*Core*MMIS *bulletin*

Core benefits – Core enhancements – Core communications

INDIANA HEALTH COVERAGE PROGRAMS BT201667 OCTOBER 20, 2016

*Core*MMIS billing guidance: Part I

On December 5, 2016, the Indiana Health Coverage Programs (IHCP) will replace the current information processing system, Indiana*AIM*, with a new system called *Core*MMIS, which stands for Core Medicaid Management Information System. Along with *Core*MMIS, a new provider interface called the Provider Healthcare Portal (Portal) will replace Web interChange.

The new system is designed to more accurately and efficiently adjudicate claims in alignment with IHCP policies and procedures and national coding guidelines to prevent the improper payment of claims. Claims not following billing guidelines or claims for services inconsistent with IHCP policy will not process for reimbursement in *Core*MMIS as they may have in Indiana*AIM.* **Such claims will deny in *Core*MMIS, even though they may not have in Indiana*AIM*.**

Make sure billing practices and systems are compliant

Implementation of the new system will be most successful if IHCP providers are prepared for the transition. Providers should review their billing practices and systems to make sure they comply with IHCP and nationally accepted billing guidelines. Verifying billing processes now will help prevent claims from unnecessarily suspending or denying after *Core*MMIS implementation.

The IHCP is revising billing guidance in some areas to support the new claim-processing system. Guidance will be issued through a series of *Core*MMIS provider bulletins. Providers should ensure that billing staff and vendors are familiar with all new guidance issued.

*Core*MMIS billing guidance will apply to all claims, whether they are submitted through an electronic data interchange (EDI) 837 transaction, through data entry in the new Portal, or by mail on paper claim forms. Providers must keep in mind that claims will transition to *Core*MMIS processing according to the transition time frames announced in *Core*MMIS *Bulletin* BT201662:

- Electronic transactions submitted for processing by 12 noon on Wednesday, November 30, 2016, will be processed in Indiana*AIM*. Claims not submitted by that time will be rejected and must be held until on or after December 5, 2016, at which time they will be processed in *Core*MMIS. Revised billing guidance for *Core*MMIS will apply to all

electronic claim transactions processed as of December 5, 2016.

- Claims submitted via Web interChange by 5:45 p.m. on Wednesday, November 30, 2016, will be processed in Indiana*AIM*. (This is a slight change from the 6 p.m. cut-off time previously announced in *Core*MMIS *Bulletin BT201662*.) Claims not submitted by that time must be held for submission on or after December 5, 2016, at which time they should be submitted through the Portal and processed in *Core*MMIS. Revised billing guidance for *Core*MMIS will apply to all claims submitted through the Portal as of December 5, 2016.
- Paper claims received on or before November 14, 2016, will be processed in Indiana*AIM*. Claims received after that date will be held for processing in *Core*MMIS on or after December 5, 2016. Revised billing guidance for *Core*MMIS will apply to all paper claims received after November 14, 2016.

HIPAA-Compliant Codes

*Core*MMIS will use *Health Insurance Portability and Accountability Act* (HIPAA)-compliant coding, as published by national coding sources, in its claim-processing logic. Providers should ensure that they are using the most up-to-date HIPAA-compliant values from the national coding source when billing the IHCP. This requirement applies to:

- Healthcare Common Procedure Coding System (HCPCS) procedure codes
- Modifiers
- International Classification of Diseases (ICD) diagnosis and procedure codes
- Place-of-service codes
- Admit source/admit type codes
- Condition codes
- Occurrence/occurrence span codes
- Patient status codes
- *UB-04* values
- HIPAA adjustment reasons
- HIPAA claim category status codes
- HIPAA claim status codes
- HIPAA remarks
- Healthcare entity identifiers
- Accident type codes
- Type-of-bill codes

HIPAA-compliant coding will apply to all claims processed in *Core*MMIS. An exception exists only for **occurrence codes** billed on claims with dates of service (DOS) before December 5, 2016. **Providers should follow previous IHCP billing guidance regarding occurrence codes on claims for DOS before December 5, 2016**.

