Frequently Asked Questions for Indiana FQHCs and RHCs:
Working with Managed Care Entities / Health Plans
Indiana Health Coverage Programs, Hoosier Healthwise and HIP

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The Indiana Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are vital partners to the State of Indiana and its contracted Hoosier Healthwise and Healthy Indiana Plan Health Plans (also known as Managed Care Entities or MCEs) in caring for Indiana Health Coverage Programs (IHCP) members in Hoosier Healthwise (including CHIP) and the Healthy Indiana Plan (HIP).

The three State-contracted MCEs for Hoosier Healthwise and HIP came together to write this Frequently Asked Questions (FAQ) to provide FQHCs and RHCs with important information about billing, claims payment and the reconciliation process. Anthem, MDwise and Managed Health Services (MHS) prepared this information after consulting Myers & Stauffer (which manages the wrap-payment process) with encouragement from the Indiana Office of Medicaid Policy and Planning (OMPP).

We hope the information presented here helps you:
1. Understand how to document services and bill for them in order to receive the highest appropriate reimbursement from the MCE on your original claims.
2. Understand how to document services and bill for them so that your providers get “credit” under any quality initiative.
3. Understand the MCE role in the wrap-payment process so you can work with them and with Myers & Stauffer to receive all appropriate payments.
4. Understand the MCE role in the wrap-payment process so you can work with them in the least burdensome manner.

Following these questions and answers, please find a guide to abbreviations and special terms.

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<th>Q.</th>
<th>Should an FQHC or RHC submit every encounter to the patient’s MCE?</th>
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<td>A.</td>
<td>Yes – FQHCs and RHCs should submit a claim for every encounter with an IHCP member. This will maximize revenue paid to FQHCs and RHCs from the MCE. Wrap-around payments are then based on the difference between what the FQHC/RHC has collected on the paid claims and the government’s Prospective Payment System (PPS) rate. These encounters should be submitted to Myers &amp; Stauffer as well. When you submit every encounter to the MCE, including those that pay at $0, your practitioner gets credit for providing the service, including preventive care. In many cases, this makes a provider eligible for quality recognition and boosts the quality score of the MCE. In addition, submitting all these encounters to Myers &amp; Stauffer, even those that pay at $0, provides them with the information needed to make all appropriate supplemental payments.</td>
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<th>Q.</th>
<th>How can a provider be sure that his or her claim qualifies as an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visit?</th>
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<td>A.</td>
<td>Claims coded correctly with supporting medical records will ensure that the practitioner receives proper credit for EPSDT services. Ensuring all EPSDT qualifying services are documented and billed helps maximize reimbursement, obtain recognition for you for quality care and serve the patients.</td>
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**For EPSDT:**
Provide preventive care using EPSDT guidelines (see IHCP & MCE Provider Manuals), document all required components of the screening in the medical record and properly code the claim to allow for the higher level of reimbursement and EPSDT credit.

- Health & development history - include assessment of physical & mental health development
- Unclothed physical exam
- Nutritional assessment
- Developmental assessment
- Vision observation at each screening & direct referral to an optometrist
- Hearing observation at each screening & objective testing with audiometer at age 4
- Dental observation at each screening & direct referral to dentist starting at 6–12 months
- Laboratory tests, including blood level assessment appropriate for age/risk factors
- Immunizations administered or referred, if needed at the time of the screening
- Health education, including anticipatory guidance, which is often provided but infrequently documented

CPT codes for EPSDT: 99381 – 99385 and 99391 – 99395
Diagnosis Code: V20.2 must be the primary diagnosis code
Enhanced EPSDT Rate: $62 or $75 vs. regular Evaluation & Management (E&M) rates.

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<th>3. Q.</th>
<th>How can a provider be sure that his or her claim qualifies as a well-child or preventive care visit?</th>
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| 3. A. | Again, coding claims correctly with supporting medical records is the key to getting credit for well-child visits, per NCQA (National Committee for Quality Assurance) Healthcare Effectiveness Data and Information Set (HEDIS).  
**Well-child HEDIS or preventive care visit:**  
Provide and document preventive care at any visit. The visit must include, at a minimum, age-appropriate health & developmental history (mental and physical), physical exam & health education/anticipatory guidance, and may include components of an EPSDT screening.  
CPT codes: 99201 – 99215, 99461, or 59425 – 59426  
Diagnosis Codes: V20.2, V70.0 or V70.3  
Count as Well–Child Measure: The diagnosis code submitted with these service codes indicates preventive care even where not all components of an EPSDT visit are present.  
Rate: Standard E&M payment rates apply |

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<th>4. Q.</th>
<th>How can a provider be sure that his or her claim for a comprehensive prenatal visit meets all requirements for a preventive adolescent well-care visit?</th>
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| 4. A. | A comprehensive prenatal visit includes the components of a preventive care visit. Visit must include, at a minimum, age-appropriate health and developmental history (mental and physical), physical exam, and health education/anticipatory guidance, which may include components of an EPSDT screening. The key is proper coding and complete documentation.  
CPT Codes: 59425 – 59426 with appropriate -U trimester modifier  
Diagnosis Codes: V20.2, V70.0 or V70.3 |
Counts as Well-Child Measure: Submit the diagnosis code for a comprehensive well-visit diagnosis in addition to pregnancy diagnosis codes indicating preventive care even when not all components of an EPSDT visit are present.

