



Tribal Compliance & Operations Work Group

May 11, 2016

Mike Longnecker

HCA Tribal Affairs Office

Agenda

- Tribal Billing Workgroup change in scope and name
- Introduce Lin Payton, HCA's Mental Health, EPSDT and ABA program manager
- Introduce Lisa DeLaVergne, presenting an overview of compliance opportunities from HCA's Section of Program Integrity
- Electronic Health Records
- 2016 IHS Encounter Rate
- Paper claims submissions in P1
- FAQ and Open Discussion
- Top 5 Denials

TRIBAL BILLING WORKGROUP REBRAND AND CHANGE IN SCOPE

Tribal Compliance and Operations Workgroup

- Scope of the TBWG is expanding to include audit and clinical staff
- TBWG renamed to reflect the update

Tribal Compliance and Operations Work Group

LIN PAYTON, HCA'S MENTAL HEALTH, EPSDT AND ABA PROGRAM MANAGER

Lin Payton

HCA Clinical Quality and Care Transformation, Mental Health, ABA and EPSDT Programs

EDUCATION:

B.A.s in Social work and psychology

Masters in Education, Guidance and Counseling

PhD (ABD) in Wisdom Studies

HISTORY:

3 yrs - **DBHR**, Children, Youth and Family Programs Senior Administrator/Supervisor

15 yrs - **Pierce County RSN**, Children's Services Coordinator/DDD Program Liaison

Director of Wai'anae Coast Community MH Center, Children's Services

Executive Director, Denise Louie Education Center

Family Studies Program Coordinator and Educator, Green River Community College

Head Start Executive Director - Fort Yuma Quechan Head Start, Somerton Migrant Head Start and AZ Associated Tribes

Elected President of Arizona Indian Head Start Directors Association.

Started career at the **Arizona State Hospital** – Adults, Geriatrics and Children's units

OTHER: Therapeutic Foster Parent – CA and AZ, **Certified Mediator, Facilitator, Training and Technical Assistance**

LISA DELAVERGNE, HCA'S OFFICE OF PAYMENT INTEGRITY

Section of Program Integrity (SPI)

Intro

Who we are and what we do?

- We are Data Analysts, Auditors, Nurses and Coders
- We conduct various program integrity activities to ensure correct payments are made to legitimate providers for covered services for eligible clients.
- We identify vulnerabilities in programs and systems, and work with appropriate staff to correct issues to prevent further improper billing.
- We educate providers and provider associations.

Program Integrity Activities

Program Integrity Activities (PIA) include but are not limited to:

- Data Analytics and Algorithms
- Audits
- Clinical Reviews
- Preliminary Investigations
- VA Benefit Enhancement
- Site Visits



Examples of Common PIA Findings

Analytics and Algorithms identify:

- Duplicate billing and payment
- Unbundled codes
- Over-the-limit time and/or unit

Audits and Reviews identify:

- Insufficient documentation
- Non-covered services
- Upcoding
- Phantom billing – services never rendered
- Inappropriate level of care
- Non-medically or dentally necessary services

Encounter Basics

How many medical encounters are allowed?

- One medical service encounter per client, per day

How is a medical encounter coded?

- Use HCPCS code T1015
- If, due to an emergency, the client returns the same date for a second unrelated visit, use modifier 59 with the HCPCS code T1015
- Code the service(s) provided using either CPT or HCPCS codes

Compliance Advice

Develop internal controls with self-audits

- Select a random sample of billed services for a given time period
- Conduct an audit to ensure the correct code, number of units, dates, properly trained and licensed personnel, etc. were billed
- If you discover improperly billed services, conduct a deeper dive to see how many times that service was improperly billed.
- Refund or rebill any improperly paid services to HCA.

Compliance Advice

Document, document, document.....

- If a service is not documented, you cannot prove it was done.
- Ensure notes and orders are dated, timed and signed.
- Ensure personnel are properly trained and licensed – document training and file licensure appropriately.
- Ensure all records are kept up-to-date and are filed in an organized manner.



