Washington State Health Care Authority

Tribal Billing Workgroup (TBWG)

November 12, 2014
Mike Longnecker
HCA Tribal Affairs Office

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Agenda

- Monthly Data and analysis
- Billing workgroup schedule for 2015
- Billing Guide
- Primary Care Incentive Payments (PCIP) by Medicare/Managed Care
- General Updates
  - Prolonged Care denials
  - Optometrist denials
- Non-Native CD billing for ABP clients
- Mental Health (RSN) modalities
- Managed Care Denials
- FAQ and Open Discussion

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August 2014 Claims Data (I/T/U)

	dollars	clients*	% of claims paid
Totals	$5,516,652	10531	See categories
Medical	$1,398,690	4488	76%
Dental	$599,720	1825	85%
Mental Health	$965,916	1261	87%
Chemical Dep	$1,997,161	1068	96%
POS	$411,187	4558	60%
Other FFS	$143,978	77	95%

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

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Medical Claims – Top Correctable Issues

EOB	Description	Comments
16, N288	Servicing taxonomy on claim is blank or one that the servicing NPI is not enrolled with	Want to find out what a provider is enrolled with? Contact Mike or refer to the Billing workgroup slides for March 11, 2014
18	Duplicate	
16, M54	Total claim charge out of balance	The billed amount needs to be the sum of the lines (even if there is a primary payment
31	Client ID not on file	Seeing a few claims that have a space after the "WA" for the client ID. If the client ID on the remittance is right then this is the most likely cause
16, N329	Client birthday mis-match	
204	Service not covered under client's benefit service plan	Usually a family planning client
167	Treatment for this diagnosis is not reimbursable	Contact Mike or refer to diagnosis cheat sheet from billing workgroup slides for October 14, 2014
24	Client in managed care	

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Medical Claims – Top Correctable Issues

EOB	Description	Comments
181	System unable to determine how to pay	Too many possible issues. Could be due to a D-dental code on a HCFA claim or sometimes the wrong taxonomy or modifier for the service. Contact Mike
4	Missing the UA or SE modifier	
A1, N59	Invalid EPSDT procedure	CPT 99381-99395 makes the claim become a well child visit. Age 0-20 only. Medical issues generally not allowed on well child visits. See Preventive Visits on today's slides
119	Claim exceeds limits	Many services (eg - well child visits, physical therapy have frequency limits)
16, M79	Missing line billed amount	
236	Code pair not allowed per NCCI Coding guidelines	Washington Medicaid follows Medicaid NCCI programming. Sometimes a modifier will allow a code-pair to pay
16, M119	Missing NDC	Most drug codes (eg, J-codes) require NDC submitted along with the drug code. Physician billing guide has billing criteria

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Medical Claims – Preventive Visits

- CPT 99381-99395 on a claim will cause the claim to become a well child (EPSDT) claim
- EPSDT claims are only for clients age 0-20
- CPT 99385-99396 are not covered for adults age 21 or greater
  - Well adult visits are not covered
- Cancer screens are covered, refer to physician billing guide (p. 94)

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Dental Claims – Top Correctable Issues

EOB	Description	Comments
16, N255	Billing taxonomy missing or not assigned to this provider	
16, N290	Servicing NPI missing or not in P1	
16, N288	Servicing taxonomy missing or not assigned to this provider	Want to find out what a provider is enrolled with? Contact Mike or refer to the Billing workgroup slides for March 11, 2014
4	Missing the 870001305 or 870001306 EPA	FQHC providers do not need this EPA
6	Service not allowed for client age	D1330 age 0-8 D1120 age 0-13 D1110 age 14+

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Dental Claims – Top Correctable Issues

EOB	Description	Comments
96, N59	Procedure code not covered	
181	System unable to determine what to pay	
119, M86	Limits exceeded	Usually prophy or fluoride – see Dental Limit Table on today's slides
16, N39	Code not allowed for this tooth	
16, N329	Client birthday mis-match	

