Washington State Health Care Authority

Tribal Billing Workgroup (TBWG)

January 13, 2016

Mike Longnecker
HCA Tribal Affairs Office

Agenda

- Clinical Data Repository Participation and the Electronic Health Record Program
- Monthly Data and Analysis
- 2016 IHS Encounter Rate – not announced yet (placeholder)
- Billing for non-Title XIX services in P1 – Physical Functional Evaluation
- Individual ProviderOne (IP) delay
- Initial point of contact at the I/T/U clinics for the MCOs
- Non-Native SUD Federal Matching Rates Update
- FAQ and Open Discussion

CLINICAL DATA REPOSITORY PARTICIPATION AND THE ELECTRONIC HEALTH RECORD PROGRAM

WASHINGTON

Link4Health

Kelly McPherson – HealthIT
Program Manager

Ginnie Eliason – HealthIT
Stakeholder Engagement &
Communications Manager

Background-How did we get here?

National Level – 2009

ARRA- American Recovery and Reinvestment Act

- Development of HIT infrastructure
- Development of the Office of the National Coordinator (ONC)
- *Develop & maintain national certifications for HealthIT equipment*
- *Developing and endorsing national level standard*

HITECH-Health Information Technology for Economic & Clinical Act

- To promote widespread exchange of integrated clinical records between authorized providers

Washington State – 2009 to now

WA ST Substitute Senate Bill 5501 built a partnership:

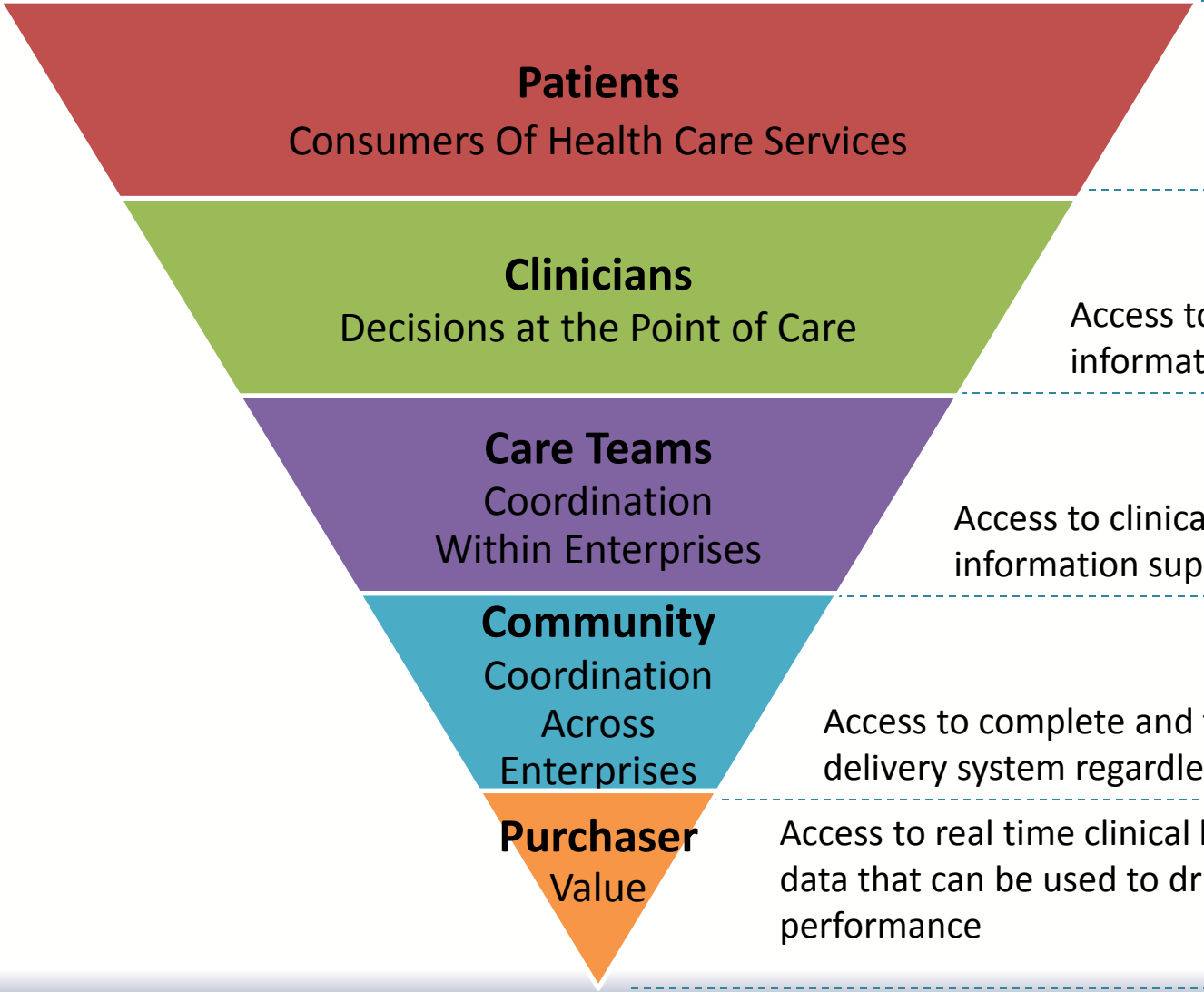
- HCA Appointed Lead for HealthIT
- OHP (OneHealthPort) awarded state HIE (Health Information Exchange)

