Washington State Health Care Authority

Tribal Compliance & Operations Work Group

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Washington State Health Care Authority

Agenda

- EHR Incentive Payment Program
- Top 10 rejections
- FAQ and Open Discussion

- Attachments – EPSDT codes, NPI list for MCOs, Molina Brochure, Molina top denials

EHR Incentive Payment Program (Promoting Interoperability)

- Presenters: Jennafer Moore, EHR Eligibility Coordinator and McKenzie Olver, Communications Coordinator
- The Electronic Health Record Incentive Payment Program, now called Promoting Interoperability (PI), is helping hospitals and providers make the transition from unsecured, paper records to secure EHR systems. Through EHR systems, providers and patients are able to work together to manage private and up-to-date health records, avoiding repetitive tests, and increasing efficiency.
- 2016 was the last year for new participants to join the program
- Opened for 2017 attestations on 9/21/18
  - Our vendor CNSI had to run mandatory updates on our attestation system so we had to delay attestations until September 2018
- The 2017 attestation deadline is 11/21/18
- Contact: healthit@hca.wa.gov
- Questions?

Medical - Top 10 EOB Translations

EOB	Description	Comments
204 ITU 02190	*This service/equipment/drug is not covered under the patient's current benefit plan*	• Claims were Medicare cross-overs and the client is a medicare-only client • Client is not full-scope coverage (e.g. family planning only) • Rendering taxonomy on claim was not adopted by P1
16 N290 ITU 01245 01010	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier*	• Claim was missing the rendering NPI • The rendering NPI on the claim has not been enrolled in P1 yet
16 N288 ITU 01485	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider taxonomy*	• Rendering taxonomy on claim is not one that the provider is enrolled with • Licensed has expired (when licenses expire, P1 automatically expires the taxonomy too)
29 ITU 00190	*The time limit for filing has expired*	Claim is outside the timely filing window. Non-Medicare-crossovers have the following timely rule • 365 days from the date of service to get the claim billed to P1 • If a claim met the initial 365 day requirement but needs correcting we get up to 2 years from the date of service for corrections

Medical - Top 10 EOB Translations

EOB	Description	Comments
26 ITU 02255	Expenses incurred prior to coverage	Client was not eligible on this date of service. NOTE: we have recently found that some clients are determined to be retroactively eligible after the claim(s) have been rejected, it is OK to reprocess claims if they are still timely
16 N48 ITU 02207	Claim/service lacks information or has submission/billing error(s). Claim information does not agree with information received from other insurance carrier	Client has Medicare (B or C) and it appears that Medicare made a payment but the claim was not billed as a "medicare cross-over"
18 ITU 98328	Exact duplicate claim/service	Dupe
16 MA39 ITU 02120	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid gender	Two different types of P1 gender issues: • "mike" is in P1 as a girl or "Sally" is in P1 as a boy – contact mike to get P1 updated • Client has identified as transgender – gender on claim must match the gender that is indicated in P1
16 N329 ITU 02125	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid patient birth date	Client birthday on claim does not match client birthday in P1 – contact mike to get P1 updated

Medical - Top 10 EOB Translations

EOB	Description	Comments
16 MA63 ITU 03055	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid principal diagnosis	Claim was submitted with a diagnosis but it was not a valid diagnosis (e.g., missing digits)
16 N290 ITU 01390	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier	Rendering NPI on the claim was either the billing group's NPI or the rendering NPI is not in P1 for the date of service
24 ITU 02035	Charges are covered under a capitation agreement/managed care plan.	Client is enrolled in one of the Apple Health Managed Care Plans (e.g., Amerigroup, CHPW, Coordinated Care, Molina or United Healthcare)
4 I/T 01220	The procedure code is inconsistent with the modifier used or a required modifier is missing.	Claim was missing modifiers AI/AN clients – modifier UA nonAI/AN clients – modifier SE
96 N30 ITU 02370	Non-covered charge(s) Patient ineligible for this service	Client is a Medicare only client (SLMB, QDWI, or QI1) and does not have P1 coverage

