Washington State Health Care Authority

Tribal Compliance & Operations Work Group

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Agenda

- Medicaid Suspension for Incarcerated clients
- Summary of Behavioral Health Managed Care changes
- Points of Contact for the MCOs and the ITUs
- Paper claims submissions
- P1 Unbundling/overpayment issue
- Denture billing update
- Reprocess claims, do not rebill
- Commercial insurance and ProviderOne
- Top 5 ProviderOne rejections
- FAQ and Open Discussion
- Attachments – MCO/Tribal points of contact and Incarceration samples

Medicaid Suspension For Incarcerated Clients

- Beginning July 5th, P1 will suspend, rather than terminate, client eligibility while the client is in jail or prison
- *Where the client lays their head at night* is the commonly used rule to determine if a client is actively incarcerated
- When looking up a client's eligibility in P1 – disregard RAC 8000 and RAC 8500 (they are only being used as placeholders in P1, they are not a benefit plan)
- Attached to today's webinar is a cheat sheet for incarcerated clients

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Summary of Behavioral Health Managed Care Changes

- There have been a few changes in regards to Behavioral Health (Mental Health and Substance Use Disorder) coverage since April, 2016
- Non-Tribal providers that have questions regarding coverage for AI/AN clients who opt out of BHO-managed care may contact DSHS at FFSQuestions@dshs.wa.gov
- Behavioral health changes are summarized on the following slie

Summary of Behavioral Health Managed Care Changes

SUD services

Prior to 04/01/2016

- SUD is billed to P1 by the provider

04/01/2016 – 06/30/2017 SUD was moved over to the BHOs for coverage. What changed?

- Tribes – continue to bill P1 for the encounter rate
- Non-Tribal programs
  - If client is AI/AN – bill P1
  - If client is not AI/AN – bill the BHO

07/01/2017+

- Tribes – continue to bill P1 directly for the encounter rate
- Non-Tribal programs
  - If client is not enrolled in a BHO – bill P1
  - If client is enrolled in a BHO – bill the BHO

NOTE: TARGET entry still required

Mental Health Services

Below access to care – there have been no recent changes

- If client is enrolled in an MCO – bill the MCO (Tribes may bill P1 directly for AI/AN clients)
- If client is not enrolled in an MCO – bill P1

Above access to care – brand new program launched on July 1, 2017

- If client is enrolled in a BHO – bill the BHO (Tribes may bill P1 directly for AI/AN clients)
- If client is in the brand new program and is not enrolled in a BHO – bill P1

Points of Contact for the MCOs and the ITUs

- Attached to today's webinar is an updated MCO contact list
- MCOs have requested an updated list of key points of contact at the clinics, please let mike know if your information needs to be updated

Paper Claims Submissions

- Except for limited circumstances, HCA only accepts electronic claim submissions
- HCA respects the Indian HealthCare Improvement Act and will continue to accept paper claims submissions from Tribal Billing offices
- The address for submitting paper claims is

  Health Care Authority

  PO box 42727

  Olympia, WA 98504-2727

Electronic billing is still preferred whenever possible

P1 Unbundling/Overpayment Issue

- Encounter payments cover all services rendered, within a category, within a 24 hour period
- If a claim is billed/paid at the encounter rate and a second claim, within the same category of encounter, is billed it will often reject the T1015 line but pay on the FFS codes, this is an overpayment due to the Unbundling issue
- Avoid the Unbundling issue by billing all services on one claim

Denture Billing Update

- To help Expedite Denture Authorizations, HCA has updated the Authorization requirements for Dentures beginning July 1, 2017
- Refer to the Dental Billing Guide for more information at https://www.hca.wa.gov/assets/billers-and-providers/Dental-related-serv-bi-20170701.pdf
- Summary of the changes are on the following slides

Denture Billing Update - Extractions

- Prior to July 1, 2017 – Prior Authorization is required if the client will have 4 or more extractions that result in the client becoming edentulous in the Arch

- Beginning July 1, 2017 – *Expedited Prior Authorization* (EPA) is now an option if the client/service meets the EPA criteria as outlined on p.96-97 in the Dental Billing Guide at https://www.hca.wa.gov/assets/billers-and-providers/Dental-related-serv-bi-20170701.pdf

