*Core*MMIS *bulletin*

Core benefits – Core enhancements – Core communications

INDIANA HEALTH COVERAGE PROGRAMS BT201671 NOVEMBER 1, 2016

*Core*MMIS billing guidance: Part III

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*.**

The IHCP is revising billing guidance in some areas to support the new claim-processing system. Providers should ensure that billing staff and vendors are familiar with new guidance issued through *Core*MMIS *Bulletins*. All *Core*MMIS provider bulletins are posted on the Indiana *Core*MMIS page at indianamedicaid.com. *Core*MMIS billing guidance will apply to all claims, whether they are submitted through an 837 EDI 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. Note: As announced in a News item posted on indianamedicaid.com October 27, 2016, the last date paper attachments associated with electronic claims will be accepted for processing in Indiana*AIM* was revised to November 28, 2016.

Federally qualified health center and rural health clinic billing

The IHCP allows reimbursement for only one Healthcare Common Procedure Coding System (HCPCS) code T1015 – *Clinic, visit/encounter, all-inclusive* per IHCP member, per billing provider, per day, **unless** the primary diagnosis code differs for additional encounters. Currently, if federally qualified health center (FQHC) and rural health clinic (RHC) providers submit claims for more than one encounter per member, per billing provider, per day, the claims are manually processed to determine whether the primary diagnosis codes differ. Claim processing in *Core*MMIS will no longer require this manual intervention; the determination of whether the primary diagnosis codes differ will be systematic. Multiple encounter claims from an FQHC or RHC for a member on the same date of service (DOS) that do not include a different primary diagnosis codes will deny as duplicate claims for explanation of benefits (EOB) 5000 or 5001 – *This is a duplicate of another claim.*

FQHCs and RHCs must strictly follow proper billing guidelines when submitting multiple diagnosis codes on a single claim. Diagnosis codes must be listed according to their importance, with the first code being the one that most strongly supports the medical necessity of the service. The diagnosis code submitted on the *CMS-1500* claim (Form Locator 21A) will be considered the primary diagnosis in *Core*MMIS for determining duplicate claims. In the Portal, the first diagnosis entered is the primary diagnosis. For electronic transactions, the first diagnosis code entered in the Loop 2300 HI segment (H101) is the primary diagnosis.

Dental codes not billable on medical claims

Providers are reminded that all dental services, including those performed in dental office, inpatient or outpatient hospital settings, or ambulatory surgical centers (ASCs) must be billed with Current Dental Terminology (CDT®[1]) codes using the *American Dental Association (ADA) 2006* claim or the 837D electronic transaction. All other associated professional services such as oral surgery, radiology, and ancillary services related to the dental services must be billed on a *CMS-1500* claim or the 837P transaction. For Hoosier Healthwise members, only dental services billed with CDT procedure codes submitted on the *ADA 2006* or 837D transaction are carved-out services and reimbursed fee-for-service (FFS).

As a reminder, the IHCP reimburses for general anesthesia provided in the dentist's office only for members younger than 21 years of age. General anesthesia for these members provided in the dentist office should be billed with the CDT code using the *ADA 2006* claim or the 837D electronic transaction. The IHCP covers general anesthesia for members 21 years of age and older only if the procedure is performed in an inpatient or outpatient hospital setting or in an ambulatory surgical center. When general anesthesia is provided in a hospital or ASC setting, the provider must bill the appropriate Current Procedural Terminology (CPT®[2])/HCPCS code using the *CMS-1500* claim or the 837P transaction; the CDT code should not be billed. For more information, refer to the *Dental Services* module on the *Provider Reference Materials* page at indianamedicaid.com.

[1]Current Dental Terminology (CDT) is copyrighted by the American Dental Association. 2015 American Dental Association. All rights reserved.

[2]CPT copyright 2015 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association

Crisis intervention services billing

Crisis intervention is a short-term emergency behavioral health service, available to any Medicaid-eligible member in crisis. Crisis intervention services are reimbursed fee-for-service (FFS) for all members, including members enrolled in managed care programs. The IHCP covers crisis intervention using HCPCS procedure H2011 – *Crisis intervention service, per 15 min.*

With the implementation of *Core*MMIS, requirements for billing crisis intervention services have been revised. Claims will no longer require the modifier HW; providers must bill HCPCS code H2011 **only** without the HW modifier. This billing change applies to **all** claims for crisis intervention services processed in *Core*MMIS, **regardless of DOS, including provider-initiated adjustments or replacement claims.** Claims processed in *Core*MMIS that contain a claim detail for HCPCS procedure H2011 with the HW modifier appended will be denied with EOB 4033 – *The modifier used is not compatible with the procedure code billed. Please verify and resubmit.*

Providers should refer to the *Core*MMIS provider bulletin BT201662 for the dates that have been established for claims and claims-related submissions (paper, online, and electronic) for the transition from processing in Indiana*AIM* to *Core*MMIS.

