MDwise 2nd Quarter IHCP Workshop

May 2013

Exclusively serving Indiana families since 1994.
Agenda

1. Provider Revalidation
2. Balance Billing of Member
3. Behavioral Health Update
4. Quality Updates
5. Provider Tools
Provider Revalidation

- Under the Affordable Care Act (ACA), the Indiana Health Coverage Programs (IHCP) is required to revalidate all provider enrollments, applying ACA criteria. A summary of these criteria is located on the Affordable Care Act (ACA) Requirements page of indianamedicaid.com.

- Providers newly enrolled on or after January 1, 2012, are being screened against these criteria at initial enrollment and will not be subject to revalidation for three to five years, depending on their provider type. Beginning in March 2012, the IHCP will revalidate all providers whose enrollments became effective before January 1, 2012. These revalidations will be scheduled in phases and will be completed by December 31, 2015.

- Providers will receive a notification letter with instructions for revalidating 90 days before their revalidation deadline. A second notification letter will be mailed 60 days before the revalidation deadline.

- Providers with multiple service locations must revalidate each location individually and will receive a separate letter for each location.

- Notification letters will be mailed to the providers mail to location.

- The revalidation process can take 20 days to process so keep this in mind when completing the application.
• **DEACTIVATION**

• Providers who fail to revalidate timely will be deactivated.

  What does this mean?

  • Claims billed with dates of service on or after the deactivation date will be denied.

  • Providers who participate in the managed care programs will have their members reassigned to other primary medical providers (PMPs).

  • Members with level-of-care (LOC) services and those in the Right Choices Program (RCP) may be denied benefits.
March 2012 requesting submission of revalidation documents. Providers should not submit revalidation documents before receiving a letter.

A list of providers whose revalidations are coming due and that will be receiving letters of notification will be posted to Web interChange, accessible at indianamedicaid.com.

Providers with multiple service locations must revalidate each location individually, according to ACA requirements. Providers will receive a separate letter for each service location.
• Providers whose IHCP enrollment was effective after January 1, 2012, will not be scheduled to revalidate their enrollment until 2015 or after.

• Providers enrolled before January 1, 2012, will begin receiving notification letters in March 2012 requesting submission of revalidation documents. Providers should not submit revalidation documents before receiving a letter.
Revalidation of enrollment will occur on a regular schedule.

Under the ACA, states are required to revalidate providers at intervals not to exceed every five years. A more frequent three-year revalidation requirement applies to durable medical equipment (DME) and home medical equipment (HME) providers, including pharmacy providers with DME or HME specialty enrollments.

Providers will be notified every three or five years when it is time to revalidate their IHCP enrollments.
Provider Revalidation

- Rendering providers will not have to revalidate individually. Providers enrolled with a group classification are responsible for revalidating the rendering providers associated with the revalidating service location. Rendering revalidation means that the group or clinic attests that the rendering providers linked to the group are still actively linked to the group’s or clinic’s service location, and that the rendering provider is not sanctioned and has an active license.

- Timely submission of revalidation paperwork is required to avoid deactivation or a gap in enrollment as an IHCP provider.

- Providers who are enrolled as Primary Medical Providers with any of the managed care entities (MCE’s) will not receive any special notice regarding revalidation from the IHCP. MDwise is working with it’s Delivery Systems to ensure its PMP’s and their members are not affected by revalidation.
Reminder: Balance billing of members is not appropriate

The Indiana Health Coverage Programs (IHCP) reminds providers that it is inappropriate to bill members for any amount in excess of the amount paid by Medicaid for covered services.

Further, as a condition of participation in the IHCP, the provider must accept the IHCP determination of payment as payment in full, whether the IHCP is the primary or the secondary payer.
Chapter 4, Section 6, of the IHCP Provider Manual documents when it is appropriate for a provider to bill the member for noncovered services. An IHCP provider can bill an IHCP member only when the following conditions are met:

The service must be an IHCP-noncovered service or a covered service for which the member has exceeded the program benefit limitations.

The member is assigned to the Qualified Medicare Beneficiary (QMB) Only or the Specified Low Income Medicare Beneficiary (SLMB) Only aid category, and the IHCP pays only the Medicare coinsurance and deductible, but does not reimburse medical coverage.
Before receiving the service, the IHCP member must be advised that Medicaid does not cover the service and that the member is responsible for the service charges. In this situation, the member must sign a waiver that documents the member’s understanding of expected out-of-pocket expenses.

The provider must maintain documentation in the member’s file that the member voluntarily chose to receive the service, knowing that the IHCP does not cover the service.
The covered or noncovered status of embellishments or enhancements to basic services can be considered separately from the basic service only if a separate procedure code, revenue code, or National Drug Code exists.

