

**MIHMS Update**

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**September 16, 2010**

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### Financial Statistics



- ✓ First Financial Cycle 9/10/10
  - TOTAL \$ 143,185.14
- ✓ Second Financial Cycle 9/17/10
  - Hospital PIP Payments \$ 7,387,697.00
  - 119,382 Pharmacy Claims \$ 3,669,653.59
  - 8,597 Med/Dent Claims \$ 1,004,397.49
  - TOTAL \$12,061,748.08

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### MIHMS Claims Statistics



September 1 - 14, 2010

Status	CLAIMS COUNT			TOTAL	Total Charges
	Prof	Inst	Dental		
IN PROCESS	2,028	460	254	2,742	\$ 1,560,956
SUSPEND	2,711	524	147	3,382	\$ 1,008,380
PAY/PAID	6,708	4,036	1,612	12,356	\$ 3,515,732
DENY/DENIED	3,023	924	98	4,045	\$ 1,719,853
<b>TOTAL</b>	<b>14,470</b>	<b>5,944</b>	<b>2,111</b>	<b>22,525</b>	<b>\$ 7,804,921</b>

Status	Prof	Inst	Dental	TOTAL	Total % of Charges
IN PROCESS	14.0%	7.7%	12.0%	12%	20%
SUSPEND	18.7%	8.8%	7.0%	15%	13%
PAY/PAID	46.4%	67.9%	76.4%	55%	45%
DENY/DENIED	20.9%	15.5%	4.6%	18%	22%
<b>TOTAL</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100%</b>	<b>100%</b>

Claims Source	% of Claims
Paper	1.9%
Web Portal	13.4%
Electronic Batch	84.6%
Total	100.0%

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## “Go-Live” Risk Mitigation Strategies



Strategy	Description
Implementation Command Center	<ul style="list-style-type: none"> <li>Meets twice daily</li> <li>Reviews and triages issues</li> <li>Identifies, develops, and distributes required communications daily</li> <li>Assigns ownership for issues follow-up</li> <li>Daily communications to Steering Committee</li> </ul>
Provider Support	<ul style="list-style-type: none"> <li>Supplemented staff to support provider enrollment and maintenance activity</li> <li>Facilitate weekly provider conference calls to address questions</li> <li>Additional training outreach, including one-on-one sessions</li> </ul>
Claims Payment	<ul style="list-style-type: none"> <li>Daily review of submitted claims by Molina and State Quality Assurance staff</li> <li>Daily monitoring of claims status to identify issues</li> <li>Developed an interim payment contingency plan (to be invoked if needed)</li> </ul>
Business Partner	<ul style="list-style-type: none"> <li>Daily meetings with Prior Authorization business partners and program offices</li> <li>Twice weekly meetings with program offices regarding medical classifications</li> </ul>
Business Processing Cycles	<ul style="list-style-type: none"> <li>Daily monitoring and reporting of various business metrics, including claims, prior authorizations, call volumes, etc.</li> </ul>

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## Quality Assurance: At Go Live



- ✓ More than 30 State and Molina QA and operations staff are reviewing claims for accuracy as they are processed
- ✓ Molina System Architects and Developers are onsite in Augusta through October to ensure timely remediation of system defects
- ✓ Implemented a controlled escalation process to handle any issues:
  - **Category 1 – System Defect:** The correction is documented and approved by the State; tested by Molina and then by the State; and moved to production once State testing is passed.
  - **Category 2 – Billing Error:** Claim denies or suspends appropriately. Provider receives an error message in the portal and/or on their remittance advice. State is tracking billing error trends and posting messages/updates for providers on the Provider Portal to clarify billing instructions.
  - **Category 3 – Provider Enrollment Update Not Completed:** This issue impacts claims and/or prior authorization processing. Molina is outreaching to providers to address this issue and have added support to expedite resolution.

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## Common Billing Errors



- ✓ The current rejection rate for paper claims is high (35%) because:
  - Whiteout or correction tape used on claim (potential fraud/abuse indicator)
  - No NPI/API on claim
  - Dates of service that span 8/31/10 and 9/1/10 (need to split bill claims between MeCMS and MIHMS)
  - Incorrect/outdated claim form
- ✓ Prior authorization number is incorrect
  - APS authorizations require a prefix of “APS”
- ✓ Referral number entered on claim – should be left blank
  - Should include Referring Provider NPI as it appears on the Referral
- ✓ Incorrect codes
  - Local Codes vs. National Codes
  - Billing to older versions of policy (i.e., consult codes no longer covered)
- ✓ Service Location ID Missing or Invalid
  - MIHMS requires service location ID number on claim for proper payment of claim

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## Warn Edits



### WARN Edits and What They Mean:

- ✓ If you are in the portal you may see a WARN edit – these edits do not affect claim payment, but are used by the State for Quality Review purposes. These are also used to notify the provider of something that may impact claims processing in the future.
  - Example #1 – “Rev Code/HCPCS inconsistency” Notifies the provider that the revenue code and procedure code combination on the claim does not follow national billing standards.
  - Example #2 – “APC Active Component conflict” This will post if a Revenue code is billed on an outpatient claim with no procedure code. This is valid for billing of outpatient services not priced by APC such as Lab Services. MaineCare is using the WARN feature for internal QA review.
  - Example #3 – “Procedure Requires Referral” Due to the transition from a paper referral process (MeCMS) to electronic process (MIHMS); MaineCare will WARN a provider if a referral for a service is not in MIHMS. Provider should contact PCP for future referrals. Beginning October 31, claims will DENY without a referral.

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## Known Issues Affecting Claims Processing



- ✓ **Issue 1: Speech Pathologists**  
DOE rules allow for certified speech/language clinicians to provide services in school settings. System configuration does not currently support billing for services provided by non-licensed clinicians.  
**Resolution:** Developing and implementing solution to allow enrollment and billing for certified practitioners in school settings.
- ✓ **Issue 2: MR Waiver**  
In Dec. 2009, MaineCare communicated enrollment instructions to MR Waiver providers for community support services. Approximately 50 MR Waiver providers did not properly complete maintenance.  
**Resolution:** Reaching out to providers affected by this issue to correct enrollments.
- ✓ **Issue 3: Behavioral Health Continued Stay Authorizations**  
Some Behavioral Health Continued Stay Authorizations did not convert properly from MeCMS to MIHMS because of duplicate authorization numbers.  
**Resolution:** Correction implemented on 9/15 and affected claims are being reprocessed.

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## Provider Reported Errors & Status



Reported Errors	Status
“Referred To” Providers unable to see referrals in MIHMS	• Corrected 9/13/10
Claims pending for Coordination of Benefits with Medicare	• Corrected 9/10/10 and reprocessed claims.
Converted PAs appearing under incorrect location/NPI	• Worked with providers on an individual basis to correct issues
If a rendering provider has multiple practice affiliations, both entities can see authorizations and referrals	• Corrected in production for referrals on 9/13/10 • Correction for PAs scheduled for 9/15/10
Conversion of member primary care provider (PCP) assignments were completed at the entity level rather than the physician level which has caused some confusion for members and providers	• MeCMS assigned PCP at practice level. MIHMS assigns at physician level (which is industry standard). Conversion allows a member to see any physician within the practice. Members can call Member Services to select another PCP if preferred. Are analyzing options to streamline this process.

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## Provider Action Required



### What Providers Need To Do:

- ✓ Update enrollment through Maintenance for:
  - Schools
  - Day Habilitation (Community Support)
  - Early Intervention
  - Targeted Case Management
- ✓ Verify converted Authorizations for accuracy – report any discrepancies

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