October 2012
IHCP Annual Workshop
Hoosier Healthwise/HIP

MDwise CMS-1500 (08-05) Provider
Enrollment and Claims Submission:
Quick tips to avoid claim denial
Purpose for today’s presentation

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 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 CMS-1500 form.
- Submit claim to appropriate MDwise delivery system claims payer.
• In the MDwise plan, claims processing is delegated to the MDwise delivery systems
• HIP claims are paid to single payer for all MDwise delivery systems
• HHW 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
• If uncertain of the members delivery system, the provider may access this information on the myMDwise provider portal at MDwise.org
• Effective January 1, 2013 all HIP claims regardless of delivery system and all Hoosier Healthwise claims for MDwise Methodist, Wishard and Total Health and all Family Planning claims, regardless of dates of service, should be sent to:

  MDwise Claims – DST
  P.O. Box 830120
  Birmingham, AL 35283-0120
MDwise Delivery Systems

- Hoosier Alliance
- Methodist
- Select Health
- St. Catherine
- Franciscan St. Margaret & St. Anthony
- St. Vincent
- Total Health
- Wishard
When a member’s RID number is entered, along with the NPI, you will see:

- The IHCP program the member is enrolled in
- The plan (MCE)

The MDwise provider portal will show the following:

- Assigned PMP and history
- Delivery system
Eligibility screen

myMDwise Login Pages

myMDwise Provider Portal
Welcome to the myMDwise Provider Portal. This web portal will allow providers to check member eligibility, view account balances, and view payment summaries. Providers can log in using credentials sent via email. If you need assistance logging in, please contact the Provider Services Department.

myMDwise Member Portal
Welcome to the myMDwise Member portal. This web portal is intended to provide eligibility, claims, and other personal account information for MDwise members.

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 your 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.
• Contractually, all in-network providers are required to submit claims within 90 days of date of service, unless the claims involve third party liability

• Providers are encouraged to submit claims electronically for faster claim adjudication

• Note: MDwise behavioral health providers are required to submit claims to the proper delivery system within 90 days of date of service
MDwise is always the payer of last resort (Medicaid)
MDwise contracts with Health Management Systems (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
HIP members should not have other insurance (but could have Wishard Advantage or VA coverage)
See enclosed TPL tip sheet for more information
90-day Rule

• 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
General claims overview

• Out-of-network providers: Send paper or electronic claims to the appropriate MDwise delivery system.

• Submit claims within 365 days of date of service.

• HIP providers—All claims go to one address. Paper claims should be submitted on RED claim form.
Top claims denials

- Duplicate claim
- Claim/Service lacks information which is needed for adjudication
- Coverage not in effect at the time the service was provided
- Payment denied/reduced for absence of, or exceeded, precertification/authorization
- Non-covered charges
- The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service
- Past the timely filing limit
- Payment adjusted due to member having primary insurance payer/coordination of benefits
- Charges exceed fee schedule or maximum allowable amount
- Diagnosis code is non-covered or invalid
EDI format–837 Professional

- ST*837*987654~
- BHT*0019*00*X2FFI*20020901*1230*CH~
- REF*87*004010X098A1~
- NM1*41*2*ANDERSON MEDICAL GROUP*****46*P123~
- PER*IC*ALICE WILSON*TE*3174880000~
- NM1*40*2*IHCP*****46*IHCP~
- HL*1**20*1~
- NM1*85*2*ANDERSON MEDICAL GROUP*****XX*1234567890~
- N3*4000 E MELROSE STREET~
- N4*INDIANAPOLIS*IN*46204~
- REF*24*311400511~
EDI format—837 Professional cont.

- CLM*755555M*126***|L::|*Y*A*Y*Y*C*AA:::IN~
- DTP*484*D8*20021019~
- DTP*435*D8*20021030~
- DTP*439*D8*20021030~
- DTP*096*D8*20021101~
- PWK*AS*BM***AC*86576~
- AMT*F5*35~
- REF*9F*12~
- REF*EA*D234345~
- HI*BK:*V723*BF:4660~
- NM1*DN*I*WILSON*JOEL****34*212222122~
- PRV*RF*ZZ*363LP0200X~
- REF*1D*100555999D~
- LX*1~
- SV1*HC:99396*110*UN*I***I:2*1~
- DTP*472*RD8*20021030-20021030~
- REF*6R*24210~
- NM1*82*2*ANDERSON*MARTIN****XX*1123321221~
- PRV*PE*ZZ*207RI0001X~
- LX*2~
- SV1*HC:99000*16*UN*I***I:2*1~
• Rejected claims are different than denied claims, which are registered in the claims processing system but do not meet requirements for payment under MDwise guideline. Example of rejected claims:

  – DX code not present
  – Valid authorization number
  – Current ICD-9*
  – If there is a 4\textsuperscript{th} or 5\textsuperscript{th} digit, the more general digit code may not be used
  – Date of illness or last menstrual period
  – Federal Tax ID
  – Provider NPI
  – RID number
  – All claims must be legible
Pre-Claims Submission/Checklist
(CMS 08-05)

• It is necessary to confirm all of the items on the checklist 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. PE member ID numbers begin with 550.
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 Hoosier Healthwise (MDwise Wishard, Methodist, Total Health delivery systems) and all HIP claims inquiries**, contact the MDwise claims department at 1-800-356-1204.
Provider Claims Dispute Form

Please print or type the following information, if applicable:

Provider's Name: ____________________________ Date: ____________________________
Telephone #: ____________________________ Fax #: ____________________________
Member Name: ____________________________ Date of Service: ____________________________
Member's RID #: ____________________________

MDwise Participating Provider? [ ] yes  [ ] no

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.

