Tribal Billing Workgroup (TBWG)

February 10, 2016
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Agenda

- Monthly Data and Analysis
- 2016 IHS Encounter Rate – not announced yet (placeholder)
- Initial point of contact at the I/T/U clinics for the MCOs
- Does Methadone qualify for the IHS encounter rate?
- FAQ and Open Discussion

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MONTHLY DATA & ANALYSIS

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December 2015 Claims Data (I/T/U)

	Dollars	Dollars, Prior TBWG	Clients*	Clients, Prior TBWG*	% Paid	% Paid, Prior TBWG
Totals	$6,530,205	$5,866,423	10,847	10,904	NA	NA
Medical	$1,357,649	$1,327,483	3771	3824	85%	83%
Dental	$652,903	$625,004	1931	1867	86%	88%
MH	$769,164	$735,148	1039	1069	94%	92%
SUD(CD)	$3,096,033	$2,682,107	1073	1129	85%	95%
POS	$507,386	$482,878	5596	5473	60%	60%
Other FFS	$147,070	$13,800	36	7	90%	100%

* Client count will not be the sum from the categories due to 'overlap' (clients can be in more than 1 category)

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Medical Claims – Top Denials

EOB	Description	Comments	Denial % *
18	Exact duplicate claim/service	Duplicate billing	31%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	The AI/AN or non-AI/AN modifier was missing	12%

* Denial percentages example: Out of the Medical claims that did not pay at the encounter rate, 31% were due to duplicate billing issues

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Medical Claims – Top Denials

EOB	Description	Comments	Denial %
24	Charges are covered under a capitation agreement managed care plan	Client is Enrolled in one of the Managed Care Plans	8%
96 N30	Patient ineligible for this service.	Client is not an encounter-eligible client (e.g., State-funds-only client or QMB-only or SLMB)	4%

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Medical Claims – Top Denials

EOB	Description	Comments	Denial %
96 N129	Not eligible due to the patient's age.	CPT 99391-99396 on a claim causes the claim to be a well-child visit, which is only for clients age 20 and younger. Eg, preventive codes (99385 99386 99395 99396) are not covered for adults and not only will the code error out but the entire claim errors out because the claim becomes a well-child visit I noticed a cancer screen diagnosis on many of these claims and the clients were over age 20. Cancer screens are covered (and encounter eligible) under different CPT/HCPCS codes. Refer to p. 116 of physician billing guide, http://www.hca.wa.gov/medicaid/billing/Documents/guides/physician-related_services_mpg.pdf	3%

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Medical Claims – Top Denials

EOB	Description	Comments	Denial %
22	This care may be covered by another payer per coordination of benefits.	Client has Medicare	3%

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Medical Claims – Top Denials

EOB	Description	Comments	Denial %
A1 N55	Procedures for billing with group/referring /performing providers were not followed.	P1 recently update for referring NPI requirements. Referring NPI must be 1. Valid (in P1) 2. Not a group (eg, a person) 3. Not the same as the servicing NPI NOTE: #3 is being reviewed by clinical staff, this is also in this month's FAQ	3%
204	This service / equipment / drug is not covered under the patient's current benefit plan	Usually a family planning only or a QMB-only client	2%

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Medical Claims – Top Denials

EOB	Description	Comments	Denial %
16 N288	Missing / incomplete / invalid rendering provider taxonomy	Claims had a valid servicing taxonomy but the taxonomy on the claim wasn't one that the servicing provider was enrolled with. Two resolutions: 1. Change the claims so that they are submitted with the taxonomy that the Dr. is enrolled with. 2. Update the provider's file to include the taxonomy that is being billed (<u>if appropriate</u>, wouldn't give a *brain surgeon* taxonomy to an FP physician). If you choose option 2 contact Mike so he can reprocess claims so you do not have to rebill Not sure what the provider is enrolled with? Contact mike	2%

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Medical Claims – Top Denials

EOB	Description	Comments	Denial %
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage	2%

