Washington State Health Care Authority

Tribal Billing Workgroup (TBWG)

March 16, 2016 (rescheduled from March 9th)

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Agenda

- Monthly Data and Analysis
- CY 2014-2015 summary and analysis of 2015 claims
- 2016 IHS Encounter Rate – not announced yet (placeholder)
- 100% FMAP update from CMS
- Mandatory assignment in BHSO in Clark and Skamania counties
- Diagnosis codes for SUD services beginning April 1st
- FAQ and Open Discussion

MONTHLY DATA & ANALYSIS

December 2015 Claims Data (I/T/U)

	Dollars	Dollars, Prior TBWG	Clients*	Clients, Prior TBWG*	% Paid	% Paid, Prior TBWG
Totals	$7,242,908	$6,530,205	11,868	10,847	NA	NA
Medical	$1,616,664	$1,357,649	4473	3771	86%	85%
Dental	$621,389	$652,903	1949	1931	82%	86%
MH	$1,111,111	$769,164	1219	1039	90%	94%
SUD(CD)	3,178,800	$3,096,033	1368	1073	96%	85%
POS	$575,038	$507,386	6009	5596	62%	60%
Other FFS	$139,906	$147,070	175	36	2%	90%

* 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	20%
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	17%

* Denial percentages example: Out of the Medical claims that did not pay at the encounter rate 20% were due to duplicate billing

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	10%
A1 N149	Rebill all applicable services on a single claim	New edit (old rule) for FQHC (Urban Indian Organizations are FQHC in P1) providers – all services (per category) must be on the same claim	5%

Medical Claims – Top Denials

EOB	Description	Comments	Denial %
96 N30	Patient ineligible for this service	Client was SLMB, QDWI or QI-1 – clients are not Medicaid eligible	4%
22	This care may be covered by another payer per coordination of benefits	Client has Medicare	3%

Medical Claims – Top Denials

EOB	Description	Comments	Denial %
204	This service / equipment / drug is not covered under the patient's current benefit plan	Two typical causes: 1. Family planning only or a QMB-only client 2. Servicing taxonomy on the claim is not eligible to see clients (eg, R.N. 163W00000x)	3%
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage	2%

Medical Claims – Top Denials

EOB	Description	Comments	Denial %
96 N129	Not eligible due to the patient's age	CPT 99381-99395 on a claim causes the claim to be a well-child visit, which is only payable for clients age 0-20. Preventive codes (99385 99386 99387 99395 99396 99397) are not covered for adults. CPT indicates 99385 & 99395 is for age 18-39. CPT 99385 & 99395 in P1 causes the *entire claim* to be an EPSDT claim (age ≤20). If the client is age 21 or over P1 will reject the *entire claim*, even if there may be other payable services on the claim Mike recommends not billing CPT 99385/99395 for clients age 21-39, doing so may cause otherwise payable services to not pay Cancer screen diagnosis was on many claims. Cancer screens are covered (and encounter eligible) under different CPT/HCPCS codes. Refer to p. 116 of physician billing guide, http://www.hca.wa.gov/medicaid/billing/Documents/guides/physician-related_services_mpg.pdf	2%

Medical Claims – Top Denials

EOB	Description	Comments	Denial %
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). Noticed 99386 99396 on some claims, HCA does not cover preventive medicine services (99381-99397) for adult clients	2%

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	15%

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 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 (<u>if appropriate</u>, 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? Contact mike	8%

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	7%
96 N59	Non-covered charge(s).	Covered codes/services are in the Dental billing guide and fee schedule	5%

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%
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	4%

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. Tribal Affairs office would be happy to walk anybody through the P1 screens to reprocess the claim(s) to add the quadrant or any other data	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	3%

Dental Claims – Top Denials

EOB	Description	Comments	Denial %
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	2%
119	Benefit maximum for this time period or occurrence has been reached	Claims were for “adult” prophy. Generally, Prophys are allowed Once per 6 months for age 0-18 Once per 12 months for age 19+ Extra prophys allowed for DDA and nursing facility clients, refer to dental guide (or call mike)	2%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing	63%
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. Most of the claims were regular duplicates but get a different EOB due to P1 design/billing dates	19%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
204	This service / equipment / drug is not covered under the patient's current benefit plan	Client not eligible for the service. Most claims were QMBonly clients	4%
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	1%

