Washington State Health Care Authority

Tribal Compliance & Operations Work Group

July 13, 2016

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Agenda

- Paper claims no longer accepted as of October, 2016
- HCA broadcast email - Health Care Authority working to fix incorrect Apple Health claim denials
- Provider file maintenance – cheat sheets
- Reminder – Crisis Services is billable to P1 (I/T providers)
- Overpayment/unbundling issues
- How/who to bill if client changes from FFS to MCO or MCO to FFS during a hospital stay
- FAQ and Open Discussion

Paper Claims Submissions

- On July 6, HCA sent a communication announcing changes to paper claims submissions, see end of slideshow for message
- Effective October 2016, the Health Care Authority (HCA) will accept only electronic claims for Apple Health (Medicaid) services, except under very limited circumstances
- The change is being made to improve efficiency in processing claims
- Providers may seek approval to submit paper claims if they are in a temporary or long-term situation outside of their control that precludes submission of claims electronically.

Health Care Authority Working to Fix Incorrect Apple Health Claim Denials

- On 07/11 HCA sent a communication regarding a fix for claims denied in error for prior authorization requirements, see end of slideshow for message
- Mike reviewed I/T/U claims for this issue, and there are no I/T/U claims that have this issue
- There are ongoing ProviderOne updates that are similar to the prior authorization issue
- Please let mike know ASAP if you notice any P1 claims issues

Provider File Maintenance

Step-by-Step cheat sheets attached to today's webinar

- Adding a new servicing provider to your group
- Update a servicing provider taxonomy

Please let mike know if you would like to see any other cheat sheets

Crisis Services

- Reminder: Crisis services is a payable service for AI/AN clients at I/T facilities
- Refer to the Tribal Health Billing guide
  - HCPCS code H2011 (rather than 90839/90840)
  - EPA required on claims to indicate that client is exercising their rights to opt out of managed care
- Coding and EPA outlined in Tribal Health Billing guide

Unbundling Issues

Q. I accidentally billed two claims for the same date (one group therapy and one individual therapy). Why did the first claim pay at the encounter rate and the second claim pay $77?

A. (I/T providers) The encounter payment is a global/bundled payment and includes all on-site services, within the category of encounter, within a 24 hour period. P1 will reject the second T1015 line but pay the billing codes. I call this the *unbundling loophole*.

There currently is no ETA for a P1 update to close the unbundling loophole for I/T providers.

What should you do if you get reimbursed, on a separate claim, for billing codes in addition to the encounter payment?

- Void the unbundled claim that paid the billing codes
- Adjust the encounter claim to include all services on the same claim

A. (Urban Indian Orgs) The unbundling loophole was recently closed for FQHC claims

FFS/MCO Clients and Hospitalization

Fee For Service (FFS) has two different meanings

1. A **FFS client** is a client who is not enrolled in a Managed Care Organization (MCO)

2. A ProviderOne claim that pays without a T1015 line is a **FFS claim**

FFS/MCO Clients and Hospitalization

Q. If a ***FFS client*** is admitted to a hospital and is enrolled in MCO ***during*** the hospital stay – who is the payer during the remainder of the hospital stay?

A. The client's eligibility on the date of admission to the hospital determines the client's eligibility until their discharge

