IHCP 2015 Annual Workshop

CMS
1500 Presentation

Exclusively serving Indiana families since 1994.
Learning Outcome – CMS 1500

- Claims processing overview
- Eligibility information
- Completing the CMS-1500 form
- Electronic claim transaction (837)
- Completing the HIPAA 837 HIPAA claim
- 90-day rule
- Prior Authorization
- Third Party Liability (TPL)
In order to receive reimbursement from MDwise, the provider must:

- Be enrolled and be actively eligible with the Indiana Health Coverage Program (IHCP). See Chapter 4 IHCP Provider Manual
- Obtain a prior authorization if the provider is out of network.
- Complete all required elements on the CMS 1500 form
- Submit claim to appropriate MDwise delivery system claims payor.
- See Quick Contact Guide for Delivery System contact info
In the MDwise plan, claims processing is delegated to the MDwise delivery systems

- MDwise Excel claims are paid by Hoosier Alliance through 12/31/15. More information will be published in the near future about changes for 1/1/16.

- DST Health Solutions pays Hoosier Healthwise medical claims for the Eskenazi, IU Health, and Total Health Delivery systems.

- CMCS pays Hoosier Healthwise medical claims for St. Margaret Mercy, St. Catherine, and St. Vincent

- If uncertain of the members delivery system, the provider may access this information on the MDwise Provider Portal at www.MDwise.org
MDwise Delivery Systems

- MDwise Excel (formerly Hoosier Alliance) – effective July 1st 2015
- Indiana University Health
- Select Health
- St. Catherine
- Saint Margaret Mercy
- St. Vincent
- Total Health
- Eskenazi Health
When a member’s RID number is entered in Web interChange, you will see:

• The IHCP program the member is enrolled in.
• The plan (MCE)
• If the member is eligible

The MDwise provider portal will display:

• Assigned PMP and history
• Delivery System
• If they are on Right Choices
MDwise Web-Portal

myMDwise

The myMDwise provider portal allows registered providers to view member eligibility information securely online for both HHOP/Medicaid and MDwise Marketplace.

Included are the following online features:
- View member eligibility information.
- View member claims information.
- View member delivery system information.
- View member PMP information.
- View patient roster (Marketplace PMPs Only).

Create a New Account
Providers must complete the sign-up process to gain access. Users are required to create individual accounts. Visit the myMDwise provider login page and click on the link which reads "Request New Account."

You will need the following information:
- Provider NPI and TIN.
- An email address.

View our sign-up guide for additional help.
CMS 1500 Form

• **National Uniform Claim Committee (NUCC)**—organization responsible for claim content

• CMS-1500 (02/12)—current paper claim approved by the NUCC

• Legacy number—provider’s identification number issued prior to the National Provider Identification system
The upper portion of the CMS-1500 claim form (Item Numbers 1-13):

- Lists demographic information about the patient and specific information about the patient’s insurance coverage
- Information is entered based on the patient information form, insurance card, and payer verification data
The lower portion of the CMS-1500 claim form (Item Numbers 14-33):

- Contains information about the provider or supplier and the patient’s condition, including the diagnoses, procedures, and charges
- Information is entered based on the encounter form
• Service line information—information about services being reported
• Place of service (POS) code—administrative code indicating where medical services were provided
• Administrative code set—required codes for various data elements
It is necessary to identify the different types of provider:

- Rendering provider  NPI number —term used to identify an alternative physician or professional who provides the procedure on a claim
- Billing provider —person or organization sending a HIPAA claim
- Referring provider
Completing the CMS-1500 Claim: Physician/Supplier Information Section

- This part identifies the health care provider, describes the services performed, and gives the payer additional information to process the claim.
- Other ID number—additional provider identification number.
- Qualifier—two-digit code for a type of provider identification number other than the NPI.
• The HIPAA-mandated electronic transaction for claims is the HIPAA X12 837 Health Care Claim or Equivalent Encounter Information—used to send a claim to primary and secondary payers
• The electronic HIPAA claim is based on the CMS-1500, which is a paper claim form
• Data element—smallest unit of information in a HIPAA transaction
• Example: a patient’s name
• Required data element—information that must be supplied on an electronic claim
• Situational data element—information that must be on a claim in conjunction with certain other data elements
Completing the HIPAA 837 Claim

- The five sections of the HIPAA 837 claim transaction include:
  - Provider information
  - Subscriber information
  - Payer information
  - Claim information
  - Service line information
• Responsible party—other person or entity who will pay a patient’s charges
• Claim filing indicator code—administrative code that identifies the type of health plan
• Individual relationship code—administrative code specifying the patient’s relationship to the subscriber
• Destination payer—health plan receiving a HIPAA claim
• Claim control number—unique number assigned to a claim by the sender

• Claim frequency code (or claim submission reason code)—administrative code that identifies the claim as original, replacement, or void/cancel action

• Line item control number—unique number assigned to each service line item reported
Checking Claims Before Transmission

- Claims are carefully reviewed before transmission
- Clean claim—claim accepted by a health plan for adjudication
- Properly completed and contains all the necessary information
- HIPAA X12 276/277 Health Care Claim Status Inquiry/Response—electronic format used to ask payers about claims
When the member has other insurance, a MDwise provider must submit claims to the other insurance carrier before submitting to the MDwise Delivery System.

- When a third-party insurance carrier fails to respond within 90 days of the providers billing date, the claim can be submitted to the MDwise Delivery System for payment consideration.
One of the following must accompany a claim to substantiate attempts to bill the third party or the claim will be denied:

- Copies of unpaid bills or statements sent to the third party, whether an individual or an insurance company. Provider must note the date of the billing attempt and the words no response after 90 days on an attachment. This information must be clearly indicated.

- Written notification from the provider indicating the billing dates and explaining that the third party failed to respond within 90 days from the billing date. The provider is required to boldly make a note of the following on the attachment:
  - Date of the filing attempt
  - The words no response after 90 days
  - Member identification number (RID) & Provider’s National Provider Identifier (NPI)
  - Name of primary insurance carrier billed
For claims filed electronically, the following must be documented in the claim note segment of the 837P transaction:

- Date of the filing attempt
- The phrase, “no response after 90 days”
- The member’s identification (RID) number & IHCP provider number
- Name of primary insurance
• For Prior Authorization lists refer to the MDwise website: http://www.mdwise.org/for-providers/forms/prior-authorization/

• The Provider Prior Authorization guide is located here: http://www.mdwise.org/MediaLibraries/MDwise/Files/For%20Providers/Forms/Prior%20Authorization/Provider_PA_guide.pdf
Third Party Liability

- MDwise is always the payer of last resort (Medicaid)
- MDwise contracts with Health Management Systems for TPL information
- (HMS) to work with coordination of benefit information
- MDwise does have a 90 day rule, providers should work with delivery systems on a case by case basis
- See enclosed TPL tip sheet for more information
MDwise uses two vendors for electronic claims:

- McKesson/Relay Health
  - Institutional payer ID 4976
  - Professional payer ID 4481
- Emdeon/Web MD
  - Institutional payer ID 12K81
  - Professional Payer ID SX 172

Please use clearinghouses to send and receive data in correct EDI format.