Washington State Health Care Authority

Tribal Billing Workgroup (TBWG)

June 10, 2015
Mike Longnecker
HCA Tribal Affairs Office

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Agenda

- Monthly data and analysis
- 2015 IHS rate and annual mass adjustment
- Non-Native CD State Match (Intergovernmental Transfer/IGT)
- Electronic Health Records (EHR) program update
- FAQ and Open Discussion

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April 2015 Claims Data (I/T/U)

	Dollars	clients*	% of claims paid	% prev month
Totals	$6,090,334	11,939	See categories	
Medical	$1,697,686	4743	74%	81%
Dental	$808,603	2231	89%	85%
MH	$954,633	1186	92%	94%
CD	$2,138,754	950	91%	92%
POS	$486,085	5777	58%	59%
Other FFS	$4,571	187	2%	34%

* 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

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Medical Claims – Top Denials

EOB	Description	Comments	Denial % *
24	Charges are covered under a capitation agreement managed care plan	Client is Enrolled in one of the Managed Care Plans	16%
167	This (these) diagnosis(es) is (are) not covered	Medicaid does not consider some diagnosis codes eligible for **medical** treatment. NOTE: 1. Office visit for prescribing Campral, ReVia, Vivitrol, Buprenorphine, Suboxone is covered – refer to physician guide, P. 257 for criteria. 1. Office visit for Suboxone and Buprenorphine are carved out of Managed Care (bill P1 directly for clients enrolled in Managed Care). Claim note of "bupren" or "suboxone" helps avoid denial errors	12%

* Denial percentages example: Out of the Medical claims that did not pay at the encounter rate, 16% were due to Managed Care.

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Medical Claims – Top Denials

EOB	Description	Comments	Denial %
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)	10%
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage	9%

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Medical Claims – Top Denials

EOB	Description	Comments	Denial %
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	AI/AN or non-native modifier was missing	6%
16 N329	Missing /incomplete /invalid patient birth date	Usually incorrect birthday on claim. Some claims had incorrect birthday and gender, which usually indicates the wrong client ID. If you think you have the right birthday on the claim or are unsure, contact Mike	5%

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Medical Claims – Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing	5%
22	This care may be covered by another payer per coordination of benefits.	Client has Medicare	4%

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Medical Claims – Top Denials

EOB	Description	Comments	Denial %
96 N129	Not eligible due to the patient's age.	CPT 99391-99396 on a claim causes the claim to be a well-child visit, which is only for clients age 20 and younger. Eg, preventive codes (99385 99386 99395 99396) are not covered for adults and not only will the code error out but the entire claim errors out because the claim becomes a well-child visit	4%
11	The diagnosis is inconsistent with the procedure.	This is a ProviderOne issue. T1015 with modifier SE is currently erroring out. Permanent fix should be in P1 on July 5th. Interim workaround – mike is gathering TCNs each Friday and sending for reprocessing	3%

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Dental Claims – Top Denials

EOB	Description	Comments	Denial %
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 in March 2015 TBWG slides	26%
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)	12%

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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	12%
16 N329	Missing/incomplete / invalid patient birth date	Usually incorrect birthday on claim. Some claims had incorrect birthday **and** gender, which usually indicates the wrong client ID. If you think you have the right birthday on the claim or are unsure, contact Mike	6%

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Dental Claims – Top Denials

EOB	Description	Comments	Denial %
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)	5%
18	Exact duplicate claim/service	Duplicate billing	5%

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Dental Claims – Top Denials

EOB	Description	Comments	Denial %
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. RPMS users please contact the Portland Area Office for getting fix in to your system for quadrants/arches.	5%
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	5%

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Dental Claims – Top Denials

EOB	Description	Comments	Denial %
A1 N81	Procedure billed is not compatible with tooth surface code	Sealants (D1351) are payable on Occlusal (O) surface on teeth 2,3,14,15,18,19,30,31,A,B,I,J,K,L,S,T for clients age 0-18 DD clients (all ages) allow sealants on Occlusal (O) surface on teeth 2, 3, 4, 5, 12, 13, 14, 15, 18, 19, 20, 21, 28, 29, 30, 31, A, B, I, J, K, L, S, T	4%
96 N428	Not covered when performed in this place of service.	Limited Visual Oral Assessments (D0190/D0191) are only covered when provided in settings other than dental offices or clinics (eg, Alternative living facility, school, home (eg, 03 12 13 14 15 31 32 33 53 54 71)	3%

