ILLINOIS MEDICAID MCO TRANSFORMATION

IHA Education Series

November 2017

Billing Instructions

MEDICAID FFS BILLING REQUIREMENTS

- Harmony implements rate and coding requirements received from HFS within contracted timeframes (45 days).

- Harmony follows HFS billing guidelines including Medicaid FFS, IP/OP, APL/Non APL, ED/OBS and Therapy Services

- Harmony reviews HFS published guidelines and uses these guidelines to work with our Operations department to implement new/updated billing requirements.

- Billing Job Aids are created and published on WellCare's site for Providers to review.

  - We provide notification to our contracted groups on any new SNIP, Coding or Configuration denials prior to implementation within our system based on contractual obligations.

- We then work with our Provider Relations department to provide feedback on the new requirements to help ensure a smoother transition to meet Medicaid FFS billing requirements going forward.

- https://www.wellcare.com/en/Illinois/Providers/Medicaid/Claims/Billing-Job-Aids

Claims Adjudication

ELECTRONIC CLAIMS

- Harmony has partnered with RelayHealth as our preferred EDI Clearinghouse.

- Providers can contact Ability Network, a RelayHealth partner, to establish free connectivity to Harmony for EDI transactions at 1-866-855-4723 or RelayHealth Clearinghouse's Provider Connectivity Services Support at 1-877-411-7271

- Daily electronic response files will indicate whether a claim has been accepted or rejected.

- If the 999 "accepts with errors" or "rejects", you can access the Washington Publishing (WPC) website for code descriptions at www.wpc-edi.com.

Reimbursement Methodology

HFS EAPG / APR-DRG

- Harmony applies HFS reimbursement methodology for EAPG/APR-DRG where applicable.
- Harmony receives EAPG/APR-DRG calculator version updates from HFS which includes pricer and/or per diem updates.
  - <u>Pricer Updates</u>: EAPG/APR-DRG calculator is sent to our Shared Services configuration team to update. We also work with our vendor, OPTUM, to identify pricer updates as checks and balances system to ensure the most current version is being used.
  - <u>Per Diem Updates</u>: Impacted providers are identified and submitted to our Shared Services configuration team to update.
- All updates are audited and validated once deployed

Provider Portal Functionality

PORTAL REGISTRATION

- Register at: https://provider.wellcare.com/

- Be sure to have your Provider ID number, primary zip code and Tax ID Number

- Please reference Appendix A for visual references

Provider Portal Functionality

PRIOR AUTHORIZATION REQUESTS

- Search by CPT code to determine if an authorization is required:
  https://www.wellcare.com/Illinois/Providers/Authorization-Lookup

- Forms can be accessed at:
  https://www.wellcare.com/en/Illinois/Providers/Medicaid/Forms

- The Quick Reference Guide will aid you in determining where to direct your authorization request. Access this via the Authorization Lookup Tool link above, or at:
  https://www.wellcare.com/Illinois/Providers/Medicaid *

  * *Scroll down to Quick Reference Guide*

- Prior Authorizations can be requested and tracked via Harmony Provider Portal

Provider Portal Functionality

VERIFYING ELIGIBILITY / BENEFITS

- Eligibility can be verified by searching the member's Harmony or HFS ID number and/or other member identifiers such as DOB, Last Name, etc.

  - Eligibility can also be verified by calling Provider Services 1-800-504-2766

- Benefits can be viewed in the Member Handbook or Certificate of Coverage at:

  https://www.wellcare.com/Illinois/Members/Medicaid-lans/Harmony-Health-Plan

  or by calling 1-800-504-2766

Provider Portal Functionality

CHECK CLAIM STATUS

- Claim status can be verified within the portal.

  - Search for claims, submit initial claims, submit corrected or voided claims.

Provider Claim Disputes

CLAIMS DISPUTE PROCESS

The Claim Payment Dispute process is designed to address claim denials for issues related to **untimely filing**, **incidental procedures**, **unlisted procedure codes** and **non-covered codes,** etc. Claim payment disputes must be submitted in writing to Harmony within 90 days of the date on the explanation of payment (EOP).