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Dental Claims – Top Denials

EOB	Description	Comments	Denial %
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Dental claims missing the 870001305 or 870001306 EPA number	12%
6	The procedure/ revenue code is inconsistent with the patient's age	Some dental services are only allowed for children (sealants, hygiene instructions, crowns, posterior root canals) Prophy ages D1110 – 14 years and over D1120 – 0 through 13 years	8%

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Dental Claims – Top Denials

EOB	Description	Comments	Denial %
204	This service / equipment / drug is not covered under the patient's current benefit plan	Usually a family planning only or a QMB-only client	7%
18	Exact duplicate claim/service	Duplicate billing	6%

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Dental Claims – Top Denials

EOB	Description	Comments	Denial %
96 N59	Non-covered charge(s).	Covered codes/services are in the Dental billing guide and fee schedule	6%
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage	5%

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Dental Claims – Top Denials

EOB	Description	Comments	Denial %
119	Benefit maximum for this time period or occurrence has been reached	Claims were for fluorides (D1206 D1208) over the annual limit Limits: • Age 0-6 (or in ortho treatment or resides in Alternate Living Facility (ALF) or DDA client) – 3 per 12 months P1 "knows" if client is DDA or claim is billed in an ALF. P1 does not "know" if the client is an ortho client or resides in an ALF, limits listed above apply, claim note needed (contains key-words "ortho" or "assisted living") • Age 7-18 – 2 per 12 months • Age 19+ - 1 per 12 months	4%

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Dental Claims – Top Denials

EOB	Description	Comments	Denial %
16 N290	Missing/ incomplete/ invalid rendering provider primary identifier	Servicing provider is not in ProviderOne yet. follow these steps 1. Enroll the provider in P1 2. Request back-date if licensed provider was working before they are approved in P1 3. Contact mike before rebilling claims	3%

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Dental Claims – Top Denials

EOB	Description	Comments	Denial %
16 N37	Missing/ incomplete / invalid tooth number / letter	Some services need either a tooth, or an arch, or a quadrant number. Most common - scaling/planing (D4341 D4342) needs a quadrant. Refer to Dental tooth, arch, quad numbering slide on the Tribal Affairs website under Quick Reference Sheets for Providers and Billing Offices	2%
A1 N81	Procedure billed is not compatible with tooth surface code	Sealants (D1351) are payable on Occlusal (O) surface on teeth 2,3,14,15,18,19,30,31,A,B,I,J,K,L,S,T for clients age 0-18 DD clients (all ages) allow sealants on Occlusal (O) surface on teeth 2, 3, 4, 5, 12, 13, 14, 15, 18, 19, 20, 21, 28, 29, 30, 31, A, B, I, J, K, L, S, T	2%

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Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
24	Charges are covered under a capitation agreement managed care plan	Client is Enrolled in one of the Managed Care Plans	20%
204	This service/ equipment/ drug is not covered under the patient's current benefit plan	Usually a family planning only client. ProviderOne also assigns benefit plans to servicing taxonomy, if the claim had an "incorrect" servicing taxonomy then there may not be a benefit plan – if you see this on a client and you feel it's incorrect please contact mike	17%

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Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing	14%
96 M80	Not covered when performed during the same session/date as a previously processed service for the patient.	Mental health related code/service already paid	7%

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Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
16 N290	Missing/ incomplete/ invalid rendering provider primary identifier	Servicing provider is not in ProviderOne yet. follow these steps 1. Enroll the provider in P1 2. Request back-date if licensed provider was working before they are approved in P1 3. Contact mike before rebilling claims	4%

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Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
16 N288	Missing / incomplete / invalid rendering provider taxonomy	Claims had a valid servicing taxonomy but the taxonomy on the claim wasn't one that the dentist was enrolled with. Two resolutions: 1. Change the claims so that they are submitted with the taxonomy that the dentist is enrolled with. 2. Update the provider's file to include the taxonomy that is being billed (if appropriate, wouldn't give an oral surgeon taxonomy to a general dentist). If you choose option 2 contact Mike so he can reprocess claims so you do not have to rebill	4%

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Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
96 N30	Patient ineligible for this service.	Client was a QMB – only client (RAC 1112 1113). Many clients are QMB-dual and generally Medicaid is secondary to Medicare. Some client are QMB-only and essentially do not have Medicaid	2%
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage	2%

