Washington State Health Care Authority

Tribal Billing Workgroup (TBWG)

November 12, 2015

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HCA Tribal Affairs Office

Agenda

- Monthly Data and Analysis
- PCCM Referrals and Billing
- 2016 Meeting Schedule
- Encounter Billing when the FFS code is a Global Code
- Vision Care Services Overview
- ProviderOne Screen Issues
- FAQ and Open Discussion

September 2015 Claims Data (I/T/U)

	Dollars	Dollars, Prior TBWG	Clients*	Clients, Prior TBWG*	% Paid	% Paid, Prior TBWG
Totals	$6,850,772	$6,893,914	12,061	11,876	NA	NA
Medical	$1,724,374	$1,528,528	4826	4602	88%	83%
Dental	$722,754	$777,087	2189	2265	69%	86%
MH	$831,155	$796,776	1170	1069	92%	91%
SUDS(CD)	$3,079,366	$3,239,930	1241	1294	90%	93%
POS	$493,095	$470,440	5799	5490	59%	55%
Other FFS	$28	$81,150	167	207	0%	10%

* Client count will not be the sum from the categories due to 'overlap' (clients can be in more than 1 category)

Medical Claims – Top Denials

EOB	Description	Comments	Denial % *
24	Charges are covered under a capitation agreement managed care plan	Client is Enrolled in one of the Managed Care Plans	18%
18	Exact duplicate claim/service	Duplicate billing	7%

* Denial percentages example: Out of the Medical claims that did not pay at the encounter rate, 18% were due to managed care

Medical Claims – Top Denials

EOB	Description	Comments	Denial %
96 / N129	Not eligible due to the patient's age.	CPT 99391-99396 on a claim causes the claim to be a well-child visit, which is only for clients age 20 and younger. Eg, preventive codes (99385 99386 99395 99396) are not covered for adults and not only will the code error out but the entire claim errors out because the claim becomes a well-child visit I noticed a cancer screen diagnosis on many of these claims and the clients were over age 20. Cancer screens are covered (and encounter eligible) under different CPT/HCPCS codes. Refer to physician billing guide, p. 116.	5%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	The AI/AN or non-AI/AN modifier was missing	5%

Medical Claims – Top Denials

EOB	Description	Comments	Denial %
22	This care may be covered by another payer per coordination of benefits.	Client has Medicare	4%
16 / N329	Missing /incomplete /invalid patient birth date	Usually incorrect birthday on claim. Some claims had incorrect birthday and gender, which usually indicates the wrong client ID. If you think you have the right birthday on the claim or are unsure, contact Mike	4%

Medical Claims – Top Denials

EOB	Description	Comments	Denial %
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage	4%
16 / MA39	Missing/ incomplete / invalid gender	Usually incorrect gender submitted on claim but we have seen some female *Mike* and male *Sally* clients in P1. Contact Mike if you have what appears to be a gender mismatch in P1	3%

Medical Claims – Top Denials

EOB	Description	Comments	Denial %
96 / N59	Non-covered charge(s).	Payable codes are listed in the Physician Related Services-HealthCare Professionals Billing Guide and Fee schedule	2%
170 / N95	Payment is denied when performed/billed by this type of provider.	Noticed on Physical Therapy (PT) claims. PT claims require billing taxonomy 225100000x along with the extra modifier (GP)	2%

Dental Claims – Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing.	19%
16 / N288	Missing / incomplete / invalid rendering provider taxonomy	Claims had a valid servicing taxonomy but the taxonomy on the claim wasn't one that the dentist was enrolled with. Two resolutions: 1. Change the claims so that they are submitted with the taxonomy that the dentist is enrolled with. 2. Update the provider's file to include the taxonomy that is being billed (if appropriate, wouldn't give an oral surgeon taxonomy to a general dentist). If you choose option 2 contact Mike so he can reprocess claims so you do not have to rebill	8%