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Dental Limit Table

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

Prophylaxis/cleaning D1110 and D1120			
Age 0-18	Age 19+	All ages, DDD	All ages, Nursing home client
1 per 6 months	1 per year	3 per year	4 per year

Exams D0120/D0150*		
All ages	All ages, DDD	* D0150 is a new patient, allowed once per 3 years if the client has not been seen in the clinic
1 per 6 months	3 per year	

Sealants D1351	
Age 0-20	All ages, DDD
1 per 3 years (per tooth)	1 per 2 years (per tooth)
Tooth # A,B,I,J,K,L,S,T, 2, 3, 14, 15, 18, 19, 30, 31 – surface O	Tooth # A,B,I,J,K,L,S,T, 2, 3, 4, 5, 12, 13, 14, 15, 18, 19, 20, 21, 28, 29, 30, 31 – surface O

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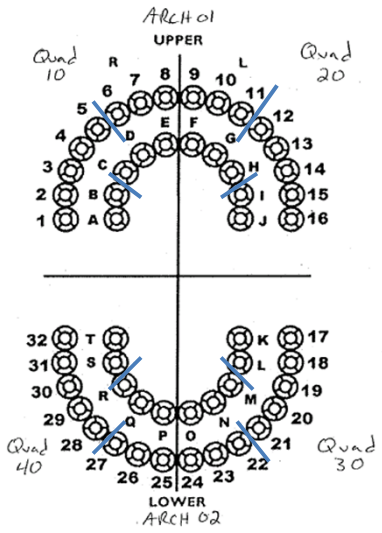
Dental Tooth, Arch, Quad numbering



Supernumerary (extra) teeth

- Only services covered are extractions
- Coding:
- Permanent dentition – add '50'
  8 becomes 58 … 21 becomes 71
- Primary dentition – add an 'S'
  A becomes AS … Q becomes QS

Tooth Surfaces (used for restorations)

- Mesial – side that comes in contact with adjacent tooth. Mesial faces the front of the mount
- Distal – side that comes in contact with adjacent tooth. Distal faces the back of the mouth
- Incisal (anterior) or Occlusal (posterior) – biting surface
- Lingual – side that is facing the tongue
- Facial (anterior) or Buccal (posterior) – side that is facing the cheek/lips

Anterior vs Posterior (blue lines)

Anterior - 6,7,8,9,10,11,22,23,24,25,26,27, C,D,E,F,G,H,M,N,O,P,Q,R

Posterior – 1,2,3,4,5,12,13,14,15,16,17,18,19,20,21,28,29,30,31,32,A,B,I,J,K,L,S,T

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Mental Health Claims - Top Correctable Issues

EOB	Description	Comments
16, N288	Servicing taxonomy missing or not assigned to this provider	Want to find out what a provider is enrolled with? Contact Mike or refer to the Billing workgroup slides for March 11, 2014
16, N290	Servicing NPI missing or not in P1	
18	Duplicate	
16, M54	Total claim charge out of balance	The billed amount needs to be the sum of the lines (even if there is a primary payment)
4	Missing HE or SE modifier	
16, M79	Missing billed amount on line	
236	Code pair not allowed per NCCI Coding guidelines	Washington Medicaid follows Medicaid NCCI programming. Sometimes a modifier will allow a code-pair to pay.

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CD Claims – Top Correctable Issues

EOB	Description	Comments
A1, N61	Missing SCI=NA or SCI=NN claim note	I currently go into P1 every couple of weeks and reprocess claims that are missing the claim note and add the claim note
16, N152	Claim (TCN) has already been reprocessed	Each TCN can only be reprocessed one time.
18	duplicate	

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2015 Billing Workgroup/Webinar schedule

- Tuesday workgroup conflicts with the Tribal Assister webinar
- Votes are tied – second week of the month:
  - Wednesday morning
  - Tuesday afternoon

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Billing Guide Update

Drafts are in final stages

Drafts represent what has been in place since October, 2012

Tentative changes to billing guide:

- No changes to billing model at this time

  no funds available for a change request.
- All updates will be to reflect what we have been doing since October, 2012

Drafts are available for review/comments – just ask Mike

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Primary Care Incentive Payment

