Washington State Health Care Authority

Tribal Compliance & Operations Work Group

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Agenda

- Maternity Support Services – Listening Tour
- Services rendered outside the 4 walls
- ProviderOne updates: Non-Native claims paying incorrect rate
- Non-Native SUD billing overview
- Clients with commercial insurance
- Top 5 ProviderOne rejections
- FAQ and Open Discussion
- Attachments
  - Draft TFQHC analysis
  - Maternity Support ***Save the Date!*** handout

Maternity Support Services – Listening Tour

- See the **Save the Date!** Letter attached to today's webinar
- Register as soon as possible, space is limited
- More information to be presented during the May 22nd Monthly Tribal Meeting (MTM)
- Visit the MSS resource table at AIHC Home Visiting Summit on June 1st

Services Rendered Outside the Four Walls

CMS Issues New Guidance on Services Provided Outside of the Clinic Facility

- Refer to TCOW slides from 01/11/2017 for background information
- On 01/18/2017 CMS shared an FAQ regarding the 100% FMAP expansion and indicates that "CMS has no present intention to review claims by Tribal "clinic services" providers for services furnished outside of the "four walls" before January 30, 2021 (Q 13)
- HCA needs time to create an Alternative Payment Methodology, update the state plan and make the necessary P1 changes before any Tribes are able to convert to this new type of FQHC that is required by CMS. This new type of FQHC is being labeled T-FQHC
- Please wait for HCA to provide analysis and make the necessary research before requesting to be a T-FQHC, you want to be able to make an informed decision
- In the meantime, keep doing what you have been doing before the CMS 4-walls discussion started – if you have been rendering clinically appropriate services in a school (or home, or mobile van, or in other outside locations) – keep doing what you have been doing and continue to bill Apple Health/Medicaid for Encounter-eligible services

ProviderOne Updates – Non-Native Claims Paying Incorrect Rate

- Medical, Dental, and Mental Health claims for non-Native Medicaid FFS clients are eligible for the full IHS encounter rate
- Medical and Mental Health claims for non-Native clients are incorrectly paying at the non-Native SUD FMAP rates
- Issue noticed 01/06/2017
- P1 corrected on 05/05/2017. Mike will reprocess incorrectly paid claims next week

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Non-Native SUD Billing Overview

	AI/AN client	NonNative classic and non-Alternative Benefit Plan (ABP)	nonNative ABP	NonNative SSI
Client RAC	Any CD encounter eligible RAC	Any CD encounter eligible RAC except 1201 or 1217	1201	1217
CD billing code modifier	Refer to the Tribal billing guide (DBHR CD outpatient general fund is *usually* HF and only HF)			
T1015 modifier	HF	HX	SE	HB
EXAMPLES				
Claim note	SCI=NA	SCI=NN	SCI=NN	SCI=NN
CD group therapy	96153 HF T1015 HF	96153 HF T1015 HX	96153 HF T1015 SE	96153 HF T1015 HB
CD individual therapy	H0004 HF T1015 HF	H0004 HF T1015 HX	H0004 HF T1015 SE	H0004 HF T1015 HB
Federal/State Match	100/0	50/50	95/5	86/14
How much does the claim pay? (2017)	$391.00	$195.50	$371.45	$336.26
How much IGT is required to be sent to DSHS?	$0	$195.50	$19.55	$54.74

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Non-Native SUD Billing Overview

Date of Service	IHS rate	Client RAC	FMAP	P1 payment	IGT match to be sent to DSHS
CY 2015	$350	1201 (ABP)	95%	$332.50	$17.50
		1217 (SSI)	86%	$301.00	$49.00
		All others	50%	$175.00	$175.00
CY 2016	$368	1201 (ABP)	95%	$349.60	$18.40
		1217 (SSI)	86%	$316.48	$51.52
		All others	50%	$184.00	$184.00
CY 2017	$391	1201 (ABP)	95%	$371.45	$19.55
		1217 (SSI)	86%	$336.26	$54.74
		All others	50%	$195.50	$195.50

FMAP and IGT rates are current as of 01/01/2017 with no planned changes until 01/01/2018

Clients with Commercial Insurance

- If a client has commercial insurance and Apple Health – you must bill the commercial insurance as primary
- If a client has commercial insurance and you do not see a Coordination of Benefits segment when you do a client benefit inquiry – P1 does not "know" that the client has commercial insurance and will reject secondary claims until P1 is updated
- Use the Contact Us portal, select Medical Provider, in the Topic drop-down select "private commercial insurance"
- Most updates take a couple of days, wait 3-5 days then run another client benefit inquiry to see if the update has made it into P1
- Refer to the ProviderOne Billing and Resource Guide for more information
- Feel free to contact mike at any time

