



## **State of Maine**

### **Department of Health & Human Services (DHHS)**

#### **MaineCare**

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# **Medicaid Management Information Systems**

*Maine Integrated Health Management Solution*

## ***MeCMS to MIHMS Transition Guide***

### ***MIHMS Implementation Information for Providers***

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## 1. Introduction

The MECMS to MIHMS Transition Guide furnishes relevant information to providers who previously billed MECMS for MaineCare services and will assist you in converting your billing and adapting your business processes. This Transition Guide gives information pertinent to the transition timeframe from MECMS to the new Maine Integrated Health Management Solution (MIHMS) as well as historical information that providers may want to retain for future reference until such time as all MECMS claims are past the audit period. This Transition Guide does not apply to those Providers who have not submitted claims to MECMS.

### 1.1 *Advances in Electronic Functionality*

The MyHealthPAS online portal will allow MIHMS providers to:

- Utilize Direct Data Entry (DDE) to submit claims
- Upload attachments online for all claim submissions
- Verify members' eligibility and create a patient roster
- Submit Prior Authorizations (PA) and Primary Case Care Management (PCCM) referrals
- View the status of claims
- Submit Electronic Data Interchange (EDI) batch transactions

### 1.2 *Advances in HIPAA Compliance*

The new system is Health Insurance Portability and Accountability Act (HIPAA) compliant to meet federal certification requirements.

### 1.3 *National Correct Coding Initiative*

Edits are applied to ensure compliance with the National Medicaid Correct Coding Initiative (CCI) that will be operational under MIHMS. Due to CCI, appropriate use of modifiers is very important. The use of modifiers will be necessary in many cases to assure proper payment. For a complete list of the CCI rules, go to [http://www.cms.hhs.gov/NationalCorrectCodInitEd/01\\_overview.asp#TopOfPag](http://www.cms.hhs.gov/NationalCorrectCodInitEd/01_overview.asp#TopOfPag)

### 1.4 *State Policy*

Numerous concurrent changes and updates have been made to MaineCare Services policies including, but not limited to, the MaineCare Benefits Manual. Many changes are effective with the implementation of MIHMS. All policy changes have been made through the formal rulemaking process which adheres to the Administrative Procedures Act.

Rules and related rulemaking documents can be reviewed at and printed from the MaineCare Services website at: [http://www.maine.gov/dhhs/oms/rules/provider\\_rules\\_policies.html](http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.html), or, for a fee, interested parties can request a paper copy of rules by calling 1-207-287-9368. For those who are hearing impaired and have a TTY machine, the TTY number is 1-800-606-0215.

## 2. MIHMS Implementation Timeline and Cutover

The goal of the MIHMS Cutover Strategy is to maintain core MaineCare Services claims operations and minimize risk while implementing the new claims processing system. As a result, MIHMS will use a Date of Service (DOS) cutover strategy, widely used today in the commercial payer environment when implementing new healthcare billing and claims processing systems.

### 2.1 Claim Submission

- Claims with service dates up to and including 7/31/2010 must be submitted using current day billing instructions for MeCMS.
- Claims with service dates on or after 8/1/2010 must be submitted using the new billing instructions for MIHMS.
- Claims that span dates of service 7/31/2010 and 8/1/2010 must be split-billed. The portion of the claim with DOS up to and including 7/31/2010 will be billed to MeCMS and the portion with DOS on or after 8/1/2010 will be billed to MIHMS, each according to their respective billing instructions.

### 2.2 Crossover Claim Submission

- Claims submitted to Medicare for dually eligible MaineCare members will be processed using the Coordination of Benefits Agreement (COBA) Program files for Medicare Part A and Part B.
- Processing will occur in MIHMS for claims with start dates on or after 8/1/2010. Crossover claims that span the Go-Live date, with the exception of Hospital claims, must be split billed to MaineCare.
- Hospital Crossovers that span 7/31/2010 to 8/1/2010:
  - Hospital crossover claims with dates of service that include a From Date (start date) of 7/31/2010 or earlier, will be processed as they are today with the BNN (Baker Newman & Noyes) workaround. Only claims where all the service dates are on or after 8/1/2010 will be processed in MIHMS.
- All Other Crossovers that span 7/31/2010 to 8/1/2010:
  - Claims with services dates before and including 7/31/2010 and ending on or after 8/1/2010 should be “split”:
    - MeCMS should be billed via the current work around for the split portion ending 7/31/2010.
    - MIHMS should be billed for the portion of services for 8/1/2010 forward using billing consistent with the MIHMS billing instructions. Alternately, the MIHMS portion may be submitted via DDE or EDI and the Medicare EOB uploaded.

### 2.3 Claim Processing

- MeCMS will only process claims for DOS 7/31/2010 or prior. Claims received for DOS 8/1/2010 forward will be denied.
- MIHMS will only process claims for DOS 8/1/2010 forward. Claims received for DOS prior to 8/1/2010 will be denied.
- Both systems will deny claims with DOS that span both of these periods and are not split-billed.
  - GHS is the Pharmacy Benefits Manager (PBM) for the State of Maine and processes all Pharmacy point-of-sale claims adjudication in the MEPOPs system. All Pharmacy

claims submitted to GHS after 7/31/2010, regardless of the date of service, will continue to be adjudicated in the MePOPs system, but will then process through MIHMS for financial payments and be included on the MIHMS Remittance Advice (RA).

- All providers, except Pharmacies, will receive multiple RAs and payments though the run-out period (separately for MeCMS and MIHMS).

#### **2.4 MeCMS Run-out Strategy**

MaineCare will continue operating MeCMS for a period of six months after the implementation of MIHMS. The one year timely-filing limit on claims still applies.

Providers are advised to bill MeCMS claims as early as possible.

- Providers are encouraged to bill DOS prior to 08/01/2010 during the six (6) month time period that MeCMS is still operational.
- Instructions will be provided at a later date for submitting claims after MeCMS is decommissioned for those claims where circumstances prevented providers from MECMS submission.
- Additional information will be published as the MeCMS Decommissioning Plan is finalized.

#### **2.5 Historical Data and Transition Dates**

- **Eligibility Information:** Do not utilize MIHMS to verify eligibility for MeCMS claims. From 7/6/2010 forward, current eligibility will be maintained in MIHMS. The MeCMS IVR will continue to provide MeCMS eligibility as long as MeCMS is operational.
  - Historical eligibility information, prior to 7/6/2010, will be loaded into MIHMS for reporting purposes only and will be viewable in the MyHealthPAS online portal. This information must not be used as the basis of establishing eligibility for claim submissions to MeCMS.
- **PCCM Referral Information:** Beginning 7/6/2010, Primary Care Providers (PCCM-PCPs) will have to initiate new Referrals for service dates on or after the 8/1/2010 Go-Live date for services that require a referral. Current PCCM referrals that extend past 7/31/2010 will expire. Providers will need to resubmit them with an 8/1/2010 start date.
- **Prior Authorization (PA) Information:** Some MeCMS PA data will be automatically converted to MIHMS. In the event that a PA will not be converted, providers will be notified and will be expected to request a new PA. The following provides guidance on the conversion process:
  - Active PAs will be transferred to MIHMS as of 7/6/2010 for any active approved PA that includes dates of service on or after 8/1/2020.
  - Converted PAs will use the existing MeCMS PA number.
  - Providers should review the converted PA through the MyHealthPAS online portal to ensure accuracy:
    - Validate NPI/API (Do the PAs shown online belong to our practice? Are all PAs included that should be?)
    - Verify procedure codes (Did the conversion from local codes to HIPAA-compliant codes derive the correct/appropriate replacement code from your perspective?)