Mental Health 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	1%
22	This care may be covered by another payer per coordination of benefits.	Client has Medicare	1%

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
16 / N255	Missing / incomplete / invalid billing provider taxonomy.	Mental health claims billed with 261QR0405x	1%
A1 N61	Rebill services on separate claims.	HF modifier on the mental health code caused P1 to think that the mental health code was an SUD service on a mental health claim	1%

Mental Health 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	1%
181	Procedure code was invalid on the date of service.	SUD codes on a mental health claim	1%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
170 N95	Payment is denied when performed/ billed by this type of provider.	Drug screens (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	19%
96 N59	Non-covered charge(s).	Usually a lab code	17%

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 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) NOTE: the code-set is expanded beginning April 1st, 2016	9%
A1 N61	Rebill services on separate claims.	Do not rebill SUD services on different claims. CD encounters always require the claim note: AI/AN client – SCI=NA Non-AI/AN client – SCI=NN	4%

Substance Use Disorder 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 or a Medicare only client. If the claim is billed with an individual servicing NPI for a CDP/CDPT this can also happen (SUD claims do not get billed with individual servicing NPI/taxonomy)	3%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	SUD claims require that modifier HF be added to the SUD billing code	3%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing	3%
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)	3%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
96 N30	Patient ineligible for this service.	Client was a QMB – only client (RAC 1112 1113). Many clients are QMB-dual and generally Medicaid is secondary to Medicare. Some client are QMB-only and essentially do not have Medicaid	2%
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%

CLAIMS ANALYSES

I/T/U 2 year snapshot (2014-2015)

	Dollars		Clients		Percentage Paid	
	CY 2014	CY 2015	CY 2014	CY 2015	CY 2014	CY 2015
Totals	$96,473,902	$106,521,138	40,217	42,363	-	-
Medical	$26,189,225	$27,453,199	27,312	27,439	76%	81%
Dental	$10,084,816	$11,384,426	15,713	17,102	83%	85%
MH	$16,678,773	$16,832,817	5,251	4,669	86%	89%
SUD(CD)	$36,396,831	$42,903,800	4,191	4,443	84%	91%
POS	$4,769,582	$6,045,228	17,738	19,824	59%	59%
Other FFS	$2,071,531	$1,876,042	536	217	64%	79%
Medicare	$6,894	$4,373	1,047	1,467	5%	2%
E.H.R	$276,250	$21,250	-	-	-	-

CY 2015 payment percentages

Payment percentages listed below are for billing NPI, not clinic. Claims Analyses will begin with the NPIs that have 0% payment rate

100%	97%	94%	92%	89%	84%	80%	70%
100%	97%	94%	91%	89%	84%	80%	68%
100%	96%	94%	91%	88%	84%	80%	66%
100%	96%	94%	91%	88%	83%	80%	56%
99%	96%	94%	90%	87%	83%	79%	53%
98%	96%	92%	90%	87%	82%	79%	42%
98%	96%	92%	90%	87%	82%	79%	32%
98%	96%	92%	90%	85%	82%	77%	31%
98%	95%	92%	89%	85%	81%	76%	28%
98%	95%	92%	89%	85%	81%	76%	0%
98%	95%	92%	89%	85%	81%	75%	0%
97%	95%	92%	89%	85%	81%	74%	0%
97%	95%	92%	89%	85%	81%	71%	0%
97%	94%	92%	89%	85%	80%	70%	

PLACEHOLDER FOR THE 2016 IHS ENCOUNTER RATE

CMS 100% FMAP UPDATE FOR SERVICES "RECEIVED THROUGH" AN IHS/TRIBAL FACILITY AND FURNISHED TO MEDICAID ELIGIBLE AI/AN CLIENTS

FMAP

Federal Medical Assistance Percentage (FMAP)

The Medicaid program is jointly funded by the federal government and states (from CMS)