Medical - Top 10 EOB Translations

EOB	Description	Comments
181 ITU 16030	Procedure code was invalid on the date of service	The Procedure code was probably valid but P1 was not able to determine how much to pay on the service
4 ITU 03390	The procedure code is inconsistent with the modifier used or a required modifier is missing.	Physical Therapy requires taxonomy 225100000x and modifier GP
6 ITU 03145	The procedure/revenue code is inconsistent with the patient's age.	Medical Nutrition is only covered for kids (age 0-20)
22 ITU 02205	This care may be covered by another payer per coordination of benefits	Client has Medicare Part B or C. If Medicare has already been billed – refer to EOB 16/N48 (the Medicare payment was not reported correctly per P1)
107 Urbans 14365	The related or qualifying claim/service was not identified on this claim	There was no paying service on the claim for the T1015 to support. The T1015 is only payable if there is a qualifying code on the claim that is also paying

Dental - Top 10 EOB Translations

EOB	Description	Comments
18 ITU 98328	Exact duplicate claim/service	Dupe
29 ITU 00190	The time limit for filing has expired	Claim is outside the timely filing window. HCA has the following timely rule: • 365 days from the date of service to get the claim billed to P1 • If a claim met the initial 365 day requirement but needs correcting we get up to 2 years from the date of service for corrections
16 N255 ITU 01475	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid billing provider taxonomy	Billing/group taxonomy not valid • FQHCs use 261QF0400x • IHS/638 use 122300000x
204 ITU 02190	This service/equipment/drug is not covered under the patient's current benefit plan	Most clients were either Medicare-only (either QMBonly or SLMB, QDWI or QI-1)
26 ITU 02255	Expenses incurred prior to coverage	Client was not eligible on this date of service. NOTE: we have recently found that some clients are determined to be retroactively eligible after the claim(s) have been rejected, it is OK to reprocess claims if they are still timely

Dental - Top 10 EOB Translations

EOB	Description	Comments
16 N288 ITU 01485	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider taxonomy	• Rendering taxonomy on claim is not one that the provider is enrolled with • Licensed has expired (when licenses expire, P1 automatically expires the taxonomy too)
16 N329 ITU 02125	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid patient birth date	Client birthday on claim does not match client birthday in P1 – contact mike to get P1 updated
16 MA39 ITU 02120	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid gender	Two different types of P1 gender issues: • "mike" is in P1 as a girl or "Sally" is in P1 as a boy – contact mike to get P1 updated • Client has identified as transgender – gender on claim must match the gender that is indicated in P1
16 MA63 ITU 03055	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid principal diagnosis	Claim was submitted with a diagnosis but it was not a valid diagnosis (e.g., missing digits) NOTE: dental claims do not require a diagnosis but if a diagnosis is submitted then it must be a valid diagnosis.
16 M54 ITU 00200	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid total charges	The total billed amount is not the sum of the line items. Billing software may be subtracting from the total amount if there is a prior payment. The total billed amount must be the sum of the lines. If the claim is reprocessed in the P1 portal, because there is no place to indicate the total billed amount, P1 will automatically re-total the claim and resolve this issue if claims are reprocessed

Dental - Top 10 EOB Translations

EOB	Description	Comments
31 ITU 02110	Patient cannot be identified as our insured	Missing client ID (the "WA" number) Client ID was on the claim but there was a space after the "WA" (this happens sometimes when data is copy/pasted. P1 treats the space as a value and it causes the client ID to become invalid)
16 N290 ITU 01245 01010	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier	• Claim was missing the rendering NPI • The rendering NPI on the claim has not been enrolled in P1 yet
107 I/T 14366	The related or qualifying claim/service was not identified on this claim	There was no paying service on the claim for the T1015 to support. The T1015 is only payable if there is a qualifying code on the claim that is also paying
96 N428 ITU 03175	Non-covered charge(s) Not covered when performed in this place of service	Oral Hygiene Instructions (D1330) and Limited Visual Oral Assessment (D0190/D0191) are not covered in a dental office or clinic setting
6 ITU 03145	The procedure/revenue code is inconsistent with the patient's age.	Oral Hygiene Instructions (D1330) are covered for clients age 0-8 Crowns are not covered for adults Root canals (molars/bicuspids) not covered for adults

