Washington State Health Care Authority

Tribal Billing Workgroup (TBWG)

October 14, 2015

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HCA Tribal Affairs Office

Agenda

- Electronic Health Records, Health IT – Guest Speakers
- Monthly Data and Analysis
- Non-AI/AN SUDs resolution
- Re-Clarification of Providers who are eligible for the encounter rate
- ICD-10 started October 1st
- Medication Assisted Treatment (Suboxone) update for 10/01/2015
- FAQ and Open Discussion

Electronic Health Records/Health IT

Getting Started

Attesting for the EHR Incentive Program is a 2-step process

Electronic Health Records/Health IT

Step 1: Registering with CMS

The first step is registering your provider with CMS for the EHR Incentive Program. There, you will report the provider's NPI #, the Payee NPI # (the NPI # to receive the payment and tax ID), contact information and the ONC Certification Number for your EHR product. You will submit the information and CMS will forward it to our system, usually in 24 hours.

Please note that there must be documentation in your file that the provider is re-assigning his/her payment to the clinic. The other choice is that the provider can have payment issued to their own NPI.

NOTE: Whichever NPI is paid, is the one that receives the IRS tax liability.

Electronic Health Records/Health IT

Contact Information

•The contact information you enter in CMS is very important. It needs to be kept current or you might miss important emails about your attestation. For security reasons, we are only permitted to contact the email entered into the registration.

- CMS requires that we communicate with the "contact" that is on record in the attestation.
  - Suggestion for email address: If you are concerned about staff turn-over or you want to share the EHR duties, it is encouraged to use a "generic email" as opposed to an email with a name in it. If it has a name attached to it we can only communicate with that person. An example might be: _____TribeEHR@yahoo.com. Most large facilities use this method.
- Automated emails will be sent "only" to the contact's email address. If it is not updated, you will miss important communication about your attestation(s).
- To change your contact information, it must be done in the CMS Registration (not in eMIPP).

Electronic Health Records/Health IT

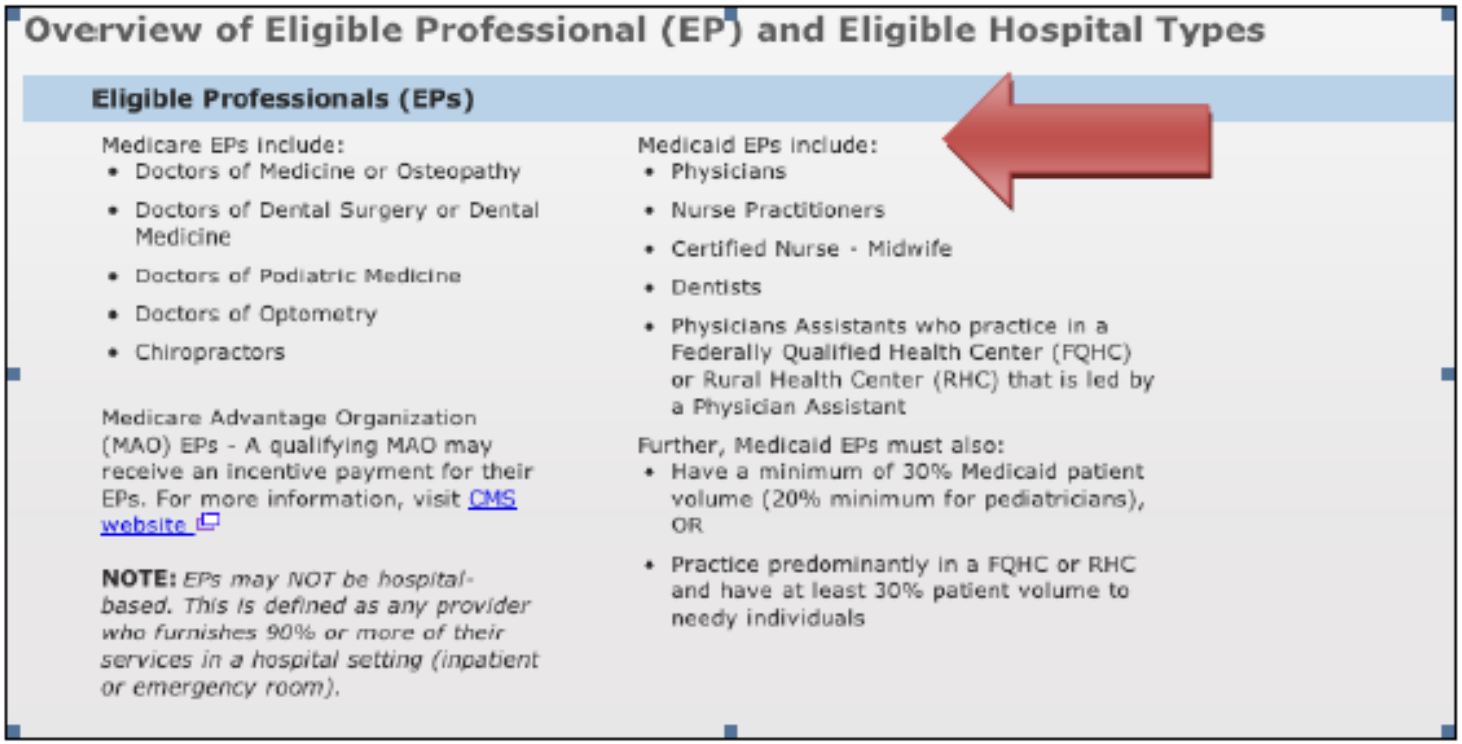
See the CMS User Guide for Instructions:

- www.cms.wa.gov
- Tab Regulations & Guidance
- Under LEGISLATION: EHR Incentive Program
- Educational Resources
- Under REGISTRATION Information:
- Medicaid Registration User Guide for Eligible Professionals

Electronic Health Records/Health IT

Step 2: Attesting with the State

Provider types eligible for the Medicaid EHR Incentive Program are listed below. Note, the Medicare and Medicaid programs are a little different:



Overview of Eligible Professional (EP) and Eligible Hospital Types

Eligible Professionals (EPs)

Medicare EPs include:

- Doctors of Medicine or Osteopathy
- Doctors of Dental Surgery or Dental Medicine
- Doctors of Podiatric Medicine
- Doctors of Optometry
- Chiropractors

Medicare Advantage Organization (MAO) EPs - A qualifying MAO may receive an incentive payment for their EPs. For more information, visit CMS website

NOTE: *EPs may NOT be hospital-based. This is defined as any provider who furnishes 90% or more of their services in a hospital setting (inpatient or emergency room).*

Medicaid EPs include:

- Physicians
- Nurse Practitioners
- Certified Nurse - Midwife
- Dentists
- Physicians Assistants who practice in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) that is led by a Physician Assistant

Further, Medicaid EPs must also:

- Have a minimum of 30% Medicaid patient volume (20% minimum for pediatricians), OR
- Practice predominantly in a FQHC or RHC and have at least 30% patient volume to needy individuals

Electronic Health Records/Health IT

Update EPs in P1 (add and end)

It is important to keep up to date on your active and inactive providers.

If a provider has left your practice you should do 2 things:

- **Change the Servicing Provider status in ProviderOne:** Log into ProviderOne and "end-date" them as a Servicing Provider. This will not affect any unbilled claims.
- **Cancel Registrations:** If you registered your EP (Eligible Provider) for the EHR program, go into that registration and "cancel" it so they are removed from automated emails and it allows them to attest with a different group or on their own.

If a provider is new to your clinic, make sure they have been added as a "Servicing Provider" in ProviderOne under your Group NPI.

Keep in mind that the Payee NPI you plan to use, must have the servicing providers listed under "that" Payee NPI in order for it to pay correctly.

If you need assistance adding or end-dating providers in ProviderOne, contact our Provider Enrollment Unit at 800-562-3022 (ext 16137). Let them know it is for the EHR program. (or contact mike for a cheat sheet)

Electronic Health Records/Health IT

Attesting in eMIPP

- The second step is the actual attestation in eMIPP (which is a sub-system within ProviderOne).
- Once CMS transmits your registration information to us you should receive automated emails with your NLR number (Registration ID), a Domain number (this will “not” be your group Domain), logon and temporary password.
- Once you are able to log in, you may begin the attestation.