Washington State Health Care Authority



Lisa DeLaVergne, Section Manager, Program Integrity

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ELECTRONIC HEALTH RECORDS

Getting Started Indian Health Clinics

Attesting for the EHR Incentive
Program is a 2-step process

Step 1: Registering with CMS

The first step is registering your provider with CMS for the EHR Incentive Program. There, you will report the provider's NPI#, the Payee NPI# (the NPI # to receive the payment and tax ID), contact information and the ONC Certification Number for your EHR product. You will submit the information and CMS will forward it to our system, usually within 24 hours.

Please note that there must be documentation in your file that the provider is re-assigning his/her payment to the clinic, if that is the agreement. The other choice is that the provider can have payment issued to their own NPI.

NOTE: The Payee NPI# that receives the incentive payment, will also receive the IRS tax liability.

Contact Information

The contact information you enter in CMS is very important. It needs to be kept current or you might miss important emails about your attestation. For security reasons, we are only permitted to contact the email entered into the registration.

- CMS requires that we communicate with the “contact” that is on record in the attestation.
 - We have a suggestion for your email address: If you are concerned about staff turn-over or you want to share the EHR duties, it is encouraged to use a “generic email” as opposed to an email with a name in it. If your email has a name attached to it, we can only communicate with that person. An example of a generic email might be: AwesomeClinicEHR@yahoo.com. Most large facilities use this method. Note: you may only use a generic email for the EHR Program, and not for group sign on for other tasks within ProviderOne. ProviderOne Security does not allow sharing of user names/logins.
- Automated emails will be sent “only” to the contact’s email address. If it is not updated, you will miss important communication about your attestation(s).
- To change your contact information, it must be done in the CMS Registration (not in eMIPP).

Access the CMS Medicaid User Guide for Registration Instructions:

www.cms.wa.gov


- Tab Regulations & Guidance
- Under LEGISLATION: EHR Incentive Program
- Educational Resources
- Under REGISTRATION Information:
- Medicaid Registration User Guide for Eligible Professionals

Step 2: Attesting with the State

Provider types eligible for the Medicaid EHR Incentive Program are listed below. Note: the Medicare and Medicaid programs are a little different:

Overview of Eligible Professional (EP) and Eligible Hospital Types

Eligible Professionals (EPs)	
<p>Medicare EPs include:</p> <ul style="list-style-type: none">• Doctors of Medicine or Osteopathy• Doctors of Dental Surgery or Dental Medicine• Doctors of Podiatric Medicine• Doctors of Optometry• Chiropractors <p>Medicare Advantage Organization (MAO) EPs - A qualifying MAO may receive an incentive payment for their EPs. For more information, visit CMS website.</p> <p>NOTE: EPs may NOT be hospital-based. This is defined as any provider who furnishes 90% or more of their services in a hospital setting (inpatient or emergency room).</p>	<p>Medicaid EPs include:</p> <ul style="list-style-type: none">• Physicians• Nurse Practitioners• Certified Nurse - Midwife• Dentists• Physicians Assistants who practice in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) that is led by a Physician Assistant <p>Further, Medicaid EPs must also:</p> <ul style="list-style-type: none">• Have a minimum of 30% Medicaid patient volume (20% minimum for pediatricians), OR• Practice predominantly in a FQHC or RHC and have at least 30% patient volume to needy individuals



Update EPs in P1 (add and end)

It is important to keep up-to-date on your active and inactive providers.

Providers must be employed at the time of attestation

If a provider has left your practice, you should do 2 things:

- Change the Servicing Provider status in ProviderOne: Log into ProviderOne and “end-date” them as a Servicing Provider. This will not affect any unbilled claims.
- Cancel Registrations: If you registered your EP (Eligible Provider) for the EHR program, go into that registration and “cancel” it so they are removed from automated emails and it allows them to attest with a different group or on their own.

If a provider is new to your clinic:

- Make sure they have been added as a “Servicing Provider” in ProviderOne under your Group NPI.
- Keep in mind that the Payee NPI you plan to use, must have the servicing providers listed under “that” Payee NPI in order for it to pay correctly. It is for EHR purposes only and will not effect your billing.

