Washington State Health Care Authority

Tribal Billing Workgroup (TBWG)

March 11, 2015

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HCA Tribal Affairs Office

Agenda

- Monthly data and analysis
- Billing workgroup schedule for 2015
- May 13 Billing Workgroup emphasis will be on Mental Health billing
- Billing guide update and RSN modalities
- Managed care issues and MCO contact list
- Vaccine billing tips
- FAQ and Open Discussion

January 2015 Claims Data (I/T/U)

	dollars	clients*	% of claims paid	% prev month
Totals	$5,377,787	11,181	See categories	
Medical	$1,399,875	4137	83%	85%
Dental	$636,166	1843	87%	89%
MH	$718,859	995	90%	84%
CD	$2,085,520	883	96%	97%
POS	$485,510	5911	60%	60%
Other FFS	$51,854	201	12%**	28%

* Client count will not be the sum from the categories due to 'overlap' (clients can be in more than 1 category)
** most of the claims are Medicare crossovers that come directly from Medicare

Medical Claims – Top Denials

EOB	Description	Comments
24	Charges are covered under a capitation agreement managed care plan	Client is Enrolled in one of the Managed Care Plans
16 N288	Missing /incomplete /invalid rendering provider taxonomy	Claims had a servicing taxonomy that the provider is not enrolled with. Two possible resolutions: 1.Change the claims so that they are submitted with the taxonomy that the provider is enrolled with 2.Update the provider's file to include the taxonomy that is being billed (if appropriate, a *brain surgeon* taxonomy would not be for a GP Dr) Not sure what the provider is enrolled with? Contact Mike If you choose option 2 contact Mike so he can reprocess claims so you do not have to rebill
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage

Medical Claims – Top Denials

EOB	Description	Comments
167	This (these) diagnosis(es) is (are) not covered	Medicaid does not consider some diagnosis codes eligible for **medical** treatment. Most claims had CD diagnoses (303-305) NOTE: 1. Office visit for prescribing Campral, ReVia, Vivitrol, Buprenorphine, Suboxone is covered – refer to physician guide, P. 257 for criteria. P 2. Office visit for Suboxone and Buprenorphine are carved out of Managed Care (bill P1 directly for clients enrolled in Managed Care)
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	AI/AN or non-native modifier was missing
18	Exact duplicate claim/service	Duplicate billing
16 N290	Missing/incomplete/invalid rendering provider primary identifier	See slide Backdating Newly Enrolled Rendering Provider

Medical Claims – Top Denials

EOB	Description	Comments
31	Patient cannot be identified as our insured	Client ID usually invalid but sometimes there is a space after the "WA" – P1 treats the space as a value and it makes the ID invalid If rebilling in the P1 screens the space issue gets automatically fixed (P1 screens ignore the space and if client ID is invalid you will get an error popup before submitting the claim)
16 N329	Missing /incomplete /invalid patient birth date	Usually incorrect birthday on claim. If you think you have the right birthday on the claim or are unsure, contact Mike
146	Diagnosis was invalid for the date(s) of service reported.	One of the diagnosis codes on the claim is not valid. Generally the diagnosis needed an extra digit (eg 250 should be 250.00)
16 M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	Most drug codes need a valid NDC. Expired NDCs and NDC codes that are not reported to Medispan (like clinic packs) will also cause this error

Dental Claims – Top Denials

EOB	Description	Comments
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)
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage
16 N329	Missing/incomplete/invalid patient birth date	Usually incorrect birthday on claim. If you think you have the right birthday on the claim or are unsure, contact Mike

Dental Claims – Top Denials

EOB	Description	Comments
119	Benefit maximum for this time period or occurrence has been reached	Various frequency limits in the dental program for office visits, cleanings, fluorides, etc. Refer to Dental Limit Table at the end of this presentation
96 N59	Non-covered charge(s).	Common codes were D1330 and Crowns D1330 is only for younger clients (0-8). Clients 9 years or older the hygiene is bundled into the prophy (D1110/D1120) Crowns are only allowed for clients 15-20 years old and require Prior Authorization
16 N288	Missing/incomplete /invalid rendering provider taxonomy	Claims had a servicing taxonomy that the provider is not enrolled with. Two possible resolutions: 1. Change the claims so that they are submitted with the taxonomy that the provider is enrolled with 2. Update the provider's file to include the taxonomy that is being billed (if appropriate, an *Oral Surgeon* taxonomy would not be for a general dentist) Not sure what the provider is enrolled with? Contact Mike. If you choose option 2 contact Mike so he can reprocess claims so you do not have to rebill

