

ISMA Coalition Meeting

September 13, 2013

Questions and Answers

1. **For OMPP and each MCE:** When will all the Medicaid payers be able to accept electronic claims (837 files) for secondary claims with Primary payment segments? Currently, Medicaid can accept the secondary claim in the electronic file (837); however, all providers must send the primary payers EOB on paper and hope they match the electronic claim to the paper EOB that has to be mailed.

MDwise Response:

MDwise can accept those claims only on paper, and the primary EOB must be included.

Anthem Response:

- COB first submissions (without attachments) can be sent electronically with primary amount noted on claim.
- COB claims WITH attachments still need to be sent on paper to:
Anthem Blue Cross & Blue Shield
PO Box 6144
Indianapolis, IN 46206-6144

MHS Response:

MHS is able to accept EOB information electronically.

2. **For OMPP and each MCE:** Will you please supply an update to the increased reimbursement for the primary care services referenced in Bulletin BT201247.
 - a. When should our membership expect regular distribution of funds?
 - b. Will the MCEs provide an itemized statement with the funds?
 - c. Will OMPP provide an itemized statement of the funds in future distributions?
 - d. If the funds are distributed without an itemized statement, what is your advice to help our practice figure out how to distribute the funds?

MDwise Response:

Supplemental payments for services provided to managed care members will be forthcoming, following approval from the Centers for Medicare & Medicaid Services (CMS). MDwise and the other MCEs are still waiting on approval. See BR201332.

Anthem Response:

Anthem HHW and HIP are waiting for CMS approval. We will follow the guidelines set forth by IHCP.

MHS Response:

We are unable to answer the above questions until a determination of the payment process is approved by OMPP and CMS.

3. **For MDwise:** Please provide written details from each delivery system on how emergency medicine claims are processed – from receipt of the original claim, record requests, PLP review process, appeal process for claims reduced to triage/screening fees, overturned appeals, process for re-adjudicating claims for full Medicaid FFS amount, and turnaround time required for each step.

MDwise Response:

When member seeks services in emergency room:

- a. If primary care provider or primary care provider's representative referred the member to seek emergency services , the claims will be paid.
- b. Emergency room claims that meet the MDwise auto-pay diagnoses list are paid.
- c. Emergency rooms claims with an authorization on file are paid.
- d. Emergency room claims that do not meet the auto-pay diagnoses list, have no referral, or have no prior authorization on file are pended for review by MDwise Medical Management.

Claim is reviewed by MDwise Medical Management:

- a. At any point during the Medical Management review, if it is determined the member's situation meets the prudent lay standard, the claim is approved for payment.
- b. If a claim is submitted without supporting clinical information, the provider or facility is notified that the clinical record should be submitted.
- c. Initial level review
 - i. The initial review focuses on presenting symptoms only.

This is a prudent layperson review to determine if member acted reasonably. Reviewer has no more than a high school education and no training in a healthcare field.

- ii. If the prudent layperson standard is not met at this level, the claim is sent to the next review level.
- d. Second level
 - iii. Case reviewer at medical management reviews case and additional clinical information to see if the prudent layperson standard applies or if medical condition was an emergency. If either were met, claim will be paid.
 - iv. If prudent layperson standard was not met, or if medical condition was not an emergency, the claim is sent to the final review level.
- e. Third level physician reviewer or other appropriate licensed practitioner
 - v. Physician or other appropriate licensed practitioner reviews the presenting symptoms and the discharge diagnosis.
 - vi. If the medical condition required an emergency room visit, claim will be paid.

1. If medical condition was not an emergency, claim will be denied with the exception of screening and facility fee. Patient will be flagged for education on emergency room usage.
- vii. With the exception of the physician screening and facility fee, MDwise is not required to reimburse providers for services rendered in an emergency room for treatment that does not meet the prudent layperson standard, was not authorized or was not for treatment of an emergency medical condition.