- Impacts Fee For Service codes only
- Primary Care Providers are eligible for a rate increase/enhanced payments on certain services
- The Encounter payment remains unchanged
- All information accessible here

  http://www.hca.wa.gov/medicaid/Documents/aca_faq.pdf

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Primary Care Incentive Payment

- If Medicare/MCO pays the incentive when Medicare pays the claim – no issue
- If Medicare/MCO pays the incentive after Medicare pays the claim and after the crossover has been billed to ProviderOne – we now have an overpayment
- The ProviderOne crossovers and MC wraparounds would need to be adjusted so that there is no overpayment issue
- See next slide for sample Medicare PCIP payment for illustration of the administrative burden that this would place
- Do not adjust/reprocess claims at this time due to the administrative burden. Tribal Affairs office is seeking guidance

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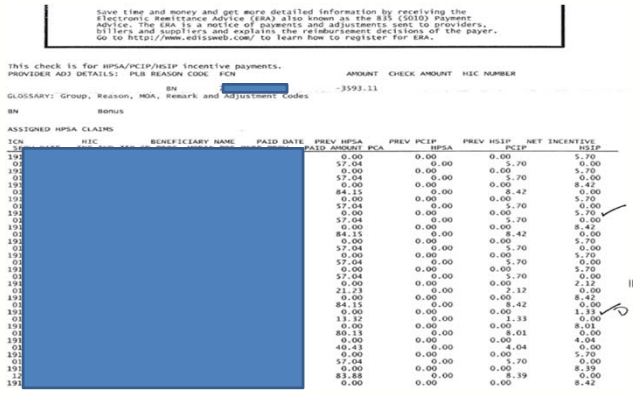
Primary Care Incentive Payment

- Sample PCIP payment, this payment was 20 pages/560 claims



Save time and money and get more detailed information by receiving the Electronic Remittance Advice (ERA) also known as the 835 (5010) Payment Advice. The ERA is a notice of payments and adjustments sent to providers, billers and suppliers and explains the reinbursement decisions of the payer. Go to http://www.edisswb.com/ to learn how to register for ERA.

This check is for HPSA/PCIP/HSIP incentive payments.
PROVIDER ADJ DETAILS: PLB REASON CODE FCN AMOUNT CHECK AMOUNT HIC NUMBER
BN -3593.11
GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes
BN Bonus
ASSIGNED HPSA CLAIMS

ICN	HIC	BENEFICIARY NAME	PAID DATE	PREV HPSA PAID AMOUNT	PCA	PREV PCIP HPSA	PREV HSIP PCIP	NET INCENTIVE HSIP
191				0.00		0.00	0.00	5.70
191				57.04		0.00	5.70	0.00
191				0.00		0.00	0.00	5.70
191				57.04		0.00	5.70	0.00
191				0.00		0.00	0.00	8.42
191				84.15		0.00	8.42	0.00
191				0.00		0.00	0.00	5.70
191				57.04		0.00	5.70	0.00
191				0.00		0.00	0.00	5.70
191				57.04		0.00	5.70	0.00
191				0.00		0.00	0.00	8.42
01				84.15		0.00	8.42	0.00
191				0.00		0.00	0.00	5.70
191				57.04		0.00	5.70	0.00
191				0.00		0.00	0.00	5.70
191				57.04		0.00	5.70	0.00
191				0.00		0.00	0.00	5.70
191				57.04		0.00	5.70	0.00
191				0.00		0.00	0.00	2.12
01				21.23		0.00	2.12	0.00
191				0.00		0.00	0.00	8.42
01				84.15		0.00	8.42	0.00
191				0.00		0.00	0.00	1.33
01				13.32		0.00	1.33	0.00
191				0.00		0.00	0.00	8.01
01				80.13		0.00	8.01	0.00
191				0.00		0.00	0.00	4.04
01				40.43		0.00	4.04	0.00
191				0.00		0.00	0.00	5.70
01				57.04		0.00	5.70	0.00
191				0.00		0.00	0.00	8.39
12				83.88		0.00	8.39	0.00
191				0.00		0.00	0.00	8.42

