MCE Process 101

Indiana Medicaid Advisory Committee Meeting – November 15, 2018

CareSource™

Utilization Management (UM)

also known as Prior Authorization (PA)

Confidential & Proprietary

Prior Authorization

Who determines it?

- The MCE must operate and maintain its own utilization management program
- The MCE may limit coverage based on medical necessity or utilization control criteria, provided the services furnished can reasonably be expected to achieve their purpose
- The MCE is prohibited from arbitrarily denying or reducing the amount, duration, or scope of required services, solely because of diagnosis, type of illness, or condition

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Prior Authorization

What is it?

- The MCE may accept a nationally recognized set of guidelines, including but not limited to Milliman Care Guidelines or InterQual
- Additional considerations:
  - ASAM
  - IAC
  - Right Choices Program
  - Clinical Guidance
  - DUR Board
  - Medicaid Contract
  - IHCP Provider Reference Modules
  - IHCP Bulletins and Banners

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Prior Authorization

When *is* it needed?

- Inpatient care – *always*
- Continuation of emergent care
- Surgery
- Changes in level of care
- Non-contracted providers
- Right Choices Program
- and more…

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Prior Authorization

When is it *not* needed?

- Preventative services
- Self-referral services
- Emergencies
- Ongoing care
- Home health post-discharge
- Preferred drug list
- And more…

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Prior Authorization

Where is the information?

- Code of federal regulations (CFR)
- Indiana administrative code (IAC), 405 IAC 5-3
- IndianaMedicaid.com
  - Banners, bulletins, medical policy manual, PA module, etc.
- MCE websites

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Prior Authorization

Where is the information?

Procedure Code: 96152
Procedure Code Range: to
Procedure Code Description:
Submit

* Code values are described on the Fee Schedule Instructions page.
View ASC Code Pricing information by clicking on the ASC Code, or you can view the entire ASC Pricing Table.
View a chart of reimbursement percentages for manually priced CPT codes with effective dates for UB-04.

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Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Service Category	Service Category Desc	Rate Type	Pricing Method	Pricing Effective Date	Pricing End Date	PA Req'd	Attach Req'd	Gender
96152*					MENTL	Mental Health	Def	RBRVS	2/1/2015		Y		
Min-Max Units	0 - 6				**Fee Schedule Amt:**	$15.47		**Base Units:**		**Age Min-Max:**	0 - 21	**ASC Code:**	
Procedure Desc:			INTERVENE HLTH/BEHAVE INDIV					**CMS Add Date:**		1/1/2002	**CMS Term Date:**		
96152*	U3				MENTL	Mental Health	Def	MAXFEE	2/6/2016		Y		
Min-Max Units	0 - 6				**Fee Schedule Amt:**	$11.60		**Base Units:**	0	**Age Min-Max:**	0 - 21	**ASC Code:**	
Procedure Desc:			INTERVENE HLTH/BEHAVE INDIV					**CMS Add Date:**		1/1/2002	**CMS Term Date:**		

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Prior Authorization

Where is the information?

MCE Websites, for *all* the programs:

- HIP Plus (x4)
- HIP Basic (x4)
- HIP State Plan Plus (x4)
- HIP State Plan Basic (x4)
- HIP Maternity (x4)
- HIP Plus Copay (x4)
- Presumptive Eligibility (x4)
- Hoosier Healthwise (x4)
- Hoosier CareConnect (x2)

34 Programs!

Don’t forget: fee-for-service, Medicaid rehabilitation option, waiver programs, and others…

