Washington State Health Care Authority

Tribal Billing Workgroup (TBWG)

April 8, 2015
Mike Longnecker
HCA Tribal Affairs Office

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Agenda

- Monthly data and analysis
- TBWG/M3 2015 schedule
- Enrolling new servicing providers
- Presumptive SSI (RAC 1217) and non-Native chem dep
- Children's Mental Health
- May 13 Billing Workgroup emphasis will be on Mental Health billing
- Billing guide is posted on line
- MCO update and contact list
- FAQ and Open Discussion

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February 2015 Claims Data (I/T/U)

	Dollars	clients*	% of claims paid	% prev month
Totals	5,218,861	10,711	See categories	
Medical	$1,348,374	4041	81%	83%
Dental	$663,155	2016	82%	87%
MH	$716,314	981	93%	90%
CD	$2,028,935	999	84%	96%
POS	$451,846	5339	59%	60%
Other FFS	$10,234	183	19%	12%**

* Client count will not be the sum from the categories due to 'overlap' (clients can be in more than 1 category)
** most of the claims are Medicare crossovers that come directly from Medicare

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Medical Claims – Top Denials

EOB	Description	Comments
16 N288	Missing / incomplete / invalid rendering provider taxonomy	Claims had a servicing taxonomy that the provider is not enrolled with. Two possible resolutions: 1.Change the claims so that they are submitted with the taxonomy that the provider is enrolled with 2.Update the provider's file to include the taxonomy that is being billed (if appropriate, a *brain surgeon* taxonomy would not be for a GP Dr). Let Mike know if you choose this option – we can reprocess claims for you after the provider's file is updated. Not sure what the provider is enrolled with? a. Contact Mike or b. you can look in P1 to see what the provider is enrolled with and make changes. Go to page 147 of this Dental workshop/webinar
24	Charges are covered under a capitation agreement managed care plan	Client is Enrolled in one of the Managed Care Plans

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Medical Claims – Top Denials

EOB	Description	Comments
18	Exact duplicate claim/service	Duplicate billing
167	This (these) diagnosis(es) is (are) not covered	Medicaid does not consider some diagnosis codes eligible for **medical** treatment. Many claims had CD diagnoses (303-305) NOTE: 1. Office visit for prescribing Campral, ReVia, Vivitrol, Buprenorphine, Suboxone is covered – refer to physician guide, P. 257 for criteria. 1. Office visit for Suboxone and Buprenorphine are carved out of Managed Care (bill P1 directly for clients enrolled in Managed Care). Claim note of "bupren" or "suboxone" helps avoid denial errors
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	AI/AN or non-native modifier was missing

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Medical Claims – Top Denials

EOB	Description	Comments
31	Patient cannot be identified as our insured	Client ID usually invalid but sometimes there is a space after the "WA" – P1 treats the space as a value and it makes the ID invalid If rebilling in the P1 screens the space issue gets automatically fixed (P1 screens ignore the space and if client ID is invalid you will get an error popup before submitting the claim)
16 N290	Missing/incomplete/invalid rendering provider primary identifier	See slide New Servicing Providers
16 N329	Missing /incomplete /invalid patient birth date	Usually incorrect birthday on claim. If you think you have the right birthday on the claim or are unsure, contact Mike
22	This Care may be covered by another payer per coordination of benefits	Client has Medicare

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Dental Claims – Top Denials

EOB	Description	Comments
18	Exact duplicate claim/service	Duplicate billing
16 N288	Missing/incomplete /invalid rendering provider taxonomy	Claims had a servicing taxonomy that the provider is not enrolled with. Two possible resolutions: 1. Change the claims so that they are submitted with the taxonomy that the provider is enrolled with 2. Update the provider's file to include the taxonomy that is being billed (if appropriate, an *Oral Surgeon* taxonomy would not be for a general dentist). Let Mike know if you choose this option, we can reprocess the claims for you. Not sure what the provider is enrolled with? a. Contact Mike or b. you can look in P1 to see what the provider is enrolled with and make changes. Go to page 147 of this Dental workshop/webinar
16 N290	Missing/incomplete/ invalid rendering provider primary identifier	See slide New Servicing Providers