What Is the Problem?

As it is Today: Patients Data Spans Many Silos

An individual's healthcare story cannot be told in pieces

Health Information Needs Hierarchy



Access to quality care based on complete, clinically relevant record describing care & needs.

Access to clinically relevant and timely information to support decision-making.

Access to clinically relevant, evidence-based information supplied by the entire care team.

Access to complete and timely patient-level data across delivery system regardless of entity delivering care.

Access to real time clinical health outcomes and quality data that can be used to drive value-based payment and performance

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Meeting Emerging Needs - CDR

WA Link4Health State HIE Provides Solution: Medicaid Data Repository

- Complete integrated health record that follows consumer across settings and over time regardless of payer, plan, care setting, or provider.
- Longitudinal record that describes all care and needs, including medical, dental, behavioral health, and social support services.
- Whole patient record, not what a single clinician, clinic or plan(payer) determines relevant, throughout lifetime.
- On demand access to shared care plans and health record for patients with complex & chronic conditions.
- Actionable data to identify gaps in care and predictive data to identify who is likely to need care.

Data First Strategy

Build and Provide Access to a Critical Mass of Clinical Information for Medicaid Patients

Stage 1

2 Years Claims & Encounter data plus when providers see a Apple Health patient assigned to a MCO, an automated process sends a care summary to the CDR using triggers set behind the scenes in EHR . HIPAA enabled data– Early 2016

And into Stage 2

When providers prepare to see Apple Health patient, they query CDR to get data

Data to analytics service – late 2016

Second Phase 2017-

Inclusion of more sensitive types of clinical info and transactions to be added to CDR.

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Types of Data Exchanged

- Early Stage 1: HCA contributes data covered under HIPAA
  - Golden rule: Data used as necessary for treatment, payment, and healthcare operations
  - HCA will verify that security measures, protocols, and practices are compliant with HIPAA regulations
  - Data usage, governance, and security policies
  - Any clinical data received will be used only as allowed under applicable state and federal law
- Future: Data covered under CFR 42.2