Denture Billing Update - Dentures

- Prior to July 1, 2017 – Prior Authorization is required for dentures
- Beginning July 1, 2017 – EPA is now an option if the client/service meets the EPA criteria as outlined on p.95 of the Dental Billing Guide
- NOTE: The Denture EPA can only be used if the extractions were billed under one of the Extraction EPAs. For example, if the client was already edentulous then the EPAs do not apply

Denture Billing with Multiple Auth Numbers

- HIPAA formatting only allows for
  - A single authorization number at document level
  - A single authorization number on each line

Q. How can you bill with two authorization numbers since the Dental claims already require the AI/AN (870001305) or non-AI/AN (870001306) EPA?

A. Refer to the November 12, 2015 TCOW for more information on billing with multiple auth numbers at https://www.hca.wa.gov/assets/program/billing-workgroup-20151112.pdf

Reprocess Claims Rather than Rebill

- A claim should only be billed one time, If a previously billed claim needs to be corrected it should be *replaced*
- Electronic (HIPAA batches) refer to *replacements* as frequency 7 (in contrast to a regular new claim, which is a frequency 1)
- Claims can also be replaced in the ProviderOne Portal but HCA split up the replacements
  - Perform a *resubmit denied/voided claim* if the original claim was denied
  - Perform a *claim adjustment/void* if the original claim was paid
- Replacing claims rather than just rebilling solves many problems
  - Timely issues are automatically not an issue because the original, timely TCN is part of the claim trail
  - Reviews/audits/analysis are so much cleaner if there are not a lot of duplicate claims submissions
  - The unbundling/overpayment issue is resolved if everything is on one claim

Commercial Insurance and ProviderOne

- If a client has commercial insurance and you want to bill a claim secondary to commercial insurance please check the client's eligibility in P1 before submitting the claim
- If P1 indicates that the client has commercial insurance and it corresponds to the information you have – bill P1 secondary to commercial insurance
- If P1 does not indicate that the client has commercial insurance – P1 needs to be updated before claims can be submitted, follow this process
- Select the "Contact HCA" link at the bottom of the HCA website https://www.hca.wa.gov/
- Choose "I am an Apple Health (Medicaid) biller or provider"
- In the "contact" section, select "Online: secure web form" under "Medical Assistance Customer Service Center (MACSC)"
- Select "medical provider" and fill out the information
- Select "private commercial insurance" in the "select topic" menu and then submit the request
- Wait 3-5 days and check to see if the client's eligibility has been updated

ITU payment snapshot

- Claims Analyses present a payment percentage. This is just a global ITU payment percentage for recent claims if you would like to compare your claims

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Medical – Top 5 Rejections

EOB	Description	Comments	Reject %
18	Exact duplicate claim/service	Duplicate billing	15%
A1/ N149	Rebill all applicable services on a single claim	The P1 overpayment/Unbundling issue was closed for the Urban Indian Orgs. All services (per category/visit) need to be on one claim	14%
204	This service/equipment/ drug is not covered under the patient's current benefit plan	Client does not have full-scope coverage, either family planning only or Medicare-only. Sometimes we will also get this rejection if the rendering taxonomy on the claim is not one that is used by P1 (eg 390200000x or 101YA0400x)	11%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	The AI/AN modifier (UA) or the non-AI/AN modifier (SE) was missing	10%
24	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in MCO	5%

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Dental – Top 5 Rejections

EOB	Description	Comments	Reject %
16/ M53	Missing/incomplete/invalid days or units of service	This was a P1/HIPAA error. Dental HIPAA claims may be billed with no units on the service line and P1 is supposed to convert the blank values to "1". This was not happening, P1 was corrected on June 30th, please rebill (mike can't reprocess because P1 scrubbed the units)	14%
204	This service/equipment/ drug is not covered under the patient's current benefit plan	Client does not have full scope coverage. Most claims were medicare-only clients	8%
6	The procedure/revenue code is inconsistent with the patient's age.	Crowns and (posterior) root canals not payable for adults. Oral Hygiene instructions (D1330) only for age 0-8 and not intended for office setting	6%
18	Exact duplicate claim/service	Duplicate billing	5%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	This is a best-fit EOB. Claim was missing the EPA AI/AN client 870001305 Non-AI/AN client 870001306	5%