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Dental Claims – Top Denials

EOB	Description	Comments
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)
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage
119	Benefit maximum for this time period or occurrence has been reached	Various frequency limits in the dental program for office visits, cleanings, fluorides, etc. Refer to Dental Limit Table in March TBWG slides

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Dental Claims – Top Denials

EOB	Description	Comments
96 N59	Non-covered charge(s).	Common codes were D1330 and Crowns D1330 is only for younger clients (0-8). Clients 9 years or older the hygiene is bundled into the prophy (D1110/D1120) Crowns are only allowed for clients 15-20 years old and require Prior Authorization
31	Patient cannot be identified as our insured	Client ID usually invalid but sometimes there is a space after the "WA" – P1 treats the space as a value and it makes the ID invalid If rebilling in the P1 screens the space issue gets automatically fixed (P1 screens ignore the space and if client ID is invalid you will get an error popup before submitting the claim)
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
A1 N192	Patient is a Medicaid/Qualified Medicare Beneficiary	QMB-only clients are only eligible for fee for service secondary to Medicare

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Mental Health Claims - Top Denials

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

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Mental Health Claims - Top Denials

EOB	Description	Comments
16 N290	Missing/incomplete/invalid rendering provider primary identifier	See slide New Servicing Providers
18	Exact duplicate claim/service	Duplicate billing
A1 N192	Patient is a Medicaid/Qualified Medicare Beneficiary	QMB-only clients are only eligible for fee for service secondary to Medicare

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Mental Health Claims - Top Denials

EOB	Description	Comments
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
200	Expenses occurred during lapse in coverage	There was an issue for a couple of months with the clients who were assigned the SSI RAC (1217). All claims identified during review have been reprocessed by Mike
16 N329	Missing/incomplete/invalid patient birth date	Usually incorrect birthday on claim. If you think you have the right birthday on the claim or are unsure, contact Mike

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Chemical Dependency Claims – Top Denials

EOB	Description	Comments
18	Exact duplicate claim/service	Duplicate billing
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-native client – SCI=NN Also see EOB code #4 below
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Refer to table at end of presentation. 1. Modifier on billing code is *always* HF 2. Modifier on T1015 is a. AI/AN client – HF b. non-native: 1. ABP (RAC 1201) - SE 2. presumptive SSI (RAC 1217) - HB 3. all others - HX

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2015 IHS encounter rate

- Federal Register vol 80 No. 66 April 7, 2015

	Calendar Year 2015
Inpatient Hospital Per Diem Rate (Excludes Physician/Practitioner Services)	
Lower 48 States	$2,443
Alaska	2,926
Outpatient Per Visit Rate (Excluding Medicare)	
Lower 48 States	350
Alaska	601
Outpatient Per Visit Rate (Medicare)	
Lower 48 States	307
Alaska	564
Medicare Part B Inpatient Ancillary Per Diem Rate	
Lower 48 States	516
Alaska	956

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2015 Meeting Schedule

Tribal Billing Workgroup (TBWG) Second Wednesday (* unless noted) 9:00-10:00 AM	Medicaid Monthly Meeting (M3) Fourth Wednesday 9:00-10:00 AM
April 8	April 22
May 13 – Focus on Mental Health	May 27
June 10	June 24
July 8	July 22
August 12	August 26
September 9	September 23
October 14	October 28
November 12 (* Thursday)	November 25
December 9	December 23

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New Servicing Providers

- Do not bill claims for new servicing providers until they are enrolled in ProviderOne – P1 is a drop-down design and if claims are billed before the new provider's NPI is loaded in the system P1 will remove it from the claim
- Suggested process/timeline for new providers
  - Do not bill any claims yet
  - Dental Webinar (p. 162) outlines the steps for enrolling a new servicing provider http://www.hca.wa.gov/medicaid/provider/documents/medicaid101dentalworkshop_2014.pdf
  - After step 18 touch base with Mike and wait for the OK to bill claims
  - Does provider need to get back-dated? Send in the back-date request form (12-333)
- Mike can reprocess claims after provider is back-dated

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Non-Native Chem Dep

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

Client RAC	Claim note	T1015 modifier	Amount claim pays	Amount for IGT
MAGI (not 1217 or 1201)	SCI=NN	HX	50%	50%
Alternative Benefit Plan	SCI=NN	SE	100%	0%
Presumptive SSI	SCI=NN	HB	TBD, probably 75%	TBD, probably 25%

- Claims for presumptive SSI clients are not paying correctly. Worst case ETA is June, 2015

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Children's Mental Health

Except for psychologists and psychiatrists, providers who render mental health services for clients 18 years of age and younger must write and sign a letter attesting to a minimum of two years' experience in providing mental health services to children, youth and their families.

