

# Life of a Claim

Indiana Health Coverage Programs  
DXC Technology  
Annual Seminar October 2019



# Agenda

- General Requirements
- System Edits
- System Audits
- Pricing Methodologies
- Pending/In Processing
- Claims Adjustments
- Remittance Advice
- Reminder
- Helpful Tools
- Questions



# General Requirements

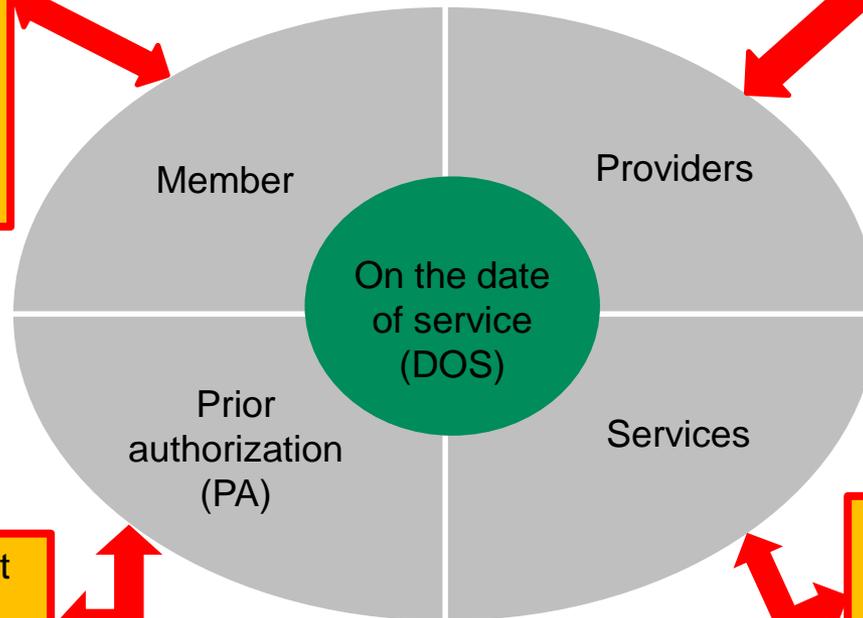


# Criteria Required for Medicaid Coverage

The member must be enrolled in an Indiana Medicaid plan. The provider must verify the member's eligibility before rendering services.

The provider must be enrolled in the Indiana Medicaid:

- Including out-of-state providers
- Rendering provider must be linked to the group provider NPI and service location



If the service requires PA, it must be approved before rendering the service.

The service rendered must be covered by the member's Medicaid plan.

# Life of a Claim

Indiana Health Coverage Programs (IHCP) claims go through the following stages:

**Date of service**

Billing for  
services

Claims  
processing

Reimbursement

- Member must be enrolled and eligible for the service (benefit plan)
- Provider must be eligible to render the service (provider contract)
- Services must be covered under the member's Medicaid plan
- PA is approved (when applicable)
- Billing/group/and rendering providers must be properly enrolled



# Life of a Claim

IHCP claims go through the following stages:

Date of service

**Billing for services**

Claims processing

Reimbursement

- Use correct claim form and billing codes
- Send claim to the right place:
  - Third Party (when applicable)
  - DXC – if fee-for-service (FFS)
  - MCE – if managed care entity (MCE) member
- Include required documentation (when applicable)
- Bill claim within the timely filing limit

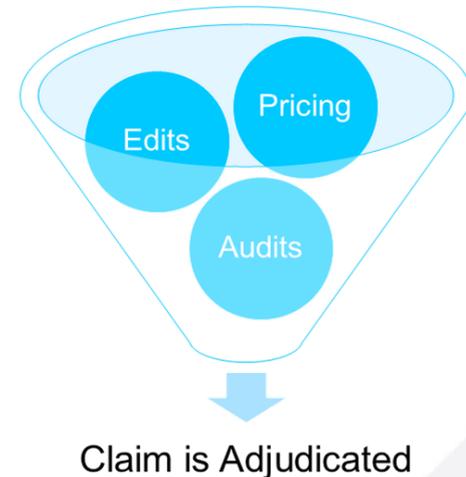


# Life of a Claim

IHCP claims go through the following stages:



- Claims that pass the initial prescreening are loaded into *CoreMMIS* for processing.
  - Paper claims or claims submitted through a clearing house that do not pass the prescreening are rejected and returned to the provider with an explanation of why the claim could not be processed.
- Claims will be processed and adjudicated following the Medicaid federal and state policies and regulations.



# Life of a Claim

IHCP claims go through the following stages:

Date of service

Billing for services

**Claims processing**

Reimbursement

- Verify that all the required information has been submitted, and information is valid, consistent, and in the right format.

- Claim Status:
  - After the weekly financial cycle is run, a remittance advice (RA) is generated to show the provider all their claims adjudicated for that week.



- Determine how to pay or reimburse a benefit.
  - The reimbursement rules define the pricing method by which to pay the service.