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Mental Health – Top 5 Rejections

EOB	Description	Comments	Reject %
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)	20%
16/ N290	Missing/incomplete/ invalid rendering provider primary identifier	Performing (*rendering, servicing*) provider not in P1	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	14%
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	12%
24	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in MCO (only affected Urban Org claims)	4%

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Substance Use Disorder – Top 5 Rejections

EOB	Description	Comments	Reject %
18	Exact duplicate claim/service	Duplicate billing	30%
204	This service/equipment/ drug is not covered under the patient's current benefit plan	Client does not have full-scope coverage	17%
16/ N288	Missing/incomplete/invalid rendering provider taxonomy	SUD claims are not billed using individual servicing provider IDs. Mike actively working with provider/RPMS on this issue	15%
16 / N290	Missing/incomplete/ invalid rendering provider primary identifier	SUD claims are not billed using individual servicing provider IDs. Mike actively working with provider/RPMS on this issue	8%
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)	4%

FAQ and Open Discussion

Q. The Mental Health Billing Guide indicates that LMHPs and Psychologists can only see patients in an outpatient setting. Can't the providers render services wherever clinically appropriate?

A. Refer to the table on 32-33 of the Mental Health Billing Guide
https://www.hca.wa.gov/assets/billers-and-providers/mental-health-svc-bi-20170801.pdf

Mental health services coverage table

CPT® Code	Short Description	Psych MD	P-ARNP PMHNP-BC	LMHP*	Psych Ph.D.	Limits	EPA/PA
[redacted]*	[redacted]	X	X	X****	X****		

The footnote previously read - *This service provided by the identified professional is allowed in an outpatient setting only*

The footnote has been corrected and now reads - *This service provided by the identified professional is not allowed in an inpatient setting*

NOTE: this is not related to the 4-walls issue

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FAQ and Open Discussion

Q. If a client is on restriction do the Managed Care Plans also have the same restriction?

A. Yes, the restricted client information in P1 is for FFS and Managed care clients, the MCOs send client restriction information to P1. Please contact mike if you have a client on restriction and you are not on the client's restriction list

Restricted Client Information

Assignment Type	Provider Name	Provider Phone Number	Period Start Date	Period End Date
Pharmacy	WAL-MART [redacted]	[redacted]	01/18/2015	04/30/2016
Hospital	[redacted] MEMORIAL HOSP INC	[redacted]	01/18/2015	04/30/2016
Primary Care Physician	[redacted] PAC	[redacted]	01/18/2015	04/30/2016

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FAQ and Open Discussion

Q. What are the diagnosis requirements for Behavioral Health claims submitted to ProviderOne?

A. Behavioral Health may be either Substance Use Disorder (SUD) or Mental Health

- The SUD billing guide indicates that the primary diagnosis on the claim be one of the diagnosis codes listed in the SUD billing guide
- The Mental Health billing guide indicate that the diagnosis be in the Mental Health range (ICD10 F-series), be appropriate for the service, and be coded to the highest level of specificity

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FAQ and Open Discussion

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

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

The Medicare rate ($349.00 in CY2017) is not part of the claim data that is forwarded to ProviderOne from Medicare

Medicaid/ProviderOne will continue to pay secondary to Medicare using the Medicare allowed, coinsurance, deductibles and payments according to the data that is received on the claim (WAC 182-501-0110)

FAQ and Open Discussion

Q. We heard that the claims submission cutoff is Tuesday for the following weekend's remittance but our claims sent on Tuesdays are never ready on the weekend's remittance

A. HIPAA batches are usually received in P1 during the middle of the night. A HIPAA batch sent anytime on Tuesday will actually be received in P1 on Wednesday

FAQ and Open Discussion

Q. We recently updated one of our doctor's taxonomies in P1, do we have to resubmit all the claims?

A. If there isn't anything that needs to be changed on the claim, please contact mike

- If there are less than about 25 claims – might be faster to reprocess from your side
- If there are more than about 25 claims – mike can request a mass adjustment, which may be quicker than reprocessing one-at-a-time

Reach out to mike for claims help at any time

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Pended Questions

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

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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).

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.

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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.