ISMA Coalition Meeting

Sept. 23, 2011

Questions and Answers

1. Will MDwise please update ISMA on the status of the Claims Eligibility issues that began 01/01/2011?

   MDwise Response: As of September 2011, MDwise believes that most of the eligibility discrepancies between Web interchange and the MDwise portal have been resolved and that these two web products are mostly showing the same MDwise delivery system and primary medical provider (PMP). We believe this trend toward better eligibility information will continue. However it is still possible for a provider to encounter an isolated discrepancy for member assigned delivery system and PMP between the two products. Providers who encounter these discrepancies can contact Customer Service at 1-800-356-1204.

2. Will MDwise advise the status of the outstanding claims back log that resulted from the eligibility issues?

   MDwise Response: MDwise released a provider bulletin in July 2011 which provides updated information regarding denied claims for eligibility reasons. This bulletin will be provided and reviewed during the coalition meeting. All MDwise payers are current with eligibility loads year to date and can accurately accept both paper and electronic claims for all eligible members. Please be aware, however, that there are always some retroactive changes which can cause a particular member to not be loaded in the system on a particular date. In these cases, please contact our customer service line and ask to be transferred to the appropriate claims department for assistance.

   As an fyi for the Healthy Indiana Plan (HIP), HIP providers will submit claims to one claims payer address. Effective 8/1/11, please submit all claims regardless of date of service to:

   MDwise HIP Claims
   PO Box 78310
   Indianapolis, In 46278

3. Is it possible for OMPP to add facility location information to the PA (prior authorization) form?
   HP Response: There is a place on the PA request form for the NPI and service location of the Requesting Provider and rendering provider's information as well, which is typically the address where the services will be performed. Can the person who submitted this question please give clarification as to what information they would like to see on the form?

4. Can the PA form be updated so it is self populating?

   HP Response: The PA request form is a word document on the IHCP website so it does not read any provider information when opened. You can type in the fields and print several copies so that you won't have to enter the provider information each time you use the PA request form. The PA request form on web interchange does populate the provider NPI, and if a user has access to more than one location, there is a dropdown menu to choose the location, however at this time it does not populate

any other information. HP would have to do some research as to the ability to populate data into the PA request on web interchange, create and submit the request to OMPP for review and approval, if the functionality is available.

5. What is the timeline for the update of the form
   HP Response: That would be determined with the approval from OMPP.

6. Will all the MCEs define the rules regarding the length of time they have for when a patient calls for an appointment, and the time the physician must see them?

   MDwise Response: MDwise follows NCQA guidelines for credentialing of our physicians that participate in its provider networks for Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP), and Indiana Care Select (ICS). These NCQA guidelines mandate that MDwise require participating physicians to comply with accessibility of services standards. These NCQA guidelines are required by our contracts with the Office of Medicaid Policy and Planning (OMPP). The appointment standards are listed below:

   - Urgent or emergent care triage 24 hours per day.
   - Emergent care 24 hours per day.
   - Urgent care 24 hours per day.
   - Non-urgent symptomatic within 72 hours.
   - Physical examination within 3 months.
   - Initial appointment (non – pregnant adult) within 3 months.
   - Routine gynecological examination within 3 months.
   - New obstetric examination within 1 month.
   - Initial well child examination within 1 month.
   - Children with Special Health Care Needs examination within 1 month.

   MHS Response:

Appointment Type	Access Guidelines
Urgent or Emergent	24 hours
Non-urgent	72 hours
Routine physical exam	Three months
Initial appointment (non-pregnant adult)	Three months
Routine gynecological exam	Three months
New obstetric patient	Within one month of date of attempt to schedule appointment
Initial appointment well child	Within one month of date of attempt to schedule appointment
Children with special health care needs	One month
Average office wait time	Equal to or less than one hour
Specialist referral Emergency: Urgent:	 24 hours 48 hours

Anthem Response: Per the Anthem Provider Operations Manual Chapter 13 page 1:

General Appointment Scheduling

- Emergency examinations: triaged and treated immediately on presentation at the PMP site
- Urgent examinations (members with persistent symptoms): treated no later than the end of the following work day after initial contact with the PMP site
- Non-urgent "sick visits": within 72 hours
- Non-urgent routine examinations: within six weeks
- Preventive health services within two weeks
- Initial Health Assessment 90 calendar days from enrollment date (strongly recommended but not required)

Specialists Appointment Scheduling

- Emergency examinations: triaged and treated immediately on presentation at the specialist site
- Urgent examinations (members with persistent symptoms): treated no later than the end of the following work day after initial contact with the specialist site
- Initial specialty care visit: within three weeks
- Non-urgent routine examinations: within eight weeks