Dental - Top 10 EOB Translations

EOB	Description	Comments
96 N130 ITU 03005	Non-covered charge(s). Consult plan benefit documents/guidelines for information about restrictions for this service	Service not covered. The dental fee schedule does a nice job of outlining covered codes
119 ITU 12195	Benefit maximum for this time period or occurrence has been reached	Fluoride limits exceeded. Refer to the dental handout for today's webinar for common dental limits
119 M86 ITU 12180	Benefit maximum for this time period or occurrence has been reached Service denied because payment already made for same/similar procedure within set time frame.	Cleaning (Prophy) too soon. Refer to the dental handout for today's webinar for common dental limits
181 ITU 16030	Procedure code was invalid on the date of service	The Procedure code was probably valid but P1 was not able to determine how much to pay on the service (e.g., a crown for an adult has no rate and may be rejected with this EOB)
197 ITU 11120	Precertification/authorization/ notification/pre-treatment absent	Some dental services require prior authorization (e.g., dentures) – easiest to refer to the dental billing guide to see which services need prior authorization

Mental Health - Top 10 EOB Translations

EOB	Description	Comments
204 ITU 02190	This service/equipment/drug is not covered under the patient's current benefit plan	Clients were either Medicare-only clients or the performing taxonomy was a taxonomy that has not been implemented in P1 (e.g. 1041c0700x and 101YA0400x are not used in P1)
16 N290 ITU 01245 01010	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier	• Claim was missing the rendering NPI • The rendering NPI on the claim has not been enrolled in P1 yet
16 N288 ITU 01485	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider taxonomy	• Rendering taxonomy on claim is not one that the provider is enrolled with • Licensed has expired (when licenses expire, P1 automatically expires the taxonomy too)
16 N255 ITU 01475	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid billing provider taxonomy	Billing/group taxonomy not valid • FQHCs use 261QF0400x • IHS/638 use 2083P0901x

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Mental Health - Top 10 EOB Translations

EOB	Description	Comments
26 ITU 02255	Expenses incurred prior to coverage	Client was not eligible on this date of service. NOTE: we have recently found that some clients are determined to be retroactively eligible after the claim(s) have been rejected, it is OK to reprocess claims if they are still timely
16 N290 ITU 01390	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier	Rendering NPI on the claim was either the billing group's NPI or the rendering NPI is not in P1 for the date of service
16 N290 ITU 01445	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier	Rendering provider is not current in P1. Could be due to licensure issues, contact mike
146 M64 ITU 03340	Diagnosis was invalid for the date(s) of service reported Missing/incomplete/invalid other diagnosis	The secondary (not primary) diagnosis on the claim was invalid
29 ITU 00190	The time limit for filing has expired	Claim is outside the timely filing window. HCA has the following timely rule: • 365 days from the date of service to get the claim to P1 • If a claim met the initial 365 day requirement but needs correcting we get up to 2 years from the date of service for corrections

Mental Health - Top 10 EOB Translations

EOB	Description	Comments
4 I/T 01220	The procedure code is inconsistent with the modifier used or a required modifier is missing.	Claim was missing modifiers • AI/AN clients – modifier HA • nonAI/AN clients – modifier SE
107 I/T 14366	The related or qualifying claim/service was not identified on this claim	There was no paying service on the claim for the T1015 to support. The T1015 is only payable if there is a qualifying code on the claim that is also paying
18 ITU 98325	Exact duplicate claim/service	Dupe
236 ITU 25000	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements	Not payable in combination per NCCI guidelines. Refer to NCCI and MH or SUD attachment on today's webinar
96 /N30 ITU 02370	Non-covered charge(s) Patient ineligible for this service	Client is a Medicare only client (SLMB, QDWI, or QI1) and does not have P1 coverage