Dental Claims – Top Denials

EOB	Description	Comments
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 sheet at the end of this presentation
A1 N192	Patient is a Medicaid/Qualified Medicare Beneficiary	QMB-only clients are only eligible for fee for service secondary to Medicare
16 N329	Missing/incomplete/invalid patient birth date	Usually incorrect birthday on claim. If you think you have the right birthday on the claim or are unsure, contact Mike
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

Mental Health Claims - Top Denials

EOB	Description	Comments
18	Exact duplicate claim/service	Duplicate claims -- 50% of our denials were dupes
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. Not sure what the MHP is enrolled with? Contact Mike. Two resolutions: 1. Change the claims so that they are submitted with the taxonomy that the MHP is enrolled with. 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
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage

Mental Health Claims - Top Denials

EOB	Description	Comments
A1 N192	Patient is a Medicaid/Qualified Medicare Beneficiary	QMB-only clients are only eligible for fee for service secondary to Medicare
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
A1 N362 or 96 N20	The number of Days or Units of Service exceeds our acceptable maximum. Or Service not payable with other service rendered on the same date.	CPT code for MH visit had more than 1 unit on the line Resolution – most CPT's that are not 'per x minutes' must be billed at 1 unit. CPT 90853 was observed most often

Mental Health Claims - Top Denials

EOB	Description	Comments
96 N59 or 181	Please refer to your provider manual for additional program and provider information or Procedure modifier was invalid on the date of service	Most claims were Crisis Services. Please continue to bill for the Crisis Services and other RSN modalities, this will establish timeliness and allow me to help find all the claims when P1 is updated
16 N286	Missing/incomplete/invalid referring provider primary identifier	Mental health claims do not require a referring NPI, HOWEVER, if a referring NPI is on the claim then it must be an NPI that is in P1
31	Patient cannot be identified as our insured	Client ID usually invalid but sometimes there is a space after the "WA" – P1 treats the space as a value and it makes the ID invalid. Resolution – rebill. If rebilling in the P1 screens the space issue gets automatically fixed (P1 screens will not accept invalid data)

Chemical Dependency Claims – Top Denials

EOB	Description	Comments
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-native client – SCI=NN Also see EOB code #4 below
18	Exact duplicate claim/service	Duplicate claims
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Refer to table at end of presentation. 1. Modifier on billing code is *always* HF 2. Modifier on T1015 is a. AI/AN client – HF b. non-native: 1. ABP (RAC 1201) - SE 2. presumptive SSI (RAC 1217) - HB 3. all others - HX

2015 IHS encounter rate

- Not announced yet
- Stay tuned

2015 Meeting Schedule

Tribal Billing Workgroup (TBWG)
Second Wednesday (* unless noted)
9:00-10:00 AM

March 11

April 8

May 13 – Focus on Mental Health

June 10

July 8

August 12

September 9

October 14

November 12 (* Thursday)

December 9

Medicaid Monthly Meeting (M3)
Fourth Wednesday
9:00-10:00 AM

March 25

April 22

May 27

June 24

July 22

August 26

September 23

October 28

November 25

December 23

Mental Health Q&A on May 13

- Billing workgroup for May 13 will focus on Mental Health services
- The May 13th date will give me time to ensure that the newly adopted RSN modalities are paying in P1
- Please send any Mental Health billing/coding/policy questions to me (during webinar or via email) – I will share the questions (anonymously) with our Mental Health experts
- Hope to have a productive Q&A on May 13th

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. The only substantive change is the addition of the RSN modalities

Drafts are available for review/comments – just ask Mike

Mental Health

- HCA is moving forward with a fee schedule and coding for the RSN modalities that have not been paying
- The RSN modalities will be defined and coded in the Tribal Health Billing Guide
- Bill claims ‘now’ even though system is not ready – this will establish timeliness.

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

Mental Health

- Service Modalities pending P1 updates, RSN codes most likely to be adopted
- Medication Monitoring (Medication training and support)

  RSN code H0033, H0034

  NOTE: this is not *Medication Management*
- 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

NOTE: These Modalities will be retroactively payable once P1 update is made.

Managed Care Denials

- Claims denied by the Managed Care Plans can still be sent to the HCA Managed Care help-desk at hcamcprograms@hca.wa.gov or their FAX # (360) xxx-xxxx

  claims can also be sent to mike for review of client coding.