Mail or fax all claim payment disputes with supporting documentation to:

Harmony Health Plan, Inc.
Attn: Claim Payment Disputes Dept.
P.O. Box 31370
Tampa, FL 33631-3370
Fax: **1-877-277-1808**

Provider Claim Disputes

CLAIMS DISPUTE PROCESS

- The Claim Payment Policy Disputes Department has created a mailbox for provider issues related strictly to **payment policy issues**. Disputes for payment policy-related issues **(EOP Codes beginning with IHXXX, MKXX or PDXXX**) must be submitted to Harmony in writing within 90 days of the date of denial on the EOP. Please provide all relevant documentation, which may include medical records, in order to facilitate the review.

- Mail or fax all disputes related to payment policy issues to:

  Harmony Health Plan, Inc.
  Attn: Claims Payment Policy Disputes
  P.O. Box 31426
  Tampa, FL 33631-3426
  Fax: **1-877-277-1808**

Provider Claims Disputes

SERVICE AUTHORIZATION APPEAL PROCESS

- Providers may file an appeal on behalf of the member with his or her consent.

- Providers may also seek an appeal through the Appeals Department within 90 days of a claims denial for lack of a prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification.

  - Examples include Explanation of Payment Codes DN001, DN004, DN0038, DN039, VSTEX, DMNNE, HRM16, and KYREC; however, this is not an all-encompassing list of Appeal codes.

  - Anything else related to authorization or medical necessity that is in question should be sent to the Appeals PO Box. Include all substantiating information like a summary of the appeal, relevant medical records and member specific information.

Provider Claims Disputes

SERVICE AUTHORIZATION APPEAL PROCESS

- Expedited appeals may be initiated orally by contacting Provider Services or submitted by mail or fax.

  - These submissions must show that "expedited processing" is needed and include the reason(s) expedited processing has been requested. The documentation must demonstrate that not applying the expedited review process could seriously jeopardize the member's life, health or ability to regain maximum function.

- Mail or fax all medical appeals with supporting documentation to:

  Harmony Health Plan, Inc.
  Attn: Appeals Department
  P.O. Box 31368
  Tampa, FL 33631-3368
  Fax: **1-866-201-0657**

TRANSITION OF CARE

- The Utilization Management team is notified of all admissions. When a member is admitted to a Out of Network facilities the team works with the transferring facility and admitting facility to safely transfer the member to a contracted facility when appropriate.

- The Discharge Planning team consists of Nurses and Social Workers who coordinate care at the members bedside prior to discharge and follow the member 30 days post –discharge to prevent avoidable readmissions.

Utilization Review

CONCURRENT REVIEW PROCESS

Notice of Admission:

- Facility or provider notifies the health plan of the admission via phone (800-504-2766), fax (877-431-8860), or web (https://provider.wellcare.com/).

- If there are no clinicals or additional medical information, UM will make three attempts to obtain clinicals information via phone/fax.

Use of Criteria:

- The records are reviewed against InterQual for Observation and Inpatient Stay. If they do not meet the criteria, they will be sent to the medical director for review.

- A determination is made within one business day from receipt of admission, if clinicals are received

Peer to Peer:

- If the request for authorization is denied, the facility has seven days from the Intent-to-Deny or Denial letter is sent (faxed), to a request for a peer-to-peer. The number to call is 866-329-7651. For Medicaid the number to call is 866-425-3508. Due to our platform update later in the year, these numbers may change. The correct number to call is located in the Intent-to-Deny or Denial letter sent to the provider.

- Once the request for peer-to-peer is received, the request is placed in the medical director's queue, and they have one business day to call the provider back.

Issue Escalation

PROVIDER ESCALATION PROCESS

- 1st point of contact uses provider dispute process noted in prior slides.

- Should an issue not be resolved, the provider can escalate the issue to the Escalation Unit.

- Allow for time for research, review, and issue identification.

- Should issue not be resolved by Provider Services or Provider Escalation Unit, next point of contact is your Provider Relations Representative.

- Provider Escalation Unit can also refer the issue to the local PR Rep for inclusion and issue resolution.

  - If the provider is not aware of who their Representative is, the Provider Services and Escalation units can assist by informing and/or directing the provider

Harmony Website

KEY PROVIDER MATERIALS

- Access key provider materials at:

  https://www.wellcare.com/Illinois/Providers/Medicaid

- Materials include, but are not limited to:

  - Policy Changes, Newsletters, and Bulletins

  - Provider Manuals, Quick Reference Guides, Key forms

  - Billing Job Aids

  - Key Updates

  - Provider directory search

  - Pharmacy tools, including preferred drug listings

Appendix A

Appendix B

Appendix C

Appendix D