October 2014
IHCP Annual Workshop
Hoosier Healthwise/HIP

MDwise UB-04
for Hoosier Healthwise and HIP:
A guide for claim adjudication
Purpose of Today’s Presentation

- Provider Enrollment: Are you a MDwise contracted provider?
- Claim submission for MDwise Hoosier Healthwise and HIP
- Top claims denials and rejected submissions
- You received a denial…now what?
- How to file a claim dispute and appeal
- Quick tips for claims adjudication (including prior authorization)

Who is MDwise?

- MDwise is a local, not-for-profit company serving Hoosier Healthwise, Care Select and Healthy Indiana Plan (HIP) members. We have been giving the best possible health care to our neighbors since 1994. In fact, we only take care of families living in Indiana. Our services are provided to over 300,000 members in partnership with over 1,400 primary medical providers.
General Claims Overview for MDwise

• In the MDwise plan, claims processing for Hoosier Healthwise is delegated to the MDwise delivery systems.
• Example: If a provider renders service for a MDwise Eskenazi member, the provider would submit their claim to MDwise Eskenazi. If the same provider rendered services to a MDwise IU member, the provider would submit claim to MDwise IU.
• All HIP claims will be processed by DST January 1, 2013 regardless of dates of service.
• If uncertain of the members delivery system, the provider may access this information on HP’s Web interChange at indianamedicaid.com and at the myMDwise provider portal at MDwise.org.

MDwise Delivery Systems

• Hoosier Alliance
• IU Health
• Select Health
• St. Catherine
• Franciscan St. Margaret & St. Anthony
• St. Vincent
• Total Health
• Eskenazi
In order to receive reimbursement from MDwise, the provider must:

- Be registered and be actively eligible with the Indiana Health Coverage Program (IHCP). See Chapter 4 IHCP Provider Manual.
- Be contracted with the appropriate MDwise delivery system. See contact quote.
- Obtain a prior authorization if the provider is out of network.
- Complete all required elements on the UB-04 form.
- Submit claim to appropriate MDwise delivery system claims payer.

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
• For Hoosier Healthwise (MDwise Eskenazi, IU Health and Total Health delivery systems), as well as all Family Planning claims, 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

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• When a member’s RID number is entered in the provider portal you will see:
  - The IHCP program the member is enrolled in
  - The plan Managed Care Entity(MCE)
  - MDwise, what delivery system they are assigned to
  - Assigned PMP

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Eligibility Screen

General Claims Processing Overview for MDwise

- Contractually, all in-network providers are required to submit claims within 90 days of date of service, out of network providers have 365 days.
- Providers are encouraged to submit claims electronically for faster claim adjudication.
- Note: MDwise behavioral health providers are required to submit claims within 90 days of date of service.
- If submitting HIP claims on paper be sure to send red copy as a black and white copy will delay processing.
MDwise is always the payer of last resort (Medicaid)
MDwise contracts with Health Management Systems (HMS) to work with coordination of benefit issues
MDwise does have a 90 day rule, providers should work with delivery system on a case by case basis
HIP members should not have other insurance (but could have Wishard Advantage or VA coverage)
See TPL tip sheet for more information

90 Day Rule—Effective 1/1/11

- 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 provider’s billing date, the claim can be submitted to the MDwise delivery system for payment consideration.
- However, 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 carrier billed
MDwise Top Ten Claims Denial (UB-04)

1. Payment denied/reduced for absence of, or exceeded pre-certification/authorization
2. Claim/Service lacks information which is needed for adjudication (accurate NPI, members RID information)
3. Duplicate claim/service
4. Payment denied due to procedure code and/or modifier are invalid on the date of service
5. Non-covered charges
6. Payment denied because the benefit for this service included in the payment/allowance to another service/procedure that has already been adjudicated
7. Past the timely filing limit
8. Member is not eligible at the time service was provided
9. Payment adjusted due to coordination of benefits by another payer
10. Billed charges do not meet the definition of emergent or urgent conditions

Electronic Rejections

- Rejected claims are returned to the provider or electronic data interchange (EDI) source without registering in the claim processing system.
- Since rejected claims are not registered in the claims processing system, the provider must resubmit the corrected claim within the claims timely filing limit.
Top Rejected Claims (Electronic)

