Washington State Health Care Authority

Tribal Compliance & Operations Work Group

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October 11, 2017

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Agenda

- Tribal Billing Guide – October 1 update
- MCO wraparounds – P1 issue
- MCO payment at the IHS encounter rate - update
- Opioid Prescribing update
- Preventive Medicine Services (CPT 99381-99397)
- IHS encounter-eligible Recipient Aid Category (RAC) codes
- Electronic Authorization Submissions
- Spenddown
- P1 payment snapshot and Top 5 rejections
- FAQ and Open Discussion
- Attachments – list of IHS-encounter-eligible Recipient Aid Category (RAC) codes, HCA Opioid Prescribing policy, Draft insurance updates reference sheet

Tribal Billing Guide – October 1 update

Changes made to the Tribal Health Billing Guide on 10/01

- The list of providers who are eligible for the encounter rate removed incorrect interpretation and re-aligned with the State Plan *The services of the following providers are included in the encounter rate*
- The Link to the Chiropractic billing guide was removed because Chiropractors are not in the list of providers who are eligible for the encounter rate
- Added the mailing address for paper claims submissions

MCO Wraparounds – P1 Issue

- IHS/638 providers are allowed to bill P1 for the balance of the IHS encounter rate secondary to Apple Health Managed Care Organization (MCO) payment for AI/AN clients
- In July the MCO wraparounds started rejecting in error in P1 (EOB 24)
- The P1 correction is scheduled for October 23. Mike will reprocess all claims that were rejected in error

MCO Payment at the IHS Encounter Rate - Update

- In an effort to decrease the administrative burden of billing twice (billing the MCO and then P1) HCA and the Managed Care Organizations (MCOs) have been making updates that will enable the claims billed to the MCOs to pay at the IHS encounter rate
- Testing has been completed in P1
- Next step – testing at the MCO level

Opioid Prescribing Update

- Refer to the 09/25/2017 Monthly Tribal Meeting for the complete update. The HCA Opioid Prescribing Policy slides are also attached to today's webinar
- Beginning 11/01/2017 – HCA and the MCOs will adopt new opioid prescribing policy
- The Goals of the policy are
  - Reduce unnecessary exposure
  - Reduce unused pills in community
  - Ensure safe transitions and best practices when chronic use is needed
  - Minimize administrative burden on providers
  - Encourage adherence to guidelines while recognizing clinical need for exceptions

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Preventive Medicine Services (CPT 99381-99397)

- CPT 99381-99395 are only covered in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program (well child visits) or in the TAKE CHARGE program (a subset of the Family Planning program)

- CPT 99381-99397 are not covered by HCA for adults (age 21 and over) outside of the TAKE CHARGE program
- During Claims Analyses, I often see one of the preventive codes billed for an adult with a GYN cancer screen diagnosis
- **Cancer screens are covered** (and encounter eligible) but under different codes
- Refer to page 140 of the current Physician-Related Services/HealthCare Professional Services Billing guide for more information

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IHS Encounter-Eligible Recipient Aid Category (RAC) Codes

The Tribal Health Billing Guide (p. 17) has a list of RAC codes that are not eligible for the IHS encounter rate

Q. Which RAC codes **do** qualify?

A. Apple Health RAC codes that are not in the list.

Please see attached list of RAC codes, all current Apple Health RACs are present along with a yes/no column to indicate if the RAC is eligible for the IHS encounter rate

Electronic Authorization Submissions

- The ProviderOne screens have always had “On-Line Prior Authorization Submission” on the home page but ProviderOne has not been ready to accept on-line authorization submissions
- The On-Line Prior Authorization Submission will be available soon, HCA is currently testing
- If you would like to help with testing the on-line Prior Authorization process please contact mike (testing will be with real authorization requests)

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Spenddown

- Spenddown is a type of client liability, similar to an insurance deductible
- Spenddown liability is the amount of medical expense a client must incur before medical coverage begins
- If the client has not accumulated enough financial obligations to obtain medical benefits the Benefit Service Package displays *Pending Spenddown – No Medical*
- A provider can fax paid or unpaid bills (including HCFA/ADA forms) incurred during the client's spenddown period to "chop away" at the spenddown rather than just write off the charges (writing off the charges will not "chop away" at the spenddown)
- Purchased and Referred Care – those bills may also be faxed to the spenddown line
- Please refer to the Spenddown step-by-step fact sheet for more information

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ITU Payment Snapshot

Payment percentages for I/T/U claims processed in the last quarter.

