Questions and Answers from the 2021 IHCP Roadshow Panel Discussion:
Federally Qualified Health Centers and Rural Health Clinics

The Indiana Health Coverage Programs (IHCP) hosted a panel discussion on Thursday, May 6, 2021, for federally qualified health centers (FQHC) and rural health clinics (RHCs) as part of the 2021 IHCP Roadshow. This document provides a summary of the questions and answers discussed during the panel.

Can the panel clarify IHCP billing guidance for COVID-19 vaccine administration?

COVID-19 vaccine administration is carved out of managed care. FQHCs and RHCs should bill all Healthy Indiana Plan (HIP), Hoosier Healthwise, Hoosier Care Connect and fee-for-service claims directly to Medicaid using the place-of-service code **71** and one of the valid vaccine administration codes (**0001A**, **0002A**, **0011A**, **0012A** or **0031A**). Providers may bill for the vaccine itself with a billed charge of **$0**. Providers may also bill for the administration of the vaccine. Reimbursement for the vaccine administration will be in place until the coronavirus disease 2019 (COVID-19) public health emergency (PHE) has ended.

For more information, please review *IHCP Bulletin BT202121*.

Can the panel clarify IHCP billing guidance for non-COVID-19 related vaccine administration?

FQHCs and RHC cannot bill separately for vaccines nor their administration. FQHC and RHC reimbursement rates already include payment for the vaccine and administration fee, as these services can be performed in conjunction with an office visit to a qualifying practitioner.

These services are not reimbursable through claim submission if performed without a face-to-face visit with a qualifying practitioner.

The FQHC/RHC prospective payment system (PPS) rate is an all-inclusive rate; therefore, reimbursement for services provided at FQHCs or RHCs that do not meet all the criteria for a valid encounter (such as injections performed by a nurse without a corresponding visit to satisfy the valid encounter definition) are included in the PPS rate.

For more information, providers can review the IHCP provider reference modules entitled *Injections, Vaccines and Other Physician-Administered Drugs* and *Federally Qualified Health Centers and Rural Health Clinics*.

How can providers obtain a complete list of assigned members to their panel?

Providers can access a list of their assigned members from each MCE as follows:

- **Anthem**: Use the Availity secure web portal, at apps.availity.com, as follows:
    1. Log in to the Availity portal.
    2. Click Payer Space.
    3. Select Anthem.
    4. Select Application.
    5. Select Provider Online Reporting.
    6. Select your organization then submit.
    7. Select Report Search.
    8. Select Member Panel Listing from the drop down box.
- **CareSource**: Contact your assigned Health Partner Engagement Specialists via email or phone. See the CareSource territory map at caresource.com.
- **Managed Health Services (MHS)**: Log in to the MHS secure provider portal, accessible under the Providers menu at mhsindiana.com, and follow the links.
- **MDwise**: By signing in to the MDwise portal and following the links. For more information, see the *Creating a myMDwise Provider Portal Account* guide, available at mdwise.org.
- **UnitedHealthcare**: Primary medical providers (PMPs) may sign in to the UnitedHealthcare secure web portal, Community Care, at uhcprovider.com.
    - Existing users can log in and click the link on the My Members tile.
        - A complete list of all members assigned to a PMP can be accessed by clicking the side bar icon, "My Members."
        - PMPs can export the member roster to Microsoft Excel by clicking the X icon.
        - PMPs can also select what member data fields they wish to include in their roster from the data field menu options.
    - New users can register by clicking the New User & User Access link at the upper-right corner of the uhcprovider.com webpage.

What is the recoupment process?

Managed care entities (MCEs) and Gainwell Technologies (for FFS claims) request recoupments when claims are overpaid or paid in error. Some common reasons for a recoupment include errors in member or provider eligibility, services billed in error, duplicate claims, or identification of third-party liability (TPL).

Providers are notified of a recoupment by letter, which states the reason(s) for recoupment and action steps for providers. See the following table for information on how the recoupment process is handled by each MCE and by Gainwell.

Recoupment Processes

MCE or Gainwell	Response time/ time to auto-recoup	Options for payment
Anthem	65 days	Anthem requests providers follow the process outlined in the recoupment notification letter.
CareSource	60 days	Funds are recovered from future Remittance Advices (RAs).
MDwise	90 days	Recoupments are obtained through future RAs or explanations of payments (EOPs) until the overpayment amount is satisfied.
MHS	60 days	Providers have an option to send a refund check or establish recoupment from future payment through a negative balance.
UnitedHealthcare	60 days	Providers have an option to send a refund check or request an offset against future claim payments.
Gainwell (FFS claims)	60 days	Providers have an option to send a refund check or request an offset against future claim payments. The recoupment process is managed by HMS.

If providers are aware of an overpayment on a claim, a recovery request must be initiated as follows:

- **Fee-for-service** – Through the IHCP Provider Healthcare Portal or by paper mail. See the *Provider and Member Utilization Review* provider reference module and the *Protocol for Voluntary Self-Disclosure of Provider Overpayments* webpage for detailed fee-for-service instructions.
- **Managed care** –
  - CareSource, UnitedHealthcare and MHS allow for an overpayment submission to be completed through their respective portals.
  - Anthem and MDwise require paper submissions.

  Please review each MCE's policy for correct submission.

When mass adjustments indicate an overpayment, the overpayment will automatically be recouped from future payments.

How do recoupments affect the wrap payment?

If an MCE recoups payments from an FQHC or RHC, the amount due for the wrap portion of the payment increases. Providers may include recoupments on future wrap requests if the recoupment is related to a date of service in the previous 12 months. If the recoupment is related to older dates of service, the difference will be included in the year-end settlement.

What is the IHCP policy for reimbursing multiple encounters on the same date of service?

In general, providers are allowed one encounter per member per date of service (DOS), unless the primary diagnosis is different on the claim. The IHCP guidelines for medical and behavioral health services performed on the same date of service are outlined in the *Claim Submission and Processing* provider reference module. If a member visits an office twice on the same day with *two different diagnoses*, a second claim can be submitted for the second visit, using a separate claim form or electronic claim submission. However, this policy does not allow a provider to bill multiple claims for a *single* visit with multiple diagnoses by separating the diagnoses on different claims.

When two valid practitioners, such as a medical provider and a behavioral health provider, see the same patient in the same day, the principal diagnoses should not be the same.

For more information, refer to *IHCP Bulletin BT2020101*.