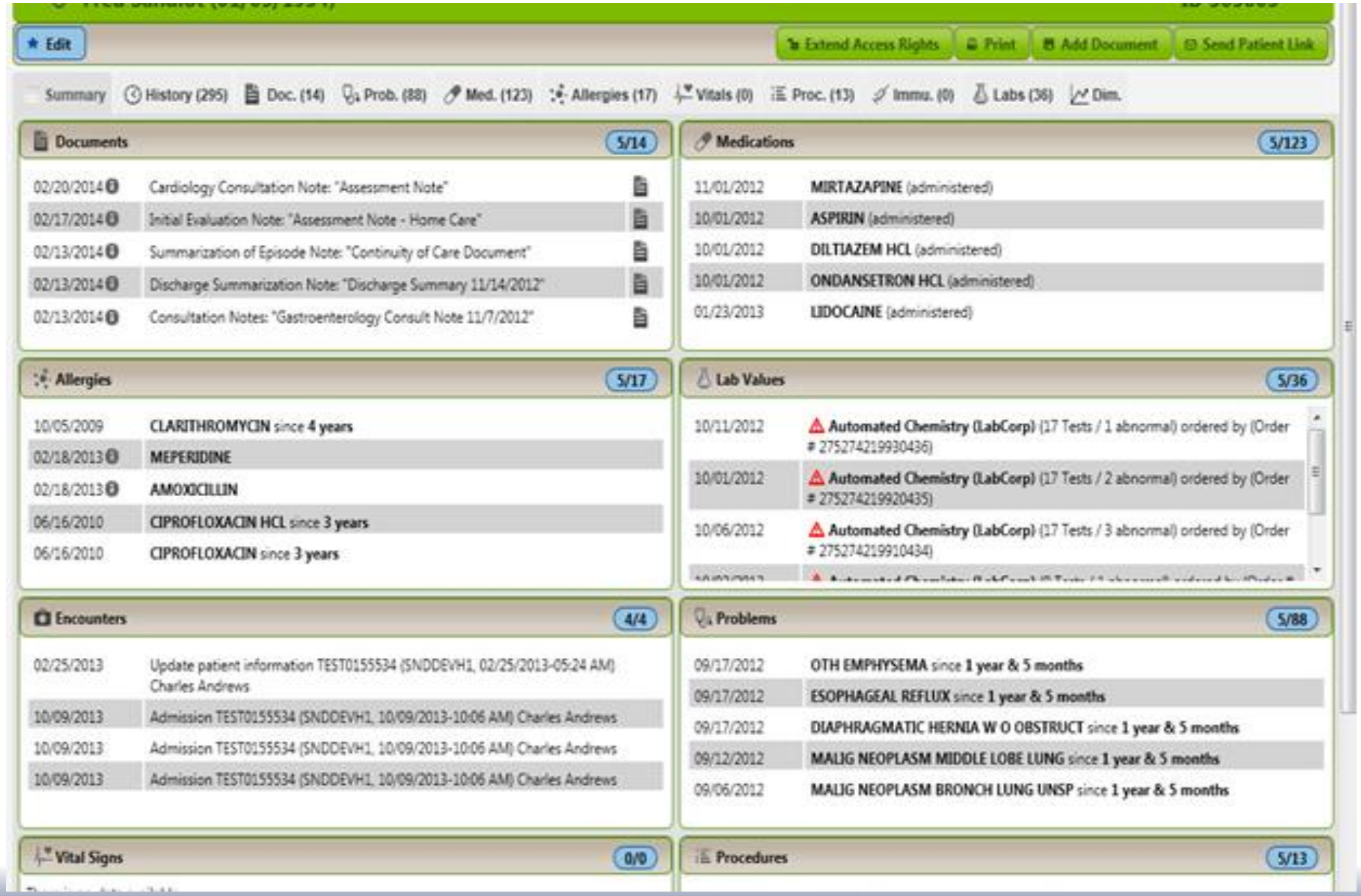
Standards for Data Exchange

- Consolidated Clinical Data Architecture (C-CDA)
  - National standard for clinical data
  - Multiple ‘templates’ available depending on service
- Includes data not available on standard HIPAA transactions
  - History: Family, Social, and Medical
  - Current medications and health problems
  - Lab results
  - Vital signs and other health measures