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- Conversion will be based on mapping the MeCMS Billing Provider numbers to the new MIHMS enrollments based on NPIs. Providers will be notified when mapping cannot be completed.
- PAs with local codes<sup>1</sup> that have a one-to-one mapping to a HIPAA compliant code will be converted to the new code.
- “Blanket” PAs will not be accepted in MIHMS. Blanket PAs that have previously been issued for a variety of services. MaineCare will re-issue those PAs using new service code groupings.
- New PA requests after 7/6/10 must be submitted to the appropriate system and will have to be split if the service request spans the Go-Live date. When submitting PA requests which span Go-Live, you are required to obtain two PAs.
- **PA conversion exceptions include:**
  - Local codes with a one-to-many mapping to HIPAA compliant codes.
  - Behavioral Health PAs with local codes issued through APS. Affected providers will receive further instruction through APS.
- ***If your MIHMS enrollment is under a different tax entity or tax ID, a different legal entity or organizational form, or a different name than your MeCMS enrollment, any PA requests that are required to continue past 8/1/2010 for the member must be resubmitted by the Provider based on the new MIHMS enrollment identity.***
- **Claims History:** Claims history will be available in MIHMS for dates of service on or after 8/1/2010.

## 2.6 Important Dates

**Table 1: Dates for the MaineCare MIHMS system implementation**

| Date       | Description   |
|------------|---|
| 8/30/2009  | Provider Enrollment Begins  |
| 12/11/2009 | Provider Maintenance opens  |
| 7/6/2010   | MIHMS “Go-Live” date for Prior Authorization and PCCM Referral covering service dates on or after Go-Live claim date. |
| 7/31/2010  | MeCMS last valid dates of service on or before this date  |
| 8/1/2010   | MIHMS first valid dates of service on or after this date  |
| 8/1/2010   | MIHMS “Go-Live” date for Claims   |

The MeCMS run-out period end date, information on timely filing limit for initial submission of MeCMS claims, etc. will be communicated via the Decommissioning Plan.

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<sup>1</sup> See local crosswalk tables on the portal at [http://www.maine.gov/dhhs/oms/providerfiles/billing\\_instructions.html#hipaa\\_codes](http://www.maine.gov/dhhs/oms/providerfiles/billing_instructions.html#hipaa_codes)

### 3. Business Interaction Options

With the implementation of MIHMS, new more effective methods of interaction with MaineCare will be available for providers, billing agents and clearing houses.

- **MeCMS:**
  - **Electronic Media Claims (EMC):** EMC is the current method of filing MaineCare claims using batch file submission. EMC will be replaced with HIPAA-compliant Electronic Data Interchange (EDI) transactions in MIHMS. EMC was limited to claim submission.
  - **Paper:** Currently supports multiple versions of the standard claim forms with instructions that are sometimes non-standard.
  - **Interactive Voice Response (IVR):** IVR system for MeCMS will be running throughout the runout period.
  - **Telephone Contact:** MeCMS support is available by calling 1-800-321-5557.
- **MIHMS:**
  - **MyHealthPAS online portal:** Direct Data Entry (DDE) is a new option allowing for online web entry of claims, PAs, and PCCM Referral submissions. In addition to verifying eligibility and checking on claim or payment status, EDI transactions requiring paper attachments can be uploaded through the portal at <https://mainecare.maine.gov/Default.aspx>.
  - **Electronic Data Interchange (EDI):** EDI refers to the structured transmission of data between organizations by electronic means. It is used to transfer electronic documents from one computer system to another, i.e. from one trading partner to another trading partner. The use of EDI requires a Trading Partner Agreement with Unisys\*, the State's former Fiscal Agent, or with Molina, the current Fiscal Agent, and completion of testing to ensure that the data file structure and contents adheres to the defined standards. This option includes inbound and outbound information for eligibility verification, PCCM Referrals, prior authorizations, claims, remittances, and payment status.  
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\*The State has confirmed that Trading Partner Agreements executed with Unisys will be assigned to Molina Healthcare.
  - **Telephone Contact:** Automated Voice Response (AVR) system will be reached by calling toll free at 1-866-690-5585. The caller will have options to use automated service functions (eligibility verification, etc.) or to reach a Call Center Representative. The Call Center will be fully staffed to assist with all MIHMS functions such as provider enrollment, EDI, and claims billing and inquiries.
  - **Paper:** Paper submissions will continue to be supported. Claims, PAs, and PCCM referrals must be on original versions (not photocopies) of the newest claim forms (CMS1500, UB04, and ADA2006). Prior claim form versions will not be accepted in MIHMS (UB92, for example).

## 4. Member Eligibility

### 4.1 Cost of Care

Cost of Care is the monthly amount that the member is expected to contribute toward the cost of his/her care in a facility. A Cost of Care can be assessed for anyone that is in a facility for more than thirty (30) days.

Cost of Care is dependent on the services provided as shown in Situations 1 and 2 below:

**1. Situation 1: Cost of Care deducted from submitted claims.** Table 2 lists the facilities that will have a Cost of Care deducted from their claims.

- **Monthly Billing Notice:** Starting with dates of service after MIHMS goes live, all providers who have Cost of Care deducted from their claims will be required to bill MaineCare monthly rather than weekly or bi-weekly

**Table 2: Facilities with Cost of Care deductions**

| MIHMS Provider Type Code              | MIHMS Specialty Code  | MeCMS Specialty   |
|---------------------------------------|---|---|
| Alternative Residential Facility      | No Specialty  | Adult Family Care Homes   |
| Boarding Home                         | Cost Reimbursed Boarding Homes (Case Mix)   | Appendix C Private Non-Medical Institutions (PNMIs); (Medical and Remedial Service Facilities)      |
| Boarding Home                         | Cost Reimbursed Boarding Homes (Non-Case Mix)   | Appendix F Private Non-Medical Institutions (PNMIs); Non-case mixed Medical and Remedial Facilities |
| Group Home (Developmentally Disabled) | ICF/MR  | ICF MRs   |
| Nursing Home                          | Brain Injury Facility   | Nursing Facilities  |
| Nursing Home                          | Cost Reimbursed Boarding Homes (Case Mix)   | Nursing Facilities  |
| Nursing Home                          | ICF/MR  | Nursing Facilities  |
| Nursing Home                          | Nursing Home  | Nursing Facilities  |
| Hospital                              | When the member is admitted to a Nursing Home or an ICR/MR from a hospital and the admit date is after the 1st of the month, Cost of Care will be deducted from the hospital claim. |   |

**2. Situation 2: Cost of Care not deducted from submitted Claims.** For Waiver services, Cost of Care will be billed by, and paid directly to, the State.

- **Section 19, 21, 22, 29 Notice:** Providers billing for waiver services under these Sections will **not** have Cost of Care deducted from their claims and consequently are not required to bill claims monthly.

## 4.2 Cost of Care Deduction Rules for Admit/Discharge Months

MeCMS pro-rates Cost of Care based on dates of service. This is not an accurate way to calculate Cost of Care. The member's Cost of Care liability has to be fully exhausted before Medicaid reimburses. To facilitate an accurate calculation, MIHMS requires that all providers who have Cost of Care deducted from their claims bill monthly.

See Section 4.1 and additional details below.

Cost of Care calculation will change in relation to the admission/discharge months.

**MeCMS:** Cost of Care is prorated based on the admission/discharge month.

**MIHMS:** See table below.

How Cost of Care is deducted on monthly claims for Appendix C and F PNMI and for Alternative Residential Facilities is also changing.

**MeCMS:** Cost of Care is deducted from all revenue codes on the claim.

**MIHMS:** Cost of Care will only be deducted from the room and board revenue code.

For Nursing Facilities billing after Medicare for members who are part of the QMB population, Cost of Care will no longer be deducted from the coinsurance/deductible claims. Nursing facilities billing for non-QMB members will continue to have Cost of Care deducted from their Medicare coinsurance/deductible claims.