Third-Party Liability and Medicare Crossover Billing

As previously communicated in *IHCP Bulletin BT201576*, with the implementation of *Core*MMIS, providers will be

required to submit third-party liability (TPL) information and Medicare information at the detail level on certain claim types. Providing this information at the detail level gives a more accurate accounting of claim reimbursement and is also more consistent with how TPL and Medicare information is processed within the larger healthcare industry.

The claim types that will require TPL information at the detail level include:

- Medical
- Dental
- Home health
- Outpatient

The claim types that will require Medicare information (such as Medicare-paid amount, deductible, coinsurance, copayment, blood deductible, and psych reductions), as well as any applicable TPL information, at the detail level include:

- Medical crossover
- Outpatient crossover
- Home health crossover

For the applicable claim types, this requirement will apply to all claims processed in *Core*MMIS regardless of the DOS, as follows:

Electronic claim transactions: The 837I, 837P, and 837D electronic transactions all support the submission of TPL and Medicare information at the detail level. Paid amounts are submitted in the SVD segment in the 2430 loop. Deductible, coinsurance, copayment, blood deductible, and psych reduction are submitted in the claim adjustment segment (CAS). Electronic transactions submitted for processing on or after December 5, 2016, will process in *Core*MMIS and must include TPL and Medicare information at the detail level, if applicable.

Provider Healthcare Portal claims: Providers will enter TPL or Medicare information on Portal claims by selecting the **Include Other Insurance** box in Step 1 of the claim submission process. Providers would then enter carrier information under **Other Insurance Details** in Step 2. After saving **Service Detail Information** in Step 3, providers will expand the detail and enter detail-level TPL or Medicare information in the **Other Insurance for Service Detail** section. Providers will repeat this process for each detail on the claim. Claims submitted via the Portal on or after December 5, 2016, will process in *Core*MMIS and must include TPL and Medicare information at the detail level, if applicable.

Paper claims: The *CMS-1500*, *UB-04*, and *American Dental Association (ADA) Dental 2006* paper claim forms do not provide a locator for submitting TPL or Medicare information at the detail level. The IHCP encourages providers to use electronic transactions or the Portal for submitting claims that contain TPL or Medicare information. For those providers that choose to submit claims on paper, the IHCP has developed the *IHCP Third-Party Liability (TPL)/ Medicare Special Attachment Form* that must be submitted with applicable paper claims to provide detail-level TPL and Medicare information. A copy of the form is attached to this publication for your reference and is posted to the Forms page at indianamedicaid.com. Paper claims received after November 14, 2016, will be held for processing in

*Core*MMIS and will require this form be attached.

National Correct Coding Initiative (NCCI) and Code Auditing Rule Changes for *Core*MMIS

*Core*MMIS will apply all National Correct Coding Initiative (NCCI) edits as well as all IHCP enhanced code auditing rules directly through its claim-processing rules; McKesson will no longer serve as a contracted vendor for the NCCI editing and code auditing functions.

NCCI Column I and Column II edits

With the enhanced NCCI editing in *Core*MMIS, IHCP providers will see new explanations of benefits (EOBs) associated with claim adjudication. The EOBs outlined in Table 1 represent the new EOBs providers will receive as

Table 1 – New NCCI EOBs effective with CoreMMIS implementation

EOB Code	EOB Description	Adjustment Reason Code (ARC)	ARC Description	Remark	Remark Description
4181	Service denied due to a National Correct Coding (NCCI) edit. Go to http://www.medicaid.gov for information regarding NCCI coding policies.	97	The benefit for this service is included in the payment/allowance for another service/ procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.
4183	Units of service on the claim exceed the medically unlikely edit (MUE) allowed per date of service. Go to http://www.medicaid.gov for information regarding maximum number of units of service allowed for the service billed.	273	Coverage/program guidelines were exceeded.	N640	Exceeds number/ frequency approved/ allowed within time period.

continued

Table 1 – New NCCI EOBs effective with CoreMMIS implementation (continued)

EOB Code	EOB Description	Adjustment Reason Code (ARC)	ARC Description	Remark	Remark Description
6396	This service is not payable with another service on the same date of service due to National Correct Coding Initiative.	236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/fee schedule requirements.	N20	Service not payable with other service rendered on the same date.
6399	A previously paid service is being recouped per National Correct Coding Initiative (NCCI) processing of another service on the same date of service by the same provider.	236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/fee schedule requirements.	N20	Service not payable with other service rendered on the same date.

