IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR202314 APRIL 4, 2023

HIP Bridge Delayed

The *Healthy Indiana Plan (HIP) Bridge* program go-live is being delayed until a later date as the Family and Social Services Administration (FSSA) focuses on transitioning Medicaid members to normal operations, and the member continuous eligibility is ending (see *Indiana Healthcare Coverage Programs (IHCP) Bulletin* BT202304). The FSSA will engage with stakeholders after a new date for the program launch has been set. Please see *BT202319* for additional information about the *HIP Bridge* program.

IHCP 2023 Provider Communications Survey

To help with evaluating its provider outreach efforts, the Indiana Health Coverage Programs (IHCP) is requesting providers' feedback, via survey, on IHCP communications and events over the past year. Providers may click on and complete this Providers Communications Survey any time between April 1, 2023, and May 1, 2023. All responses will be kept anonymous. The IHCP will use providers' feedback to plan and improve future communication and events, such as IHCP Live webinars, the IHCP Roadshow and the IHCP Works seminar. Thank you for your time in helping us create a better experience for all.

IHCP identifies issue with FQHC and RHC outpatient crossover claim denials

The Indiana Health Coverage Programs (IHCP) identified an issue with outpatient crossover claims denying for explanation of benefits (EOB) code 0558 – *Coinsurance and deductible amount is missing indicating that this is not a crossover claim*, as noted in *IHCP Banner Page* BR202242.

The claim-processing system has been corrected. An electronic claim mapping change caused outpatient crossover claims to deny incorrectly when submitted without coinsurance, deductible or copayment amounts in the claim header. This issue affects electronic outpatient crossover claims submitted on or after Nov. 9, 2021.

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Federally qualified health center (FQHC) and rural health clinic (RHC) providers that submitted claims denied for EOB 0558 on a professional claim (*CMS-1500* claim form or electronic equivalents) will be recouped and the corresponding institutional claim (*UB-04* claim form or electronic equivalents) will be reprocessed.

Providers should start seeing claim recoupments beginning May 9, 2023, with internal control numbers (ICNs)/Claim IDs that begin with 56 (mass void request or single claim void).

IHCP reminds providers of changes made to E/M coding guidelines

Due to changes in 2021 and 2023 to the evaluation and management (E/M) coding guidelines, the Office of Medicaid Policy and Planning (OMPP) Program Integrity (PI) would like to remind providers of a few major changes which would impact coding E/M services. Most importantly the selection of the appropriate level of E/M services for all codes is now based on **one of the two following options:**

- The level of medical decision making (MDM) as defined for each service, or
- The total time for E/M services performed on the date of the encounter

Modifications were made to the MDM table as well as the definitions that support that table. Make sure you are using the table, but also use the guidelines and the definitions that have been provided to support the proper use of the MDM table.

E/M guidelines now include a requirement for a medically appropriate history and exam. This removed the history and exam component when determining what code level to bill. Providers will now select a code for the appropriate level of E/M service based on time or medical decision making. It is still very important to include a medically appropriate history and/or examination. This is needed for each encounter for the continuity of care and to clearly identify the status of the patient among other reasons. As a reminder, when using total time, the time listed in the descriptor MUST meet or exceed the time listed for the code billed. As a best practice, when you have time that is out of the normal time for a visit, a qualification statement would be useful for coders and payors. This statement might include what the time was spent doing or why that amount of time was needed.

Note: Qualification statements for time are driven by medical necessity.

Hospital Inpatient and observation care E/M code changes

Another change in 2023 is specific to the definition of “problem addressed.” While the definition of “problem” will not change in 2023, two additional sentences were added to the definition of “problem addressed” to clarify the meaning as it applies to hospital inpatient and observation care services:

“For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or other qualified healthcare professional and may not be the cause of admission or continued stay.”

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Observation care E/M codes have been deleted, and inpatient hospital E/M codes that were historically for inpatient will now be used for hospital inpatient or observation care.

Note: This does not change how you approach observation care as it is still considered an outpatient service. Per Centers for Medicare & Medicaid Services (CMS) the place of service codes does not change. If the patient is in observation, you will still want to use the observation place of service codes.

Prolonged services E/M

Prolonged services codes were also updated in 2023. They are only to be reported when the highest level of service is reached for that code family for the total time. Keep in mind that prolonged service codes are not used if you are strictly using MDM.

Additional reminders and things to consider:

- Medical necessity must be documented in the medical record to substantiate the reason reimbursement should be allowed for the visit or encounter.
- Remember to update templates, especially those that auto-import information in the note.

Resources

For in-depth information on these changes, please see the information listed in the following links:

- AMA Office or Other Outpatient and Prolonged Services Code and Guideline Changes at ama-assn.org
- American Medical Association (AMA) E/M Code and Guideline Changes at ama-assn.org
- BC Advantage current issue (subscription required) at billing-coding.com
- *CPT Evaluation and Management* at ama-assn.org

The PI Unit is always happy to answer questions from providers that are undergoing audits or have general questions about other PI-related activities. We would also welcome any suggestions for educational topics as well. Please send any questions or suggested topics for educational pieces to ProgramIntegrity.FSSA@fssa.in.gov.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 800-457-4584.

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