Washington State Health Care Authority

Tribal Billing Workgroup (TBWG)

December 9, 2015

Mike Longnecker
HCA Tribal Affairs Office

Agenda

- Monthly Data and Analysis
- Review of Mental Health Billing and RSN Access to Care
- Billing and Servicing NPI and Taxonomy on Claims
- Provider Enrollment in P1 and MCO - Soliciting Feedback
- Managed Care Plans and their Qualified Health Plans
- 2016 Meeting Schedule
- Draft IHS encounter payment table
- FAQ and Open Discussion

MONTHLY DATA & ANALYSIS

October 2015 Claims Data (I/T/U)

	Dollars	Dollars, Prior TBWG	Clients*	Clients, Prior TBWG*	% Paid	% Paid, Prior TBWG
Totals	5,585,165	$6,850,772	12,052	12,061	NA	NA
Medical	$1,368,295	$1,724,374	4450	4826	79%	88%
Dental	$752,046	$722,754	2242	2189	85%	69%
MH	$1,017,341	$831,155	1246	1170	86%	92%
SUDS(CD)	$1,885,462	$3,079,366	1170	1241	81%	90%
POS	$507,394	$493,095	5846	5799	60%	59%
Other FFS	$54,625	$28	25	167	52%	0%

* 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 % *
18	Exact duplicate claim/service	Duplicate billing	26%
24	Charges are covered under a capitation agreement managed care plan	Client is Enrolled in one of the Managed Care Plans	11%

* Denial percentages example: Out of the Medical claims that did not pay at the encounter rate, 26% were due to duplicates

Medical Claims – Top Denials

EOB	Description	Comments	Denial %
96 / N59	Alert: Please refer to your provider manual for additional program and provider information.	Claim format was UB. Some I/T providers are FQHC with Medicare and Medicare forwards the claim to P1 in UB format. I/T encounters need to be in HCFA format in P1	9%
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	7%

Medical Claims – Top Denials

EOB	Description	Comments	Denial %
A1 / N149	Rebill all applicable services on a single claim.	New edit (old rule) for FQHC (Urban Indian Organizations are FQHC in P1) providers – all services (per category) must be on the same claim	7%
96 / N30	Patient ineligible for this service.	Client is not an encounter-eligible client (e.g., State funds only client or QMB-only or SLMB)	6%

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	4%
16 / N4	Missing / Incomplete / Invalid prior Insurance Carrier(s) EOB	Medicare secondary (“crossover”) claims. A Medicare secondary claim must have a Medicare paid and/or deductible. If there is no Medicare paid and/or deductible then the claim is not a Medicare secondary claim (P1 may pay primary, depending on the medicare EOB)	3%

Medical Claims – Top Denials

EOB	Description	Comments	Denial %
22	This care may be covered by another payer per coordination of benefits.	Client has Medicare	3%
167	This (these) diagnosis(es) is (are) not covered	Medicaid does not consider some diagnosis codes eligible for **medical** treatment. If you would like a copy of the diagnosis reference sheet (list of diagnosis codes that usually do not pay if billed as the primary diagnosis on a medical claim) – ask Mike.	3%

Dental Claims – Top Denials

EOB	Description	Comments	Denial %
16 / MA63	Missing / incomplete principal diagnosis	**Dental claims do not need diagnosis codes** but if a diagnosis code is entered on a claim then it needs to be valid and OK for the service	14%
119	Benefit maximum for this time period or occurrence has been reached	Claims were for fluorides (D1206 D1208) over the annual limit Limits: • Age 0-6 (or in ortho treatment or resides in Alternate Living Facility (ALF) or DDA client) – 3 per 12 months P1 "knows" if client is DDA or claim is billed in an ALF. P1 does not "know" if the client is an ortho client or resides in an ALF, limits listed above apply, claim note needed (contains "ortho" or "assisted living") • Age 7-18 – 2 per 12 months • Age 19+ - 1 per 12 months	9%

Dental Claims – Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing.	9%
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))	8%

Dental Claims – Top Denials

EOB	Description	Comments	Denial %
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Dental claims missing the 870001305 or 870001306 EPA number	6%
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	6%

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	6%
96 / N59	Non-covered charge(s).	Covered codes/services are in the Dental billing guide and fee schedule	5%

Dental 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	3%
16 / N37	Missing/ incomplete /invalid tooth number/letter	Some services need either a tooth, or an arch, or a quadrant number. Most common - scaling/planing (D4341 D4342) needs a quadrant. Refer to Dental tooth, arch, quad numbering slide on the Tribal Affairs website under Quick Reference Sheets for Providers and Billing Offices.	3%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
16 /255	Missing / incomplete / invalid billing provider taxonomy	Claims billed with wrong taxonomy (I/T claims need billing taxonomy 2083P0901x)	50%
24	Charges are covered under a capitation agreement managed care plan	Client is Enrolled in one of the Managed Care Plans.	22%

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	6%
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 (<u>if appropriate</u>, 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? Contact Mike	5%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
22	This care may be covered by another payer per coordination of benefits.	Client has Medicare	3%
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	2%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
96 N30	Patient ineligible for this service.	Client is SLMB, QDWI or QI-1 (similar to QMB only)	2%
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage	2%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing.	2%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	The HE (AI/AN) or SE (non-AI/AN) modifier was missing	2%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
181	Procedure code was invalid on the date of service.	P1 can't figure out how to pay the claim (the code is usually 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)	62%
18	Exact duplicate claim/service	Duplicate billing.	13%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
16 N255	Missing / Incomplete / Invalid billing provider taxonomy	Billing taxonomy wasn't 261QR0405x (Urbans continue to use 261QF0400x)	10%
11	The diagnosis is inconsistent with the procedure	SUDs claims require that the primary diagnosis be 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 (ICD-10)	7%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
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	4%