Dental Claims – Top Denials

EOB	Description	Comments	Denial %
119 / M80	Not covered when performed during the same session/date as a previously processed service for the patient.	Similar to duplicate billing – office visit denies if an office visit has already been paid on same date of service	5%
204	This service/ equipment/ drug is not covered under the patient's current benefit plan	Usually a family planning only client	3%

Dental Claims – Top Denials

EOB	Description	Comments	Denial %
96 / N428	Not covered when performed in this place of service.	Limited Visual Oral Assessments (D0190/D0191) are only covered when provided in settings other than dental offices or clinics (eg, Alternative living facility, school, home (eg, 03 12 13 14 15 31 32 33 53 54 71))	3%
6	The procedure/ revenue code is inconsistent with the patient's age	Some dental services are only allowed for children (sealants, hygiene instructions, crowns, posterior root canals) Prophy ages D1110 – 14 years and over D1120 – 0 through 13 years	3%

Dental Claims – Top Denials

EOB	Description	Comments	Denial %
119 / M86	Service denied because payment already made for same/similar procedure within set time frame.	Prophy limits Kids (age 0-18) – one prophy per 6 months Adults (age 19+) – one prophy per 12 months Any age client residing in nursing facility – one prophy per 4 months Any age Development Disabilities Administration (DDA) client – three prophy per 12 months	3%
96 / N59	Non-covered charge(s).	Covered codes/services are in the Dental billing guide and fee schedule	3%

Dental Claims – Top Denials

EOB	Description	Comments	Denial %
16 / N75	Missing/ incomplete/ invalid tooth surface information.	Noticed on restoration codes. Restorations can be 1,2,3 or 4 or more surfaces. The number of surfaces on the claim needs to match the code	3%
96 / N54	Claim information is inconsistent with pre-certified / authorized services	Service is noncovered **or** the authorization is mismatched with the claim	3%

Dental Claims and Multiple Authorization Numbers

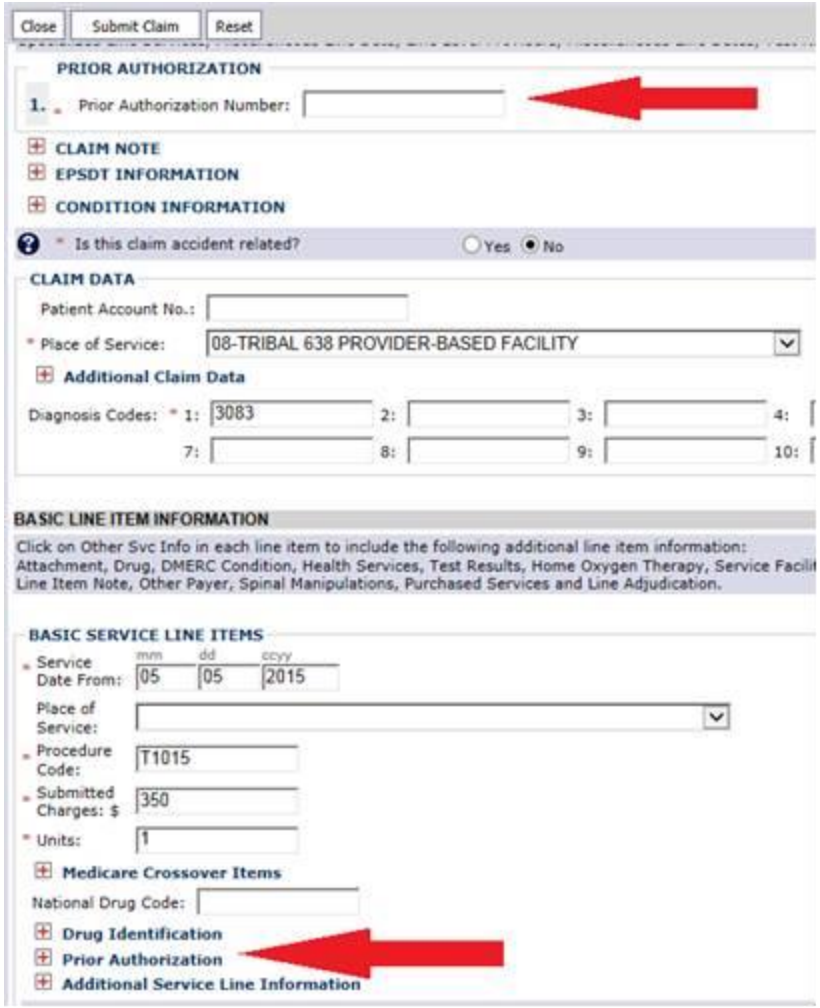
- Dental claims require an Expedited Prior Authorization (EPA) in order to determine whether the client is AI/AN or non-AI/AN
  - 870001305 = AI/AN
  - 870001306 = non-AI/AN
- Some services (like crowns and orthodontics) require an authorization number too
- HIPAA rules allow **one** authorization at document level and **one** authorization at line level
- If a dental claim requires two authorization numbers
  - Submit the AI/AN or non-AI/AN EPA at document level
  - Submit the authorization for the service on the line that requires authorization
- Examples on next page