Mental Health - Top 10 EOB Translations

EOB	Description	Comments
96 N30 IT 03841	Non-covered charge(s) Patient ineligible for this service	The IHS encounter rate is not payable if a client is on state-funds only. Refer to page 20 of the Tribal Health Billing Guide for the list of RAC codes that do not qualify for the encounter rate
107 Urbans 14365	The related or qualifying claim/service was not identified on this claim	There was no paying service on the claim for the T1015 to support. The T1015 is only payable if there is a qualifying code on the claim that is also paying
16 / N255 I/T 00305	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid billing provider taxonomy	Billing/group taxonomy not valid • FQHCs use 261QF0400x • IHS/638 use 2083P0901x
96 / N130 ITU 03005	Non-covered charge(s). Consult plan benefit documents/guidelines for information about restrictions for this service	Service not covered. Refer to the code-tables on page 35-40 of the Mental Health Billing Guide for the list of HCA-covered mental health codes

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SUD - Top 10 EOB Translations

EOB	Description	Comments
204 ITU 02190	This service/equipment/drug is not covered under the patient's current benefit plan	Most claims had a taxonomy issue. SUD claims are billed at the clinic level only with 261QR0405x (FQHCs use 261QF0400x + 261QR0405x)
16 /N288 ITU 01485	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider taxonomy	Claims were billed with a rendering NPI and taxonomy – SUD claims are billed at the clinic level only
16 /N290 ITU 01010	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier	Claims were billed with a rendering NPI and taxonomy – SUD claims are billed at the clinic level only
16 / N255 ITU 01475	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid billing provider taxonomy	Billing/group taxonomy not valid • FQHCs use 261QF0400x (+ 261QR0405x) • IHS/638 use 261QR0405x
16 / MA39 ITU 02120	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid gender	Two different types of P1 gender issues: • "mike" is in P1 as a girl or "Sally" is in P1 as a boy – contact mike to get P1 updated • Client has identified as transgender – gender on claim must match the gender that is indicated in P1

SUD - Top 10 EOB Translations

EOB	Description	Comments
26 ITU 02255	Expenses incurred prior to coverage	Client was not eligible on this date of service. NOTE: we have recently found that some clients are determined to be retroactively eligible after the claim(s) have been rejected, it is OK to reprocess claims if they are still timely
4 I/T 14369	The procedure code is inconsistent with the modifier used or a required modifier is missing.	Non AI/AN SUD claims at Tribal IHS and 638 facilities have certain modifier requirements due to the FMAP. Refer to SUD FMAP 2018 attachment
16 /N329 ITU 02125	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid patient birth date	Client birthday on claim does not match client birthday in P1 – contact mike to get P1 updated
29 ITU 00190	The time limit for filing has expired	Claim is outside the timely filing window. HCA has the following timely rule: • 365 days from the date of service to get the claim billed to P1 • If a claim met the initial 365 day requirement but needs correcting we get up to 2 years from the date of service for corrections
107 I/T 14366	The related or qualifying claim/service was not identified on this claim	There was no paying service on the claim for the T1015 to support. The T1015 is only payable if there is a qualifying code on the claim that is also paying

SUD - Top 10 EOB Translations

EOB	Description	Comments
18 ITU 98325	Exact duplicate claim/service	Dupe
24 Urbans 01365	Charges are covered under a capitation agreement/managed care plan	FQHCs only – client is enrolled in a BHO, BHSO or IMC
4 I/T/U 00800	The procedure code is inconsistent with the modifier used or a required modifier is missing.	EOB 4 has a few different meanings, in this instance it was regarding the modifier on the SUD code (almost always HF, refer to SUD codes attachment)
181 ITU 16030	Procedure code was invalid on the date of service	The Procedure code was probably valid but P1 was not able to determine how much to pay on the service. Labs and acupuncture are not payable
4 I/T 01220	The procedure code is inconsistent with the modifier used or a required modifier is missing.	EOB 4 has a few different meanings, in this instance it was regarding the modifier on the T1015 code (refer to SUD FMAP attachment)

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SUD - Top 10 EOB Translations

