October 2012
IHCP Annual Workshop
Hoosier Healthwise/HIP

MDwise UB-04
for Hoosier Healthwise and HIP:
A guide for claim adjudication

Exclusively serving Indiana families since 1994.
1. Provider Enrollment: Are you a MDwise contracted provider?
2. Claim submission for MDwise Hoosier Healthwise and HIP
3. Top claims denials and rejected submissions
4. You received a denial…now what?
5. How to file a claim dispute and appeal
6. Quick tips for claims adjudication (including prior authorization)
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 more than 280,000 members in partnership with over 1,400 primary medical providers.
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 Wishard member, the provider would submit their claim to MDwise Wishard. If the same provider rendered services to a Methodist member, the provider would submit claim to MDwise Methodist. 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](http://indianamedicaid.com) and at the myMDwise provider portal at [MDwise.org](http://MDwise.org).
MDwise Delivery Systems

- Hoosier Alliance
- Methodist
- Select Health
- St. Catherine
- Franciscan St. Margaret & St. Anthony
- St. Vincent
- Total Health
- Wishard
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 guide
- 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.
HIP Electronic Claims Information

- 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 Wishard, Methodist 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
General Claims Processing Overview
for MDwise

• 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 (MCE)
  – MDwise, what delivery system they are assigned to
  – Assigned PMP
Eligibility Screen

**myMDwise Provider Portal**

The myMDwise Provider web portal allows providers to securely view member eligibility for the MDwise Healthy Indiana Plan, Hoosier Healthwise, and Care Select. New users can request an account online. Please fill out form completely and allow 1-5 days for account to be activated. **Login Now.**

**myMDwise Member Portal**

The myMDwise Member web portal allows Hoosier Healthwise, Healthy Indiana Plan and Care Select members to view eligibility, claims, and POWER account information. NEW users can create an account online or existing users can **Login Now.**
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 behaviorial 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 enclosed TPL tip sheet for more information
• 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.
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 4th or 5th digit extension, the more general digit code may not be used
- Federal Tax ID
- Provider NPI
- RID number
- All claims must be legible
<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Relation</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alleman Evelyn J</td>
<td>07/31/1951</td>
<td>X</td>
<td>2579 Wagon Wheel Dr</td>
<td>Lebanon</td>
<td>OR</td>
<td>973359476</td>
</tr>
<tr>
<td>Alleman Martin W.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2579 Wagon Wheel Dr</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lebanon</td>
<td>OR</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>973359476</td>
<td>541</td>
<td>5553957</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>77439</td>
<td>01/27/1949</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>Sitka Modular Homes</td>
</tr>
</tbody>
</table>
Electronic Claim Example

- ST*837*987654~
- BHT*0019*00*X2FF1*20020901*1230*CH~
- REF*87*004010X096A1~
- NMI*41*2*ANDERSON MEDICAL GROUP******46*P123~
- PER*IC*ALICE WILSON*TE*3174880000~
- NMI*40*2*IHCP******46*IHCP~
- HL*1**20*1~
- NMI*85*2*ANDERSON MEDICAL GROUP******XX*1234567890~
- N3*4000 E MELROSE STREET~
- N4*INDIANAPOLIS*IN*46204~
- REF*EI*211311411~
- REF*ID*100444000A~
- HL*2*1*22*0~
- SBR*P*18**IHCP*****MC~
- NMI*IL*1*DOE*JACK*****MI*100444555999~
- N3*6000 WEST STREET~
- N4*INDIANAPOLIS*IN*46410~
Electronic Claim Example cont.

- HI*BK:51881*BJ:51881~
- HI*BH:51:D8:20021118~
- HI*BG:C1~
- QTY*CA*30*DA~
- NM1*71*2*ANDERSON*JOEL****XX*1234567890~
- PRV*AT*ZZ*363LP0200N~
- REF*0B*0123454321~
- LX*1~
- SV2*120***31500*UN*30*1050~
- LX*2~
- SV2*250**25276.85*UN*791~
- LX*3~
• 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
• 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 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
# Universal Prior Authorization Form

**Indiana Health Coverage Programs**

**Prior Authorization Request Form**

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Advantage Traditional</th>
<th>P: 888-389-5728</th>
<th>F: 888-088-2710</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hoosier Healthwise</td>
<td>Anthem Hoosier Healthwise</td>
<td>P: 866-688-7187</td>
<td>F: 866-966-2085</td>
</tr>
<tr>
<td></td>
<td>MDwise Hoosier Healthwise</td>
<td>See <a href="http://www.mdwise.org">www.mdwise.org</a></td>
<td></td>
</tr>
<tr>
<td>Healthy Indiana Plan</td>
<td>MISH Health</td>
<td>P: 866-966-4445</td>
<td>F: 866-962-4245</td>
</tr>
<tr>
<td></td>
<td>MDwise HIP</td>
<td>See <a href="http://www.mdwise.org">www.mdwise.org</a></td>
<td></td>
</tr>
<tr>
<td>Care Select</td>
<td>Advantage Care Select</td>
<td>P: 866-966-3981</td>
<td>F: 866-966-2425</td>
</tr>
<tr>
<td></td>
<td>MDwise Care Select</td>
<td>P: 866-966-3180</td>
<td>F: 877-932-7186</td>
</tr>
</tbody>
</table>

Please complete all appropriate fields.

<table>
<thead>
<tr>
<th>Medical Information</th>
<th>Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Tax ID #</td>
</tr>
<tr>
<td>Address</td>
<td>Provider Name</td>
</tr>
<tr>
<td>Clar/refer/zip</td>
<td></td>
</tr>
<tr>
<td>Patient/Guardian Name</td>
<td></td>
</tr>
<tr>
<td>PMP Name</td>
<td></td>
</tr>
<tr>
<td>PMP NPI</td>
<td></td>
</tr>
<tr>
<td>PMP Phone</td>
<td></td>
</tr>
</tbody>
</table>

**Medical Diagnosis:**

- [ ] **SNF**
- [ ] **SNF**

Please check requested assignment category below:

- [ ] SNF
- [ ] Home Health
- [ ] Oral Health
- [ ] Outpatient
- [ ] Physical Therapy
- [ ] Speech Therapy
- [ ] Transportation
- [ ] Other

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Start</th>
<th>Stop</th>
<th>Procedure/Service Codes</th>
<th>Modifying Codes</th>
<th>Requested Service</th>
<th>T narrative</th>
<th>POS</th>
<th>Units</th>
<th>Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:

**PLEASE NOTE:** Your request MUST include medical documentation to be reviewed for medical necessity.

Signature of Qualified Practitioner: ___________________________ Date: __________
• 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
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?
So Your Claim Has Been 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**
Provider Claims Dispute Form

Please print or type the following information, if applicable:

<table>
<thead>
<tr>
<th>Provider's Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone #:</td>
<td>Fax #:</td>
</tr>
<tr>
<td>Member Name:</td>
<td>Date of Service:</td>
</tr>
<tr>
<td>Member's RID#:</td>
<td></td>
</tr>
<tr>
<td>MDwise Participating Provider?</td>
<td>yes</td>
</tr>
</tbody>
</table>

Service(s) Disputed:

Describe disputed claim. Description should include, but not be limited to the following items: reason given for denial and position statement that explains why this claim should be paid.

Form Completed By: Date:

Please send completed form to:

MDwise
PO Box 441423
Indianapolis, IN 46244-1423
Attn: MDwise Grievance Coordinator
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.
Inside folders:

- 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