If you need assistance adding or removing providers in ProviderOne, contact mike

Attesting in eMIPP

- The second step is the actual attestation in eMIPP (which is a sub-system within ProviderOne).
- Once CMS transmits your registration information to us, you should receive automated emails with your NLR number (Registration ID), a Domain number (this will “not” be your group Domain), logon and temporary password.
- Once you are able to log in, you may begin the attestation.

Special Rules

- Since you are an Indian Health Clinic you are able to attest as if you were a FQHC.

Please go to White Paper #1 on our website:

www.hca.wa.gov/healthit

- Hover over Library and Training Tools
- Click on Electronic Health Records Library
- Scroll down to Helpful Tip Sheets
- Click on White Paper #1- Patient Volume Calculations

FQHC Attestation Advantages

If you attest as a FQHC you have Medicaid “encounter power!” You not only can use the Medicaid encounters, but you can include medically needy encounters as well (CHIP, Charity Care and Sliding Fee Scale). Please note that the encounters do not have to be paid or billed - they just have to be an encounter with a Medicaid or Medically Needy individual.

Medically Needy Encounters

Medically Needy encounters include:

- CHIP
- Charity Care
- Sliding Fee Scale

**** Note:** Charity Care and Sliding Fee Scale must be determined prior to the encounter with an agreement or contract with your patient. It is not uncollectible money or bad debt write-off.

State Recourses for Attesting

Website: www.hca.wa.gov/HealthIT

- On the left side, hover over LIBRARY AND TRAINING REOURCES and choose ELECTRONIC HEALTH RECORDS LIBRARY
- Look under ELIGIBLE PROVIDERS (Including Specialists and Dentists)
- Click on these links:
- Click on "EP AIU AND MU eMIPP USER GUIDE 2015"-(step-by-step process)
- and/or the PATIENT VOLUME WORKSHEET (tool for you to gather your numbers)
- These will walk you through the basic process.
- Please see our other training tools and resources on our website.

Webinar Requests?

If your clinic has a topic of interest for a brief webinar, please send us an email at:

HealthIT@hca.wa.gov

2016 IHS ENCOUNTER RATE

2016 IHS Encounter Rate

- 2016 IHS Encounter rate is \$368
- P1 updated on March 22nd, claims started paying at 2016 rate in April
- Mass adjustment of 2016 claims that previously paid at the 2015 rate is scheduled for late May

PAPER CLAIMS SUBMISSIONS IN P1

Paper Claims Submissions in P1

- HCA may discontinue accepting paper claims in the future. Date has not been established yet. There will be prior notification if HCA discontinues accepting paper claims
- Will this cause any issues?
- Mike reviewed ITU claims for CY 2015 and found that out of 235,000 claims only 650 were billed on paper (<0.2%)

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. Are vision exams covered? Are there exceptions to the frequency limits?

A. Vision exams are covered. Generally one exam per year for youth and one exam per 2 years for adults.

Attached to this week's billing webinar is a Vision Exam and Hardware reference sheet

Questions Log

Q. Our clients receive an E&M or an initial evaluation by a provider prior to entering the suboxone program. (1) Are there any diagnosis requirements for the suboxone exam? (2) Is the E&M or initial evaluation billable by providers other than the prescribing physician?

A. Office visits *related to* buprenorphine/naloxone are covered by HCA. If the client is in a Medicaid Managed Care Organization (MCO), services are covered through the client's MCO

(1) Prior to 01/01/2016, there were diagnosis restrictions (ICD9 304.00-304.03 or ICD10 F11.20-F11.288) and an EPA (870000050) for Suboxone office visits.