- Compare current claim against other paid services on the member's claim history file to ensure:
  - Benefit limitations are not exceeded
  - IHCP does not pay twice for the same service
  - Providers follow appropriate billing practices



# Life of a Claim

IHCP claims go through the following stages:

Date of service

Billing for  
services

Claims  
processing

**Reimbursement**

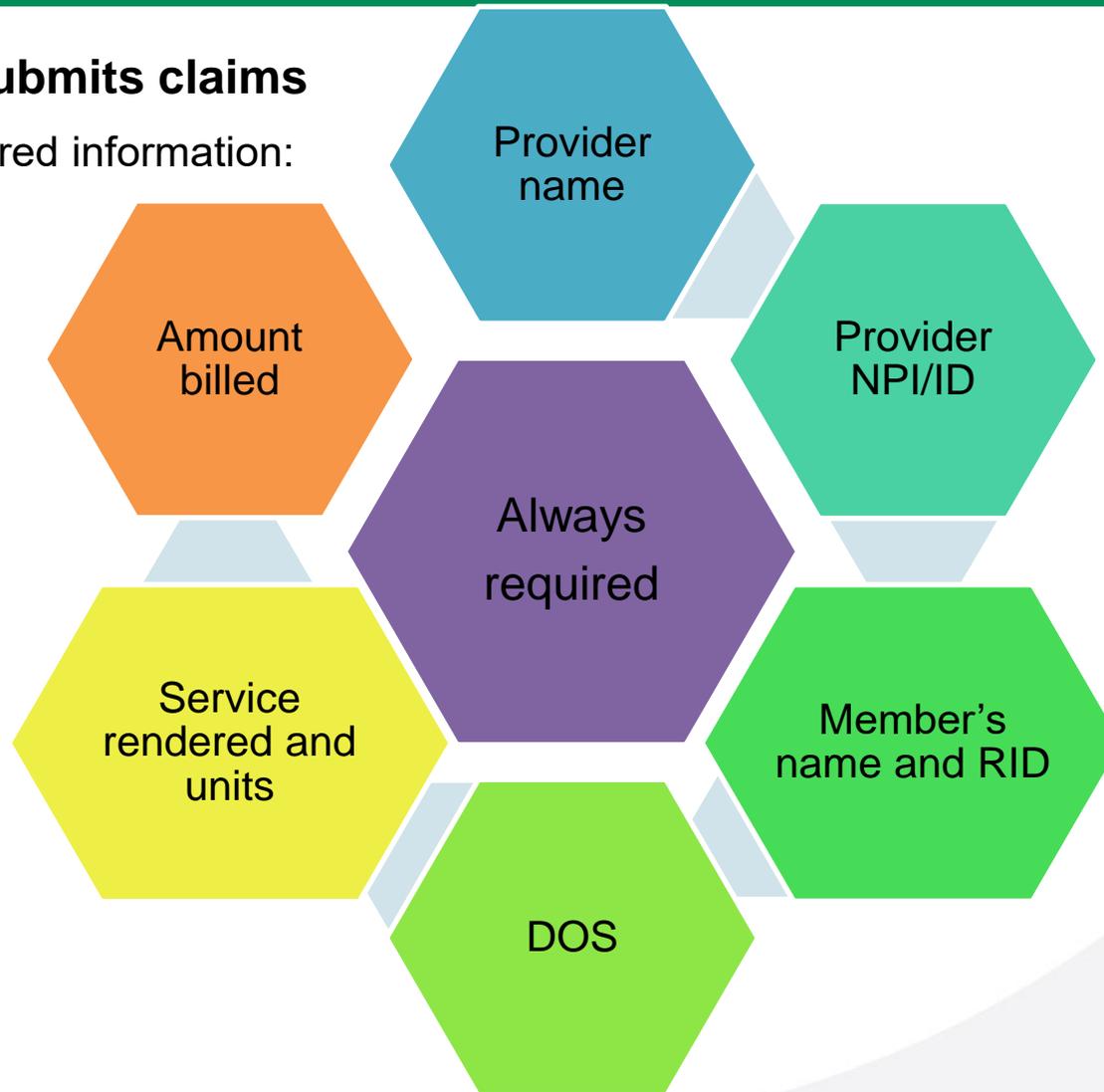
When a claim is adjudicated, and is in a paid status, the provider is reimbursed after the weekly financial cycle has processed.



# Life of a Claim

## Provider submits claims

Claim's required information:



# Life of a Claim

What is the National Provider Identifier (NPI)?

- A standard, unique identifier for healthcare providers
- All healthcare providers must bill using their NPI on all claims.
- Only atypical, non-healthcare providers can bill using their IHCP Provider ID.

NPI Crosswalk:

- CoreMMIS to establish a one-to-one match between the NPI and the service location (Provider ID) where the member was treated.