Rates: Standard prenatal visit rates apply.

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<th>Can FQHCs and RHCs bill a sick visit and an EPSDT visit for the same patient on the same day of service and be reimbursed for both service codes?</th>
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| A. | Yes, if a member comes in for a sick visit and the provider also captures an EPSDT service, both can be billed. All components of the EPSDT visit must be documented, including age-appropriate health and developmental history (mental and physical), physical exam and health education/anticipatory guidance and EPSDT components, as well as the problem-focused visit.  
  - Provider must maintain in the medical record both a complete problem-focused visit exam for the presenting problem and a complete preventive visit documenting the EPSDT components of the screening exam.  
  - The problem-focused exam must be separate and significant and of moderate intensity or greater by the same physician on the same day.  
  - Use the 25 modifier with the E&M procedure code and the diagnosis code V20.2 in the first position on the claim for the EPSDT services, adding the multiple diagnoses for the presenting problems to support the separate E&M service. |

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<th>Q.</th>
<th>Why are some claims that FQHCs and RHCs submit to Myers &amp; Stauffer then denied by the MCE? This is confusing when we try to predict the amount of our wrap-payments.</th>
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| A. | The MCE must adjudicate claims before Myers & Stauffer can calculate the wrap-payment. If a claim is not payable by the MCE, it may not be eligible for a wrap-payment. The claim must be considered an “encounter” under the wrap-payment rules to be eligible for a wrap-payment.  
When the FQHC/RHC sends its claims to Myers & Stauffer before they are adjudicated by the MCE, the wrap-payment is subject to adjustment if some of those claims are found not to be eligible “encounters.”  
Not all claims are “encounters” for wrap-payment and settlement purposes under the FQHC/RHC Prospective Payment System (PPS). Most immunizations, vaccines, lab and other services that do not involve a face-to-face encounter between a patient and an approved clinic practitioner (physician, PA, NP, LCSW, clinical psychologist, DDS, dental hygienist, podiatrist, optometrist, or chiropractor) are not “encounters” under the PPS. FQHC/RHC PPS rates are developed to include the cost of these services, so there is no separate supplemental payment for them in the wrap and settlement process.  
Myers & Stauffer recommends that providers submit claims to them for supplemental payment only after receiving adjudication from the MCE.  
The MCEs recommend that providers regularly and promptly review their explanations of payment from the MCEs. This is important because there is limited time to file a claim and limited time to correct or appeal a claim.  
(When working with an IHCP Program MCE, contracted providers must file claims within ninety (90) days of the date of service; non-contracted providers must file within one year of the date of service. All providers must appeal or correct & resubmit a processed claim within sixty (60) days of receipt of an EOP. For more information on filing claims, please go to the IHCP Indiana Medicaid Provider website: http://provider.indianamedicaid.com.) |
7. **Q.** How often may an FQHC or RHC submit claims to Myers & Stauffer to receive supplemental payments?

7. **A.** FQHC/RHC RBMC and Dental Supplemental Payment request forms may be submitted no more than monthly to Myers & Stauffer for payments based on the providers’ accounting/billing records. Links to the payment process and forms are below:

   - [http://in.mslc.com/uploadedFiles/FQHC-RHC%20RBMC-DENTAL%20Supplemental%20Request%20Form.pdf](http://in.mslc.com/uploadedFiles/FQHC-RHC%20RBMC-DENTAL%20Supplemental%20Request%20Form.pdf)

8. **Q.** Are FQHCs and RHCs required to reconcile their MCE claims every month? How do we reconcile?

8. **A.** FQHCs and RHCs are not required to reconcile every month. The MCEs are required to work with FQHC/RHCs to reconcile claims every quarter. This process is aimed at making wrap-payment amounts more reliable and less subject to later adjustment.