Electronic Health Records/Health IT

Resources

Website: www.hca.wa.gov/HealthIT

On the left side, hover over **LIBRARY AND TRAINING RECOURCES** and choose **ELECTRONIC HEALTH RECORDS LIBRARY**

Look under **ELIGIBLE PROVIDERS** (Including Specialists and Dentists)

Click on these links:

Click on "**EP AIU AND MU eMIPP USER GUIDE 2014**"-(step-by-step process)

and/or the **PATIENT VOLUME WORKSHEET** (tool for you to gather your numbers)

These will walk you through the basic process.

Please see our other training tools and resources on our website.

eMail: HealthIT@hca.wa.gov

Electronic Health Records/Health IT

Webinar Requests?

If your clinic has a topic of interest you would like covered in a brief webinar, please send us an email at HealthIT@hca.wa.gov

Please click on the link below for a brief survey for HCA EHR/Health IT Staff

https://www.surveymonkey.com/r/J2TXWX7

August 2015 Claims Data (I/T/U)

	Dollars	Dollars, Prior TBWG	Clients*	Clients, Prior TBWG*	% Paid	% Paid, Prior TBWG
Totals	$6,893,914	$6,558,826	11,876	11,397	NA	NA
Medical	$1,528,528	$1,577,196	4602	4455	83%	73%
Dental	$777,087	$712,645	2265	2114	86%	81%
MH	$796,776	$815,936	1069	1068	91%	86%
SUDS(CD)	$3,239,930	$2,960,207	1294	1117	93%	83%
POS	$470,440	$483,129	5490	5559	55%	60%
Other FFS	$81,150	$9,710	207	135	10%	14%

* 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 % *
24	Charges are covered under a capitation agreement managed care plan	Client is Enrolled in one of the Managed Care Plans	18%
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 servicing provider was enrolled with. Two resolutions: 1. Change the claims so that they are submitted with the taxonomy that the Dr. 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 FP physician). 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 217 of this Medicaid webinar	18%

* Denial percentages example: Out of the Medical claims that did not pay at the encounter rate, 18 % were due to managed care

Medical Claims – Top Denials

EOB	Description	Comments	Denial %
119	Benefit maximum for this time period or occurrence has been reached	Well child (EPSDT) visit limits • Age 0-0 -- 5 screenings in first year • Age 1-2 -- 3 screenings in second year • Age 3-6 – 1 screening per year • Age 7-20 – 1 screening per 24 months* * Foster care clients allow 1 screening per year	5%
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	4%

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 I noticed a cancer screen diagnosis on many of these claims and the clients were over age 20. Cancer screens are covered (and encounter eligible) under different CPT/HCPCS codes. Refer to physician billing guide, p. 116.	3%
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage	3%

Medical Claims – Top Denials

EOB	Description	Comments	Denial %
167	This (these) diagnosis(es) is (are) not covered	Medicaid does not consider some diagnosis codes eligible for **medical** treatment. NOTE: Office visits for prescribing Campral, ReVia, Vivitrol, Buprenorphine, Suboxone are covered – refer to physician guide for criteria. Claim note of "bupren" or "suboxone" helps avoid denial errors If you would like a copy of the diagnosis reference sheet (list out diagnosis codes that usually do not pay if billed as the primary diagnosis on a medical claim) – ask Mike. This diagnosis reference sheet will be replicated with ICD10 codes when they are available	2%
107	The related or qualifying claim/service was not identified on this claim.	Claim had just a T1015 line.	2%

Medical Claims – Top Denials

EOB	Description	Comments	Denial %
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	2%
22	This care may be covered by another payer per coordination of benefits.	Client has Medicare	1%

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	10%
204	This service/equipment/ drug is not covered under the patient's current benefit plan	Usually a family planning only client	10%

Dental Claims – Top Denials

EOB	Description	Comments	Denial %
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 dentist was enrolled with. Two resolutions: 1. Change the claims so that they are submitted with the taxonomy that the dentist is enrolled with. 2. Update the provider's file to include the taxonomy that is being billed (if appropriate, wouldn't give an oral surgeon taxonomy to a general dentist). 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 24 of this Dental workshop/webinar	8%
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))	7%

