEs: Do you follow Medicare's requirements for E&M guidelines as it relates to the Chief Complaint and History of Present Illness documentation? When billing an Evaluation and Management service?

HP Response: Evaluation and Management (E&M) billing guidelines can be found in the IHCP provider manual Chapter 8 Section 4 page 8-247, and it states Per 405 IAC 5-9-2, office visits should be appropriate to the diagnosis and treatment given and properly coded. The documentation should be kept in that member's file to support the treatment provided.

MHS Response: MHS follows E&M guidelines.

Anthem HHW/ HIP: Anthem expects documentation in the chart to reflect complaint, illness history, and services performed in the office.

MDwise response: MDwise follows IHCP guidelines for Hoosier Healthwise regarding billing for E&M codes. MDwise follows Medicare guidelines for HIP regarding billing for E&M codes.

8. For HP and all MCEs do you have an audit form that can be shared with ISMA's Medicaid Coalition?

HP Response: At this time, HP does not have an audit form to give to providers.

MHS Response: This question is unclear and MHS is unable to respond.

Anthem HIP/ HHW: Anthem does not currently have an audit form that can be shared. Quality is looking into developing a form that will be made available to providers.