



2024 IHCP Roadshow

Agenda

- Medicaid Cost Sharing Restart
- Inappropriate Member Billing Reminder
- Authorization Limits – Behavioral Health
- Address Updates
- Timely Filing Timeframes
- Social Determinants of Health (SDoH)
- MHS Provider Engagement Team
- Questions

Medicaid Cost Sharing

Medicaid Cost Sharing Restart

Starting July 1, 2024, HIP Basic/State Basic/HHW Package C (CHIP) members will have co-pays.

Monthly POWER Account contributions will resume for Healthy Indiana Plan (HIP) members on July 1, 2024.

Hoosier Healthwise (CHIP) premiums resume on July 1, 2024.

HIP Plus members will receive their first invoice in July 2024, which will be due August

Program	Power Account Contributions/ Premiums	Copayments
HHW Package C (CHIP)	Monthly premium based on income.	\$3 generic drugs \$10 name brand drugs
HIP Basic/HIP State Basic	No monthly contribution but will have copayments for most covered services.	\$4 outpatient services \$75 inpatient services \$4 preferred drugs \$8 non-preferred drugs \$8 ER visit (non-emergency use)
HIP Plus/HIP State Plus	Monthly contribution based on income and tobacco use.	\$8 ER visit (non-emergency use)
HIP State Plus Copays (Members who are medically frail w/ income above 100% FPL that don't pay their monthly PAC)	Monthly contribution based on income and tobacco use and copayments for most covered services. Will incur debt for unpaid monthly premiums.	\$4 outpatient services \$75 inpatient services \$4 preferred drugs \$8 non-preferred drugs \$8 ER visit (non-emergency use)

Balance Billing

Balance Billing Reminder

Per banner [BR202111](#) providers are reminded not to bill members with some exceptions.

Applies to providers in both fee-for-service and managed care delivery systems.

As an Indiana Health Coverage Programs participating provider, providers must accept the IHCP payment as full payment of service.

Balance Billing Reminder

The following exceptions apply to all IHCP members, regardless of their eligibility category or program.

An IHCP provider may bill a member for noncovered services only when these conditions are met:

- The member must understand, before receiving the service, that the service is not covered under the IHCP, and that the member is responsible for the service charges.
- The provider must maintain documentation in the member's file that clearly demonstrates that the member voluntarily chose to receive the service, knowing it was not covered by the IHCP.

Reference Banner [BR202111](#) for additional information and exceptions.

Additional reference; <https://www.in.gov/medicaid/providers/provider-references/bulletins-banner-pages-and-reference-modules/ihcp-provider-reference-modules/>

Authorization Limits

Authorization Limits – Behavioral Health

Limitations on Behavioral Health Outpatient Therapy (BHOP):

The following Current Procedural Terminology codes, in combination, are limited to 20 units per member, per practitioner, per calendar year.

<u>Code</u>	<u>Description</u>
90832 – 90834	Individual Psychotherapy
90837 – 90840	Psychotherapy, with patient and/or family member & Crisis Psychotherapy
90845 – 90847 90849 – 90853	Psychoanalysis & Family/Group Psychotherapy with or without patient

Please Note: CPT codes 90833, 90836, and 90838 for psychotherapy with medical evaluation and management are medical services. Therefore, the IHCP does not reimburse clinical social workers, clinical psychologists, or any mid-level practitioners (excluding nurse practitioners and clinical nurse specialists) for these codes.

Authorization Limits – Behavioral Health

Limitations on BHOP Therapy (Cont.):

Claims exceeding the limit will deny EXTh: “Services exceeding 20 visits require Prior Authorization.”

If the member requires additional services beyond the 20-unit limitation, practitioners may request prior authorization for additional units. Approval will be given based on the necessity of the services as determined by the review of medical records.

- Please do not submit for BHOP Prior Auth until the 20 allowed visits have been fully exhausted. Requesting Prior authorization prematurely will result in the loss of a portion or all 20 allowed visits as the PA will take precedent over the 20 allowed visits.

“Per Practitioner” is defined by MHS as per individual rendering practitioner NPI being billed on the CMS-1500 claim form (Box 24J).

