ISMA Coalition Meeting
March 22, 2013

Questions and Answers

1. For the Office of Medicaid Policy and Planning (OMPP): The final rule (42 CFR 447.700) under the Affordable Care Act (ACA) provision, provides for increased payment at the Medicare rate for codes 99201-99499 and 90460, 90461 and 90471-90474. The Indiana Health Care Program (IHCP) stated in BT 201247 that 90460 and 90461 will remain noncovered. As a pediatric practice, we utilize codes 90460 and 90461, which include billing the parent for counseling about the risks/benefits of the vaccine The new billing instructions require that we submit claims with codes 90471-90474, even though we're providing a higher level of service.

   The potential for increased reimbursement is greatly diminished when 90460 and 90461 are noncovered. Can this be changed? If not, why?

   HP response: The OMPP makes all decisions on what codes are covered and approves the provider rates for each covered code. If a provider wants a specific code considered for coverage they must contact OMPP via email for consideration of coverage. The email address is Policyconsideration@fssa.in.gov.

2. For MDwise: The IHCP Bulletin 201247 dated Nov. 27, 2012, includes 2013 and 2014 billing instructions for vaccines and administration codes, as well as changes to billing for services provided by a nurse practitioner. It is my understanding that MDwise, with whom we have a panel of more than 500 patients, will not have the capability to process these changes until their system is updated. We have concerns about the probability of claims denials, which will require additional administrative work and create cash flow and accounts receivable issues.

   MDwise response: The following is written to clarify information provided in Bulletin BT201247 and subsequently published bulletins discussing increased physician payments under the auspices of the Affordable Care Act (ACA). Simply stated, the billing instructions for mid-level practitioner services outlined in chapter 8, page 293 of the Indiana Health Coverage Program (IHCP) provider manual still apply and should be followed with one basic exception.

   "Individually enrolled nurse practitioners, under the direct supervision of a physician in a physician-directed group, must bill using the SA modifier and the rendering (supervising) physician's NPI in field 24J of the Centers for Medicare & Medicaid Services (CMS) 1500" in order to qualify for the ACA physician rate increase. Only physicians who have completed the self-attestation process as described in BT201247 are eligible for the increase rate of reimbursement.

   The Centers for Medicare & Medicaid Services (CMS) has stated "that the rule assumes a relationship in which the physician has professional oversight or responsibility for the services provided by the practitioners under his or her supervision" and thus, "precludes

the types of arrangements in which independent nurse managed clinics or other practitioners enter into arms-length arrangements with physicians for purposes of establishing a relationship that leads to higher payment for the practitioner services. The rule makes clear that, while deferring to state requirements regarding supervision, the expectation is that the physician assumes professional responsibility for the services provided under his or her supervision. This normally means that the physician is legally liable for the quality of the services provided by individuals he is supervising. If this is not the case, the practitioner would be viewed as practicing independently and would not be eligible for higher payment."

Read more at www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/CMCS-Ask-Questions.html.

Please watch for further clarification by the OMPP in the near future. MDwise follows IHCP guidelines in regard to mid-level practitioner billing. If you have specific claims-related questions, please contact your contracted MDwise delivery system provider representative.

3. For OMPP and Medicaid Coverage Expansion (MCE): The new billing instructions require the use of modifier SL on all vaccine administration codes to signify that a state-supplied vaccine was given. As a participant in Vaccine for Children (VFC) program for many years, we have never been required to use a modifier to differentiate. Doesn't billing the vaccine CPT with a zero charge, as instructed, demonstrate that VFC was used? A privately purchased vaccine would certainly not be billed with a zero charge.

   Anthem response: Anthem's system will be set up to accept vaccine claims in the manner described in the bulletin to keep the billing practices streamlined.

   MDwise response: MDwise follows IHCP guidelines for billing vaccines and administration codes. Please see chapter 8, page 293 of the IHCP Provider Manual for more information.

   From BT201247 and enhanced reimbursement for primary care services: For dates of service from Jan. 1, 2013, through Dec. 31, 2014, providers using VFC-provided vaccines should bill the IHCP for the VFC vaccine administration fee by using V20.2 as the primary diagnosis, the procedure code of the specific vaccine administered with a billed amount of $0.00, and the appropriate vaccine administration code with the SL modifier (see the following list of procedure codes).