Three data elements:

- Billing provider NPI
- Billing provider taxonomy code
- Billing provider office location ZIP Code + 4

One-to-one Match



*If CoreMMIS is not able to establish a one-to-one match, the claim will be denied.*

# Internal Control Number (ICN)

- IHCP claims are identified, tracked, and controlled using a unique 13-digit Claim ID assigned to each claim called an ICN.
- The ICN identifies when the claim was received, the claim submission method used, and the claim type.
- The ICN identifies the:
  - **Region code** – Is identified by two digits or the submission media used (paper or electronic) and whether it is a new claim or an adjusted claim  
XX00000000000
  - **Year** – Is identified by two digits to the calendar year the claim was received  
00XX000000000
  - **Julian date** – Is identified by three digits to the date the claim was received  
0000XXX000000
  - **Batch range** – First three digits after the Julian date indicates the type of claim submitted  
0000000XXX000
  - **Sequence** within a batch – Last three digits identifies the claim's number within each batch  
0000000000XXX

# ICN Region Codes (First Two Digits of ICN)

## Common region codes:

- 10 Paper claims with no attachments
- 11 Paper claims with attachments
- 20 Electronic claims (837 transaction) with no attachments
- 21 Electronic claims (837 transaction) with attachments
- 22 Internet claims (Provider Healthcare Portal) with no attachments
- 23 Internet claims (Provider Healthcare Portal) with attachments
- 50 Paper single replacement claim, non-check
- 51 Replacement claims, check related
- 55 Mass replacement, institutional provider retroactive rate
- 56 Mass void request or single claim void
- 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
- 80 Reprocessed denied claims
- 91 Special batch requiring manual review

# Prior Authorization

According to the IHCP regulations, providers must request PA for certain services:

- to **determine medical necessity**, or
- when **normal limits are exhausted** for certain services

The main purpose of the PA process is to ensure that Indiana Medicaid funding is utilized only for those services that are:

Medically Necessary

Appropriate

Cost Effective



*PA is not a guarantee of payment.*



# Prior Authorization Administrator

- DXC Technology is the PA contractor for non-pharmacy services in the Fee-for-Service delivery system.
- The DXC PA department reviews all PA requests on an individual, case-by-case basis.
- The DXC decision to authorize, modify, or deny a given request is based on medical necessity, appropriateness, and other criteria.
- Refer to bulletin [BT201957](#) for information about the change from Cooperative Managed Care Services to DXC for prior authorization.

**FFS**  
**Non-pharmacy**

**DXC**

**1-800-269-5720**  
**1-800-689-2759 (fax)**

*Please contact the member's MCE for PA information.*



# Is the service covered by IHCP Program?

- In order for the provider to be reimbursed for services rendered, the provider must make sure that the service is covered by the member's benefit plan.
- When a PA is required, the PA must be requested and approved before the service is rendered.
- A provider can verify if a service is covered by the member's benefit plan and/or whether it requires PA by referring to the fee schedules, accessible from the [IHCP Fee Schedules](https://www.in.gov/medicaid/providers) page at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers).



*PA belongs to the member, not the provider.*

# IHCP Fee Schedules

- *Professional Fee Schedule*

The *Professional Fee Schedule* is updated weekly. This fee schedule includes reimbursement information for providers that bill services using professional claims and dental claims reimbursed under the FFS delivery system.

- *Outpatient Fee Schedule*

The IHCP publishes the rates for outpatient hospitals and Ambulatory Surgical Centers (ASCs) in the *Outpatient Fee Schedule*. This fee schedule reflects current IHCP coverage and reimbursement rates for procedure codes billed for IHCP outpatient services. It is updated monthly to reflect any change to methodology.

# Professional Fee Schedule

**Procedure Code:** Enter at least three characters of the Procedure Code to filter by specific Procedure Code. This search criteria cannot be used in combination with the Procedure Code Range criteria.

**Procedure Code Range:** Enter a beginning and ending five-character Procedure Code to obtain all Procedure Codes within a range. This search criteria cannot be used in combination with the Procedure Code criteria.

**Procedure Code Description:** Enter a text string to obtain records containing the entered text in either the short or long Procedure Code Description. This search criteria can be used in combination with the Procedure Code or the Procedure Code Range criteria.

**Procedure Code:**   
**Procedure Code Range:**  to   
**Procedure Code Description:**

*The Professional Fee Schedule is updated weekly.*

\* Code values are described on the [Fee Schedule Instructions](#) page.

1

Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Service Category	Service			Pricing		PA	
						Category Desc	Rate Type	Pricing Method	Effective Date	Pricing End Date	Req'd	Attach Req'd
92507					THEPY	Therapy Services	Def	RBRVS	2/1/2015		Y	
<b>Min-Max Units</b>	0 - 1				<b>Fee Schedule Amt:</b>	\$57.88	<b>Base Units:</b>			<b>Age Min-Max:</b>		
<b>Procedure Desc:</b>	SPEECH/HEARING THERAPY					<b>CMS Add Date:</b>		1/1/1984	<b>CMS Term Date:</b>			



# Outpatient Fee Schedule

## Outpatient Fee Schedule

The Outpatient Fee Schedule is intended for use by outpatient hospitals and ambulatory surgical centers (ASCs) that bill services using institutional claims (UB-04 claim form or electronic equivalent) under the fee-for-service or the managed care service delivery systems.