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Medical – Top 5 Rejections

EOB	Description	Comments	Reject %
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Claim was missing the AI/AN (UA) or non-AI/AN (SE) modifier	19%
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	Client does not have full-scope coverage or claim has Servicing taxonomy issues, see EOB 204 in the September, 2016 TCOW	5%
22	This care may be covered by another payer per coordination of benefits.	Client has Medicare	4%
18	Exact duplicate claim/service	Duplicate billing	4%

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Dental – Top 5 Rejections

EOB	Description	Comments	Reject %
18	Exact duplicate claim/service	Duplicate billing	9%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Claim was missing the AI/AN (870001305) or non-AI/AN (870001306) EPA number (modifier EOB is a "best fit" EOB	7%
204	This service/equipment/ drug is not covered under the patient's current benefit plan	Client does not have full-scope coverage	7%
119	Benefit maximum for this time period or occurrence has been reached	Fluoride limitations, see Dental Billing Guide for complete policy. At a high level Age 0-6 - once every 4 months Age 7-18 - once every 6 months Age 19+ - once every 12 months	7%
26	Expenses incurred prior to coverage.	Client is not eligible on this date (could be before or after coverage ends)	5%

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Mental Health – Top 5 Rejections

EOB	Description	Comments	Reject %
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Claim was missing the AI/AN (HE) or non-AI/AN (SE) modifier	19%
204	This service/equipment/ drug is not covered under the patient's current benefit plan	Client does not have full-scope coverage or claim has Servicing taxonomy issues, see EOB 204 in the September, 2016 TCOW	15%
16 / N288	Missing/incomplete/invalid rendering provider taxonomy	Performing (*rendering, servicing*) taxonomy on claim is not a taxonomy that the performing provider is enrolled with	9%
119 / M80	Not covered when performed during the same session/date as a previously processed service for the patient	Similar to duplicate, usually involves different levels of mental health services on same day	7%
16/ N290	Missing/incomplete/ invalid rendering provider primary identifier	Performing (*rendering, servicing*) provider not in P1	3%

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Substance Use Disorder – Top 5 Rejections

EOB	Description	Comments	Reject %
181	Procedure code was invalid on the date of service	EOB on 181 is almost always because the code did not have the HF modifier or the code isn't in the SUD fee schedule	10%
204	This service/equipment/ drug is not covered under the patient's current benefit plan	Client does not have full-scope coverage or claim has Servicing taxonomy issues, see EOB 204 in the September, 2016 TCOW	10%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	SUD claims have modifier requirements for the SUD codes. I/T/U claims will almost always have HF modifier on the SUD code (refer to SUD billing guide)	10%
16 / N288	Missing/incomplete/invalid rendering provider taxonomy	SUD claims can't be billed with individual servicing NPIs. SUD claims are only billed with the clinic NPI	8%
273 / N362	The number of Days or Units of Service exceeds our acceptable maximum.	P1 error has since been corrected – max units (CMS Mandated MUE) erroneously applied to SUD – HCA has approval from CMS to waive the MUE for SUD services	3%

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FAQ and Open Discussion

Q. I have a claim for SUD crisis services (H2011) that is rejected in P1 as not covered

A. Crisis Services, is a payable mental health service. However, crisis for SUD is not covered by HCA, it is covered under the BHO benefit but not under the fee-for-service benefit

FAQ and Open Discussion

Q. If the MCO rejects the claim can it be billed to P1?

A. No, P1 will reject the claim to bill the primary payer.

If the MCO is supposed to pay and does not pay the issue needs to be fixed at the MCO level

- You can call the MCO's 1-800 number
- You can contact mike (I will need the actual EOB, claim numbers for MCOs don't work like claim numbers for P1)
- You can contact the Tribal Liaison at the MCO

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FAQ and Open Discussion

Q. Are telephone calls (CPT 99441-99443) covered by Medicare?

A. These codes are not covered by Medicare. If the client is a Medicare-dual eligible there is no need to bill Medicare for a denial – P1 has been coded to pay primary for these codes for the dual eligibles

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FAQ and Open Discussion

Q. Why did P1 reject the encounter payment for a CNP client with EOB N30 (*Patient ineligible for this service*)?

A. CNP clients with RAC 1211 are *State funded,* ***non-citizen*** clients. Non-citizen clients are not eligible for an encounter payment.

