Washington State Health Care Authority

Tribal Billing Workgroup (TBWG)

May 13, 2015
Mike Longnecker
HCA Tribal Affairs Office

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Agenda

- Monthly data and analysis
- Meeting schedule for 2015
- Case Management – review of billing guides
- 2015 IHS rate is in ProviderOne (except for non-native CD for presumptive SSI and classic medicaid clients)
- Mental Health Q&A
- FAQ and Open Discussion

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March 2015 Claims Data (I/T/U)

	Dollars	clients*	% of claims paid	% prev month
Totals	$6,236,300	14,241	See categories	
Medical	$1,645,754	4591	81%	81%
Dental	$788,238	2308	85%	82%
MH	$917,078	1089	94%	93%
CD	$2,245,835	1118	92%	84%
POS	$509,448	5892	59%	59%
Other FFS	$129,946	83	34%	19%

* 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	Denial %
24	Charges are covered under a capitation agreement managed care plan	Client is Enrolled in one of the Managed Care Plans	23%
16 N288	Missing / incomplete / invalid rendering provider taxonomy	Claims had a servicing taxonomy that the provider is not enrolled with. Two possible solutions: 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	16%

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Medical Claims – Top Denials

EOB	Description	Comments	Denial %
167	This (these) diagnosis(es) is (are) not covered	Medicaid does not consider some diagnosis codes eligible for **medical** treatment. 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	13%
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)	10%

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Medical 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	7%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	AI/AN or non-native modifier was missing	6%
18	Exact duplicate claim/service	Duplicate billing	6%
16 N329	Missing /incomplete /invalid patient birth date	Usually incorrect birthday on claim. Some claims had incorrect birthday and gender, which usually indicates the wrong client ID. If you think you have the right birthday on the claim or are unsure, contact Mike	2%

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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	13%
16 N288	Missing/incomplete /invalid rendering provider taxonomy	Claims had a servicing taxonomy that the provider is not enrolled with. Two possible solutions: 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). 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	12%
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	8%

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Dental Claims – Top Denials

EOB	Description	Comments	Denial %
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)	8%
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)	7%
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 2015 TBWG slides	6%

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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	7%
18	Exact duplicate claim/service	Duplicate billing	7%
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. RPMS users please contact the Portland Area Office for getting fix in to your system.	7%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	AI/AN or non-native EPA number was missing EPA for Native is 870001305 EPA for non-Native is 870001306 Some claims will need 2 authorization numbers, contact mike	4%

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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	31%
N20	Service not payable with other service rendered on the same date.	CPT code for MH visit had more than 1 unit on the line. Resolution – most CPT's that are not 'per x minutes' must be billed at 1 unit. CPT 90853 was observed most often	10%
A1 N192	Patient is a Medicaid/Qualified Medicare Beneficiary	QMB-only clients are only eligible for fee for service secondary to Medicare	8%

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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? 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	8%
N152	Missing/incomplete/invalid replacement claim information.	TCN being reprocessed has already been reprocessed. A claim number can only be reprocessed once. If a claim needs to be re-reprocessed then the last TCN is the TCN to reprocess	6%

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Mental Health 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	5%
16 N290	Missing/incomplete/ invalid rendering provider primary identifier	Servicing provider is not in ProviderOne. Get the provider enrolled and then remember to request a back-date if they started working before they were approved in P1	3%
18	Exact duplicate claim/service	Duplicate billing	2%

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Chemical Dependency Claims – Top Denials

EOB	Description	Comments	Denial %
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 *almost 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 3. Claim note still required a. AI/AN client SCI=NA b. non-native client SCI=NN	28%
18	Exact duplicate claim/service	Duplicate billing	24%
170	Payment is denied when performed/billed by this type of provider.	Usually happens when modifier HF is not on the billing code. Billing code (eg 96153 96154 96155 H0001) is almost always HF (refer to page 17-18 of CD guide).	6%

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Chemical Dependency Claims – Top Denials

EOB	Description	Comments	Denial %
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	6%
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage	6%
107	The related or qualifying claim/service was not identified on this claim	Claim had just a T1015 for the date of service	5%

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Chemical Dependency Claims – Top Denials

EOB	Description	Comments	Denial %
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	5%
16 N152	Missing/ incomplete/ invalid replacement claim information.	TCN already being reprocessed. A TCN can only be reprocessed one time, if a claim needs to be re-reprocessed then the most current TCN is the only one that is reprocessable	5%
181	Procedure code was invalid on the date of service	Claim was either a lab code or was a valid CD code but didn't have the HF modifier	5%

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2015 Meeting Schedule

Tribal Billing Workgroup (TBWG)
Second Wednesday (* unless noted)
9:00-10:00 AM

June 10
July 8 cancelled
August 12
September 9
October 14
November 12 (* Thursday)
December 9

Medicaid Monthly Meeting (M3)
Fourth Wednesday
9:00-10:00 AM

May 27
June 24
July 22
August 26
September 23
October 28
November 25
December 23

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Is Case Management Billable?