	AI/AN client at IHS/638 facility	Non-AI/AN classic client at IHS/638 facility	AI/AN classic client at specialty clinic	Non-AI/AN classic client at specialty clinic
Claim payment	$350	$350	$123.00	$123.00
State match	$0	$175	61.50	61.50
Federal match	$350	$175	61.50	61.50
FMAP comment	100% FMAP (AI/AN at IHS/Tribal facility)	50% FMAP	50% FMAP	50% FMAP

100% FMAP

100 percent FMAP will be available for services that are either furnished directly by the facility to a Medicaid-eligible AI/AN patient or by a non-IHS/Tribal provider when the service is provided at the request of an IHS/tribal facility practitioner on behalf of his or her patient and the patient remains in the Tribal facility practitioner's care in accordance with a written care coordination arrangements (CMS)

100% FMAP

(a) services furnished by the facility to a AI/AN patient, or
(b) by a non-IHS/Tribal provider when the service is provided at the request of an IHS/tribal facility practitioner on behalf of his or her patient and the patient remains in the Tribal facility practitioner's care in accordance with a written care coordination arrangements

	AI/AN client at IHS/638 facility	Non-AI/AN classic client at IHS/638 facility	AI/AN classic client at specialty clinic with care coordination agreement with Tribal facility	Non-AI/AN classic client at specialty clinic
Claim payment	$350	$350	$123.00	$123.00
State match	$0	$175	$0	61.50
Federal match	$350	$175	$123	61.50
FMAP comment	100% FMAP (AI/AN) (a)	50% FMAP	100% FMAP (b)	50% FMAP

MCO ENROLLED AI/AN CLIENTS BEING ENROLLED INTO BHO

MCO Clients auto-enrolled into BHSO

AI/AN MCO clients in Clark and Skamania counties are being enrolled into BHSOs beginning April 1st with no option to re-enroll back in the MCO.

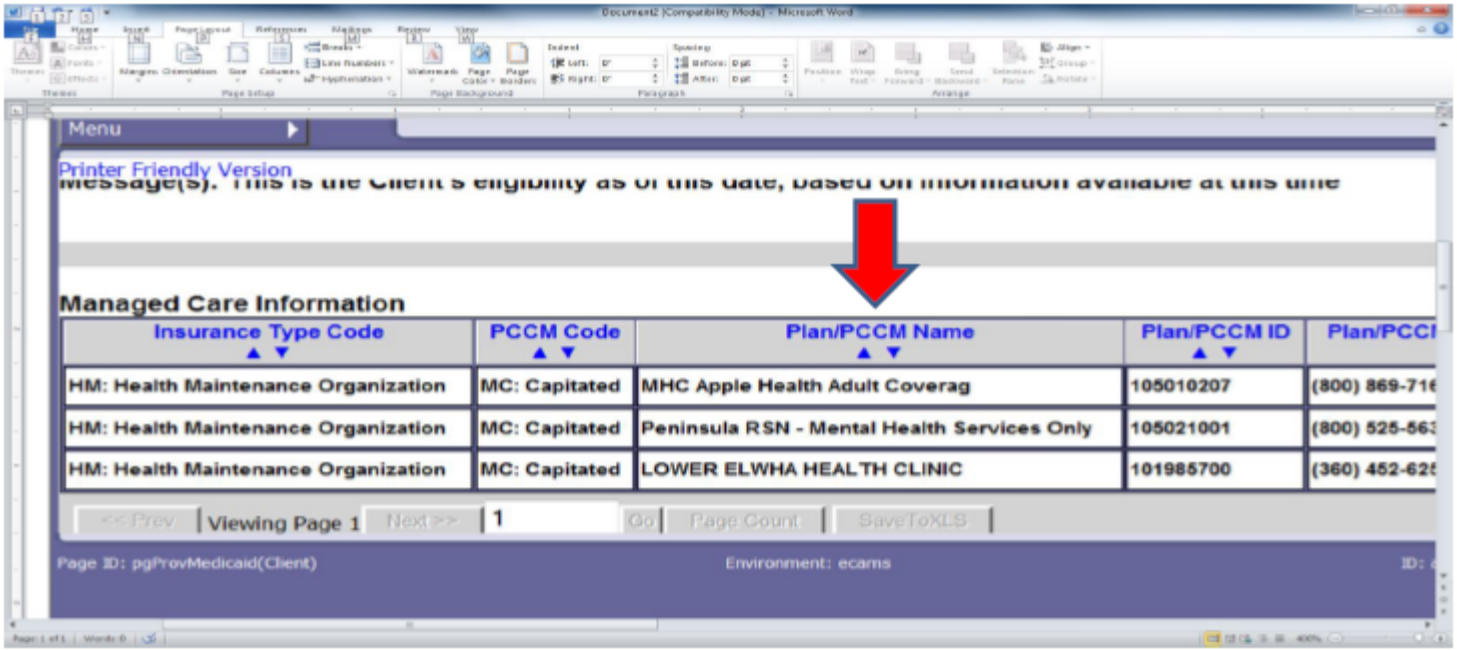
High priority issue being addressed by software vendor.