If you have questions regarding the MIHMS monthly billing requirement and how it will affect you as a provider serving members with Cost of Care, please e-mail: [MaineCare2010.DHHS@maine.gov](mailto:MaineCare2010.DHHS@maine.gov)

When any facility bills for the month of discharge to either a PNMI or an ARF, use Patient Status Codes of 01 (discharge to home/self care routine discharge) or 70 (discharge/transfer to another type of health care institution not defined elsewhere in the code list).

Please Note: It remains the facility's responsibility to reimburse the member any unused portion of their Cost of Care if the full amount is not used during the month.

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**Table 3 Facility Transfer Cost of Care Rules**

| If Member moves: |                             |  |
|------------------|-----------------------------|--|
| From             | To                          | Is Cost of Care Owed?  |
| Home             | NF                          | No, unless admitted on 1st of the month and is a resident the entire month.  |
| Home             | PNMI                        | No, regardless of day of admit.  |
| NF #1            | NF #2                       | Yes to NF #1 for allowable charges not exceeding Cost of Care owed to facility.  |
| NF               | PNMI                        | No to either facility.   |
| NF               | Hospital                    | Yes to NF for allowable charges not exceeding Cost of Care owed to facility.   |
| NF               | Home                        | No.  |
| NF               | Deceased                    | Yes to NF up to allowable charges.   |
| PNMI             | NF                          | Yes to PNMI for allowable charges not exceeding Cost of Care owed to facility.   |
| PNMI #1          | PNMI #2                     | Yes to PNMI #1 unless admitted on 1st of the month. If member is admitted to PNMI #2 on first of the month, no COC is deducted from either facility. |
| PNMI             | Hospital                    | Yes to PNMI for allowable charges not exceeding Cost of Care owed to facility.   |
| PNMI             | Home                        | Yes to PNMI up to allowable charges.   |
| PNMI             | Deceased                    | Yes to PNMI up to allowable charges.   |
| Hospital         | NF                          | Yes to Hospital for allowable charges not exceeding Cost of Care owed to hospital.   |
| Hospital         | NF (under skilled Medicare) | Yes to Hospital up to allowable charges.   |
| Hospital         | PNMI                        | No to either facility.   |

Note: PNMI rules also apply to ARFs

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#### Chart Key:

AFCH=Adult Family Care Homes

ARF=Alternative Residential Facility (formerly Adult Family Care Home in MECMS)

Hospital=Inpatient Beds and Swing Beds

ICF/MR=Group Home ICF/MR

ICF=Intermediate Care Facility

NF= Nursing Facility

PNMI=Private non-Medical Institution (Appendices C and F)

### 4.3 Eligibility Verification

MeCMS: Eligibility verification is available through the IVR or by calling MaineCare Provider Services.

MIHMS: Eligibility verification will be available by calling Fiscal Agent Provider Services at 1-866-690-5585 to reach a Provider Services representative or to access the information through an Automated Voice Response System. In addition, expanded eligibility verification is available through the MyHealth PAS online portal and will include the following:

**Table 4 Plans/Types/Coverage Codes (Financial Eligibility)**

| Plans  | Types    | Coverage Codes (Financial Eligibility)  |
|--|----------|---|
| MaineCare  | Medical  | Adult and Children Services, Adult Non-Categorical, defined Emergency Services Only, Defined Benefits |
| Primary Care Case Management                       | Medical  | Adult and Children PCCM, Adult Non Categorical PCCM   |
| Office of Elder Services                           | Medical  | PA Only Adult and Elder Services  |
| Maine CDC-Maine Breast and Cervical Health Program | Medical  | Breast and Cervical Health Screening  |
| Office of Child and Family Services                | Medical  | Adult and Children Services   |
| Maine CDC CSHN                                     | Medical  | Children Special Health Needs   |
| Maine Eye Care                                     | Medical  | Medical Eye Care  |
| Maine RX   | Pharmacy | Maine Rx  |

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| Plans                       | Types    | Coverage Codes (Financial Eligibility) |
|-----------------------------|----------|--|
| Buy-In                      | Medical  | Qualified Medicare Beneficiary (QMB)   |
| Drugs for the Elderly (DEL) | Pharmacy | DEL                                    |

Coverage Codes (Medical Eligibility): Known in MeCMS as classification, Medical eligibility is needed for some MaineCare Services. Coverage Codes in MIHMS will name the specific MaineCare Section of Policy where the member has been declared medically eligible.

Other Insurance: Any other health insurance coverage for the member.

Cost of Care: The monthly amount the individual is expected to contribute toward the cost of his/her care in a facility.

PCP Assignment: The contact information for the assigned Primary Care Provider (PCP) of the Primary Care Case Management (PCCM) member.

## 5. Provider

### 5.1 Provider Enrollment and Identifiers

- National Provider Identifier (NPI) structure will be implemented in MIHMS.
- Never use MeCMS Billing Provider Numbers in MIHMS.
- Following Re-Enrollment in MIHMS and throughout the run-out period, providers will need to submit any provider file changes both to MIHMS and to MeCMS if they continue to bill pre 8/1/2010 claims.
- Sites enrolled as PCCM in MeCMS need to re-enroll in MIHMS. To participate, you will then need to indicate your site is a PCCM service location during enrollment or by adding it later through Provider Maintenance.
- Generally, MaineCare Provider Enrollment should mirror the enrollment with Medicare to facilitate crossover transactions.
- This change in the MaineCare billing requirements will require that hospitals enroll all rendering (servicing) providers as part of the provider re-enrollment process.

### 5.2 Provider Credentialing

**MeCMS:** MaineCare staff reach out and retrieve many licenses or certifications and update the provider enrollment file. Letters are only sent to providers when an updated license or certification cannot be retrieved.

**MIHMS:** Providers need to update license or certification information through MIHMS Online Provider Maintenance.

- Providers will receive a 60-day reminder letter and another one at the 30-day mark. The reminder letters advise providers to update their license or certification information in their provider file through Provider Maintenance.
- Staff will validate the license information with the licensing entity and will outreach the provider only when/if additional information is needed.
- Providers who do not update license or certification information through Provider Maintenance prior to the expiration date of their current license or certification will automatically lapse in MIHMS and claims will be automatically pended for post-expiration dates of service. During each weekly cycle, such claims will be re-examined and checked for a current license or certification:
  - If the license or certification has come in, the claims will be released to process;
  - If the license or certification has not come in and expired less than 21 days prior, the claims will re-pend; or
  - If the license or certification expired more than 21 days prior, the claims will deny.
    - An exception may be granted for the license or certification expiration date in cases where MaineCare is behind on the facility survey. You may receive an extension letter to that effect. If you have not, contact Provider Enrollment 866-690-5585 to verify if your date has been extended and for what period of time.

## 6. Primary Care Case Management (PCCM) Referral

Managed services are payable by MaineCare only when provided by the member's Primary Care Provider (PCP) or by other MaineCare providers with a referral for the date(s) of service from the member's PCP. Obtaining a referral from the PCCM-PCP is required for specific services as stated in Policy.

### 6.1 Making a Referral

- **MeCMS:**
  - The PCCM-PCP submits a referral form by fax or mailing.
- **MIHMS:**
  - PCCM-PCP referrals from the PCCM-PCP may be received by DDE, a 278 EDI file submission, phone, AVR, fax or mail. Referrals are made for a visit, not at the procedure code level. Diagnosis codes are required.