  Update – when forwarding EOBs – please batch the EOBs per MCO – this helps avoid HIPAA privacy issues so that (eg) Molina does not get a CHPW claim

- MCO will only pay noncontracted providers if the client is AI/AN in ProviderOne – you do not have a way to tell if a client is coded as AI/AN in P1
- Claims denied by HCA/P1 can be sent to mike, as always – a claim number (TCN) is all I need

Managed Care Organization Contacts

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[To be determined]

Immunization Billing

- The Department of Health (DOH) supplies free vaccines for children age 0-18, these immunizations require modifier SL and pay an administration fee ($5.96)
- Immunizations for clients age 19 or greater are paid at the fee schedule rate and up to 2 administration fees (admin fees use CPT 90471/90472)

Immunization Billing - Age 0-18

- Refer to EPSDT billing guide, p.24 and the Injectable drugs fee schedule
- Immunizations that are free from DOH will be noted as "Free from DOH" in the EPSDT billing guide/injectable fee schedule
- If the immunization is free from DOH - bill for the administration by reporting the procedure code for the vaccine and add modifier SL (after adding our UA or SE modifier) (e.g., 90686 UA SL). DO NOT bill CPT 90471/90472

- Immunizations do not qualify for the encounter rate
- Immunizations generally happen during office visits (E&Ms or well child visits)
- HCA has policy that office visits do not pay on the same day as an immunization (NCCI type rule) unless modifier 25 is on the E&M code. Modifier 25 on the E&M code indicates that the client was not seen for just the immunization

Immunization Billing – Age 19 and Older

- Refer to Physician billing guide p.149 and the Injectable drugs fee schedule
- Bill for the cost of the vaccine by reporting the procedure code for the vaccine given
- Bill for the administration using CPT 90471 (first vaccine) and 90472 (each additional vaccine)

- Immunizations do not qualify for the encounter rate.
- Immunizations generally happen during office visits (E&Ms)
- HCA has policy that office visits do not pay on the same day as an immunization (CCI type rule) unless modifier 25 is on the E&M code. Modifier 25 on the E&M code indicates that the client was not seen for just the immunization

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

Where will we find information regarding billing for the managed care patients?

New Billing Guide anticipated to be published and on-line on April 1st.

The MCO is primary payor for medical services.

AI/AN clients are eligible for the IHS encounter rate secondary to MCO payment (the wraparound)

We billed crisis codes 90839/90840 but the RSN code is H2011, how will we be paid for 90839/90840 already billed? Also should we change to H2011 and rebill?

Start billing with the *new* RSN modalities as soon as possible, let's make sure that your claims are paying.

If you have already billed for crisis services (or any other modality) you get a choice:

a. do a replacement claim with the new codes

b. touch base with Mike. We can change the codes for you. I will want to make sure that I have captured all the claims.

The new RSN modalities are payable at the encounter rate retroactive to 10/01/2012, when the billing model changed.

Questions Log

Psychiatrists, Medical or Mental Health?

I think it should be billed under Mental health

I agree. Moving it to mental health seems to make more sense

We bill psychiatry under taxonomy 2084P0800X Specialized medical encounter as instructed in 04/06/2010

So, are you saying we should, or should not bill psych under medical?

i think its mental health

Psychiatrists are physicians and should be billed under medical

The IHS encounter type for a billed service is based on the provider guide in which the service is described. Psychiatrists, however, are licensed to provide some services that are described in two provider guides (i.e.., the Mental Health Provider Guide and the Physician-Related Services/Health Care Professional Services Provider Guide), that translate to two permitted encounter types. In these situations, the Tribe may choose **one** of the two permitted encounter types based on the Billing Taxonomy the Tribe uses for the claim.

Questions Log

What if we are not contracted with MCO? Just bill P1 as primary?

If client is AI/AN then MCO is primary payer (WAC 284 43 200 (7)).

If MCO denies - forward claim to mike to review client coding and update as appropriate (MCOs request a 4 week delay for systems to sync up then rebill claim)

If client is not AI/AN – MCO is the primary payer, no P1 wraparound option

How long does it take to enroll a provider? we've had some that take over 6 weeks

Goal for electronic applications is 30 days. Paper applications sometimes take up to 90 days. Sometimes there are delays. Please feel free to contact mike if you have any questions or would like to check status of an application or request expedite (I prefer to follow established processes and wait until the 30 or 90 days has elapsed -- remember to ask to have a provider back-dated if they have started working before they are approved in P1)

PQRS was mentioned, during webinar it got confused with Sequestration. This is a CMS program

PQRS is a reporting program that uses a combination of incentive and negative payment adjustments to promote reporting of quality information by eligible professionals

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/

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.