MCO Clients auto-enrolled into BHSO

Client's Managed Care Information tab in P1 can have 3 types of Managed Care plans

- True Managed Care (Amerigroup, Columbia United Providers, Community Health Plan of Washington, Coordinated Care, Molina Healthcare, United Healthcare Community Plan)
- Behavioral Health (RSN and BHSO)
- Primary Care Case Management (PCCM)

This client has PCCM, Managed care and RSN



NOTE: PCCM and Managed care do not occur during the same date-spans, screen shot does not include the dates

DIAGNOSIS CODES FOR SUD SERVICES BEGINNING APRIL 1ST

SUD ICD-10 coding beginning April 1st

Refer to the Access to Care Standards and ICD information page at

https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/access-care-standards-acs-and-icd-information

The allowable ICD-10 diagnosis codes for SUD services will be posted in the Tribal Health Billing Guide

SUD ICD-10 coding beginning April 1st

ICD-10-CM Code	Description
F10.10	*Alcohol abuse, uncomplicated* Alcohol use disorder, Mild
F10.129	*Alcohol abuse with intoxication, unspecified* Alcohol intoxication, With mild use disorder
F10.20	*Alcohol dependence, uncomplicated* Alcohol use disorder, Moderate Alcohol use disorder, Severe
F10.229	*Alcohol dependence with intoxication, unspecified* Alcohol intoxication, With moderate or severe use disorder
F10.259	*Alcohol dependence with alcohol-induced psychotic disorder, unspecified* Alcohol-induced psychotic disorder, With moderate or severe use disorder
F11.10	*Opioid abuse, uncomplicated* Opioid use disorder, Mild
F11.129	*Opioid abuse with intoxication, unspecified* Opioid intoxication, With perceptual disturbances, With mild use disorder
F11.20	*Opioid dependence, uncomplicated* Opioid use disorder, Moderate Opioid use disorder, Severe
F11.221	*Opioid dependence with intoxication delirium* Opioid intoxication delirium, With moderate or severe use disorder
F11.222	*Opioid dependence with intoxication with perceptual disturbance* Opioid intoxication, with perceptual disturbances, With moderate or severe use disorder
F11.229	*Opioid dependence with intoxication, unspecified* Opioid intoxication, Without perceptual disturbances, With moderate or severe use disorder

SUD ICD-10 coding beginning April 1st

ICD-10-CM Code	Description
F11.23	*Opioid dependence with withdrawal* Opioid withdrawal Opioid withdrawal delirium
F11.24	*Opioid dependence with opioid-induced mood disorder* Opioid-induced depressive disorder, With moderate or severe use disorder
F11.281	*Opioid dependence with opioid-induced sexual dysfunction* Opioid-induced sexual dysfunction, With moderate or severe use disorder
F11.282	*Opioid dependence with opioid-induced sleep disorder* Opioid-induced sleep disorder, With moderate or severe use disorder
F11.288	*Opioid dependence with other opioid-induced disorder* Opioid-induced anxiety disorder, With moderate or severe use disorder
F12.10	*Cannabis abuse, uncomplicated* Cannabis use disorder, Mild
F12.129	*Cannabis abuse with intoxication, unspecified* Cannabis intoxication, Without perceptual disturbances, With mild use disorder
F12.20	*Cannabis dependence, uncomplicated* Cannabis use disorder, Moderate Cannabis use disorder, Severe
F12.221	*Cannabis dependence with intoxication delirium* Cannabis intoxication delirium, With moderate or severe use disorder
F12.229	*Cannabis dependence with intoxication, unspecified* Cannabis intoxication, With perceptual disturbances, With moderate or severe use disorder
F12.259	*Cannabis dependence with psychotic disorder, unspecified* Cannabis-induced psychotic disorder, With moderate or severe use disorder
F12.280	*Cannabis dependence with cannabis-induced anxiety disorder* Cannabis-induced anxiety disorder, With moderate or severe use disorder