Prenatal and Postpartum Visits

- 1st Trimester: within 14 calendar days of request
- 2nd Trimester: within 7 calendar days of request
- 3rd Trimester: within 3 business days of request
- High Risk Pregnancy: Within 3 business days of identification or Immediately if an emergency exists
- Post Partum Exam: 3 to 8 weeks after delivery
- A postpartum visit should be included as a routine part of care

7. Will HP, HMS and OMPP create a contact plan so physicians have someone who can assist them with retroactive Medicare coverage for claims paid long ago by Medicaid issues, when regular avenues are not working? (when calling the number indicated on the HMS letter, contacting the TPL department of HP, or contacting the HP field rep)

   HMS Response: The Affordable Care Act became effective on January 1, 2011. Prior to the passage of this Act, Medicare claims could be submitted up to three calendar years following the year in which such services were rendered. The new law, Section 6404 specifically, reduces the time period to one calendar year after the date of service for all claims with service dates on or after January 1, 2010.

   Accordingly, the Coordination of Benefits (COB) process supporting the Indiana Medicaid program has been modified. Effective January 1, 2011, the Medicare A/B disallowance cycles are executed every other month (previously they were executed quarterly). Additionally, we are only including provider claims with dates of service equal to or less than one year from the disallowance cycle date.

Consideration will be given to provider claims which cannot be submitted to Medicare due to the reduction in the filing limit. Providers should directly contact HMS with specific adjustments needing to be reviewed.

NOTE: Failure of the provider to timely file a Medicare claim during the allowed 60 day disallowance review period will not receive the above considerations. It is imperative for providers to respond immediately to the HMS disallowance letters in order to avoid the Medicare timely filing denial and the reimbursement from Medicare.

According to HMS, the best and most appropriate point of contact is the contact information on the disallowance letter received by providers.

8. Will OMPP offer guidance as to what a Medicaid Waiver should look like? And specific guidance as to how and when it should be used.

HP Response: The information as to the acceptable conditions to bill a member can be found in chapter 4 of the IHCP provider manual on page 4-45,46 and also the conditions when it is appropriate to use a waiver. These guidelines apply to all members regardless of their eligibility category or program. Prior to billing the patient, the provider must notify the patient or his or her healthcare representative in writing that the patient will be responsible for the cost of services provided after the date of the notice. A provider should consult with its attorney or other advisor with any questions concerning its responsibilities in this process. If a waiver is used to document that a member has been informed that a service is non-covered, the waiver must not include conditional language such as "if the service is not covered by the IHCP, or not authorized by the member's primary medical provider (PMP), then the member is responsible for payment." This language appears to circumvent the need for the provider to verify eligibility or seek PMP authorization or PA as needed.

9. In box 24 H of the 1500 form the IHCP manual states "If the patient is pregnant, indicate with a P in this field on each applicable line. Required, if applicable." Some of the MCE's require a Y in this box. Is there a way to make this a uniform standard for all plans? If not why? What value does each of the MCE's require in this box? Are hospital based physicians such as ER physicians now required to indicate this pregnancy indicator and is the LMP also required.

MDwise Response: MDwise follows the claim guidelines outlined in the IHCP Provider Manual Chapter 8, Section 4, 8-157. At this time, OMPP has not authorized MDwise to adopt Medicare claim guidelines for the completion of the CMS-1500 claim form. Box 24H requires the following information:

- **EPSDT Family Plan** – If the patient is pregnant, indicate with a **P** in this field on each applicable line. **Required, if applicable**.

Providers who experience claim denials regarding information in Box 24H should contact their delivery system provider relations representative to discuss this denial. Please have examples available for discussion with the representative.
HP Response: The pregnancy indicator "**P**" is required in field locator 24H of the CMS-1500 form if applicable as is the LMP for Traditional Medicaid Members. This would be a policy consideration for OMPP to change the requirement of this information.

MHS Response: The billing requirement of Y in box 24H is a National Uniform Claim Committee billing practice. This is stated in www.nucc.org. The LMP is required in box 14 and would be required for all providers billing on the 1500.

Anthem Response: Anthem requires the P indicator and it is required for all physicians.

10. Will Anthem, MDwise and MHS please update Coalition attendees on their process for 90 day TPL non-payment of claims?

MDwise Response: At the request of the Office of Medicaid Policy and Planning (OMPP), MDwise has worked with our delivery systems to develop a 90 Day Insurance Rule to account for instances when a third party commercial insurance hasn't responded to a provider claim within 90 days of the bill date. These guidelines apply for all Hoosier Healthwise members and Healthy Indiana Plan (HIP) members where TPL was not disclosed by the member at the time of eligibility determination, but discovered later by the OMPP. The information below is a summary of MDwise's 90 Day Insurance Rule. This information will be added to our provider manual at www.mdwise.org.

