Washington State Health Care Authority

Tribal Compliance & Operations Work Group

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HCA Tribal Affairs Office
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Agenda

- Overview of Billing a Client
- Paper claims no longer accepted as of October, 2016
- SUD group therapy update
- SUD and NCCI editing
- Mental Health Peer Counseling
- Hepatitis C Treatment update
- Medicaid Medical Necessity: Alert for Tribal PRC/CHS Programs
- FAQ and Open Discussion
- Updated MCO contact list

Billing A Client

Refer to the Billing a Client webinar on HCA's webinars page

http://www.hca.wa.gov/billers-providers/providerone/webinars

For today's webinar we will be using the slides from the dental webinar located at

http://www.hca.wa.gov/assets/billers-and-providers/medicaid101dentalworkshop_0.pdf

Form 13-879 is available here

http://www.hca.wa.gov/billers-providers/forms-and-publications?combine=13-879&field_topic_tid=All&field_billers_document_type_value_1=Form&sort=filename+ASC&=Apply

Paper Claims Submissions

- Effective October 2016, the Health Care Authority (HCA) will accept only electronic claims for Apple Health (Medicaid) services, except under very limited circumstances
- HCA is making this change to improve efficiency in processing claims
- Providers who wish to ask for an exemption from submitting claims electronically may do so using the Request a Waiver form. You can access this form by visiting the ProviderOne Billing and Resource Guide web page on the agency's website, which should be available during the second week of August
- Less than 0.2% (650 out of 235,000) ITU claims for CY 2015 were submitted on paper

Paper Claims Submissions

Indian Health Care Improvement Act

https://www.ihs.gov/ihcia/includes/themes/newihstheme/display_objects/documents/home/USCode_Title25_Chapter%2018.pdf

An insurance company, health maintenance organization, self-insurance plan, managed care plan, or other health care plan or program (under the Social Security Act [42 U.S.C. 301 et seq.] or otherwise) may not deny a claim for benefits submitted by the Service or by an Indian tribe or tribal organization based on the format in which the claim is submitted if such format complies with the format required for submission of claims under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] or recognized under section 1175 of such Act [42 U.S.C. 1320d–4]

Forwarded to HCA paper-claims team

Stay tuned, the waiver form is not available yet for review

SUD Group Therapy

- Prior to April 1, 2016 SUD for group therapy (CPT 96153) was only covered if at least 45 minutes (3 units)

  P1 did not correctly enforce this policy and only rejected claims that had 30 minutes (2 units) of SUD group therapy, 15 minutes (1 unit) of group therapy continued to pay (OK per DSHS)

- Beginning April 1, 2016 there is no longer a 45 minute minimum for SUD group therapy in the SUD billing guide
- Claims processed after April 1 that had 30 minutes of group and were denied in P1 (EOB B5) have been submitted for reprocessing

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

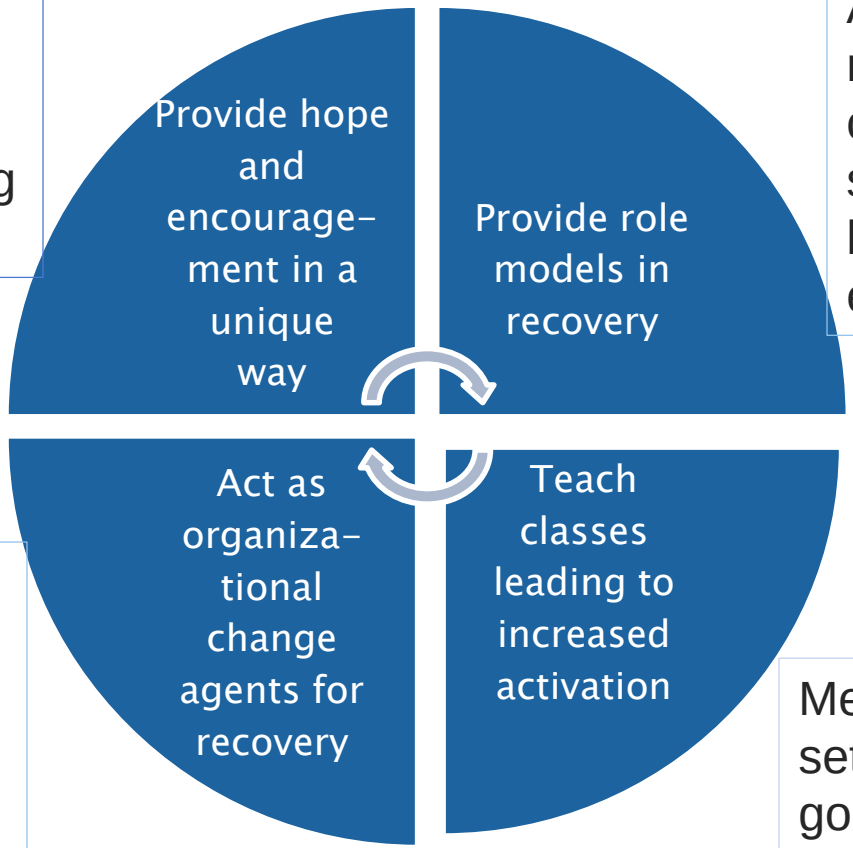
- Claims that exceed the MUE values are rejected in P1
- *Individual therapy for SUD is H0004. The MUE for CPT 96152 (individual therapy) is 6 (1.5 hours).
- **Family therapy with client (96155) had a pre-existing MUE that has not been implemented in P1 yet