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Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
96 N59	Non-covered charge(s).	Claims were CPT 90839/90840 Crisis Services is covered (for AI/AN clients at I/T clinics, just under a different code – H2011) Remember to add the EPA to the claims if client meets criteria	2%
110	Billing date predates service date.	Paper claims had scanner issues	<1%

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Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing	81%
11	The diagnosis is inconsistent with the procedure	SUDs claims require that the primary diagnosis be F10.10, F10.20, F11.10, F11.20, F12.10, F12.20, F13.10, F13.20, F14.10, F14.20, F15.10, F15.20, F16.10, F16.20, F18.10, F18.20 (ICD-10)	2%

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Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
170 N95	Payment is denied when performed/ billed by this type of provider.	Claim was either a valid SUD code but was missing the HF modifier or a drug screen (CPT 8030x). Drug screen labs are not covered in the SUD program. The agency pays for UAs only when provided by DBHR's contracted provider	3%
B5	Coverage/ program guidelines were not met or were exceeded.	Group therapy (96153) only covered if at least 45 minutes (3 units) During the December billing workgroup it was mentioned that some folks have always been billing group at 1 unit and receiving payment. Uncovered a P1 issue – P1 is allowing group of 1 unit or 3+ units (P1 is only rejecting group therapy when it is 2 units). If we follow the billing instructions we will avoid potential issues	2%

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Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
96 N59	Non-covered charge(s).	Usually a lab code	1%
16 N290	Missing/ incomplete/ invalid rendering provider primary identifier	Do not bill with individual servicing providers on SUD claims	<1%

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PLACEHOLDER FOR THE 2016 IHS ENCOUNTER RATE

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INITIAL POINT OF CONTACT AT I/T/U CLINICS FOR THE MCOS

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Initial Point of Contact at the Tribes for the MCOs

- MCOs have requested initial points of contact at each ITU clinic
- Please let Mike know if you would like to offer an initial point of contact for the MCOs
- Mike can split the contacts up as necessary (e.g. Medical claims are *Mike*, Behavioral health claims are *Jessie*)
- No need to include NPI/tax ID numbers, Mike has that information

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DOES METHADONE QUALIFY FOR THE IHS ENCOUNTER RATE?

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Does Methadone Qualify for the IHS Encounter Rate?

Q. When a patient goes into a facility solely for methadone dosage intake, does that qualify for an encounter rate?

A. The following slides identify the criteria that determine if a service qualifies for the IHS encounter rate.

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What Services Qualify for the IHS Encounter Rate?

How do I determine if a service qualifies as an encounter? The service must be

1. Medically necessary
2. Conducted face-to-face
3. A covered service according to the Medicaid State Plan
4. Performed by a health care professional within their scope of practice
5. Documented in the client's file in the provider's office
6. Performed in the facility identified on the IHS facility list or at satellite or branch locations (SUD must be in the approved facility)
7. Rendered by qualified staff who are eligible for the encounter rate

The following slides will address each item individually

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What Services Qualify for the IHS Encounter Rate?

1. What is *Medically Necessary?*

WAC 182-500-0070 defines Medically necessary as

A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purposes of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all.

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What Services Qualify for the IHS Encounter Rate?

2. What is *Face to Face?*

Stay tuned – We are researching this definition based on CMS guidance with regard to telemedicine.

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What Services Qualify for the IHS Encounter Rate?

3. What is *A Covered Service According to the State Plan?*

The service is described in the Medicaid State Plan. In general, if the service is listed in an HCA Provider Guide, the service is probably covered.

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What Services Qualify for the IHS Encounter Rate?

4. What is *Performed by a health care professional within their scope of practice?*

"Health care professional" means a licensed provider; for Indian health care providers, federal rules require Medicaid to accept providers licensed in any state.

"Within their scope of practice" means services that the health care professional is authorized to perform by virtue of their license. In general, HCA relies on DOH for guidance on scope of practice matters.

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What Services Qualify for the IHS Encounter Rate?