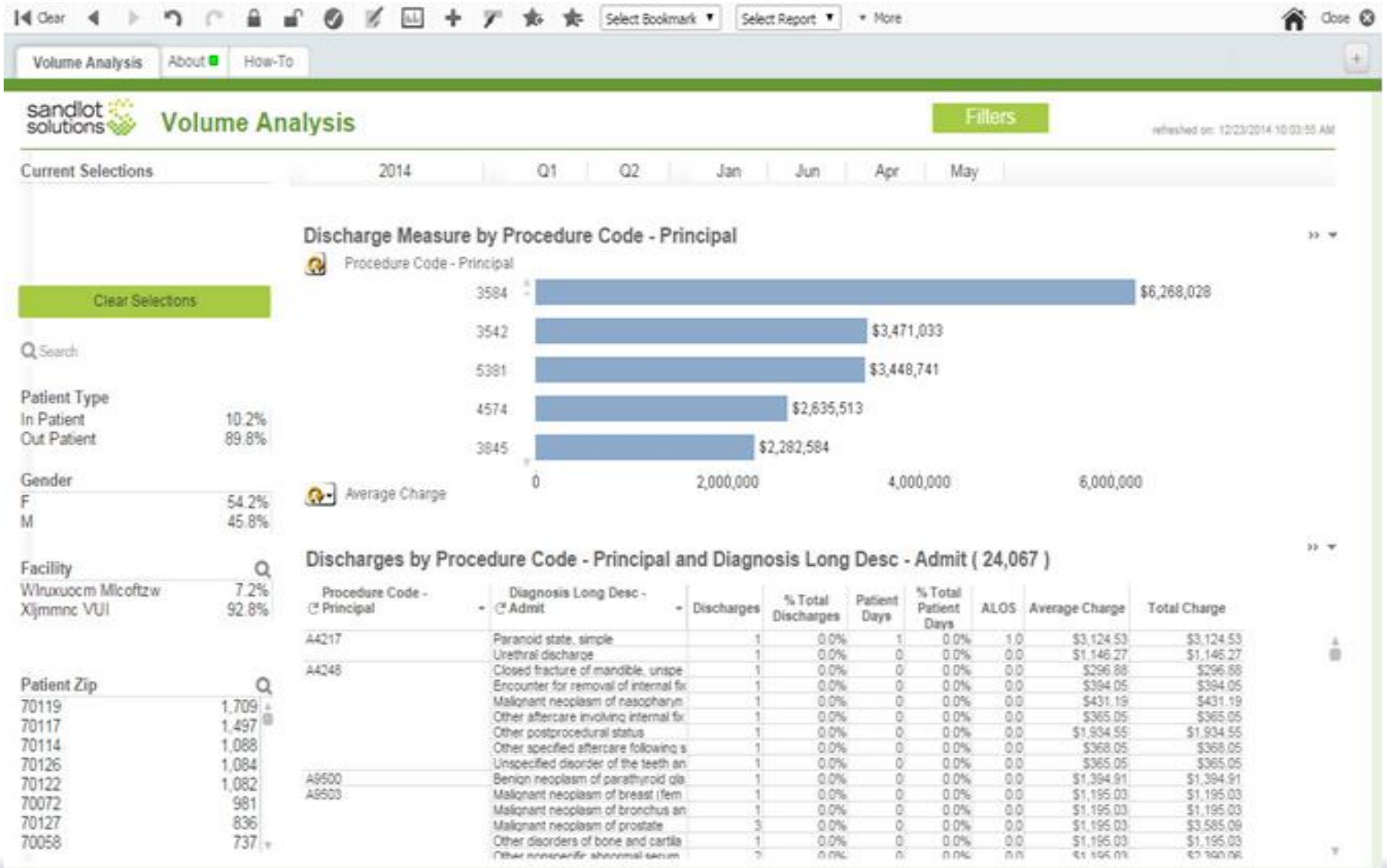
Role Based Access

- Access defined by a tiered role
- User level
  - Define access to restricted/very restricted data
  - Allow access to Connect or Dimensions
- Group level
  - Can enhance access to user level roles, i.e. physician in a psychiatric clinic
- Health Plan level
  - Ensures access to ‘own’ information

Connect Portal- what an authorized viewer may see(UNDER DEVELOPMENT)



Dimensions Portal- What an Authorized Viewer May See-Under Development



HEDIS 5 Star Quality Measures- Under Development

What is Next for DVA?

- Identify benefits and business process simplification opportunities
- Provide WA Link4Health with your administration's person to serve as your state agency *authorizing Executive Sponsor* for involvement with WA Link4Health.
- We arrange DVA's Executive Sponsor's participation in monthly briefings with all Sponsors and HCA ELT members.

Questions ? Need additional Information? :

Team email: HealthIT@hca.wa.gov and put HIE in the subject line with any questions you have

Website: HealthIT.wa.gov- sign up for monthly updates and watch for upcoming webinars and meetings

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MONTHLY DATA & ANALYSIS

November 2015 Claims Data (I/T/U)

	Dollars	Dollars, Prior TBWG	Clients*	Clients, Prior TBWG*	% Paid	% Paid, Prior TBWG
Totals	$5,866,423	5,585,165	10,904	12,052	NA	NA
Medical	$1,327,483	$1,368,295	3824	4450	83%	79%
Dental	$625,004	$752,046	1867	2242	88%	85%
MH	$735,148	$1,017,341	1069	1246	92%	86%
SUD(CD)	$2,682,107	$1,885,462	1129	1170	95%	81%
POS	$482,878	$507,394	5473	5846	60%	60%
Other FFS	$13,800	$54,625	7	25	100%	52%

* 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 % *
18	Exact duplicate claim/service	Duplicate billing	16%
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	11%

* Denial percentages example: Out of the Medical claims that did not pay at the encounter rate, 16% were due to duplicate billing issues