- The Outpatient Fee Schedule reflects IHCP coverage and reimbursement policy for individual procedure codes. It is updated regularly to reflect any change in policies. Schedules reflecting the most recent updates are posted for your reference.
  - [Outpatient Fee Schedule – Effective July 1, 2019](#)
  - [Outpatient Fee Schedule – Effective June 1, 2019](#)
  - [Outpatient Fee Schedule – Effective May 1, 2019](#)
  - [Outpatient Fee Schedule – Effective April 1, 2019](#)
  - [Outpatient Fee Schedule – Effective March 1, 2019](#)
  - [Outpatient Fee Schedule – Effective February 1, 2019](#)

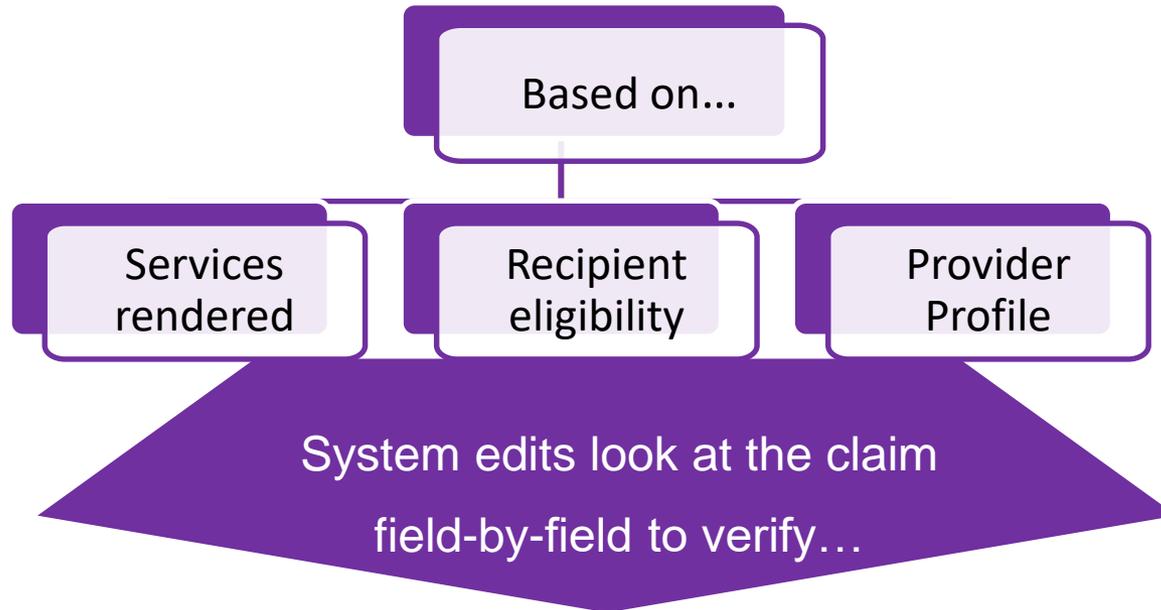
*The Outpatient Fee Schedule is updated monthly and posted as a Microsoft Excel document.*



# System Edits



# Claim Processed by CoreMMIS System Edits



- If all the required information has been submitted.

- If the information is valid and in the right format.

- If there is consistency in the information submitted throughout the claim.

# Claim Processed by CoreMMIS System Edits



- Edits:
  - Verify and validate claim data
  - Check the information entered (or missing) in specific fields of the claim
  - Ensure that the information submitted by the provider is valid and in the correct format
  - Are not intended to exclude services
- Claims that **do not** pass the system edit review are **denied or suspended** for further review, depending on the specific edit.

# Claim Processed by CoreMMIS

## Examples of System Edits/EOB Codes

CoreMMIS claim system		Provider remittance advice	
Edit code	Description	EOB code	Description
0545	Claim Past Filing Limit (PFL)	0545	Claim Past Filing Limit (PFL)
1002	Render Provider Not Eligible	1004	Rendering Provider Not Enrolled At The Service Location
1010	Render Provider Not Member Of Billing Provider Group	1010	Rendering Provider Is Not An Eligible Member Of The Billing Group or Group Provider Number
2504	Member Covered By Private Insurance	2505	This Member Is Covered By Private Insurance Which Must Be Billed Prior To Medicaid
3001	Prior Authorization Not Found	3001	Dates Of Service Not On The P.A. Master File
5000	Possible Duplicate	5000	This Is A Duplicate Of Another Claim

# Claim Processed by CoreMMIS

## National Correct Coding Initiative Edits

- As required by National Correct Coding Initiative (NCCI), the IHCP implemented two types of edits within the CoreMMIS claim-processing system:
  - NCCI Procedure-to-Procedure (PTP) Edits
  - Medically Unlikely Edits (MUEs)
- The IHCP applies Medicaid NCCI methodologies of MUEs and PTP edits for the following types of services:
  - Medical services billed on professional claims (applicable for practitioner and ambulatory surgical centers)
  - Outpatient services in hospitals (including emergency department, observation, and hospital laboratory services)
  - Durable medical equipment

