*Core*MMIS *bulletin*

Core benefits – Core enhancements – Core communications

INDIANA HEALTH COVERAGE PROGRAMS BT201715 FEBRUARY 14, 2017

IHCP provides additional claim-related guidance for the new *Core*MMIS

The Indiana Health Coverage Programs (IHCP) is providing additional claim-related information and clarification associated with the Core Medicaid Management Information System (*Core*MMIS) implementation.

Searching for Indiana*AIM* claims in the Portal

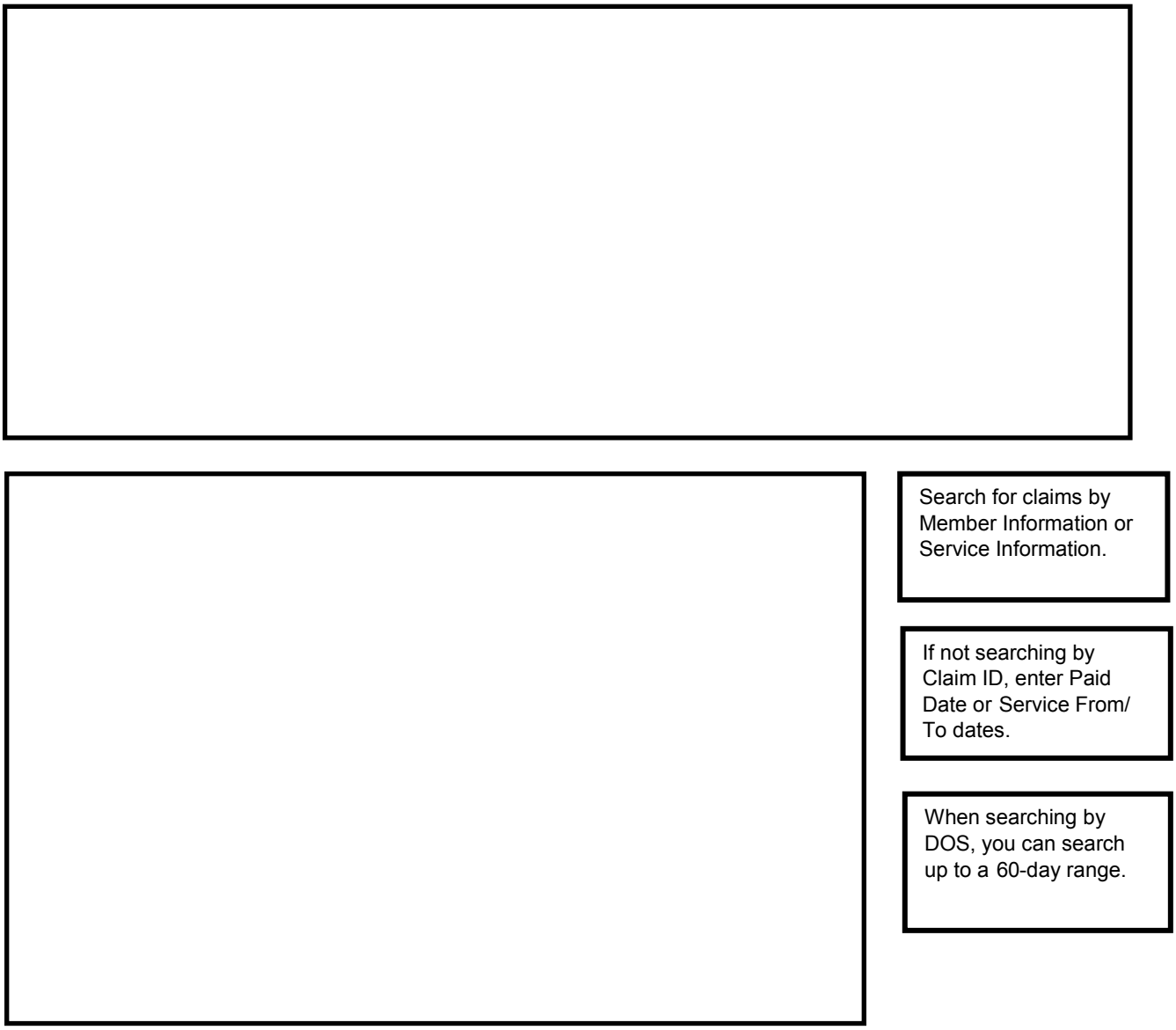
With the implementation of the new *Core*MMIS claim-processing system, seven years of information on claims processed in Indiana*AIM* were converted to *Core*MMIS. Providers can access information on past claims through the Provider Healthcare Portal (Portal). Portal accounts will be linked to Provider IDs. (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 information to search for a claim.