Dental Claims – Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing If this EOB appears at “document level” then the entire claim was a duplicate (eg, duplicate batch)	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%

Dental Claims – Top Denials

EOB	Description	Comments	Denial %
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	5%
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	4%

Dental Claims – Top Denials

EOB	Description	Comments	Denial %
16 N290	Missing/ incomplete/ invalid rendering provider primary identifier	Servicing provider is not in ProviderOne yet. Get the provider enrolled and then remember to request a back-date if they started working before they were approved in P1	4%
A1 N192	Patient is a Medicaid/ Qualified Medicare Beneficiary	QMB-only clients are only eligible for fee for service secondary to Medicare on a Medicare secondary (“crossover”) claim. Medicare does not cover dental, therefore dental not payable for QMB-only clients	3%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
16 N255	Missing/incomplete/ invalid billing provider taxonomy	Claims had taxonomy that the group isn't enrolled with (I/T providers are 2083P0901x, Urbans are 261QF0400x)	23%
170 N95	Payment is denied when performed/ billed by this type of provider.	Mental health codes are in the HCA mental health guide or in the Tribal Health guide (for the RSN modalities)	15%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
96 N59	Non-covered charge(s).	Mental health codes are in the HCA mental health guide or in the Tribal Health guide (for the RSN modalities)	15%
24	Charges are covered under a capitation agreement managed care plan	Client is Enrolled in one of the Managed Care Plans.	13%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
96 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 90837, 90853 was observed most often	4%
16 N255	Missing/incomplete/ invalid billing provider taxonomy	Claims billed with wrong taxonomy (I/T claims need billing taxonomy 2083P0901x)	3%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing. When this EOB happens at document level then it is due to a duplicate batch submission	2%
204	This service/ equipment/ drug is not covered under the patient's current benefit plan	Usually a family planning only client but sometimes is due to "invalid" servicing taxonomy. P1 is set up to pay the client's benefit packages based on the servicing taxonomy. If a claim has a taxonomy that is not set up in P1 then this error may occur	2%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing. When this EOB happens at line level then it is due to a duplicate claim line submission	2%
96 N30	Patient ineligible for this service.	Client is SLMB, QDWI or QI-1 (similar to QMBonly)	1%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate batch billing	30%
18	Exact duplicate claim/service	Duplicate encounter-line billing	27%

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	6%
96 N59	Non-covered charge(s).	Usually a lab code	6%

Substance Use Disorder 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	6%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	SUDs codes need modifier HF (sometimes also due to the non-AI/AN SSI clients that had modifier HB, that were incorrectly errored out, this issue has been resolved)	6%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
11	The diagnosis is inconsistent with the procedure	SUDs claims require that the primary diagnosis be either ICD-9 303.90, 304.90 (all clients) or 305.00, 305.90 (age 10-20 and/or pregnant clients) ICD-10 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	3%
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	2%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
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 servicing provider is enrolled with. Since SUDs claims do not require servicing NPI this is most likely due to erroneous servicing NPI or taxonomy	1%
96 N30	Patient ineligible for this service.	Client is in a State-only program and not eligible for the encounter rate	1%

Non-Native SUDs

- SUDs claims for all clients are working great
- Last week I pulled data on non-AI/AN SUDs claims that had mis-match modifiers and shared information.
- If you would like a "sweep" of your SUDs claims – just ask

Non-AI/AN SUDs encounter billing					
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	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	On/after 10/01/2015	80%	20%

Providers who are eligible for the IHS encounter rate at I/T clinics

During the September TBWG we presented information on which providers are eligible for the IHS encounter rate. There are no policy changes, we received clarification from CMS that services must be rendered by the listed providers (rather than under the supervision of the listed providers).

For Example, a dental service (fluoride or Sealant) is rendered by a hygienist, under the supervision of a dentist.

- The Service is not encounter eligible because the hygienist is not in the list of encounter eligible providers
- The claim itself does not tell me whether the service was rendered by the hygienist (under the supervision of a dentist) or the dentist because the dentist NPI is most like the NPI on the claim

Providers who are eligible for the IHS encounter rate at I/T clinics

We gave some answers in last month's TBWG, to questions about mental health associates, that need clarification.