   The allowed amount per claim for the administration of a VFC vaccine will remain at $8. Any increase in reimbursement will be paid in a supplemental payment. Providers are reminded that reimbursement for a VFC vaccine is not appropriate because providers receive VFC vaccines at no charge. However, to ensure that the vaccine is appropriately included in the Children and Hoosier Immunization Registry Program (CHIRP), the provider must bill the appropriate Current Procedural Terminology (CPT®1) code for the vaccine and a billed amount of $0.00.
   Procedural Codes:

- 90471 SL – Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections); one vaccine (single or combination vaccine/toxoid); VFC vaccine administration
- 90472 SL – Each additional vaccine (single or combination vaccine/toxoid); VFC vaccine administration
- 90473 SL – Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid); VFC vaccine administration
- 90474 SL – Each additional vaccine (single or combination vaccine/toxoid); VFC vaccine administration

When a VFC vaccine is administered by a nurse practitioner employed by a physician in a physician-directed group or clinic, the previous codes should be billed followed by the SA modifier (for example, 90471 SL SA) to identify that the service is performed by a nurse practitioner.

HP response: The SL/SA modifier is used to identify providers participating in the increased reimbursement for 2013 to 2014. VFC providers are required to follow the billing guidelines to receive the rate increase. Claims that are not part of the VFC can be submitted for both the vaccine and its administration. See BT201247 for additional information.

MHS response: MHS will require billing consistent with IHCP guidelines.

OMPP response: "The Principals of CPT Coding," a publication of the American Medical Association, instructs the provider to utilize the SL modifier when reporting VFC services.

4. For OMPP: For services provided by a nurse practitioner (NP), claims can no longer include the rendering NP's own NPI. Instead, modifier SA must be used to identify all services rendered by a NP. The bulletin included no specific instructions concerning billing codes 99201-99499 when provided by a physician. If these codes do not require special instructions or identification, why is it necessary to create the additional administrative burden for NP services and vaccines and administration codes?

   HP response: The billing process change is related to reimbursement for increased payment. If the provider is non-participating, the billing practice would not change. When a VFC vaccine is administered by a nurse practitioner employed by physicians in a physician-directed group or clinic, the codes should be billed followed by the SA modifier to identify that the service is performed by a nurse practitioner.

5. For OMPP: It is unclear how quarterly payments for increased reimbursement will be distributed and identified. Ideally, supplemental payments will include an itemized explanation, including the provider name, patient name, service date, CPT and payment amount by line item. Can you please explain?

   HP response: Payment distribution and reporting methodologies are currently under review.

6. For OMPP: The Package B members who have a miscarriage: Medicaid is not getting updated by the patient, so they stay on for 10 months or so. The services are not related to the pregnancy, so no one gets paid unless they get the patient to sign a waiver. I realize we are responsible for that, but sometimes we can't even keep up with the training for it with new employees, or it just gets missed. I am sure other providers are having the same problem, unless they are billing the patients without a waiver. Could physicians have an online form that they submit with the diagnosis showing the pregnancy ended? We brought it up several years ago but it never went any further. With all the upgrades, there must be some way they can get that diagnosis information to the enrollment and benefit department. The providers have to write it off constantly because of the Medicaid benefit rules, and we don't know what will happen when the denials for family planning benefits start coming in. It would be helpful to have assistance on this issue.

   OMPP response: Chapter 2, section 3, page 16 of the Indiana Health Coverage Programs Provider Manual states: "It is the responsibility of the physician or practitioner to determine if the service is related to the pregnancy or if the condition will endanger the mother or fetus if the service is not provided. Postpartum care can continue for two months."

7. For OMPP: I'd like to know about Indiana Medicaid's coverage of the TAVR procedure (Transcatheter Aortic Valve Replacements).

   a. In 2012 the CPT codes were 0256T, 0257T, 0258T and 0259T

   b. In 2013 the CPT codes are 33361, 33362, 33363, 33364, 33365, 0318T, 33367, 33368 and 33369

   These codes do not show on the Medicaid fee schedule. I'm wondering if this is because it is completely noncovered, or because it is a newer technology and reviewed individually.

   HP response: OMPP makes all decisions on what codes are covered and approves the rates for each covered code. If a provider wants a specific code considered for coverage, they must contact OMPP via email for consideration of coverage. The email address is Policyconsideration@fssa.in.gov.

8. For OMPP: I am still waiting on a list of items considered to prevent implantation for the Family Planning program. Do they have a list? Can you please supply this list?

   OMPP response: The IC (12-15-46 chapter 46. Medicaid Waivers and State Plan Amendments) and bulletin both state that family planning services do not include the performance of abortions or the use of a drug or device intended to terminate fertilization. We do not state anywhere that items considered to prevent implantation are not covered.