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Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing	28%
16 N288	Missing / incomplete / invalid rendering provider taxonomy	Claims had a valid servicing taxonomy but the taxonomy on the claim wasn't one that the MHP was enrolled with. Two resolutions: 1. Change the claims so that they are submitted with the taxonomy that the MHP is enrolled with. 2. Update the provider's file to include the taxonomy that is being billed (if appropriate, wouldn't give a *brain surgeon* taxonomy to an MHP). If you choose option 2 contact Mike so he can reprocess claims so you do not have to rebill Not sure what the provider is enrolled with? a. Contact Mike or b. you can look in P1 to see what the provider is enrolled with and make changes. Go to page 147 of this Dental workshop/webinar	17%

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Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
11	The diagnosis is inconsistent with the procedure.	This is a ProviderOne issue. T1015 with modifier SE is currently erroring out. Permanent fix should be in P1 on July 5th. Interim workaround – mike is gathering TCNs each Friday and sending for reprocessing	13%
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage	11%

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Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
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	7%
A1 N192	Patient is a Medicaid/Qualified Medicare Beneficiary	QMB-only clients are only eligible for fee for service secondary to Medicare	7%

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Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
N20	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	4%
16 MA39	Missing/incomplete / invalid gender	Usually incorrect gender submitted on claim but we have seen some female *Mike* and Male *Sally* clients in P1. Contact Mike if you have what appears to be a gender mismatch in P1	2%

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Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
146	Diagnosis was invalid for the date(s) of service reported	Diagnosis codes were missing the extra digit. Eg, 312.2 was on the claim but 312.2 needs a 5th digit (312.20, 312.21, 312.22 or 312.23)	2%
22	This care may be covered by another payer per coordination of benefits.	Client has Medicare	2%

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Chemical Dependency Claims – Top Denials

EOB	Description	Comments	Denial %
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 *almost 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 3. Claim note still required a. AI/AN client SCI=NA b. non-native client SCI=NN	26%
18	Exact duplicate claim/service	Duplicate billing	19%
181	Procedure code was invalid on the date of service	Claim was either a lab code, mental health code or was a valid CD code but didn't have the HF modifier. The only payable CD codes are listed in the CD billing guide, CD also always requires a modifier (almost always HF on the CD code)	16%

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Chemical Dependency Claims – Top Denials

EOB	Description	Comments	Denial %
16 N255	Missing/ incomplete/ invalid billing provider taxonomy	Most claims had billing taxonomy 261Q00000x	10%
107	The related or qualifying claim/service was not identified on this claim	Claim had just a T1015 for the date of service	5%

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Chemical Dependency Claims – Top Denials

EOB	Description	Comments	Denial %
96 N59	Non-covered charge(s).	Lab codes are not covered on CD (UA is bundled)	5%
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	3%

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2015 IHS encounter rate

- 2015 outpatient per visit/IHS rate ($350) is in ProviderOne with the exception of non-AI/AN Chemical Dependency claims for ABP SSI (RAC 1217) clients
- Claims previously paid at the 2014 rate ($342) were sent to P1 System techs in May, 2015 for reprocessing. Current ETA on the mass adjustment is approximately August 30th

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Non-Native Chem Dep

- CD claims for AI/AN clients are working great
- CD claims for non-Native clients are supposed to pay only the federal share of the encounter

Client RAC	Claim note	Modifier for T1015 line	Date of claim submission (not date of service)	Amount of IHS encounter rate claim pays	Amount of IHS encounter rate for IGT
MAGI (not 1217 or 1201)	SCI=NN	HX	Prior to 10/01/2015	50.03%	49.97%
			On/after 10/01/2015	50%	50%
Alternative Benefit Plan (1201)	SCI=NN	SE	Prior to 01/01/2017	100%	0%
Alternative Benefit Plan, SSI (1217)	SCI=NN	HB	Prior to 10/01/2015	80.01%	19.99%
			On/after 10/01/2015	80%	20%

- Claims for presumptive SSI clients are not paying correctly. Current ETA is August 30, 2015

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Non-Native Chem Dep

- The State requires the local matching funds equal to the State's portion of Medicaid expenses for CD treatment under 42 C.F.R. 433.51
- Send the state/local match to DSHS by the 15th of each month for the previous month's claims
- Claims currently pay at the Federal share, in the future claims may pay at the IHS rate (state/local match will be required **prior** to payment)

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Electronic Health Records

Christine Chumley, Health Record Technology (HIT) Program Manager

CMS UPDATE:

Three proposed rules:

- Program changes for 2015-2017 (includes 90 day reporting period for 2015) – Comment period closes June 15th
- 2015 Certification criteria updates for CEHRT (Certified Electronic Health Record Technology) – comment period closed
- Stage 3 to be optional in 2017 and mandatory by 2018 – comment period closed

Washington is currently accepting attestations for program year 2015 under the existing rules. This applies if you are attesting for AIU (Adopt/Implement/Upgrade) or Stage 1 Year One.