Appeals for denials

- a. Providers have 60 days from the date of the EOB to submit an initial dispute. MDwise will respond within 30 days.
 - viii. For more information on disputes, appeals, independent review and arbitration and necessary timelines, please see our dispute process at: www.mdwise.org/hoosierhealthwise/providers/docs/claims/hhprov-claimsdisputeprocess.pdf.
 - b. Disputes and appeals on clinical matters are sent to the MDwise Appeals and Grievance manager.
 - ix. The Appeals and Grievance manager or a designee will submit the dispute, case information and any additional research to the medical director for review.
 1. If upon review of the case it is found that supporting documentation is needed, a letter will be sent to the provider asking for additional information. The provider will have 30 days to submit this additional information.
 2. Without additional information, the denial may be upheld. If additional information is submitted, the medical director will review the case with the additional information.
 - x. The medical director will render a decision to uphold or overturn the denial. MDwise will send a written response with the result of the decision to the provider within 30 days of receipt of the dispute.
 1. If the denial is upheld, the response will include information about the next level of appeal action the provider can take. The provider has 60 days from receiving the notice to appeal.
 2. If the denial is overturned, MDwise has 30 days to remit payment to the provider.
4. **For HP:** For a patient that has Medicare and Medicaid, we were told by drug reps that when billing drugs (J codes) that Medicaid will pick up the 20 percent after Medicare pays. Can you tell us the process for getting Medicaid to pay on drugs after Medicare has paid? We are getting denials stating that Medicare has paid more than the Medicaid allowable when Medicare crosses the claim over to IHCP; however, when claims are submitted with the NDC number, they are getting paid. Can HP explain the protocol or best process for submitting these claims? Is there an edit or problem with the crossover claims?

HP response:

HP does not pay claims based on the NDC. Claims will be processed and payment will be based on the allowed amount for the code that is billed. If you have examples of claims paying differently, please forward them to HP. The Indiana Health Coverage Programs (IHCP) reimburses covered services for Medicare crossover claims only when the Medicaid-allowed amount exceeds the amount paid by Medicare. When the Medicare-paid amount exceeds the Medicaid-allowed amount, claims are processed with a paid claim status with a zero reimbursed amount. If the Medicaid-allowed amount exceeds the Medicare-paid amount, the IHCP reimburses using the lesser of the co-insurance plus deductibles, or the difference between the Medicaid-allowed amount and the Medicare-paid amount.

5. **For HP and each MCE:** If a practice gets a report from Indiana Scheduled Prescription Electronic Collection & Tracking Program (INSPECT), and they have a new patient not assigned to them and that patient shows up on the report, can the practice refuse to see the patient so they do not get caught with possible abandonment? Can they refuse to see the patient as they would any cash-pay or commercial patient?

MDwise Response: If you are a PMP and a patient is assigned to you, you must treat or refer. To request a Provider Request for Member Reassignment, the request must meet the criteria outlined in the form and would be subject to medical director review.

Anthem Response:

Anthem follows the IHCP guidelines regarding eligibility. Anthem requires that members see their assigned PMP. Any errors on the INSPECT report should be reported to the team that compiles this information.

MHS Response:

Our contracts do not allow providers to discriminate based on health status.

HP Response:

This will not apply to Traditional Medicaid patients as they do not have primary care physicians.

6. **For MDwise/St. Catherine:** We checked the Medicaid interChange for eligibility when the patient is here to order glasses and when they pick up the glasses to make sure they are eligible for vision exams and materials. We have had problems in the past with the exam and/or materials claims being denied because the benefits were already used. When I called on these claims, I was told by MDwise/St. Catherine that we cannot go off the interChange to verify eligibility for vision exams and materials because the interChange is not updated in a timely manner. I was told that we have to call MDwise/St. Catherine to verify eligibility. If we have a printout of interchange, can we send in an appeal?

MDwise Response:

Yes, the provider needs to call St. Catherine to see if vision benefits have already been utilized by the member. A printout of the eligibility screen showing that the patient is an

eligible HHW member is not enough since Web interChange does not provide detailed information on the use of benefits by the member.

7. **For MDwise HIP/St. Margaret & St. Catherine:** A vision office called MDwise HIP and was told by Donna that MDwise HIP patients have always needed prior authorization for vision exams and diagnostic tests. The office told her that they have received payments in the past on MDwise HIP claims without prior authorization, but she informed them if they did get paid in the past, then they were paid in error and payback would be requested. Do you need a prior authorization for vision exams and diagnostics?

MDwise Response:

Prior authorization is required for all medical eye and vision services in the HIP program.

8. **For HP:** A vision office has a patient they show has spenddown and it has not been met. But because the claim has been denied, they cannot bill the patient for the spenddown. The office called Medicaid several times and was told that the denial is because there is not an amount in the net amount section, and they would have to call the Division of Family Resources to tell them to put an amount in. The patient got involved, and the patient and office had a conference call with Medicaid. They were finally able to talk to a supervisor who said she would get the problem fixed. She called the patient to let him know that it was fixed and that the office could submit the claim again, which they did. But it was denied once again. Now what can they do to get this taken care of so they can bill the patient the spenddown?

HP Response:

HP does have a process in place to get these spenddown issues resolved. If you receive these denials, please contact your field consultant and they can get a resolution so that you can re-bill any denied spenddown claims.

9. **For OMPP:** We are still having problems with pregnant women with Package A getting dropped from coverage in the third trimester. Is Medicaid looking at any solution for this problem?

No response from OMPP.