Dental Claims and Multiple Authorization Numbers

ProviderOne screens

- Put the 870001305 or 870001306 in the top Prior Authorization field

- Put the service authorization on the line(s) that need authorization. (Lower prior authorization field)



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Dental Claims and Multiple Authorization Numbers

HIPAA billing

- Bill the 870001305 or 870001306 at document level
  - Loop 2300, segment REF, data element 01 – Identification qualifier – enter in G1
  - Loop 2300, segment REF, data element 02 – enter in the correct EPA
- Bill the service authorization on the line(s) that need authorization
  - Loop 2400, segment REF, data element 01 – Identification qualifier – enter in G1
  - Loop 2400, segment REF, data element 02 – enter in the authorization for the service

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing. When this EOB happens at document level then it is due to a duplicate batch submission	21%
24	Charges are covered under a capitation agreement managed care plan	Client is Enrolled in one of the Managed Care Plans.	19%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
16 N288	Missing / incomplete / invalid rendering provider taxonomy	Claims had a valid servicing taxonomy but the taxonomy on the claim wasn't one that the MHP was enrolled with. Two resolutions: 1. Change the claims so that they are submitted with the taxonomy that the MHP is enrolled with. 2. Update the provider's file to include the taxonomy that is being billed (if appropriate, wouldn't give a *brain surgeon* taxonomy to an MHP). If you choose option 2 contact Mike so he can reprocess claims so you do not have to rebill Not sure what the provider is enrolled with? a. Contact Mike or b. you can look in P1 to see what the provider is enrolled with and make changes. Go to page 217 of this Medicaid webinar	9%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
204	This service/ equipment/ drug is not covered under the patient's current benefit plan	Usually a family planning only client but sometimes is due to "invalid" servicing taxonomy. P1 is set up to pay the client's benefit packages based on the servicing taxonomy. If a claim has a taxonomy that is not set up in P1 then this error may occur	8%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
96 / M80	Not covered when performed during the same session/date as a previously processed service for the patient.	Mental health related code/service already paid	7%
22	This care may be covered by another payer per coordination of benefits.	Client has Medicare	2%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Missing the HE or SE modifier	2%
16 N290	Missing/ incomplete/ invalid rendering provider primary identifier	Servicing provider is not in ProviderOne yet. Get the provider enrolled and then remember to request a back-date if they started working before they were approved in P1	1%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
16 M54	Missing / incomplete / invalid total charges.	Total billed amount was $0 – looks like the T1015 line was separated from the billing code(s)	1%
96 N59	Non-covered charge(s).	Mental health codes are in the HCA mental health guide or in the Tribal Health guide (for the RSN modalities) NOTE: Crisis Services is a payable service. Normally the client is referred to the RSN for crisis services but AI/AN clients and Clinical Family Members can opt out of RSN managed care – see Tribal guide for Crisis Services (HCPCS code H2011 with an EPA)	1%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing.	78%
170 N95	Payment is denied when performed/billed by this type of provider.	Usually a valid SUDs code that didn't have the HF modifier	2%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
11	The diagnosis is inconsistent with the procedure	SUDs claims require that the primary diagnosis be either ICD-9 303.90, 304.90 (all clients) or 305.00, 305.90 (age 10-20 and/or pregnant clients) ICD-10 F10.10, F10.20, F11.10, F11.20, F12.10, F12.20, F13.10, F13.20, F14.10, F14.20, F15.10, F15.20, F16.10, F16.20, F18.10, F18.20	1%
96 N59	Non-covered charge(s).	Usually a lab code	1%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Noticed only on the T1015 line for non-AI/AN claims ABP (RAC 1201) requires modifier SE on T1015 SSI (RAC 1217) requires modifier HB on T015 All other clients require modifier HX on T1015	1%
181	Procedure code was invalid on the date of service.	This EOB happens if P1 can't figure out how to pay the claim (the code may be valid) Claims were either billed with a Mental Health code or were a methadone claim (H0020) but didn't have the additional methadone taxonomy (261QM2800X is billed as servicing taxonomy with the group NPI)	<1%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
B5	Coverage/ program guidelines were not met or were exceeded.	Group therapy (96153) only covered if at least 45 minutes (3 units)	<1%
16 MA39	Missing / incomplete / invalid gender.	Usually incorrect gender submitted on claim but we have seen some female Mike and male Sally clients in P1. Contact Mike if you have what appears to be a gender mismatch in P1	<1%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
204	This service / equipment / drug is not covered under the patient's current benefit plan	Usually a family planning only client	<1%
96 N30	Patient ineligible for this service.	Client is not an encounter-eligible client (eg, State funds only client)	<1%