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General Updates

Prolonged Care (CPT 99354-99357)

- Prolonged care codes are add-on codes. CPT added 90837 to the list of qualifying codes for prolonged care for 2014.
- HCA does not allow prolonged care codes on a mental health claim
- Prolonged Care claims with 90837 are currently being denied in full
- Beginning 11/28/2014 (retroactive) the Prolonged Care line will be denied and the rest of the claim will be payable (and Mike will reprocess claims)

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General Updates

Optometrist encounters

- Optometrist claims are encounter eligible.
- Optometrist encounters should be billing taxonomy 152W00000X
- Claims are currently erroring out but should start paying on 11/22/2014
- Mike will reprocess claims after update

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Non-Native CD Claims for Newly Eligible ABP Clients

- Test claims passed testing and scheduled implementation is November 22nd, 2014 (retroactive)
- Non-Native CD claims at the I/T clinics for the newly eligible clients (ABP/N05/RAC 1201) will be eligible to pay the federal portion (100% of $342 for 2014)
- Do not bill claims prior to November 22
- Please bill about 10 claims and touch base before billing all the claims
- Already billed and been paid 50%? Contact Mike

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Non-Native CD Claims for Newly Eligible ABP Clients

	AI/AN client	NonNative classic and non-Alternative Benefit Plan (ABP)	nonNative ABP	NonNative SSI
Client RAC	Any CD encounter eligible RAC	Any CD encounter eligible RAC except 1201 or 1217	1201	1217 **(starts 02/2015)**
CD billing code modifier	Refer to the CD billing guide (DBHR CD outpatient general fund is usually HF)			
T1015 modifier	HF	HX	SE	HB
EXAMPLES				
Claim note	SCI=NA	SCI=NN	SCI=NN	SCI=NN
CD general fund group therapy	96153 HF T1015 HF	96153 HF T1015 HX	96153 HF T1015 SE	96153 HF T1015 HB
CD general fund individual therapy	96154 HF T1015 HF	96154 HF T1015 HX	96154 HF T1015 SE	96154 HF T1015 HB
Federal/State Match	100% Federal	About 50/50*. Tribes submit IGT for the State Match	100% Federal for RAC 1201 for the first 2 years then moving to 90%. Tribes submit IGT for the State match	About 75% Federal/25% state. Tribes submit IGT for the State match
How much does the claim pay? (2014)	$342.00	$171.00*	$342.00	$256.50

Note * The state Match had a recent change of 0.03% (not 3%) - this may result in a change in payment/IGT

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Mental Health

- HCA is moving forward with a fee schedule for the RSN modalities that have not been paying
- Anticipated ETA for fee schedule is 01/01/2015
- Bill claims 'now' even though system is not ready – this will establish timeliness.

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Mental Health

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

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

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

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Mental Health

- Service Modalities pending code decision, RSN codes most likely to be adopted
- Medication Monitoring (Medication training and support)
  RSN code H0033, H0034
- Crisis Services
  RSN code H0030, H2011
- Day Support
  RSN code H2012
- Peer Support
  RSN code H0038
- Stabilization services
  RSN code S9484
- Therapeutic Psycho-Education
  RSN code H0025, H2027

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Managed Care Denials

- Claims denied by the Managed Care Plans can be sent to the HCA Managed Care help-desk at hcamcprograms@hca.wa.gov
  - Include a copy of the EOB
  - Indicate that you are billing from a Tribal Health Clinic
- MCO will only pay noncontracted providers if the client is AI/AN in ProviderOne
- What if client is coded incorrectly?

  refer client to Assister, HPF or CSO for update
- Claims denied by HCA/P1 can be sent to mike
  - Claim number (TCN) is all I need

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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 will stay on the log until answered

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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.

Your can add Spend Downs to next agenda.

