Washington State Health Care Authority

Tribal Billing Workgroup (TBWG)

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Agenda

- **New Business**
  - Monthly Data & helpful hints
  - Billing instructions – propose billing model
- **Old Business**
  - Non-Native CD billing model for ABP clients
  - Annual Mass adjustment second sweep finalized
- **Weekly FAQ and Open Discussion**
- **Old Business Pended, but not Forgotten**

May 2014 Claims Data (I/T/U)

	April, 2014 dollars	April, 2014 clients*	April, $ per client	% of claims paid
Medical	$1,568,083	4,603	$340	74%
Dental	$513,409	1,551	$331	82%
Mental Health	$1,304,761	1,498	$871	91%
Chemical Dep	$1,789,087	1,054	$1,697	95%
Nursing	$52,356	15	$3,490	84%
POS	$378,116	4,795	$79	60%
Totals	$5,605,815	10,678*	$524	See categories

NOTE: claim count has been removed, this bit of data was not useful
Note: U claims are not easily sorted into Medical vs Mental health. At this time U claims for non-CD, non-Dental are added to the medical category

* Client count will not be the sum from the categories due to 'overlap' (clients can be in more than 1 category)
prior client counts only counted the paid claims – current and future client counts will count paid and denied claims

Medical Claims – Top Denial Reasons

EOB 26 Client not eligible on this date

EOB 31 Client ID not on file

- If there is a space after the "WA" the system treats the space as an invalid value

EOB 204 Service not covered for client's Benefit plan

- Usually Family Planning client & claim is not for FP services

EOB 16+N290/16+N288 Servicing NPI missing/not on file or taxonomy is not one that the servicer is enrolled with

- March 11 TBWG has information on provider file updates

Medical Claims - Top Denial Reasons

EOB 4 – Missing the UA/SE modifier

EOB 24 – Client in Medicaid Managed Care

EOB 22 – Client has Medicare

EOB 181 – Procedure is invalid

- Usually 99386 99396 – preventive visits for adults not covered (cancer screens are covered, interested? Contact mike)
- Office visits/E&Ms are covered

Dental Claims – Top Denial Reasons

EOB 16+N290 Servicing provider missing or not on file

EOB 26 – Client not eligible on this date

EOB16 + N39 tooth # not allowed for this code

- Usually anterior restorations on posterior teeth

EOB 6 service not allowed for client's age

- D1330 age 0-8
- D1120 age 0-13
- D1110 age 14+

EOB 18 - duplicates

Dental Claims – Top Denial Reasons

EOB 119 – exceeds limits

Cheat sheet for the common dental limits

Fluoride D1206/D1208				
Age 0-6	Age 7-18	Age 19+	Age 0-18 in ortho	All ages, DDD
3 per year	2 per year	1 per year	3 per year	3 per year

Prophy/Cleaning D1110/D1120			
Age 0-18	Age 19+	All ages, DDD	All ages, Nursing Home client
1 per 6 months	1 per year	3 per year	4 per year

Exams D0120/D0150	
All ages	All ages, DDD
1 per 6 months	3 per year

Mental Health Claims – Top Denial Reasons

- **91% payment rate**

EOB 26 – Client not eligible on this date

EOB 18 or 96+N20 – duplicate – either a regular duplicate or group + individual on same day

CD Claims – Top Denial Reasons

- **95% payment rate**

EOB 26 – Client not eligible on this date

EOB 170+N95 – taxonomy vs code. Usually due to MH/medical code on CD claim

EOB 11 – Diagnosis not allowed

Primary diagnosis on CD must be:

- 303.90-303.93 or 304.90-304.93

  (kids and pregnant clients also allow 305.00, 305.90)

EOB 18 – duplicates – either a regular duplicate or group + individual on same day

Billing Guide Update

Let Mike know if:

- You want to have your voice heard or
- You want to be able to review the billing guide

Tentative changes to billing guide:

- Remove Tribal modifiers *for AI/AN clients*
- Code-set for CD and for mental health (medical is too large of a code-set and dental is limited)
- 1-stop cheat sheet with all the billing taxonomies and references to the 'parent programs'

Billing Model Proposal

- **Last October I asked *what's broke?*** and one of the top answers was the AI/AN and NonNative 'modifier' requirement

- **What if the billing model was simplified** and Tribal Health claims no longer need to indicate when the client is AI/AN?