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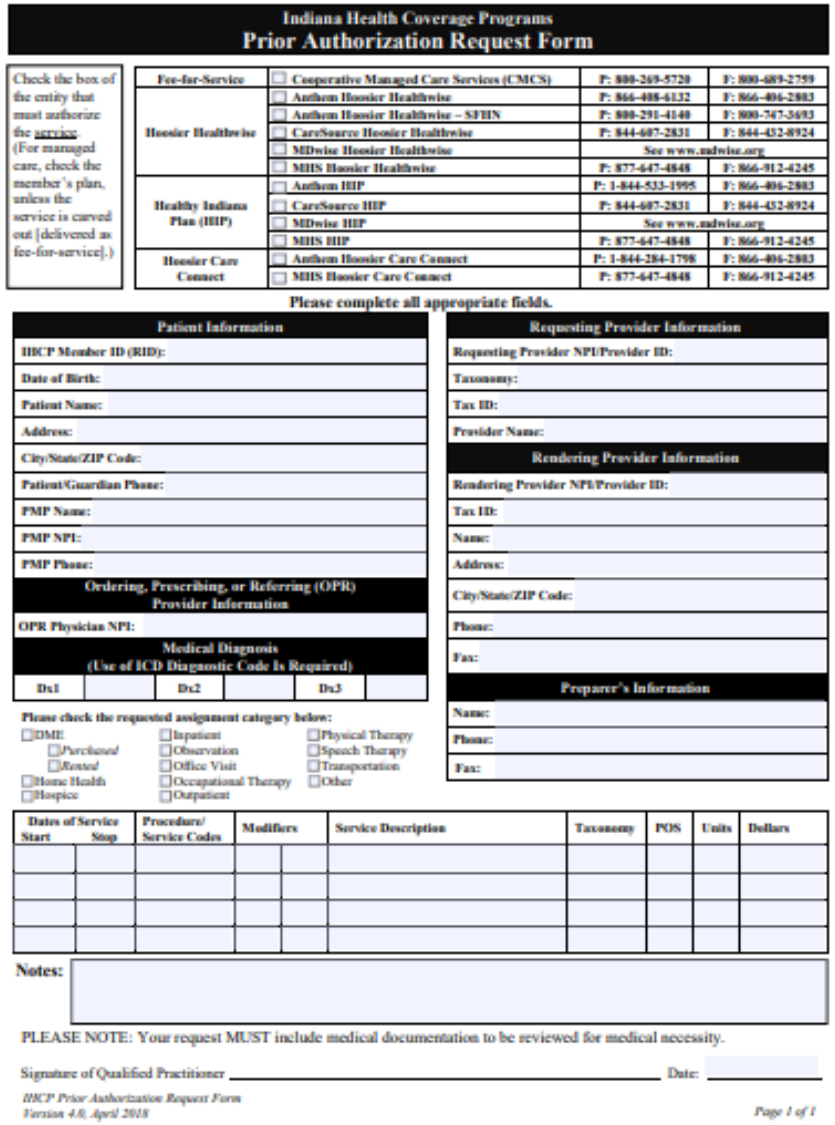
Prior Authorization

Where is the information?

- Pièce de résistance:

  Universal PA



Indiana Health Coverage Programs
Prior Authorization Request Form

Check the box of the entity that must authorize the service. (For managed care, check the member's plan, unless the service is carved out [delivered as fee-for-service].)

Fee-for-Service	☐ Cooperative Managed Care Services (CMCS)	P: 800-269-5720	F: 800-689-2759
Hoosier Healthwise	☐ Anthem Hoosier Healthwise	P: 866-488-6132	F: 866-406-2883
	☐ Anthem Hoosier Healthwise – SFHN	P: 800-291-4140	F: 800-747-3693
	☐ CareSource Hoosier Healthwise	P: 844-607-2831	F: 844-432-8924
	☐ MDwise Hoosier Healthwise	See www.mdwise.org	
	☐ MHS Hoosier Healthwise	P: 877-647-4848	F: 866-912-4245
Healthy Indiana Plan (HIP)	☐ Anthem HIP	P: 1-844-533-1995	F: 866-406-2883
	☐ CareSource HIP	P: 844-607-2831	F: 844-432-8924
	☐ MDwise HIP	See www.mdwise.org	
	☐ MHS HIP	P: 877-647-4848	F: 866-912-4245
Hoosier Care Connect	☐ Anthem Hoosier Care Connect	P: 1-844-284-1798	F: 866-406-2883
	☐ MHS Hoosier Care Connect	P: 877-647-4848	F: 866-912-4245

Please complete all appropriate fields.

Patient Information

- IHCP Member ID (RID):
- Date of Birth:
- Patient Name:
- Address:
- City/State/ZIP Code:
- Patient/Guardian Phone:
- PMP Name:
- PMP NPI:
- PMP Phone:

Ordering, Prescribing, or Referring (OPR) Provider Information

- OPR Physician NPI:

Medical Diagnosis (Use of ICD Diagnostic Code Is Required)

Dx1		Dx2		Dx3	

Requesting Provider Information

- Requesting Provider NPI/Provider ID:
- Taxonomy:
- Tax ID:
- Provider Name:

Rendering Provider Information

- Rendering Provider NPI/Provider ID:
- Tax ID:
- Name:
- Address:
- City/State/ZIP Code:
- Phone:
- Fax:

Preparer's Information

- Name:
- Phone:
- Fax:

Please check the requested assignment category below:

☐ DME ☐ *Purchased* ☐ *Rented* ☐ Home Health ☐ Hospice
☐ Inpatient ☐ Observation ☐ Office Visit ☐ Occupational Therapy ☐ Outpatient
☐ Physical Therapy ☐ Speech Therapy ☐ Transportation ☐ Other

Dates of Service Start	Stop	Procedure/ Service Codes	Modifiers		Service Description	Taxonomy	POS	Units	Dollars

Notes:

PLEASE NOTE: Your request MUST include medical documentation to be reviewed for medical necessity.

Signature of Qualified Practitioner _____ Date: _____

IHCP Prior Authorization Request Form
Version 4.0, April 2018

Page 1 of 1

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Prior Authorization

Why have it?

- Care Management
- Disease Management
- Utilization of Services (under and over)
- Fraud, Waste, and Abuse (FWA)
- Quality of Care
- Health Outcomes
- Early Detection

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Prior Authorization

How do I get a Prior Authorization?

- Call me
- Fax me
- Hit me up online

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Prior Authorization

Questions?

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Claims Process

Providing health coverage to Indiana families since 1994

Claims Submission

Claim Submission Timelines:

- Contracted or In-Network providers: 90 calendar days from the date of service or discharge date.
- Non-Contracted or Out-of-Network providers:
- 365 calendar days from the date of service or discharge date
- **Effective January 1, 2019** 180 calendar days from the date of service or discharge date

Exceptions:

- Newborns: Services rendered within the first 30 days of life have a 365 day timely filing limit.

Claims Submission Continued

Billing requirements for *CMS-1500*:

- Box 24J –rendering provider NPI
- Box 33 –group/billing provider's address/service location on file with IHCP-complete address with complete 9-digit zip code
- Box 33A –billing provider NPI
- Box 33B –billing taxonomy code

Billing requirements for UB-04

- Box 1–billing provider service location name, address and expanded ZIP Code + 4
- Box 56–10 digit NPI for the billing provider

Note: The National Provider Identifier (NPI) number, Tax Identification Number (TIN) and Taxonomy Code are ***required on all claims***.

Note: Remember to attest all of your NPI numbers with the State of Indiana at **www.indianamedicaid.com**.

Claims Processing Timelines

Processing time:

- 21 days for electronic clean claims
- 30 days for paper clean claims
- Before you resubmit, check the claim status via the portals. If there is no record of the claim, resubmit.

Note: A "clean claim" is one in which all information required for processing the claim is present.

Claim Disputes

Claims disputes must be:

- Filed within 60-calendar days from the date on the remittance **(MHS allows 67 days)**
- Submitted in writing (Anthem takes verbally, CareSource can be done via portal)
- Completed prior to requesting an appeal

Note:

- Disputes that are not filed within the defined time frames will be denied without a review for merit.
- Disputes are available for participating and non-participating providers

Claim Appeals

Appeals must:

- Be filed after the dispute decision
- While FFS requires filing within 15 days of the date of dispute determination, Anthem allows 30 days and CareSource, MDwise and MHS allow 60 days

Appeals will be resolved within 45 calendar days from the date of the receipt of the appeal.

All appeal decisions are final.

Claim Statistics

Claims Timeliness

Type of Claims	Metric	MDwise Quarter 3 2018		Anthem Quarter 3 2018		Caresource Quarter 3 2018		MHS Quarter 3 2018	
		HHW	HIP	HHW	HIP	HHW	HIP	HHW	HIP
Professional paper claims processing timeliness (CMS 1500)	Metric Target >=98%	86.53%	76.71%	98.33%	99.24%	98.53%	98.34%	98.52%	98.68%
Professional electronic claims processing timeliness (CMS 1500)	Metric Target >=98%	95.00%	94.14%	99.82%	99.77%	98.60%	97.75%	99.19%	99.56%
Institutional paper claims processing timeliness (UB-04)	Metric Target >=98%	73.15%	72.64%	99.63%	99.43%	92.57%	93.54 %	97.54%	97.83%
Institutional electronic claims processing timeliness (UB-04)	Metric Target >=98%	85.55%	88.56%	99.71%	99.52%	98.60%	97.82%	98.49%	98.73%