5. What is *Documented in the client's file in the provider's office*?

The standards for documentation by a provider are generally provided in WAC – DOH or DSHS. In general, the client's file should reflect the diagnoses and services provided by the provider.

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What Services Qualify for the IHS Encounter Rate?

6. What is *Performed in the facility identified on the IHS facility list or at satellite or branch locations (SUD must be in the approved facility)?*

IHS maintains a list of IHS and 638 facilities, which IHS delivers to CMS as needed; HCA works with IHS PAO to maintain its list of IHS/638 facilities.

"Performed in the facility…" usually means rendered on-site, but certain places of service are also acceptable depending on medical necessity or client benefit (making sure all other criteria and HIPAA privacy are met). SUD services must always be rendered on-site, in the approved facility.

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What Services Qualify for the IHS Encounter Rate?

7. What is *Rendered by qualified staff who are eligible for the encounter rate* ?

Services rendered by the following individuals are eligible for the encounter rate (if other criteria met)

- Chemical Dependency Professional or Chemical Dependency Professional Trainee (within Certified CD Treatment Facilities)
- Mental Health Professional (MHP), which includes:
  - Psychologists
  - Psychiatric Advanced Registered Nurse Practitioners (P-ARNP)
  - Psychiatric mental health nurse practitioners-board certified (PMHNP-BC)
  - Independent Clinical Social Workers or Licensed Advanced Social Workers
  - Mental Health Counselor
  - Marriage and Family Therapists
- Dentist
- Advanced Nurse Practitioner
- Audiologist
- Nurse Midwife
- Occupational Therapist
- Optometrist
- Physician (including Naturopathic Physician)
- Physician Assistant
- Physical Therapist
- Podiatrist
- Speech-Language Pathologist

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Does Methadone Qualify for the IHS Encounter Rate?

Does Methadone dosing or administration qualify for the IHS encounter rate?

If the Methadone administration

(1) Is medically necessary,

(2) Is rendered face to face,

(3) Is a covered service,

(4) Is performed by a professional within his/her scope of practice (i.e., physician/ ARNP/PA) (Note: CDPs are not authorized to dispense methadone),

(5) Must be documented in the client's file,

(6) Is performed in the approved facility, and

(7) Is rendered by an encounter-eligible provider (i.e., physician/ARNP/PA),

Then it meets the criteria and qualifies for the IHS encounter rate.

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Open Questions and Open Discussion

- Please feel free to ask to be unmuted or use the questions pane
- If you think of questions or issues for the Billing workgroup later please send to Mike or Jessie
- Questions that have "stay tuned" for an answer or "interim" will stay on the log until answered

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Questions Log

Q. Columbia United Providers is no longer a MCO, their clients now with Molina?

A. Effective January 1, 2016 - Columbia United Providers is no longer a Medicaid-contracted managed care plan. Members were either transferred to Molina Healthcare or to another contracted health plan of their choosing.

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Questions Log

Q. Is there a reason that my Medicaid secondary billing randomly denies for reason "covered under capitated plan" when I've clearly submitted information correctly?

A. The MC secondary (wraparound) claims are worked manually by claims processing and coordination of benefits staff and sometimes are processed incorrectly. Please continue to forward these to Mike.

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Questions Log

Q. What Dx should be used if patient is sent for a CD assessment by a court and no diagnosis is made? Will a Z code as primary be allowed?

A. SUD claims require that the primary diagnosis be one of the following. Non-SUD claims may not pay if the primary diagnosis is in the list of generally not payable diagnoses.

ABUSE (Mild)		DEPENDENCE (Moderate or Severe)	
F10.10	Alcohol abuse, uncomplicated	F10.20	Alcohol dependence, uncomplicated
F11.10	Opioid abuse, uncomplicated	F11.20	Opioid dependence, uncomplicated
F12.10	Cannabis abuse, uncomplicated	F12.20	Cannabis dependence, uncomplicated
F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated	F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F14.10	Cocaine abuse, uncomplicated	F14.20	Cocaine dependence, uncomplicated
F15.10	Other stimulant abuse, uncomplicated	F15.20	Other stimulant dependence, uncomplicated
F16.10	Hallucinogen abuse, uncomplicated	F16.20	Hallucinogen dependence, uncomplicated
F18.10	Inhalant Abuse, Uncomplicated	F18.20	Inhalant Dependence, uncomplicated

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Questions Log

Q. Why are some claims taking longer to process than others?

A. Many different factors can be involved. P1 is not fully automated and some claims need to be reviewed by an examiner. Claim notes may cause an otherwise auto-payable claim to hang up in the system. Please contact Mike to review claims and provide suggestions if you notice some claims are taking longer than others.