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	9%
96 N30	Patient ineligible for this service.	Client is not an encounter-eligible client (e.g., State-funds-only client or QMB-only or SLMB)	8%

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%

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	3%

Medical Claims – Top Denials

EOB	Description	Comments	Denial %
16 N255	Missing / Incomplete / Invalid billing provider taxonomy	Billing (group) taxonomy was not 208D00000x (general medical) or 2084P0800x (med-psyc) or 225100000x (Physical Therapy) or 235Z00000x (Occupational Therapy) or 152W00000x (optometrist) (Urbans please continue to use 261QF0400x)	2%
16 N290	Missing/ incomplete/ invalid rendering provider primary identifier	Servicing provider is not in ProviderOne yet. follow these steps 1. Enroll the provider in P1 2. Request back-date if licensed provider was working before they are approved in P1 3. Contact mike before rebilling claims	2%

Medical Claims – Top Denials

EOB	Description	Comments	Denial %
96 N59	Non-covered charge(s).	Some services are not covered. Covered services are listed in the physician fee schedule	2%
9	The diagnosis is inconsistent with the patient's age.	Some diagnosis codes are only for newborns or youth or adults. NOTE: Z13.89 was coded incorrectly in P1 and I sent claims for reprocessing and touched base with provider on the claims	2%

Dental Claims – Top Denials

EOB	Description	Comments	Denial %
16 MA63	Missing / incomplete principal diagnosis	**Dental claims do not need diagnosis codes** but if a diagnosis code is entered on a claim then it needs to be valid and OK for the service	26%
16 N290	Missing/ incomplete/ invalid rendering provider primary identifier	Servicing provider is not in ProviderOne yet. Follow these steps 1. Enroll the provider in P1 2. Request back-date if licensed provider was working before they are approved in P1 3. Contact mike before rebilling claims	9%

Dental Claims – Top Denials

EOB	Description	Comments	Denial %
204	This service / equipment / drug is not covered under the patient's current benefit plan	Usually a family planning only or a QMB-only client	7%
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	6%

Dental Claims – Top Denials

EOB	Description	Comments	Denial %
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Dental claims missing the 870001305 or 870001306 EPA number	5%
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	4%

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	4%
96 N59	Non-covered charge(s).	Covered codes/services are in the Dental billing guide and fee schedule	4%

Dental 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	3%

Dental Claims – Top Denials

EOB	Description	Comments	Denial %
119	Benefit maximum for this time period or occurrence has been reached	Claims were for fluorides (D1206 D1208) over the annual limit Limits: • Age 0-6 (or in ortho treatment or resides in Alternate Living Facility (ALF) or DDA client) – 3 per 12 months P1 "knows" if client is DDA or claim is billed in an ALF. P1 does not "know" if the client is an ortho client or resides in an ALF, limits listed above apply, claim note needed (contains key-words "ortho" or "assisted living") • Age 7-18 – 2 per 12 months • Age 19+ - 1 per 12 months	2%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
16 N255	Missing / Incomplete / Invalid billing provider taxonomy	Billing taxonomy wasn't 2083P0901x (Urbans continue to use 261QF0400x)	46%
24	Charges are covered under a capitation agreement managed care plan	Client is Enrolled in one of the Managed Care Plans	15%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
204	This service/ equipment/ drug is not covered under the patient's current benefit plan	Usually a family planning only client	9%
18	Exact duplicate claim/service	Duplicate billing	9%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
96 M80	Not covered when performed during the same session/date as a previously processed service for the patient.	Mental health related code/service already paid	7%

Mental Health 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 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? Contact Mike	2%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	The HE (AI/AN) or SE (non-AI/AN) modifier was missing	2%
11	The diagnosis is inconsistent with the procedure	I/T Mental Health Claims with this EOB are generally an error in P1. claims sent for reprocessing, if you see an 11 on a mental health claim please contact mike	2%