- The State Plan (http://www.hca.wa.gov/tribal/Documents/encounter_def_state_plan_031315.pdf) includes MHPs in the list of encounter-eligible providers
- WAC 388-877-0200 (http://app.leg.wa.gov/wac/default.aspx?cite=388-877-0200) defines an MHP as:
  - Psychiatrist,
  - Psychologist,
  - Psychiatric advanced registered nurse practitioner (ARNP),
  - Social worker, or
  - Person
    - With a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university
    - Who has at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, that was gained under the supervision of a mental health professional and is recognized by the department

A mental health associate is encounter-eligible if he or she has:

a) A master's degree (or higher) in counseling or a social science (from an accredited college), and

b) At least two years of experience in direct treatment of persons with mental illness or emotional disturbance, that was gained under the supervision of a MHP.

So, the determination of who is an MHP can depend on how much experience the provider has.

ICD-10

- ICD-10 coding required beginning 10/01/2015 (date of service)
- Access the HCA ICD-10 Implementation website
  - http://www.hca.wa.gov/Pages/ICD-10_Implementation.aspx
- **HCA does not require diagnoses on dental claims** (ICD9 or ICD10). However, if a diagnosis is on a claim then it needs to be a valid diagnosis & related to the service (eg, a broken toe diagnosis may not be appropriate for a dental visit)
  - Note: the old billing model, prior to 2012 required dental encounters on a HCFA and HCFA claims always require diagnoses
- Do not bill claims that span October 1st, 2015
  - Claim can be for all dates prior to 10/01/2015 or
  - Claim can be for all dates on/after 10/01/2015

ICD-10 and SUDs Billing

- SUDS claims require that the primary diagnosis be in the approved list of diagnoses
- Currently allowable primary diagnosis codes for SUDs claims are below. Note that there is no longer a different allowable code-set for youth/pregnant clients and adults

Abuse (Mild)		Dependence (Moderate or Severe)	
F10.10	Alcohol abuse, uncomplicated	F10.20	Alcohol dependence, uncomplicated
F11.10	Opioid abuse, uncomplicated	F11.20	Opioid dependence, uncomplicated
F12.10	Cannabis abuse, uncomplicated	F12.20	Cannabis dependence, uncomplicated
F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated	F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F14.10	Cocaine abuse, uncomplicated	F14.20	Cocaine dependence, uncomplicated
F15.10	Other stimulant abuse, uncomplicated	F15.20	Other stimulant dependence, uncomplicated
F16.10	Hallucinogen abuse, uncomplicated	F16.20	Hallucinogen dependence, uncomplicated
F18.10	Inhalant Abuse, Uncomplicated	F18.20	Inhalant Dependence, uncomplicated

ICD-10 Q & A

Send me your questions!

Is there a cheat-sheet of diagnosis codes?

HCA policy is to not provide diagnoses to bill; the only guidance we provide is in those places where we actually define an ICD to bill within our billing guide.

I had an ICD-9 list of codes that indicated

diagnosis codes that **Never Pay** (usually need extra digit(s))

diagnosis codes that ***Usually*** **Do Not Pay** on a medical claim

The **Never Pay** diagnoses are <u>not</u> loaded in P1 and if billed the claim will reject due to invalid diagnosis

The ***Usually*** **Do Not Pay** diagnoses are loaded in P1. The codes are included with the billing workgroup invitation. The Physician Related Services/Healthcare Professional Services Provider Guide also indicates that some ICD-10 codes are not covered if billed as the primary diagnosis (see page 40 of current slides)

ICD-10

Examples of ICD-10 codes that are not billable (the **Never Pay** list)

M70.86 and M70.89 need extra digit(s) and are not billable, but M70.88 and M70.89 do not need extra digit(s)

+ **M70.86** Other soft tissue disorders related to use, overuse and pressure lower leg
  - **M70.861** Other soft tissue disorders related to use, overuse and pressure, right lower leg
  - **M70.862** Other soft tissue disorders related to use, overuse and pressure, left lower leg
  - **M70.869** Other soft tissue disorders related to use, overuse and pressure, unspecified leg

