Washington State Health Care Authority

Tribal Compliance & Operations Work Group

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Washington State Health Care Authority

Agenda

- ITU and MCO Meeting
  - Prior Authorizations
  - Open Discussion
- Dental Managed Care
- Adult Preventive visits
- Top 5 rejections
- Prior TCOW questions
- FAQ and Open Discussion

ITU and MCO

We have several providers that are concerned about the Managed Care Plans taking over the payment of the Medicaid encounter rate. Managed Care Plans may require authorizations for specific services. One provider's exact words were, "they have a strenuous pre-authorization process that scrutinizes every request, of which more times than not, end up in a denial".

- On the P1 side, there are commonly two different types of authorizations
  - **The code** needs auth. It is clearly indicated in the billing guides or fee schedules if **the code** needs authorization (dental, and medical)
  - The code does not need authorization but **the service** may need authorization. Examples – if **the service** exceeds HCA's frequency schedule or a referral is required (a best fit denial EOB would be *exceeds limits* or *referral required* but sometimes the catch-all EOB 197 may be used. The most specific EOB should be assigned if possible)
- Do the Managed Care plans have a similar authorization model?
- Is EOB 197 (*Precertification/authorization/notification absent*) the EOB that the MCOs assign to claims if rejected for **the code** needing authorization and for **the service** not being payable without an authorization (because the service needs referral or exceeds limits, etc)?

I/T

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ITU and MCO

Open Discussion

Are there any questions or issues for the Managed Care Plans?

Is there anything that the Managed Care Plans would like to share?

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Dental Managed Care

During the 2017 legislative session, Substitute Senate Bill 5883 passed, requiring the Health Care Authority (HCA) to contract through the competitive procurement process with licensed dental health plans or managed health care plans to provide carved-out managed care dental services by January 1, 2019. The purpose of the legislation is to allow for greater efficiency, and facilitation of better access and oral health outcomes for Washington Apple Health (Medicaid) enrollees.

How does this impact Indian Health Care Providers?

I/T – the *Draft IHS Encounter Payment Table* has been updated and attached to today's webinar. At a high level Dental Managed Care services will be billed and reimbursed similarly to physical Managed Care (MCO) services.

- AI/AN client – bill managed care plan then P1 for the balance of the encounter rate
- nonAI/AN client – contract with the managed care plan, not encounter-eligible

U - Services will be billed to the client's managed care plan

I/T/U

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Dental Managed Care

Q. If we contract with one of the new dental managed care plans, will the dental managed care plans be required to pay the encounter rate?

A. We do not know if the approved dental managed care plan will be able to pay at the encounter rate (for AI/AN clients) or if claims will be submitted to the Dental Managed Care plan then to P1 for the balance of the IHS rate similar to current MCO wraparounds.

Q. If we contract with one of the new dental managed care plans and the dental managed care plan covers (for example) cast metal partial dentures. Would those services be eligible for the encounter rate?

A. The Tribe is eligible for the encounter rate for **medicaid covered** services. Cast metal partials are not a medicaid-covered service. Cast metal partials are an added value benefit, they would not be encounter-eligible because they are not a medicaid covered service

Q. For dentures, we are allowed up to 5 encounters to account for the (unbillable) face-to-face visits. will the dental managed care plans also pay for multiple encounters?

A. The Multiple encounter concept will be retained. If the Managed care plan is paying at the IHS encounter rate then they will need to have the multiple encounter concept programmed into their payment systems

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Adult Preventive Visits

- Preventive Medicine Services (CPT 99381-99397) have limited coverage in Apple Health
- The Preventive Medicine Services CPT codes listed above are used in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (*well child*) program. The EPSDT program is for clients through age 20*
- Claims for clients age 21 and over that are submitted to P1 with the Preventive codes are not payable.
- Many of the claims have a cancer screen diagnosis – refer to page 154 of the Physician-Related Services and Health Care Professionals billing guide for the HCA-billable codes for cancer screens

* The Preventive codes are also used in the TAKECHARGE Program (not encounter-eligible and no ITUs are TAKECHARGE providers)

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Medical - Top 5 Rejections

EOB	Description	Comments	Reject %
18 ITU	Exact duplicate claim/service	Duplicate billing	17%
204 ITU 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)	7%
24 ITU 02035	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in MCO	6%
96 / N30 ITU 02370	Patient ineligible for this service	Clients were SLMB (Medicare only)	4%
167 ITU 03755	This (these) diagnosis(es) is (are) not covered.	Some ICD-10 diagnosis codes are *generally not payable if billed as the primary diagnosis on a medical claim.* The list of codes is attached to today's webinar	4%