Peer Support Services

- Peer support is a service provided to improve recovery outcomes through connections with people with shared lived experience
- In Washington State, peer supporters whose services are Medicaid reimbursable are called Certified Peer Counselors
- Peer supporters are important members of the clinical team, and enhance services that can be provided

Peer Support Services
Examples of Peer Counselor Roles

Assist in engaging with and communicating with providers



Assist in maintaining community living skills, including housing and employment

Provide a "bridge" for people transitioning from inpatient to the community

Meet in outpatient settings to work on goals and crisis stabilization

Washington State Health Care Authority

Peer Support Values

Recovery

- Hope
- Empowerment
- Strengths based
- Respect

Resiliency

- Personal Responsibility
- Self direction
- Individualized
- Non-linear

Wellness

- Holistic
- Trauma Informed
- Culturally appropriate

Peer Support - The Certification Process

Peers must:

- Be mental health consumers
- Apply for training and be accepted as a candidate
  - Attest to consumer status (including as parent of consumer)
  - Adequate reading and writing skills
  - In recovery at least one year
- Complete the 10 hour online course and the 40 hour in-person class
  - DBHR offers about six classes per year, and organizations can also purchase trainings from an approved contractor.
- Take and pass the state test
- If employed by a licensed agency, gain Agency Affiliated Counselor credential from DOH

Other Considerations

- Peer Services can only be billed by DBHR certified peers
- Must be supervised by a mental health professional
- May be employed by a health agency or subcontracted to a peer run organization
- Should receive on-going continuing education as well as role-specific training
- Employment expectations should be equal to other employees

Peer Support Outcomes

- Satisfaction
  - Almost universal satisfaction and appreciation by individuals and families
- Outcomes
  - Decrease in symptoms
  - Increased coping skills and awareness of early warning signs
  - Fewer hospitalizations, shorter lengths of stay
  - Improved social functioning
  - Increased feelings of hopefulness, self-advocacy and empowerment

Peer specialists say **“We are the evidence”**

Peer Support: Billing

This service is payable today

- This service has been payable in ProviderOne since April 1, 2015 for all dates of service

Peer Support: Billing Requirements

- Client: Medicaid-enrolled AI/AN or clinical family member (CFM)
- Peer Support Service Provider: Certified Peer Support Counselor
- Minimum Time per Client: 10 minutes
- Daily Maximum Time per Client: 4 hours
- Payment Rate: $60 per hour (¼ hour increments)
- Site of Service: Any location that meets privacy requirements
- Support Group Peer Counselor-to-Client Ratio: No more than 1-to-20
- Procedure Code: H0038 - “Self-help/peer services, per 15 minutes”
- Procedure Code Modifier:
- “HE” for AI/AN client
- “SE” for non-AI/AN clinical family member client

Peer Support: Billing Requirements

- Billing NPI: IHS or Tribal 638 facility
- Billing Taxonomy: 2083P0901x
- Servicing NPI: Supervising ProviderOne-enrolled Mental Health Professional who understands rehabilitation and recovery
- Servicing Taxonomy: As applicable
- Diagnosis Code: Valid ICD-10 diagnosis as appropriate for service
- Referring NPI: Not required
- Prior Authorization: Not required other than EPA (see next)
- Expedited Prior Authorization (EPA): Required - 870001349
- "Either: (1) client has elective exemption from Medicaid Managed Care under 42 U.S.C.1396u-2 (e.g., client is AI/AN); or (2) client is a Clinical Family Member."

