Washington State Health Care Authority

HCA Tribal Affairs Billing Work Group

April 8, 2014

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Agenda

- **Tribal Affairs Updates**
  - Tribal Assister Workshop yesterday
  - ICD-10 delayed until 2015
  - Monthly data
- **New Business**
  - Mental Health code-set, almost ready
- **Old Business**
  - Mental Health claims denied to bill Medicare are finalized
- **Weekly FAQ and Open Discussion**
- **Old Business Pending, but not Forgotten**
  - Pharmacists – what services can they render on professional claims?
  - MPG update
  - NonNative CD match
  - Managed Care Wraparound – what if the plan denies the claim
  - Residents on limited license – do we expect them to be the rendering NPI or their supervisor to be the rendering NPI (with GC modifier)

Tribal GET COVERED Workshop

- Tribal Assister Workshop at HCA on Monday
- Almost 70 Assis
- HBE and HCA le

ICD-10 Update

- ICD-10 implementation postponed until 10/01/2015

February 2014 Claims Data (I/T/U)

	Billed	Paid	Denied	% pay
All Medicaid Prof/dental	973,065	694,705	278,360	71%
All Tribal ITU Prof/Dental	19,156	15,583	3,573	81%
Tribal Med	9,718	7,667	2,051	79%
Tribal Mental	2,500	2,219	281	89%
Tribal CD	2,020	1,925	95	95%
Tribal dental	2,565	1,976	589	77%
Tribal Other prof/dental	2,353 (1900 are FQHC)	1,796	557	76%
Tribal non-prof/dental	16,927 (16,500 are POS)	9,599	7,328 (6,850 are POS)	57%

This is all claims processed in February 2014, regardless of date of service.
The format will evolve

Mental Health

- Service Modalities pending code decision
- Medication Monitoring (Medication training and support)
  - MD, P-ARNP, PMHNP-BD visit for drug monitoring is currently M0064 or bundled into E&M
- Crisis Services
- Day Support
- Peer Support
- Stabilization services
- Therapeutic Psycho-Education

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 Claims Denied to Bill Medicare

- Claims have been reprocessed to pay
- Have any outstanding Mental Health claims that denied to bill Medicare? (EOB 22) – contact Mike

- THANK YOU for your help and patience

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 Karol

Open Discussion Q&A

Private Insurance

Do we need to refund HCA when we become aware that a client has primary insurance?

It is not necessary to refund HCA or void a paid claim when you first find out about other primary insurance. The provider should bill the insurance once you have been made aware that there is a primary insurance, and if the insurance company pays on the claim, either refund HCA by check or by adjusting/voiding the HCA claim on file (indicating the insurance payment amount). Providers have voided claims only to bill the insurance and not receive any payment (non-covered or applied to deductible). They then have to rebill us to receive the Medicaid payment back. It is best to hold off on adjusting/voiding until you have received the payment from the primary. COB does invoice paid claims out to the insurance company for recovery once we find out about a primary insurance. If the insurance company pays us, we apply that money to the claim. Once this is done, the claim cannot be voided/adjusted by the provider. It is best to call COB if there are other questions about this process.

Mike comment – sending in a check breaks the integrity of the claim trail, always best to reprocess claims.

Open Discussion Q&A

Private Insurance

If a client has an insurance payment do we enter the insurance payment at document level or line-by-line?

Entering a payment at line or header in P-one is working ok, but it is important not to do both on the same claim. One way or the other will be fine. I will say we still see the majority of claims coming in with the insurance payment at the header level.

Mike comment – document level is best because of the encounter payment model.

Open Discussion Q&A

Private Insurance

Why do COB claims take so long to process?

We strive to have the majority of our claims finalized before they become aged (30days 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.

What is the correct way to submit the non-Native match for non-Native claims with primary insurance.

Stay tuned

Open Discussion Q&A

SBIRT

For medical and 99408 (99409) can an encounter rate be used?

YES, checkthe SBIRT billing guidelines (Feb 11 TBWG)

or the Physician Billing Guide

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

Open Discussion Q&A

Managed Care Wraparound

Many Tribal clients are in managed care without their knowledge and claims are mostly unbillable, can I bill with this system?

Yes, AI/AN clients who are in Managed Care are eligible for the encounter with a wraparound. More interested in whether or not the client wanted to be in managed care. Most likely cause is that client is not coded in P1 as AI/AN and the first step is to get the client coded correctly then opt out. Some AI/AN clients choose to stay in managed care & their claims are eligible for the wraparound.

Open Discussion Q&A

Managed Care Wraparound

I would like to find out how to bill appropriately for managed care patients

We are here to help, did we help?

If we provide wraparound services in the community setting can we bill the encounter rate?

I might need to ask for clarification – AI/AN clients in Managed Care are eligible for the wraparound.

Open Discussion Q&A

Managed Care Wraparound

Will we have to hand bill the wraparound as we did in the past?