PCCM Referrals

The ProviderOne Billing and Resource Guide has the following under the PCCM section

All clients enrolled with a Primary Care Case Management (PCCM) provider must have a referral from their PCCM in order for health care services to be paid to an outside provider.

If a claim is billed and the referring NPI is a "group" then the claim may error out. A referring NPI must be a person, a "group" technically can't refer a client. Future billing guides will include the words "must have a referral from one of the healthcare professionals from their PCCM"

2016 Meeting Schedule

Tribal Billing Workgroup (TBWG)

Second Wednesday 9:00-10:00 AM

January 13

February 10

March 09

April 13

May 11

June 08

July 13

August 10

September 14

October 12

November 09

December 14

Medicaid Monthly Meeting (M3)

Fourth Wednesday 9:00-11:00 AM

January 27

February 24

March 23

April 27

May 25

June 22

July 27

August 24

September 28

October 26

November 23

December 28

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Global Billing and Encounters

An encounter covers services that occur during the face-to-face visit that occur during a 24 hour period. Most global services are billed one time, with a single date of service and payment for the service includes pre/post care that extend beyond a 24 hour period. Examples of global services include dentures, deliveries and most surgical codes.

How do face-to-face visits get billed when there are global services?

Global Billing and Encounters

Post-Operative Global

Some services have a global (post-operative) follow up period. Post operative care is covered in the payment for the service. This does not account for encounter billing because the encounter is tied to the fee for service code and the fee for service code is only billable and payable one time

Example: CPT 28470 has a 90 day post-op period

- FFS providers bill CPT 28470 and follow up care is included in the FFS payment. Related E&M's billed during the follow up period are denied as included in the global payment
- Encounter providers (FQHC and Tribal) bill CPT 28470 and follow up care is billable. E&M's billed during the follow up period are payable at the encounter rate* Modifier 24 on the E&M is not required

*this was a CMS update spring, 2014. previously the services were bundled into the surgery fee

Global Billing and Encounters

Multiple Visit Global

Some services are billed one time, on a single date of service, even though there were visits that occurred prior to the final billing. The visits that occurred prior to the final billing may also be encounter eligible. These are different from the post-operative global services

Examples:

Dental Crowns: The crown is billed one time, on the seat date of the crown. The tooth prep is not billed separately but is included in the crown fee. The tooth prep may meet the definition of a payable encounter

Dentures: The denture is billed one time, on the final seat date. The prep work is not billed separately but is included in the denture fee. Denture fee also includes three-month post-delivery ("post-op") care.