Substance Use Disorder Claims – Top Denials

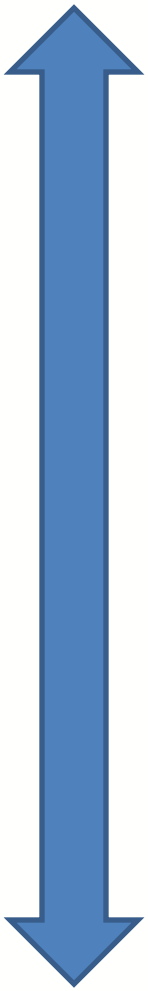
EOB	Description	Comments	Denial %
B5	Coverage/ program guidelines were not met or were exceeded.	Group therapy (96153) only covered if at least 45 minutes (3 units)	1%
96 N59	Non-covered charge(s).	Usually a lab code	1%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
A1 N61	Rebill services on separate claims.	**DO NOT REBILL ON SEPARATE CLAIMS.** CD encounters always require the claim note: AI/AN client – SCI=NA Non-AI/AN client – SCI=NN Also see EOB code #4	1%

REVIEW OF MENTAL HEALTH BILLING & RSN ACCESS TO CARE

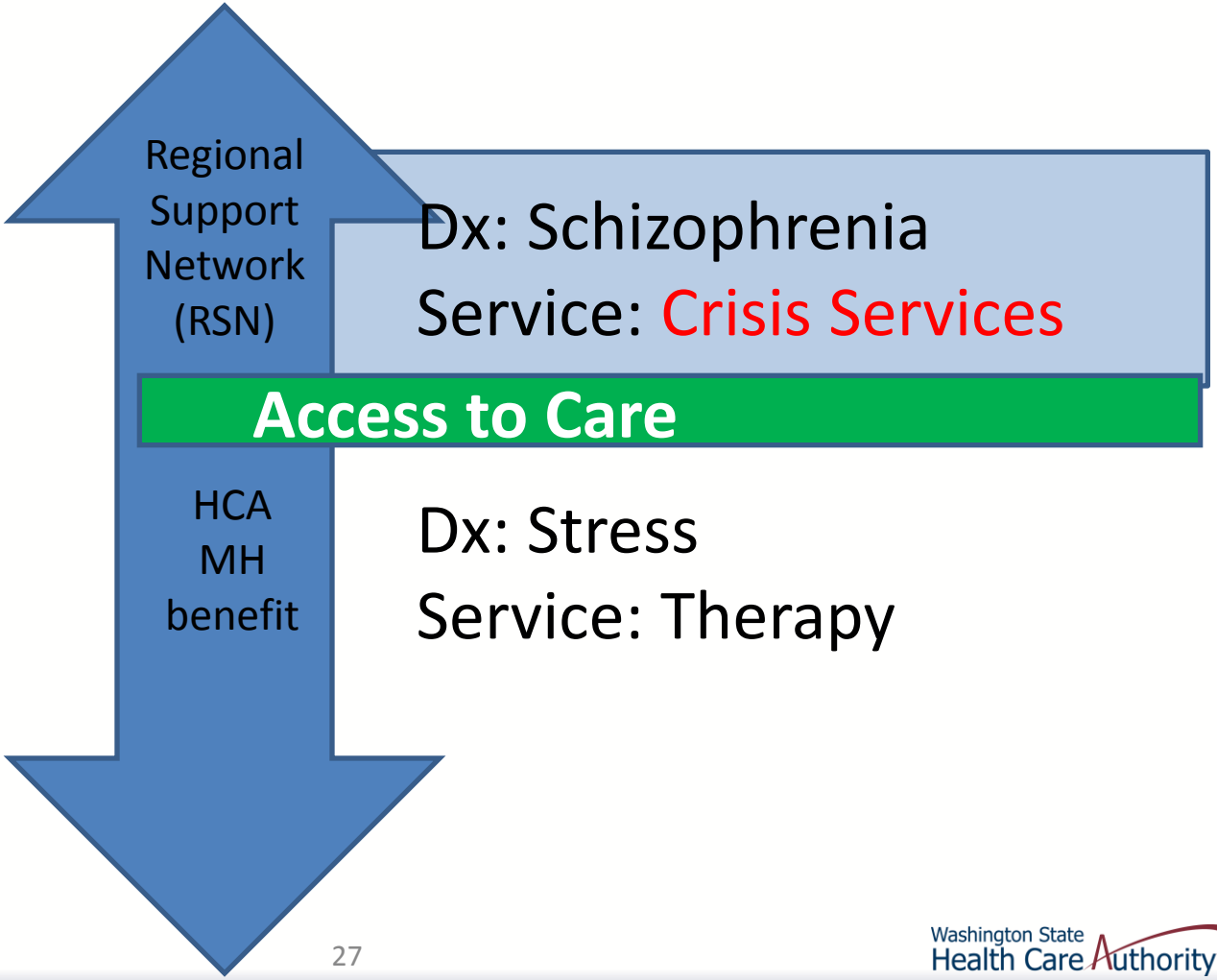
Mental Health Spectrum



Schizophrenia

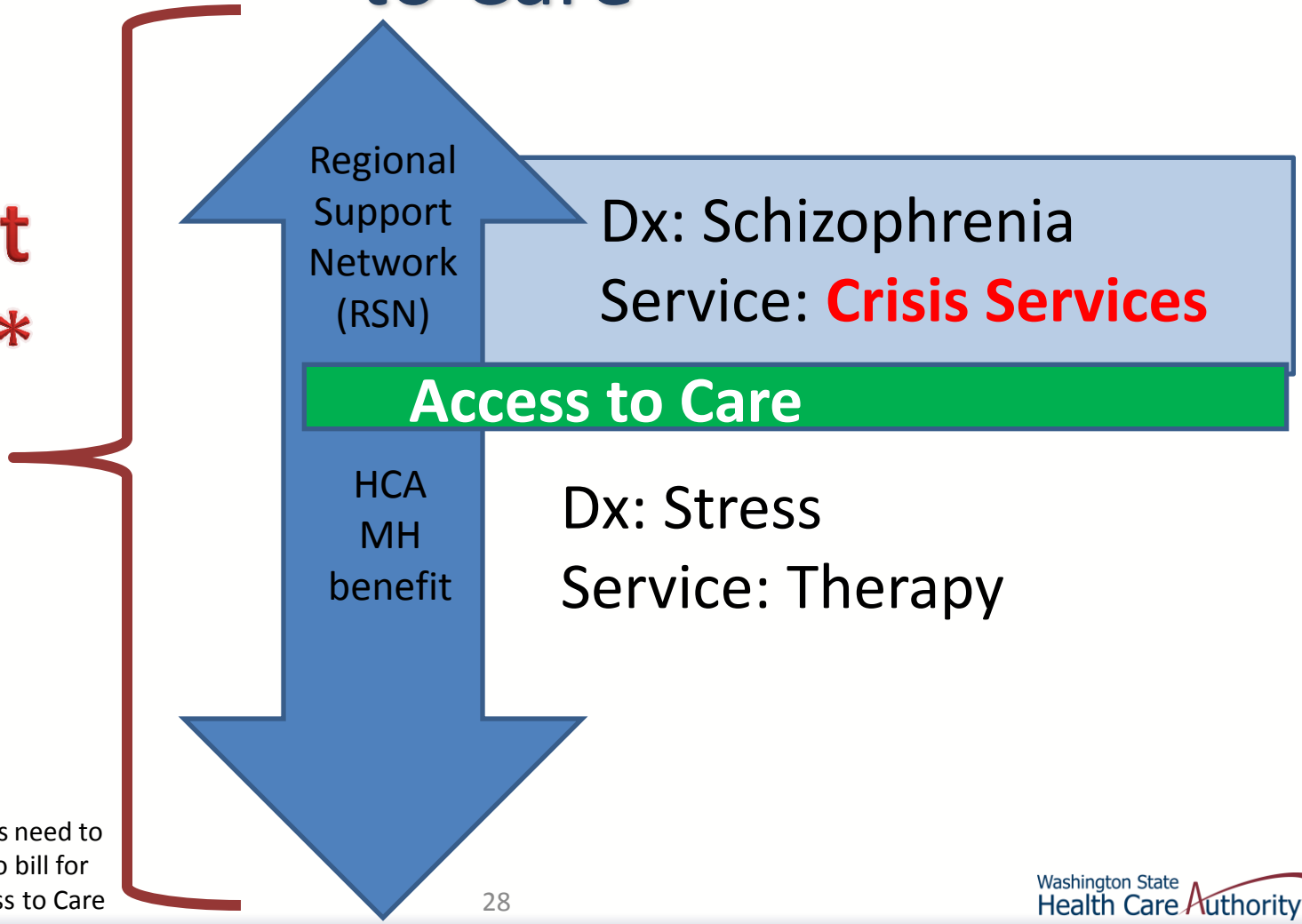
Stress

Mental Health Modalities and Access to Care



Mental Health Modalities and Access to Care

AI/AN at I/T or U*



* Urban Indian Organizations need to contract with RSN in order to bill for services that meet the Access to Care Standard

Billable Mental Health Modalities

Mental Health Services are divided into two categories

- Below the RSN Access to Care Standard
  - Follow the HCA Mental Health Billing Guide
- Above the RSN Access to Care Standard
  - AI/AN clients (and clinical family members) at IHS/638 facilities may receive services at the Tribal Clinic
    - Non-AI/AN clients (who are not clinical family members) are referred to the RSN
  - Urban Indian clinics need to contract with the RSN
  - Non I/T/U clinics refer clients to the RSN

Billable Mental Health Modalities

- Services above the RSN access to care are billable to P1 at the IHS encounter rate if the client is AI/AN (or clinical family member) and the client chooses to opt out of RSN managed care and receive services at the Tribal clinic. I/T clinics refer to the Tribal Health Program provider guide for CPT/HCPCS codes and EPA criteria

- **Crisis Services** is one of the RSN modalities that are billable by I/T clinics
  - HCPCS code is H2011 (**Note: DSHS is not using 90839 or 90840 for crisis services**)
- Urban Indian Organizations need to contract with the RSN in order to render RSN modalities. Services are billed according to the RSN contract.