SUD ICD-10 coding beginning April 1st

ICD-10-CM Code	Description
F13.10	*Sedative, hypnotic or anxiolytic abuse, uncomplicated* Sedative, hypnotic, or anxiolytic use disorder, Mild
F13.129	*Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified* Sedative, hypnotic, or anxiolytic intoxication, With mild use disorder
F13.20	*Sedative, hypnotic or anxiolytic dependence, uncomplicated* Sedative, hypnotic, or anxiolytic use disorder, Moderate Sedative, hypnotic, or anxiolytic use disorder, Severe
F13.221	*Sedative, hypnotic or anxiolytic dependence with intoxication delirium* Sedative, hypnotic, or anxiolytic intoxication delirium, With moderate or severe use disorder
F13.229	*Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified* Sedative, hypnotic, or anxiolytic intoxication, With moderate or severe use disorder
F13.231	*Sedative, hypnotic or anxiolytic dependence with withdrawal delirium* Sedative, hypnotic, or anxiolytic withdrawal delirium
F13.232	*Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance* Sedative, hypnotic, or anxiolytic withdrawal, With perceptual disturbances
F13.239	*Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified* Sedative, hypnotic, or anxiolytic withdrawal, Without perceptual disturbances
F13.24	*Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder* Sedative-, hypnotic, or anxiolytic-induced depressive disorder, With moderate or severe use disorder
F13.259	*Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified* Sedative-, hypnotic-, or anxiolytic-induced psychotic disorder, With moderate or severe use disorder

SUD ICD-10 coding beginning April 1st

ICD-10-CM Code	Description
F13.27	*Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia* Sedative-, hypnotic-, or anxiolytic-induced major neurocognitive disorder, With moderate or severe use disorder
F13.280	*Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder* Sedative-, hypnotic-, or anxiolytic-induced anxiety disorder, With moderate or severe use disorder
F13.281	*Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction* Sedative-, hypnotic-, or anxiolytic-induced sexual dysfunction, With moderate or severe use disorder
F13.282	*Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder* Sedative-, hypnotic-, or anxiolytic-induced sleep disorder, With moderate or severe use disorder
F13.288	*Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder* Sedative-, hypnotic-, or anxiolytic-induced mild neurocognitive disorder, With moderate or severe use disorder
F14.10	*Cocaine abuse, uncomplicated* Cocaine use disorder, Mild
F14.122	*Cocaine abuse with intoxication with perceptual disturbance* Cocaine intoxication, With perceptual disturbances, With mild use disorder
F14.129	*Cocaine abuse with intoxication, unspecified* Cocaine intoxication, Without perceptual disturbances, With mild use disorder
F14.20	*Cocaine dependence, uncomplicated* Cocaine use disorder, Moderate Cocaine use disorder, Severe

SUD ICD-10 coding beginning April 1st

ICD-10-CM Code	Description
F14.221	*Cocaine dependence with intoxication delirium* Cocaine intoxication delirium, With moderate or severe use disorder
F14.222	*Cocaine dependence with intoxication with perceptual disturbance* Cocaine intoxication, With perceptual disturbances, With moderate or severe use disorder
F14.229	*Cocaine dependence with intoxication, unspecified* Cocaine intoxication, Without perceptual disturbances, With moderate or severe use disorder
F14.23	*Cocaine dependence with withdrawal* Cocaine withdrawal
F14.24	*Cocaine dependence with cocaine-induced mood disorder* Cocaine-induced bipolar and related disorder, With moderate or severe use disorder Cocaine-induced depressive disorder, With moderate or severe use disorder
F14.259	*Cocaine dependence with cocaine-induced psychotic disorder, unspecified* Cocaine-induced psychotic disorder, With moderate or severe use disorder
F14.280	*Cocaine dependence with cocaine-induced anxiety disorder* Cocaine-induced anxiety disorder, With moderate or severe use disorder
F14.281	*Cocaine dependence with cocaine-induced sexual dysfunction* Cocaine-induced sexual dysfunction, With moderate or severe use disorder
F14.282	*Cocaine dependence with cocaine-induced sleep disorder* Cocaine-induced sleep disorder, With moderate or severe use disorder
F14.288	*Cocaine dependence with other cocaine-induced disorder* Cocaine-induced obsessive-compulsive and related disorder, With moderate or severe use disorder
F15.10	*Other stimulant abuse, uncomplicated* Amphetamine-type substance use disorder, Mild Other or unspecified stimulant use disorder, Mild