Orthodontics: The banding is billed one time, on the banding (appliance placement) date. Banding includes prep work includes a 3-6 month global ("post-op") period. Subsequent visits are also billed as global visits

Global Billing and Dental Encounters

- D-Dental codes are billed at 1 unit per line
- Crowns (D2710-D2799) and root canals (D3310-D3330) qualify for up to 2 encounters (per crown/root canal). T1015 code is billed at 2 units (assuming that there were 2 client visits)
- Dentures/Partials (D5110-D5226) qualify for up to 5 encounters (per denture), depending on the number of visits that were required prior to the final seating and the number of visits during the 3 month post-delivery care
- Orthodontic

  Limited Ortho (D8030) – Banding qualifies for up to 4 encounters, subsequent visits qualify for up to 2 encounters with each payable follow up visit

  Interceptive Ortho (D8060) – qualifies for up to 2 encounters

  Comprehensive Ortho (D8080) - Banding qualifies for up to 5 encounters, subsequent visits qualify for up to 2 encounters with each payable follow up visit

  Refer to Orthodontic billing guide for other requirements for Orthodontic billing

- In order to avoid billing for services that have not been rendered it may be necessary to bill at the end of the global period (with the date of service being the date that the service was rendered)

Global Billing and Medical Encounters

- Some maternity services are also billed globally and qualify for multiple encounters when the maternity service is billed
  - Postpartum care only (CPT 59430) – up to 3 encounters
  - Antepartum care only (CPT 59425) – up to 6 encounters
  - Antepartum care only (CPT 49426) – up to 15 encounters
  - Delivery (CPT 59400, 59410, 59510, 59515, 59610, 59612, 59614, 59618, 59620, 59622) – up to 15 encounters
- Examples listed above require additional modifier (TH), refer to Tribal Billing Guide and Physician-Related Services/Health Care Professional Services Guide
- Some labs (eg CPT 81000, 81001, 81002, 81003, 81007) and non-maternity services can be billed outside of the maternity package

ProviderOne Screen Issues

Since the ProviderOne update on October 24th I have heard of issues with ProviderOne such as (a) slowness/unresponsiveness, (b) getting logged out while in the middle of a claim, (c) getting timed out in less than 60 minutes

The Log out/time out issues have been occurring since summer, 2015. This has been identified as a *P1 defect*. The System Techs advise a workaround:

1. Log out of ProviderOne.

2. From the Home Page go to: Tools - Delete Browsing History: uncheck the first box (Preserve Favorite's, this will NOT delete your Favorites web pages) and then check the boxes below (Temp Files, Cookies, History, Download History, Form Data, Passwords & Tracking Protection).

3.Once this has been completed, go to File, and select New Session

ProviderOne and Microsoft “Edge”

HCA and DSHS have received reports of providers encountering issues while using ProviderOne using Microsoft’s new Edge internet browser, which replaces Internet Explorer in the new Windows 10 release. Most of the issues surround the fact that Edge automatically enables a pop-up blocker.

When using ProviderOne, your browser’s pop-up blocker must be disabled. Please refer to the instructions attached to this communication for instructions on how to set the pop-up blocker to off in Edge. In addition, ProviderOne is not yet fully compatible with Edge, so to prevent further issues, you can also enable Edge to open as Internet Explorer 11. Those instructions are also included in the attachment and should be used if there are additional problems encountered while using the system in Microsoft Edge.