[Tribe] is billing the plan BUT NOT the wrap around have billed for BH, but that is the hand bill part.

That was the old Basic Health Wraparound, ended in 2013.

Open Discussion Q&A

Managed Care Wraparound

One managed care plan told me they want a minimum of 1,000 Medicaid patients before they'd consider us

Which plan was that? Alison was following up

What if managed care denies the claim?

Stay tuned, in the interim can you email/fax mike denials?

Open Discussion Q&A

Managed Care Wraparound

Mike/Karol asked if anybody is currently billing Managed care:

- *We don't – they usually get rejected by Molina*
- *We are not billing the managed care plans and yes I would like more information*
- *We have never billed managed care. not sure we know we can bill managed care*
- *I'm very interested if Managed Care plans allow us to refer patients as if we were the primary care provider?*
- *Ideally, there would be a discussion, perhaps HCA facilitated with one Managed Care plan at a time to ask if PCP status is possible*

Open Discussion Q&A

Managed Care Assignment

IF the AI/AN was indicated on the application but the beneficiary was still assigned to an MCO can the correction be made immediately or does the correction have to wait until the first of the next month?

Will be first of the next month. Hopefully we see fewer new AI/AN clients being assigned to MCO due to sharing information on how to ensure that client demographics are correctly captured by ProviderOne

Open Discussion Q&A

Managed Care Assignment

If we assist a client with disenrolling from managed care does the effective date into regular Medicaid have to go to the first of the next month?

Yes, disenrollment begins on the following month.

What phone number should they call to disenroll?

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

Open Discussion Q&A

Managed Care Assignment

Can we have non native clients assigned to our tribal clinic?

No, the PCCM program is for AI/AN clients only

Open Discussion Q&A

Billing at $0 or $0.01

Regarding the using zero amount or $0.01 instead of the individual charges plus the T1015 code... I recall with the newer billing requirements with outpatient, we were told to keep the full billable charge that the facility charges on its standard fee schedule for compliance so each patient would essentially have the same fee charged. Sure the amount billed appears inflated but the other option is for us to do the math on each claim and only put the T-code amount so it did not exceed the encounter rate.

Billing at $0 or $0.01 will artificially decrease expenses on the billing codes, this would have a negative impact on budget forecasting

Open Discussion Q&A

New Clients

Newly eligible are codes N05, so are presumptive SSI, which are 25%. We may not know who is who

NonNative CD and matching is being reviewed by DSHS staff, staying on Agenda until resolved

Will ABP pay Mental Health Services? I billed for ABP for MH and was denied

***YES**, they are eligible for MH. Denial issue to be corrected soon (mental health code set)*

Open Discussion Q&A

Children's Mental Health

Any updates on Tribal sites doing an attestation regarding the experience for Mental Health Counselors?

Stay tuned, in the meantime if you get a B7 denial contact Mike first.

Open Discussion Q&A

Provider File Maintenance

How do you request a retro date, we were told this is not allowed

- *WAC 182-502-0005 indicates enrollment date is the date the agency approves the application*
- *A written request to the chief medical officer may be submitted to request a back-date, refer to subsection 6 of WAC*

Open Discussion Q&A

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?

Stay tuned

Open Discussion Q&A

Medicare Crossovers

Is it still applicable that Medicare crossovers must be received within 6 months of the Medicare paid date? I tried billing some older claims with a date of service still within 1 yr but they denied. Need to look at 6 month time frame from Medicare paid date, correct?

Timeliness rules (for Medicare crossovers)

1a. Claim must be received within 6 months of Medicare EOMB date

1b. Original TCN proves timely, remember to either reprocess the claim or reference the original TCN in the claim notes if you are outside of the 6 month window

2. Claims with a date of service greater than 2 years old must be received within 6 months of the Medicare EOMB date

Open Discussion Q&A

Briefly mentioned closing overpayment loophole

(e.g., encounter can pay and then later a fee for service can pay, this may be an unbundling issue)

Some times there are separately identifiable services from the encounter that should pay and not part of the services that day; patient may be seen for URI and after visit goes to lab for a standing order for

*Point noted, update won't be taken lightly and **if** update proceeds will share so there are no surprises*

Open Discussion Q&A

IUD payable separately outside of Encounter?

Not sure if this was already asked but can we bill for the implants separately also?

Yes, IUDs and Implants are payable outside of encounter (needs to be on different claim, otherwise System will try to bundle it into the encounter payment)

What about other supplies/services that may have a cost that is greater than the Encounter rate?

Good question, working on answer that may cover this question most of the time without visiting issue code-by-code

Open Discussion Q&A

Suboxone

Can the Suboxone prior-authorization process be made easier? It seems to take months for it to process through the approval process.

I assume that this is for form 13-720. stay tuned

Please feel free to contact Mike at any time with claims/billing issues. We are here to help

Thank you

Send TBWG comments and questions to:

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