EOB	Description	Comments
A1 N61 I/T 01515	Claim/Service denied Rebill services on separate claims	**DO NOT rebill on separate claims.** Tribal IHS and 638 SUD claims need a claim note. EOB N61 happens when the claim note is not correct AI/AN clients – SCI=NA (or sci=na) nonAI/AN clients – SCI=NN (or sci=nn)
4 I/T 03610	The procedure code is inconsistent with the modifier used or a required modifier is missing.	SUD billing codes always need a modifier, refer to SUD codes attachment
170 N95 ITU 03740	Payment is denied when performed/billed by this type of provider This provider type/provider specialty may not bill this service	• Labs and acupuncture are not payable • If the SUD code is missing a modifier (e.g. HF) we may also see this EOB
258 ITU 02224	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	Clients are not eligible for (outpatient) P1 coverage while incarcerated. If the client was at the clinic but the claim rejected with EOB 258 – contact mike to get the client's eligibility corrected in P1
96 N30 IT 03841	Non-covered charge(s) Patient ineligible for this service	The IHS encounter rate is not payable if a client is on state-funds only. Refer to page 20 of the Tribal Health Billing Guide for the list of RAC codes that do not qualify for the encounter rate

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

FAQ and Open Discussion

Q. Does HCA plan to conduct on site audits of the Indian Health Care Providers? (IHS-Direct, Tribal 638 and/or Urban Indian Organizations)?

A. HCA is not conducting audits any differently from how HCA is auditing non-tribal providers.

FAQ and Open Discussion

Q. Clients of the Developmental Disabilities Administration (DDA) are eligible for extra services according to the dental billing instructions, why didn't P1 pay for the extra services for a Developmentally Disabled client?

A. Check the client's eligibility in P1. If the client has registered with DDA there will be Development Disability section in the Benefit Inquiry screen (screenshot below)

If there is no Developmental Disability section in the client's benefit inquiry but you feel that the client may qualify, refer the client to the DSHS Developmental Disabilities Administration at https://www.dshs.wa.gov/dda

FAQ and Open Discussion

Q. ProviderOne requires Drug Enforcement Administration (DEA) numbers be entered for our providers. Do the DEA numbers automatically get updated like professional licenses are automatically updated?

A. No, DEA numbers are not automatically updated in P1. If you have issues with prescription rejections due to a DEA licensure lapse, contact mike

FAQ and Open Discussion

Q What are the requirements to be a Diabetic Education Provider?

A. Stay tuned. We have a Department of Health Representative scheduled to present during the November TCOW

Refer to page 7 of the Diabetic Education Billing Guide for background information

FAQ and Open Discussion

Survey – Purchased and Referred Care

Can HCA ask others a few questions regarding Purchased and Referred Care and share the answers?

Q. When you receive a bill for PRC funds, how do you determine how much to pay?

- We follow Medicare rates in paying claims. MLR (Medicare like rates) are on the web
- We use a fee schedule
- For Hospital visits we pay the Medicare Like Rate. If the amount paid by insurance is more than the Medicare Like rate for that facility we pay zero. For clinic visits, we pay the co-pay, we have not signed up with IHS to do the Medicare like rate for office visits. All of our PRC/CHS eligible patients are on an alternate resource Private insurance if they are not on Medicaid.
- We use MLR rates. If there are no MLR rate such as dental then we use our network rate as we use the Ameritas Network for Dental and FCHN for medical pricing. We use a Third Party Administrator to process claims and not the PO process.
- Depends on the type of bill. Hospital based vs private practice
- If we don't have a contract with the provider, we use Medicare Like Rates if the bill is from a facility then we pay at Medicare Like Rates. We are given the rates for [regional hospital] which changes frequently and [another regional hospital], which hasn't changed since I've been here. If it's for a facility outside of our area I go to this awesome website that I was given from this very nice person at HCA. Here's the link https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/hospital-reimbursement and I chose IPPS.
- We use the MLR rate unless our network rate is less

Q. Can you share the source of the fee schedule?

- The fee schedule is on the web and may possibly be accessible through IHS
- We download the Noridian Part B fee schedule
- We use our network fees and pay a small per person per month fee for this network
- Optum Encoder Pro.