SUD ICD-10 coding beginning April 1st

ICD-10-CM Code	Description
F15.122	*Other stimulant abuse with intoxication with perceptual disturbance* Amphetamine or other stimulant intoxication, With perceptual disturbances, With mild use disorder
F15.129	*Other stimulant abuse with intoxication, unspecified* Amphetamine or other stimulant intoxication, Without perceptual disturbances, With mild use disorder
F15.159	*Other stimulant abuse with stimulant-induced psychotic disorder, unspecified* Amphetamine (or other stimulant)-induced psychotic disorder, With mild use disorder
F15.20	*Other stimulant dependence, uncomplicated* Amphetamine-type substance use disorder, Moderate Amphetamine-type substance use disorder, Severe Other or unspecified stimulant use disorder, Moderate Other or unspecified stimulant use disorder, Severe
F15.221	*Other stimulant dependence with intoxication delirium* Amphetamine (or other stimulant) intoxication delirium, With moderate or severe use disorder
F15.222	*Other stimulant dependence with intoxication with perceptual disturbance* Amphetamine or other stimulant intoxication, With perceptual disturbances, With moderate or severe use disorder
F15.229	*Other stimulant dependence with intoxication, unspecified* Amphetamine or other stimulant intoxication, Without perceptual disturbances, With moderate or severe use disorder
F15.23	*Other stimulant dependence with withdrawal* Amphetamine or other stimulant withdrawal
F15.24	*Other stimulant dependence with stimulant-induced mood disorder* Amphetamine (or other stimulant)-induced bipolar and related disorder, With moderate or severe use disorder Amphetamine (or other stimulant)-induced depressive disorder, With moderate or severe use disorder

SUD ICD-10 coding beginning April 1st

ICD-10-CM Code	Description
F15.259	*Other stimulant dependence with stimulant-induced psychotic disorder, unspecified* Amphetamine (or other stimulant)-induced psychotic disorder, With moderate or severe use disorder
F15.280	*Other stimulant dependence with stimulant-induced anxiety disorder* Caffeine-induced anxiety disorder, With moderate or severe use disorder
F15.281	*Other stimulant dependence with stimulant-induced sexual dysfunction* Amphetamine (or other stimulant)-induced sexual dysfunction, With moderate or severe use disorder
F15.282	*Other stimulant dependence with stimulant-induced sleep disorder* Amphetamine (or other stimulant)-induced sleep disorder, With moderate or severe use disorder Caffeine-induced sleep disorder, With moderate or severe use disorder
F15.288	*Other stimulant dependence with other stimulant-induced disorder* Amphetamine (or other stimulant)-induced obsessive-compulsive and related disorder, With moderate or severe use disorder
F16.10	*Hallucinogen abuse, uncomplicated* Other hallucinogen use disorder, Mild Phencyclidine use disorder, Mild
F16.129	*Hallucinogen abuse with intoxication, unspecified* Other hallucinogen intoxication, With mild use disorder Phencyclidine intoxication, With mild use disorder
F16.20	*Hallucinogen dependence, uncomplicated* Other hallucinogen use disorder, Moderate Other hallucinogen use disorder, Severe Phencyclidine use disorder, Moderate Phencyclidine use disorder, Severe