# System Audits



# Claim Processed by CoreMMIS System Audits



## **IHCP Policies**

**All Indiana health coverage programs have certain limitation of services, which are determined by IHCP Medical Policy (state and federal regulations).**

- All programs under the IHCP have certain service limitations
- The extent of these limitations is determined by the aid categories and defined by state and federal regulations
  - These regulations are usually referred to as the IHCP medical policy
  - The Family and Social Services Administration (FSSA) is responsible for establishing medical policy guidelines



# Claim Processed by CoreMMIS System Audits

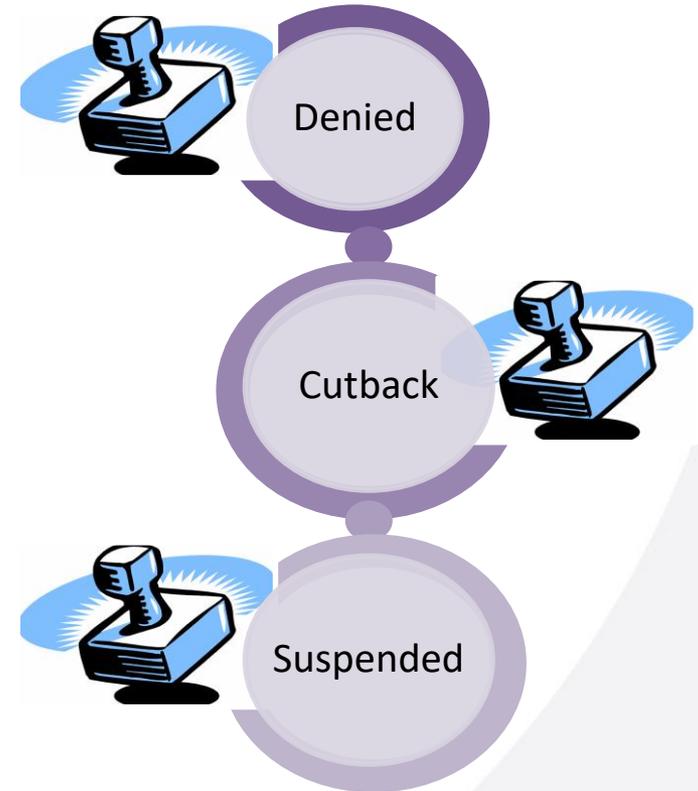


**Audits are designed to monitor or regulate the IHCP medical policy.**

- Audits:
  - Compare current claim against all other paid services on the member's claim history file to ensure that:
    - Benefit limitations are not exceeded for that member
    - Medicaid does not pay twice for the same claim (service)
  - Ensure that providers follow appropriate billing practices.
  - Ensure State and federal regulations regarding the frequency, extent, length of stay, and cost of service are followed.

# Claim Processed by CoreMMIS System Audits

- If the claim fails any of the system audits, and depending on the specific audit, the claim can be:
  - Systematically denied
  - Systematically cut back (pays only a portion of the units billed)
  - Suspended



# Pricing Methodologies



# Claim Processed by CoreMMIS

## Pricing Methodology

- After claims have passed the system edits and audits, they are subjected to pricing review.
- CoreMMIS determines whether or not the claim can be automatically priced, or needs to be suspended for manual pricing.
- This determination is based on:
  - Claim type
  - Procedure-specific pricing indicator
  - Provider specialty
  - DOS

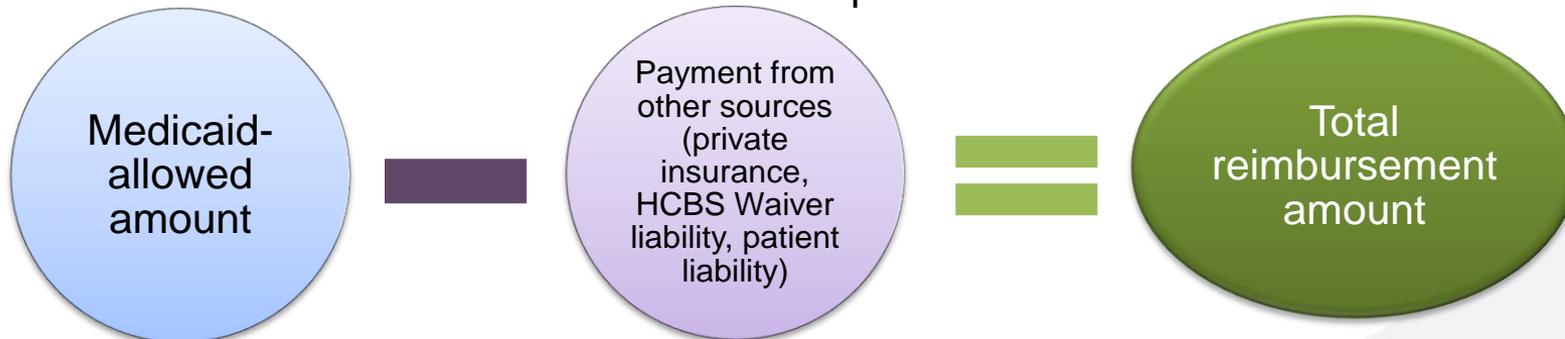


# Claim Processed by CoreMMIS

## Pricing Methodology



- The claim pricing process calculates the Medicaid-allowed amount for claims based on claim type, pricing modifiers, and defined pricing methodologies:
  - Based on the claim type, CoreMMIS directs the claim to the appropriate pricing methodology.
  - If a third-party liability (TPL) amount is present, the system subtracts this figure, plus applicable spend-down, copays and patient liability from the IHCP-allowed amount to get the amount paid.