• Rejected claims are different than denied claims, which are registered in the claims processing system but do not meet requirements for payment under the MDwise guideline. Examples of rejected claims:
  – DX code not present
  – Valid authorization number
  – Current ICD-9\* must be used. If there is a 4\textsuperscript{th} or 5\textsuperscript{th} digit extension, the more general digit code may not be used
  – Federal Tax ID
  – Provider NPI
  – RID number
  – All claims must be legible

Prior Authorization

• Effective 1/1/2011 use of the Universal Prior Authorization was required
• Form is to be used by all providers for all PA requests except dental, pharmacy and behavioral health
• Please refer to IHCP Bulletin BT201045 for more information
• For MDwise please submit to delivery system medical management
• See quick contact sheet at MDwise.org
Role of Medical Management

- MDwise delegates medical management functions to the MDwise delivery systems (MDwise.org)
- Medical management focuses on the outcome of treatment with an emphasis on:
  - Appropriate screening activities
  - Reasonableness and medical necessity of all services
  - Quality of care reflected by the choice of services provided, type of provider involved, and the setting in which the care was delivered
  - Prospective and concurrent care management
  - Evaluation of standards of care/guidelines for provision of care
  - Best practice monitors

Medical Management

Medical management service authorization activities conducted by the medical management staff include:
- Preauthorization of inpatient and selected outpatient services, management of concurrent review and retrospective review on selected inpatient and outpatient services authorization and denial notification
- Contacting member’s medical management department for services that require authorization
• Generally, follow the same rules as fee-for-service
• MDwise requires Federal Tax ID in Form Field 5
• Form Field 63a-63c “Treatment Authorization Codes” required by MDwise
• HIP is a hybrid of Medicare
• Presenting diagnosis for home health
• Overhead in Field 61 for Hoosier Healthwise and HIP
• HIP outpatient claims follow Medicare rules, all CPT codes must be present on claim

* Please consult with the appropriate MDwise delivery system medical management department for authorization requirements
• The current version of the UB-04 paper claim form will continue to be used; however, Form Locator field 66 will be a required field as of January 6, 2014 (see Figure 1). The appropriate ICD indicator must be entered on paper claim forms:
  Enter the number “9” to indicate ICD-9.
  Enter the number “0” to indicate ICD-10.

Pre-Claims Submission/Checklist
(CMS 08-05)

• It is necessary to confirm all of the items on the check list prior to rendering services and submitting a claim.
  – Is the member eligible for services today?
  – What IHCP Plan is the member enrolled in? (Hoosier Healthwise [Anthem, MDwise, MHS], Care Select, Traditional, Presumptive Eligibility)*
  – Is the member enrolled in the Healthy Indiana Plan?
  – Who is their Primary Medical Provider (PMP)?
  – Does the member have primary health insurance other than Medicaid or HIP?

*Presumptively eligible members are not eligible for any INPATIENT SERVICES.
So your claim is denied…now what?

- Claims Inquiry
  - In- and out-of-network providers need to contact the MDwise delivery system to inquire about a claims denial.
  - MDwise delivery systems are required to respond within 30 calendar days of inquiry to the provider with the decision of the inquiry.

- Appeals/Dispute—Must be in writing & include the following:
  (Providers have 60 calendar days to file an appeal and must include the following documentation):
  - Appeal form, remittance advice and a copy of the claim.
  - If a delivery system fails to make a determination or the provider disagrees with the determination, the provider should forward their appeal to:
    MDwise
    P.O. Box 441423
    Indianapolis, IN 46244-1423
    Attention: Grievance Coordinator.

- For HIP Claims inquiries contact MDwise claims department at 1-800-356-1204.

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Quick Tips to Avoid Claims Denial or Rejections

- Submit claims and corrected claims timely.
- Inquire or dispute claims within contractual timeline.
- Check with medical management or online for services that require PA.
- Follow correct coding guidelines for claims submission.
- Check member eligibility at the time of service.
- Verify payer ID information before claims are submitted electronically.
- Providers must report NPI to IHCP.
Quick Tips/Tools for Claims Submission

At MDwise.org:
- Quick contact sheets
- Program information
- Health plan overview
- Right Choices Program brochure
- Tip Sheets for TPL, Vision and DME

Thank you from the staff at MDwise and our delivery systems