Beginning 01/01/2016 there are no diagnosis restrictions or EPA numbers required for the Suboxone office visit

(2) An E&M (CPT 99201-99215) is covered when medically necessary & the Physician-Related Services/Health Care Professional Services Provider Guide indicates “the agency pays for office visits related to buprenorphine/naloxone (Suboxone®)” and does not indicate that the E&M or initial visit must be performed by the prescribing physician

Questions Log

Q. What EPA numbers are used on Mental Health claims?

A. It depends on the service and whether the EPA is a Tribal Health EPA or a Mental Health EPA. The next three slides outline the Tribal Health EPA and the current Mental Health EPAs

Questions Log

EPA numbers on Mental Health claims (cont'd)

Tribal Health EPA

AI/AN clients who are exercising their rights to opt out of RSN/BHO managed care may receive culturally competent care at the Tribal IHS or 638 facility rather than be referred to the RSN/BHO. Refer to the Tribal Health Billing Guide for examples. EPA is 870001349

Questions Log

EPA numbers on Mental Health claims (cont'd)

Mental Health EPA

Refer to the HCA Mental Health Guide for the EPA criteria

870001207 – used for neuropsych testing (CPT **96118 and 96119**)

870001369 – Professional psychiatric services for an MCO client in a BHO authorized **inpatient** setting

870001370 – Professional psychiatric services for an MCO client in an **E.R.** setting

870001315 – Psychological testing to diagnose autism spectrum disorders at a **Center of Excellence**

Questions Log

Mental Health EPA (cont'd)

EPA is also required for Evidence and Research-based practices. Table below is from the current Mental Health Provider Guide

Programs/Coding for Mental Health Professionals	EPA number
Positive Parenting Program (Triple P) (Level 2)	870001318
Positive Parenting Program (Triple P) (Level 3)	870001319
Parent-Child Interaction Therapy (PCIT)	870001330
Cognitive Behavioral Therapy (CBT)+ for Behaviors, Anxiety and Depression	870001331
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	870001332
Bonding and Attachment via the Theraplay model (Promising Practice)	870001333
Cognitive Behavioral Therapy (CBT)	870001334
Strengthening Families Program	870001335

Questions Log

Q. Can the mental health services that require an EPA be billed at the IHS encounter rate?

A. If it meets the definition of an encounter, yes

Q. Even the RSN (BHO) modalities?

A. I/T providers - yes, if it meets the definition of an encounter

Urban Indian Organizations - no

Questions Log

Q. Does the client have to opt out of MCO in order to bill mental health services at the IHS encounter rate?

A. AI/AN clients do not have to opt out of MCO, Tribe may bill MCO+P1 or bill P1 directly

Non-AI/AN clients must be clinical family members and claims will need to be billed to P1 directly in order to receive the encounter rate

Questions Log

Q. Do clinical family members need to opt out of MCO?

A. The MCO opt out option is only available for AI/AN clients

Q. Is Crisis Services (H2011) only for inpatient?

A. No, Crisis Services is payable in IHS/638 facilities (POS code 05 06 07 or 08)

Questions Log

Q. Prolonged care add-on codes (CPT 99354-99357) added CPT 90837 as an allowable parent code along with the E&Ms. Mental Health claims billed with 90837+99354 are paying the 90837 but rejecting the 99354

A. HCA defined 99354-99357 as *medical* and not payable on a *mental health* claim.

Note: If the 90837 is paying then the claim qualifies for the encounter rate

Questions Log

Q. Can nurse only visits (e.g. vaccinations) be billed? How are these billed if the Nurses do not get enrolled in P1?

A. Claims are billed under their supervisor's NPI

Q. Are the services of an RN/LPN eligible for the encounter rate?

A. **IHS/638 clinics** - Nurses (RN/LPN) are not included in the list of IHS-encounter-eligible providers. Services of an RN (and any other provider who is not in the list of encounter-eligible providers) are not encounter eligible, even if under the supervision of an encounter-eligible provider (e.g. the performing NPI on the claim isn't what truly matters)

FQHC – Nurses (RN/LPN) are included in the list of providers who may provide services at an FQHC. (claims are not billed with the RN/LPN's performing NPI)

Q. What if the RN/LPN does not have a supervising provider? Nurse only visits do occur and are generally not signed off on by a provider for things such as immunizations or pregnancy tests etc

A. Pending DOH guidance, stay tuned. All nurses have a supervising provider – the physician or the clinic. Nurses are not licensed independently (and have no NPI)

Questions Log

Q. Are there circumstances when a claim may be billed and the client (Client ID on the claim) is not present?

A. It depends on the category of the service

Medical & Dental claims are not billable if the client is not present.

