*Core*MMIS *bulletin*

Core benefits – Core enhancements – Core communications

INDIANA HEALTH COVERAGE PROGRAMS BT201674 NOVEMBER 10, 2016

IHCP reminds providers to prepare for the transition to *Core*MMIS on December 5, 2016

On December 5, 2016, the Indiana Health Coverage Programs (IHCP) will replace its current information system, Indiana*AIM*, with the new *Core*MMIS, which stands for Core Medicaid Management Information System. Along with *Core*MMIS, a new interface called the Provider Healthcare Portal (Portal) will replace Web interChange. As *Core*MMIS implementation approaches, providers are reminded of key information that will help make transition to the new system as smooth as possible.

Transition Schedule

As announced in *Core*MMIS *Bulletin* BT201662, the IHCP will suspend business transactions in the current system in the days and hours before *Core*MMIS implementation. These suspensions are necessary to finalize processing in the current system and to convert historical information to the new system. As a reminder, Table 1 summarizes the transition dates for the affected transactions. For details, review *Core*MMIS *Bulletin* BT201662.

Table 1 – Transition schedule for CoreMMIS implementation

Date	Transition
Monday, November 14, 2016	■ Last day paper fee-for-service (FFS) claims and paper FFS claim adjustments will be accepted for processing in Indiana*AIM.* ■ Paper FFS claims and adjustments received after this date will be held until after *Core*MMIS implementation and will be subject to revised *Core*MMIS billing guidance. ■ Last day provider enrollment applications and profile updates will be accepted for processing before *Core*MMIS implementation. ■ Paper provider enrollment transactions received after this date will be held until after *Core*MMIS implementation.

continued

Table 1 – Transition schedule for CoreMMIS implementation (continued)

Date	Transition
Wednesday, November 23, 2016	■ Last day written correspondence will be accepted for processing *before Core*MMIS *implementation.* ■ Written correspondence received after this date will be held until after *Core*MMIS implementation.
Monday, November 28, 2016	■ Last day paper attachments associated with electronic FFS claims will be accepted and matched with the related claim for processing in Indiana*AIM*. (This November 28 deadline was published in *IHCP Bulletin* BT201671 and supersedes the previously announced deadline of November 30.) ■ Paper attachments associated with electronic FFS claims received after this date will not be matched with the related claim for processing until after *Core*MMIS implementation. These claims will be subject to revised *Core*MMIS billing guidance.
Wednesday, November 30, 2016	■ Last day – at 12 noon – electronic batch FFS claims will be accepted for processing in Indiana*AIM*. ■ Last day – at 5:45 p.m. – FFS claims submitted through Web interChange will be accepted for processing in Indiana*AIM*. ■ Final FFS claim-processing cycle in Indiana*AIM*. ■ Last day Indiana Client Eligibility System (ICES) updates will be made in Indiana*AIM*; final updates will be processed and files transmitted by 6 a.m., December 1, 2016. ■ Last day Indiana Medicaid ID cards will be generated in Indiana*AIM*.
Sunday, December 4, 2016	■ Last day – at 6 p.m. – eligibility verification via the Automated Voice Response (AVR) system will be available; eligibility will be based on the November 30, 2016, ICES update. ■ Last day – at 12 midnight – EDI eligibility verification transactions will be processed; eligibility will be based on the November 30, 2016, ICES update.

continued

Table 1 – Transition schedule for CoreMMIS implementation (continued)

Date	Transition
Sunday, December 4, 2016	■ Last day – between midnight and 6 a.m. on December 5, 2016 – eligibility verification via Web interChange will be available; eligibility will be based on the November 30, 2016, ICES update. (Eligibility verification functionality on Web interChange will be disabled after eligibility verification functionality is available on the Portal.) ■ Last day – between midnight and 6 a.m. on December 5, 2016 – Presumptive Eligibility (PE) applications can be processed via Web interChange. (PE functionality on Web interChange will be disabled after PE functionality is available on the Portal.)
Monday, December 5, 2016	■ Electronic batch FFS claims will be accepted for processing in *Core*MMIS. ■ FFS claims submitted through the Portal will be accepted for processing in *Core*MMIS. ■ Paper FFS claims and adjustments held during transition will begin processing in *Core*MMIS. ■ FFS claims suspended or systematically denied in Indiana*AIM* will begin reprocessing in *Core*MMIS. ■ The first ICES update – by 6 a.m. – and file transmittal in *Core*MMIS. ■ Eligibility verification available – by 6 a.m. – through EDI transmissions, the Interactive Voice Response (IVR) system, and the Portal.
Tuesday, December 6, 2016	■ The final Remittance Advice (RA) from Indiana*AIM* will be accessible via Web interChange. (Historical RAs from the last 12 weeks before implementation will continue to be viewable in Web InterChange for 30 days after implementation.)
Monday, December 12, 2016	■ First RA released from *Core*MMIS.
Wednesday, January 4, 2017	■ Last day historical RAs from Indiana*AIM* claim activity will be accessible via Web interChange.

Registering on the Portal

The Portal is available for providers to set up their provider accounts, to identify Portal delegates, and assign roles to delegates. Once authorized, delegates can register in the Portal. It is critical that all Portal accounts be established before *Core*MMIS implementation.