### 6.2 Referral Status

- **MIHMS:** PCCM-PCP Referrals made to other MaineCare providers can be viewed through the MyHealthPAS online portal. The Referral and its status will be viewable by both the provider submitting the referral and the Provider to whom the referral has been made. To use the online lookup, however, a provider must be a Registered Trading Partner.

### 6.3 Billing for Referred Services

- **MeCMS:** Providers are required to bill MeCMS with a Referral ID number. These Referral ID numbers will not be used in MIHMS. The current MeCMS billing instructions state:
  - CMS1500 Box 17a: Providers are required to enter 1D which is the 2-digit qualifier indicating that it is MaineCare managed care provider in the first box and the PCP's

site-specific, 9-digit Referral Number, in the box beside it. All Managed Care referral numbers begin with 000.

- UB04 Box 50 Line A: Providers are required to enter the MaineCare Managed Care Referral number.
- **MIHMS:** Providers are required to include the NPI of the referring provider.
  - CMS1500 Box 17b: Providers may enter the NPI of the PCCM-PCP.
  - UB04 Box 50 Line A: Providers should not enter the MeCMS referral ID on the UB04 claim form.

## 7. Prior Authorization (PA)

Prior Authorization is the process where a MaineCare employee or their assigned agent formally reviews a certain medical service[s] to be administered to a specific MaineCare member by a specific provider. Specific delivery timeframes, units and dollar amounts are part of a PA.

- **MeCMS:** Multiple governmental or service units review, approve, and process PAs.
- **MIHMS:** With the implementation of MIHMS a more formal business process will be in place for the management of MaineCare PA requests. Most PA requests will be handled through MIHMS using a more efficient process that will take advantage of the following:
  - Standardized PA types
  - Use of State generated and McKesson criteria sheets for identifying submission requirements and decision making criteria

There are three (3) broad groups of authorizations. The first group (Group 1) identifies the authorization requests, by type, that will be managed in MIHMS through a single centralized venue and will follow the PA request process outlined in [Section 7.1](#). The Group 2 and Group 3 list those that are submitted by third parties outside of MaineCare and other State agencies, respectively.

- **Group 1:** Prior Authorizations for medical and other services (managed through MIHMS)
  - **OMS (MaineCare Services)**
    - Dental
    - Dentures
    - Durable Medical Equipment (DME)/Medical Supplies
    - Early and Periodic Screening, Diagnosis and Treatment–Optional Treatment Services
    - Early and Periodic Screening, Diagnosis and Treatment–Optional Treatment Services Durable Medical Equipment (DME)
    - Hearing Aids
    - Home Health for individuals below age 21
    - In-State Inpatient Procedures
    - In-State Outpatient Procedures
    - In-State Podiatric Related Services
    - In-State Professional Services
    - In-State Transportation
    - Orthodontia

- Orthotic/Prosthetic Devices
- Out of State Inpatient Procedure
- Out of State Inpatient Transplants
- Out of State Outpatient Procedures
- Out of State Long Term Placement
- Out of State Transportation
- Physician Administered Drugs
- Private Duty Nursing for individuals below age 21
- Temporomandibular Joint Services (TMJ) Procedures
- Vision
- *Abortion form should be submitted along with the claim. This service is not prior authorized. A special form is submitted with the claim after the service is performed. The form is signed by the physician and attests to certain conditions.*
- **Medical Eye Care Program**
  - All services
- **Group 2:** Prior Authorization requests for Behavioral Health Services (submitted through a Third Party entity managed outside of MIHMS, essentially unchanged)
  - **APS**
    - Behavioral services for children & adults and substance abuse services.
      - **MeCMS:** Use of local codes is allowed.
      - **MIHMS:** Use HIPAA-compliant codes.
        - The authorization number will include the three letter “APS” prefix and will include the PA number assigned by APS through “Care Connection.”
        - Providers must use the PA number when submitting claims.
        - **SUBMIT all PA requests directly to APS for both MeCMS and MIHMS.**
- **Group 3:** Authorization requests managed outside of MIHMS. Approved authorizations will be passed to MIHMS for claims processing. Providers in this group are not required to use the PA number on the claim.
  - Office of Adult with Cognitive & Physical Disability Services (OACPDS)
    - The Summary of Authorized Service (SAS) is the authorization for service.
    - For waiver services under sections 21 and 29 of MaineCare policy.
    - For other services under sections 12 and 102 of MaineCare policy.
  - Office of Elder Services (OES)
    - The plan of care, entered through MeCares, is the authorization for service.
    - For services under sections 19 and 96 of MaineCare policy.
  - Children’s Behavioral Health Services (CBHS)
  - Office of Child and Family Services (OCFS)
  - Children with Special Health Needs (CSHN)

### 7.1 Making a Prior Authorization (PA) Request

- **MeCMS:** The Provider submits a PA request to the appropriate processing unit. MeCMS data will be converted subject to certain limitations. See [Section 2.5](#).

- **MIHMS:** PA requests may be received by DDE, a 278 EDI file submission, AVR, fax, phone or mail.

## 7.2 PA Status

- **MeCMS:** Under MeCMS, an approval number was given if the PA was approved.
- **MIHMS:** All PAs requested are assigned a number which stays with the PA request through final approval/denial.
  - Statuses may be confirmed through the MyHealthPAS online portal (forms entry, authorization status) or by other valid means (mail, telephone, EDI confirmation).
  - Line level status could be different from header when multiple service lines are requested.

## 8. Claims Submission

For all providers, only the most current versions of the paper claim forms (CMS1500, UB04, and ADA2006) will be accepted with the implementation of MIHMS.

- **MeCMS:** Under MeCMS, the providers below use the HCFA1500 or CMS1500 claim form.
- **MIHMS:** The following providers will be required to switch to the UB04 billing form:
  - Federally Qualified Health Centers (FQHC)
  - Regional Health Clinics (RHC)
  - Dialysis Center (DC)

### 8.1 Billing Changes—All Claim Forms

This section highlights claim submission changes between MeCMS and MIHMS. These descriptions include both claim-level and line-level elements and pertain to the paper claim form. Use the Companion Guide for EDI and the MyHealthPAS Online Guide for DDE located on <https://mainecare.maine.gov>.  
*Note: This document does not take the place of billing instructions and is only highlighting differences between MeCMS and MIHMS. A thorough review of the MIHMS billing instructions is recommended.*

#### 8.1.1 Form changes

- Correction Tape or Liquid Correction Fluid
  - **MeCMS:** The use of correction tape and liquid correction fluid has been allowed on submitted claim documents.
  - **MIHMS:** The use of correction tape and liquid correction fluid on paper claims will not be allowed and the claim documents will be returned to the provider.
- Paper Claim Dollar Limit
  - **MeCMS:** Paper claims dollar limit cannot exceed \$99,999.99.
  - **MIHMS:** Providers should not encounter an issue with dollar limits.
- Paper Claims Line Limit
  - **MeCMS:** Paper claims are limited to a single page.
  - **MIHMS:** Multiple page claims can be submitted. See Billing Manuals for specific instructions on how to submit multi-page claims located on <https://mainecare.maine.gov>.