SUD ICD-10 coding beginning April 1st

ICD-10-CM Code	Description
F16.221	*Hallucinogen dependence with intoxication with delirium* Other hallucinogen intoxication delirium, With moderate or severe use disorder Phencyclidine intoxication delirium, With moderate or severe use disorder
F16.229	*Hallucinogen dependence with intoxication, unspecified* Other hallucinogen intoxication, With moderate or severe use disorder Phencyclidine intoxication, With moderate or severe use disorder
F16.24	*Hallucinogen dependence with hallucinogen-induced mood disorder* Other hallucinogen-induced bipolar and related disorder, With moderate or severe use disorder Other hallucinogen-induced depressive disorder, With moderate or severe use disorder Phencyclidine-induced depressive disorder, With moderate or severe use disorder
F16.259	*Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified* Other hallucinogen-induced psychotic disorder, With moderate or severe use disorder Phencyclidine-induced psychotic disorder, With moderate or severe use disorder
F16.280	*Hallucinogen dependence with hallucinogen-induced anxiety disorder* Other hallucinogen-induced anxiety disorder, With moderate or severe use disorder Phencyclidine-induced anxiety disorder, With moderate or severe use disorder
F18.10	*Inhalant abuse, uncomplicated* Inhalant use disorder, Mild
F18.159	*Inhalant abuse with inhalant-induced psychotic disorder, unspecified* Inhalant-induced psychotic disorder, With mild use disorder
F18.180	*Inhalant abuse with inhalant-induced anxiety disorder* Inhalant-induced anxiety disorder, With mild use disorder
F18.188	*Inhalant abuse with other inhalant-induced disorder* Inhalant-induced mild neurocognitive disorder, With mild use disorder

SUD ICD-10 coding beginning April 1st

ICD-10-CM Code	Description
F18.20	*Inhalant dependence, uncomplicated* Inhalant use disorder, Moderate Inhalant use disorder, Severe
F18.221	*Inhalant dependence with intoxication delirium* Inhalant intoxication delirium, With moderate or severe use disorder
F18.229	*Inhalant dependence with intoxication, unspecified* Inhalant intoxication, With moderate or severe use disorder
F18.24	*Inhalant dependence with inhalant-induced mood disorder* Inhalant-induced depressive disorder, With moderate or severe use disorder
F18.259	*Inhalant dependence with inhalant-induced psychotic disorder, unspecified* Inhalant-induced psychotic disorder, With moderate or severe use disorder
F18.280	*Inhalant dependence with inhalant-induced anxiety disorder* Inhalant-induced anxiety disorder, With moderate or severe use disorder
F18.288	*Inhalant dependence with other inhalant-induced disorder* Inhalant-induced mild neurocognitive disorder, With moderate or severe use disorder
F19.10	*Other psychoactive substance abuse, uncomplicated* Other (or unknown) substance use disorder, Mild
F19.20	*Other psychoactive substance dependence, uncomplicated* Other (or unknown) substance use disorder, Moderate Other (or unknown) substance use disorder, Severe

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. Payments are being taken back with EOB N55: *"Procedures for billing with group / referring / performing providers were not followed."* These are billed the way we always have, are you able to tell me what they want different?

A. Tribal Health claims that were recouped in error have been reprocessed

P1 was updated in December to correct payment issues and bring P1 into compliance with federal requirements. The policy for radiology referrals was re-reviewed and P1 was re-updated in late February. The following slide has the current referring NPI rules that are in P1

Questions Log

Referring Provider Requirements (continued)

A referring NPI is not always required, however, if a referring NPI is on a claim then the referring NPI must be a valid NPI in P1.

When is a referring NPI required on a P1 claim?

- Consultations (CPT 99241-99245, 99251-99255, 99261-99263, 99271-99275),
- Global (no modifier) or technical (modifier TC) components of x-rays (CPT 70000-79999), unless rendered in an office setting (POS 05 07 11), or
- If the claim is billed by
  - Physical, Speech, and Occupational Therapists, Dieticians (and interpreter services, prosthetists, home infusion agencies, DD facilities, labs, Durable Medical Equipment (DME) suppliers, pharmacies)
- For the 3 examples above, the referring NPI must be a "person" (not a billing group) and must be different from the servicing NPI on the claim (except for radiology) (red font is being re-reviewed by policy folks)

Questions Log

Q. We are getting overpaid on claims for IUD/implant insertions

A. The overpayments were for the professional service of inserting IUD/implant (CPT 11981, 11983 or 58300). If the billed amount on these 3 codes is less than the fee schedule amount, P1 is currently overpaying. HCA is researching this issue.