Category	Payment percentage
Medical	76%
Dental	76%
Mental Health	90%
SUD	95%

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Medical – Top 5 Rejections

EOB	Description	Comments	Reject %
204 02190	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%
16 / N34 02207	Incorrect claim form/format for this service	Claims were billed to P1 secondary to Medicare B or C but were not billed as "crossovers"	9%
22	This care may be covered by another payer per coordination of benefits.	Client has Medicare (see 16/N34 too)	9%
24	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in MCO	7%
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	7%

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Dental – Top 5 Rejections

EOB	Description	Comments	Reject %
18	Exact duplicate claim/service	Duplicate billing	11%
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 covered in office-type settings	6%
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	6%
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	5%
26	Expenses incurred prior to coverage.	Client is not eligible on this date (could be before or after coverage ends)	4%

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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) we will also get this rejection if the rendering taxonomy on the claim is not one that is used by P1 (eg 101YA0400x)	27%
16/ N290	Missing/incomplete/ invalid rendering provider primary identifier	Performing (*rendering, servicing*) provider not in P1	17%
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	11%
24	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in MCO (only affected Urban Org claims)	7%
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	3%

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Substance Use Disorder – Top 5 Rejections

EOB	Description	Comments	Reject %
204	This service/equipment/ drug is not covered under the patient's current benefit plan	Client does not have full-scope coverage there were a few large batches of claims that had servicing taxonomy 101YA0400x (SUD is basically always 261QR0405x (except methadone and case management)	26%
16/ N290	Missing/incomplete/ invalid rendering provider primary identifier	Related to the 204 EOB. Reminder – SUD claims cannot contain individual servicing NPIs, SUD claims are billed with clinic NPIs only	17%
16 / N288	Missing/incomplete/invalid rendering provider taxonomy	Related to 204 EOB	11%
4 00800	The procedure code is inconsistent with the modifier used or a required modifier is missing	Refer to SUD billing guide for modifier requirements – modifier on the billing code is almost always HF	9%
170/ N95	This provider type/provider specialty may not bill this service	Most of the claims were UAs/lab codes or acupuncture. The only payable codes for SUD are in the SUD guide	2%

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FAQ and Open Discussion

Q. Is there a way to bill P1 a secondary claim without attaching a denial EOB if the primary insurance did not make a payment?

A. Yes, please refer to P.71-72 of the P1 Billing and Resource Guide

If the primary insurance denial EOB was any of the following and the EOB is entered the claim *should* automatically process for primary payment in P1

1, 2, 3, 6, 9, 11, 35, 39, 40, 45, 49, 50, 51, 54, 55, 56, 59, 94, 96, 97, 119, 149, 151, 167, 168, 170, 198, 202, 204, 222, 234, 248, A1, B1

Stay tuned for a Step by step reference sheet in a future webinar

FAQ and Open Discussion

Q. P1 indicates that a client is incarcerated but the client is at our clinic for services. What do we do?

A. Check the client's eligibility in P1. When you see RAC code 8000 or 8500 – **ignore it**, look at the other RAC codes for the date of service

If the Benefit Service Package for the date of service says *Suspended – Inpatient Hospital Services Only* that means that the client is coded as incarcerated and benefits have been suspended during the client's incarceration.

If a client's P1 eligibility indicates *Suspended – Inpatient Hospital Services only* and the client is seeking services for any date within the suspension then 1 of 2 things have happened

1. The client has escaped from incarceration

2. The client has been released but P1 has not been updated yet, if this happens just let mike know and mike will try to get the client's eligibility fixed up ASAP

Sample Benefit Inquiry on the next slide

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FAQ and Open Discussion

Incarcerated clients, continued

Below is a sample Client Benefit Inquiry from P1

A – client is full scope/ABP until 09/01/2017

B – client is incarcerated (suspended) from 09/02/2017 – 09/07/2017

C – RAC 8500, ignore this line

D – client is full scope/ABP beginning 09/08/2017

Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group
MC: Medicaid D	1201	ABP	09/08/2017	12/31/2999	N05
MC: Medicaid C	8500	SBP - Institutionalized Dates	09/01/2017	09/08/2017	
MC: Medicaid B	1201	Suspended - Inpatient Hospital Services Only	09/02/2017	09/07/2017	N05
MC: Medicaid A	1201	ABP	01/01/2015	09/01/2017	N05

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FAQ and Open Discussion

Q. We had an EPSDT screening (Well Child visit) on the same day as an E&M. The EPSDT screen was rejected for services too soon (EOB 119) but why didn't P1 pay on the E&M? The E&M was billed because the client was diagnosed with an illness and received E&M after the Well Child Visit

A. If a claim has CPT 99381-99395 then the **entire claim** becomes an EPSDT claim and E&Ms (99201-99215) are not payable on EPSDT claims.