## 8.2 Billing Changes—CMS 1500 Line-Level

- Box 1 Designate a Medicaid claim by marking an **X** in the Medicaid checkbox (2<sup>nd</sup> of four items).
  - **MeCMS:** The Medicare checkbox (1<sup>st</sup> item) is used as a work around in MeCMS to identify claims that should have systematically crossed over from Medicare but that have been dropped to paper.
  - **MIHMS:** Always enter an **X** in the **Medicaid** box for a claim to be paid by MIHMS. Never use any other checkbox.
    - Paper Medicare secondary claims should have an **X** in the **Medicaid** box when submitting claims to MIHMS and providers should no longer place an X in the **Medicare** box.
- Box 2 Name
  - **MeCMS** requirements around name matching are quite specific and mandate the removal of punctuation.
  - **MIHMS:** Providers should continue to follow the billing instruction guidance to use the name as it appears on the Member’s ID card or that they have verified via EDI or through the MyHealthPAS online portal.
- Box 10 B Auto Accident
  - **MIHMS:** If this box is marked as a Yes a provider must provide the two character State designation of where the accident occurred.
- Box 11D Other Insurance
  - **MIHMS:** In all cases, it is now required for providers to check a Yes or No to identify whether or not there is another Health Benefit Plan.
- Boxes 9, 9a-9d Additional Insurance Coverage
  - **MIHMS:** The detail must be provided when 11D is checked.
- Box 17 Referring Provider
  - **MeCMS Box 17a:** Providers are required to enter “1D” which is the 2-digit qualifier indicating that it is a MaineCare PCCM provider in the first box and the PCP’s site-specific, 9-digit referral number, in the box beside it. All PCCM referral numbers begin with 000.
  - **MIHMS:** Box 17b: Used by MIHMS to enter the NPI of the Primary Care Provider. The Referral ID is not required when billing in MIHMS. Providers should verify that referral from the PCP has occurred using either the EDI option or by reviewing referral status in the MyHealthPAS online portal.
- Box 24B Place of Service
  - **MeCMS:** Providers were directed to use 99 as a location of service even when other locations were more appropriate.
  - **MIHMS:** Providers should use 99 only when an appropriate location code is not shown on the list.
- Box 24D Procedures, Services or Supplies
  - **MeCMS:** Extensive use of local codes; providers need to examine codes used in billing to discontinue the use of local codes.
  - Limits usage to one drug code (J-Code/NDC) per claim form. Drug claims must be billed on paper.

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- **MIHMS:** Only HIPAA-compliant codes will be acceptable for billing in MIHMS—local codes are no longer acceptable in Box 24D. Some providers are all ready billing in MeCMS with HIPAA-compliant codes. Providers who are unsure about the codes they are billing should consult the local code crosswalks provided by specific policy section to understand any coding changes that might be required. The local code crosswalk is found at [http://www.maine.gov/dhhs/oms/providerfiles/billing\\_instructions.html#hipaa\\_codes](http://www.maine.gov/dhhs/oms/providerfiles/billing_instructions.html#hipaa_codes).
  - When billing J-Codes, it is necessary to provide the National Drug Code (NDC). The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N499999999999) is added to the top portion of the service line that is shaded in red on an original claim form. Each service line may contain a J-Code and one NDC. There is no longer a limit of one per claim.
- Box 24F Charges
  - **MIHMS:** The amount should reflect the provider's usual charges except in the event of a claim submitted with Coordination of Benefit (COB) information when the amount should be the allowed amount from the primary payor.
  - **MIHMS:** An Explanation of Benefits (EOB) should be attached when submitting a paper claim with COB (crossover or TPL). Third Party Claims may be submitted electronically via EDI or DDE with the EOB uploaded as an image of the document and attaching it directly to the claim within the MyHealthPAS online portal. Paper claims with EOBs may also be mailed together.
- Box 24J Rendering Provider ID#
  - **MeCMS:** Servicing provider IDs (typically ending in a 99) are used in the top part of the box.
  - **MIHMS:** MeCMS Servicing Provider IDs cannot be used when billing to MIHMS; any claim using those IDs will be rejected. Those providers required to enroll rendering providers must supply the NPI of the rendering provider information in the bottom portion of the service line in box 24J.
  - Limit yourself to one unique rendering provider per claim to ensure proper payment. Multiple rendering providers on a single claim form could result in improper reimbursement.
- Box 26 Patient Account #/Control #
  - **MIHMS:** This is now a required field that is created by the provider. The detail of this field is given back as information on the Remittance Advice (RA) and is contained within the 835 EDI file. This is an alpha-numeric field.
- Box 29 Amount Paid
  - **MeCMS:** Enter any other third party payment from an insurance company. Do not enter the Medicare payment.
  - **MIHMS:** Should reflect the amount paid by any other Health Plan to include submission of the EOB as directed in 24F for paper claims.
- Box 32B Service Location ID (NPI/API+3)

- **MIHMS:** Any provider identifying more than one service location during the enrollment process must identify the relevant service location ID in this manner on the claim form. Providers with a single service location for any given enrollment do not need to complete this field.
- Box 33A NPI (Pay To)
  - **MIHMS:** This is used to designate who should receive payment for providers who have enrolled using a National Provider Identifier (NPI). The NPI replaces the MeCMS provider IDs which should never be used when billing to MIHMS.
- Box 33B API (Pay To)
  - **MeCMS:** Providers use 33b to report their MeCMS Provider ID.
  - **MIHMS:** This is used to designate who should receive payment if you are a transportation provider you have elected not to obtain an NPI. The API replaces the MeCMS provider IDs which should never be used when billing MIHMS.

### 8.3 Billing Changes—UB04 Claim-Level

An Explanation of Benefits (EOB) should be attached when submitting a paper claim with COB (crossover or TPL) to MIHMS. Third Party Claims may be submitted electronically via EDI or DDE with the EOB uploaded as an image of the document and attaching it directly to the claim within the MyHealthPAS online portal. Paper claims with EOBs may also be mailed together.

### 8.4 Billing Changes—UB04 Line-Level

- FL 02: Service Location ID (NPI/API+3)
  - **MIHMS:** Any provider identifying more than one service location during the enrollment process must identify the relevant Service location ID in this manner on the claim form. Providers with a single service location for any given enrollment do not need to complete this field.
- FL 03a: Patient Account #/Control #
  - **MIHMS:** This is now a required field that is created by the provider. The detail of this field is given back as information on the Remittance Advice (RA) and is contained within the 835 EDI file. This is an alphanumeric field.
- FL 04: Type of Bill
  - **MeCMS:** Will allow a three digit Type of Bill in addition to the non-HIPAA-compliant codes of 025x, 026x and 027x.
  - **MIHMS:** Only HIPAA-compliant Facilities and Bill Classes will be used in MIHMS, therefore include the leading zero on bill types to make them 4-characters long.
- FL 08b Name:
  - **MeCMS:** Requirements around name matching are quite specific and mandate the removal of punctuation.
  - **MIHMS:** Providers should continue to follow the billing instruction guidance to use the name as it appears on the Member's ID card or that they have verified via EDI or through the MyHealthPAS online portal.
- FL 18-28: Condition Codes
  - **MIHMS:** Use an A1 to identify a service provided under the Early Periodic Screening Diagnosis and Treatment (EPSDT) section of Medicaid. In Maine, this coverage is known as Bright Futures.