Medical Review Team billing

With the implementation of *Core*MMIS, **all** Medical Review Team (MRT) services **must** be billed with the modifier **SE - *State and/or federally funded programs/services*** on the claim detail. This requirement applies to claims for all MRT services that are processed in *Core*MMIS, **regardless of the date of service (DOS)**. Provider-initiated adjustments or replacement claims processed in *Core*MMIS must also include the SE modifier. The *Medical Review Team Codes* posted on the *Code Sets* page at indianamedicaid.com will be updated to reflect this change. Providers should refer to the *Core*MMIS *Bulletin* *BT201662* for the dates that have been established for claims and claims-related submissions (paper, online, and electronic) for the transition from processing in Indiana*AIM* to *Core*MMIS.

Also, effective with the implementation of the new system, members approved for MRT services will no longer be issued a special member identification (RID) number that begins with the '850' prefix. Providers must use the members 12-digit RID number as indicated via the IHCP Eligibility Verification System (EVS).

Updating rendering linkages

IHCP policy requires rendering providers be linked to the specific location(s) where they render services for a group practice. Further, rendering providers may *not* bill for services at a service location to which they are not linked. For

example, a physician's group has three locations: A, B, and C. Dr. Smith practices only at locations A and B. Dr. Smith must be linked only to locations A and B and should not bill as a rendering provider at location C.

Group providers should review their provider profiles to ensure each group location has the correct rendering providers linked with accurate effective and end-dates and make appropriate updates as needed. Claims billed for services performed by a rendering provider not linked to the specific service location on the claim will be denied in CoreMMIS for EOB 1010 – *Rendering provider is not an eligible member of billing group or the group provider number is reported as rendering provider. Please verify provider number and resubmit*.

Uploading electronic attachments to claims

With the implementation of *Core*MMIS, providers will have the option of transferring attachments and supporting documentation for claims submitted through the Portal as electronic files or of sending them by mail. Although electronic file transfers are more efficient and preferred, they are limited by total file size and by document type:

- Size limitation: 5 MB total
- Allowed document types: PDF, BMP, GIF, JPG/JPEG, PNG, and TIFF/TIF

The Portal will display an error message when a user attempts to transfer files that exceed the maximum allowed size or are not in an allowable format. Documents that do not comply with the limitations can be submitted by mail. Attachments and supporting documentation sent by mail must include a cover sheet indicating the claim's identification number to tie the documents to the proper electronic transaction.

Claim payment and Remittance Advices

With *Core*MMIS implementation, the paid date for claims will be on Wednesdays rather than Tuesdays. Providers will continue to be able to view Remittance Advices (RAs) for claims processed in *Core*MMIS each Monday, for payment the following Wednesday. RAs will be viewable through the Portal by delegates who have been assigned the *Payment History-Inquiry* function. RAs for claim activity processed in *Core*MMIS will not be limited to 12 weeks of activity, but will be viewable to providers on an ongoing basis for historical reference. RAs for claim activity that occurred before the implementation of the *Core*MMIS will not be converted to the new system.

Providers will need to access RAs for claims processed in Indiana*AIM* through Web interChange. Web interChange will be available *only* for accessing historical RAs until January 4, 2017. Web interChange will show 12 weeks of RAs during this time frame. The procedures to access RAs via Web interChange will remain unchanged. **Providers will need their Web interChange user IDs and passwords to get access.** After the 30-day period, providers will not be able to access their RAs from Web interChange. The IHCP strongly encourages providers to review and print RAs, as necessary, during the 30-day window. Providers who do not access RAs within the allotted time will need to contact the IHCP to request copies.

Searching for Indiana*AIM* claims in *Core*MMIS

With *Core*MMIS implementation, seven years of information on claims processed in Indiana*AIM* will be converted to *Core*MMIS. Providers can access information on past claims through the Portal. Provider Portal accounts will be linked to the provider's Provider ID. (A Provider ID consists of the provider's Legacy Provider Identifier (LPI) and the service location code.) When logged into the Portal, delegates who have been assigned the *Claim Inquiry* function can navigate to **Claims**, select **Search Criteria**, and enter the relevant criteria.

Although all viewable claim information will be available in the Portal, claims processed in Indiana*AIM* that are converted to *Core*MMIS will have *new* claim identification numbers (Claim IDs); the ICNs assigned by Indiana*AIM* will not be used. Providers will not be able to search for claims processed in Indiana*AIM* in the Portal using the old ICN, but *will* be able to use other criteria, such as member ID, date of service, and so on to retrieve claims information. After a claim is identified in the new system, providers should keep a record of the new Claim ID associated with that claim for easy reference.

Use these search criteria in the Portal to find claims processed in Indiana*AIM*:

- Member ID
- Claim type
- From and through dates of service
- Claim status

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 Hewlett Packard Enterprise (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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