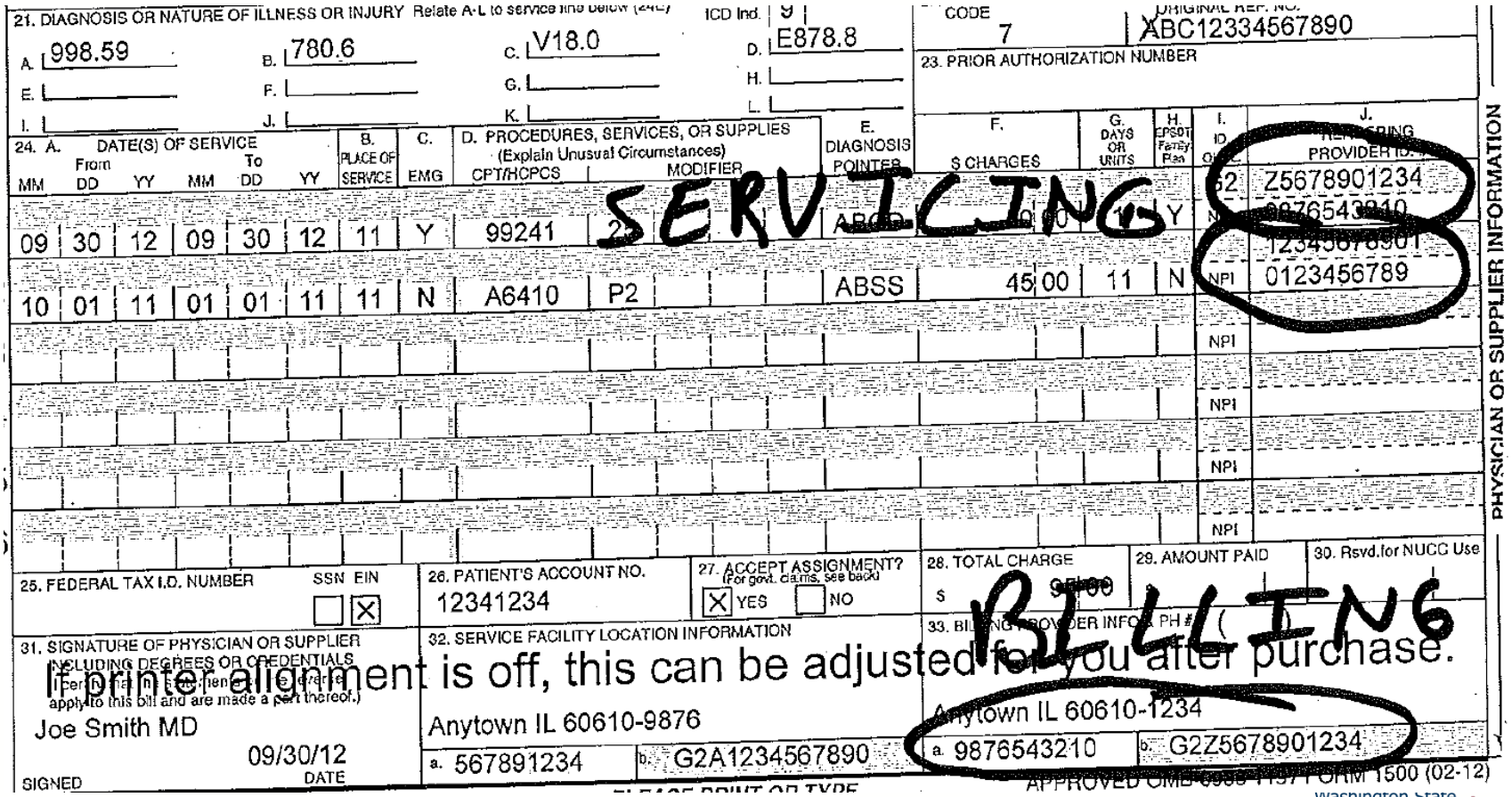
BILLING VS. SERVICING DATA

Billing vs Servicing NPI and Taxonomy

- What is the difference between Billing and Servicing NPI/taxonomy?
  - *Billing* refers to the billing group
  - *Servicing* (also known as performing or rendering) refers to the individual provider

Billing vs Servicing NPI and Taxonomy

Sample HCFA



Billing vs Servicing NPI and Taxonomy – HCFA claims

- Billing NPI goes in box 33a
  - HIPAA loop 2010AA, segment NM1, data element 09
- Billing taxonomy goes in box 33b
  - HIPAA loop 2000A, segment PRV, data element 03

- Servicing NPI goes in box 24J lower
  - HIPAA loop 2310B, segment NM1, data element 09
- Servicing taxonomy goes in box 24J upper
  - HIPAA loop 2310B, segment PRV, data element 03

Billing Taxonomy

- IHS/638 encounters require that the billing taxonomy be one of the following, sorted by categorical encounter

Category	Sub-category	Billing Taxonomy
Medical	General	208D00000X
	Psychiatric	2084P0800X
	Physical Therapy	225100000X
	Occupational Therapy	225X00000X
	Speech Therapy	235Z00000X
	Optometrist	152W00000X
Dental	No sub-category	122300000X
SUD	No sub-category	261QR0405X
Mental Health	No sub-category	2083P0901X

Servicing NPI and Taxonomy

- All Professional (HCFA) and Dental (ADA) claims require an individual's (servicing) NPI and taxonomy **except for SUD claims**.
- What Servicing taxonomy should be on the claim?
    1. Taxonomy that the servicing provider is enrolled with
    2. Taxonomy that is appropriate for the code/service

INITIAL POINT OF CONTACT AT I/T/U CLINICS FOR THE MCOS

Initial Point of Contact at the Tribes for the MCOs

- MCOs asked for an initial point of contact at each ITU clinic.
- Please let Mike know if you would like to offer an initial point of contact for the Managed Care Organizations
- Mike can split the contacts up as necessary (e.g. Medical claims are *Mike*, Behavioral health claims are *Jessie*)

PROVIDER ENROLLMENT IN P1 AND AT THE MCO

Provider Enrollment in P1 and MCO

New providers need to be added to your group.

Steps for enrolling a new provider in P1 are on the following slides. Two paths:

1. Servicing provider is already a P1 provider.

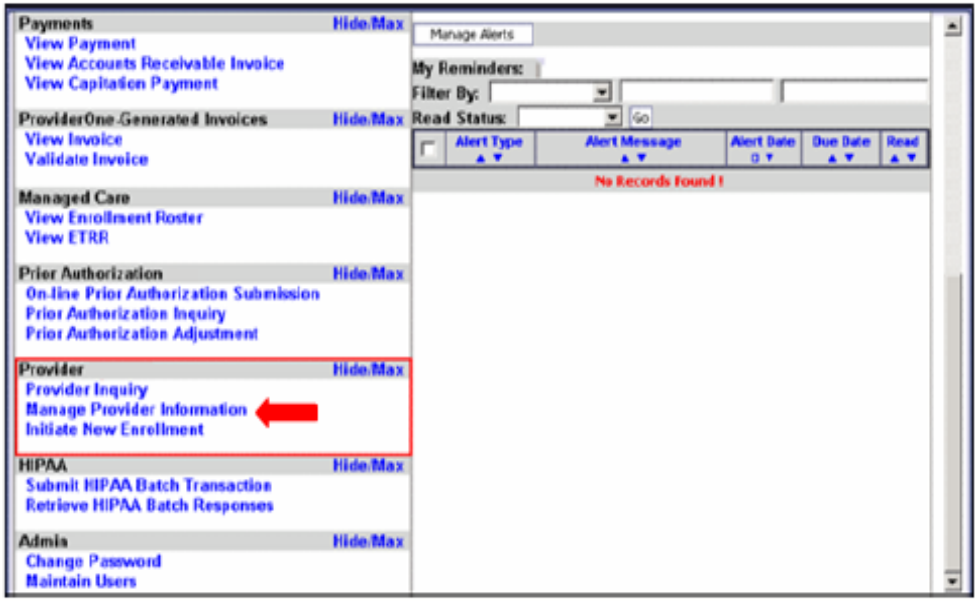
   one-step to add provider to your group