Q. How do you bill P1 for a client who gets enrolled in MCO during their hospital stay?

A. P1 needs the hospitalization dates submitted on the claim.

1. Paper claims (don't bill on paper, this is just for reference)

    Box 18 is for Hospitalization dates

2. HIPAA batch (837P)

    Admission Date = Loop 2300, DTP01 = 435, DTP03

    Discharge Date = Loop 2300, DTP01 = 096, DTP03

3. ProviderOne screens on next page

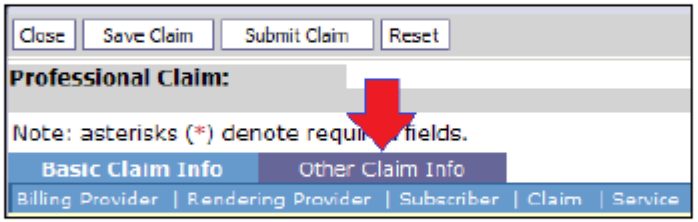
FFS/MCO clients and Hospitalization

Continued

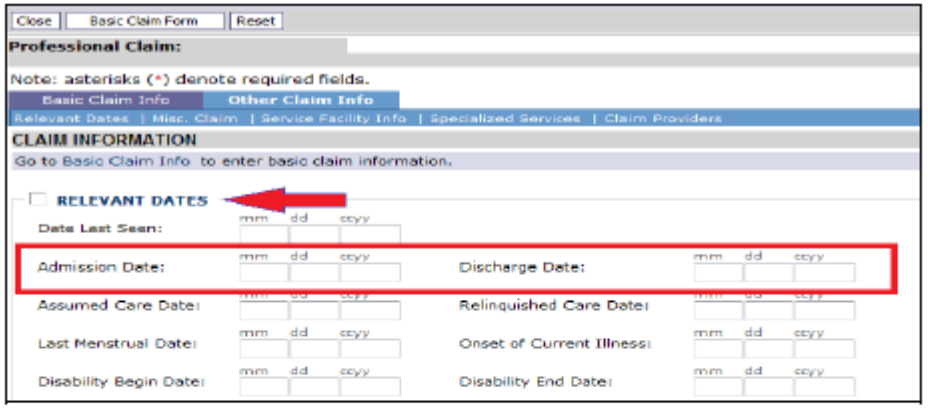
How to add Hospitalization dates to a professional claim in the P1 screens

Fill out the claim form as normal and before submitting a claim for a continuous hospital stay enter the hospital admit date and discharge date following the instructions below.

Click on the "**Other Claim Info**" tab at the top of the page:



On the Other Claim Info page open the first expander "**Relevant Dates**":



Enter the Admission Date and Discharge Date for the hospital stay.

Click on the **Basic Claim Form** button at the top of the page to get back to the first page of the claim screen.

FAQ and Open Discussion

Q. If there is a MH group with two MHPs co-facilitating and the clients are also in individual treatments, can each co-facilitator document on half of the participants regardless of who the primary individual therapist is?

A1. – Billing – bill the group as a group (one claim per client)

A2. – Charting – all clients should have documentation in their charts. It doesn't matter which facilitator does the documentation. They need to keep in mind that they are not billing for their individual client work – they are billing for the group so other relationships they have, or don't have, with the client in the group does not matter

FAQ and Open Discussion

Q. Do Naturopath providers get the encounter rate?

A. Yes, Naturopaths are “physicians” and their services are eligible for the IHS and FQHC encounter rates

FAQ and Open Discussion

Q. Why are my claims for Naturopaths (NDs) being rejected to bill Medicare? Naturopaths cannot enroll with Medicare

A. This is related to the prior authorization issue on today's agenda. There are ongoing ProviderOne automation updates being made & the automation is not 100% accurate

If a service/provider is **never** covered by Medicare, P1 should allow the claim to pay without billing Medicare. Some services/providers are setup to automatically pay in P1, and some services/providers are reviewed manually by Claims Processing Staff. However, services by NDs are set up to be reviewed manually by Claims Processing Staff

HCA system techs advise adding a claim note to alert Claims Processing staff on ND claims for dual-eligible clients. There is no HCA-approved/suggested claim note for this issue and claim notes, in general, are best avoided. If you have a claim for a ND for a dual eligible client that is rejected to bill Medicare (EOB #22) – **call mike**

FAQ and Open Discussion

Q. Why did I get EOB B20 (Procedure/service was partially or fully furnished by another provider)? The only other claim for this client was a Medical visit and the B20 is on a Mental Health visit

A. This is related to the Prior Authorization issue on today's agenda. P1 is currently rejecting *some* (I/T) encounters if there was a previous encounter paid under a different category.

HCA system techs advise adding a claim note to alert Claims Processing staff that the claim is not a duplicate. There is no HCA-approved/suggested claim note for this issue and claim notes, in general, are best avoided. If you have a claim that you feel rejected for EOB B20 in error, **call mike**.