FFS providers may split the claim into 2 separate claims if the services were significantly separate

IHS/638 providers can't split the claim because that would result in the unbundling /overpayment issue, resolution is to reprocess the claim without the EPSDT code, this will convert the claim back to a regular medical visit

Urban Orgs (FQHCs) may split the claim if the services have unrelated diagnoses and are significantly separate and receive separate encounter payments

Note: per NCCI coding rules – An E&M is not payable on the same day as a well child visit when rendered by the same provider unless the services were significantly separate (e.g. meets the requirements for modifier 25 on the E&M)

FAQ and Open Discussion

Q. We had a client who was retroactively eligible for Medicare and HCA recouped the claims. After we bill Medicare and try to bill P1 our claims are being rejected as duplicates (EOB 18). What can we do?

A. When a client is retroactively eligible for Medicare HCA recoups the Medicare-eligible claims and pays them at $0 (rather than deny). When the new Medicare cross-over claim is billed it will reject as a duplicate because technically it is a duplicate.

You have 2 options for billing when this scenario occurs

- Reprocess the claim that recouped the money (contact mike for assistance finding the TCN), this is the cleanest way because it maintains a single claim trail
  - Or a two-step process
- Void the claim that was recouped (it will recoup the $0 but it will no longer be technically paid)
- Bill the Medicare cross-over claim.

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FAQ and Open Discussion

Q. Why did my SUD claim deny the T1015 line with EOB 204? The billing codes paid but not the T1015

A. Currently clients in the Children's Health Insurance Program (CHIP, RAC 1206 1207) are listed in the billing guide as not eligible for an SUD encounter (eligible for other categories, just not SUD)

Stay tuned for more information

FAQ and Open Discussion

Q. How do we bill for Locum Tenens?

A. Claims for Locums are billed using the Locum's servicing NPI and taxonomy (and modifier Q6) (page 27 of the Physician Billing Guide)

Background

In 2012 the billing for Locums changed as a result of the implementation of ACA. Previously services of Locums were billed using the regular practitioner's NPI (and mod Q6), currently services of a Locum are billed using the Locum's NPI (and mod Q6)

The services of a Locums are allowed for up to 90 contiguous days (42 USC Chapter 7, subchapter XIX sec 1396a 32(c))

If you will have a Locum Tenens or other temporary provider please contact mike for tips on how to get the provider enrolled in P1 in order to avoid payment issues

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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FAQ and Open Discussion

Q. If we can't receive reimbursement for those in the poky, and county/city jails bring their inmates to IHS so they don't have to pay for the medical/dental care, how do we recoup costs from the city/county jail. If they go to private entities or the hospitals they are allowed to bill the jail entity so shouldn't I/T/U's be able to be reimbursed somehow?

A. Stay tuned, in the interim -- The Jail is responsible for the healthcare of their enrollees while the enrollee is in custody

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FAQ and Open Discussion

Q. If a provider sees a patient in Federal jail (BIA) they can bill Medicaid? Or is that considered outside the tribes 4-walls?

A. Stay tuned, in the interim – the jail is responsible for the health care of their enrollees during the incarceration.

I want to separate the 4-walls question – the jail would be outside the 4-walls unless the Health Clinic has a jail within the facility

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FAQ and Open Discussion

Q. We have a pregnant patient in Tribal jail, they bring her for her prenatal appts but we do not bill. When she delivers she'll be in hospital, can we bill delivery only or the prenatal package?

A. The prenatal package wouldn't be billable because the client was incarcerated during those days

FAQ and Open Discussion

Q. Having issues with notifying HCA that there is private insurance not disclosed by the client to HCA or that the private insurance as stated on P1 has changed or termed. We used to send the COB office a fax. That is no longer acceptable and it is sent back with no instructions. Who do we contact about updates? What is the current procedure regarding informing HCA about billable (or unbillable) private insurance?

A. Draft Insurance Update reference sheet attached, feedback is appreciated

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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.