Denial Rates & Provider Call Statistics

MDwise

Denial Rates

Type of Claims	Metric	MDwise Quarter 3 2018		Anthem Quarter 3 2018		Caresource Quarter 3 2018		MHS Quarter 3 2018	
		HHW	HIP	HHW	HIP	HHW	HIP	HHW	HIP
Professional claims overall denial rate (CMS 1500)	Metric Target <=15%	14.10%	15.52%	14.28%	16.35%	12.09%	13.62%	8.36%	9.77%
Institutional claims overall denial rate (UB-04)	Metric Target <=15%	13.74%	11.39%	18.08%	17.01%	6.70%	7.80%	9.30%	7.15%

Call Center Statistics

Type of Claims	Metric	MDwise Quarter 3 2018		Anthem Quarter 3 2018		Caresource Quarter 3 2018		MHS Quarter 3 2018	
		HHW	HIP	HHW	HIP	HHW	HIP	HHW	HIP
% Calls Answered within 30 Seconds	≥ 85%	94.48%	94.38%	95.02%	93.49%	89.49%	88.06%	85.40%	85.66%

McLaren

Questions?

Anthem Blue Cross and Blue Shield
Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

Managed Care Provider Portal and Provider Representative Responsibility

How to Access the IHCP Portal

Through the Indiana Health Coverage Programs (IHCP) secure and easy-to-use internet portal, healthcare providers can:

- Submit claims
- Check on the status of their claims
- Inquire on a patient's eligibility
- View their Remittance Advices
- Request prior authorization

Managed Care Entities (MCE) Provider Portals

- **Anthem – via Availity**
- **CareSource**
- **Managed Health Services**
- **MDwise**

Through the MCE portals providers can:

- Enroll, disenroll, and update primary medical providers
- Review their encounter claims
- Inquire on a managed care member's eligibility

Anthem Portal - Availity

Availity is a secure multi-health plan portal that will get you the information you need instantly. It can be accessed at www.availity.com and used to do the following:

- Eligibility and Benefits Inquiry
- Claim Submission and Inquiry
- Patient Care Summaries
- Care Reminders
- Member Certificate Booklets
- Online Remittances
- Request Prior Authorization through the Interactive Care Reviewer (ICR)
- Obtain status of an Authorization request through the ICR.

CareSource Provider Portal

The CareSource Provider Portal allows providers to save money and time.

Providers can access the following:

- Prior Authorization
- Provider Grievance
- Provider Appeals
- Submit Claims
- Review Quality Ratings
- Provider Maintenance

MHS Secure Provider Portal

Providers may register at mhsindiana.com to access **MHS' Secure Provider Portal**, where they can:

- Manage multiple practices under one account
- Check member eligibility
- View member panels
- View medical history and gaps in care
- Submit/check authorizations
- Submit/check/adjust claims
- Submit claims in batch
- View HEDIS Pay for Performance Reports
- Access explanation of payments
- Communicate electronically with MHS, with one business day response time
- Access electronic copies of manuals, presentations, training material and various forms
- Access free online health library with click & print patient education material

MDwise Provider Portal

myMDwise Provider Portal

•The myMDwise provider portal allows registered providers to view member eligibility information securely online for IHCP/Medicaid.

Included are the following online features:
•View member eligibility information.
•View member claims information.
•View member delivery system information.
•View member PMP information.
•View patient roster. (PMP Only)
•Access to online Provider Opioid Resource Center
•Submit requests for care management disease management programs.
•Request access to Quality Reports.
•Request access to Member Health Profile.
•Contact MDwise Provider Relations online.

MCE Portals - Links

Anthem (Availity): https://apps.availity.com/availity/web/public.elegant.login?source=ABB

MHS: https://www.mhsindiana.com/providers.html

MDwise: https://www.mdwise.org/for-providers/mymdwise-provider-porta

CareSource: https://providerportal.caresource.com/IN/User/Login.aspx

Role of the Provider Education Representative

What is Provider Relations?