We have a list of covered contraceptives and services, as provided in BT201301, but we do not have a list of non-covered items that prevent implantation. I reviewed the IC (12-15-46, chapter 46. Medicaid Waivers and State Plan Amendments) and bulletin, which both state that family planning services do not include the performance of abortions or the use of a drug or device intended to terminate fertilization. We do not state anywhere that items considered to prevent implantation are not covered. We have a list of covered contraceptives and services, as provided in BT201301, but we do not have a list of non-covered items that prevent implantation.

9. For HP: The presumptive eligibility (PE) manual is out of date!! It states that we can perform PE on Saturday, so we recently did one for a patient who could not come during the week. When we made the final phone call, we could only leave a message. We received a call back the next day and were told that there had been no Saturday hours for quite some time. I reported this to my HP rep but didn't hear back. Please advise when this issue will be resolved.

HP response: The PE manual is currently being updated to reflect current changes.

10. For HP: There is a glitch in the notification of pregnancy (NOP) submissions that we just encountered. When we click *submit* we get a pop-up that the information is incomplete and must be corrected prior to submission. We double checked, then click *submit* again, and were told that the NOP had already been submitted -- but now we can't print out a copy for our records. Please advise when this issue will be corrected.

HP response: Please verify that the pop-up blocker is not on during submission. If it continues, make a screen shot and contact your area representative for assistance with the submission problem, or contact the HP EDI department at 1-877-877-5182, or (317) 488-5160.

11. For OMPP: Eligibility issue - Can you please give us an update on eligibility issues that we continue to have? Will this ever be resolved?

HP response: HP is not aware of any current eligibility issues relating to Web interChange. If the problem the provider is having relates to one of the MCEs, the provider would have to work with the MCE for resolution.

12. For HP: Sterilization forms (See above) - Can you tell us when this form will be updated? The expiration date was Dec. 31, 2012.

HP response: The form is currently under review by OMPP and waiting for approval.

13. For HP: Our claims continue to deny for Medicare Primary EOB after we have submitted this information to them numerous times. How can we resolve this issue?

HP response: Additional information/claims review is required to provide method of correction for denial. Your field representative would have to verify if crossover claim detail information is entered correctly or on a paper claim if field 22 is correct. These are just a few examples of why a claim would deny. Please contact your area representative to provide claim-specific information for review.

14. For HP: Our claims continue to deny regarding Medicare, stating the primary has paid more than the Medicaid-allowable rate. However, Medicare has paid nothing at all. How can we resolve this issue?

HP response: Additional information/claims review is required to provide method of correction for denial. Please contact your area representative to provide examples.

15. Anthem Medicaid - Anthem Medicaid continues to deny Anthem St. Francis family planning claims. This has been an ongoing issue since 2011. We have brought this issue to OMPP and to provider relations several times. We continue to appeal our claims or submit the issue to Indiana Anthem Medicaid Solutions (IAMS). Can you tell us if this will ever be resolved? Is this a system issue or is this a manual process issue? We would like to have a firm date that this issue will be resolved.

Anthem response: If the claim is billed correctly, there should not be any problem with payment. If a member's eligibility is in question, then the claim may be denied. A call to our Provider Services department should provide guidance to get the claim paid.

16. For Anthem and OMPP: Due to the eligibility issues, we are now having problems with Anthem St. Francis regarding our 2011 claims and some 2012 claims. It appears that Anthem St. Francis has updated its patent's eligibility information; they are now recouping their money. The reason for the recoupment states, "The payment was made in error and the patient is part of Anthem Medicaid Network". Can these issues be fixed behind the scenes so the physician doesn't have to deal with them?

Anthem response: Both organizations need to have an accurate way to account for payment, and at the present time, there is no other process. St. Francis Health Network (SFHN) and Anthem have worked together to compile a list of scenarios that spell out when a member belongs to Anthem and when they belong to SFHN. This information has been distributed to Claim, Membership and Customer Service departments for both companies and should help as we move forward this year.

17. For Anthem and OMPP: We are now submitting our claims to Anthem Medicaid, along with all documentation on why our claims are being filed late. Anthem Medicaid continues to deny our claims/appeals for past-filing limit even after documentation has been sent.

HP response: Claims submitted outside billing requirements will deny for timely filing. Providers are encouraged to appeal the denial decision with appropriate documentation. Claims will continue to deny if there is no valid justification to waive timely submission.