Please attach a copy of the Explanation of Benefits and/or denial letter and any documentation that you believe may be relevant to support this request.

Form Completed By: ____________________________ Date: ____________________________

Please send completed form to:

MDwise
PO Box 441423
Indianapolis, IN 46244-1423
Attn: MDwise Grievance Coordinator
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 red line claim within the claims timely filing limit.
HIP and Pregnant Women

- Pregnant women are not eligible for HIP services
  - Pregnancy related services are non-covered (with exception of the first pregnancy claim)
  - Physicians are encouraged to assist members to submit a statement of pregnancy to the Division of Family Resources (DFR)
  - The member’s HIP plan can also assist in the members reassignment

- HIP members who become pregnant are encouraged to contact the DFR to request re-assignment to Hoosier Healthwise (members are not automatically termed from HIP)
  - There will be no break in coverage

- Pregnant women may re-enroll in HIP following the pregnancy
Notification of Pregnancy

- NOP data used to support provider plan of care with services and resources available through MCEs according to case management risk stratification guidelines developed by the State
  - Care and case management programs from MCE.
  - Supplemental member education materials, services and phone calls.
- Assist provider in linking member to community resources.
- Additional revenue source—$60 per NOP/member/pregnancy
- High risk: A woman must have at least two medical risk factors in her current pregnancy or an obstetrical history that places her at risk for pre-term birth or poor pregnancy outcome.
  - May receive additional antepartum care visits for high risk pregnancies beyond the maximum 14 visits allowed for normal pregnancy.
  - Reimbursement of additional $10 per prenatal visit.

**Note:** Per Banner BR201134, NOP is the only acceptable method of documentation for high risk pregnancy. In order for providers to receive additional visits and reimbursement they must submit an NOP.
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 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
Out-of-Network Authorizations

MDwise members who require covered services not available within the network must have prior authorization from the delivery system’s medical management department (before services are rendered).
Prior Authorization for DME

– Contact the member’s delivery system medical management department for approved providers and DME (durable medical equipment) prior authorization requirements
– Universal prior authorization form available online at MDwise.org/providers
Behavioral Health Prior Authorization

• Standardized forms for behavioral health:
  – BH/Primary Medical Provider Coordination Form
  – Behavioral health does **NOT** utilize Universal PA Form—Please use OTR form
  – Therapy/Outpatient Treatment Form (OTR) Form (NEW)
  – Psychological Testing Form
  – Neuropsychological Testing Form

• These forms can be found on our website: MDwise.org/providers/forms/behavioralhealth
Helpful Hints to Get Started for All PA

• Always verify eligibility on PA submission date
• Submit PA to the member’s health plan and for MDwise the appropriate delivery system medical management
• Suspended PA requests must be completed within 30 days by the provider
• Fax the PA form along with supporting documents together
• Mail – Submit PA request form along with supporting documents
### Indiana Health Coverage Programs

**Prior Authorization Request Form**

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Advantage Traditional</th>
<th>P: 800-209-0720</th>
<th>F: 800-089-2700</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hoosier Healthways</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid Healthplan</td>
<td></td>
<td></td>
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<tr>
<td>Healthy Indiana Plan</td>
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<tr>
<td>Care Select</td>
<td></td>
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</tr>
</tbody>
</table>

**Provider Information**

- **Name:**
- **Tax ID:**
- **Provider Number:**
- **Provider Name:**
- **Address:**
- **City/State/Zip:**
- **Patient/Guardian Phone:**
- **PMP Name:**
- **PMP NPI:**
- **PMP Phone:**
- **Patient Diagnosis:**

**Please check requested assignment category below:**

- **DMU**
- **DME**
- **IPN**
- **IPN Referral**
- **Observation**
- **Physical Therapy**
- **Speech Therapy**
- **Transportation**
- **Home Health**
- **Occupational Therapy**
- **Other**

**Dates of Service**

<table>
<thead>
<tr>
<th>Start Date</th>
<th>Stop Date</th>
<th>Service Code</th>
<th>Mod/Date</th>
<th>Requested Service</th>
<th>Tissuegr</th>
<th>POS</th>
<th>Units</th>
<th>Dollars</th>
</tr>
</thead>
</table>

**Notes:**

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**Please Note:** Your request MUST include medical documentation to be reviewed for medical necessity.

**Signature of Qualified Practitioner:** ___________________________  **Date:** ___________________________
Submit claims and corrected claims timely.
Inquire or dispute claims within contractual timeline.
Check with medical management or online for services that require PA. HHW and HIP requirements differ.
Follow correct coding guidelines for claims submission.
Check member eligibility at the time of service through MDwise provider portal.
Verify payer ID information before claims are submitted electronically (see next slide).
Providers must report NPI to IHCP.
Corrected claims are not claims disputes.
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
Hoosier Healthwise Electronic Claims Information

- 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
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  - McKesson/Relay Health
    - Institutional Payer ID–4976
    - Professional Payer ID–4481
Quick Tips/Tools for Claims Submission

Inside folders:

• Quick contact sheets
• Program information
• Health plan overview
• Program information
• Right Choices Program brochure
• Tip Sheets for TPL, Vision and DME
Thank you from the staff at MDwise and our delivery systems