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Questions Log

Q. When the BHO's launch in April of 2016 how will the billing for the Tribes be affected?

A. P1 billing by I/T clinics should not be affected

- If the Tribe is not contracted with the BHO and is providing Medicaid-funded services, then the billing for WA Apple Health will not change. Claims may continue to be billed directly to P1 for mental health and substance use disorders.
  - There may be a code-update for SUD services, but any updates will just be coding issues and will be shared by Tribal Affairs and published.
- If the Tribe is contracted with the BHO, then billing will be through the BHOs.

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Questions Log

Q. We have always billed with ICD-9 V72.2 diagnosis on dental claims, what ICD-10 diagnosis code should we use?

A. The old billing model (prior to 10/01/2012) required dental claims to be billed on a HCFA with diagnosis V72.2. Beginning 10/01/2012, dental claims are billed on an ADA form and diagnosis codes are no longer required. Dental claims will process for payment without a diagnosis code on the claim. However, if your billing system requires a diagnosis, in that case, which one should you choose?

One that is valid and appropriate for the service.

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Questions Log

Q. Payments are being taken back with EOB N55: *"Procedures for billing with group / referring / performing providers were not followed."* These are billed the way we always have, are you able to tell me what they want different?

A. P1 was updated in December to correct payment issues and bring P1 into compliance with federal requirements. The next page has steps to follow for referring provider requirements.

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Questions Log

Referring Provider Requirements (continued)

A referring NPI is not always required, however, if a referring NPI is on a claim then the referring NPI must be:

- A valid NPI in P1,
- A "person" (not a group), and
- *Different from the billing and servicing NPI on the claim (?)*

When is a referring NPI required?

- Consultations (CPT 99241-99245, 99251-99255, 99261-99263, 99271-99275),
- Global (no modifier) or technical (modifier TC) components of x-rays (CPT 70000-79999). (NOTE: Global radiology in an office based setting (05, 07, 11) does not require referral), or
- If the claim is billed by
  - Physical, Speech, and Occupational Therapists
  - Dieticians, onterpreter services, prosthetists, home infusion agencies, DD facilities, labs, Durable Medical Equipment (DME) suppliers, pharmacies

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Questions Log

Q. Is it possible to correct an authorization online? In particular the billing provider is incorrect on the authorization.

A. Please submit the correct NPI in P1 for the authorization request so that it can be updated. The provider just has to add a note/letter to be added to authorization. Include on the note/letter the authorization number and the NPI for the clinic.

The following slide shows the steps for authorization file corrections

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Questions Log

Authorization file corrections (continued)

Please follow the instructions below to update an existing request:

1. Go to the following link: http://www.hca.wa.gov/medicaid/billing/Pages/index.aspx
2. Click on "Document Submission Cover Sheets" and then select "PA (Prior Authorization) Pend Forms"
3. Type the 9-digit Reference Number from your letter into the "Authorization Reference #" field and hit Enter (this will expand the barcode shown)
4. Click on the "Print Cover Sheet" button; choose "Yes" if you're asked whether you want to allow the document to print
5. Fax the barcode sheet as the FIRST page, (no coversheet) then the supporting documents to 1-866-668-1214 and the documents will be added to this authorization

The Authorization department may be reached directly at 1-800-562-3022

Medical/surgical authorizations – ext 52018

Dental authorizations – ext 15468

Pharmacy authorizations – ext 15483

All others – ext 15471

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Questions Log

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. HCA is researching this issue.

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.