Mental Health 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	1%
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage	1%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing.	63%
170 N95	Payment is denied when performed/ billed by this type of provider.	Claim was either a valid SUD code but was missing the HF modifier or a drug screen (CPT 8030x). Drug screen labs are not covered in the SUD program. The agency pays for UAs only when provided by DBHR's contracted provider	14%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
96 N59	Non-covered charge(s).	Usually a lab code	9%
11	The diagnosis is inconsistent with the procedure	SUDs claims require that the primary diagnosis be 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 (ICD-10)	3%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
B5	Coverage/ program guidelines were not met or were exceeded.	Group therapy (96153) only covered if at least 45 minutes (3 units) During the December billing workgroup it was mentioned that some folks have always been billing group at 1 unit and receiving payment. Uncovered a P1 issue – P1 is allowing group of 1 unit or 3+ units (P1 is only rejecting group therapy when it is 2 units). If we follow the billing instructions we will avoid potential issues	3%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
A1 N362	The number of Days or Units of Service exceeds our acceptable maximum.	H0001 was billed at greater than 1 unit (H0001 should always be a single unit for billing)	1%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
96 N30	Patient ineligible for this service.	Client is not an encounter-eligible client (e.g., State funds only client or QMB-only or SLMB)	1%
181	Procedure code was invalid on the date of service.	P1 can't figure out how to pay the claim (the code is usually valid) Claims were either billed with a Mental Health code or were a Methadone claim (H0020) but didn't have the additional methadone taxonomy (261QM2800X is servicing taxonomy)	1%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
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	1%

PLACEHOLDER FOR THE 2016 IHS ENCOUNTER RATE

BILLING NON-TITLE XIX (NON-MEDICAID) PHYSICAL FUNCTIONAL EVALUATIONS IN PROVIDERONE

Non-Title XIX Services in ProviderOne

- ProviderOne is the payment system for billing for the Physical Functional Evaluations. Refer to form 13-021 https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/13-021.pdf
- Services are not eligible for the IHS/FQHC encounter rate because they are not Medicaid covered services
- Refer to the contact list and reference sheet for coding/billing

Individual ProviderOne Delay

Update – Individual ProviderOne

The implementation of Individual ProviderOne, the new payroll system for Individual Providers (IPs), has been delayed until March 1, 2016.

- The delay is due to system defects that could result in inaccurate or late payments. IP payments in January and February will continue to be made out of SSPS.
- IPs are not technically required to contact IPOne, "register" or log-in; however, it is highly recommended to ensure IPOne has their correct information (contact information, updated direct deposit, access to training materials, etc.).
- Currently, over 40% of active IPs have updated/verified their information in ProviderOne in preparation for the change.
- Announcements to IPs continue to be made via www.ipone.org, mailings, and flyers attached to SSPS payment invoices.
- The IPOne Call Center has been available since November 2, 2015 to assist IPs in all areas related to the future payments/payroll system. The IPOne Call Center can be reached at 1-844-240-1526, Monday through Friday, 7 a.m. to 7 p.m. Starting in March, the Call Center will be available on Saturdays as well, 8 a.m. to 1 p.m.

INITIAL POINT OF CONTACT AT I/T/U CLINICS FOR THE MCOS

Initial Point of Contact at the Tribes for the MCOs

- MCOs have requested initial points of contact at each ITU clinic
- Please let Mike know if you would like to offer an initial point of contact for the MCOs
- Mike can split the contacts up as necessary (e.g. Medical claims are *Mike*, Behavioral health claims are *Jessie*)
- No need to include NPI/tax ID numbers, Mike has that information

NON-NATIVE SUD FEDERAL MATCHING RATES UPDATE

Non-Native SUD FMAP Update

- Substance Use Disorder claims for non-AI/AN clients pay the federal portion of the Federal Medical Assistance Percentages (FMAP) rate with the IGT process for the local matching funds
- The FMAP rate for Presumptive SSI clients (RAC 1217) was updated on 01/01/2016 from 80% to 85%. NOTE: The FMAP rate is based on the date that the claim is paid, not the date of service

Benefit package/RAC	FMAP as of 01/01/2016
ABP/1201	100%
Presumptive SSI/1217	85%
Classic, MAGI/all others	50%

- The next anticipated FMAP change is scheduled for January, 2017
  - ABP changes from 100% to 95%
  - Presumptive SSI changes from 85% to 86%

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

Q. We were discussing the “Unspecified” and “Other Specified” clauses that can be used with nearly all diagnoses (e.g., depression, trauma stress related disorder, neurodevelopmental). How long are we able to utilize, for example a diagnosis of Unspecified Depressive Disorder vs. Other Specified Depressive Disorder?