When the member has other insurance, an 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

This information is included in our Spring 2011 newsletter. Providers who have questions regarding this policy should contact their MDwise delivery system representative using the MDwise Quick Contact Guide located at www.mdwise.org or MDwise Customer Service at 1-800-356-1204.
MHS Response: MHS follows the state's 90 day TPL primary insurance non-payment guidance.
Anthem Response: Anthem does follow the 90 day TPL non-payment of claims. Please follow the guidelines in the IHCP manual for payment.

11. In box 33 is there a way to make the information provided in this box uniform for all MCE's and Traditional Medicaid? Currently this information varies with the plan, and is problematic for providers. It would be cost saver in the form of fewer denials and less follow up if all the MCE's and Traditional Medicaid would agree to accept the same information.

    HP Response: The claims guidelines are outlined in the Indiana Health Coverage Programs (IHCP) Provider Manual, Chapter 8, Section 4, pg. 8-158. Box 33 requires several pieces of information that include the following:

    - **33 -** BILLING PROVIDER INFO & PH # – Enter the billing provider office location name, address, and the ZIP Code+4.
    - **33A** - BILLING PROVIDER NPI – Enter the billing provider NPI. If the U.S. Postal Service provides an expanded ZIP Code (ZIP Code + 4) for a geographic area, this expanded ZIP Code must be entered on the claim form.
    - **33B** - BILLING PROVIDER QUALIFIER AND ID NUMBER **–** Healthcare providers may enter a billing provider qualifier of ZZ and taxonomy code. Taxonomy may be needed to establish a one-to-one NPI/LPI match if the provider has multiple locations. If the billing provider is an atypical provider, enter the qualifier 1D and the LPI.

    MDwise Response: MDwise follows the claims guidelines outlined in the Indiana Health Coverage Programs (IHCP) Provider Manual, Chapter 8, Section 4, pg. 8-158. Box 33 requires several pieces of information that include the following:

    - ***33 - BILLING PROVIDER INFO & PH #*** *– Enter the billing provider office location name, address, and the ZIP Code+4.* ***Required***.
    - *33A -* ***BILLING PROVIDER NPI*** *– Enter the billing provider NPI.* ***Required***. *If the U.S. Postal Service provides an expanded ZIP Code (ZIP Code + 4) for a geographic area, this expanded ZIP Code must be entered on the claim form.*
    - *33B -* ***BILLING PROVIDER QUALIFIER AND ID NUMBER –*** *Healthcare providers may enter a billing provider qualifier of ZZ and taxonomy code. Taxonomy may be needed to establish a one-to-one NPI/LPI match if the provider has multiple locations. If the billing provider is an atypical provider, enter the qualifier 1D and the LPI.* ***Required***.

    Providers who experience claim denials regarding information in Box 33 should contact their delivery system provider relations representative to discuss this denial. Please have examples available for discussion with the representative.

    MHS Response: MHS requires the billing provider's service location and nine digit zip code. This is the same requirement as the State. This information is reported to the State and MHS will verify this information with the State file.
    Anthem Response: Anthem requires the billing information in box 33.

12. In box 31 some of the Medicaid payers will accept the facility name since we are a laboratory; however there are other Medicaid payer's that will deny the claims for a lack of the physicians name, title, and degree. The lack of standardization within the different Medicaid plans is problematic for

providers, and usually requires additional programming to accommodate each individual payer's requirements. If the requirements were standard across all the Medicaid payers, both the provider and Medicaid payers would save money. The savings would be accomplished by fewer denials, less manual processing of claims/appeals and less follow up with the MCE's. It would be even more beneficial to all parties if all the Medicaid payers would follow Medicare rules, and accept Medicare cross-over claims.

MDwise Response: MDwise follows the claim guidelines outlined in the IHCP Provider Manual Chapter 8, Section 4, 8-158. At this time, OMPP has not authorized MDwise to adopt Medicare claim guidelines for the completion of the CMS-1500 claim form. Box 31 requires the following information:

- ***SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS*** – *An authorized person, someone designated by the agency or organization, must sign and date the claim. A signature stamp is acceptable; however, a typed name is not.* ***Required***.
- ***DATE*** – *Enter the date the claim was filed.* ***Required***.

Providers who experience claim denials regarding information in Box 31 should contact their delivery system provider relations representative to discuss this denial. Please have examples available for discussion with the representative.

HP Response: For traditional and Careselect claims, the guidelines outlined above are also required, however if a provider has a signature on file, then it is not required that an authorized individual sign the claim. Providers can record their signature by completing the IHCP Claim Certification Statement of Signature on File within the IHCP Provider Application and Maintenance Form.