2. Servicing provider is a new provider in P1.

   provider needs to be added to P1 along with their data (specialty, billing group, license)

Provider File Maintenance

- Modifying Provider File Information
  - ✓ Log into ProviderOne with the **Provider File Maintenance** or **Supers User** profile.
  - ✓ Click on the **Manage Provider Information** hyperlink

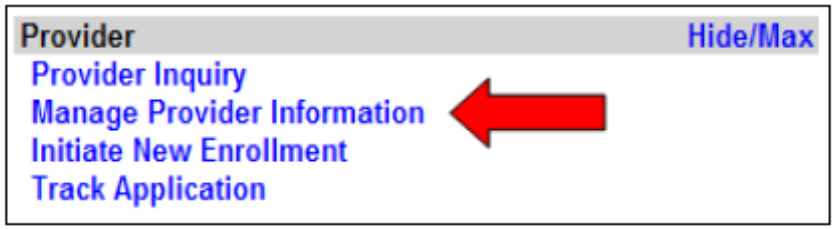


Provider Types include:

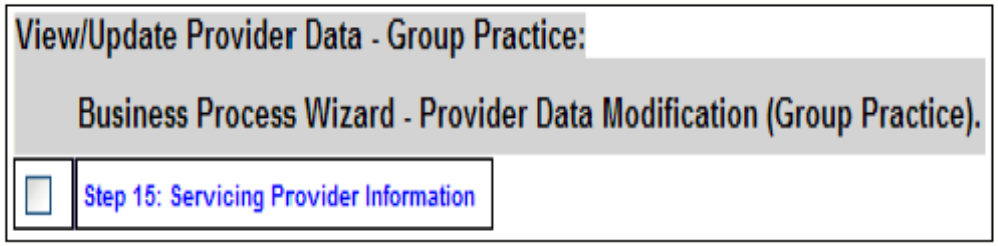
- ✓ Individual
- ✓ Group
- ✓ Tribal
- ✓ Facilities (FAOI)
- ✓ Servicing

Enroll a New Rendering Provider- Existing Provider

- Log into ProviderOne using the File Maintenance or Super User profile.



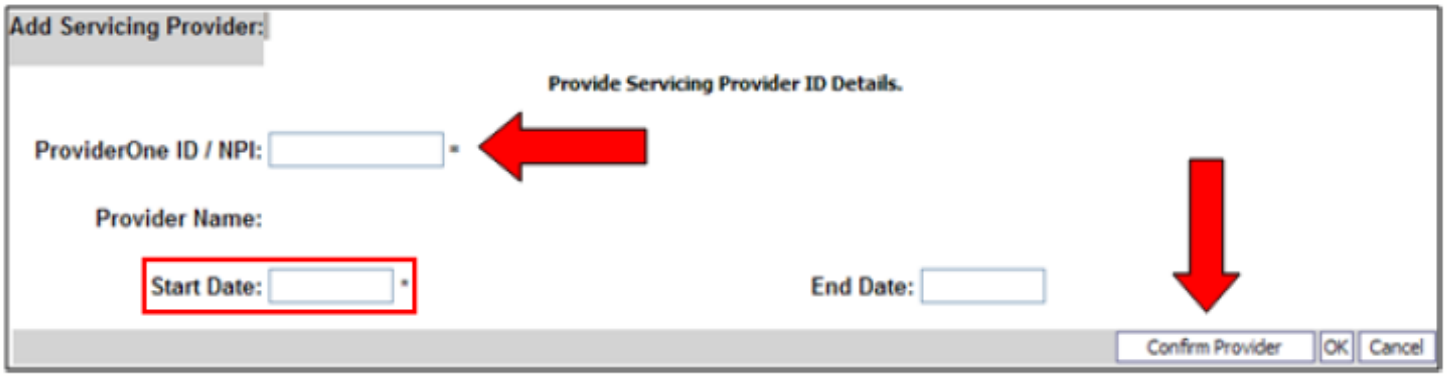
Under Provider click on the hyperlink **"Manage Provider Information"**.



At the Business Process Wizard click on **"Step 15: Servicing Provider Information"**.

Enroll a New Rendering Provider- Existing Provider

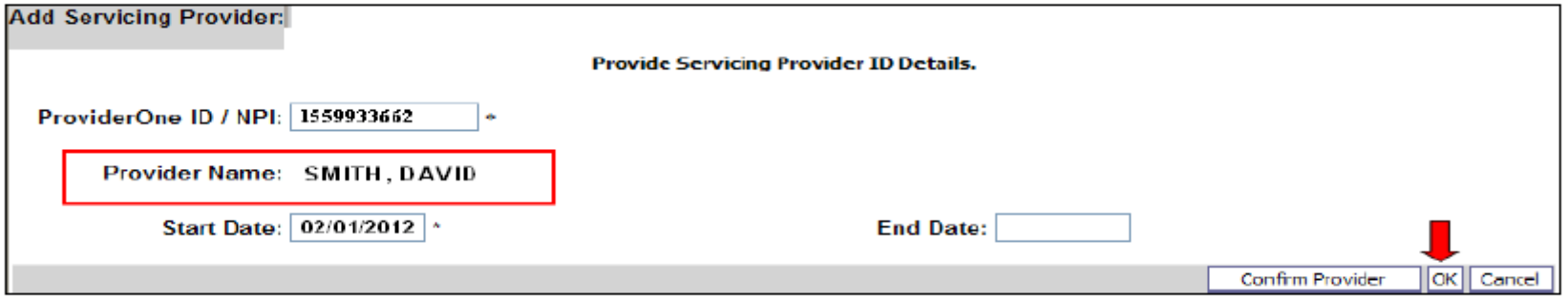
- When the Servicing Provider List opens, click on the **"Add"** button.



- At the Add screen:
  - ✓ Enter the providers NPI.
  - ✓ Enter their start date at your clinic.
  - ✓ Click on the **"Confirm Provider"** button.