Mike has noticed that some clients who are RAC 1211 later get assigned a different CNP RAC that **is** eligible for the encounter rate. When this happens I can tell that the RAC 1211 was assigned due to failure to verify social security number when the client signed up for benefits. If the client corrects the social security number they are assigned a different CNP RAC that is eligible for encounter payments. The prior RAC 1211 dates can be corrected in P1 to reflect citizenship but only if the claim is forwarded to mike

FAQ and Open Discussion

Q. Can you remind us of the guidelines for telemedicine? Does it qualify for an encounter?

A. Telemedicine is currently not eligible for an IHS/FQHC encounter because it does not appear to meet the definition of face-to-face.

From the Physician billing guide - *The agency reimburses medically necessary covered services through telemedicine when the service is provided by a Washington Apple Health provider and is within their scope of practice*

- Originating site (where client sits) – bills a facility fee (Q3014)
- Distant site (where provider sits) – bills the actual service with modifier GT or 95
  - The Physician billing guide indicates to use Place of Service code 02 for telehealth (distant site)

HCA does not follow CMS guidelines in regards to the code-set for telemedicine-qualified services. *Services that are normally performed face to face but can be rendered without being actually in the same room may be billed as telemedicine for HCA*

FAQ and Open Discussion

Q. If we provide a service that should not be paid should we send a claim? Scenario I have is for SUD services and client received a group therapy in the morning and an individual therapy in the afternoon

A. I have a mantra "bill for what you did" but in this instance if you bill for what you did you would risk overpayment due to the overpayment loophole that exists in ProviderOne. It will be necessary to put all services onto one claim.

During last month's TCOW we noticed that UAs (CPT 80307) will pay if they are billed on an SUD claim – to avoid overpayment/audit risks in SUD please only bill for the codes listed in the SUD billing guide, this will avoid other P1 loopholes but it doesn't support my "bill for what you did" mantra

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FAQ and Open Discussion

Q. A few months ago mike shared a cheat sheet with Medicare denial codes and the resulting disposition in P1. I had a claim that medicare rejected with EOB #49, which was in the list of EOBs that would allow P1 to pay primary.

A. The P1 techs tried to code P1 to pay primary for the dual eligible clients if the service is **never** covered by Medicare (e.g., dental and SUD). Some services are **sometimes** covered by Medicare and P1 needs the denial EOB but, due to P1 automation, the claims are being auto-rejected. The only way to get these claims to pay in P1 is to contact mike

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FAQ and Open Discussion

Q. Our clinicians are required to actively observe clients taking TB and STD medications due to outbreaks. Is this reimbursable?

A. Directly Observed Treatment (DOT) information can be found at DOH's TB site - http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/Tuberculosis

DOT is covered by HCA for **Health Departments**. Refer to page 56 of the physician billing guide.

Stay tuned for more information

FAQ and Open Discussion

Q. How long do we have to retain the billing information in our office?

A. 6 years. Refer to WAC 182 502 0020 for record retention requirements. Partial excerpt below

Providers must:

(1) Maintain documentation in the client's medical or health care records to verify the level, type and extent of services provided to each client to fully justify the service and billing, including, but not limited to:

(a) Client's name and date of birth;

(b) Dates of services;

(c) Name and title of person performing the service;

(d) Chief complaint or reason for each visit; … ….

(q) Specific claims and payments received for services;

(5) Make charts and records available to the medicaid agency, its contractors or designees, and the United States Department of Health and Human Services (DHHS) upon request, for six years from the date of service or longer if required specifically by federal or state law or regulation;

Followup questions received during April TCOW

Q. does the 6 year rule also apply to SUD services? Yes, the DSHS rule mirrors the HCA rule WAC 388 877 0630

Q. What if the audit is going back 10 years? Stay tuned

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FAQ and Open Discussion

Q. Why isn't chiropractic covered for adults?

A. Chiropractic is an optional benefit & historically, for Medicaid, has only been covered for children who are referred during a well child (EPSDT) visit. Chiropractic is not listed as one of the essential benefits in the Affordable Care Act. Adult Chiropractic may be covered by the Managed Care Organizations, question pending the quarterly Tribe and MCO meeting (June 10th)

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

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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?

04/12/2017 – if Tribes convert to TFQHC status (after HCA is ready) then the Tribes may contract with individual providers (and pay the individual providers) and the Tribes may be able to bill for services at the encounter rate.

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

Pended Questions

Q. Why doesn't Medicare pay the All Inclusive Rate on Medicare claims?

A. Stay tuned. Here is the 2017 rate announcement - https://www.gpo.gov/fdsys/pkg/FR-2017-01-18/pdf/2017-01075.pdf

The *Medicare Rate* for 2017 is $349.00 does that mean that the states need to pay the encounters at $349.00 for Medicare dual eligible or does it mean that Medicare should pay $349.00 for Part B service or does it mean something else?

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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.