Until P1 is corrected I will be proactively looking for B20 denials on a weekly basis

FAQ and Open Discussion

Q. Why did P1 reject my office visit for Tuberculosis screening (EOB 11)? Our area got hit by a TB outbreak last year and we test a lot to prevent another outbreak

A. Office visits for TB tests are covered.

This is similar to the Prior Authorization issue

Great example of getting issues resolved by sending claims issues to mike

P1 is being updated to pay correctly

NOTE: The issue only occurs with ICD9 codes, ICD10s are currently paying. Mike will reprocess claims after P1 update

FAQ and Open Discussion

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

FAQ and Open Discussion

Q. Is group therapy for domestic violence survivors covered at the encounter rate?

A. Yes, with comments

Proper intake must be completed on each individual (and documented), a treatment plan developed with clear, specific, measurable, achievable, realistic, goals indicating group therapy as the treatment modality, and provided by an appropriately trained individual then documented in each chart appropriately.

What you need to be careful about is that this is a proper, time limited therapy and not a support group

FAQ and Open Discussion

Q. Can you clarify which providers are not covered by Medicare and may be billed directly to P1?

A. Some providers are not enrollable with Medicare and P1 is coded to allow those claims to be billed directly to P1

MSS, billing taxonomy 171M00000x

SUD, billing taxonomy 261QR0405x

Dentists, billing taxonomy 122300000x

Mental Health Counselor at I/T facility, 101YM0800x

Social Worker at I/T facility, 104100000x

Marriage and Family Therapist at I/T facility, 106H00000x

Naturopaths are also not covered by Medicare, However, P1 is not coded to allow ND claims to be billed directly – ND claims are reviewed by Claims Processing staff

FAQ and Open Discussion

Q. Can you clarify whether Mental Health Services for Medicare dual-eligible clients are eligible for the IHS encounter rate for:

- AI/AN clients
- Non-AI/AN clients

A. Medicare dual-eligible clients are currently not enrolled in MCOs. Since they are not enrolled in MCOs, their services are encounter eligible. Refer to attached *Draft IHS Encounter Payment Table*

FAQ and Open Discussion

Q. What is the timely filing rule for MH for the Medicare dual-eligible clients that are paid primary in P1 because Medicare does not enroll the provider (or reimburse for the service)?

A. If you do not bill Medicare or if you bill Medicare and Medicare denies the service:

- 365 days from the date of service for timely filing
- Up to 2 years from the date of service if a claim met the original 365 day timely requirement and needs reprocessing

FAQ and Open Discussion

Q. Why did I get EOB B13 (*Previously paid. Payment for this claim/service may have been provided in a previous payment*) on a Medicare secondary claim?

A. Two common scenarios for B13

- Claim is a duplicate of a previously paid claim
- Client is retroactively enrolled in Medicare and P1 recouped the original non-Medicare secondary claim

If a client is retroactively enrolled in Medicare and there are paid P1 claims that should be billed to Medicare, HCA recoups the original claim but instead of recouping and denying the original claim HCA recoups and repays the original claim at $0. Since the claim is technically paid the new Medicare secondary claim gets rejected as a duplicate

Resolution:

Void the TCN that paid at $0 and then reprocess the Medicare secondary claim. If you need any help, **call mike**

FAQ and Open Discussion

Q. How many clients are required for SUD to be considered “group”? We often have no-shows and our Group sessions sometimes have one or two clients

A. SUD guide was recently updated:

Group therapy - Planned therapeutic or counseling activity conducted by one or more certified CDPs or CDPTs to a group of ***two or more*** *unrelated individuals*

FAQ and Open Discussion

Q. Does Medicaid pay for H0046 for travel to see patients?

A. CMS does not allow payment for staff travel time or costs.

This is why, although folks realize treatment in natural settings is more effective, it is not cost effective so we are seeing more and more services being offered only in the office setting so that clients can be seen back-to-back

FAQ and Open Discussion

Q. Don't the Medicare Part C plans have to follow the Federal guidelines to pay a claim even if the clinic is out of network?