# Claim Processed by CoreMMIS

## Example of Pricing Methodologies

Pricing methodology	Applied to....
Diagnosis-Related Group (DRG)	Inpatient services
Procedure code max fee or revenue code flat rate	Outpatient services
Resource-Based Relative Value Scale (RBRVS)	Physician medical services
Overhead cost rate/staffing cost rate	Home Health services
Max fee	Dental
Lab fee	Lab services
Manual pricing	Durable medical equipment (DME) services
Level of Care (LOC)	LTC, IP Psychiatric, burn, rehab

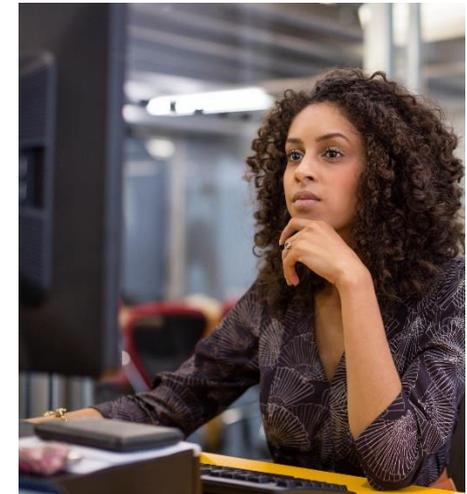
# Pending/In Processing

*Suspended Claims*



# Claim Adjudicated Pending/In Process - Suspended

- When a claim suspends, processing is suspended until the edit causing the failure is manually reviewed and resolved:
  - Adjustments that fail any edit or audit are routed to the DXC Adjustment Unit or the appropriate medical policy department.
  - Medical policy edit and audit failures are routed to the DXC Medical Policy department.
  - Prepayment provider review edits are routed to Prepayment Review (PPR) staff within the FSSA Program Integrity team.
  - The remaining edit and audit failures are routed to the DXC Claims Resolution Unit.



# Claim Adjustments



# Claim Adjustments

- A voided claim results in the full recoupment of the originally paid claim.
- A replacement claim is a paid claim reprocessed with the appropriate modifications.
- There are three types of claim adjustments:
  - Check-related adjustments
  - Non-check-related adjustments
  - Mass adjustments, including mass replacements for retroactive rate adjustments for long-term care facilities and end-of-month adjustments for waiver liability



# Claim Adjustments

Check-related

- Claim Adjustments:
  - Initiated when an excess payment has been made
  - The provider sends a check in the amount of the excess payment with the adjustment form and appropriate attachments
  - Check-related adjustment is called a refund
  - Provider can refund a partial payment on a claim or the entire payment on a claim

# Claim Adjustments

- Claim adjustments initiated by a provider due to an underpayment or overpayment that do not include a refund check from the provider
- Types of non-check-related adjustments:
  - Underpayment adjustment – adjustment was requested because provider was underpaid; adjustment is processed based on the adjustment request form and appropriate documentation
  - Overpayment adjustment – request is to adjust an overpayment, the overpaid amount is deducted from future claim payments through an accounts receivable adjustment.
  - Full claim overpayment – request is to void the claim; the accounts receivable can be set up to recoup the entire amount of the claim.

Noncheck-  
related



# Claim Adjustments

Mass  
adjustment

*FSSA, HMS, Myers and Stauffer, or DXC can initiate a mass adjustment.*

- Mass adjustments are initiated when a unique set of claims are identified as requiring an adjustment due to new policies or special circumstances.
- Mass adjustment requests are applied to change a large number of paid claims at one time:
  - Positive adjustments, or additional money to the provider, are corrected by additional payment through the regular claim payment process.
  - Negative adjustments, or money owed to the IHCP, are recouped through the accounts receivable function and are usually collected through the offset of future claims payments



# Claim Adjustments

- Retroactive rates for LTC facilities are initiated when Myers and Stauffer updates a per diem rate for a specific time frame.
- CoreMMIS reprocesses all claims submitted by the provider for the DOS affected by the retroactive rate adjustment.