   Each MCE (Anthem, MDwise and MHS) sends each FQHC/RHC a quarterly report of its processed claims. The FQHC/RHC compares that listing with its own list of claims filed with that MCE for that reporting period. Any claims that are missing or show a different status or different paid amount should be worked by the FQHC/RHC. Steps for working the claim are below:

   - Check the explanation of payment to be sure you have the correct status and paid amount
   - Submit claims that the MCE does not show it received
   - Correct and then resubmit claims you believe were denied by the MCE in error

   Providers must still submit the FQHC/RHC RBMC & Dental Supplemental Payment request form to Myers & Stauffer to receive supplemental payments. For HIP member claims, use the separate HIP Supplemental Payment request form.

9. **Q.** How can FQHCs and RHCs work with MCEs to improve the reconciliation process, maximize our reimbursements and reduce re-work?

9. **A.** The MCEs suggest the following helpful tips:

   - On a quarterly basis, each MCE generates individual FQHC/RHC claim reports. The reports include all adjudicated claims within the quarterly reporting period. They are in Microsoft Excel format and are distributed electronically by secure e-mail to the designated FQHC/RHC contact person. These reports are generated as a checkpoint to compare your information with the MCEs’ information so any errors can be corrected.
   - Please notify the MCE immediately if you have a change in contact name or e-mail address to ensure proper communication with your organization.
   - Please work your weekly explanations of payments (included with checks) timely so MCEs can make all proper payments and establish proper status on your claims.
   - Please be sure your FQHC/RHC status and practitioner list is up to date with the OMPP.
   - Please review the FQHC/RHC claim reports generated by each MCE to confirm that the MCE has the most up-to-date list of practitioners, including accurate effective and end dates.
for each practitioner.

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| 10. | A. | ANTHEM: If you are not receiving the Quarterly Anthem Reports or have questions, please contact LaShon Hodge, Network Development Analyst at 317-287-2668.  
MDWISE: If you are not receiving the Quarterly MDwise Reports or have questions, please contact Steve Brown, Medical Economist, at 317-822-7144.  
MHS: If you are not receiving the Quarterly MHS Reports or have questions, please contact Jeff Dill, Data & Enrollment Manager, at 317-684-9478, Ext. 20168. |

Some of the special terms used in this document:

**EPSDT**: Early and Periodic Screening, Diagnostic and Treatment services are primary care services recommended for children that have detailed and specific requirements. If your provider sees a child for a well-child visit and does a thorough examination but does not document it, that visit will not count as an EPSDT visit. Likewise, if the provider skips any one of several specific requirements, it will not be counted as an EPSDT visit. Both of these examples are likely payable as office visits. For example, EPSDT visits for infants require head circumference be measured and documented. If a provider does not do the measurement or document it, the visit is counted only as a well-child visit, not an EPSDT. Reimbursement for an EPSDT visit is slightly higher than for a well-child visit.

**HEDIS**: The National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set are measurements that MCEs report each year to the State of Indiana and to the NCQA. These reported measurements can be used by the public to compare plan performance. When auditors look at the MCE’s claims and at the medical records of the plan’s providers, they determine which visits include the required specifics to count as well-child visits for HEDIS reporting. Again, thorough work-ups and documentation are key to ensure all visits count under HEDIS.

**Wrap-Payments**: Wrap-payments are supplemental payments from the Federal government to FQHCs and RHCs in addition to payment received from the MCE for certain services provided to IHCP members. The amount of the wrap-payment is dependent on the Prospective Payment System (PPS) rate for any given service. Wrap-payments are not payable on duplicate claims or on claims that are denied by the MCE for certain reasons including, but not limited to, “patient not eligible on date of service” or “service excluded under Medicaid.” To calculate the correct payment total due to each FQHC/RHC, the actuaries at Myers & Stauffer need the MCEs and the FQHC/RHCs to help reconcile their claims listings each quarter.

**CPT Codes**: These are the codes used to refer to various medical procedures and services under the American Medical Association’s standard Code of Procedural Terminology. This listing is updated each year.

**E&M Codes**: These are the CPT codes that indicate office visits for Evaluation and Management of patients. They include codes such as 99211, 99212, 99213, etc.

**MCE**: Managed Care Entity is the term that the State of Indiana and the Federal Government use to refer to the Health Plans contracted by the State to administer the Indiana Health Coverage Programs, which
include Hoosier Healthwise and the Healthy Indiana Plan (HIP). MCEs contract with providers, process claims, and act as the members’ health insurance plan.

OMPP: The Office of Medicaid Policy and Planning is the designated department within the Indiana Family and Social Services Administration that is responsible for oversight of the Indiana Health Coverage Programs.

IHCP: Indiana Health Coverage Programs refers to Indiana Medicaid programs which includes Hoosier Healthwise, HIP, Care Select and Traditional Medicaid. Populations served by Indiana Medicaid include low-income, pregnant, disabled, and children (under the Children’s Health Insurance Program or CHIP).