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Electronic Health Records

Need EHR help?

Please contact our team at: *HealthIT@hca.wa.gov*

- Security or log in issues with ProviderOne? Please contact: ProviderOneSecurity@hca.wa.gov for assistance with your P1 password or when you have a change in staff resulting in a new System Administrator for your office.
- Please remember that if you do not have your own security credentials granting you access to the EHR domain in ProviderOne, our staff is not able to discuss any information with you.
- CMS EHR Help Desk: 1-888-734-6433 Option #1
- CMS Account Security and to update your accounts contact person: 1-866-484-8049 Option #3
- Website for Health IT: HealthIT.wa.gov

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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 or “interim” will stay on the log until answered

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Questions Log

If the T1015 is billed at $0 and it gets denied (eg, a duplicate or state-only client) – HIPAA rules do not allow EOB codes on $0 lines.

Thoughts from everybody?

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Questions Log

I need a better guided direction how to bill mental health secondary claims that were previously billed to primary, such as molina. It seems its different than other medicaid secondary claims

HCA does pay the encounter rate secondary to private insurance, Medicare and Medicaid Managed Care Organizations (MCO wraparound is only available for AI/AN clients)

MCO and private insurance secondary claims are similar. The name of the prior payer changes and the MCOs do not have carrier codes. MCO secondary claims need a claim note to help prevent errors (AI/AN MC WRAPAROUND)

Refer to the Tribal Health Program Billing Guide, page 41 for basic instructions/referral for billing secondary claims

Refer to the Tribal Affairs Website , Toggle on Resources then scroll down to Quick Reference Sheets for Providers and Billing Offices for cheat sheet for MCO secondary billing.

Let Mike know if you want other or different cheat sheets

Questions Log

How can i find out if my MH Provider has been approved in P1?

Take a peek at the slides from a Medicaid workshop

- p. 214 – view the providers in your group
- p. 224-226 – add a new servicing provider (provider is already in P1)
- p. 227-231 – add a new servicing provider (provider is not already in P1)
- p. 216 – remove/end association of a servicing provider
- p. 217 – view the taxonomy codes a provider is enrolled with

Or… ask Mike

Descendants do not have the native qualifiers. When tribal assistors are not being allowed to attest is what I am being told (The member is not enrolled in a tribe)

Question sent to Healthplanfinder, this is in regards to AI/AN clients being able to select no managed care. Stay tuned

Questions Log

Would there be a way for Provider 1 to know the taxonomy without needing to populate it on a claim? Other payors can not send the Taxonomy (MCR) and therefore this is why it is your largest denial. If it was not required on the clm, but rather part of the provider build info in P1 then the denials would not occur

ProviderOne was designed to use Billing (required) and servicing (situational) taxonomy submitted on the claim. servicing taxonomy is situational, however on Professional claims that require a servicing NPI then servicing taxonomy is required.

Some CPT/HCPCS codes are shared among different programs and the billing taxonomy is what is used to tell the difference between the programs

Since Billing taxonomy is required the Tribal Affairs office opted to use Billing taxonomy to define the category of the service

Provider1 often does not match NPPES (National Plan & Provider Enumeration System)

The NPPES website is designed to issue, maintain, and validate NPIs, it is not used or designed to validate other information (such as taxonomies or demographic) that providers may have supplied the NPPES when acquiring their NPI

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Questions Log

Re: non-Native Chem dep that has State/Federal Matching funds

Should we bill the SSI when there is a match required?

Normally we send the match ahead of time and once received by you then we are allowed to submit the claims. Also, we won't know what amount to billed because of the match

Can we start using the non-native rate now also. Is this still 50%

See page 23 of current slides.

The claims are billed first and then the State Match submitted. If the IGT enforcement is activated then it will be required to have a claim in the system in order for DSHS to send an invoice

WHEN CAN WE START USING THE NEW RATE

Feel free to start using the new rate at any time.