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

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

Interim update:

PharmD's are currently not encounter eligible but they are eligible to perform the following services:

Tobacco cessation for pregnant clients (physician billing guide)

Clozaril case management (physician billing guide)

Emergency contraception counseling (Pharmacy guide)

Vaccine administration fee (Pharmacy guide)

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 might be starting with the FQHCs

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

5 contacts listed in this presentation. Will update when the 6th (C.U.P.) is announced

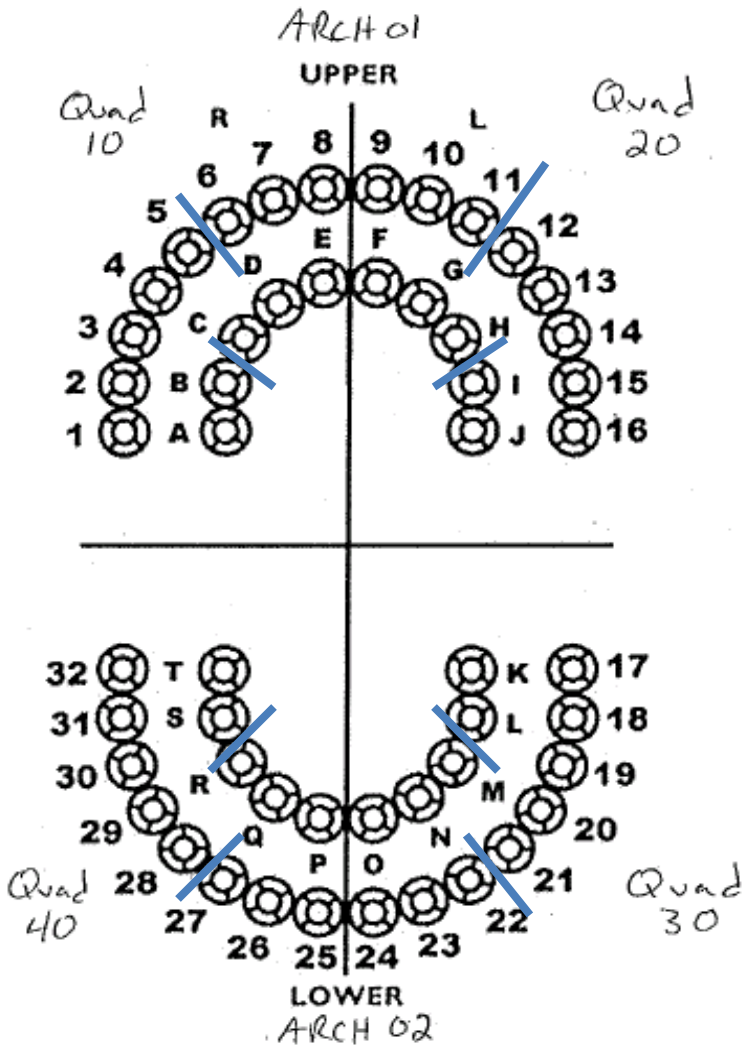
Chemical Dependency Billing

Client Type	AI/AN Client	Non-Native Client		
Apple Health (Medicaid) Program	All Programs	All Programs Except RAC 1201 or RAC 1217	Apple Health for Adults (RAC 1201)	Apple Health Presumptive SSI (RAC 1217)
Chemical Dependency Billing Code Modifier	Refer to the Chemical Dependency Billing Guide (DBHR Chemical Dependency Outpatient General Fund is usually modifier "HF")			
T1015 Line Modifier	HF	HX	SE	HB
Claim Note	SCI=NA	SCI=NN	SCI=NN	SCI=NN
IGT Required?	No	Yes	No – changes in 2016 to Yes	Yes

Back-Dating Newly Enrolled Rendering Providers

- The Effective/start date of a rendering provider is the date that the rendering provider is approved by HCA (WAC 182-502-0005 (6))
- Provider Enrollment allows back-dating of newly enrolled providers (form # 12-333)
- Claims for Providers who were back-dated are erroring out internally in P1 (EOB N290)
- P1 correction might be ready by June, 2015
- In the interim, the servicing providers are manually being corrected and claims fixed
- Get an EOB 290? Send to mike

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

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

Thank you

Send TBWG comments and questions to:

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