Enroll a New Rendering Provider- Existing Provider

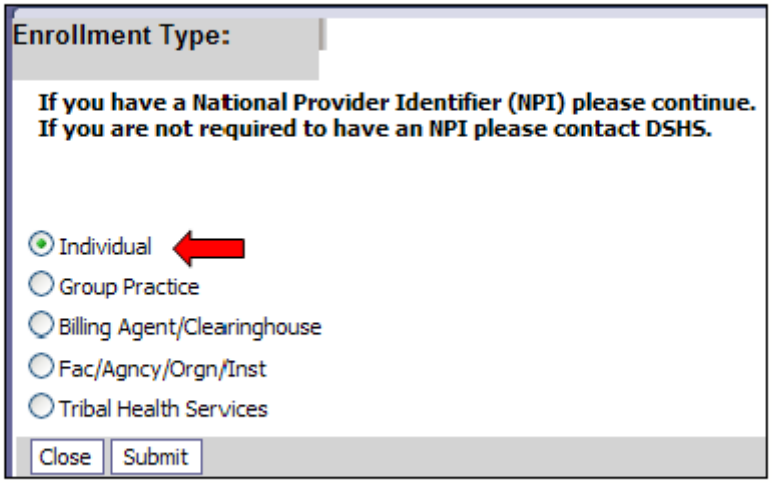
- If the provider is already entered into ProviderOne their name will be confirmed.



- Click the **"OK"** button to add the provider to your list.
- Remember to click **"Step 18: Submit Modification for Review"**.
- The State will then review your request.

Adding a New Rendering Provider

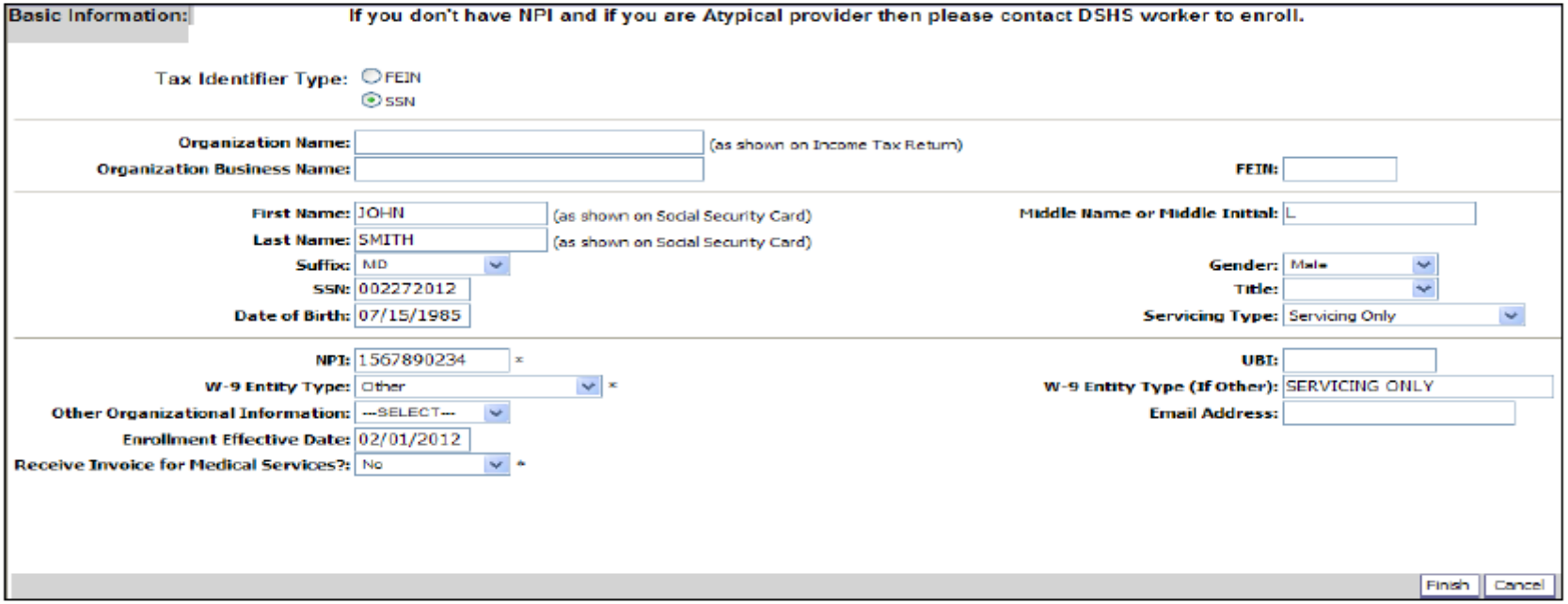
- There are two ways to add a new provider to your domain:
  - ✓ Follow the steps above. When you **"Confirm"** the provider and they are not in the system follow the steps below to enroll them.
  - ✓ At your Portal click on **"Initiate New Enrollment"** hyperlink.



- ✓ Click on **"Individual"** to add the rendering/servicing provider to your domain.
- ✓ Click on the **"Submit"** button.

Adding a New Rendering Provider

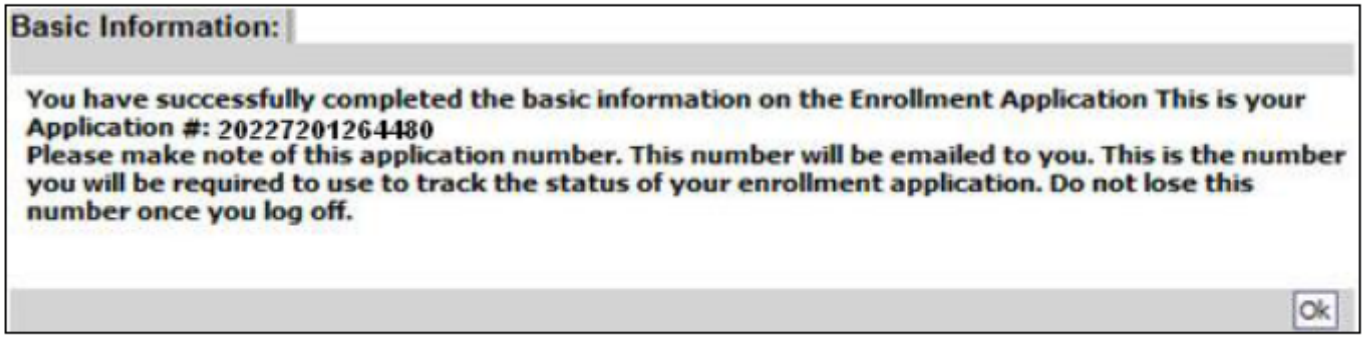
- At the Basic Information page for the rendering provider enrollment:



- ✓ **Most important check the SSN radio button!**
- ✓ When filling in the rest of the data fields be sure to select **"Servicing Only"** as the Servicing Type.