The rates for AI/AN clients and non-Native ABP CD claims are ready

The rates for non-Native Presumptive SSI and classic Medicaid are pending Finance approval

Claims that paid at the old (2014) rate will be reprocessed. ETA for reprocessing is mid-June

Re: ICD10 is launching this fall, is there going to be training available?

I heard the Portland coding training is full and not accepting anymore

I said that I would see what was offered in Portland (flyer is part of attachment with May TBWG)

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Questions Log

Re: let Mike know if you want to ask the rest of the group for help

Is there any FQHC Tribal clinic contact that I may be able to access? (Kristen Garcia at Jamestown, krgarcia@hopepma.com)

I would like to work with other FQHC/Tribal organizations. Cynthia Trueblood with Seattle Indian Health Board 206-324-9360, ext. 1117. cynthiat@sihb.org

Phone numbers/emails shared after the April Billing Workgroup

Medicare issues (will be moved to the Medicare slide for future TBWG)

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

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Questions Log

During April TBWG Ed Fox shared the IHS encounter rate back to 2005 with a percentage increase/decrease. Here is a 25 year history

CY	IHS rate	Change from Previous year	
1990	$76	$4	5.5%
1991	$78	$2	2.6%
1992	$85	$7	9%
1993	$88	$3	3.5%
1994	$88	$0	0%
1995	$95	$7	8%
1996	$147	$52	54.7%
1997	$152	$5	3.4%
1998	$168	$16	10.5%
1999	$172	$4	2.4%
2000	$172	$0	0%
2001	$185	$13	7.6%
2002	$197	$12	6.5%

CY	IHS rate	Change from Previous year	
2003	$206	$9	4.6%
2004	$216	$10	4.9%
2005	$223	$7	3.2%
2006	$242	$19	8.5%
2007	$256	$14	5.8%
2008	$253	$-3	-1.2%
2009	$268	$15	5.9%
2010	$289	$21	7.8%
2011	$294	$5	1.7%
2012	$316	$22	7.5%
2013	$330	$14	4.4%
2014	$342	$12	3.6%
2015	$350	$8	2.3%

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Questions Log

CD diagnosis requirements

303.9x alcohol dependence, 304.9x drug dependence, 305.0x alcohol abuse, 305.9x drug abuse

5th digits: 0 unspecified, 1 continuous, 2 episodic, 3 in remission

DSM V example

305.00 mild presence of 2-3 symptoms, 303.90 moderate presence of 4-5 symptoms, 303.90 severe presence of 6 or more symptoms

The DSM V does not refer to the fifth digits for coding purposes. Only the ICD-9 or ICD-10 books refer to the use of the fifth digit codes.

The DSM V states

In early remission: After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, "Craving , or a strong desire or urge to use alcohol," may be met.

In sustained remission: After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, "Craving , or a strong desire or urge to use alcohol," may be met.

The ICD book does not have descriptions for: 1 continuous, 2 episodic, 3 in remission

Are there standards the auditors want to use? I would assume In Remission is for a period of 12 months or longer. I have been told this by a commercial ins. company that performed an audit of one patient's chart notes.

Any clarification or input would be appreciated. We really like only using the unspecified codes but want to be compliant for coding and billing

Continued on next page

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Questions Log

CD diagnosis requirements, continued

Draft answer - The short answer is, the state is not using DSM-V codes until October of this year. So the codes would not be accessible to bill until then. … … stay tuned

It has been brought to my attention that our chemical dependant department would like to bill a lab service for a requesting physician. For example, our Suboxone doctors will request a CBC for a patient as part of monitoring. The doctor will order and receive results, but lab performed at medical clinic. Can the requesting physician even bill?

The ordering provider doesn't have a billable service, just the lab (for this example)

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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.

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

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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

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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, this would require an update to the State Plan. To add pharmacists to the list of encounter-eligible providers, the section of the Medicaid State Plan that provides for the IHS encounter rate would need to be amended and then reviewed by CMS for approval. In the past, Tribes have not been willing to re-open this section of the State Plan for review by CMS for several important and complex reasons.

As a result, HCA would prefer to receive a request from a majority of the Tribes before re-opening this sections of the State Plan for any reason, such as to include pharmacists in the list of IHS encounter-eligible providers.

What services can a pharmacist render on a professional/HCFA claim?

PharmD's are eligible to perform the following services (FFS):

- *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

Thank you

Send TBWG comments and questions to:

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