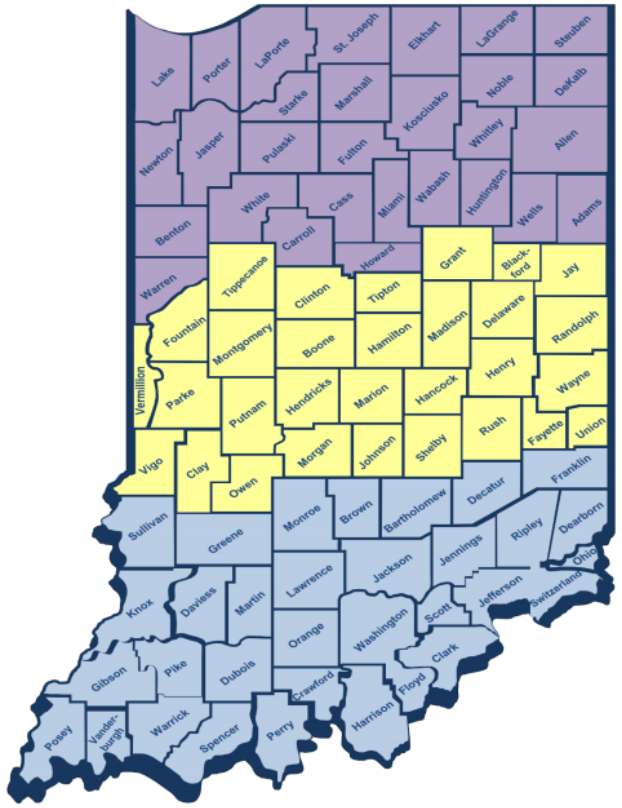
Provider Relations

- The purpose of the Provider Relations Representative is to provide exceptional customer service by supporting providers
- Provider Relations Representatives are liaisons between the provider and health plan
- We are here to answer provider inquiries regarding verification of benefits and claims status and engage in a variety of other duties such as providing education, answering inquiries and assisting with navigating health plan processes

Provider Relations

- Our goal is to proactively educate providers on how to utilize available resources from the health plan and the state and navigate systems efficiently to accurately verify eligibility and provide verification of benefits for members
- Think of your Provider Relations Representative as a concierge to help enhance your experience working with the health plan as you care for our members

Anthem Behavioral Health Territory Map



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Behavioral Health Relations Team:
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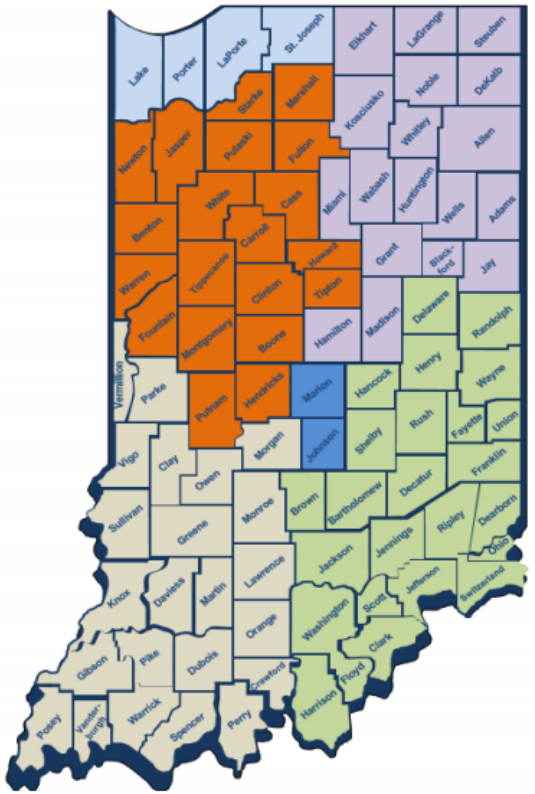
Provider Network Relations
Behavioral Health
State of Indiana

Anthem Blue Cross and Blue Shield
Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