Adding a New Rendering Provider

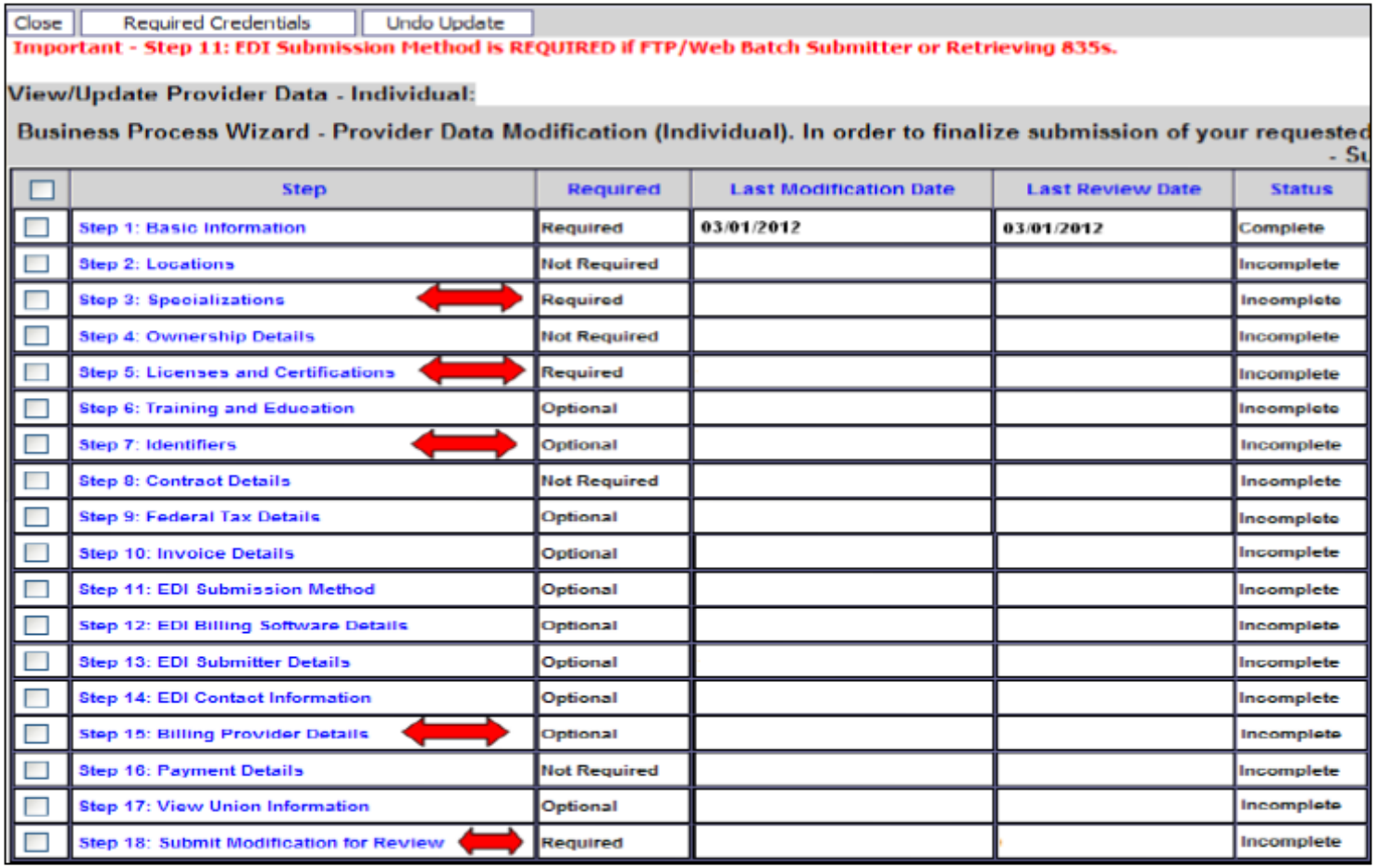
- Once the Basic Information page is filled in click the **"Finish"** button.
- The basic information on the enrollment application is submitted into ProviderOne which generates the Application number.



- Be sure to record this application number for use in tracking the status of the enrollment application. Then click **"OK"**

Adding a New Rendering Provider

- The steps with the arrows should be filled out.



Close | Required Credentials | Undo Update

Important - Step 11: EDI Submission Method is REQUIRED if FTP/Web Batch Submitter or Retrieving 835s.

View/Update Provider Data - Individual:

Business Process Wizard - Provider Data Modification (Individual). In order to finalize submission of your requested - Su

	Step	Required	Last Modification Date	Last Review Date	Status
☐	Step 1: Basic Information	Required	03/01/2012	03/01/2012	Complete
☐	Step 2: Locations	Not Required			Incomplete
☐	Step 3: Specializations	Required			Incomplete
☐	Step 4: Ownership Details	Not Required			Incomplete
☐	Step 5: Licenses and Certifications	Required			Incomplete
☐	Step 6: Training and Education	Optional			Incomplete
☐	Step 7: Identifiers	Optional			Incomplete
☐	Step 8: Contract Details	Not Required			Incomplete
☐	Step 9: Federal Tax Details	Optional			Incomplete
☐	Step 10: Invoice Details	Optional			Incomplete
☐	Step 11: EDI Submission Method	Optional			Incomplete
☐	Step 12: EDI Billing Software Details	Optional			Incomplete
☐	Step 13: EDI Submitter Details	Optional			Incomplete
☐	Step 14: EDI Contact Information	Optional			Incomplete
☐	Step 15: Billing Provider Details	Optional			Incomplete
☐	Step 16: Payment Details	Not Required			Incomplete
☐	Step 17: View Union Information	Optional			Incomplete
☐	Step 18: Submit Modification for Review	Required			Incomplete

Adding a New Rendering Provider

- Step 3: Specializations
  - ✓ Add Taxonomy here.
- Step 5: Licenses and Certifications
  - ✓ Enter license/certification issued by the Department of Health.
- Step 7: Identifiers
  - ✓ If you have a Drug Enforcement Agency (DEA) number enter it here

Adding a New Rendering Provider (Cont.)