Retroactive rate  
for LTC facilities



# Remittance Advice



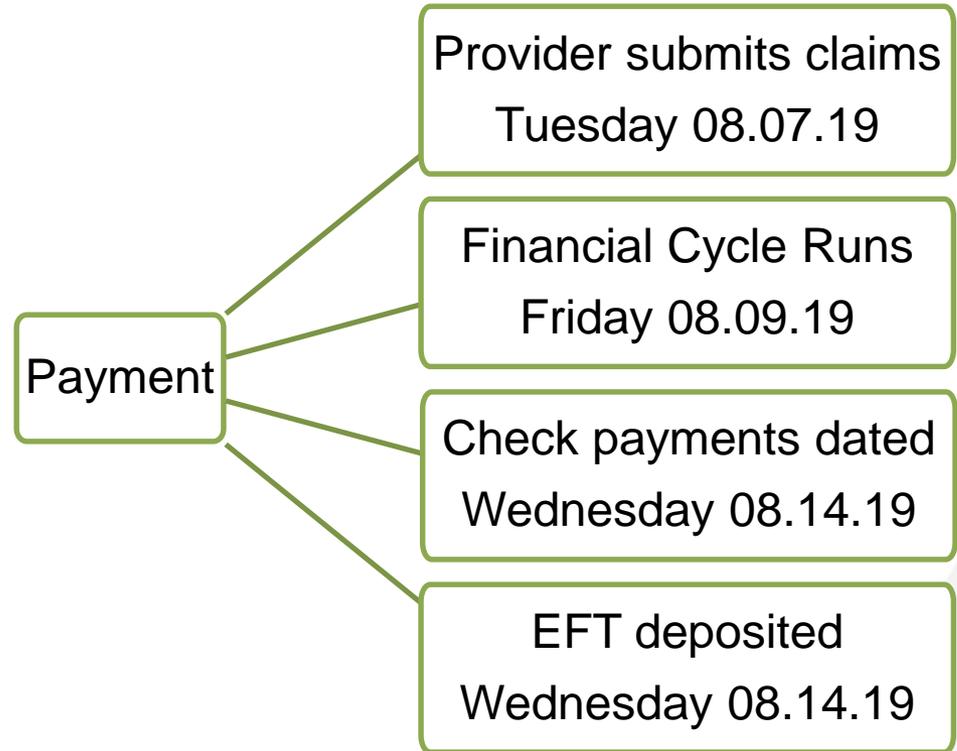
# Remittance Advice

- Remittance Advice (RA) statement provides information about claim processing and financial activity:
  - Sorts according to claim type and status (paid, denied, in-process)
- RA provides information about in-process claims, suspended claims, and adjudicated claims that are paid, denied, or adjusted.
- RA statements are available to providers via the Provider Healthcare Portal for downloading and saving.



# Remittance Advice

- The IHCP financial cycle runs every Friday.
- Payments are calculated based on paid claims.
- Check payments are dated for the Wednesday following the financial cycle.
- Electronic Funds Transfer (EFT) payments are deposited to the provider's designated bank account each Wednesday following the financial cycle.



# Remittance Advice

## Search Results

To see payment details, click on the Payment ID link.

To access a copy of the Remittance Advice, select the RA icon. Access to the RA will require Adobe Acrobat Reader.