Anthem Network Education Territory Map

Network Relations — State of Indiana Territory Map

Northwest region/Franciscan	Northeast region/IU Health	Southwest region/Deaconess
Randall Mills randall.mills@anthem.com **1-317-452-6219**	Matt Swingendorf matthew.swingendorf@anthem.com **1-317-306-0077**	Jonathan Hedrick jonathan.hedrick@anthem.com **1-317-601-9474**
West Central region/St. Vincent	**Southeast region**	**Community health**
Angelique Jones angelique.jones@anthem.com **1-317-619-9241**	Sophia Brown sophia.brown@anthem.com **1-317-775-9528**	Ron Gibson – Network Support Mgr. rondinel.gibson@anthem.com **1-317-432-6325**
Central region		
Marvin Davis marvin.davis@anthem.com **1-463-201-3718** **Marion County:** 46280, 46240, 46250, 46256, 46236, 46216, 46235, 46229, 46220, 46205, 46226, 46218, 46201, 46219, 46203, 46239, 46107, 46259, 46237, 46227, 46204 **Johnson County:** 46162 (Needham), 46124 (Edinburgh), 46184 (New Whiteland), 46131 (Franklin)	Tina Mason tina.mason@anthem.com **1-317-501-7251** **Marion County:** 46290, 46260, 46268, 46278, 46254, 46228, 46208, 46202, 46222, 46224, 46214, 46234, 46221, 46225, 46217, 46221, 46241, 46231, 46183, 46113 **Johnson County:** 46106 (Bargersville), 46181 (Trafalgar), 46142 and 46143 (Greenwood), 46164 (Nineveh)	
Out-of-state providers		
Nicole Bouye **nicole.bouye@anthem.com** **1-317-517-8862**		



Anthem Blue Cross and Blue Shield
Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

MHS Behavioral Health Network Territories

Behavioral Health

PROVIDER NETWORK TERRITORIES

WEST TERRITORY

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EAST TERRITORY

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Kelvin Orr
Director of Network Operations
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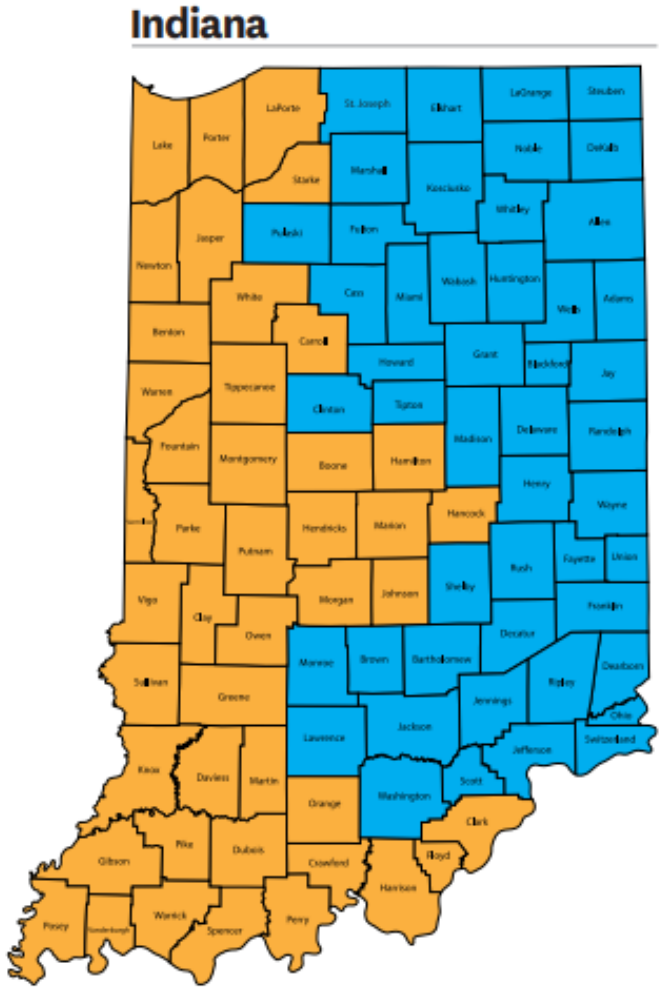
kelvin.d.orr@mhsindiana.com



MHS Provider Network Territories

Physical Health

PROVIDER NETWORK TERRITORIES

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Exception to map: Franciscan Alliance