- Mental Health Billing Guide, page 10
- Policy has been in place since 01/01/2014
- Blank Mental Health Provider attestation forms can be sent directly to Mike, email or fax (360)586-9551

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Mental Health Q&A on May 13

- Billing workgroup for May 13 will focus on Mental Health services
- The May 13th date will give me time to ensure that the newly adopted RSN modalities are paying in P1
- Please send any Mental Health billing/coding/policy questions to me (during webinar or via email) – I will share the questions (anonymously) with our Mental Health experts
- Hope to have a productive Q&A on May 13th

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Billing Guide

- Tribal Health Program Provider Guide is posted on line.

  http://www.hca.wa.gov/medicaid/billing/documents/guides/tribal_health_program_bi.pdf
- Questions/comments/concerns?

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Managed Care Denials

- MCO will only pay noncontracted providers if the client is AI/AN in ProviderOne – you do not have a way to tell if a client is coded as AI/AN in P1. Please forward MCO denials to Mike to check client Coding in the system. Sometimes the clients will need to be updated to AI/AN. MCOs request a 4 week turnaround before claim is rebilled
- After verifying that the client is coded correctly you can forward the EOB directly to the MCO, this will most likely result in the best response time from the MCOs (please batch the EOBs per MCO so that client information is not inadvertently sent to the wrong payer)
- Claims denied by HCA/P1 can be sent to Mike, as always – a claim number (TCN) is all I need

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Managed Care Organization Contacts

Managed Care Plan	General Contact Information	Single Point of Contact for Tribes
Amerigroup RealSolutions in healthcare	Customer Service: 1-800-600-4441 Website: www.amerigroup.com Provider line: 1-800-454-3730	Elizabeth Peterson Regulatory Oversight Manager Elizabeth.peterson@amerigroup.com 206 674 4485 (direct), 206 674 4466 (fax)
Columbia United Providers	Customer Service: 1-800-315-7862 Website: https://www.cuphealth.com/home Provider line:	
COMMUNITY HEALTH PLAN of Washington	Customer Service: 1-800-440-1561 Website: www.chpw.org Provider line: 1-800-440-1561	Thomas Melville Contract Administrator thomas.melville@chpw.org 206 652 7282 (direct), 206 521 8834 (fax)
coordinated care	Customer Service: 1-877-644-4613 Website: www.coordinatedcarehealth.com Provider line: 1-877-644-4613	Daniel Mero Provider Relations Representative dmero@centene.com 253 370 9262 (direct), 877 644 4602 (fax)
MOLINA HEALTHCARE	Customer Service: 1-800-869-7165 Website: www.molinahealthcare.com Provider line: Phone: 1-800-869-7175	Crystal Cutter External Provider Service Representative crystal.cutter@molinahealthcare.com 425 424 1174 (direct), 877 814 0342 (fax)
UnitedHealthcare Community Plan	Customer Service: 1-877-542-8997 Website: www.uhccommunityplan.com Provider Line: 1-877-542-9231	Debra Butler Senior Physician Advocate debra_butler@uhc.com 360 871 8013 (direct), 855 576 1243 (fax)

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Open Questions and Open Discussion

- Please feel free to ask to be unmuted or use the questions pane
- If you think of questions or issues for the Billing workgroup later please send to Mike or Jessie
- Questions that have "stay tuned" for an answer or "interim" will stay on the log until answered

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Questions Log

At some point---- we believe our patients are being charged a $125 co-pay for glasses for the alternative benefit package. This is not allowed for AIANs (ARRA 2009) -can providers be reminded of this?