ProviderOne Screen Issues

- The ProviderOne system was updated to a new version the weekend of October 24, 2015. Since the implementation of the upgrade a number of issues have been identified that HCA and our vendor staff are giving utmost attention to.
- We have discovered that the majority of the identified issues seem to be most prevalent for users who are utilizing older versions of Internet Explorer (IE). One key aspect of the ProviderOne version update was to increase the number of supported browsers that ProviderOne is compatible with. As a result, we have determined that a number of the reported issues do not seem to be as impactful to ProviderOne functionality on the newly supported browsers, e.g. Chrome, Firefox, Edge, etc.
- It is recommended that all Internet Explorer (IE) users take the following steps:
  - Update Temporary Internet Files Setting:

    Internet> Tools> Internet Options> Settings> select “Every time I visit the webpage”
  - Delete internet browsing history:

    Internet> Tools> Internet Options> Delete> select “Delete”
  - Reset Internet Settings:

    Internet> Tools> Internet Options> Advanced Tab> Reset> select “Reset”
  - Interim Workaround:

    Attempt to complete your activities by accessing ProviderOne using one of the additional supported browsers, e.g. Chrome, Firefox, Edge, IE11, Safari, etc

Vision Care

- Vision exams and eyeglasses are a covered benefit. The Professional service (exam) is covered and is eligible for the IHS encounter rate when rendered by an encounter-eligible provider (eg Optometrist). Vision Hardware is covered for clients age 0-20

Vision Care

Professional Services

- Eye and refraction examinations and fitting services are covered
  - Once every 24 months for asymptomatic clients age 21 or older
  - Once every 12 months for asymptomatic clients age 20 or younger and for all age clients of the Developmental Disabilities Administration (DDA)
- Additional examinations are covered if
  - Provider is diagnosing or treating a medical condition that has symptoms of vision problems or disease
  - Client is on medication that affects vision, or
  - Service is necessary due to lost or broken eyeglasses or contacts.
    - Clients under age 20 or DDA clients – no authorization required
    - Clients age 21 or greater – EPA required and the last vision exam was at least 18 months ago, refer to Physician Billing Guide

Vision Care

Hardware

- Vision Hardware is covered for clients age 20 and younger, refer to the Vision Hardware for Clients age 20 and Younger guide
- Call Correctional Industries (CI) (888-606-7788) to get registered with CI and be given purchase orders to be faxed into CI Optical, this allows CI optical to keep data on vision hardware
- Glasses are ordered through CI and CI bills Apple Health for the hardware
- Hardware for adults may be ordered through CI Optical at a very deep discount. The client would be responsible for payment to the provider/Tribe
- Contact CI at ciopticalcustomercare@doc1.wa.gov

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 have “stay tuned” for an answer or “interim” will stay on the log until answered

Questions Log

Q. How do we enroll for vision/optometrist services?

A. Did the previous slides help?

Questions Log

Q. Some time back I asked an HCA representative how the client's PCCM assignment happens and was told "if a person indicates that he/she is Native American ….their name(s) are mechanically assigned…".

Also, some of our patients are assigned to PCCMs in Seattle, Spokane, Puyallup, Nooksack (etc)

A.

- PCCM auto-assignment was turned off in April, 2015.
- Recent State Plan Amendment allows Tribal health programs and urban Indian health programs to serve as PCCM for any Medicaid beneficiary in FFS, regardless of AI/AN or non-AI/AN status
- Please us the "Contact Us" website at https://fortress.wa.gov/hca/p1contactus/ to submit requests to enroll/disenroll clients from PCCM (same link that is used to disenroll AI/AN clients from Managed Care)

Questions Log

Q: Many times our foster kiddos annual screenings are denied. I have been told previously it is due to the fact that you cannot tell on your end that the child are indeed foster kids. Are we any closer to closing this gap?