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- FL 29 ACDT State
  - **MIHMS:** If the Auto Accident Condition code is provided anywhere in FLs 18-28 a provider must provide the two character State designation of where the accident occurred in FL29.
- FL 39-41 Value Codes
  - **MeCMS:** The code for spend down is D3.
  - **MIHMS:** The code for spend down is 66.
- FL 43 Description
  - **MeCMS:** NDC information is submitted quarterly outside of the claims process via a roster file.
  - **MIHMS:** When billing J-Codes in FL 44, it is necessary to provide the National Drug Code (NDC) in FL 43. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N499999999999). Each service line may contain a J-Code and one NDC.
- FL 49 Non-Covered
  - **MeCMS:** Providers are not able to report items in the non-covered column as MeCMS does not support use of the Non-Covered Column.
  - **MIHMS:** Supports reporting of non-covered items.
- FL 50a Payer Name (Primary Payer)
  - **MeCMS:** Should only contain the word MaineCare. Do not use the word Medicare when billing for Medicare non-covered services.
  - **MIHMS:** Should be used to identify the Health Care Plan who is the Primary payer of the services claimed on the billing form.
- FL 56: NPI (Pay To)
  - **MIHMS:** This is used to designate who should receive payment for providers who have enrolled using a National Provider Identifier (NPI). The NPI replaces the MeCMS provider IDs which should not ever be used when billing MIHMS.
- FL 57 Other Provider ID
  - **MeCMS:** Used for the MaineCare billing provider number assigned by MaineCare.
  - **MIHMS:** Not used in MIHMS.
- FL58-FL62: Additional Insurance Coverage
  - **MIHMS:** While not a new requirement, additional insurance information must be entered when applicable.
- FL 63 Treatment Authorization Codes
  - **MeCMS:** Requires the MaineCare PCCM Referral number in Line A and requires the use Line C for any Authorization numbers. The specific instructions for this line in MeCMS are NOT applicable in MIHMS.
  - **MIHMS:** Providers should align the MaineCare Prior Authorization Number with the row (a, b, or c) identified as MaineCare in FL 50.

### **8.5 Billing Changes—ADA2006 Claim-Level**

MIHMS follows the ADA2006 claim form standards. Unlike MeCMS, MIHMS adheres to:

- No boxes for modifiers
- No box for quantity

### **8.6 Billing Changes—ADA2006 Line-Level**

- Box 1: Type of Transaction is required

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- **MIHMS:** A claim must be indicated with an **X** in either the Statement of Actual service or in EPSDT/Title XIX when providing a service under the Early Periodic Screening Diagnosis and Treatment (EPSDT) section of Medicaid. In Maine, this coverage is known as Bright Futures.
- Box 4: Other Dental or Medical Coverage
  - **MIHMS:** In all cases, it is now required for providers to check a Yes or No to identify whether or not there is another Health Benefit Plan.
- Box 12 Policyholder/Subscriber Name
  - **MeCMS:** Requirements around name matching are quite specific and mandate the removal of punctuation.
  - **MIHMS:** Providers should continue to follow the billing instruction guidance to use the name as it appears on the Member's ID card or that they have verified via EDI or through the MyHealthPAS online portal.
- Box 23: Patient Account #/Control #
  - **MIHMS:** This is now a required field that is created by the provider. The detail of this field is given back as information on the Remittance Advice (RA) and is contained within the 835 EDI file. This is an alpha-numeric field.
- Box 26: Box 26: Tooth System
  - **MeCMS:** Requires that providers enter units in this box.
  - **MIHMS:** Will use the box as it is intended.
- Box 30: Description
  - **MeCMS:** Procedure Code in MeCMS allows for the use of modifiers in this box.
  - **MIHMS:** Will use the form as it is intended, so modifiers are not allowed in this box.
- Box 32: Other Fee(s)
  - **MIHMS:** This box should be used to report any Coordination of Benefits (COB) information. The amount would be entered in Box 32 causing the Total Fee in Box 33 to be reduced by subtracting the amount Other Fee amount from the Total of all services listed in the Fee column under Box 31. An Explanation of Benefit (EOB) should be attached when submitting a paper claim with COB (crossover or TPL). Third Party Claims may be submitted electronically via EDI or DDE with the EOB uploaded as an image of the document and attaching it directly to the claim within the MyHealthPAS online portal. Paper claims with EOBs may also be mailed together.
- Box 35: Remarks (Left Justified): Service Location ID (NPI/API+3)
  - **MIHMS:** Any provider identifying more than one service location during the enrollment process must identify the relevant Service location ID in this manner on the claim form. Providers with a single service location for any given "Pay-To NPI" do not need to complete this field.
- Box 35: Remarks (Right Justified): Reversal/Replacement
  - **MIHMS:** While this is not a change from MeCMS it is included to reinforce the dual purpose of Box 35.
- Box 47: Auto Accident State
  - **MIHMS:** If auto accident is marked with an **X** in Box 45, the two character State designation of where the accident occurred must be provided.
- Box 49: NPI (Pay To)
  - **MIHMS:** This is used to designate who should receive payment. The NPI replaces the MeCMS provider IDs which should never be used when billing MIHMS.

#### 8.6.1 Codes

HIPAA-compliant codes will replace local codes. The HIPAA-complaint codes crosswalk from local codes are located at:

[http://www.maine.gov/dhhs/oms/providerfiles/billing\\_instructions.html#hipaa\\_codes](http://www.maine.gov/dhhs/oms/providerfiles/billing_instructions.html#hipaa_codes)

Be sure to utilize HIPAA-compliant modifiers and units wherever appropriate.

- Anesthesia Codes following the 2009 Reverse CROSSWALK® © 2008 American Society of Anesthesiologists will be used in MIHMS.

##### 8.6.1.1 Use of Modifiers

- **MeCMS:** Providers have been instructed to use modifiers as workarounds in MeCMS when submitting claims. This was often done to allow for proper review of claims.
  - **MIHMS:** Providers should use modifiers in accordance with standard industry coding practice.
1. Modifier 22 is defined as Increased Procedural Services and is used in MeCMS to cause a claim to suspend for additional review:
    - **MeCMS:** Providers have been instructed to use this modifier when submitting either a UB or 1500 claim where payment is supposed to be at a contracted rate rather than at a provider rate or using the standard fee schedule.
    - **MIHMS:** Providers should only use modifier 22 in accordance with standard industry coding practices. Pricing a claim will be done using Provider Contracts.
  2. Modifier FP is the family planning modifier “FP”
    - **MIHMS:** The family planning modifier “FP” must now be used to bill for Family Planning services in MIHMS on the CMS1500 and the UB04 (for example by FQHC/RHC).

##### 8.6.1.2 Local Code Crosswalks

- If you do not see your section of Policy in the crosswalks, it may be because you already file HIPAA-compliant codes. Some of the codes you are currently billing may be HIPAA-compliant, but may now have added modifiers in our usage.
- Units may be changed as a result of the other changes and you should pay particular attention to units. This means many provider types/policy sections will have to bill units differently—such as 15 minutes vs. hourly vs. event, or daily vs. monthly.

#### 8.6.2 Claim TCNs

There are some minor differences between the 18-character TCN in MeCMS and the 11 or 13-character Claim ID Number in MIHMS, but they are parallel terms. See Table 3 for MeCMS TCN logic.

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**Table 5: Structure of a MeCMS TCN**

| Positions/Columns                    | Coding   | Explanation   |
|--------------------------------------|--|---|
| First two positions<br>(cols 1-2)    | 00<br>01<br>10<br>15<br>20<br>22<br>33<br>66<br>77<br>99 | The method of provider claim submission<br>Paper submission<br>HIPAA<br>Legacy<br>Management Fees<br>MBCHP Management Fees<br>Web<br>Web Batch<br>Crossover Part B<br>Crossover Part A<br>Electronic  |
| Next four positions<br>(cols 3-6)    | CCYY   | Century and Year that the claim was received by OMS   |
| Next three positions<br>(cols 7-9)   | JJJ  | The Julian Day the claim was received by OMS. A claim received on January 2 would show 002. Counting from the first day of the year, January 28 would show as 028 and December 21 would show as 355, for example.   |
| Next three positions<br>(cols 10-12) | BBB  | The batch range assigned to submitted claims. It is a sequence of numbers starting with 0 for claims loaded in MeCMS each day.<br>Batch Ranges for Paper Claims <ul style="list-style-type: none"> <li>• 001-500 - HCFA/CMS 1500</li> <li>• 501-799 - UB92/UB04</li> <li>• 800-999 - Dental</li> </ul> Batch ranges for other sources like EMC, Web, Web Batch, Crossover Part A, Crossover Part B, etc., will be sequential. |
| Next three positions<br>(cols 13-15) | CCC  | The claim number within the batch. The additional 0 allows for expansion.   |
| Last three positions<br>(cols 16-18) | LLL  | Line # Header will always end in 000.<br>Individual line numbers will end in 001, 002, and continuing sequentially.   |