Although claim information will be available in the Portal, claims processed in Indiana*AIM* that were converted to *Core*MMIS will have new claim identification numbers (Claim IDs); the internal control numbers (ICNs) assigned by Indiana*AIM* will not be used. Providers will not be able to search for claims processed in Indiana*AIM* using the old ICNs. Other search criteria will be required to retrieve claim information. After a claim is identified in the new system, providers are encouraged to record the new Claim ID, as needed, for later reference. Use these search criteria in the Portal to find claims processed in Indiana*AIM*:

- Member identification number (Member ID) [formerly known as RID number]
- Claim Type
- From and To DOS
- Claim Status
- Paid Date

See Figure 1 for screenshots of how to access and use the claim search panels in the Portal.

Figure 1 – Searching for claims in the Portal



Changes to region codes

The IHCP has made changes to region codes for the *Core*MMIS. The two-digit region code refers to the submission source assigned to a particular type of claim; for example, a paper claim, an electronic claim, or a mass reprocessing of claims. See Table 1 for the updated codes.

Table 1 – Updated region codes in CoreMMIS

Code	Description
10	Paper claims with no attachments
11	Paper claims with attachments
20	Electronic claims with no attachments
21	Electronic claims with attachments
22	Internet claims with no attachments (web)
23	Internet claims with attachments (web)
24	MCO denied encounter claims
27	HIP encounter claims and HCC Dental (paid and denied) claims
28	HIP Employer Link claims with/without attachments
40	Fee-for-service (FFS) original claim converted from old Medicaid Management Information System [MMIS] to *Core*MMIS
41	Encounter original shadow claim converted from old MMIS
42	FFS original special projects region 90 claims converted from old MMIS
43	Future use
44	Encounter adjusted shadow claims converted from old MMIS
45	FFS adjusted claims converted from old MMIS
47	Encounter voided shadow claims converted from old MMIS
48	FFS voided claims converted from old MMIS
49	History only member link claims
50	Paper single replacement claim, non-check or automatic SUR agency non-check (for partial replacement)
51	Replacement claims, check related (for paper or automatic SUR agency, partial replacement)
52	Mass replacements non-check related

continued

Table 1 – Updated region codes in CoreMMIS (continued)

Code	Description
54	Stale check voids
55	Mass replacement, institutional provider retroactive rate
56	Mass void request or single claim void (paper or SUR full recoupments)
57	Replacements – void check related (paper or SUR full recoupments)
61	Provider replacement – Electronic with an attachment or claim note
62	Provider replacement – Electronic without an attachment or claim note
63	Provider-initiated electronic void
64	Waiver liability (formerly referred to as spend-down) or end-stage renal disease (ESRD) liability end of month (EOM) auto-initiated mass replacement
70	Encounter claims
72	Encounter claims replacements/voids
73	Encounter mass replacements
74	Reprocessed denied encounter claims
80	Reprocessed denied claims
91	Special batch requiring manual review

Updating rendering linkages

IHCP policy requires rendering providers be linked to the specific locations 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. If Dr. Smith practices only at locations A and B, he 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 *Core*MMIS for explanation of benefits (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*.

QUESTIONS?

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

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