*Core*MMIS *bulletin*

Core benefits – Core enhancements – Core communications

INDIANA HEALTH COVERAGE PROGRAMS BT201673 NOVEMBER 4, 2016

IHCP issues general guidance for the new *Core*MMIS

On December 5, 2016, the Indiana Health Coverage Programs (IHCP) will replace the current 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 implementation of *Core*MMIS will enhance many of the daily interactions between the IHCP and providers. Providers will experience better customer service with more efficient self-service options and improved communication tools. The Portal will be providers' most effective tool for conducting IHCP-related business. It will offer familiar features currently available in Web interChange as well as new functions.

Enhanced Customer Assistance

With the implementation of *Core*MMIS, the IHCP will have a single Customer Assistance telephone number, 1-800-457-4584, to eliminate confusion about which telephone number to call for support. This number is new to providers, so please make note of it for easy reference. Providers calling Customer Assistance will be able to get information about a variety of topics, including information about billing, claims, member eligibility, coverage limitations, assistance with the Portal, and more.

Providers will access Customer Assistance through an Interactive Voice Response (IVR) system that offers a user-friendly self-serve option for answers to routine inquiries. Providers calling Customer Assistance first need to authenticate their identity as they currently do. To protect personally identifiable information (PII) or protected health information (PHI), when a caller is seeking disclosure of member information, additional authentication will continue to be required. Depending on the type of inquiry, the IVR system may also require additional information. Table 1 identifies the types of routine inquiries that can be addressed through the IVR system and the type of information a provider should have ready to respond to system prompts.

Table 1 – Information needed to receive immediate answers via the IVR system

Inquiry	Information Required
Basic provider authentication	• Provider ID (the nine-digit Legacy Provider Identifier, LPI, plus the service location code) or National Provider Identifier (NPI) • ZIP Code plus 4 for the service location • Last four digits of tax identification number (TIN)
Member eligibility and other information	• Member identification (RID) number • Member date of birth or date of service (DOS) • Member first and last name
Provider enrollment status	• Tracking number provided during the enrollment application process • Last four digits of TIN
Claim status	• Claim ID **OR** • Member identification number (RID) • DOS
Prior authorization status	• Authorization number
Payment history	• Payment ID

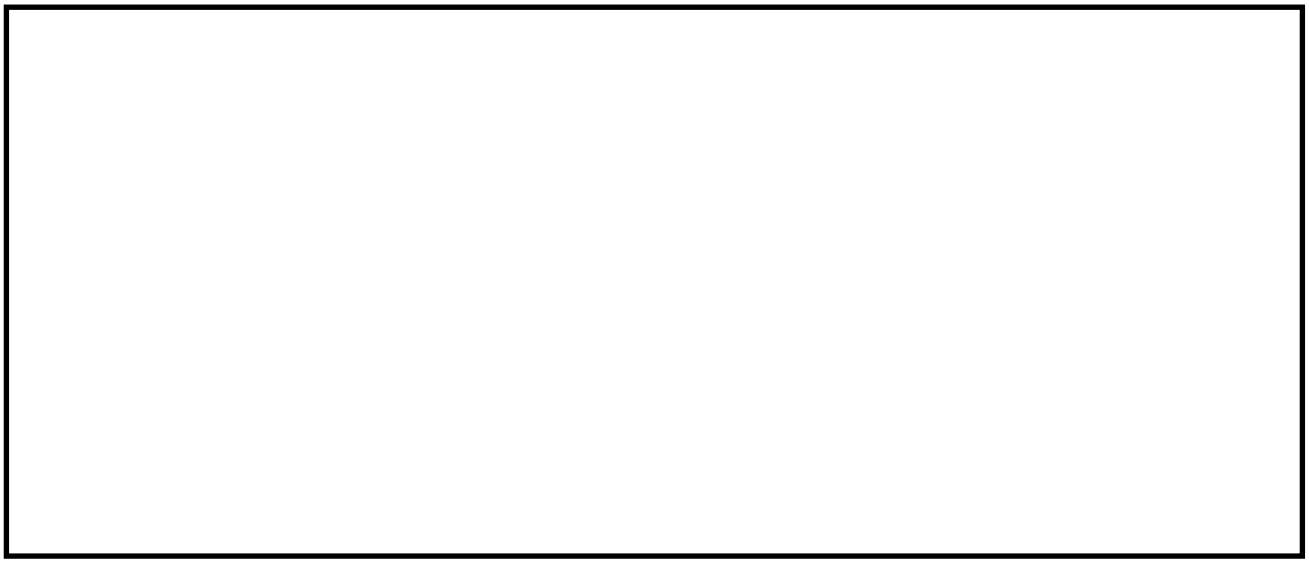
If providers have additional questions the IVR system cannot answer, Customer Assistance representatives are available to help. Customer Assistance hours will be extended beyond the current 8 a.m. to 6 p.m. Eastern time Monday through Friday (except holidays), to include Saturday hours from 8 a.m. to 1 p.m. Providers will also have the option of leaving a secure voice mail message and can expect a Customer Assistance representative to return the call within one business day.