Anthem response: Disputes and appeals are reviewed on a case-by-case basis. Anthem requires proof of timely filing in the form of acceptance of your electronic claim. Please check your electronic claim submissions for acceptance by Anthem, as submission does not mean we received the claim.

18. For OMPP: From our previous meeting with OMPP concerning the eligibility issue, it was mentioned that if the wrong network paid claims in error due to eligibility (wrong network) a re-coupment would not happen. The network in which the payment was made will ask for its money from the other network. Is this not the case anymore?

OMPP, please respond.

19. For HP and the MCOs: Is there a policy regarding continuity of care? If so, is it in the Medicaid Manual? One of our locations (doctor office) is out of network with Medicaid. The patient is now eligible for Medicaid. She is now in her third trimester. We called to get a prior authorization (PA) and we were denied the authorization. We advised the patient she will need to sign a waiver for her services because of this reason. The patient refused. What should we do? Can we still get paid for her delivery care?

HP response: The IHCP does not require continuity of care because services are self-referred. If a member changes plans that require prior authorization, the provider has 30 days to use current PA on file or until PA exhausts.

Anthem response: Anthem does provide continuity of care services. Please contact our Utilization Management Department to discuss the requirement for prior authorization for services rendered.

MDwise response: Information regarding continuity of care is available in chapter 13 of the MDwise provider manual. The manual is located at MDwise.org.

Women in third trimester of pregnancy at the time they become your MDwise member may access continued medically necessary care for prenatal, delivery and postpartum care from their previous physicians.

MDwise strongly encourages providers to refer members to MDwise in this situation as we have several resources to assist our members.

Response: MHS is committed to providing continuity of care for our members as they transition between IHCP programs. If MHS is aware an out-of-network, non-IHCP provider

is balance billing a member, we shall instruct the provider to stop billing the member and to enroll in the IHCP in order to receive reimbursement.

MHS response: MHS' Continuity of Care policy specifies that members who are in their second and third trimester of pregnancy at the time they become eligible with MHS may continue to receive prenatal, delivery and postpartum care from their previous physician(s) if the conditions listed below are met. The MHS Medical Management Referral Specialist:

1. Receives notification from the member or the member representative of her wish to maintain her existing relationship with the current IHCP-enrolled provider for the duration of the pregnancy
2. Contacts the doctor to confirm the existing relationship
3. Arranges for payment of services to the out-of-network provider

20.For OMPP: My office was advised to change the provider of service from a nurse practitioner to the physician, to assure reimbursement from the Medicaid rate to the Medicare rate. Please confirm that this is the direction practices should be taking. If so, will all the MCEs be directed to follow this same guidance? Additionally, will the incident to guidelines have to be met?

HP response: If the provider is participating in the increased reimbursement, the provider would submit claims under the physician using the SA modifier, which would indicate the NP provided the service. However, if the physician is not participating in the increased reimbursement program, the provider would submit claims according to the provider who rendered service.

21. For OMPP: How will the new bonus affect crossover claims? Does the provider of service need to be changed to receive the additional funds?

HP response: No, providers should submit claims using the SA modifier to indicate who rendered service.

22. For HP: Are you planning on providing education to pharmacies beyond the banner pages? One pharmacy has advised me that emergency contraception is not a covered benefit as it causes abortion. Of course, this isn't true from a medical or a policy standpoint.

HP response: No, training is not scheduled for pharmacies regarding any of the current changes. If the provider feels a particular pharmacy has some general problems or concerns, the provider can refer the pharmacy to the customer service line at (800) 577-1278 or (317) 655-3240, option 2, or email INXIXPharmacy@EDS.com, or refer the pharmacy to their field representative.

23. For OMPP/Anthem/HIP: Requiring CPT codes at time of authorization – Where is it published that a provider must specify each individual CPT code? After working with Hoosier Alliance, they have fixed this workflow, removing the office CPT code requirement. No other entity requires this.

HP response: Please refer to chapter 6, section 2, for required information for PA submission.

Anthem response- The Indiana Health Coverage Program for both Healthy Indiana Plan and Hoosier HealthWise for prior authorization asks for medical diagnosis and the ICD-9 code is required, which is indicated on the form. The form may be accessed on the Anthem website, www.anthem.com; select Plans & Benefits, State Sponsored Plans, Provider Resources. Scroll to Prior Authorization and Preservice Review. Then click on the link titled "Services Requiring Prior Authorization: Effective: April 10, 2011."