Mental Health claims may sometimes be billed without the client present:

- 90846 is family therapy without patient present
- Otherwise, Mental health treatment can be provided to a client, the client's spouse, parent, guardian, or child, or a person with whom the client has a child in common, if the treatment is directly related to the client's care, is medically necessary and is in accordance with WAC 182-531-1400

SUD claims may sometimes be billed without the client present

- 96155 is individual family therapy without the enrollee present

Does client need to be present for billing?

Questions Log

Q. Can my fee for service clients choose a BHO but are not required to receive services at the BHO?

A. BHOs replaced the RSNs. Clients are assigned to BHO based on their address. Exception:

AI/AN clients will be exempted (“carved out”) from BHO assignment (if client is *coded* as AI/AN in P1)

Q: Where do I send my MH and CD claims if my client is in the SW region (enrolled in FIMC)

Medical – no changes (AI/AN - bill MCO+P1 for wraparound)

Dental – no changes (bill P1)

Mental Health – AI/AN - bill MCO+P1 or bill P1 directly

SUD – AI/AN - bill MCO+P1 or bill P1 directly

BHO questions

Questions Log

Q. Licensed Mental Health Associates are not billable to private insurers, if a client has apple health as secondary can we bill?

A. From the kind of feedback we have received from providers who have come across this, the likelihood that the primary will cover is low. However, it is still recommended that the primary carrier is billed at least once for a formal rejection letter/EOB denial code that can be included on a HCA claim so that information is seen by COB and we can make our update within P-one. Future claims would not have to be billed to the primary – just HCA.

If the primary will not process a claim to produce an EOB, the next step would be to contact COB @ 800-562-3022 ext. 16134 so we can assist further.

Questions Log

Questions/comments during prior billing webinar regarding 100% FMAP

- Has the state thought about how to identify FMAP claims? What would be the incentive of having agreements with outside referring providers and the outside providers
- You can require the referring provider NPI to identify IHS facility referrals
- Will the HCA work with AIHC on developing a boilerplate care coordination agreement?
- We have issues with referrals and outside specialty providers accepting Medicaid or at their limit. It would be nice if FMAP would help with opening doors to specialty clinics. Especially with the tribes in rural areas. Can we look into increasing payment amounts for certain areas?
- Hopefully the 1115 waiver will provide a way to work this out, so outside providers can access the 100% FMAP

Stay tuned, feel free to share comments/suggestions/ideas

Questions Log

During previous webinar I noted that P1 was recently updated to not allow self-referral (this issue has been corrected). Comment below is from the February billing webinar and is a great example of how open communication helps resolve issues

Standard billing requirements state that if there is any service besides the E/M, the E/M code must be appended with Modifier 25 AND have the referring provider stated in box 17 and 17a/b (or the corresponding data field). In the clinical setting if the doc orders labs but saw the patient, to support those labs you must have the doc stated as the referring doc. So I question the statement that the doc can't refer for their own services.

Example of how feedback helps to resolve issues

Questions Log

Q. We are billing for in house Dieticians do I need to add a referring NPI to the claim?

A. Yes, Dietician claims require a referring NPI.

Very few services on a professional claim actually **require** a referring NPI, examples of services that require a referring NPI:

- Dietician services, Physical/speech/occupational therapy, pharmacy
- Medical consults (CPT 99241-99275)
- Radiology (technical or global component)

Questions Log

- Just a FYI. The NPI website is taking longer to process new providers. We cannot credential/contract providers until they get an NPI. The NPI process used to take a few days and now takes 2 weeks or more (60-90 days). Therefore we are having to get submit effective date change request forms
- Followup question - What type of Letter should be included with the Back Date Request?

Questions Log

Q. We currently do not have any MH providers that are qualified for Medicare Billing. Can we submit these claims directly to P1?