Only if a separate code exists can a noncovered enhancement be billed to the member and the basic charge billed to the IHCP. Otherwise, the service is considered covered or noncovered in its entirety.
A provider can bill the member in situations where the provider took appropriate action to ascertain and identify a responsible payer for a service. The provider must maintain documentation to support the member billing and/or show that primary payer information was requested.

A provider can bill the member if the member failed to advise the provider of Medicaid eligibility within one year from the date of service. The provider must maintain documentation to support the member billing and/or show that primary payer information was requested.
If the provider is notified of the member’s eligibility within the one-year filing limit, the provider must bill the IHCP for the covered service. Under this circumstance, any monies collected by the provider from the member must be reimbursed in full to the member.

Providers can bill the member the amount credited to the member’s spend-down.

A hospital can bill a member for services if the hospital’s utilization review committee established under 42 CFR 482.30 makes a determination that a continued stay is not medically necessary. The determination must comply with the requirements of 42 CFR 482.30(d).
After the initial diagnostic interview (90791 or 90792), member can receive up to twelve (12) therapy sessions without PA per billing provider. Individual and Family therapy sessions can be used interchangeably, therefore authorization applies to this group of codes.

Group sessions can be provided as part of the initial 12 sessions without PA, however PA for group sessions are not interchangeable with individual and family therapy sessions and must be specifically requested.
Providers are allowed 12 Therapy visits without PA:

CPT code:
90832 Psytx Office 30 min
90834 Psytx Office 45 min
90846 Family medical psychotherapy
90847 Family Psytx conjoint

90837 – Now included in the bucket-1-1-13

Group Therapy Visits included in 12 initial visits but not interchangeable:
90853 Group Psychotherapy
19 Medication Management visit per billing provider PA rule

99201-99203, New patient, office
99211-99213, Existing patient, office
99241-99242, Consultation, office

After the initial diagnostic interview (90791 or 90792), PA is not required for the first 19 visits per billing provider for this group of codes. (Service provided by a psychiatrist or nurse practitioners/clinical nurse specialists who have prescription authority.) All other therapy visits for these codes beyond initial 19 require PA. See NOTE below for authorization application guideline.

99214 – 99215 included in the 1+ 19 effective 5-1-13

90833 Ind. Psytx with medical E/M 30min and 90836 Ind. Psytx with medical E/M 45 min may be reimbursed in conjunction with these E/M codes and do not require a separate authorization.

Interactive Complexity (CPT code 90785) is an add-on code to this CPT group and does not require a separate authorization.
Behavioral Health Contacts

Lynn Bradford, Ph. D., HSPP
Director of Behavioral Health
MDwise, Inc.

Jacquie Marsalis
Behavioral Health Representative
jmarsalis@mdwise.org
317-822-7364 –phone
MDwise Delivery Systems

• Hoosier Alliance
• Methodist
• Select Health
• St. Catherine
• Saint Margaret Mercy
• St. Vincent
• Total Health
• Wishard
• Claims Address:
  • For all HIP delivery systems, effective January 1, 2013, paper claims should be submitted to:
    MDwise Claims – DST
    P.O. Box 830120
    Birmingham, AL 35283-0120
  • All electronic EDI numbers below remain unchanged:
    – Emdeon, TK Software and WebMD/Emdeon
      • Institutional Payer ID–12K81
    – Payer ID for all EDI clearinghouses
      • MDWIS Professional Payer ID–SX172
    – McKesson/Relay Health
      • Institutional Payer ID–4976
      • Professional Payer ID–4481
Resource Links

2013 Second Quarter IHCP Workshops – Important Resource Links


Common Behavioral Health Forms including the Outpatient Treatment Request (OTR) Form

MDwise Web Portal Password Request Page: [http://www.mdwise.org/login.html](http://www.mdwise.org/login.html) (This is Free!)


2013 Incentivized **HEDIS** Measures for HHW

- Adolescent Well Care Ages 12–21
- Well-Care for Children Ages 3–6
- Well-Care for Children 0–15 months
- Emergency Room Utilization
- Physicians Advising Smokers to Quit
- Timeliness of Postpartum Care (21–56 days after delivery)
- Frequency of Ongoing Prenatal Care
- Follow-up after Hospitalization from Mental Illness Within 7 days
- LDL-C Screenings for Diabetic Members
• ER Utilization

• Rollover Measure-Adult Preventive Care

• Physicians advising smokers to quit
How We Promote Quality Care

- Provider and staff education
- Network Improvement Program (NIP) Team
- Billing and process audits
- ManagedCare.com
- Member education
- Member incentives
- Provider Incentives
- Implementing Bright Futures
- Promote Presumptive Eligibility
- Promote Notification of Pregnancy (NOP)
- Case management services for members
- Case management for members receiving behavioral health services
How NIP Can Help

