Washington State Health Care Authority

Tribal Compliance & Operations Work Group

Mike Longnecker
HCA Tribal Affairs Office
September 14, 2016

Washington State Health Care Authority

Agenda

- Guest Speaker – Paul Meury, Non-Emergency Medical Transportation
- Paper claims update for October, 2016
- NCCI and SUD services
- NCCI and medical services
- Billing P1 secondary to other insurance
- ProviderOne claims issue: MCO wraparounds
- ProviderOne claims issue: multiple encounters
- Billing for an assessment or evaluation if no diagnosis is made
- Top 5 denials
- FAQ and Open Discussion
- Attachments: (a) MCO contact list, (b) generally non-payable ICD-10 diagnosis codes, and (c) draft IHS/638 encounter rate billing

Washington State Health Care Authority

(NEMT)
Non-Emergency Medical Transportation

Name of Presenter: Paul Meury
Title: Supervisor of Transportation Unit
Division: Medicaid Program Operations & Integrity
Date: September 14, 2016

Brokered Transportation

Overview

Purpose:

- Provide transportation access to necessary non-emergency healthcare services for all eligible clients who have no other available means of gaining access to these services

- Pre-authorized access to covered healthcare services is provided by the most cost-effective mode which meets the clients' mobility status and personal capabilities

- NEMT services are authorized under 42 CFR 440.170 for Title XIX Medicaid clients; WACs: 182-546-5000 through 6000

Transportation Costs

- Transportation Program is a $75M program
- About 3.6 Million Trips / year; 13,000 Trips/day

- Costs keep rising as a result of:
  - ✓increasing caseloads (Medicaid Expansion)
  - ✓longer trips
  - ✓out-of-area costs
  - ✓clients may have less resources

Transportation Brokers

Central & Eastern Washington:

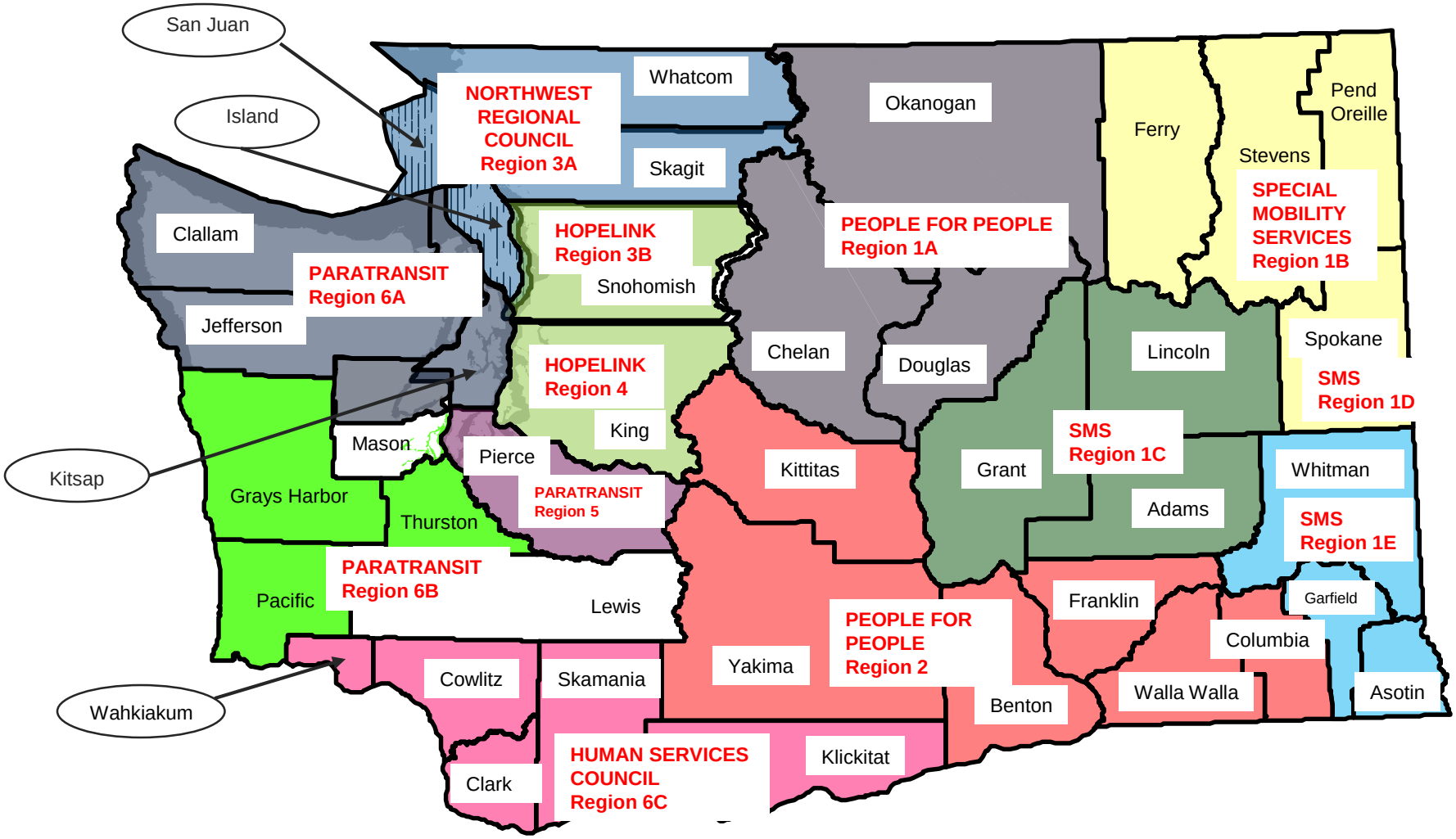
- **People for People:** Regions: 1A, 2
- **Special Mobility Services:** Regions: 1B, 1C, 1D, 1E