+ **M70.87** Other soft tissue disorders related to use, overuse and pressure of ankle and foot
  - **M70.871** Other soft tissue disorders related to use, overuse and pressure, right ankle and foot
  - **M70.872** Other soft tissue disorders related to use, overuse and pressure, left ankle and foot
  - **M70.879** Other soft tissue disorders related to use, overuse and pressure, unspecified ankle and foot

M70.88 Other soft tissue disorders related to use, overuse and pressure other site

M70.89 Other soft tissue disorders related to use, overuse and pressure multiple sites

ICD-10

What Diagnosis codes are valid (don't need extra digits) but **Usually do not pay**?

- Refer to the Source Program Billing Guide first (eg, Substance Use Disorders) to see if there are diagnosis requirements
- Refer to the Physician-Related Services/Health Care Professional Services guide:

  The agency requires valid and complete ICD diagnosis codes. When billing the agency, use the highest level of specificity (6th or 7th digits when applicable) or the services will be denied.

  The agency does not cover the following diagnosis codes when billed as the primary diagnosis:

  - *V00-Y99 codes (Supplementary Classification)*
  - *C and D codes (Morphology of Neoplasms)*
  - *Most codes in Z00-Z99 (factors influencing health status and contact with health services)*

  Electronic submitters: External cause codes (V00-Y99) are required to be submitted in groups of three in order for a claim to be processed. This does not apply to paper claim submissions.

- Refer to the Diagnosis reference sheet attached to this TBWG invite for a list of diagnosis codes that are set up in P1 to **Usually do not pay** on Medical claims.

  NOTE: This list is accurate as of 10/13/2015 and may be subject to change

  NOTE: Policy from Physician Billing Guide takes priority over any reference sheet

Suboxone (Medication Assisted Treatments)

Effective for dates of service on and after October 1, 2015, all drugs prescribed as medication assisted treatments (MAT) to clients enrolled in an Apple Health Managed Care Organization (MCO) must be billed directly to the client's plan.

MCOs are required to cover MAT according to HCA published policies. Clients are not required to be enrolled in a DSHS treatment program in order to receive MAT, and there are no limitations on treatment duration if ongoing MAT is appropriate in meeting the client's needs. Most MAT products will not require authorization, including buprenorphine/naloxone at doses up to 24mg per day. HCA's Clinical Guidelines and Coverage Limitations for Medication Assisted Treatment (MAT) and drug specific criteria can be found on HCA's Fee For Service (FFS) Drug Coverage Criteria page.

If treatment continues for longer than six months, prescribers must complete form HCA 13-333 Medication Assisted Treatment Patient Status every six months and maintain it in the patient's records for later audit and review by Health Care Authority. The requirement to complete and maintain the form HCA 13-333 Medication Assisted Treatment Patient Status applies to all MAT, including those not requiring prior authorization. The form can be found HCA's Fee For Service (FFS) Drug Coverage Criteria page .

If you have any difficulty with claim payment or authorizations for Medication Assisted Treatment, please contact the patient's MCO for assistance:

- Apple Health Fee-for-Service 1-800-562-3022
- Amerigroup 1-800-454-3730
- Columbia United Providers 1-800-315-7862
- Community Health Plan of Washington 1-800-440-1561
- Coordinated Care Health Plan 1-877-644-4613
- Molina Healthcare 1-800-869-7165
- UnitedHealthcare 1-877-542-8997

For additional information please see the Prescription Drug Program Medicaid 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