NIP Team Responsibilities

- Created to take improvement efforts to a higher level
- Educating providers on HEDIS, NCQA, and OMPP standards
- Providing providers with information about their quality performance
- Identify office practices that may result in missed opportunities to provide care or cause services to not be billed correctly
- Creating and distributing reference/educational materials and tools
- Initiating programs and tools that assist the Plan in meeting quality targets
- Communicating to delivery systems and providers about areas of opportunity for improving efficient healthcare resource utilization
- Maximize the opportunity for MDwise, Inc. to recoup as much of the State withhold on quality as possible in the targeted Pay for Performance measures
- Create and implement pilot projects to improve quality of care in medical and behavioral health
<table>
<thead>
<tr>
<th>Measure</th>
<th>NCQA 90th Percentile</th>
<th>MDwise Delivery System</th>
<th>GROUP A</th>
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<td>Adolescent Well-Care Visits</td>
<td>63%</td>
<td>2,323</td>
<td>1,575</td>
<td>67.8%</td>
<td>85</td>
<td>146</td>
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<td>Well-Child Visits - Ages 3-6</td>
<td>83%</td>
<td>2,015</td>
<td>1,685</td>
<td>83.6%</td>
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<td>Six or More Visits</td>
<td>76%</td>
<td>525</td>
<td>395</td>
<td>75.2%</td>
<td>48</td>
<td>66</td>
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<td>LDL-C Screening</td>
<td>84%</td>
<td>66</td>
<td>42</td>
<td>63.6%</td>
<td>9</td>
<td>13</td>
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<td>Timeliness of Postpartum Care</td>
<td>74%</td>
<td>450</td>
<td>342</td>
<td>76.0%</td>
<td>24</td>
<td>34</td>
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<td>Follow-Up after BH Inpatient Stay (7)</td>
<td>64%</td>
<td>63</td>
<td>39</td>
<td>61.9%</td>
<td>11</td>
<td>16</td>
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• Maximize every member interaction to provide preventive and well-care
  – Well care visits for children when they are in for acute care
  – Schedule the 15th month EPSDT visit prior to the 15th month of life
  – LDL-C screens for diabetics when in for acute care
• Staff who does scheduling can identify members that need services to schedule in a timely fashion
• Ensure proper billing for services rendered
• Be sure that the documentation is complete
• If all components of EPSDT were not provided, remember to submit the appropriate E&M code along with the appropriate diagnosis code V20.2, V70.0, or V70.3 to ensure the services count towards the HEDIS measure.
• If EPSDT services were provided along with acute care, be sure to submit the appropriate EPSDT code along with the E&M code and the 25 modifier to ensure the services are counted towards the HEDIS measure.
Opportunities For Improvement

• A primary medical provider (PMP) office could take the opportunity to convert a sick visit into a well–child visit when the member is in the office for acute care.
• If the PMP office has electronic medical records (EMR), implement alerts to reflect the non–compliant members in the quality measures.
• If the PMP office receives a list of non–compliant members, the office should reach out to the members and schedule preventive services.
• If a member is being seen for an initial prenatal visit or post partum visit, all the components of a preventive well–child exam are provided. The appropriate V20.2 or V70.0 can be submitted as a secondary diagnosis code and count towards the AWC measure.
• If all components of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services were provided, remember to submit the appropriate procedure codes 99381–99385 or 99391–99395 with the diagnosis code V20.2 as primary.
What can a Care Manager do for your MDwise patient?

- Encourage the patient to follow the physician’s plan of care
- Review/reinforce proper use of the prescribed medication
- Provide educational materials to help the patient understand their disease
- Coordinate/identify need for social service agencies
- Help decrease no call / no show
- Assist your practice in meeting HEDIS guidelines
Resources

- MDwise website: MDwise.org
- INcontrol
- Your MDwise Provider Rep
- Case managers
- American Academy of Pediatrics
- CAHPS Poster
- Provider and Member Incentives
- Provider Education Visits
- www.indianamedicaid.com
- MDwiseREWARDS
Resources

• Performance Reports
• HEDIS Lists
• Well-Child First Poster
• 2013 Performance Poster
• Well 15 Tip Sheet
• Best Practices Booklet
• EPSDT Coding Guide
• Notification of Pregnancy Quick Reference Guide
• 40 Weeks of Pregnancy Provider Toolkit
• Revalidation Toolkit
• Diabetes Toolkit
Thank you!

• Questions?