- Step 15: Billing Provider Details
  - ✓ Add the NPI and Name of clinic that will bill for this rendering provider's services.
- Step 18: Submit Modification for Review
  - ✓ Open this and click the Submit Button to send to the State for approval.
- Send in all required supporting documentation (CPA, Certifications, etc)

Provider Enrollment in P1 and MCO - Soliciting Feedback

- Previous slides identified the steps required to enroll a new provider in P1
- What experiences have others had with enrollment at the MCOs?

MANAGED CARE PLANS AND THEIR QUALIFIED HEALTH PLANS (QHPS)

Managed Care Plans and their Qualified Health Plans

Medicaid MCO	Qualified Health Plan
Amerigroup	*Not Applicable*
Community Health Plan of Washington	CHPW HealthEssentials
Coordinated Care	Ambetter
Molina	Molina Marketplace
UnitedHealthcare	UnitedHealthcare

2016 MEETING SCHEDULE

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 + BHSIA Monthly Meeting

PROPOSED SCHEDULE

Fourth Monday 9:00-12:00 PM

January 25

February 22

March 28

April 25

May 23

June 27

July 25

August 22

September 26

October 24

November 28

December (TBD)

Washington State Health Care Authority

Draft IHS Encounter Table

Refer to attachment for full-size copy of the draft IHS encounter payment table

Are Apple Health (Medicaid) clients eligible for the IHS encounter rate?							
		AI/AN Clients			Non-AI/AN Clients		
Encounter Type:	**Program:**	**Medicaid Only**	**Medicaid + Medicare**	**Medicaid + Private Insurance**	**Medicaid Only**	**Medicaid + Medicare**	**Medicaid + Private Insurance**
Medical	**FFS or PCCM**	**Yes** – Bill P1	**Yes** – Bill Medicare primary and P1 for balance	**Yes** – Bill private insurance primary and P1 for balance	**Yes** – Bill P1	**Yes** - Bill Medicare primary and P1 for balance	**Yes** – Bill private insurance primary and P1 for balance
	MCO	**Yes** – Bill MCO primary and P1 for balance	N/A		**No** – Bill MCO only	N/A	
Dental		**Yes** – Bill P1		**Yes** – Bill private insurance primary and P1 for balance	**Yes** – Bill P1		**Yes** – Bill private insurance primary and P1 for balance
Mental Health	**FFS or PCCM**	**Yes** – Bill P1	**Yes** - Bill Medicare primary and P1 for balance	**Yes** – Bill private insurance primary and P1 for balance	***Yes**– Bill P1	***Yes** - Bill Medicare primary and P1 for balance	***Yes**– Bill private insurance primary and P1 for balance
	MCO	**Yes** – Tribe may bill either of two ways: (1) Bill P1 (2) Bill MCO primary and P1 for balance	N/A		**Yes, if client is a clinical family member** - Tribe must bill P1 directly to receive encounter rate	N/A	
Substance Use Disorder		**Yes** – Bill P1		**Yes** – Bill private insurance primary and P1 for balance	**Yes** – Bill P1 (claims are eligible for the federal portion of the encounter rate, which varies by Medicaid program)		**Yes** – Bill private insurance primary and P1 for balance up to federal portion of the encounter rate, which varies by Medicaid program

* Under the State Plan:
- If the non-AI/AN mental health client is in the fee-for-service program, the Tribal clinic may receive the IHS encounter rate for mental health services.
- If the non-AI/AN mental health client is in Managed Care, the Tribal clinic may receive the IHS encounter rate for mental health services ONLY IF the client is a clinical family member.
  - If the Managed care organization is billed then MCO payment is final payment (the "wraparound" option does not exist for non-AI/AN clients, regardless of category)

We are in the process of updating the billing guide to reflect the state plan. The State Plan supersedes the provider guide

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 the services of a Mental Health Associate billable?

A. Associates must be licensed and under the supervision of an MHP (claims are billed using the supervisor's servicing NPI/taxonomy)

Q. are the services of a Mental Health Associate who are pending licensure billable?

A. Services for a person pending licensure are not billable. The services are billable starting on the date of license.

Questions Log

Q. Will we be able to bill for Chronic Care Management services under the encounter rate? (CPT 99487 99489 99490)

A. Chronic Care Management codes are not covered by HCA, however, extended E&M's may be billed if services meet E&M criteria

Questions Log

Q. How can I request a replacement ProviderOne services card for a client?

A. Tribal Representatives can request services cards for AI/AN clients if the representative is:

- From the Tribe or Tribal clinic
- A Tribal In-person Assister or Navigator
- A Tribal Liaison

The request must include the

- Tribal representative's name
- Title
- Statement that the recipient is American Indian/Alaska Native

Use the "contact us" link at https://fortress.wa.gov/hca/p1contactus/

Questions Log

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. If the service is Medically necessary (medical necessity is determined by the provider) it may be rendered as part of an E&M (non-psych ARNP) or part of a mental health therapy (Psych ARNP or other MHPs) and would qualify for the encounter rate

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 (30 days 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.

Will billing Transition to the MCOs? This is being developed and MCOs might start paying at the encounter rate in 2016. Stay tuned.

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:

mike Longnecker
michael.longnecker@hca.wa.gov
360-725-1315

Jessie Dean
Jessie.dean@hca.wa.gov
360-725-1649

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.