- Case Management is not an encounter eligible service but is payable on Fee-For-Service
- Billing Guides referenced below can be accessed from this link - http://www.hca.wa.gov/medicaid/billing/Pages/bi.aspx

MEDICAL services

- Refer to **Physician-Related Services/Healthcare Professional Services Provider Guide**
  - Clozaril case management is covered. Bill using applicable E&M code for drug monitoring (p. 62)
  - Bariatric case management is covered. Must be an approved Center of Excellence (p. 204)
- Refer to HIV AIDS Case Management provider guide. Must be approved by Department of Health (DOH)
- Refer to Maternity Support Services & Infant Case Management Provider Guide
- Refer to Applied Behavior Analysis Program for clients age 20 and Younger Provider Guide. ABA helps children/families with autism spectrum disorders or other developmental disabilities

DENTAL services

- Case management is not a covered service

Mental Health services

- Refer to Mental Health Services Provider Guide
  - Psychiatrists, Psychiatric ARNPs, and Psychiatric mental health nurse practitioners-board certified can provide some case management services (p. 15). Case Management is not listed as covered for LMHPs
- There is a Q&A from David Reed (DSHS/BHSIA/MH) that addresses why case management is not covered. The Mental Health Q&A accompanies this presentation.

Chemical Dependency services

- Refer to Chemical Dependency (outpatient) Provider Guide (definitions, p. 3-7. criteria p. 16. coding p18)

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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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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	TBD, probably 50.03%	TBD, probably 49.97%
Alternative Benefit Plan	SCI=NN	SE	100%	0%
Presumptive SSI	SCI=NN	HB	TBD, probably 80.01%	TBD, probably 19.99%

- Claims for presumptive SSI clients are not paying correctly. Current ETA is July, 2015

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Non-Native Chem Dep

- The Federal Match (FMAP) Rate varies depending on the date that the claim is received (not the date of service).
- Here are the FMAP rates for the ABP, Presumptive SSI and classic Medicaid clients

Client program	Federal Match Rate						
ABP	100% FMAP to 12/2016	95% FMAP to 12/2017	94% FMAP to 12/2018	93% FMAP to 12/2019	90% FMAP to 06/2021		
SSI	80.01% FMAP to 09/2015	80% FMAP to 12/2015	85% FMAP to 12/2016	86% FMAP to 12/2017	89.6% FMAP to 12/2018	93% FMAP to 12/2019	90% FMAP to 06/2021
Classic	50.03% FMAP to 09/2015	TBD					

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Mental Health Q&A

- Refer to Mental Health Questions Received and Forwarded (sent with webinar slides)
- Feel free to send any questions using the question pane or ask to be unmuted

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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

Would there be a way for Provider 1 to know the taxonomy without needing to populate it on a claim? Other payors can not send the Taxonomy (MCR) and therefore this is why it is your largest denial. If it was not required on the clm, but rather part of the provider build info in P1 then the denials would not occur

ProviderOne was designed to use Billing (required) and servicing (situational) taxonomy submitted on the claim. servicing taxonomy is situational, however on Professional claims that require a servicing NPI then servicing taxonomy is required.

Some CPT/HCPCS codes are shared among different programs and the billing taxonomy is what is used to tell the difference between the programs

Since Billing taxonomy is required the Tribal Affairs office opted to use Billing taxonomy to define the category of the service

Provider1 often does not match NPPES (National Plan & Provider Enumeration System)

The NPPES website is designed to issue, maintain, and validate NPIs, it is not used or designed to validate other information (such as taxonomies or demographic) that providers may have supplied the NPPES when acquiring their NPI

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Questions Log

Re: non-Native Chem dep that has State/Federal Matching funds

Should we bill the SSI when there is a match required?