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Dental - Top 5 Rejections

EOB	Description	Comments	Reject %
119 ITU 12195	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	6%
204 ITU 02190	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%
96 / N428 ITU 03175	Not covered when performed in this place of service	Limited Visual Oral Assessment (D0190 D0191) and Oral Hygiene Instructions (D1330) are not covered in office settings	5%
6 ITU 03145	The procedure/revenue code is inconsistent with the patient's age	Oral Hygiene instructions is for age 0–8 Prophy age is divided as follows D1110, adult – age 14 and over D1120, child – age 0 – 13	5%
15 ITU 11120	The authorization number is missing, invalid, or does not apply to the billed services or provider.	Most services were technically not payable (crowns/root canals or core buildup) for adults. I/T providers may see this EOB if the AI/AN (870001305) or nonAI/AN (870001306) authorization is missing	4%

Mental Health - Top 5 Rejections

EOB	Description	Comments	Reject %
18 ITU	Exact duplicate claim/service	Duplicate billing	14%
204 ITU 02190	This service/equipment/ drug is not covered under the patient's current benefit plan	Client is not full-scope (e.g. QMB/Medicare only) we will also get this rejection if the rendering taxonomy on the claim is not one that is used by P1 (eg 101YA0400x)	11%
16/ N290 ITU 01010	Missing/incomplete/ invalid rendering provider primary identifier	Performing (*rendering, servicing*) provider not in P1. contact mike, let's get the provider onboarded (if applicable)	6%
16 / N255 01475	Missing/incomplete/invalid billing provider taxonomy	Claims appear to just have software issues Urbans – Billing taxonomy is 261QF0400x IHS/Tribal – Billing taxonomy is 2083P0901x (for mental health)	5%
16/ N288 ITU	Missing/incomplete/invalid rendering provider taxonomy	Performing (*rendering, servicing*) taxonomy on claim is not a taxonomy that the performing provider is enrolled with	4%

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SUD - Top 5 Rejections

EOB	Description	Comments	Reject %
18 ITU	Exact duplicate claim/service	Duplicate billing	17%
204 ITU 02190	This service/equipment/ drug is not covered under the patient's current benefit plan	Client was a Medicare-only client or claim had taxonomy issues (101YA0400x is not used by P1, outpatient SUD is billed using 261QR0405x)	8%
24 U 01365	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in a BHO (or FIMC)	7%
4 ITU 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	7%
170/ N95 ITU 03740	This provider type/provider specialty may not bill this service	Acupuncture and labs are not payable on SUD claims. Some claims were missing the HF modifier on the SUD code	5%

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Prior TCOW Questions

- Attached to today's webinar is a list of the TCOW questions received during the TCOWs beginning with the March, 2018 TCOW
- An ongoing TCOW questions file is being developed and will eventually be on the Tribal Affairs website

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FAQ and Open Discussion

Q. We will have a Locums provider soon, how are claims for Locums billed?

A. Contact mike as soon as you think you will have a Locums, he will help get the new provider onboarded into P1

Follow the Physician-Related Services/Health Care Professional Services Billing Guide (p. 26) for billing

When billing, enter in the Locum's (performing) NPI and taxonomy

- Professional (HCFA) claims – add modifier Q6
- Dental claims – no modifier needed for Locums, just use the Locum's NPI and taxonomy

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FAQ and Open Discussion

Q. How do we get a facility added to the facilities list?

A. Stay tuned, I will try to find someone in the Portland Area Office to help with this question. This is in regards to the 4-walls limitation.

I/T

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FAQ and Open Discussion

Q. How do I determine if a client is AI/AN and eligible for federal funds?

A. A client must meet the provisions of 25 U.S.C. 1603(c) (d) for federally recognized Tribal members and their descendants

Q. How do folks at the clinics verify that the client is eligible?

25 U.S.C. 1603 (c) (d) The term ''Indians'' or ''Indian'', unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) hereof,1 except that, for the purpose of sections 1612 and 1613 of this title, such terms shall mean any individual who 2 (A),3 irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or
(B) is an Eskimo or Aleut or other Alaska Native, or
(C) is considered by the Secretary of the Interior to be an Indian for any purpose, or
(D) is determined to be an Indian under regulations promulgated by the Secretary.