Please feel free to touch base with any Managed Care issues, appears that the biggest issue is that the plans do not know that the client is AI/AN ('Race code 4')

We have an average of 15 patients at any time with errors on the HCA side due to gender or DOB issues. They take six weeks to get repaired so we can re-process

Please feel free to contact Mike. A claim number avoids confidentiality issues. I freely reprocess claims after the system is fixed

I will never request you to rebill a claim unless there is something about how the claim was billed that needs to be changed

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Questions Log

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

Lab codes do not pay on Chem Dep claims

Urine Drug screens for Benzodiazepines, amphetamine/methamphetamine, cocaine, methadone, opiates, and barbiturates must be done before each prescription is dispensed during the first month of therapy. Clients must be enrolled in DBHR-certified treatment.

Refer to Suboxone drug screening Policy (page 120) and Expedited Prior Authorization Criteria Coding List (page 274) in the Physician-Related Services/Health Care Professional Services guide, page for drug screen coding

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Questions Log

Psychiatrists – Medical or Mental Health?

New billing guide offers choice of Medical or Mental Health

What about if the psychiatrist bills 30 min for mental Health and 30 min was Medical.

Pick one.

I understand that but what I am saying is what encounter would it be for the 30 min and 30 min psychotherapy would this be visit considered medical or Mental Health

If it is evenly 50/50 this is more difficult but is there more time/effort spent in one area?

But, will medical pay a psych dx?

Usually (too many nuances) but generally the psych diagnoses will pay on a medical claim (except chem dep)

over the past year - we started billing them under medical, then we switched to mental health - I don't think they're paying either way. I need to research and see if it's a taxonomy issue, etc

Please let me know, I can't help if I don't know it's broke

I like to say "don't even try to interpret the EOB codes, send my way and I'll try my best"

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Questions Log

We billed crisis codes 90839/90840 but the RSN code is H2011, how will we be paid for 90839/90840 already billed? Also should we change to H2011 and rebill?

Start billing with the *new* RSN modalities as soon as possible, let's make sure that your claims are paying.

If you have already billed for crisis services (or any other modality) you get a choice:

a. do a replacement claim with the new codes

b. touch base with Mike. We can change the codes for you. I will want to make sure that I have captured all the claims.

The new RSN modalities are payable at the encounter rate retroactive to 10/01/2012, when the billing model changed.

Mental Health Q&A meeting on 05/13

I think you already have my questions but I can send them again

Please send if you don't see the question in the sent-questions list. I would rather have too many questions than not enough

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Questions Log

Spend-down

We're having huge issues with spend-downs, especially the childrens' prior to 10/1/13. Any contact info with be appreciated

Spend-down claims applied to spend-down amount or do we need to send in an invoice to spend down dept?

Who is eligible to request a spend down through HCA? Classic Medicaid is understood, no questions.

Interim update:

- Eligibility Overview for Apple Health (Medicaid) – page 9 - http://www.hca.wa.gov/medicaid/publications/documents/22_315.pdf
- Spenddown Flyer – 2015
- HCA Medicaid Update: Spenddown Webinar - Session 7 (Spenddown) | Presentation Slides
- Apple Health (Medicaid) Manual: Medically Needy and Spenddown - http://www.hca.wa.gov/medicaid/manual/Pages/50-500.aspx

DSHS Customer Service Center can be reached at 1-877-501-2233 for questions regarding SSI-Related Spenddown coverage

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Questions Log

Medicare crossovers

it would be helpful if Medicare would accept T1015 on claims, they are rejecting them. If they accepted T1015 and denied as not covered then it would assist electronic processing of these claims

Contractors are rejecting the claim rather than deny the line.

Stay tuned, In the Interim –

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

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

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Questions Log

Pharmacists

What about PharmD's? encounter or FFS? Are we lobbying for pharmacists to be able to get encounter rate for med therapy management?

PharmD's are not encounter eligible at this time. What services can a pharmacist render on a professional/HCFA claim? Stay tuned

Interim update:

PharmD's are currently not encounter eligible but they are eligible to perform the following services:

Tobacco cessation for pregnant clients (physician billing guide)

Clozaril case management (physician billing guide)

Emergency contraception counseling (Pharmacy guide)

Vaccine administration fee (Pharmacy guide)

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Questions Log

Managed Care

Is there a way to get the medical claims to pay directly even if they have an MCO since they are Native and not required to have an MCO?

Stay tuned

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Thank you

Send TBWG comments and questions to:

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360-725-1315

Jessie Dean
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360-725-1649

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