Verifying member eligibility

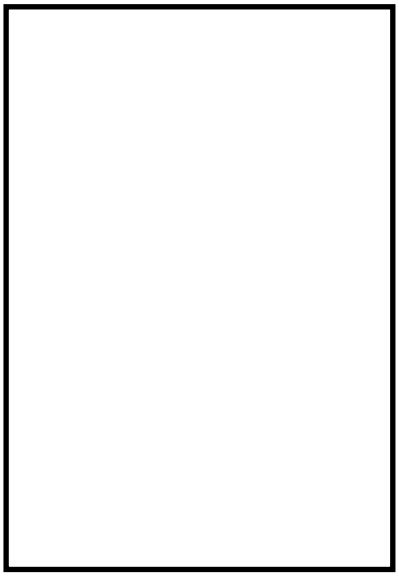
*Core*MMIS offers providers options for verifying member eligibility that are similar to those currently available. Providers will be able to verify member eligibility through either the IVR system or the Portal. The IVR process is similar to the current process used by providers today to verify member eligibility.

In the Portal, providers can verify member eligibility by submitting a member's name and date of birth, Social Security number (SSN), or RID, along with the applicable DOS, in the *Eligibility Verification Request* panel. The response is a general eligibility statement that links to additional coverage information. Figure 1 shows the *Eligibility Verification Request* panel and a sample response to a request. Please note that if a span date is used to verify eligibility, the "from" DOS will be used to return member eligibility information. As a reminder, providers should verify eligibility using the single DOS when the visit/procedure was performed, except for inpatient services, which should be verified based on the date of admission.