A. I’m guessing this is a best practice question vs anything written in policy?

- To my knowledge there is no specific policy, rather best practice guidelines and vague descriptions for use in the DSM-5 AND each diagnosis has a somewhat different take on the unspecified/other specified rationale. For the most part, other specified requires delineation of the rationale for that diagnosis. If the symptoms meet the definition of a mental health disorder (symptoms causing significant dysfunction and distress), the diagnosis can be indefinite.
- For unspecified, generally it is used as a placeholder in emergency situations or when not enough info is obtained to specify the diagnosis. So typically that would be changed after “a period of time” when more information has been obtained. Perhaps unspecified could be viewed as a Rule Out (R/O) diagnosis but I am not sure that holds true for all diagnoses outlined in the DSM-5. I know that R/Os are normally expected to be dropped by the end of the treatment period (either the dx was ruled in or ruled out).

Questions Log

Q. If patient is in a motor vehicle accident, will P1 pay?

A. Yes, Medicaid will pay. When there may be some other third party liability (such as motor vehicle accidents), Medicaid will pay and then try to recover from any liable third parties after the claim is paid (pay & chase). Sometimes there's just no insurance to recover from and the Medicaid payment stays

Questions Log

Q. Do we need to start billing 8 units for our groups? The WAC states that a group must be at least 1 hour and at least 3 times a week. This WAC is on our license by the state for SUD. We currently perform group for 2 hours 3 times a week

A. During a prior TBWG we had claims for group therapy (96153) that errored out because they were not billed at the minimum of 45 minutes (3 units). The SUD billing guide indicates that group must be a minimum of 45 minutes. One of the attendees mentioned that her groups are always paying if billed at 15 minutes (1 unit). Further research found that P1 is enforcing the 45 minute minimum only if the claim is billed at 30 minutes (2 units). Even though P1 is allowing group billing of 15 minutes please follow the current guidelines and only bill for groups if the group session was 45 minutes or longer

Questions Log

Q. In the past, we were told to use 96154 for individual therapy but the SUD guide says H0004

A. Code-table adapted from the SUD billing guide below

Code	Service	Billed units
H0001+HF	Substance Use Disorder Assessment	Always 1
H0001+HD	Substance Use Disorder Assessment, Pregnant and Postpartum Women	
H0002+HF	Intake Processing	
H0003+HF	Children's Administration, Initial Screening	
H0004+HF	Individual Therapy, without family present	1 unit per 15 minutes
96153+HF	Group Therapy	
96154+HF	Individual family therapy with enrollee (client) present	
96155+HF	Individual family therapy without enrollee (client) present	
H0020+HF	Opiate Substitution Treatment	Always 1

Questions Log

Q. Can we bill for services rendered to our tribal jail inmates?

A. No. While an individual is placed in a city, county, or state institution, they are not eligible for Medicaid coverage WAC 182-503-0505 (#5)

Health Care Authority has worked with city, county, and state correctional facilities to create a process for inmates to apply for medical coverage at the time of release

What about the day of incarceration or release? The Dept of Corrections folks like to use the example of where the client lays his head down to go to sleep – if he is going to go to sleep in the jail then he is incarcerated

Questions Log

The Mental Health billing guide has a link to the agency's *Program Policy Approved Diagnosis Codes for Mental Health Services.*

Q. Are the diagnosis codes in this list considered an exhaustive list?

A. No, this is not an exhaustive list. This is a partial list of ICD-9 to ICD-10 crosswalked codes

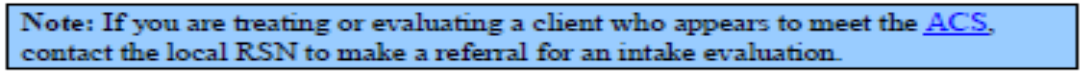
Q. If a claim is billed and paid and the diagnosis on the claim is not in the list, can the claim potentially be considered an overpayment?

A. No. The mere absence of the diagnosis on the crosswalk does not make the claim an overpayment. Medical Necessity criteria is outside of the scope of billing and is subject to post-pay review

Questions Log

Q. The Mental Health Billing Manual has a link to the access to care standards (ACS) for RSN but these are dated 2006. Have these been updated or is this what we need to follow?

A. Page 37 has a link to the ACS, when you click on the Link the ACS standards are dated 01/01/2006



The ACS standards have not been updated. A new version will go into effect on April 1st. Tribal providers do not have to refer to the RSN/BHO if the patient wants to continue receiving services at the Tribal clinic. The client may be referred to an RSN/BHO if the person meets ACS and has treatment needs beyond the scope of the Tribal clinic

Questions Log

Q. Is there a contact for pharmacy billing questions?

A. For general claims questions you can call

800-568-3022 ext: 15499

If you are having problems with a particular drug paying in the system or any claims-specific questions you may contact Mike, who will work with the pharmacy staff

Questions Log

Q. For next work group meeting can we discuss the face to face requirement for encounters and how it relates to telemedicine.