Clear Claim Connection, a web-based tool currently available to providers in Web interChange to explain claim denials and coding rationale, will no longer be available. Medicaid-specific NCCI edit files and Medicaid NCCI reference documents are located on *The National Correct Coding Initiative in Medicaid* page at medicaid.gov. Providers are encouraged to access this site for educational materials and to download NCCI PTP and MUE files. Additional information is also available in the *National Correct Coding Initiative* provider reference module at indianamedicaid.com.

IHCP Code Auditing Rules

With the enhanced application of IHCP code auditing rules in *Core*MMIS, IHCP providers will see new explanations of benefits (EOBs) associated with claim adjudication. The EOBs outlined in Table 2 represent the new EOBs providers will receive in response.

Table 2 – New IHCP code auditing rule EOBs effective with Core*MMIS implementation*

EOB Code	EOB Description	ARC	ARC Description	Remark	Remark Description
4186	This is a component of a more comprehensive service. Please resubmit claim with the procedure code that most comprehensively describes the services performed.	236	This procedure or procedure/ modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/fee schedule requirements.	N/A	N/A
6382	Routine preoperative medical visits performed on the day of surgery are not separately payable. Documentation not present or not sufficient to justify care was of a non-routine nature.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/ procedure.
6384	Routine preoperative medical visits performed within one day prior to surgery are not separately payable. Documentation not present or not sufficient to justify care was of a non-routine visit.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/ procedure.
6386	Postoperative medical visits performed within 90 days of surgery are payable only for a surgical complication and if documented as medically indicated. Documentation not present or does not justify the visit billed.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/ procedure.

continued

Table 2 – New IHCP code auditing rule EOBs effective with Core*MMIS implementation* (*continued*)

EOB Code	EOB Description	ARC	ARC Description	Remark	Remark Description
6387	Postoperative medical visits performed within 0 -10 days of surgery are payable only for a surgical complication and if documented as medically indicated. Documentation not present or does not justify the visit billed.	B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/ test.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
6389	Multiple units of the same laboratory service are not payable for the same date of service, same member and same or different provider without medical necessity.	272	Coverage/program guidelines were not met.	N/A	N/A
6390	Add-on codes are performed in addition to the primary service or procedure and must never be reported as a stand-alone code.	272	Coverage/program guidelines were not met.	N/A	N/A
6391	A primary service or procedure code is limited to one unit per date of service.	272	Coverage/program guidelines were not met.	N/A	N/A

Emergency Indicators are required at the claim detail level for emergency services

The IHCP provides coverage for emergency services, and guidelines for these services are subject to the member's program enrollment. Emergency services are defined in *Indiana Administrative Code 405 IAC 5-2-9.* For services deemed emergent:

- A "Y' must be entered in the **Emergency Indicator** field on *CMS-1500* paper claims and 837P electronic transactions (field 24C on paper claims; 2400/SV109 on electronic transactions) to indicate an emergency
- The "**EMG**" box for the claim detail line must be checked on *CMS-1500* claims submitted via the Portal to indicate an emergency

If "N" (paper) or nothing (electronic transaction) is entered in the **Emergency Indicator** field or the "**EMG**" box is not checked (Portal), the claim *detail* will not be considered an emergency and will be processed accordingly.

Stay Informed

The IHCP appreciates the quality services providers offer our members and is committed to working closely with the provider community during this transition. It is critical that providers stay informed as *Core*MMIS implementation approaches. All *Core*MMIS provider bulletins are posted on the Indiana *Core*MMIS page at indianamedicaid.com. Sign up for IHCP Email Notifications to be alerted when future bulletins are released. Direct questions to your HPE Provider Relations field consultant or email incoremmis2015im@hpe.com.