CHAD PRATT
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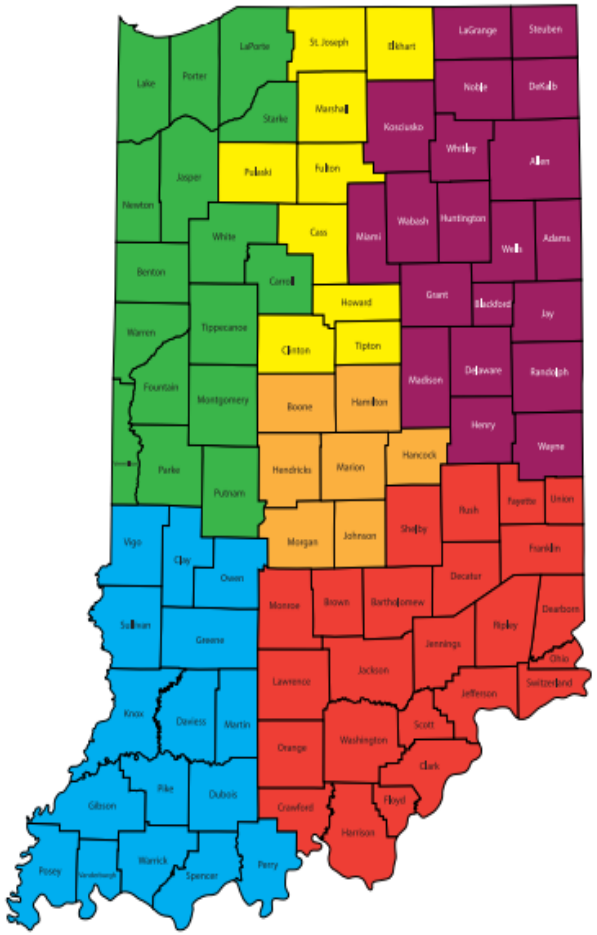
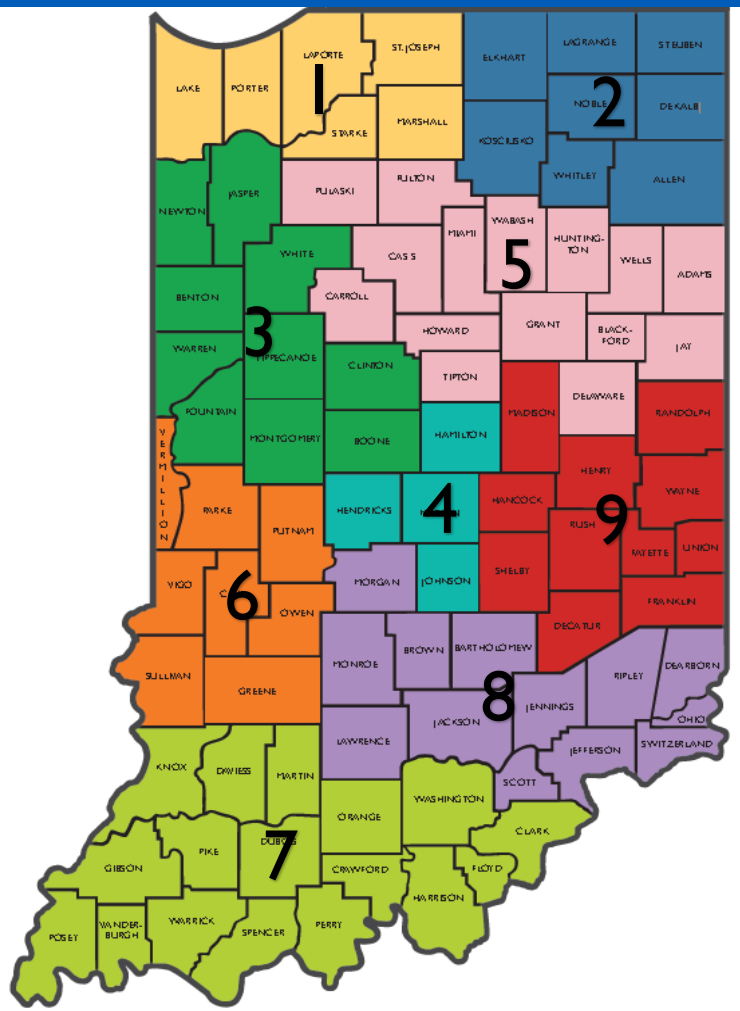
Exception to map: IU Health, Eskenazi Health



MDwise Provider Relations Territory Map



Region 1
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Region 3
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Behavioral Health
CMHCs, OTPs, IMDs, Residential