FAQ and Open Discussion

Q With the onset of the Electronic Database and Patient Records Management systems and platforms, and the conversion to Electronic Medical records (EMR). Is there a WAC that address the duration of time that we need to retain the hardcopy behavioral health records on-site or in an off-site storage?

A. Department of Health (DOH) WAC 246-341-0425(4) lists a 6 year requirement. The WAC is not online yet but is available here.

Followup Questions:

Q. "Individual's clinic record" including an "electronic record": Is this a either/or application? If we are operating an Electronic Medical Record System only. Are we also required to retain a hardcopy of the clients medical record for six years?

Q. Secure system: We are using a cloud based EMR system data is stored in an encrypted system. Does this meet HCA/WAC requirements? Or, are we required to download from the Cloud based system and save our client medical records in an off-site EMR system and location?

A. (from DOH) *There is no need to retain a hardcopy of records as long as the electronic record is retained. Whatever system agencies use is up to them. They will just be required to provide us the records when we review.*

FAQ and Open Discussion

Q P1 rejected a claim with EOB 26 (Expenses incurred prior to coverage). When we look at the client in P1 it looks like the client is eligible.

A. Some clients are retroactively eligible. If you get an EOB 26 and it appears that the client is eligible, it may be fastest to reprocess the claim in P1. If the claim re-rejects with EOB 26, contact mike

FAQ and Open Discussion

Q. Now that an SUD assessment no longer requires an abuse or dependence diagnosis, is there guidance in regards to the diagnoses for SUD assessments?

A. Follow the clinician's coding in the chart notes and always code to the highest level of specificity.

We know that CDPs should not do SUD assessments "for the fun of it". Below are some possible ICD-10 diagnosis codes that may be applicable for situations regarding substance issues that do not require a definitive abuse/dependence diagnosis. Refer to coding guidelines

- Alcohol – F10920 alcohol use, unspecified with intoxication, uncomplicated
- Opioid - F1190 opioid use, unspecified, uncomplicated
- Cannabis – F1290 cannabis use, unspecified, uncomplicated
- Sedative, hypnotic or anxiolytic – F1390 sedative, hypnotic or anxiolytic use, unspecified, uncomplicated
- Cocaine – F1490 cocaine use, unspecified, uncomplicated
- Other stimulant – F1590 – other stimulant use, unspecified, uncomplicated
- Hallucinogen – F1690 hallucinogen use, unspecified, uncomplicated
- Inhalant – F1890 inhalant use, unspecified, uncomplicated
- Other psych substance – F1990 other psychoactive substance use, unspecified, uncomplicated

FAQ and Open Discussion

Q When did we have to start changing the units for billing SUD codes but we don't have to change units for Mental Health codes?

A. Some codes (e.g., 96153, SUD group) are "timed codes" and each billed unit corresponds to the unit of time. 96153 is a "per 15 minute" and one hour of SUD group therapy would be reported as 96153 x 4.

Many other codes (e.g., 90853, MH group) are reported at a single unit per session, regardless of duration.

Refer to the CPT/HCPCS manuals for more information, or contact mike

FAQ and Open Discussion

Q. Do the Managed Care plans accept HIPAA frequency 7 (replacement) and 8 (void) transactions electronically?

A. (from the webinar) –

- *yes they do, it takes about 2-3 weeks to get the claim processed for correct payment*
- *For Molina a corrected claim, I have to submit paper as the resubmission code & old claim #s don't show up electronically*

FAQ and Open Discussion

Q. Are we able to bill MCO directly for Tribal Encounter or do we still need to bill the wrap claims to HCA?

A. P1 should be ready to support the MCO payment of the encounter rate in early 2019. In the meantime, continue to forward claims for AI/AN clients to P1 for the balance of the IHS encounter rate

FAQ and Open Discussion

Q. Doesn't EOB N236 (*This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.*) conflict with the SPA?

A. The State Plan allows *for up to five (5) outpatient visits per Medicaid beneficiary per calendar day for professional services.*

An outpatient visit is, "A face-to-face or telemedicine contact between any health care professional authorized to provide services under the State Plan and a Medicaid beneficiary for the provision of Title XIX defined services, as documented in the patient's record."