Stay tuned

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Questions Log

Medicare crossovers

Mike mentioned the usual basic steps required to get a Medicare crossover to process (only works if Medicare and P1 needs HCFA/professional format)

Do a resubmit denied/voided claim in P1

1. make sure the billing taxonomy is a encounter eligible taxonomy
2. make sure that UA or SE (or sometimes HE) is on every line
3. add the T1015 (and UA or SE or HE) line

It would be great if Tribes could use an A19 instead of the manual process for Medicare Primary/Mediciaid secondary

The HCA Form A-19 is an invoice that was used by the Basic Health program because the claims were not in ProviderOne, the state Medicaid billing system. Medicare claims are in ProviderOne and these claims can be resubmitted using either HIPAA or direct data entry (DDE).

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Questions Log

Medicare crossovers (cont'd)

FQHC's now are required to add a T1015 like code for all Medicare claims eff. 10/1/14.

NO T1015 and similar new code G0466 and yes to QMB duals

G0466, G0467, G0468, G0469, G0470 are now required for all FQHC Medicare claims eff. 10/1/14

Why add a T1015 for crossover claims? We already receive a FQHC rate from Medicare. I do not believe I can do both.

The addition of the T1015 is only for the IHS encounters

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 currently rejecting the claim rather than deny the line.

Stay tuned.

Questions Log

Pharmacists

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

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

11/12/2014 – pending CMO approval – stay tuned

Questions Log

Managed Care

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

Stay tuned, pilot project is starting with the FQHCs

Can you please email out contact info for the 5 HCA staff that are in charge of MCO's? Thanks!

Waiting for direct contact information. I have one so far:

Molina Healthcare

Kevin Siu, Contract Specialist, Government Services
Kevin.Siu@Molinahealthcare.com
425 424 1100 ext 144235

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Questions Log

Managed Care Timeliness

- Why can managed care plans set timely billing to 90 days when HCA is 365?
- CHPW allows a year for billing.
- We have been told that all Managed Medicaid plans must follow the 1 year timely filing rules. We must first appeal with the plan and if not resolved, then the state will cut a check
- Amerigroup has 90 day limit
- Amerigroup allows billing up to 6 months
- I believe the timely issues for managed care are because the contract each provider has signed has stated the time frames and I do believe you can negotiate with each insurance regarding these time billing frames. I know this to be true in private practices
- Stay tuned, I have requested the timely rules for all 5 MCOs with/without contract

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Questions Log

QMB mentioned during billing workgroup

PLEASE CLARIFY QMB COVERAGE

QMB will pay the fee basis "copay" on the FQHC claims - correct??

- QMBonly clients have premiums paid and are only eligible for FFS claims on Medicare crossovers (generally Medicare pays more than HCA so most claims deny)
- QMBdual clients have premiums paid and are eligible for encounters secondary to Medicare (dental, CD and some mental health is not paid by Medicare so HCA is primary)

How do you tell the difference between a QMBonly and a QMBdual?

Below are two eligibility screen shots. The first is QMBonly and the second is QMBdual

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number
MC: Medicaid	1113	QMB	06/01/2009	12/31/2999	S03	xxxxxxx

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number
MC: Medicaid	1109	CNP/QMB	07/01/2009	12/31/2999	S02	xxxxxxxx

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Questions Log

Can we can only bill for services done in this facility? Meaning not done at school, berry picking, etc.. There seems to be some question regarding the place of service. Private pay (regence, hma, etc only allows services done at the facility only)

Billing guide below, I *italicized*

- **How Do I Determine If a Service Qualifies as an Encounter?**
- For a health care service to qualify as an encounter, it must meet all the following criteria.
- The service must be:
- • Medically necessary.
- • Face-to-face.
- • Identified in the Medicaid State Plan as a service that is:
  - Covered by the Agency;
  - Performed by a health care professional within their scope of service.
- • Documented in the client's file in the provider's office. Client records must be maintained by the primary health care facility to ensure HIPAA compliance.
- • Performed in the health care facility identified on the IHS facility list *or at other locations where tribal facility-supported activities are performed by qualified clinic staff.* Services provided in any other location must comply with HIPAA provisions regarding confidentiality.

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Thank you

Send TBWG comments and questions to:

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