A. If the service is covered by Medicare then Medicare needs to be billed first. If a service is **never** covered by Medicare then every attempt is made to allow those services to be billed to P1 directly.

Medicare does not enroll the following providers

- 101YM0800x – Mental Health Counselor
- 104100000x - Social Worker
- 106H00000x - Marriage and Family Therapist

Services by these providers may be billed directly to P1. For other providers who are not enrollable with Medicare a letter/denial from Medicare indicating that Medicare does not pay this type of service or provider will need to be attached to the claim

Questions Log

Q. What if a Mental Health or SUD assessment is done and the client doesn't have a problem so there is no code? Are we out for any type of reimbursement for our time? Especially with this limited code set....will there be more codes after April 1st?

A. Received during webinar – Medical necessity is a requirement for Medicaid coverage. With respect to SUD, the code set was recently expanded. The agency uses standard MH diagnosis codes.

Questions Log

Q. Molina still refuses to reimburse for Part C Medicare Advantage Plans that are supposedly combined with Medicaid coverage. Numerous appeals unresolved

Answers received during webinar:

- All Medicare advantage plans will not pay out of network providers even under the WAC because you have to be a Medicare provider and be contracted with the Medicare advantage plan.
- Technically IHS and Tribal clinics are in-network regardless of having a contract signed or unsigned and is required to reimburse as if the clinic/facility is in network at the same rate they would reimburse others in the group who are not Native. Then Medicaid is billed as secondary provided they are correct Medicaid coverage category

Reminder, an Insurance company may offer different types of health insurance, e.g.

- Managed Care Organization (MCO), or
- Private insurance company, or
- Medicare part C (Advantage) plan

Billing requirements are different depending on the type of insurance

Questions Log

Q. How far in the future will the MCOs start paying at the full encounter rate?

A. The MCO payment of the encounter rate does not have an established date yet. Best estimate at this time is Summer, 2017.

Questions Log

Q. What is the status on the fix for re-submit claims within P1 for secondary dental claims?

A. The client's primary payer information (plan name, plan ID) are required on claims billed in P1. The P1 screens for Professional and Dental services are formatted differently and insurance information is not in the same place in the screens

Questions Log

Q. Are in-custody assessments billable and encounter eligible?

A. No, if the client is incarcerated they do not have Medicaid coverage during his/her incarceration. In addition, in-custody assessments are not covered by Medicaid.

Q. The client's eligibility in P1 still shows coverage during the incarceration, should we notify Medicaid?

A. These are the guidelines for Medicaid eligibility during incarceration

- Typically the individual remains Medicaid eligible if the event is expected to last less than 30 days. HCA does not need to know about any stay less than 30 days.
 - But, if the individual remains incarcerated for 30 days or more with no release date known, then you should notify HCA or have a Tribal Assister update Healthplanfinder to indicate that the individual is “incarcerated”.
- If the individual can complete treatment in lieu of jail time and get a bed date within 30 days of the decision to access treatment, the Medicaid coverage should stay in place

Questions Log

Q. Regarding inmates, I recall a WAC that states that the City, County, Tribal or State entity that is holding the individual is financially responsible for their care. How do we bill a county jail for an inmate's care?

A. The WAC is Chapter 137-91 WAC. To provide care to incarcerated individuals for payment, a provider needs to negotiate a contract with the facility or the Department of Corrections. This is outside the scope of Medicaid.

Questions Log

Q. I still have issues with Coordinated Care not following up on claim status, When I call the provider line they do not see our PT provider so still have 2 outstanding PT claims

A. General phone-staff may not always be aware of Tribal Health requirements. If there are any issues please contact the MCO Tribal Liaison and/or mike

Questions Log

Q. How would we bill for fluoride when it is done by a hygienist without the dentist present? Can we bill under the dentist's NPI but not add the T1015?

A. Yes, if the service is rendered by a provider who is not in the list of encounter-eligible providers then the claim should be billed as FFS, without a T1015 line. Great example of how the servicing NPI on a claim is not sufficient to determine whether the claim is encounter eligible. Claim scenarios illustrate, **red font** is the claim with an error.