I am getting timed out or kicked out of ProviderOne

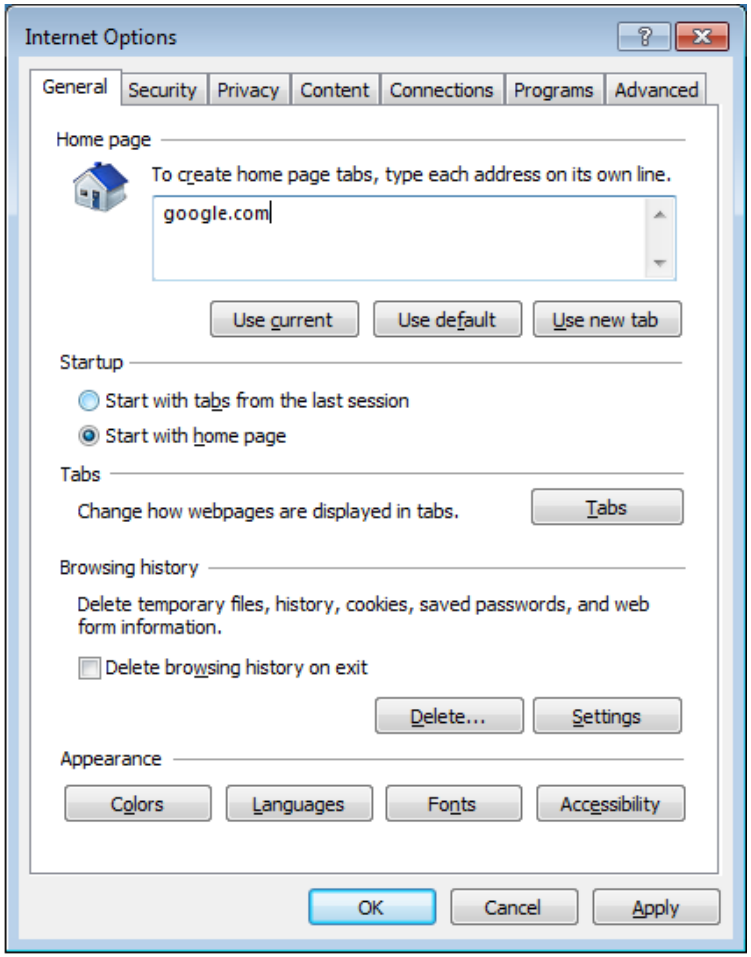
P1 Tech section advises to clean out your internet browsing history

Please refer to the next two slides for the screen shots

- Open an internet window; click tools; click Internet Options; click the Delete button; click Delete. After your history has been deleted, an alert will appear. Close all windows and open a new internet window.
- Uncheck Preserve Favorites website data and Tracking Protection, ActiveX Filtering and Do Not Track
- Check Temporary Internet files and website files, Cookies and website data and History
- Click Delete
- After your history has been deleted, the alert below will appear. Close all windows and open a new internet window.

Please let me know if you are having any P1 screen issues, the help desk wants to get these resolved.

Delete Browsing History



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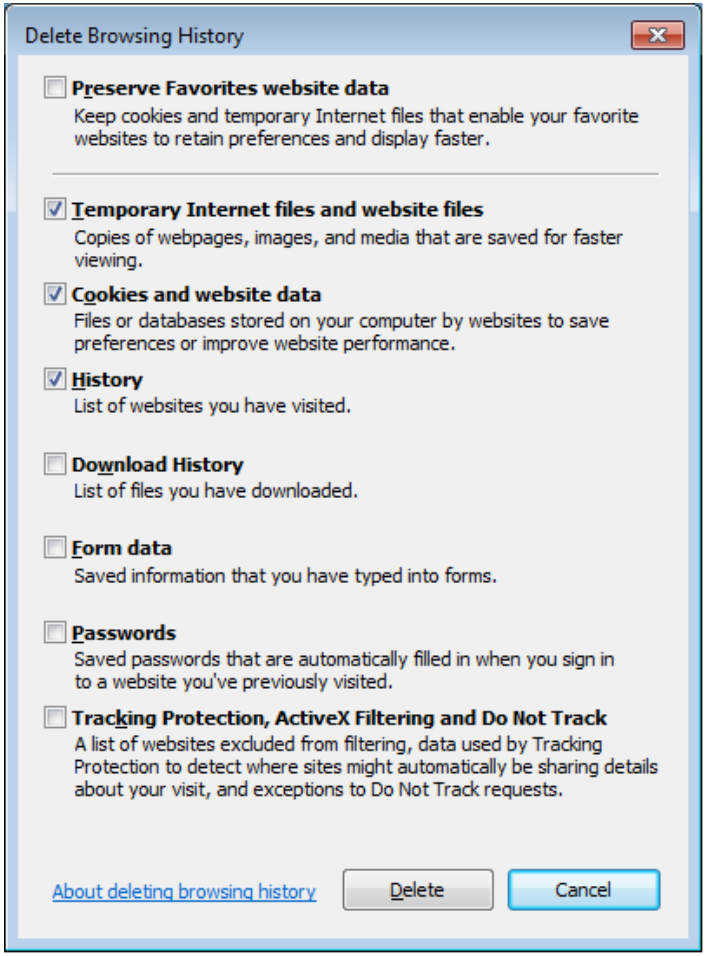
Delete Browsing History