Normally we send the match ahead of time and once received by you then we are allowed to submit the claims. Also, we won't know what amount to billed because of the match

Can we start using the non-native rate now also. Is this still 50%

See page 20 of current slides. This information is from HCA Accounting department and is pending approval and implementation from HCA Finance department.

WHEN CAN WE START USING THE NEW RATE

Feel free to start using the new rate at any time.

The rates for AI/AN clients and non-Native ABP CD claims are ready

The rates for non-Native Presumptive SSI and classic Medicaid are pending Finance approval

Claims that paid at the old (2014) rate will be reprocessed. ETA for reprocessing is mid-June

Re: ICD10 is launching this fall, is there going to be training available?

I heard the Portland coding training is full and not accepting anymore

I said that I would see what was offered in Portland (flyer is part of attachment with May TBWG)

Please....because we need to add one more coworker...thank you

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Questions Log

Re: let mike know if you want to ask the rest of the group for help

Is there any FQHC Tribal clinic contact that I may be able to access? (Kristen Garcia at Jamestown, krgarcia@hopepma.com)

I would like to work with other FQHC/Tribal organizations. Cynthia Trueblood with Seattle Indian Health Board 206-324-9360, ext. 1117. cynthiat@sihb.org

Phone numbers/emails shared after the April Billing Workgroup

Medicare issues (will be moved to the Medicare slide for future TBWG)

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

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Questions Log

During April TBWG Ed Fox shared the IHS encounter rate back to 2005 with a percentage increase/decrease. Here is a 25 year history

CY	IHS rate	Change from Previous year	
1990	$76	$4	5.5%
1991	$78	$2	2.6%
1992	$85	$7	9%
1993	$88	$3	3.5%
1994	$88	$0	0%
1995	$95	$7	8%
1996	$147	$52	54.7%
1997	$152	$5	3.4%
1998	$168	$16	10.5%
1999	$172	$4	2.4%
2000	$172	$0	0%
2001	$185	$13	7.6%
2002	$197	$12	6.5%

CY	IHS rate	Change from Previous year	
2003	$206	$9	4.6%
2004	$216	$10	4.9%
2005	$223	$7	3.2%
2006	$242	$19	8.5%
2007	$256	$14	5.8%
2008	$253	$-3	-1.2%
2009	$268	$15	5.9%
2010	$289	$21	7.8%
2011	$294	$5	1.7%
2012	$316	$22	7.5%
2013	$330	$14	4.4%
2014	$342	$12	3.6%
2015	$350	$8	2.3%

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Questions Log

CD diagnosis requirements

303.9x alcohol dependence, 304.9x drug dependence, 305.0x alcohol abuse, 305.9x drug abuse

5th digits: 0 unspecified, 1 continuous, 2 episodic, 3 in remission

DSM V example

305.00 mild presence of 2-3 symptoms, 303.90 moderate presence of 4-5 symptoms, 303.90 severe presence of 6 or more symptoms

The DSM V does not refer to the fifth digits for coding purposes. Only the ICD-9 or ICD-10 books refer to the use of the fifth digit codes.

The DSM V states

In early remission: After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, "Craving , or a strong desire or urge to use alcohol," may be met.

In sustained remission: After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, "Craving , or a strong desire or urge to use alcohol," may be met.

The ICD book does not have descriptions for: 1 continuous, 2 episodic, 3 in remission

Are there standards the auditors want to use? I would assume In Remission is for a period of 12 months or longer. I have been told this by a commercial ins. company that performed an audit of one patient's chart notes.

Any clarification or input would be appreciated. We really like only using the unspecified codes but want to be compliant for coding and billing

Continued on next page

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Questions Log

CD diagnosis requirements, continued

Draft answer - The short answer is, the state is not using DSM-V codes until October of this year. So the codes would not be accessible to bill until then. … … stay tuned

It has been brought to my attention that our chemical dependant 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?

The ordering provider doesn't have a billable service, just the lab (for this example)

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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.

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

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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)

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

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	Billing code modifier	T1015 modifier	Amount claim pays	Amount for IGT
MAGI (not 1217 or 1201)	SCI=NN	Follow the Chemical Dependency billing guide for modifiers required on the billing codes. (Almost always HF)	HX	TBD, probably 50.03%	TBD, probably 49.97%
Alternative Benefit Plan	SCI=NN		SE	100%	0%
Presumptive SSI (RAC 1217)	SCI=NN		HB	TBD, probably 80.01%	TBD, probably 19.99%

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

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Thank you

Send TBWG comments and questions to:

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