- Dentist applies the fluoride

Claim billed with DDS NPI + T1015 & pays encounter rate

- Hygienist applies the fluoride

Claim billed with DDS NPI, no T1015 & pays FFS rate

Claim billed with DDS NPI + T1015 & pays encounter rate

Questions Log

Q. What are other folks doing about timeliness when there is a primary payer? Sometimes the primary takes almost a year to process the claim and by the time it gets to P1 it is denied for timely

A. What are other folks doing? Some HCA staff recommend billing the primary + P1 at the same time so that the P1 claim is timely (but this could cause overpayment issues)

Pended Questions

Q. For next work group meeting can we discuss the face to face requirement for encounters and how it relates to telemedicine.

A. Refer to May 16th TBWG for more background on FFS (code) billing. Does telemedicine meet the HCA definition of *face to face*? Stay tuned

Pended Questions

Q. Two MCO's have optical claims going to a different entity. The two subcontractors will not accept our claims or provide required subcontractor info to be able to bill. Therefore optical claims to those two MCOs are useless

A. Pending guidance from CMS on Federal Ownership Disclosure requirements for I/T/Us. This issue is also on the MTM (Monthly Tribal Meeting) log. Stay tuned

Pended Questions

Q: Can ARNP (not psych) providing 'mindfulness' session bill encounter rate? See UW webpage on mindfulness-based stress reduction: <http://www.uwhealth.org/alternative-medicine/mindfulness-based-stress-reduction/11454>

A. Stay tuned.

Pended Questions

Q. What do I do when I get EOB N61 on a Mental Health claim?

A. Call mike. Some clients have dual eligibility in P1 (eg, Apple Health + Department of Corrections or Apple Health + Social Services). P1 is erroneously picking the non-Apple Health eligibility on some claims.

P1 System techs are reviewing. ETA on fix might be June 5th. Stay tuned

Pended Questions

Q. We are getting overpaid on claims for IUD / implant insertions

A. The overpayments were for the professional service of inserting IUD/implant (CPT 11981, 11983 or 58300). If the billed amount on these 3 codes is less than the fee schedule amount, P1 is currently overpaying. P1 update is scheduled for June 5th, mike will review and reprocess claims

Reminder - IUDs (and pharmaceuticals/drugs that are filled outside of the clinical visit) can be billed separately from the encounter and paid fee-for-service, along with (in addition to) the encounter.

Many IUDs/pharmaceuticals are payable on a professional claim and in the Pharmacy system. Do not bill for the same service/product in both systems

Claims Analysis

- Claims Analysis format updated
 - Claims payments and client counts no longer reported
 - Payment percentages retained
- Top 5 denial issues reviewed

Claims Analysis – Payment Percentages

Category	ALL providers payment percentage	ITU payment percentage
Medical	77%	84%
Dental	91%	88%
Mental Health	90%	94%
SUD	56%	94%

Medical Claims – Top 5 Denials

EOB	Comments	Percent
4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	I/T claims missing the AI/AN or non-AI/AN modifier	18%
24 - Charges are covered under a capitation agreement/managed care plan.	Client enrolled in Managed Care (MCO)	15%
16+M54 - Missing/incomplete/invalid total charges.	Either the total billed amount was \$0 or the total billed amount was not equal to the sum of the lines	12%
18 - Exact duplicate claim/service	Duplicate billing	10%
16+N288 - Missing/incomplete/invalid rendering provider taxonomy.	Servicing provider taxonomy missing or servicing provider not enrolled with the taxonomy on the claim	5%

Dental Claims – Top 5 Denials

EOB	Comments	Percent
6 - The procedure/revenue code is inconsistent with the patient's age	Some services are only covered for youth (e.g. crowns, posterior root canals, Oral Hygiene instructions/D1330)	10%
4 - The procedure code is inconsistent with the modifier used or a required modifier is missing	I/T claims missing the AI/AN or non-AI/AN EPA number	7%
96+N130 - Consult plan benefit documents/ guidelines for information about restrictions for this service	Non-covered code	5%
204 - This service/equipment/drug is not covered under the patient's current benefit plan	Usually a Medicare-only client. QMBonly (RAC 1112 1113), SLMB (RAC 1116)	4%
16+N37 - Missing/ incomplete/ invalid tooth number/letter	Many dental services need either a tooth number or an arch/quad number	4%