Reminder, IUDs (and pharmaceuticals/drugs that are filled outside of the clinical visit) can be billed separately from the encounter and paid fee-for-service, along with (in addition to) the encounter.

Many IUDs/pharmaceuticals are payable on a professional claim and in the Pharmacy system. Do not bill for the same service/product in both systems

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. Telemedicine currently does not meet the CMS definition of "face to face", does it 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

WAC 182 531 1730 http://apps.leg.wa.gov/wac/default.aspx?cite=182-531-1730

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 not 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

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

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Usually the Medicare crossovers that are received by the agency have 3 items that can be corrected while in the P1 screens doing a "Resubmit Denied/Voided claim":

1. billing taxonomy must be encounter eligible (usually 208D00000x)
   note: if you bill Medicare with this taxonomy Medicare should forward to P1
2. appropriate AI/AN or non-native modifiers need to be added
3. T1015 line needs to be added

Questions Log

Q. Should IUDs/implants be billed in the POS or the HCFA system?

A. Many drugs (IUDs/implants are considered drugs) are payable on a professional (HCFA) claim as well as in the POS system.

Questions Log

Q. Is Shasta primary or secondary?

A. Stay Tuned

Interim answer – if the insurance is secondary (IHS is secondary to Medicaid) then do not include it on the claims because it could delay the processing of the claim

Questions Log

Q. Can we balance bill (bill the client) for the balance owing after Medicare?

A. No, balance billing is not allowed

https://med.noridianmedicare.com/web/jfb/article-detail/-/view/10546/prohibition-on-balance-billing-dually-eligible-individuals-enrolled-in-the-qmb-program-second-revision

Questions Log

Q. Do I need prior auth for AEM?

A1. If question asked between 10/14/2015-02/29/2016:

Yes, As of November 1st 2015, all claims related to the Alien Emergency Medical program must contain an authorization number for the diagnosis submitted that qualified the client for this program.

The Health Care Authority is currently working on providing accurate information to our providers that serve the Alien Emergency Medical population. In doing so, a letter is being developed for providers that outline the client's benefit coverage, dates of eligibility and qualifying diagnosis required for claims submission.

To obtain the assigned authorization number and diagnosis information for ERSO/AEM clients, please contact the Medical Authorization line:

Phone: 1-800-562-3022, extension: Medical/Enteral: 15471

A2. if question asked after 02/29/2016

The policy is currently being reviewed. An Emergency Related Services Only (ERSO) billing guide is anticipated to be published for April 1st

Questions Log

Q. Does Medicaid have an exclusions list for providers who are excluded from billing Medicaid? We check the OIG exclusions list and the SAMSA list but I attended a workshop that stated many states also have their own exclusion list for Medicaid and these should be checked as well.

A. yes
http://www.hca.wa.gov/medicaid/provider/documents/termination_exclusion.pdf

Questions Log

Q. What do I do when I get EOB N61 on a Mental Health claim?

A. Call mike. Some clients have dual eligibility in P1 (eg, Apple Health + department of corrections or Apple Health + Social Services). P1 is erroneously picking the non-Apple Health eligibility on some claims.

P1 correction scheduled for April 1st, mike will reprocess claims after P1 correction

Questions Log

Q. What if the client's primary insurance only covers the service in certain settings? For example, Regence states that only face to face services performed in an office setting are covered for behavioral health and yet P1 pays for behavioral health in non-office settings (where clinically appropriate)

A. A claim note seems to help alert the Coordination of Benefits staff. Following is an example of a claim note that could be used: **Regence BlueShield does not cover services performed outside of the office**

Questions Log

Q. Chemical dependency used to be payable only if a dependence diagnosis and youth/pregnant clients were payable if abuse or dependence diagnosis, I do not remember any trainings that included this new information relating to ICD-10. Is this in writing somewhere or in a TWG meeting minutes? This is really helpful news for our clients and providers.

A. There is no longer a different allowable diagnosis code set for adults and youth. There is also an expanded code-set beginning April 1st (covered in this webinar)

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

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.