P1 (Medicaid/Title XIX) is mandated to follow NCCI guidelines and if the service is not payable per NCCI guidelines then it is not a payable Title XIX defined service

FAQ and Open Discussion

Q Can you bill a well child visit with modifier SP to show they are doing a wellness with a sports physical component?

A. Even though SP is not a valid modifier I understand the question.

ICD-10 Z025 (*Encounter for examination for participation in sport*) is in the list of diagnosis codes that are generally not payable if billed as the primary diagnosis. Z025 is a valid diagnosis and P1 will process claims for payment if the Z025 is in the secondary/other diagnosis field (just not a primary diagnosis)

FAQ and Open Discussion

Q what if a client previously received a Zostervax immunization and now wants Shingrix?

A. Shingrix is recommended for everyone 50 and over. They recommend everyone who had the Zostavax vaccine be revaccinated with Shingrix because it is a much better vaccine in terms of effectiveness and duration of immunity.

FAQ and Open Discussion

Q What if a patient is in for a wellness and disguises that they have been having a reccuring headache for the last 6 months and provider refers PT for eye exam. Does that constitute as a well visit **and** an E&M (for the headache issue)

A. Maybe

If the eye exam is Medicaid covered and is distinct and separate from the wellness visit and is not Incident To the Physician Service (see August, 2018 TCOW)

The agency pays for up to five (5) encounters per day, per client, regardless of the type of service, provided that the facility does not:

- Unbundle services that are normally rendered during a single visit for the purpose of generating multiple encounters;
- Develop facility procedures or otherwise ask clients to make repeated or multiple visits to complete what is considered a reasonable and typical office visit, unless it is medically necessary. Medical necessity must be clearly documented in the client's record.

The following slide has a copy of a page from the 2017 CPT manual

FAQ and Open Discussion

Scanned image from page 37 of 2017 CPT Professional Version

Preventive Medicine Services

The following codes are used to report the preventive medicine evaluation and management of infants, children, adolescents, and adults.

The extent and focus of the services will largely depend on the age of the patient.

If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier 25 should be added to the Office/ Outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.

An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported.

The "comprehensive" nature of the Preventive Medicine Services codes 99381-99397 reflects an age and gender appropriate history/exam and is **not** synonymous with the "comprehensive" examination required in Evaluation and Management codes 99201-99350.

FAQ and Open Discussion

Q. For FQHCs billing dental (for example D2740 crown), are the Lab Fees included in the allowable fee amount. One of our dentists was told in Tribal or Urban clinics the lab fee was not included. can we confirm?

A. The lab fee is included in the payment for the dental service. The only time that dental lab fees may be reported and billed separately is in the case of dentures when the client is not able to complete the denture process (e.g., the client is not eligible at the final seat date or client moves from the state, more examples on page 61 of the dental billing guide

Q. Can we report the face to face visits for the lab fees if the denture lab fee is authorized?

A. yes

FAQ and Open Discussion

Q. Our Providers are not always here when the pt comes in for follow up incident to visits. Per the basic requirements "Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services." We have other providers here but not the ordering. Would these visits be billable?

A. Stay tuned

FAQ and Open Discussion

Q. Are there guidelines to documentation needed for 96372 services to qualify for encounter billing?

A. I need to split the question up

Q1 – are there guidelines to documentation needed for CPT 96372?

Q2 – are there guidelines to documentation needed claims billed at the IHS encounter rate

Stay tuned

FAQ and Open Discussion

Q. When will P1 be ready for the Match for SUD?

A. Stay tuned, HCA needs to complete analysis on the CPE process

FAQ and Open Discussion

Q. Would a pharmacist be eligible for incident to billing

A. Stay tuned, this is a CMS policy that mike will need to research further

FAQ and Open Discussion

Q. We billed D2394 (*restoration, 4 or more surfaces*) for 5 surfaces but P1 rejected the claim indicating incorrect number of surfaces – was this an error?