24. For OMPP/Anthem/HIP: Will you please explain your authorization requirements? Sometimes you require authorization for all office services, sometimes not. Examples would be casting/fracture care/injections (Visco or Botox) Please explain.

HP response: Please see chapter 6, section 5, for authorization requirements for claims-specific questions. Providers should also utilize the fee scheduled to verify which procedures require PA.

Anthem response: The utilization management (UM) and precertification guidelines for the Healthy Indiana Plan (HIP) may be found and accessed through the Anthem website, under State Sponsored Business Precertification; therefore, services rendered in an office visit that appear on the Precertification list or prior-authorization should be submitted to Anthem for approval. The Hoosier HealthWise list is also available on the state-sponsored business webpage. Questions regarding specific circumstances may be referred to UM.

25.For OMPP/Anthem/HIP: Why do you require a primary care provider's (PMP) NPI on claims to indicate a referral was obtained?

HP response: A PMP NPI is required on a claim to track services rendered by the members assigned to the PMP, versus services performed by another medical provider. Members are assigned a PMP to help coordinate their medical care.

Anthem response: In order that our members receive the best possible care, we believe it's important for the PMP to oversee all medical care, even when members are referred to another provider for services. When submitting claims for services provided to a member not assigned to you, you enter the individual NPI (not the billing NPI) of the referring PMP in box 17b on the CMS-1500 claim form. Please refer to Anthem BCBS State Sponsored Business Provider Bulletin May 2011.

26. For OMPP/All MCEs: We are getting denials saying "past timely filing" when an authorization was obtained and Web interChange showed the patient as eligible. How can we get this constantly irritating situation resolved?

HP response: Although authorization was obtained and benefits were verified, providers are required to submit claims within guidelines for reimbursement. PA and verification of eligibility does not guarantee payment.

Anthem response: Providers have 90 days to timely file claims. Claims filed past the 90-day limit will receive timely filing denials regardless of authorization or eligibility status.

MDwise response: MDwise would like to see examples from the provider in order to research solutions and connect the provider to the appropriate delivery system staff.

MHS response: MHS participating providers have 90 days from date of service to submit their claims. Non-participating providers have 365 days from date of service to submit their claims. If claims are received past these timeframes, the claim will deny as past timely. MHS cannot respond otherwise without specific details.

27. For Hoosier Alliance HIP/MDwise/MDwise Total Health/MHS: (minor): We are experiencing delayed turnaround times for receiving approval or denial longer than 48 hours. The provider only has the day of the appointment or up to 48 hours after. How do we get a timely approval?

MDwise response: MDwise would like to see examples from the provider in order to research solutions and connect the provider to the appropriate delivery system staff.

MHS response: MHS is compliant with 405 IAC 5-3-14 that sets the prior review and authorization timeframe as seven days from submission of all necessary documentation. Our average turnaround time is less than one day. However, there are circumstances that may delay this turnaround time (i.e., incomplete request, additional information needed for medical necessity reviews, reviews pending medical director review). We encourage providers to call us to obtain authorizations except in the cases of durable medical equipment, home health and therapy, which should be faxed. Details about the process are available in the MHS Provider Manual.

28. For MHS/HIP: We are getting claim denials for no authorization when the department insists no authorization is needed. How do we get this fixed?

MHS response: MHS cannot respond without specific details.

29. For MDwise Hoosier Alliance: Claims are denied for lack of authorization on all codes when we provided ALL surgical codes for authorization. The information is not connecting within MDwise system. How do we get this fixed?

MDwise response: MDwise would like to see examples from the provider in order to research solutions and connect the provider to the appropriate delivery system staff.

30. For HP/OMPP: We are getting incorrect Web interChange eligibility info for "other insurance." Claims are denied for primary EOB but when contacted, HP provides little more info than the web. How can we get the information needed to submit a correct third-party liability (TPL) claim?

HP response: Unfortunately, the DFR/patient is responsible for ensuring the member eligibility file is correct. When it is discovered the information is not accurate, the provider can submit a TPL update through Web interChange. Providers are encouraged to reach out to the member to retrieve correct insurance information due to HIPPA.

31. For HP/OMPP: Claims are being denied for no authorization, even if we provide the authorization number on a claim. It also seems that the information on Web interChange is not loaded on a timely basis; therefore, our claims deny. Can you please provide a solution to this?

HP response: The authorization number is not required or needed on the claim for processing. Once the information is loaded into our system, we process the claims accordingly. Please contact the PA vendor for clarification of timely transmission of PA information.