A. Telemedicine generally involves two separate services/claims:

1. The originating site (where the client is) is paid a facility fee, there is no encounter eligible service rendered
2. The distant site (where the provider is) is paid the fee schedule amount for the service provided. Does this service meet the Medicaid definition of “face to face”? Stay tuned.

The next two slides highlight the HCA FFS policy regarding telephone services and telemedicine. Refer to the Physican-Related Services/Healthcare Professional Services Provider Guide at http://www.hca.wa.gov/medicaid/billing/pages/physician-related_services.aspx

Questions Log

Telephone Services

The agency pays for telephone services when used by a physician to report and bill for episodes of care initiated by an established patient (i.e., someone who has received a face-to-face service from you or another physician of the same specialty in your group in the past three years) or by the patient's guardian. Report and bill for telephone services using CPT codes 99441-99443.

1. Telephone services must be personally performed by the physician.
2. If the telephone service relates to and takes place within the postoperative period of a procedure provided by the physician, the service is considered part of the procedure and should not be billed separately.
3. Telephone services should not be billed when the same services are billed as care plan oversight or anticoagulation management
4. When a telephone service refers to an E/M service performed and billed by the physician within the previous seven days, it is not separately billable, regardless of whether it is the result of patient-initiated or physician-requested follow-up.
5. This service should not be billed if the service results in the patient being seen within 24 hours or the next available appointment.

Questions Log

Telemedicine

- Telemedicine is when a health care practitioner uses HIPAA-compliant, interactive, real-time audio and video telecommunications to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located.
- Using telemedicine when it is medically necessary enables the health care practitioner and the client to interact in real-time communication as if they were having a face-to-face session
- Originating site (where the client is) a facility fee may be billed using HCPCS Q3014
- Distant site (where the eligible provider is) may bill with the appropriate CPT codes along with modifier GT

Questions Log

Q. If a client has private insurance how do I find the “carrier code” that the P1 screens require in order to bill P1 secondary?

A. The client Benefit Inquiry will show the Carrier Code if it has been entered into P1. Screen shot below. If there is no Carrier Code listed please call the Coordination of Benefits line at 800 562 3022 ext 16134 so that we can update the insurance information on the client file. The sooner we know about a new insurance or a change to an existing policy the better

Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	PREMERA BLUE CROSS/BCBS OF AK (800) 345-6784	BC01	SUPER MAN	100883158			03/01/2007	12/31/2999

Questions Log

Q. Two MCO's have optical claims going to a different entity. The two subcontractors will not accept our claims or provide required subcontractor info to be able to bill. Therefore optical claims to those two MCOs are useless.

A. Pending guidance from CMS on Federal Ownership Disclosure requirements for I/T/Us. This issue is also on the MTM (Monthly Tribal Meeting) log.

Questions Log

Q. Are the services of a Mental Health Associate billable?

A. Associates must be licensed and under the supervision of an MHP (claims are billed using the supervisor's servicing NPI/taxonomy)

Q. Are the services of a Mental Health Associate who are pending licensure billable?

A. Services for a person pending licensure are not billable. The services are billable starting on the date of license

Questions Log

Q. Will we be able to bill for Chronic Care Management services under the encounter rate? (CPT 99487 99489 99490)

A. Chronic Care Management codes are not covered by HCA. In addition, these codes are typically not face-to-face services, and, therefore, are encounter-eligible. However, E&M's may be billed if services meet E&M criteria

Questions Log

Q. How can I request a replacement ProviderOne services card for a client?

A. Tribal Representatives can request services cards for AI/AN clients if the representative is:

- From the Tribe or Tribal clinic
- A Tribal In-person Assister or Navigator
- A Tribal Liaison

The request must include the

- Tribal representative's name
- Title
- Statement that the recipient is American Indian/Alaska Native

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

Questions Log

Q: Can ARNP (not psych) providing 'mindfulness' session bill encounter rate? See UW webpage on mindfulness-based stress reduction: *http://www.uwhealth.org/alternative-medicine/mindfulness-based-stress-reduction/11454*

A. Stay tuned.

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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If there is a difference between information in this webinar and current agency documents (e.g., provider guides, WAC, RCW), the agency documents will apply.