Western Washington:

- **Northwest Regional Council:** Region: 3A
- **Hopelink:** Regions: 3B, 4
- **Paratransit Services:** Regions: 5, 6A, 6B
- **Human Services Council:** Region: 6C

Transportation Broker Regions

Washington State Health Care Authority



6 Transportation Brokers Serving 13 Regions Statewide

Transportation Broker's Responsibility:

- Confirm client eligibility
- Authorize the type of transportation
- Select transportation service provider
- Select type of transportation mode that is:
  - ✓ appropriate to a client's medical condition and capabilities
  - ✓ lowest cost available
  - ✓ accessible

Tribal Relationships

- HCA transportation Brokers are encouraged to contract with Tribes to provide **non-emergency medical transportation** (NEMT) services, as requested by any federally recognized tribe that resides within the Broker's service region.

- Billing agreements are required between the transportation Broker and the Tribe.

- Contact the Broker that services your region: http://www.hca.wa.gov/medicaid/transportation/pages/phone.aspx

Tribal Billing Agreements

- Brokers authorize the Tribe to schedule and provide trips for eligible Tribal members without prior approval and bill the Broker for payment after the trips are provided
- Brokers conduct a post-trip review to determine allowable trips upon receipt of a Tribal transportation bill. Payment is made following the verification of the trips.
- Allowable trips must be for eligible Medicaid Tribal members or their immediate family. Transportation is provided to covered healthcare services (refer to eligibility).

Tribal Billing Agreements

Process

1. Tribe contacts the Broker in their region to begin the process.
2. Tribe and the Broker negotiate the rates.
3. Contract/Billing Agreement is discussed and signed.
4. Tribe invoices Broker for trips.
5. Broker reviews all trips and makes payment for approved NEMT trips and associated costs.
6. Broker conducts post-trip verification of trip information.
7. Broker invoices HCA for all verified NEMT trips provided by all its contracted service providers. The Brokers submit a monthly trip report to HCA.
8. HCA makes payment based on approved NEMT trips.

Tribal Participation by Broker Region

Western Washington:

- Northwest Regional Council/Region 3A:

  $231,975 Paid in CY2015

  - Lummi
  - Nooksack
  - Sauk Suiattle
  - Stillaguamish
  - Swinomish
  - Upper Skagit

Tribal Participation by Broker Region

- Paratransit Services/Regions: 5, 6A & 6B

  $457,943 Paid in CY2015

  - Lower Elwha
  - Port Gamble S'Klallam
  - Makah
  - Shoalwater Bay
  - Suquamish

- Hopelink/Regions: 3B & 4

  $205,391 Paid in CY2015

  - Tulalip-pending
  - Snoqualmie
  - Cowlitz-pending
  - Muckleshoot-pending

- Human Services Council/Region: 6C
  - Cowlitz-pending

Tribal Participation by Broker Region

Central & Eastern Washington:

- Special Mobility Services/Regions: 1B, 1C, 1D, 1E

  $19,089.40 Paid in CY2015

  - Kalispel Tribe
  - Spokane Tribe

- People for People/Regions: 1A, 2

  - None

Contact Information

NEMT Transportation Program:

- ✓ Website: (Broker list by county)

http://www.hca.wa.gov/medicaid/transportation/pages/index.aspx

- ✓ E-mail Address:

HCA DL DHS OCS NEMT TRANSPORTATION
HCANEMTTRANS@hca.wa.gov

- ✓ HCA Customer Service Center:

1-800-562-3022 (ask for Transportation Program)

Questions?

More Information:

James Walters: 360-725-1721

Stephen Riehl: 360-725-1441

Tracy Graves: 360-725-9791

Paul Meury, NEMT Supervisor

Health Care Authority

Medicaid Program Operations & Integrity

paul.meury@hca.wa.gov

360-725-1317

NEMT Transportation Program

The End

Paper Claim Submissions

- HCA is in compliance with 25 U.S. Code § 1621e(h). Tribes and Tribal organizations will be able to continue to submit paper claims to HCA if the claim is not able to be billed electronically. Refer to the FAQ at *http://www.hca.wa.gov/assets/billers-and-providers/no-paper-FAQ.pdf*
- Otherwise, effective October 2016, the Health Care Authority (HCA) will accept only electronic claims for Apple Health (Medicaid) services, except under very limited circumstances
- Sometimes paper claims are submitted because the electronic billing may be difficult. If you have an unusual situation and you want help billing electronically, please ask mike for help.

NCCI and SUD Services

- Washington Medicaid is required to follow CMS National Correct Coding Initiative (NCCI)
  - Procedure to procedure (PTP) editing
    - PTP editing involves code-pairs that should not be reported together
  - Medically Unlikely Edits (MUE)
    - MUE's code the maximum units of service that a provider would report under most circumstances on a single date of service
- MUE updates that impact SUD claims are highlighted on the next page

NCCI and SUD Services

SUD Modality	CPT/HCPCS Code	MUE value	Effective date
Group	96153	8 (2 hours)	7/1/2016
Family with client	96154	8 (2 hours)	7/1/2016
Family without client	96155	6 (1.5 hours)	Pre-existing*
Individual	H0004	None	none

- Claims that exceed the MUE values are rejected in P1
- *Family therapy with client (96155) had a pre-existing MUE that was recently implemented in P1
- HCA/DSHS is requesting an exception to the MUE for 96153 and 96154. Stay tuned for more information and outcome

NCCI and Medical Services

- NCCI PTP editing indicate that E&Ms (99201-99215) are not payable on the same day as some other services, such as immunizations or immunization administrations
- When the E&M is rejected and the only paying service on the claim is for the immunization or immunization administration the claim pays as a FFS claim
- Modifier 25 (*Significant, separately identifiable E&M ... on the same day of the procedure or other service*) added to the E&M will often waive the NCCI rule the E&M will pay, which will allow the claim to pay at the encounter rate

Billing P1 Secondary to Other Insurance

Claims may be billed to P1 secondary to other insurance for most dual-eligible clients. The format for billing the secondary claim depends on the type of insurance the primary insurer is

- **Private Insurance** – bill P1 a regular insurance secondary claim ("electronic TPL")
- **Medicare Part B or C (Advantage)** – bill P1 a Medicare cross-over
- **Medicaid Managed Care Organization (MCO)** – bill P1 a MCO Wraparound (AI/AN clients at IHS/638 facility only)