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Questions Log

Q. Does Medicaid cover a prescription for Antabuse or the generic Disulfiram?

A. Yes

Refer to the current Prescription Drug Billing Guide at http://www.hca.wa.gov/medicaid/billing/pages/prescription_drug_program.aspx

Page 56 has criteria for Medication Assisted Treatment (MAT) and has a link to Apple Health's Drug Coverage Criteria (http://www.hca.wa.gov/medicaid/pharmacy/Pages/ffs_drug_criteria.aspx)

Open Clinical Guidelines and Coverage Limitations for MAT (http://www.hca.wa.gov/medicaid/pharmacy/Documents/matguidelines10115.pdf)

Coverage for disulfiram

Covered without limitations or authorization.

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Questions Log

Q. For non-AI/AN SUD service, which modifier do we choose if the client has RAC 1201 **and** 1217 for the same date of service?

A. ABP clients who have both RAC codes 1201 and 1217 were retroactively determined to be SSI; therefore, if the client has RAC 1201 and 1217 on their benefit inquiry, they are 1217 for non-AI/AN billing

Benefit Package/RAC	FMAP as of 01/01/2016	Modifier for T1015
ABP/1201	100%	SE
Presumptive SSI/1217	85%	HB
ABP Presumptive SSI/ 1201 and 1217	85%	HB
Classic, MAGI/all others	50%	HX

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Questions Log

Q. Should tribes be worried that one day the encounter rate could go away?

A. HCA leadership is committed to the IHS encounter rate, as provided for in the State Plan. HCA cannot speak to changes in federal requirements that may happen in the future.

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Questions Log

Q. We were discussing the "Unspecified" and "Other Specified" clauses that can be used with nearly all diagnoses (e.g., depression, trauma stress related disorder, neurodevelopmental). How long are we able to utilize, for example, a diagnosis of Unspecified Depressive Disorder vs. Other Specified Depressive Disorder?

A. I'm guessing this is a best practice question vs anything written in policy?

- To my knowledge, there is no specific policy; rather, there are best practice guidelines.
- For the most part, "other specified" requires delineation of the rationale for that diagnosis. If the symptoms meet the definition of a mental health disorder (symptoms causing significant dysfunction and distress), the diagnosis can be indefinite.
- For "unspecified", generally it is used as a placeholder in emergency situations or when not enough info is obtained to specify the diagnosis. So typically that would be changed after "a period of time" when more information has been obtained. Perhaps unspecified could be viewed as a Rule Out (R/O) diagnosis, but I am not sure that holds true for all diagnoses outlined in the DSM-5. I know that R/Os are normally expected to be dropped by the end of the treatment period (either the Dx was ruled in or ruled out).

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Questions Log

Q. If patient is in a motor vehicle accident, will P1 pay?

A. Yes, Medicaid will pay. When there may be some other third party liability (such as motor vehicle accidents), Medicaid will pay and then try to recover from any liable third parties after the claim is paid (pay & chase). Sometimes there's just no insurance to recover from and the Medicaid payment stays

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Questions Log

Q. Do we need to start billing 8 units for our groups? The WAC states that a group must be at least 1 hour and at least 3 times a week. This WAC is on our license by the state for SUD. We currently perform group for 2 hours 3 times a week

A. During a prior TBWG we had claims for group therapy (96153) that errored out because they were not billed at the minimum of 45 minutes (3 units). The SUD billing guide indicates that group must be a minimum of 45 minutes. One of the attendees mentioned that her groups are always paying if billed at 15 minutes (1 unit). Further research found that P1 is enforcing the 45 minute minimum only if the claim is billed at 30 minutes (2 units). Even though P1 is allowing group billing of 15 minutes please follow the current guidelines and only bill for groups if the group session was 45 minutes or longer

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Questions Log

Q. In the past, we were told to use 96154 for individual therapy but the SUD guide says H0004

A. Code-table adapted from the SUD billing guide below

Code	Service	Billed units
H0001+HF	Substance Use Disorder Assessment	Always 1
H0001+HD	Substance Use Disorder Assessment, Pregnant and Postpartum Women	
H0002+HF	Intake Processing	
H0003+HF	Children's Administration, Initial Screening	
H0004+HF	Individual Therapy, without family present	1 unit per 15 minutes
96153+HF	Group Therapy	
96154+HF	Individual family therapy with enrollee (client) present	
96155+HF	Individual family therapy without enrollee (client) present	
H0020+HF	Opiate Substitution Treatment	Always 1