Details about the registration process were announced in *Core*MMIS *Bulletin* *BT201661*. Web-based training (WBT) on how to register is available on the *Provider Healthcare Portal Training* page at indianamedicaid.com. A link to the Portal is provided on the Indiana *Core*MMIS web page at indianamedicaid.com.

Providers and other portal users are reminded of the following key points:

- **Register a *Provider* account on the Portal**
  - A provider account representative must be designated to register the *Provider* account on the Portal.
  - Each service location must have one – and only one – *Provider* account on the Portal.
  - The *Provider* account belongs to the service location. The provider account representative may also create a *Delegate* account for himself or herself.
  - The provider account representative must authorize and assign all delegate (user) roles for the *Provider* account; there is no system restriction on the number of delegates per service location.
  - When a delegate is authorized, the system creates a delegate code. The delegate code must be provided to each delegate before the delegate can register on the Portal.
  - The same delegate may work on behalf of multiple service locations or *Provider* accounts using the same user ID; delegates may have different assigned roles with each.
  - Billing agencies can be delegates if their business relationship requires them to have access to the information available in the Portal. Trading partners do not need Portal access to submit electronic data interchange (EDI) transactions.
- **Delegates must register on the Portal:**
  - Using the delegate code provided by the provider account representative, each delegate must register an account on the Portal.
  - For recordkeeping purposes, delegates must report their *Delegate* account information to the provider account representative.

- **Key things to remember about Portal registration**
  - A valid email address is required to register.
  - Each user ID must be unique; the system will ensure that the user ID entered is not already being used by someone else.
  - Portal passwords:
    - ⇒ Cannot be the same as the provider's user ID
    - ⇒ Must be 8-20 characters long
    - ⇒ Can contain letters, numbers, and special characters
    - ⇒ Must contain at least one number, one uppercase letter, and one lowercase letter
    - ⇒ Are case-sensitive
  - When all registration information has been entered, users must **verify** their account registration to complete the registration process. Users receive an account verification email and must follow its instructions to verify their account.
  - When registration is complete, users receive a *User Successfully Registered* pop-up message and a confirmation email with the user's Portal username and password.
  - Providers who do not receive a registration email should check their spam or junk email folders to see if the email is there. If providers are still unable to find the email, providers should click **Contact Us** at the top of the Portal page to find the telephone number for the Electronic Solutions Help Desk and call for assistance.
  - Passwords on all Portal accounts must be changed every 60 days. If a password has not been changed within the past 60 days, the user will be required to update the password before being able to log in. (Note: This is a change from previous communications that indicated passwords had to be reset every 30 days.)
  - Users who mistype the password five times will be locked out of the Portal for 60 minutes. After the lockout expires, users can log in with the correct user ID and password.
  - Users can get help with forgotten user IDs and passwords.
    - ⇒ Forgotten user IDs – Click **Forgot User ID?** The user will be asked to provide the account security qualifiers that they used during registration. Upon successful authentication, they will receive their user ID via email.
    - ⇒ Forgotten passwords – Click **Forgot Password?** A temporary password is sent to the user via email.
  - If a delegate leaves an organization, the provider account representative *must deactivate* the delegate's account. Deactivating the delegate's account prevents a delegate from accessing the Portal for that organization after they have left the organization.

Preparing for system and billing changes

The *Core*MMIS system is designed to more accurately and efficiently adjudicate claims in alignment with IHCP policies and procedures and national coding guidelines. The IHCP is also revising billing guidance in some areas to support the new system. Providers should refer to the billing guidance reminders and changes announced in *Core*MMIS Bulletins. Content for each of the billing guidance bulletins is outlined below. For details, click the link to the publication itself.

BT201667:

- *Core*MMIS will systemically apply HIPAA-compliant coding guidelines; certain exceptions exists for occurrence codes.
- Third-party liability (TPL) information is required at the detail level on certain claim types.
- *Core*MMIS will systematically apply National Correct Coding Initiative (NCCI) edits as well as IHCP enhanced code auditing rules resulting in new explanation of benefits (EOB) messages.
- Emergency indicators are required at the claims detail level for emergency services.

BT201669:

- Outpatient billing guidance is revised regarding billing of procedure codes and revenue codes.
- *Core*MMIS will apply Centers for Medicare & Medicaid Services (CMS) guidelines when reimbursing bilateral surgery procedures.
- Home health billing guidance is revised regarding occurrence codes.
- Hospice billing guidance is revised regarding patient status and occurrence codes
- *Core*MMIS will strictly enforce existing IHCP billing guidance regarding renal dialysis billing – including composite rate, non-routine medically necessary laboratory services, and primary diagnosis codes.

BT201671:

- *Core*MMIS will systematically apply restrictions regarding federally qualified health centers (FQHCs) and rural health clinic (RHC) encounters based on primary diagnosis.
- *Core*MMIS will require billing dental services, and related anesthesia services, on the correct claim type.
- Crisis intervention billing guidance is revised regarding use of the HW modifier.
- Medical Review Team billing guidance is revised regarding use of the SE modifier.
- *Core*MMIS will systematically enforce rendering linkages with group provider service locations.
- *Core*MMIS will allow electronic attachments, with some limitations.
- Changes will occur with claim payment and remittance advise access with *Core*MMIS.
- Claims processed in Indiana*AIM* will have new Claim IDs in *Core*MMIS.

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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