Billing Model Proposal

CURRENT BILLING MODEL		
Category	**AI/AN**	**NonNative**
Medical	UA	SE
Dental	EPA 870001305	EPA 870001306
Mental Health	HE	SE
CD	HF and SCI=NA	HX and SCI=NN (or SE +SCI=NN for ABP ***soon***)

Billing Model Proposal

PROPOSED BILLING MODEL		
Category	**AI/AN**	**NonNative**
Medical	--	EPA 870001306
Dental	--	EPA 870001306
Mental Health	--	EPA 870001306
CD	--	HX (or SE for ABP ***soon***) and SCI=NN

Race-Code May Not Match Billing

	Without EPA	With EPA
AI/AN	Match	Mismatch 1
NN	Mismatch 2	match

Non-Native CD Claims for Newly Eligible ABP Clients

Non-Native CD claims at the I/T clinics for the newly eligible clients (ABP/N05/RAC 1201) will start paying the federal portion (100% of $342 for 2014) soon

Refer to slides from July 8th Billing Workgroup for more information

Annual Encounter Rate adjustment

- **Medical and Dental claims have been reprocessed**
  - Took 2 sweeps let me know if I missed any – in late August I will search for any more $330 claims
- **CD claims for AI/AN clients have been reprocessed**
  - CD claims for nonNatives are pending the update for ABP clients
- **Claims recouped the old paid amount ($330) and reprocessed to pay at the 2014 rate ($342)**
- **Claims are all TCN 4x141552 and 4x142032**
  - (credits/take backs have various claim numbers)

Open Questions and Open Discussion

- **Please feel free to ask to be unmuted or use the questions pane**
- **If you think of questions or issues for the Billing workgroup later please send to Mike or Jessie**
- **Questions that had “stay tuned” for an answer will stay on the log until answered**

Open Discussion Q&A

NonNative Chemical Dependency

Why are providers responsible to identify types of Medicaid coverage utilizing modifiers for Medicaid payment processing. It is difficult to have to look up each patient eligibility to determine classic Medicaid vs ABP

The CD program, ran by DSHS, has various funding sources and procedure/modifier combinations are always required on CD claims in order for codes/services to pay under appropriate funding sources

Pharmacists

What about PharmD's? encounter or FFS? Are we lobbying for pharmacists to be able to get encounter rate for med therapy management?

PharmD's are not encounter eligible at this time. What services can a pharmacist render on a professional/HCFA claim? Stay tuned

Open Discussion Q&A

Managed Care Wraparound

What if managed care denies the claim?

Stay tuned, in the interim can you email/fax mike denials?

Most denials so far have been denied in error by the Managed Care Plans

Children's Mental Health providers must have 2 years of experience working with kids

Is this required for RSN contracted providers as well?

Stay tuned

Open Discussion Q&A

Spend-down

We're having huge issues with spend-downs, especially the childrens' prior to 10/1/13. Any contact info with be appreciated

Spend-down claims applied to spend-down amount or do we need to send in an invoice to spend down dept?

Stay tuned

June 10, we're closer. Need to make sure that HCA answer does not break any federal rules.

July 8, progress?

Open Discussion Q&A

IUD payable separately outside of Encounter?

Not sure if this was already asked but can we bill for the implants separately also?

Yes, IUDs and Implants are payable outside of encounter (needs to be on different claim, otherwise System will try to bundle it into the encounter payment)

UPDATE 06/10/2014 – State Plan – "pharmaceuticals/drugs are outside the encounter rate and are reimbursed under the fee-for-service…." (needs to be on different/separate claim)

What about other supplies/services that may have a cost that is greater than the Encounter rate?

Good question, working on answer that may cover this question most of the time without visiting issue code-by-code

Open Discussion Question Log from Previous TBWG

Is there a way to get the medical claims to pay directly even if they have an MCO since they are Native and not required to have an MCO?

Stay tuned, pilot project is starting with the FQHCs

Why did you deny my prolonged care (CPT 99354-99357) claim?

CPT 90837 was added for 2014 as an allowable service for prolonged care, system update to allow 90837 to be billed with 99354-99357 started. ETA unknown, most likely 4-8 weeks. **Stay tuned.**

Open Discussion Question Log from Previous TBWG

Billing managed care and receiving denials for non-network. WAC is not honored cannot bill Medicaid wrap around without payment from HO

Information being forward to the Managed Care Plans. Keep sending denials to mike so we can forward to the MCO plans and look for common issues

Old Business - Mental Health

- Service Modalities that have been coded
- Brief Intervention – refer to Individual, Family, and Group
- Family Treatment – 90846, 90847
- Group Treatment – 90849, 90853
- Individual Treatment Services – 90785, 90832, 90833*, 90834, 90836*, 90837, 90838*
- Intake Evaluation – 90791, 90792*, E&M*
- Medication Management – M0064*, E&M*
- Psychological Assessment** – 96101, 96110, 96111, 96116, 96118, 96119

* services rendered by Psych MD, Psych ARNP or Psych Mental Health Nurse Practitioner-board certified

** Assessment/testing has limits/PA/EPA criteria , refer to Mental health billing guide

Old Business - Mental Health

- Service Modalities pending code decision
- Medication Monitoring (Medication training and support)
- Crisis Services
  - Suggested CPT – 90839 and 90840
- Day Support
- Peer Support
- Stabilization services
- Therapeutic Psycho-Education – refer to individual treatment services

Thank you

Send TBWG comments and questions to:

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