The (primary) MIHMS ID Number structure is:

**Table 6: Structure of a MIHMS Claim ID Number**

| Positions/Columns                  | Coding          | Explanation  |
|------------------------------------|-----------------|--|
| First two positions<br>(cols 1-2)  | YY              | Year   |
| Next three positions<br>(cols 3-5) | JJJ             | Julian Date  |
| Next position<br>(col 6)           | E<br><br>S<br>W | Value of 'E' coded for EDI claim.<br>Claims submitted on paper are also converted to 'E' when they are processed.<br>Value of 'S' coded for Secondary claim<br>Web (DDE) |
| Last five positions<br>(cols 7-11) | xxxxx           | Sequence number assigned to claim by the system for that date  |

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| Positions/Columns      | Coding      | Explanation |
|------------------------|-------------|-------------|
| Sample Claim ID Number | 10213W00001 |             |

The claim ID is extended by two additional positions if the claim is reversed or replaced:

**Table 7: Additional Positions in the Structure of a MIHMS Claim ID Number for a Reversal or Replacement**

| Positions/Columns       | Coding                         | Explanations   |
|-------------------------|--------------------------------|--|
| Next position (col 12)  | R<br>A                         | Value of 'R' indicates Reversal claim<br>Value of 'A' indicates Replacement claim  |
| Next position (col 13)  | n                              | A unique sequence number in the form of a single numeric digit used in ordered pairs to match up reversals and replacements.<br>For example, the first reversal would be R1.<br>It's replacement would be A1, etc. |
| Sample Claim ID Numbers | 10213W00001R1<br>10213W00001A1 |  |

### 8.6.3 Service Specific Changes

#### 8.6.3.1 Interpreter Services

- **MeCMS:** Providers bill the Interpreter Service charges with their billing number in the servicing provider field because these services are set up in MeCMS to be covered under the billing provider specialty/subspecialty.
  - If the "From" date of service for the Interpreter Service charge matches the "From" date of service of the paid claim (same member, same billing provider), the interpreter claim is then paid.
  - The "From" date of service is also used to pay Interpreter Service charges billed for follow up services related to a paid global service; as above the "From" date of service on the Interpreter claim matches the "From" date of service of the global charge.
  - The provider can either bill the entire date span for Interpreter Services related to the paid global service or they can bill each month by adjusting the previous month's claim (extending the "To" date, adding units and dollars).
- **MIHMS:** Providers should bill using their NPIs and may submit the Interpreter Services on the same claim along with the MaineCare service(s) being billed.

#### 8.6.3.2 Billing for State-supplied Vaccine

- **MeCMS:** Providers are required to bill both for the injection and the vaccine:
  - \$0 for State-supplied or the actual cost with the CPT code if they had to purchase it, and;
  - The corresponding CPT code for the administration of the vaccine (at the appropriate rate identified);

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- Providers are reimbursed a standard rate for the administration, regardless of the source of the vaccine.
- **MIHMS:** Providers will be required to bill for the administration of a State-supplied Vaccine using the appropriate CPT Code and adding the SL modifier. The modifier indicates the vaccine is State-supplied and the reimbursement will be the standard rate for the administration.

### Hospital Claims

- **MIHMS:** Hospitals must bill consistent with Medicare billing requirements. This billing requirement is necessary to ensure that hospital claims (to include crossovers) are processed accurately.
- **MIHMS:** MaineCare will allow Critical Access Hospitals (CAH) to bill consistently with how they have elected to bill Medicare. CAH providers billing Medicare who have elected Option 2 methodology for payment; bill out-patient professional services on the UB04 and in-patient professional services on the CMS1500. Billing on the CMS1500 will require that the rendering providers be enrolled in the MaineCare system.
  - Implementation of Diagnosis Related Group (DRG) and Ambulatory Payment Classification (APC) will be implemented based on the start dates listed below and will be phased in with the start of the hospital's fiscal year start date.
    - Non-Critical Access Hospitals
      - DRG: 8/1/2010
      - APC: 4/1/2011
    - Critical Access Hospitals
      - Migration to DRG/APC for Critical Access Hospitals will be revisited in the next fiscal year.

#### 8.6.3.3 Nursing Facilities

- **MeCMS:** MaineCare case mix adjusts payments to nursing facilities based on a point in time facility average case mix index. Quarterly, facilities review a roster of residents whose RUG group will be used to calculate the average case mix index. Once verified by the facility, a final roster is used to calculate a new rate. This new rate is set for a quarter. Facilities bill with a single daily rate for all MaineCare members in their facility. The facilities bill with the 0167 revenue code.
- **MIHMS:** With MIHMS implementation, nursing facilities will bill two (2) codes for the care they provide MaineCare members, based on rates calculated at least annually:
  - A revenue code for the non-case mix component (direct care add-on, routine and fixed), and
  - A revenue code with the HCPCS RUG<sup>2</sup> code using the three characters RUG III Group (e.g. SC2) and the two-digit extension "00." The weight associated with the HCPCS RUG<sup>3</sup> code will be multiplied by the Total Allowable Inflated Direct Care Rate. The case mix adjustment to the rate is associated with the resident's active assessment.
  - Updated revenue codes to be used for room & board (non-case mix), hospital leave, and therapeutic leave are covered in the Billing Instructions.

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<sup>2</sup> Healthcare Common Procedure Coding System (HCPCS) Resource Utilization Groups (RUG) codes

<sup>3</sup> Healthcare Common Procedure Coding System (HCPCS) Resource Utilization Groups (RUG) codes

### 8.6.3.4 Medicare Non-covered Services

- **MeCMS:** When billing for services after Medicare, MeCMS is programmed to look for a value code. However, there is no valid value code for Medicare non-covered services. When using the word Medicare in field locator 50a for non-covered charges the system has been inappropriately applying reimbursable charges to the contractual adjustment.
- **MIHMS:** When billing for excluded or non-covered services, please bill MaineCare appropriately as primary.

### 8.6.4 Crossovers

- **MeCMS** is unable to process crossovers. The work around solution is to submit claims on paper. The hospital crossover workaround is managed by BNN. See appendix 1 of the MeCMS UB billing instructions.
- **MIHMS:** Under MIHMS, Crossovers will be processed normally.
  - Claims, including adjustments, submitted to Medicare for dually eligible MaineCare members will be processed using the Coordination of Benefits Agreement (COBA) Program files for Medicare Part A and Part B.

## 9. Claims Processing

### 9.1 Multiple Services on the Same Date

- **MeCMS:** When a provider bills for more than one revenue code/HCPSC for the same day, they are required to roll up the lines and report as one line. This is also currently required for hospitals that do split billing for their hospital based practices. Their facility component dupes out against the professional charge.
- **MIHMS:** Under MIHMS, Providers will be able to bill more than one revenue code/HCPSC for the same day except for room and board codes.

### 9.2 Members Enrolled in Multiple Benefit Plans

- **MeCMS:** When there is more than one eligibility on a multi-line claim, the entire claim is paid with each line adjudicating against the appropriate eligibility segment.
- **MIHMS:** Upon implementation of MIHMS, when one or more lines of a claim are eligible to be paid under separate eligibilities, the original claim will process against the first eligibility segment for the member and all lines not able to be paid under that first eligibility will be denied. The claim will then go out to the provider on the RA showing the paid and denied lines. MIHMS will then also automatically create a secondary claim in the next cycle where the lines not paid against the first eligibility will be available to process against the next eligibility. That claim will be linked to the original claim through the claim id (TCN). The paid claim lines from the first claim will now appear as denied and the remaining lines will process against the next eligibility. This will occur in cascading fashion with each subsequent cycle until all lines have been adjudicated. All lines will appear as separate claims on the RA.