A. HCA cannot answer questions regarding Medicare (CMS) programs.

FAQ and Open Discussion

Q. Is Coordinated Care going to become a Fully Integrated Managed Care (FIMC) plan like CHPW and Molina since they started the Apple Health for Foster Care program?

A. The Apple Health for Foster Care program is not a FIMC program, and there is no plan for it to become a FIMC program. In the future, Coordinated Care could become a FIMC plan if they successfully bid to do so for a new FIMC region.

Pended Questions

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

A. **Call mike**. Some clients have dual eligibility in P1 (e.g., Apple Health + Department of Corrections or Apple Health + Social Services). P1 is erroneously picking the non-Apple Health eligibility on some claims.

P1 was updated on June 5th & claims reprocessed

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). If the billed amount on these 3 codes is less than the fee schedule amount, P1 is currently overpaying. P1 updated on June 5th, mike will review and reprocess claims soon

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

Pended Questions

Q. What are other folks doing about timeliness when there is a primary payer? Sometimes the primary takes almost a year to process the claim and by the time it gets to P1 it is denied for timely

A. What are other folks doing? Some HCA staff recommend billing the primary + P1 at the same time so that the P1 claim is timely (but this could cause overpayment issues)

Answers received during webinar

- We do monthly aging reports to make sure that the primary pays on a timely manner
- There are times we've had to call a primary payer weekly to push a claim through in order to get timely
- Tertiary claims are also denying untimely often, we are working on finding a way to send claims through prior to P1 responsibility but are also worried that we will be overpaid
- Tertiary timely rules follow Medicare payment at 6 months, will this ever be looked at again? 2nd coverage = commercial, which would allow greater timely allowance
- Some of the tertiary issue is improving if the secondary payer is an MCO after the patient's private insurance. Notifying the COB office has helped immensely for future encounters since the client is exempt from the MCO if they have a private insurer as primary

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.

Communication *Health Care Authority working to fix incorrect Apple Health claim denials*

July 11, 2016

Provider Alert

Health Care Authority working to fix incorrect Apple Health claim denials

A recent change to ProviderOne caused the Health Care Authority (HCA) to deny some fee-for-service claims in error. The affected claims were denied as "prior authorization required."

HCA will update ProviderOne on July 29, 2016, to correct this problem. After that fix, claims should no longer deny incorrectly for authorization requirements.

Please do not resubmit claims denied for this reason between now and July 29.

HCA will reprocess the affected claims for providers after July 29 to pay these claims. Providers should see the reprocessed claims on their August 5 and August 12 remittance advices, where claims will appear as either paid or with a correct reason for denial.

If claims submitted after July 29 are inappropriately denied, please contact the HCA Customer Service Center at 1-800-562-3022.

Communication *Apple Health Paper Claims Submission Practices Changing*

Washington State Health Care Authority
Apple Health (Medicaid)

Apple Health Paper Claims Submission Practices Changing

Effective October 2016, the Health Care Authority (HCA) will accept only electronic claims for Apple Health (Medicaid) services, except under very limited circumstances.

We are making this change to improve efficiency in processing claims.

Providers may seek approval to submit paper claims if they are in a temporary or long-term situation outside of their control that precludes submission of claims electronically. Examples of these unusual circumstances may include but are not limited to:

- HCA notifies provider in writing that paper claims will be accepted due to ProviderOne System issues precluding acceptance of electronic claims.

- The provider can demonstrate that the information needed for adjudication of an Apple Health (Medicaid) claim cannot be submitted electronically using the claim formats required under the ProviderOne Billing and Resource Guide.

- The provider is experiencing a disruption in their electricity or communication connection that is outside of his or her control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted.

- Providers that have not submitted any electronic claims within the past state fiscal year (July 1, 2015 to June 30, 2016).

Providers who wish to ask for an exemption from submitting claims electronically may do so using the Request a Waiver form. Look for this form to arrive with a second notice in August.

If you need further information regarding this notice, please contact: HCA Customer Service Center at 1-800-562-3022.

Thank you

Send comments and questions to:

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