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Questions Log

Q. Can we bill for services rendered to our tribal jail inmates?

A. No. While an individual is placed in a city, county, or state institution, they are not eligible for Medicaid coverage WAC 182-503-0505 (#5)

Health Care Authority has worked with city, county, and state correctional facilities to create a process for inmates to apply for medical coverage at the time of release

What about the day of incarceration or release? The Dept of Corrections folks like to use the example of where the client lays his head down to go to sleep – if he is going to go to sleep in the jail then he is incarcerated

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Questions Log

The Mental Health billing guide has a link to the agency's *Program Policy Approved Diagnosis Codes for Mental Health Services*

Q. Are the diagnosis codes in this list considered an exhaustive list?

A. No, this is not an exhaustive list. This is a partial list of ICD-9 to ICD-10 cross-walked codes

Q. If a claim is billed and paid and the diagnosis on the claim is not in the list, can the claim potentially be considered an overpayment?

A. No. The absence of the diagnosis on the crosswalk does not make the claim an overpayment.

Washington State Health Care Authority

Questions Log

Q. The Mental Health Billing Manual has a link to the access to care standards (ACS) for RSN but these are dated 2006. Have these been updated or is this what we need to follow?

A. Page 37 has a link to the ACS, when you click on the Link the ACS standards are dated 01/01/2006

Note: If you are treating or evaluating a client who appears to meet the ACS, contact the local RSN to make a referral for an intake evaluation.

The ACS standards have not been updated. A new version will go into effect on April 1st. Tribal providers do not have to refer to the RSN/BHO if the patient wants to continue receiving services at the Tribal clinic. The client may be referred to an RSN/BHO if the person meets ACS and has treatment needs beyond the scope of the Tribal clinic

Washington State Health Care Authority

Questions Log

Q. Is there a contact for pharmacy billing questions?

A. For general claims questions you can call

800-568-3022 ext: 15499

If you are having problems with a particular drug paying in the system or any claims-specific questions you may contact Mike, who will work with the pharmacy staff

Washington State Health Care Authority

Questions Log

Q. For next work group meeting can we discuss the face to face requirement for encounters and how it relates to telemedicine.

A. Telemedicine generally involves two separate services/claims:

1. The originating site (where the client is) is paid a facility fee, there is no encounter eligible service rendered
2. The distant site (where the provider is) is paid the fee schedule amount for the service provided. Does this service meet the Medicaid definition of "face to face"? Stay tuned

The next two slides highlight the HCA FFS policy regarding telephone services and telemedicine. Refer to the Physican-Related Services/Healthcare Professional Services Provider Guide at http://www.hca.wa.gov/medicaid/billing/pages/physician-related_services.aspx

WAC 182 531 1730 http://apps.leg.wa.gov/wac/default.aspx?cite=182-531-1730

Washington State Health Care Authority

Questions Log

Telephone Services

The agency pays for telephone services when used by a physician to report and bill for episodes of care initiated by an established patient (i.e., someone who has received a face-to-face service from you or another physician of the same specialty in your group in the past three years) or by the patient's guardian. Report and bill for telephone services using CPT codes 99441-99443.

1. Telephone services must be personally performed by the physician.
2. If the telephone service relates to and takes place within the postoperative period of a procedure provided by the physician, the service is considered part of the procedure and should not be billed separately.
3. Telephone services should not be billed when the same services are billed as care plan oversight or anticoagulation management
4. When a telephone service refers to an E/M service performed and billed by the physician within the previous seven days, it is not separately billable, regardless of whether it is the result of patient-initiated or physician-requested follow-up.
5. This service should not be billed if the service results in the patient being seen within 24 hours or the next available appointment.