Address Updates

MHS Address Updates

CLAIMS MAILING ADDRESS:

To send paper claims to MHS, kindly forward the red and white forms to:

MEDICAL CLAIMS ADDRESS:

Managed Health Services
P.O. Box 3000
Farmington, MO 63640-3800

Behavioral Health CLAIMS ADDRESS:

MHS Behavioral Health
ATTN: Claims Department
P.O. Box 6800
Farmington, MO 63640-3817

Involve Dental:

Claims: IN
P.O. Box 20847
Tampa, FL 33622-0847

Involve Vision:

P.O. Box 7548
1151 Falls Road, Suite 2000
Rocky Mount, NC 27804

MHS Address Updates (Cont.)

MEDICAL CLAIMS APPEALS:

Providers are allotted 60 calendar days from the Explanation of Payment's date to initiate an adjustment, resubmission, or appeal of a decision.

Managed Health Services:

ATTN: Appeals Department
P.O. Box 3002
Farmington, MO 63640-3802

Behavioral Health Claims:

Centene Corporation
13620 Ranch Road 620 N
Building 300C
Austin, TX 78717-1116

MHS Arbitration:

MHS Arbitration
550 N. Meridian Street, Suite 101
Indianapolis, IN 46204

MHS Address Updates (Cont.)

MEDICAL NECESSITY APPEALS ONLY ADDRESS:

MHS must receive Medical Necessity appeals within 60 calendar days from the date indicated on the denial determination letter.

ATTN: APPEALS

P.O. Box 441567

Indianapolis, IN 46244

MEDICAL CLAIMS REFUNDS AND OVERPAYMENTS:

To refund claims overpayments, kindly forward the check and accompanying documentation to:

Coordination Care Corporation

P.O. Box 856420

Minneapolis, MN 55485-6420

Claims Disputes and Appeals

Claim Dispute and Appeal

Level 1 – Informal Claim Dispute

- 60 calendar days of receipt of the MHS Explanation of Payment (EOP).
- MHS will make all reasonable efforts to review your documentation and respond to you within 30 calendar days.
- At that time (or upon receipt of our response if sooner), you will have up to 60 calendar days from date of dispute response to initiate a formal claim appeal (Level 2).

Claim Dispute and Appeal (Cont.)

Level 2 - Formal Claim Dispute, Administrative Claim Appeal

- The appeal must be filed within 60 calendar days from date of the EOP of the informal dispute resolution notice.
- An administrative claim appeal must be submitted via the Secure Portal or in writing by using the Medical Claim Dispute/Appeal form with an explanation including any specific details which may justify reconsideration of the disputed claim. The appeal clearly marked on the form as Level 2.

Claim Dispute and Appeal (Cont.)

Level 3 - Arbitration

- In the event a provider is not satisfied with the outcome of the administrative claim appeal process (Level 2), the provider may request arbitration. Claims with similar issues from the same provider may be grouped together for the purpose of requesting arbitration.
- To initiate arbitration, the provider should submit a written request to MHS on company letterhead. The request must be postmarked no later than 60 calendar days after the date the provider received MHS' decision on the administrative claim appeal.

Social Determinants of Health (SDoH)

Social Determinants of Health (SDoH)

MHS is working to improve Social Determinants of Health (SDoH) impact on member outcomes.

When including SDoH diagnoses on claims, providers are providing our team with information that allows us to identify members for additional outreach and assistance.

Social Determinants of Health (SDoH) (Cont.)

We are currently focused on enhancing programs and community connections to address the SDoH diagnosis codes listed below:

Diagnosis Code	Description
Z55	<ul style="list-style-type: none">• Problems related to education and literacy, Example billable code• Illiteracy and low-level literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk factors
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances

MHS Provider Engagement Team

MHS Provider Engagement Team (Cont.)

Northeast Region: Joy Diarra

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Northwest Region: Candace Ervin

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MHS Provider Engagement Team (Cont.)

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Provider Groups:

Community Health Network

Indiana University Health

Wayspring Health

Reid Hospital

Norton Hospital

St. Elizabeth Hospital

Mona Green

mona.green@mhsindiana.com

Provider Groups:

St. Vincent/Ascension

Wellcare Complete

Lutheran Medical Group

Parkview Health System

Beacon Medical Group

American Senior Care

CarDon & Associates

OrthoIndy

Heart City Health

ONE

Franciscan Health

Questions?