Figure 1 – A sample eligibility verification request and response in the Portal

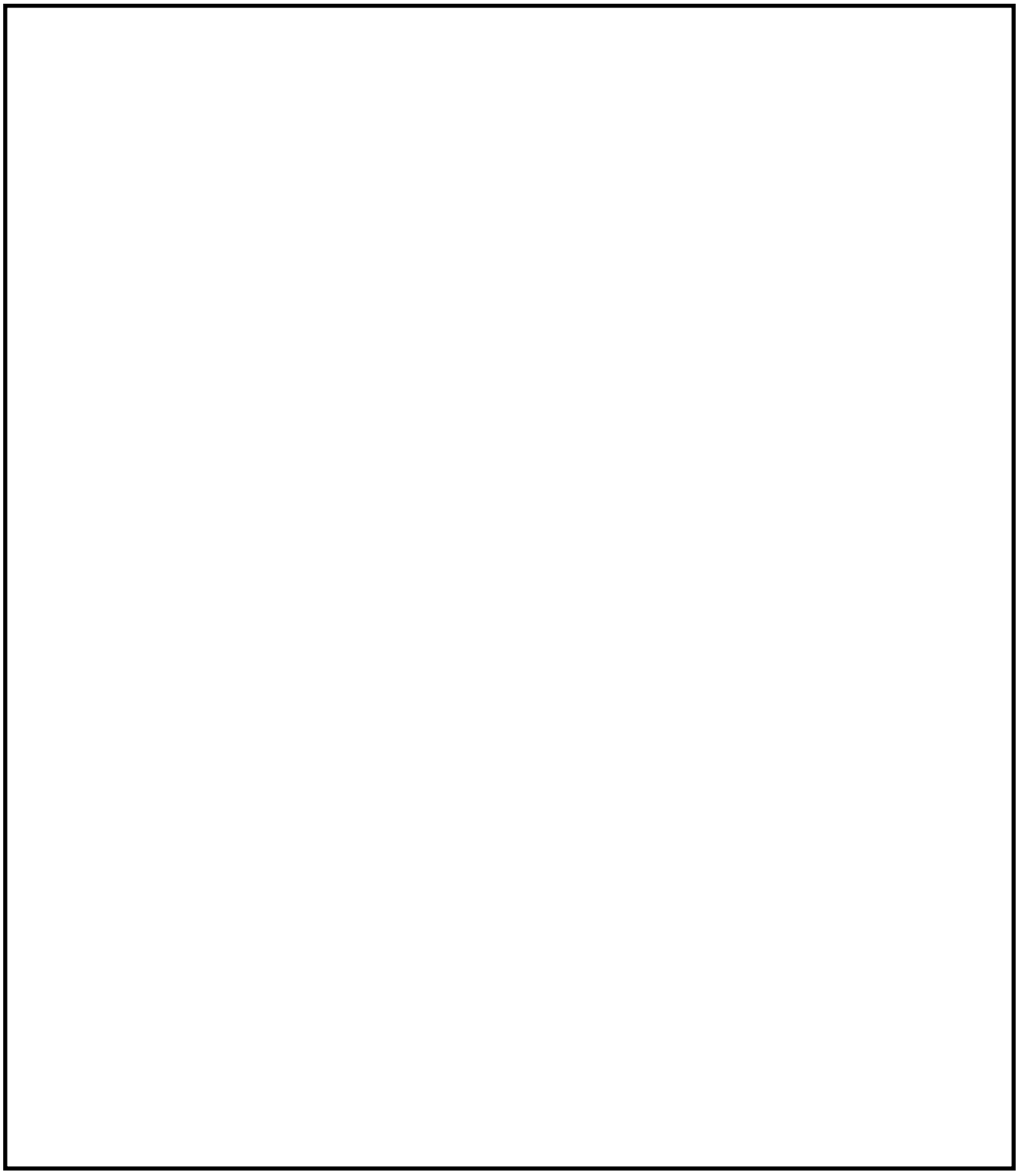


Providers must click the Coverage link on the eligibility response to see applicable coverage details. The *Coverage Details* panel (Figure 2) shows all member eligibility information available for the member for the specified dates, as applicable. The response contains the following information:



- *Benefit Limits* shows limits on services based on the member's eligibility, including information for the services, and dollar limits used and available for the member.
- *Managed Care Assignment* shows the managed care entity (MCE) that the member is enrolled with, along with applicable primary medical provider (PMP) information associated with the member.
- *Right Choices Program* indicates that the member is locked-in to certain service providers.
- *Waiver Liability* shows the member's waiver liability obligation amount and the waiver liability balance for the coverage period. This includes liability information for members with End Stage Renal Disease (ESRD) who are covered through Indiana's 1115 waiver.
- *Nursing Home/Hospice Level of Care* shows the provider, level of care, and patient liability/obligation amount for the coverage period.
- *Member Demographics* shows the member's demographic information.

Figure 2 – Sample coverage details available through the Eligibility Verification Response panel



Secure Correspondence through the Portal

The new Portal will offer a Secure Correspondence feature for submitting inquiries to the IHCP. All messages sent through the Portal comply with *Health Insurance Portability and Accountability Act* (HIPAA) requirements for the protection of PHI and PII. Users receive automatic acknowledgements that their correspondence was received, with contact tracking numbers for reference. Providers can expect responses to inquiries within one to four business days. Providers should use Secure Correspondence for inquiries such as:

- Policy clarification
- Benefit limit clarification
- Claim resolution (payment/denial/adjustments)
- Claim Administrative Review/appeals requests/questions
- Remittance Advice (RA) questions/requests
- Follow-up questions on previous correspondence

The Secure Correspondence feature allows providers to upload electronic attachments to their submissions. File transfers using this feature are limited by total file size and document type:

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

The Portal will display an error message when the user attempts to transfer files in excess of the maximum allowed size or in formats other than those allowed. Providers are encouraged to scan supporting documentation to create electronic files in the appropriate formats for online submission. Provider inquiries and attachments that do not comply with Portal limitations are still accepted via mail as written correspondence.

Prior authorization enhancements

With the implementation of CoreMMIS, providers will experience enhanced features in the Portal when submitting prior authorization (PA) requests.

- *Uploading electronic attachments:* Providers will have the option of transferring attachments and supporting documentation for PA requests submitted through the Portal as electronic files or of sending them by fax or 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, TIFF/TIF, DOC, DOCX, RTF, and TXT

  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 fax or mail. Attachments and supporting documentation sent by fax or mail must include identifying information to tie them to the proper electronic submission.
- *Prospective authorizations:* The Portal will display up to twenty prospective authorizations associated with the requesting/rendering provider. Prospective authorizations are considered PA requests with current or future service dates.

Fee Schedule Changes

The IHCP Fee Schedule will be updated with *Core*MMIS implementation. The Fee Schedule will continue to provide information regarding fee-for-service reimbursement of all procedure codes pertinent to CMS-1500, and ADA 2006 billers. CoreMMIS updates include some enhancements and new terminology.

- **Service Categories:** The new Fee Schedule indicates a Service Category for all procedure codes, grouping similar types of codes together. These categories do not affect reimbursement or billing restrictions – which are dictated by IHCP policy and IHCP billing guidance. A legend defining each Service Category and the types of codes included in that category will be accessible through the Fee Schedule web page.
- **Manually priced codes:** The Fee Schedule continues to indicate those procedures billable on the CMS-1500 that are manually priced. The new Fee Schedule will include the reimbursement percentages for all manually priced codes. Reimbursement percentages for manually-priced codes billable on the UB-04 will continue to be provided on a chart accessible through the Fee Schedule web page.
- **Service restrictions:** The Fee Schedule continues to indicate minimum and maximum unit restrictions that apply to procedure codes. Restriction information will be enhanced to display age and gender restrictions as well.
- **Rate information:** Providers will see more than one rate on the Fee Schedule for procedure codes that are priced differently based on varying factors included in the claim detail.
- **Excel conversion:** Instructions have been added to convert the Fee Schedule text file into an Excel spreadsheet using a template. Additional instructions are also provided for converting the data using the Excel Wizard or Access Wizard. An Excel version of the Fee Schedule allows providers to use the sort function to filter the data based on any column within the spreadsheet.

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 via email at incoremmis2015im@hpe.com.

QUESTIONS?

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

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