Peer Support: IHS Encounter Rate

- The services of certified peer support counselors are not eligible for the IHS encounter rate
- Peer support counselors are not included in the State Plan list of IHS encounter-eligible provider types
- Peer support services are considered a mental health service
- The facility may not bill for the peer support counselor's services if the facility receives an IHS encounter payment for mental health services for the same client during the same 24-hour period

Peer Support: Billing Examples

Date of Service	Procedure Code	Modifier	EPA	Billed Amount	Billed Units
1/5/01	H0038	HE (AI/AN) or SE (CFM)	870001349	$60.00	4
1/6/01	H0038	HE (AI/AN) or SE (CFM)	870001349	$240.00	16
1/15/01	H0038	HE (AI/AN) or SE (CFM)	870001349	$15.00	1

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan
1	01	01	16	01	01	16	07		H0038	HE *	1	60.00	4	
2	01	15	16	01	15	16	07		H0038	HE *	1	240.00	16	
3	01	31	16	01	31	16	07		H0038	HE *	1	15.00	1	

Peer Support Counselors: Other Payable Services

- Day Support
  - H2012 - “Behavioral health day treatment, per hour”
  - Rate: $31.05 per hour
- Medication Monitoring
  - H0034 - “Medication training and support, per 15 minutes”
  - Rate: $22.47 per 15 minutes
- Therapeutic Psycho-Education
  - H0025 – “Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)”
  - Rate: $6.58 per service
  - H2027 – “Psycho-educational service, per 15 minutes”
  - Rate: $12.01 per 15 minutes

DBHR Contact

Jennifer Bliss, Senior Manager,
Office of Consumer Partnerships
Peer Support Program Administrator

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360-725-3709

Hepatitis C Treatment Policy

HCA is complying with a federal judge's order to provide hepatitis C treatment for all Apple Health (Medicaid) clients, not just those with a certain level of fibrosis. A U.S. District Court judge recently granted a preliminary injunction that orders HCA to cover the treatment for Apple Health clients. HCA's previous policy included a measure of liver scarring (fibrosis). HCA has stopped denying requests for all direct acting antiviral agents based on fibrosis score for Apple Health clients.

Moving forward, we are placing the highest priority on authorization for individuals whose cases are in appeal status or who are currently waiting for a response to their request for reconsideration

Refer to the Hepatitis C Treatment Policy updated on June 17, 2016
http://www.hca.wa.gov/assets/billers-and-providers/WA%20Apple%20Health%20Hepatitis%20C%20Clinical%20Policy.pdf

Medicaid Medical Necessity: Alert for PRC Programs

In fee-for-service, HCA processes requests for authorization of service by requesting information from providers.

If a provider does not provide the requested information, HCA will issue a denial of the request

It appears that some providers may not be submitting the information but using the denial to ask a Tribe's PRC/CHS program to pay for the service

Medicaid Medical Necessity: Alert for PRC Programs

HCA's denial language for failure to submit information:

Your healthcare provider was sent a request for more information and did not respond within the required timeline, so this request is denied (see WAC 182-501-0165)

A copy of this request was also sent to you so you would know what was needed

Your provider may request a reconsideration of this decision by submitting the requested information. We encourage you to contact your provider regarding the requested information

Medicaid Medical Necessity: Alert for PRC Programs

We recommend Tribes require a copy of HCA's denial letter for any provider who seeks Tribal payment for services because HCA denied authorization

Reason for Denial	Next Steps
Provider failed to provide the requested information	Provider should provide the requested information
Provider failed to refer the client to a specialist	Provider should refer the client to a specialist for confirmation that the service is in the best interest of the client
HCA determined that the service is not medically necessary (provider submitted the information)	Provider may submit additional information for a new review OR Tribe could decide to use PRC/CHS funds

Medical - Top 5 Rejections

EOB	Description	Comments	Denial %
24	Charges are covered under a capitation agreement/ managed care plan	Client is enrolled in Managed Care (MCO)	17%
18	Exact duplicate claim/service	Duplicate	6%
167	This (these) diagnosis(es) is (are) not covered	Some diagnosis codes are not payable in P1 if billed as the primary diagnosis. Ask Mike for the current list	5%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Missing the UA or SE modifier	4%
16/ N290	Missing/incomplete/ invalid rendering provider primary identifier	Performing (*rendering, servicing*) provider not in P1	4%

Dental - Top 5 Rejections

EOB	Description	Comments	Denial %
204	This service/ equipment/ drug is not covered under the patient's current benefit plan	Usually a Medicare-only client	11%
119	Benefit maximum for this time period or occurrence has been reached	Fluoride limitations, see Dental Billing Guide for complete policy Age 0-6 3 per year Age 7-18 2 per year Age 19+ 1 per year	6%
26	Expenses incurred prior to coverage	Client not eligible on this date (could be before or after coverage ended)	5%
6	The procedure/revenue code is inconsistent with the patient's age	Some services are only allowed for youth. Noticed a few D1330, which is only covered for age 0-8 and not in an office setting (oral hygiene instructions is generally bundled into the prophy)	5%
15	The authorization number is missing, invalid, or does not apply to the billed services or provider	Some dental services require prior authorization, refer to the dental guide	5%