Encounter Billing Secondary to Other Insurance – Native client

Private Insurance	Medicaid Managed Care (MCO)	Medicare Part B or C
Medical, Dental, Mental Health and Chemical Dependency encounters: Private insurance is primary P1 is secondary Claims pay up to the encounter rate after private insurance Bill a Secondary claim	**Medical encounter**: MCO is primary P1 is secondary Claims pay up to the encounter rate after MCO Bill an MCO wraparound **Mental Health Encounter**: If MCO pays – bill an MCO wraparound If MCO denies – bill P1 primary (do not indicate other insurance on claim) **Dental and Chemical Dependency encounters** P1 is primary	**Medical encounter** Medicare is primary P1 is secondary Claims pay up to the encounter rate after Medicare Bill a Medicare "cross-over" **Mental Health encounter** Medicare is primary if the servicing provider is not a Counselor (101YM0800x) Social Worker (104100000x) Marriage and Family Therapist (106H00000x) P1 is secondary Claims pay up to the encounter rate after Medicare Bill a Medicare "cross-over" *Note*: counselor, social worker, Marriage and family therapist claims are billed directly to P1 for IHS/638 clinics. Licensed Clinical Social Workers (LCSW)are enrollable with Medicare and claims should be billed to Medicare first for LCSW **Dental and Chemical Dependency encounters** P1 is primary

Encounter Billing Secondary to Other Insurance – Non-Native client

Private Insurance	Medicaid Managed Care (MCO)	Medicare Part B or C
Medical, Dental, Mental Health and Chemical Dependency encounters: Private insurance is primary P1 is secondary Claims pay up to the encounter rate after private insurance Bill a Secondary claim	**Medical and Mental Health claims**: MCO is primary if group has contract with the MCO No Secondary payment after MCO **Dental and Chemical Dependency encounters** P1 is primary **Clinical Family Member exception** (for Mental Health services only): If client is a clinical family member the claim may be billed directly to P1 at the encounter rate	**Medical encounter** Medicare is primary. P1 is secondary Claims pay up to the encounter rate after Medicare Bill a Medicare "crossover" **Mental Health encounter** Medicare is primary if the servicing provider is not a Counselor (101YM0800x) Social Worker (104100000x) Marriage and Family Therapist (106H00000x) P1 is secondary Claims pay up to the encounter rate after Medicare Bill a Medicare "cross-over" *Note*: counselor, social worker, Marriage and family therapist claims are billed directly to P1 for IHS/638 clinics. Licensed Clinical Social Workers (LCSW)are enrollable with Medicare and claims should be billed to Medicare first for LCSW **Dental and Chemical Dependency encounters** P1 is primary

ProviderOne Claims Issues – MCO Wraparounds

- Tribal Affairs office was recently alerted to MCO wraparound claims that were billed correctly to P1 but rejected in P1 with EOB 24 (*charges are covered under a capitation agreement/managed care plan*)
- It appears that the claim note (*AI/AN MC wraparound*) is being disregarded and claims are being rejected in error
- More information will be in next month's webinar

ProviderOne Claims Issue – Multiple Encounters

- Some services are billed one time, on a single date of service, even though there were visits that occurred prior to the final billing. Refer to the 11/12/2015 billing slides for more information
  http://www.hca.wa.gov/assets/program/billing-workgroup-20151112.pdf
- Claims that have multiple units on the T1015 line are currently paying as FFS only (rejecting the T1015 line with EOB N362)
- Please contact Mike if you have any claims for multiple encounters that are not paying correctly
- P1 should be corrected on September 26th to start paying the multiple encounter claims correctly. Claims will be reprocessed after P1 is corrected

Claims Diagnosis Requirements

Question Asked: If an assessment or evaluation does not lead to a definitive diagnosis will HCA pay for the assessment or evaluation?

The next few slides will highlight diagnosis criteria for the different categories of service. Below are 2 sample diagnosis codes

- Z71.1 person with feared health complaint in whom no diagnosis is made
- Z00.00 encounter for general adult medical examination without abnormal findings

Claims Diagnosis Requirements - Medical

- Refer to attachment *Generally not payable ICD10 diagnoses* included with this month's webinar
- Medical claims generally will not be paid in P1 if the primary diagnosis is in the list of *Generally not payable ICD10 diagnoses*

Claims Diagnosis Requirements - Dental

Dental claims do not require a diagnosis be submitted on the claim

Claims Diagnosis Requirements – Mental Health

- Mental Health claims billed by Tribal Health clinics are required to have a valid ICD10 diagnosis
- Claims will not be rejected for diagnosis codes that are generally not payable

Claims Diagnosis Requirements - SUD

- SUD services billed to P1 are required to have a primary diagnosis that is from the list of diagnoses in the SUD billing guide