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Questions Log

Telemedicine

- Telemedicine is when a health care practitioner uses HIPAA-compliant, interactive, real-time audio and video telecommunications to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located.
- Using telemedicine when it is medically necessary enables the health care practitioner and the client to interact in real-time communication as if they were having a face-to-face session
- Originating site (where the client is) a facility fee may be billed using HCPCS Q3014
- Distant site (where the eligible provider is) may bill with the appropriate CPT codes along with modifier GT

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Questions Log

Q. If a client has private insurance how do I find the "carrier code" that the P1 screens require in order to bill P1 secondary?

A. The client Benefit Inquiry will show the Carrier Code if it has been entered into P1. Screen shot below. If there is no Carrier Code listed please call the Coordination of Benefits line at 800 562 3022 ext 16134 so that we can update the insurance information on the client file. The sooner we know about a new insurance or a change to an existing policy the better

Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	PREMERA BLUE CROSS/BCBS OF AK (800) 345-6784	BC01	SUPER MAN	100883158			03/01/2007	12/31/2999

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Questions Log

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.

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Questions Log

Q. Are the services of a Mental Health Associate billable?

A. Associates must be licensed and under the supervision of an MHP (claims are billed using the supervisor's servicing NPI/taxonomy)

Q. Are the services of a Mental Health Associate who are pending licensure billable?

A. Services for a person pending licensure are not billable. The services are billable starting on the date of license

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Questions Log

Q. Will we be able to bill for Chronic Care Management services under the encounter rate? (CPT 99487 99489 99490)

A. Chronic Care Management codes are not covered by HCA. In addition, these codes are typically not face-to-face services, and, therefore, are not encounter-eligible. However, E&M's may be billed if services meet E&M criteria

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Questions Log

Q. How can I request a replacement ProviderOne services card for a client?

A. Tribal Representatives can request services cards for AI/AN clients if the representative is:

- From the Tribe or Tribal clinic
- A Tribal In-person Assister or Navigator
- A Tribal Liaison

The request must include the

- Tribal representative's name
- Title
- Statement that the recipient is American Indian/Alaska Native

Use the "contact us" link at https://fortress.wa.gov/hca/p1contactus/

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Questions Log

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.

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Questions Log

Spend-down

We're having huge issues with spend-downs, especially the childrens' prior to 10/1/13. Any contact info with be appreciated

Spend-down claims applied to spend-down amount or do we need to send in an invoice to spend down dept?

Who is eligible to request a spend down through HCA? Classic Medicaid is understood, no questions.

Interim update:

- Eligibility Overview for Apple Health (Medicaid) – page 9 - http://www.hca.wa.gov/medicaid/publications/documents/22_315.pdf
- Spenddown Flyer – 2015
- HCA Medicaid Update: Spenddown Webinar - Session 7 (Spenddown) | Presentation Slides
- Apple Health (Medicaid) Manual: Medically Needy and Spenddown - http://www.hca.wa.gov/medicaid/manual/Pages/50-500.aspx

DSHS Customer Service Center can be reached at 1-877-501-2233 for questions regarding SSI-Related Spenddown coverage

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Questions Log

Medicare crossovers

it would be helpful if Medicare would accept T1015 on claims, they are rejecting them. If they accepted T1015 and denied as not covered then it would assist electronic processing of these claims

Contractors are rejecting the claim rather than deny the line.

Medicare requires the correct taxonomy therefore the taxonomies you require for each specialty does not always match up

crossovers with T1015 will not process, because MCR will not accept T1015 and rejects claims with T1015 on the claim.

MCR will not allow T1015 to enter their system at all

It isn't necessarily Medicare that won't accept the T1015 but the Fiscal Intemediary Novitas which we are required to use. They set the rules and requirements as they want regardless of CMS regs

Not all tribes use Novitas some use WA state Medicare as well

Stay tuned, In the Interim –

Usually the Medicare crossovers that are received by the agency have 3 items that can be corrected while in the P1 screens doing a "Resubmit Denied/Voided claim":

1. billing taxonomy must be encounter eligible (usually 208D00000x)
   note: if you bill Medicare with this taxonomy Medicare should forward to P1
2. appropriate AI/AN or non-native modifiers need to be added
3. T1015 line needs to be added

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Thank you

Send TBWG 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.

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