Mental Health - Top 5 Rejections

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing	63%
204	This service/ equipment/ drug is not covered under the patient's current benefit plan	Usually a Medicare-only client	5%
16/ N255	Missing/incomplete/invalid billing provider taxonomy	Billing/group taxonomy should be 2083P0901x (Urbans continue to use 261QF0400x)	4%
24	Charges are covered under a capitation agreement/ managed care plan	Client is enrolled in Managed Care (MCO)	3%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Missing the HE or SE modifier	2%

SUD - Top 5 Rejections

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing	88%
170/ N95	Payment is denied when performed/billed by this type of provider	Usually a lab code (lab codes not payable in SUD) or an SUD code that was missing the HF modifier	2%
96/ N130	Consult plan benefit documents/ guidelines for information about restrictions for this service	Lab codes are not payable in SUD	1%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Non-AI/AN T1015 modifier mis-match (I/T claims only) • ABP (RAC 1201) – T1015+SE • ABP SSI (RAC 1217) – T1015+HB • All other clients/RACs – T1015+HX	1%
B5	Coverage/program guidelines were not met or were exceeded	Group therapy previously required minimum of 45 minutes. Requirement removed and claims reprocessed	1%

FAQ and Open Discussion

Q. Why are claims taking longer to reprocess?

A. Staffing changes at HCA due to shift in business needs

- Previously, claims sent to HCA's Claims Processing section were reprocessed and paid in about 1 week
- Currently, claims sent to HCA's Claims Processing section are being reprocessed in about 4-8 weeks or longer

Sometimes it might be faster for the biller to reprocess claims

- Clean claims that automatically process in P1 are typically finalized within a week
- Clean claims that suspend for manual review by Claims Processing or Coordination of Benefits take longer

FAQ and Open Discussion

Q. Can you send us a workflow of Direct Data Entry (DDE) claims for clients who have Medicare and tertiary insurance?

A. Cheat sheet attached to today's webinar

Are there requests for any other cheat sheets?

FAQ and Open Discussion

Q. Nurse (RN/LPN) visits don't pay at the IHS encounter rate but what about dental hygienists? Hygienists spend a lot more in-depth time with clients. Do the hygienists get the IHS encounter rate?

A. Hygienists are not listed in the state plan as an encounter-eligible provider for IHS/638 facilities

FAQ and Open Discussion

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

FAQ and Open Discussion

Q. Why did I get an EOB 107 (*The related or qualifying claim/service was not identified on this claim*) rejection on the T1015 line?

EOB 107 posts on the T1015 line if there is not a qualifying code on the claim that is paying

EOBs are a best fit selection from the national database

EOB 107 really means *The encounter line is only payable if there is a qualifying code on the same claim that is also paying, there was not a qualifying code on this claim that is paying*

If you get an EOB 107 – refer to the EOB on the billing code ("FFS") lines to determine why the billing code did not pay

FAQ and Open Discussion

Q. Can P1 let you do an adjustment the same day or the next day when there is a billing error?

- Once a claim has been submitted to P1 it will not be reprocessable until the Remittance is generated
- Clean Claims that do not suspend for manual review will usually be on the following week's remittance
- Clean Claims that suspend for manual review take longer
- Please wait for the remittance to do a replacement claim, rebilling before the remittance will cause duplicate claim issues

FAQ and Open Discussion

Q. What are the prompt payment requirements for P1 claims?

A. Prompt payment requirements are determined by CMS

- 90% of clean claims received by the State must be paid (or denied) within 30 days of receipt
- 99% of clean claims received by the State must be paid (or denied) within 90 days of receipt

Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity (42 CFR 447.46)

FAQ and Open Discussion

Q. What is the current lag time for P1 to approve and add new providers or updates?

A. Expect up to 30 days for HCA to process the application. Some applications take more or less time. Providers should not see Medicaid clients until they have received a welcome letter. For more information refer to the HCA Enrollment website at

http://www.hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-billing-provider

FAQ and Open Discussion

Q. Does HCA require that the Tribes have a Qualified Service Organization Agreement (QSOA)? Are Tribes required to have a QSOA to bill *any* insurer?

A. Stay tuned

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. How far in the future will the MCOs start paying at the full encounter rate?

A. The MCO payment of the encounter rate does not have an established date yet. Best estimate at this time is Summer 2017.

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

Pended Questions

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). P1 was updated on June 5th. I/T/U encounter claims for the IUD/implant insertions are paying at the I/T/U rate

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

Managed Care Organization (MCO) contacts update

- Updated copy of MCO contacts is attached to today's webinar

Questions?

Send comments and questions to:

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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.