Medical - Top 5 Rejections

EOB	Description	Comments	Denial %
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Claim missing the UA or SE modifier	16
24	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in MCO	9
204	This service/ equipment/drug is not covered under the patient's current benefit plan	Servicing taxonomy issues, see EOB 204 in this month's FAQ	5
16 / N288	Missing/incomplete/invalid rendering provider taxonomy	Servicing taxonomy on the claim is not a taxonomy that the servicing provider is enrolled with	4
167	This (these) diagnosis(es) is (are) not covered.	Some diagnosis codes are not payable if billed as the primary diagnosis on a medical claim. Generally not payable ICD-10 codes attached to webinar	3

Dental - Top 5 Rejections

EOB	Description	Comments	Denial %
16/ M53	Missing/ incomplete/ invalid days or units of service	Units are required on the billing code line(s). Claims are being received with 0 units	17
16 / N288	Missing/incomplete/ invalid rendering provider taxonomy	Servicing taxonomy on the claim is not a taxonomy that the servicing provider is enrolled with	5
204	This service/equipment/ drug is not covered under the patient's current benefit plan	Client is not full-scope (e.g. QMB only or Family Planning)	5
6	The procedure/revenue code is inconsistent with the patient's age.	Crowns and (posterior) root canals not payable for adults	4
26	Expenses incurred prior to coverage.	Client is not eligible on this date (could be before or after coverage ends)	3

Mental Health - Top 5 Rejections

EOB	Description	Comments	Denial %
204	This service/equipment/drug is not covered under the patient's current benefit plan	Servicing taxonomy issues, see EOB 204 in this month's FAQ	30
16/ N288	Missing/incomplete/invalid rendering provider taxonomy	Servicing taxonomy on the claim is not a taxonomy that the servicing provider is enrolled with	10
24	Charges are covered under a capitation agreement/ managed care plan	Client is enrolled in MCO	9
18	Exact duplicate claim/service	Mental Health visit previously paid	6
22	This care may be covered by another payer per coordination of benefits.	Client has Medicare	3

SUD - Top 5 Rejections

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate	20
A1 N362	The number of Days or Units of Service exceeds our acceptable maximum	CMS adopted maximum units (MUE) for 96153 (8), 96154 (8) and 96155 (6). Claims that are over the maximum units are denied in P1	17
170 N95	This provider type/provider specialty may not bill this service	Lab codes (CPT 80000 series) are not payable on SUD claims	6
96 N130	Consult plan benefit documents/guidelines for information about restrictions for this service	Lab codes (CPT 80000 series) are not payable on SUD claims	5
204	This service/equipment/drug is not covered under the patient's current benefit plan	Taxonomy issues. See EOB 204 in this month's FAQ. Claims had CDP taxonomy (101 series taxonomy). The only payable taxonomy codes for SUD are in the SUD guide (almost always 261QR0405x)	4

FAQ and Open Discussion

Q. All our phone call claims are being denied, was there a P1 change?

A. Telephone E&Ms (CPT 99441-99443) are covered under the following programs

Physician Billing guide (p. 43) and Mental Health Billing guide (p. 28)

The Tribal Health Billing guide (p.33) lists the Crisis Hotline for Mental Health Services that may be billed by Tribal Clinics for AI/AN clients who opt out of RSN/BHO managed care

Telephone calls are not encounter eligible and are reimbursed as fee-for-service

FAQ and Open Discussion

Q. SUD intake processing (H0002) is no longer in the SUD billing guide. Is it billed under case management or a therapy now?

A. Intake processing is included as part of the Assessment (H0001)

FAQ and Open Discussion

Q. Does HCA pay a Mental Health Professional (MHP) for reading laboratory reports?

A. Which lab codes are you asking about? Very few lab codes offer a global/professional split option

FAQ and Open Discussion

Q. The MCO wraparound is not available for non-Native clients. Currently if a client has private insurance or Medicare, they are not enrolled in an MCO, is this going to change in the future?

A. Stay tuned

FAQ and Open Discussion

Q. Why are SUD claims being rejected for Client Benefit Plan (EOB 204)? The client is an ABP client.

A. EOB 204 usually happens when one of the following occur

- The service is not covered under the client's Benefit Plan (e.g. family planning only client)
- The servicing provider taxonomy submitted on the claim is not associated to any client benefit plan.
    - Example: HCA does not enroll CDPs (e.g. taxonomy 101YA0400x) under the SUD program. SUD claims do not require individual servicing provider NPI or taxonomy codes and will often error out if individual servicing providers are billed on the claim. The only payable taxonomy codes on SUD claims are in the SUD billing guide and they are appropriate for SUD clinics only.
      Resolution – do not bill with individual servicing providers on SUD claims

FAQ and Open Discussion

Q. If a client is admitted to a hospital for crisis and the hospital is going to bill for the services, can the client's regular MHP (who is not an employee of the hospital) see the client and bill for services?