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FAQ and Open Discussion

Q. A pharmacist's professional services are encounter eligible now with the new SPA. What professional services are payable to pharmacists (on a HCFA claim)

A. The professional services that are payable for a pharmacist's services include

- Tobacco cessation for pregnant clients (physician billing guide)
- Clozaril case management (physician billing guide)
- Emergency contraception counseling (prescription drug billing guide)
- Vaccine Administration fee (prescription drug billing guide)

NOTE: pharmacist's professional services for Medicaid-covered services are eligible for the IHS encounter rate but not the FQHC encounter rate

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FAQ and Open Discussion

Q. Why did P1 reject my claim with EOB 31 (*patient cannot be identified as our insured*)? I double checked the client ID and it is correct

A. If P1 rejects with EOB 31 and you are confident that the client ID is correct – there is probably a space after the WA in the client ID. P1 is treating the space as if it is a value and P1 considers the client ID invalid. If you do a *resubmit denied/voided claim* in P1 and enter in the client ID without getting an error popup then the space after the WA was most likely the issue

For example, drag your cursor over these 3 samples to "see" the space after the WA. The last one has a lot of spaces to help illustrate

123456789wa

123456789wa

123456789wa

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FAQ and Open Discussion

Q. Periodic and Comprehensive Dental Evaluations (D0120 and D0150) are covered once per 6 months*, what if the client has a condition and needs to be seen before the 6 months have elapsed?

A. Refer to the Dental Billing Guide, other medically necessary services that are not subject to the 6 month limitation include

- Limited Oral Evaluations (D0140), and
- Palliative (emergency) treatment (D9110)

These services are not subject to the once per 6 month rule because these are not Periodic evaluations (*Periodic evaluations*, by definition occur at intervals, whereas the limited and Palliative care are rendered on an as-need basis)

*D0150 is a *new patient code* and is only for clients who meet the new patient criteria.
*DDA clients may receive an exam more often than once per 6 months, refer to the billing guide for more information

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FAQ and Open Discussion

Q. Does CPT 96372 (*therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular*) qualify for the encounter rate?

A. Yes, this service qualifies for the encounter rate

CPT 96372 is more than "just giving a client a shot"

Note, however that CPT 90471 (*immunization administration*) and 90472 90460 90461 which are other immunization administration codes do not qualify for the encounter rate

FAQ and Open Discussion

Q. We have a dual-credentialed provider (MHP and CDP) who would like to bring clients in for group therapy but split the sessions

The first half of the session is Mental Heatlh

The second half of the session is SUD

Are these separately billable?

A. Yes, the services are separately billable if all of the following are true

- The services did not occur concurrently
- The services each have separate and distinct chart notes
- The services each have separate and distinct treatment plans
- The services comply with NCCI requirements

- IT (AND U? pending guidance for Urbans)

FAQ and Open Discussion

Q. We have a client who is on electronic monitoring and is attending treatment services. All of his claims are being denied because P1 indicates he is incarcerated. Is home monitoring a form of incarceration?

A. No, Home Monitoring is not incarceration, benefits are not suspended for Home Monitoring. Refer to the Medicaid Suspension website

The *where you lay your head to go to bed* rule is often used

If person sleeps in jail → they are incarcerated

If person does not sleep in jail → they are not incarcerated

If a client presents to your clinic for services and P1 indicates that the client is incarcerated, contact mike, chances are 1 of 2 things has happened

1. The client has escaped from incarceration
2. The client is not incarcerated and P1 incorrectly indicates that the client is incarcerated

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FAQ and Open Discussion

Q. We have been using the CPT 96154 for one-on-one SUD therapy instead of the H0004 – should we correct all the previous claims?

A. Start using the correct coding on new claims. There is no need to reprocess the prior claims for two reasons

1. one-on-one (H0004), family with client (96154), family without client (96155) all have the same rate.

2. Claims are paid at the encounter rate

Confirmed with DBHR

I/T/U

FAQ and Open Discussion

Q. How often should an SUD assessment be conducted?

A. An assessment should be done as soon as a person begins to seek out services, we used to follow a 6 month process for new assessments if the patient left services and/or relapsed. It would now depend on the agency, the contract requirements, RCW and WAC

Q. If a client's last assessment was 2 or more years ago and there has not been a change in the client's condition is there a need for a re-assessment?