A. Well Child visits (non-foster kids) have frequency limits

- Age 0-0 -- 5 screenings in first year
- Age 1-2 -- 3 screenings in second year
- Age 3-6 – 1 screening per year
- Age 7-20 – 1 screening per 24 months*

  * Foster care clients allow 1 screening per year and within 30 days of foster care placement

If the client is a foster care client add modifier TJ to the well child visit code. Modifier TJ serves two purposes

1. Allows P1 to pay the enhanced rate for foster kids (encounter rate is higher than enhanced rate)
2. Allows P1 to waive the frequency limits listed above. This step is important when ProviderOne does not yet "know" that a client is in foster placement

Questions Log

Q: Can ARNP (not psych) providing 'mindfulness' session bill encounter rate? “mindfulness” training was from UW

A. Forwarded to clinical staff. Stay tuned

Questions Log

During discussion of Psych ARNP's the overall answer is that a Psych ARNP should consider the special training they received for their psych credential. Any time they are using that training they are providing Mental Health care/treatment

Q: when it is a medication mgmt encounter with psychotherapy, CPT guidelines direct you to bill E&M plus the Medical psychotherapy (90833 90836 90838 are add-ons)

A. This Question was response to last month's Q&A & is being revisited

Q. Is an E&M OK on a mental health claim? Wrong Answer (October TBWG)- No

Revised answer - Mental Health billing guide (p. 17) indicates that Psychiatrists and Psych ARNPs can bill E&M codes on a mental health claim

Q: If the patient is only receiving medicine management from Psych ARNP, then it's an E&M visit under Medical

Q: Medication mgmt has always been a medical encounter, see old billing instruction with the taxonomy

A. Questions forwarded to clinical policy staff, stay tuned

Questions Log

Q. We have COB claims that were sent in May to P1 (ML – 90 days out) and are still not paid. Is this issue going to be fixed or will HCA eventually transition all billing to MCOs so this will be a non issue

A. We strive to have the majority of our claims finalized before they become aged (30days or older). The TPL edits that post and hold a claim are usually farther on the claims 'waterfall' – so we are usually at the end of the line when it comes to getting the claim to finalize out the door as it can post in other areas before coming over to us to work.

Touch base with Mike if you have claims that seem to be taking longer than normal.

Can I say "stay tuned" on whether all billing will transition to the MCOs?

Questions Log

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?

Who is eligible to request a spend down through HCA? Classic Medicaid is understood, no questions.

Interim update:

- Eligibility Overview for Apple Health (Medicaid) – page 9 - http://www.hca.wa.gov/medicaid/publications/documents/22_315.pdf
- Spenddown Flyer – 2015
- HCA Medicaid Update: Spenddown Webinar - Session 7 (Spenddown) | Presentation Slides
- Apple Health (Medicaid) Manual: Medically Needy and Spenddown - http://www.hca.wa.gov/medicaid/manual/Pages/50-500.aspx

DSHS Customer Service Center can be reached at 1-877-501-2233 for questions regarding SSI-Related Spenddown coverage

Questions Log

Medicare crossovers

it would be helpful if Medicare would accept T1015 on claims, they are rejecting them. If they accepted T1015 and denied as not covered then it would assist electronic processing of these claims

Contractors are rejecting the claim rather than deny the line.

Medicare requires the correct taxonomy therefore the taxonomies you require for each specialty does not always match up

crossovers with T1015 will not process, because MCR will not accept T1015 and rejects claims with T1015 on the claim.

MCR will not allow T1015 to enter their system at all

It isn't necessarily Medicare that won't accept the T1015 but the Fiscal Intemediary Novitas which we are required to use. They set the rules and requirements as they want regardless of CMS regs

Not all tribes use Novitas some use WA state Medicare as well

Stay tuned, In the Interim –

Usually the Medicare crossovers that are received by the agency have 3 items that can be corrected while in the P1 screens doing a "Resubmit Denied/Voided claim":

1. billing taxonomy must be encounter eligible (usually 208D00000x)
   note: if you bill Medicare with this taxonomy Medicare should forward to P1
2. appropriate AI/AN or non-native modifiers need to be added
3. T1015 line needs to be added

Thank you

Send TBWG comments and questions to:

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If there is a difference between information in this webinar and current agency documents (e.g., provider guides, WAC, RCW), the agency documents will apply.