A. No, this is not billable because the hospital Mental Health inpatient rate is a bundled rate that covers all services during the stay

Pended Questions

Q. Pharmacists can now be billed at the same rate as ARNPs and PAs. Why doesn't HCA pay for the pharmacists doing clinical work?

A. Question forwarded to clinical staff. Stay tuned

Answer from June, 2015 TBWG (TCOW):

Q. What services can a pharmacist render on a professional/HCFA claim?

A. PharmD's are eligible to perform the following services (FFS):

- Tobacco cessation for pregnant clients (physician billing guide)
- Clozaril case management (physician billing guide)
- Emergency contraception counseling (Pharmacy guide)
- Vaccine administration fee (Pharmacy guide)

Note: pharmacists are not eligible for the IHS or FQHC encounter rate

Pended Questions

Q. During the June webinar you listed out diagnosis codes that would waive the once-per-two-year vision exam limit. Why are only some of the diabetes diagnoses listed? Type II (E11.xx) is the most common category of diabetes within the AI/AN population, and I believe that the standard of care is that diabetic patients, regardless of the cause of the DM have an annual eye exam. This shouldn't be determined if the symptoms are in control or not because retinopathy can be found during an annual eye exam even with a patient that has very good control over their glucose. If it wasn't necessary the requirement would not have been included on so many quality measure requirements for DM patients. I also routinely see chart notes of patients who were non-compliant until the beginning of retinopathy.

A. Medical consultants are reviewing the codes & policy. Stay tuned

Pended Questions

Q. Can nurse only visits (e.g., vaccinations) be billed? How are these billed if the Nurses do not get enrolled in P1?

A. Claims are billed under their supervisor's NPI

Q. Are the services of an RN/LPN eligible for the encounter rate?

A. **IHS/638 clinics** - Nurses (RN/LPN) are not included in the list of IHS-encounter-eligible providers. Services of an RN (and any other provider who is not in the list of encounter-eligible providers) are not encounter eligible, even if under the supervision of an encounter-eligible provider (e.g. the performing NPI on the claim isn't what truly matters)

FQHC – Nurses (RN/LPN) are included in the list of providers who may provide services at an FQHC. (claims are not billed with the RN/LPN's performing NPI)

Q. What if the RN/LPN does not have a supervising provider? Nurse only visits do occur and are generally not signed off on by a provider for things such as immunizations or pregnancy tests, etc.

A. Pending DOH guidance, stay tuned. All nurses have a supervising provider – the physician or the clinic. Nurses are not licensed independently (and have no NPI)

Pended Questions

Questions/comments during prior billing webinar regarding 100% FMAP

- Has the state thought about how to identify FMAP claims? What would be the incentive of having agreements with outside referring providers and the outside providers
- You can require the referring provider NPI to identify IHS facility referrals
- Will the HCA work with AIHC on developing a boilerplate care coordination agreement?
- We have issues with referrals and outside specialty providers accepting Medicaid or at their limit. It would be nice if FMAP would help with opening doors to specialty clinics. Especially with the tribes in rural areas. Can we look into increasing payment amounts for certain areas?
- Hopefully the 1115 waiver will provide a way to work this out, so outside providers can access the 100% FMAP
- When will Tribes be able to meet with the state to work on FMAP coordination? Tribes received clear instructions to work with the state to implement FMAP
- Is there a template for the FMAP Coordination of Care agreement that we can access?

Stay tuned, feel free to share comments/suggestions/ideas

Pended Questions

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

A. Refer to May 16th, 2015 TBWG/TCOW for more background on FFS (code) billing. Does telemedicine meet the HCA definition of *face to face?* Stay tuned

Pended Questions

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. Stay tuned

Pended Questions

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?

Send comments and questions to:

Mike Longnecker

michael.longnecker@hca.wa.gov

360-725-1315

Jessie Dean

jessie.dean@hca.wa.gov

360 -725-1649

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