### 9.3 Reversals and Replacements

With the implementation of MIHMS, industry standard language will be adopted for Voids and Adjustments. Voids will be referred to as Reversals and Adjustments will be called Replacements. These continue to be the same EDI transaction types as in the past but with different labels.

**Table 8: EDI 837 Transaction Types**

| 837 Transaction Type | MeCMS      | MIHMS       |
|----------------------|------------|-------------|
| 7                    | Adjustment | Replacement |
| 8                    | Void       | Reversal    |

- **MeCMS:** All corrections, whether reversal or replacement, were done at the line-level.
- **MIHMS:** Reversals and replacements may be done at EITHER the line-level or the claim-level (document-level).

## 10. Remittance Advice

### 10.1 Remittance Advice (RA) and Electronic Remittance Advice (ERA or 835)

Remittance Advices can be either Paper or Electronic and will provide details about claim payments and will provide EOBs if the claims are denied. The RA is a human-readable report; the ERA is intended for computer programs to utilize.

- **MeCMS:** The paper RA is mailed to the provider and an electronic remittance is available via File Transfer Protocol (FTP). However, the MeCMS electronic remittance does not follow the HIPAA EDI standard. Pharmacy claims are separate.
- **MIHMS:** Providers will have access to both RAs and ERAs that will include both Medical and Pharmacy claims. Other features of the new RA include history-only adjustments and a cover page that will include alerts and memos, when applicable. Transactions will be separated by service location ID and then grouped under paid, denied & adjusted.
  - **Remittance Advice:** Providers who are also Trading Partners will have the choice to receive the RA via download or by US mail. . The download, which is the default setting for Trading Partners, is available through the MyHealthPAS online portal and may be changed by the provider at any time. A checkbox in the Trading Partner Account Maintenance section controls how the RA is delivered. A check in the box means that the RA will be downloaded and will not be mailed.
    - Providers who are not Trading Partners will receive the RA via US mail.
  - **Electronic Remittance Advice:** Providers may access an industry standard ERA with data in the HIPAA X12N 835 standard through the MyHealthPAS online portal. Providers may send the 835 to a registered billing agent or clearinghouse instead of accepting the default to have it go to their Trading Partner account.

## 11. Operations

The Fiscal Agent is under contract with MaineCare to perform ongoing operational tasks and call center activities:

- **Provider Enrollment**—Provider enrollments and provider file maintenance will be the responsibility of the Fiscal Agent effective 3/1/2010 for MIHMS enrollments.
  - MeCMS enrollments will continue to be maintained until 8/1 for services provided through 7/31/2010.
- **Provider Services**—Call Center activities to support Trading Partner Agreements and EDI testing have been in effect since 12/14/09, support for Prior Authorization and PCCM Referral submissions will be in effect 7/6/2010 and billing information, and claim inquiries will be in effect 8/1/2010 utilizing MIHMS. The Call Center will have the ability to direct calls to customer service staff from 7:00AM to 6:00PM, Monday through Friday, excluding State Holidays.
  - OMS will continue to support MeCMS call center and customer service activities for services provided prior to 8/1/2010.
  - Note that the Call Center does not support PAs for Groups 2 and 3 in Section 7 above.
- **Member Services**—Call Center activities to support PCCM, Member Services and Third Party Liability (TPL) will transition to the Fiscal Agent effective 8/1/2010. Members may call to request replacement ID cards or obtain them via the Member portal.
- **Provider Training**—Provider Training will continue to be offered periodically and training videos will be available online.

### 11.1 Claims Mailing

**Table 9: Old & New Contact Information**

| Claims Mailing Address  | MIHMS  |       |
|---|--|-------|
| Common mailing address for MaineCare claims effective 8/1 with mailstops for each type of claim form. | MaineCare Claims Processing<br>11 State House Station,<br>M-500 (CMS1500)<br>M-100 (for UB-04)<br>M-600 (ADA Dental)<br>Augusta, ME <b>04332</b> |       |
| Below are those mailstops which will change for MIHMS for specific provider types that are affected:  |  |       |
| Provider Type   | MeCMS  | MIHMS |
| Transportation  | M-1400   | M-500 |
| Nursing Home  | M-400  | M-100 |
| ICF-MR  | M-400  | M-100 |
| Assisted Living Services  | M-700  | M-100 |
| Adult Family Care Home  | M-700  | M-100 |
| Private Non-Medical Institution   | M-700  | M-100 |

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| EMAIL ADDRESSES for service and assistance |   |
|--|---|
| Provider Enrollment                        | <a href="mailto:MainecareEnroll@unisys.com">MainecareEnroll@unisys.com</a> (effective 3/1/2010)       |
| Support.                                   | <a href="mailto:MainecareSupport@unisys.com">MainecareSupport@unisys.com</a> (effective 3/1/2010)     |
| Technical                                  | <a href="mailto:MainecareTechnical@unisys.com">MainecareTechnical@unisys.com</a> (effective 3/1/2010) |
| Member questions                           | <a href="mailto:MainecareMember@unisys.com">MainecareMember@unisys.com</a> (effective 8/1/2010)       |
| Provider questions                         | <a href="mailto:MainecareProvider@unisys.com">MainecareProvider@unisys.com</a> (effective 8/1/2010)   |

| TELEPHONE NUMBERS for service and assistance (Toll-Free) |  |   |
|--|--|---|
| Provider Services  | Provider Services<br>toll free phone:<br>800-321-5557 option 8   | Provider Services<br>toll free phone:<br><b>866-690-5585</b><br>Effective 3/1/2010<br>for Provider Enrollment<br>Effective 7/5/2010<br>for Prior Authorization/Referral<br>Effective 8/2/2010<br>for Claims |
| Member Services  | Local Numbers in many cities such<br>as 624-8090 in Augusta, or<br><br>Toll free phone<br>800-452-1926 | Member Services toll free phone:<br><b>800-977-6740</b><br>(effective 8/1/2010)<br><br>TTY for Member Services:<br>800-977-6741<br>(effective 8/1/2010)   |

## 12. Additional Material

### 12.1 Terminology

Terminology will be changing as we move from MeCMS to MIHMS. For example, Claims Adjustments and Voids are now going to be called Replacements and Reversals.

**Table 10: Terminology**

| Old Terminology                  | New Terminology                | Notes |
|----------------------------------|--------------------------------|-------|
| MeCMS                            | MIHMS                          |       |
| Adjustments                      | Replacements                   |       |
| Voids                            | Reversals                      |       |
| Servicing Provider               | Rendering Provider             |       |
| Interactive Voice Response (IVR) | Automated Voice Response (AVR) |       |

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| Old Terminology | New Terminology | Notes  |
|-----------------|-----------------|--|
| TCN             | Claim ID Number | If TCN is used in MIHMS, it means the Claim ID Number. |

## 12.2 Reference Information

[MIHMS Billing Instructions](#)

[EDI Companion Guides](#)

[Crosswalks for Local Codes](#)

## 12.3 Useful Life of this Document

This Transition Guide will assist you in preparing for the conversion to MIHMS and continue through the transition until MeCMS is no longer processing claims, by helping you identify where to adjust your billing, prior authorization, and other business practices. After MeCMS is shut down, this document will be more of a historical reference and the current MIHMS billing guides will always be your best source of information on how to bill under MIHMS.