A. If the client is still in services, a new assessment is not needed as long as there has been constant contact. If the client has had a gap in service and wants to re-enter services the assessment would need to be redone or updated

Confirmed with DBHR

FAQ and Open Discussion

Q. If the client's last assessment was in 2014 (in the DSM-4 days) is there a need to update the assessment due to DSM5?

A. An update to the last assessment would need to be completed whenever there is a break in service, if the client has not received services for an extended time and the agency seeing the client does not have a copy of the assessment a new one should be completed

Confirmed with DBHR

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FAQ and Open Discussion

Q. Can a client undergo therapy without an assessment in place?

A. No, they could receive a brief intervention (a short meeting with a client at a hospital, medical clinic, school, or other non-traditional setting) but the definition is clear intervention only to support the next step in services

Confirmed with DBHR

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FAQ and Open Discussion

Q. If a client receives an Assessment but the clinician determines that the client does not meet the criteria for any of the diagnoses listed in the SUD billing guide, can the assessment be paid?

A:

Currently - SUD claims are only payable if the primary diagnosis is in the list of approved diagnoses in the SUD billing guide, this includes the Assessment service

Beginning October 1, 2018 – SUD claims for Assessment will no longer require that the client meet any SUD diagnosis criteria

Other SUD services (therapies) will still require that the primary diagnosis be in the list of approved diagnoses

Confirmed with DBHR

I/T/U

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FAQ and Open Discussion

Q. We billed P1 using the taxonomy code that we found on the NPPES NPI Registry but P1 rejected the claim for taxonomy, doesn't P1 follow the taxonomy from NPPES?

A. No, the NPPES site is not a valid source for gathering taxonomy information. The NPPES does not validate the taxonomy codes, HCA refers to the provider's licensure to determine which taxonomy is appropriate

FAQ and Open Discussion

Q. If we have a client receiving SUD family therapy. One of the family members (not the client) is incarcerated and the incarcerated family member is included in the group therapy. Is this OK to bill?
A. yes, because **the client** is not incarcerated

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FAQ and Open Discussion

Q. The IHS Encounter rate has always been referred to as an "outpatient". Does that mean that only "outpatient" services are payable at the IHS encounter rate?

A. yes

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FAQ and Open Discussion

Q. For Telemedicine services, what documentation is required for real-time telemedicine?

A. The Physician-Related Services/Health Care Professional Services billing guide was updated in April (page 88)

Documentation must:

- Be legible to be considered valid.
- Support the level of service billed.
- Support medical necessity for the diagnosis and service billed.
- Be authenticated by provider performing service with date and time.

Keys to documenting medical necessity to support E/M service:

- Document all diagnoses managed during the visit.
- For each established diagnosis, specify if the patient's condition is stable, improved, worsening, etc.
- Document rationale for ordering diagnostic tests and procedures.
- Clearly describe management of the patient (e.g., prescription drugs, over the counter medication, surgery).

(this first set of requirements applies to E&M services as well as telemedicine services)

Additional documentation requirements for telemedicine services:

- Verification that the service was provided via telemedicine
- The location of the client and a note of any medical personnel with the client
- The location of the provider
- The names and credentials (MD, ARNP, RN, PA, CNA, etc.) of all people involved in the telemedicine visit, and their role in the encounter at both the originating and distant sites

FAQ and Open Discussion

Q. Can HCA reprocess the claims that were previously billed due to the retroactive approval of the SPA?

A. If the claim was billed without a T1015 – Mike doesn't have a way to change the data on a claim, they will need to be resubmitted and the T1015 added

Q. Can mike pull data on claims that were billed without a T1015?

A. I have data with claims processed since 09/29/2017 that did not have a paid T1015, I am sorting though the claims this week.

Q. Can mike reprocess the claims that had the T1015 rejected but the rest of the claim paid?

A. yes, the hardest part is not reprocessing the duplicates

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FAQ and Open Discussion

Q. Is Medicaid going to cover the new Shingles vaccine? The new vaccine is more effective than the current vaccine. Shingrix (CPT 90750)

A. Stay tuned

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FAQ and Open Discussion

Q. In a previous webinar you indicated that some commercial insurance EOB codes can be added to the claim so that the denial EOB doesn't need to be sent. Can you share the EOBs?

A. Stay tuned

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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.