QUESTIONS?

For additional questions about *Core*MMIS, email incoremmis2015im@hpe.com.

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Indiana Health Coverage Programs

Third-Party Liability (TPL)/Medicare Special Attachment Form

This supplemental form is used to submit other payer information for detail line items on *UB-04*, *CMS-1500*, and dental paper claims. This form must be attached to any paper claim that includes TPL and must be submitted to the appropriate address based on claim type.

1.	Billing Provider NPI	a.	Name	b.
2.	Member ID	a.	Name	b.

3. List other payers in order of responsibility. 1– Primary, 2 – Secondary, 3 – Tertiary

Seq	Health Plan ID	Payer Name and Address	Policy Number	Date Paid
1				
2				
3				

4. Enter prior payment amounts per claim detail.

Detail #	Payer Seq	Deductible PR 1	Coinsurance PR 2	Copayment PR 3	Blood Ded PR 66	Psych Red PR 122	Amount Paid	ARC Required if Amount Paid = 0

Third-Party Liability (TPL)/Medicare Special Attachment Form Instructions

When submitting paper claims, providers should place this special attachment form directly behind the paper claim form. If additional attachments need to be submitted, those attachments should be placed behind this form. Paper claim forms and all relevant attachments should be mailed to the appropriate address based on claim type, as indicated in the Indiana Health Coverage Programs (IHCP) Quick Reference Guide at indianamedicaid.com.

1a	Billing Provider NPI	Required. Enter the Billing Provider NPI (or Medicaid ID, if atypical). This MUST match the billing provider number submitted on the claim, or the claim and attachment will be returned to the provider.
1b	Name	Enter the name of the billing provider.
2a	Member ID	Required. Enter the 12-digit member ID. This MUST match the member ID submitted on the claim, or the claim and attachment will be returned to the provider.
2b	Member Name	Enter the first and last name of the member.
3.1	Health Plan ID	Required. This should match the health plan ID submitted on the claim form. Sequence number one (3.1) is used for Medicare crossover claims **only**. Other insurance/TPL information should be submitted on sequence two (3.2).
3.1	Payer Name and Address	Enter the Medicare payer name and address.
3.1	Policy Number	Enter the Medicare policy number.
3.1	Date Paid	Required.
3.2	Health Plan ID	Required. Sequence number two (3.2) is used for submitting other insurance/TPL information **only**. Medicare crossover information should be submitted on sequence one (3.1).
3.2	Payer Name and Address	Enter the third-party (commercial insurance) payer name and address.
3.2	Policy Number	Enter the third-party (commercial insurance) policy number.
3.2	Date Paid	Required.
3.3	Health Plan ID	Sequence number three (3.3) is used for submitting additional insurer information beyond 3.1 (Medicare) and 3.2 (TPL payer), if applicable (for instance liability insurance due to an accident).
3.3	Payer Name and Address	Enter the commercial insurance payer name and address.
3.3	Policy Number	Enter the commercial insurance policy number.
3.3	Date Paid	Required.
4	Detail #	Enter 1, 2, 3, and so on, to correspond to the detail number submitted on the accompanying claim.
	Payer Seq	Relates to payer identified in section 3. One (1) is always used for Medicare, and two (2) is always used for other insurance (TPL). Payer Seq 3 is not currently used by the IHCP.
	Deductible – PR 1	Required for Medicare crossover claims only.
	Coinsurance – PR 2	Required for Medicare crossover claims only.
	Copayment – PR 3	Required for Medicare crossover claims only.
	Blood Ded – PR 66	Required for Medicare crossover claims only.
	Psych Red – PR 122	Required for Medicare crossover claims only.
	Amount Paid	For Payer Seq 1, this amount indicates the Medicare paid amount. For Payer Seq 2, this amount represents the other Insurance/TPL amount.
	ARC	Required for other insurance/TPL amount claims ONLY if the amount paid = 0.