Questions Log

Is the finance dept. aware of the SSI non-native match and do we submit this non-native match along with the MAGI claims or do they need submitted separately. I have yet to hear how this process is suppose to be done

Do I need to send in a match for the SSI claims? I just want to know how to do this particurlar match payment to finance

Yes, DSHS is aware that there are currently 3 different match rates for non-AI/AN clients (100%, 80% and 50%). You may submit a single match payment for all three match rates or 3 separate payments.

DSHS is working toward a new process that will better track Tribal match amounts against claims being covered by the match amount (this may involve the State sending an "invoice" for the claims). This new process is intended to pass an audit.

I am curious how long treatment plans for chemical dependency billing last for auditing regulations for Medicaid or if there are any regulations/guidelines regarding treatment plans and billing like how long they are valid for?

The treatment plans must be valid for the period of time the individual is in treatment. If they change the level of care and remain in treatment all billing must be aligned with the treatment plan, group and individual sessions, progress notes and case management. With Medicaid the billing must match the service date as well as any non-Medicaid billing.

Questions Log

Which providers are eligible for the IHS encounter rate?

So are associate licensed providers no longer allowed to perform services and bill under the supervising provider?

So if the DR. does not see the paitent but the RN (a nurse olny) gets advice and does labs it is not billable for encounter rate?

It would be billed under the Dr. and this is billable to all other insurances

But if the nurse and doctor follow the incident to guidelines it should be an encounter rate

Great examples of how initial answers during billing workgroup are sometimes incomplete. Please see detailed answer in today's slides, pages 34-35

If we have a MH Associate that will be seeing a patient and we will be billing under the supervisor would the supervisor need to do the initial visit or anything like that?

If the MH Associate meets the definition of mental health professional (basically masters level with two years mh experience working under the supervision of a MHP), the associate can make the initial determination of medical necessity. If not, a MHP has to do the diagnosis and determination of medical necessity that starts the course of treatment (David, DSHS/BHSIA)

I didn't see Naturopaths listed on those eligible for the encounter rate - do they fall under "physicians"

-- yes, Naturopaths are considered Physicians

Questions Log

Unbundling

Can I separate the Office visit from Labs/radiology? To bill OV at flat rate and the Labs Rad as FFS on same day visits?

It states in the billing manual these services are bundled in the encounter rate per the state plan

No you can't bill labs and xray separately, but hey I've been around too long

J codes can be bill outside of the encounter rate

If they are like FQHC, we have to refund all services paid at the fee for service level. Better to bill all together.

Labs/xrays are included in the encounter rate. Splitting up the claims is similar to “unbundling” & may be denied in P1

Questions Log

Medical vs Mental Health

We have an ARNP provider who see BH patients continues to use 99213 E &M even though it is a mental health visit. Should he be using 90832, 90834 or 90837 instead? I don't want it to be confused with a medical visit

Can ARNP's render mental health services?

If the ARNP is a Psychiatric ARNP – yes. if the ARNP is not a psychiatric ARNP – no.

Can ARNP's render medical services?

Yes, however, If the service is being rendered under the psych ARNP scope of practice – it should be billed as MH whether it is therapy or psych med management or other services.

Would an E&M be OK on a mental health claim?

No

Would a psychotherapy code be OK on a medical claim?

No

Overall, Psych ARNP should consider the special training they received for their psych credential. Any time they are using that training they are provider MH care/treatment

Questions Log

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

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.

Touch base with Mike if you have claims that seem to be taking longer than normal.

Can I say "stay tuned" on whether all billing will transition to the MCOs?

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:

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