CareSource Health Partner Engagement Representatives

CareSource Health Partner Engagement Representatives

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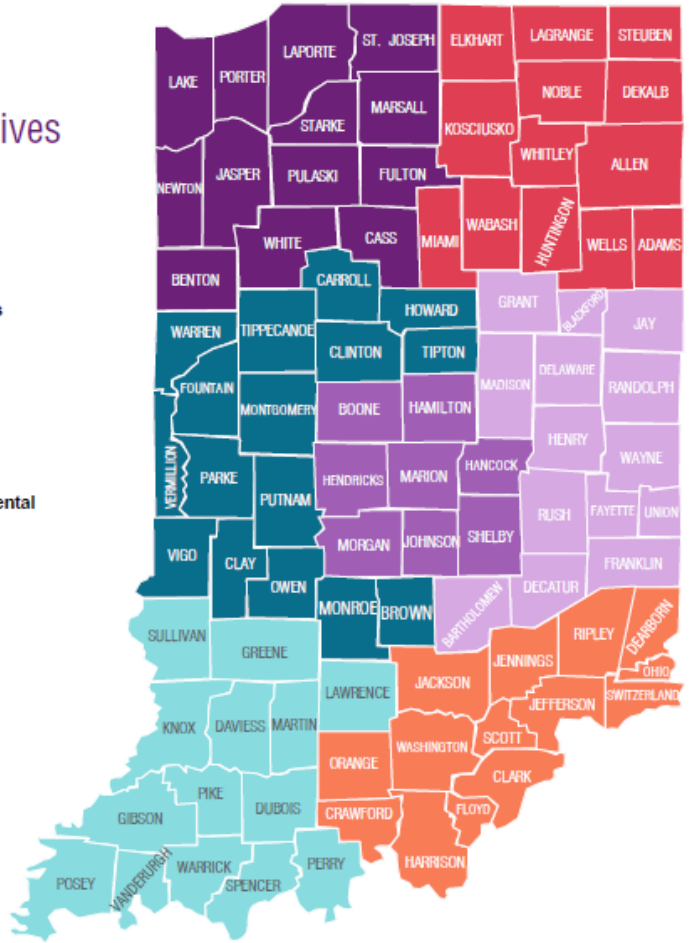

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KentuckyOne, Norton, Baptist Health Floyd

Thank You

Questions?

www.anthem.com/inmedicaiddoc

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Process for Grievances and Appeals

mhs™

Hoosier Healthwise | Healthy Indiana Plan | Hoosier Care Connect

ACCREDITED NCQA HEALTH PLAN

Utilization Management

- Previously approved prior authorizations can be updated for changes in dates of service or CPT/HCPCS codes within 30 days of the original date of service
- Determination will be communicated to the provider within 20 business days of receipt
- Remember: Prior Authorization Appeals must be initiated within **33 calendar days** of the denial to be considered. Please note, this is different than a claim appeal request which is **67 calendar days**.

Definition of Grievances

Grievances are defined by 42 CFR 43.8.400 (b) as any dissatisfaction expressed by the member, or a representative on behalf of a member, about any matter other than an action, as defined below:

- This may include dissatisfaction related to the quality of care of services rendered or available, rudeness of a provider or employee, or the failure to respect member's rights

- Grievances are further defined in 760 IAC 1-59-3 as any dissatisfaction expressed by or on behalf of a member regarding the availability, delivery, appropriateness or quality of health care services and matters pertaining to the contractual relationship between an enrollee and a MCE group individual contract holder for which the enrollee has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of the dissatisfaction

Grievance Timeline

- Grievances must be submitted within:
  - HHW/HIP = 33 calendar days
  - HCC = 60 calendar days

- MCE will acknowledge a grievance was received within 3 business days

- MCE will send a declaration letter within 5 business days

Prior Authorization Grievance Statistics

Grievance Type, Q3 2018	Metric	MHS	MDwise	Anthem	CareSource
Medicaid	Volume	164	642	1240	3,590
	TAT	30 days	30 days	30 days	30 days
	% Timely	100%	100%	99.84%	100%
	Grievances per 1,000 members	0.66	1.64	2.82	28.17

Definition of Appeals

Appeal is defined as a request for review of an action and/or request to change a previous decision. An action, as defined in 42 CFR 438.400(b), is the:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner, as defined the State; or
- Failure of an MCE to act within the required timeframes
- For a resident of a rural area with only one MCE, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network
- The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities

Prior Authorization Appeals Timeline

- Appeals must be initiated within **33 calendar days** of the denial to be considered
- MCE will acknowledge an appeal was received within **3 business days**
- MCE will send decision letter within **5 business days** of the clinical decision/determination

Prior Authorization Appeals Statistics

Appeal Type, Q3 2018	Metric	MHS	MDwise	Anthem	CareSource
Medicaid	Volume	545	165	385	30
	TAT	30 days	30 days	30 days	30 days
	% Timely	100%	100%	100%	100%
	Appeals per 1,000 members	2.21	0.42	0.88	0.13

Questions?