Mental Health Claims – Top 5 Denials

EOB	Comments	Percent
16+N290 – Missing incomplete / invalid rendering provider primary identifier	Servicing NPI on claim is not in P1 (yet)	33%
204 - This service/ equipment/ drug is not covered under the patient's current benefit plan	Usually a Medicare-only client or a family planning only client. A batch of claims was submitted with taxonomy 101YA0400x, which isn't a taxonomy that P1 uses & also causes this error	30%
18 - Exact duplicate claim/ service	Duplicate billing	12%
119+M80 - Not covered when performed during the same session/date as a previously processed service for the patient	Similar to duplicate, usually involves different levels of mental health services on same day	5%
B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.	Mental Health Services for children require that the provider have attestation on file in P1 that they have experience working with children	5%

SUD Claims – Top 5 Denials

EOB	Comments	Percent
16+N290 - Missing incomplete / invalid rendering provider primary identifier	SUD claims are not billed with individual servicing NPIs or taxonomies. SUD claims are billed with facility NPI only (Urbans have the FQHC taxonomy issue, contact mike)	28%
204 - This service/ equipment/ drug is not covered under the patient's current benefit plan	claims submitted with taxonomy 101YA0400x, which isn't a taxonomy that P1 uses	25%
170+N95 - Payment is denied when performed/billed by this type of provider	Lab codes not payable on SUD claims	9%
96+N130 - Consult plan benefit documents/ guidelines for information about restrictions for this service	Non-covered code or SUD code didn't have the HF modifier	7%
11 - The diagnosis is inconsistent with the procedure	SUD claims require that the primary diagnosis on the claim be one of the approved diagnoses in the billing guide	5%

Vision Exam & Hardware Reference Sheet

Vision Exam and Hardware Reference Sheet

Eye Exams are covered through the client's MCO if client enrolled in MCO. Hardware is paid FFS through P1 and hardware must be ordered from the agency's contractor (Correctional Industries)

Vision Exam policy – refer to the Physician Related Services/Health Care Professional Services Provider Guide.

Vision Hardware policy – refer to the Vision Hardware for clients age 20 and Younger Provider Guide

Service	Client age 0-20	Client age 21+	Developmental Disabilities Administration (DDA) clients age 21+
Eye exam, asymptomatic clients	1 per 12 months	1 per 24 months	1 per 12 months
Additional eye exams are covered when: <ul style="list-style-type: none"> diagnosing or treating a medical condition that has symptoms of vision problems or disease clients are on medication that affects vision 	If diagnosis on claim is in the list of Medical diagnoses P1 will waive the vision exam frequency limit. Otherwise, if Chart notes are attached the claim will be reviewed for possible payment	If diagnosis on claim is in the list of Medical diagnoses P1 will waive the vision exam frequency limit. Otherwise, if Chart notes are attached the claim will be reviewed for possible payment	If diagnosis on claim is in the list of Medical diagnoses P1 will waive the vision exam frequency limit. Otherwise, if Chart notes are attached the claim will be reviewed for possible payment
Additional eye exams are covered when eyeglasses or contacts are lost or broken	Add claim note that indicates that the eyeglasses or contacts were lost or broken	Covered if last exam was at least 18 months prior, use EPA 870000610	Add claim note that indicates that the eyeglasses or contacts were lost or broken
Glasses	Covered up to once every 12 months	Not covered (but Tribe may want to help purchase through Correctional Industries (pricing is great))	Not covered (but Tribe may want to help purchase through Correctional Industries (pricing is great))
Contact lenses	Covered up to once every year (number of lenses varies depending on type of lens) if client vision is at least +/- 6.0 diopters in at least one eye. See Vision Hardware Billing Guide for exceptions	Not covered	Not covered

A full page/readable version of this reference sheet is available, ask mike

Thank you

Send 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.