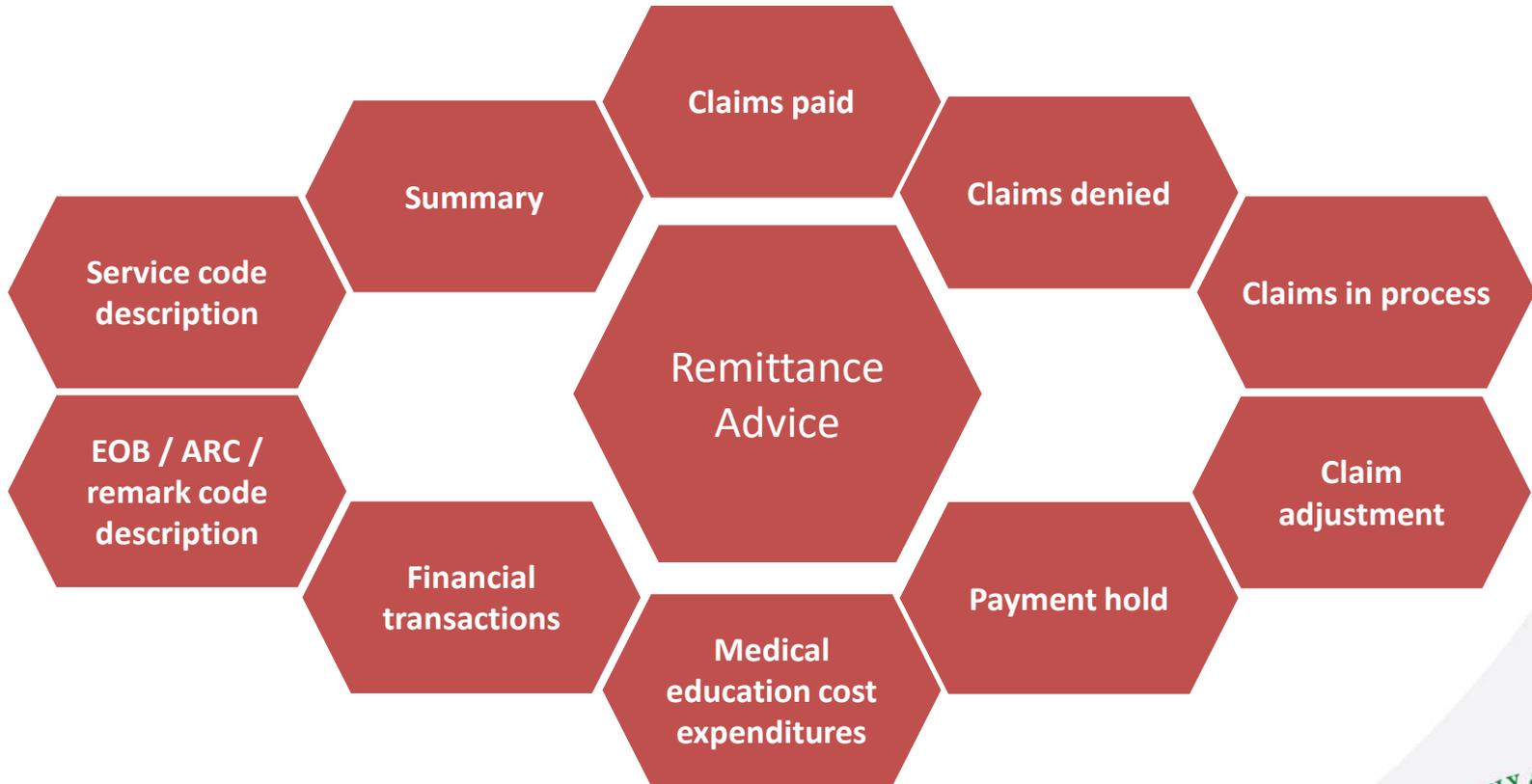
Total Records: 14

<u>Issue Date</u> ▼	<u>Payment Method</u>	<u>Payment ID</u>	<u>Total Paid Amount</u>	<u>RA Copy (PDF)</u>
05/22/2019	Check		\$0.00	
05/15/2019	Check		\$0.00	
05/08/2019	Check		\$0.00	
05/01/2019	EFT		\$713,094.24	

1 2

*The Remittance Advice opens in a PDF file.*

# Remittance Advice



# Reminder



# Claim Filing Limit

- The IHCP mandated a 180-day filing limit for FFS claims, effective January 1, 2019. Refer to [BT201829](#), published on June 19, 2018, for additional details.
- The 180-day filing limit is effective based on DOS:
  - Claims for services rendered on or after January 1, 2019, are subject to the 180-day filing limit.
  - Claims with DOS before January 1, 2019, are subject to the one-year filing limit.



# Helpful Tools



# Helpful Tools

## Provider Relations Consultants



REGION	FIELD CONSULTANT	EMAIL	TELEPHONE	COUNTIES SERVED
Illinois Michigan	1 Jean Downs	INXIXRegion1@dxc.com	(317) 488-5071	Dekalb, Elkhart, Fulton, Jasper, Kosciusko, LaGrange, Lake, LaPorte, Marshall, Newton, Noble, Porter, Pulaski, St. Joseph, Starke, Steuben, Whitley Chicago, Watseka Sturgis
Illinois	2 Shari Galbreath	INXIXRegion2@dxc.com	(317) 488-5080	Allen, Adams, Benton, Blackford, Cass, Carroll, Clinton, Delaware Fountainm Grant, Howard, Hutington, Jay, Madison, Miami, Montgomery, Randolph, Tippecanoe, Tipton, Wabash, Warren, Wells, White Danville
	3 Crystal Woodson	INXIXRegion3@dxc.com	(317) 488-5324	Boonem Hamilton, Hendricks, Johnson, Marion, Morgan
	4 Ken Guth	INXIXRegion4@dxc.com	(317) 488-5153	Clay, Crawford, Daviess, Dubois, Gibson, Greene, Knox, Lawrence, Martin, Orange, Owen, Parke, Perry, Pike, Posey, Putnam, Spencer, Sullivan, Vanderbirgh, Vermillion, Vigo, Warrick Owensboro
Kentucky Ohio	5 Virginia Hudson	INXIXRegion5@dxc.com	(317) 488-5186	Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Hancock, Henry, Jackson, Jennings, Monroe, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington, Wayne Louisville Cincinnati, Harrison, Hamilton, Oxford
	Judy Green		(317) 488-5026	All other out of state areas not previously listed
Team Lead	Jenny Atkins		(317) 488-5032	

# Helpful Tools

## IHCP website at [in.gov/medicaid/providers](http://in.gov/medicaid/providers):

- *IHCP Provider Reference Modules*
- *Medical Policy Manual*
- Contact Us – Provider Relations Field Consultants

## Customer Assistance available:

- Monday – Friday, 8 a.m. – 6 p.m. Eastern Time
- 1-800-457-4584

## Secure Correspondence:

- Via the Provider Healthcare Portal
  - (After logging in to the Portal, click the **Secure Correspondence** link to submit a request)



# Questions

Please review your schedule for the next session  
you are registered to attend



# Session Survey - Tuesday

Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.



<https://tinyurl.com/fssa1048>



# Session Survey - Thursday

Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.



<https://tinyurl.com/fssa1061>