Advantage response: We would have to have specifics examples to address the question.

32. For OMPP/Anthem: Per Chapter 8 of the IHCP Manual (revision dated May 2012), each routine OB visit is billed with the following CPT codes 59425 (visits 1-6) or 59426 (visit 7 and on) plus 81002 for the urine dip, if performed. Beginning with an EOB dated Dec. 24, 2012, Anthem Medicaid is now denying the 81002 based on the ACA. The billing for OB care for Medicaid programs is vastly different from commercial plans in which the entire routine OB care is billed globally using the delivery date as the date of service. So for commercial plans, the insurance is not billed until after the delivery. Per IHCP guidelines for OB care for Medicaid eligible patients, each visit is billed separately, and per the IHCP Manual, the above coding is utilized.

We have been told that the urine dip (CPT 81002) is being denied by Anthem Medicaid based on the ACA, but the customer service rep at Anthem Medicaid cannot cite the section of the act that indicates this. Our Anthem Medicaid rep said we had to lodge a complaint with their Customer Service Department before she could look into it. We have done this but again, the customer service representative just states per the act, not a specific section. It seems to me that IHCP decided on the guidelines for billing for OB care

so that only the services performed were reimbursed, and the specific MCO on the date of service is billed, as this sometimes changes over the course of a pregnancy. Supplies are needed to perform the urine dip, and if the IHCP Manual says to bill separately, then this would not be included in the allowance for the visit (59425 or 59426).

Anthem response: This is a known issue within our system and was corrected during an update the weekend of Feb. 16. All claims affected by this error will be reprocessed. The estimated date for all claims to be completed is March 13.

33. For Anthem: We are finding with Anthem Medicaid that they are starting to recoup money for OB patients based on a Sept. 7, 2012, bulletin for dates of service prior to the bulletin. The bulletin states that for all OB patients for dates of service effective Oct. 15, 2012, there must be a "U1, U2, or U3" modifier (for prenatal care) or diagnosis code V24 (for postpartum care). The modifiers for prenatal care have been utilized for a number of years. The diagnosis code V24 is not a valid diagnosis and needs an additional digit. All V24.X codes are for routine postpartum care, not for complications. One service where money was recouped involved a problem visit during the postpartum period in which the patient was having tachycardia. A diagnosis of routine postpartum care would be inappropriate. It was also from April 2012, six months prior to the effective date of the bulletin. Can you ask Anthem Medicaid to address this at the next meeting?

Anthem response: Claims are not routinely denied for the V24 diagnosis as we utilize a series of diagnosis codes that indicate pregnancy. Please provide claim specific examples for review.

34. For HP/OMPP: There is a problem with providers being required to submit an adjustment. Here is the problem: These were crossover claims and the provider did NOT submit an incorrect claim. Our providers do not have the time or the dollars required to fix a system problem that is not theirs. My suggestion for a fix is to have HP run a report and do a mass adjustment from their end. It is not the providers' responsibility to fix this problem. You simply cannot expect the provider to be responsible for this error. What are HP and or OMPP doing to fix this problem without burdening the physician? Again this should NOT be the responsibility of the provider.

HP response: When a billing problem is identified, it is presented to OMPP to determine best method for claims correction. The decision made does not always include a mass reprocess as it could cause other claim issues or may not be systematically possible. Each case presented is looked at very carefully to see the impact it could have on the provider. HP/OMPP determined this crossover issue did not warrant a mass reprocess based on system data. Therefore, providers are encouraged to correct claims online.

35. For all MCEs: Will the MCEs (i.e. Anthem, MDWise, MHS) retroactive an effective date if you send in a CMS 1500 showing that you actually provided a service to their member in good faith?

Anthem response: Anthem does not retroactively date contracts.

MHS response: In general, MHS does not retroactively set up contracted providers due to the need to credential practitioners prior to being effective in the network.

MDwise response: MDwise does not retroactively enroll providers. Providers must be credentialed and contracted prior to providing services to MDwise members. MDwise is accredited by the National Committee for Quality Assurance and follows its guidelines.

36. Medicaid Bulletin BT201301 dated Jan. 8, 2013, indicates that two of the payable J codes for oral and injectable contraceptives are J1055 and J1056. However, these codes are no longer valid as of Jan. 2, 2013. Please verify that J1050 is the correct code for this policy now and if not, what is the appropriate code?

HP response: CPT code update is currently in process. Please look for future publications for updated information.