A. P1 rejected claim in error. P1 update is scheduled for September 22, mike will reprocess claims after the P1 fix

D2161, D2335, D2394 are for *4 or more surface* codes that are currently being rejected in error if there are 5 surfaces. Do not rebill, mike will reprocess claims

FAQ and Open Discussion

Q. Dental assistants are not licensed, however some are certified. If a dental service was performed by a non-certified dental assistant would that qualify for an encounter?

A. Certified Dental Assistants and Licensed Dental Hygienist are consider a 'Health Care Professional' Per current SPA and Tribal Billing guides. if the service was rendered by a non-certified dental assistant – HCA has not completed the analysis on this question yet, stay tuned

I/T

FAQ and Open Discussion

Q. During the February 2018 TCOW, you shared a list of codes that are payable on a Well Child (EPSDT) claim. E&M codes (99201-99215) not in the list, can these be billed separately?

A. Codes from the February TCOW are re-attached to today's webinar. If a Well Child code is billed (CPT 99381-99395) and the client is age 0-20 then the **entire claim** becomes a Well Child visit and only the codes from the list can be paid on a Well Child claim. Below are two common scenarios and solutions

- Client receives a Well Child visit and client diagnosed with warts to be removed (e.g., CPT 17000)
  - CPT 17000 is not payable on the same claim as the Well Child visit.
  - CPT 17000 may be reported on a separate claim and if the services are distinctly separate from the Well Child visit it may also qualify for the encounter rate
- Client receives a Well Child visit and clinician would also like to conduct an evaluation (e.g., CPT 99213) to address a medical issue
  - CPT 99213 is not payable on the same claim as the Well Child visit.
  - CPT 99213 may be reported on a separate claim and if the services are distinctly separate from the Well child visit it may also qualify for the encounter rate

NOTE: Medicaid is mandated to follow NCCI guidelines. Modifiers may be required under certain circumstance and, depending on the actual CPT/HCPCS codes, the services may not be payable together regardless of modifier (per NCCI)

I/T and Urban? Pending approval for Urbans

FAQ and Open Discussion

Q. Can P1 be updated so that it will show the client's managed care account number when we do a Client Benefit Inquiry?

A. P1 currently does not show the client's managed care account number. It would require a P1 change in order to show the managed care account number

FAQ and Open Discussion

Q. Does HCA cover paramedicine?

A. Not yet. House Bill 1358 has not been implemented yet.

Paramedicine is an emerging profession, it allows EMTs/Paramedics to provide some healthcare services to underserved populations.

A scenario explains why the question was asked

Over the years, paramedics have routinely been called out to various sites and, when they get there, they find that the client is not "sick" enough to need to go to the hospital.

For example – client calls because he has chest pain. The EMT's get there and determine that there is no need to go to the hospital, they see he has elevated BP and suggest a primary care visit. The EMTs do not have a billable service, even after driving to the site

Stay tuned

I/T/U

FAQ and Open Discussion

Q. What is considered a gap in services for SUD?

A. Stay tuned

This is in regards to the following Q&A during the June TCOW

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 and how long a person has been away from services

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

I/T/U

FAQ and Open Discussion

Q. Where can we find the I.H.S. facility list?

A. The I.H.S. facilities are on the I.H.S. website

The 638 facilities are provided to the states by CMS

Q. Is there a list of the addresses for the facilities so that we can comply with the CMS requirement?

A. Stay tuned

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

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

FAQ and Open Discussion

Q. My Intergovernmental Transfer (IGT) matching funds for SUD was 'rejected' – what do we do?

A. Stay tuned, IGT will eventually be replaced by a Certified Public Expenditure (CPE) process. The reason for the rejection was unrelated to the CPE change – the bank account information for DSHS/HCA was updated recently. The Tribal Health Billing Guide will be updated for October 1st. The information is on the Tribal Affairs website under Resources-Quick Reference sheets

I/T

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

Questions?

Send comments and questions to:

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- The bottom-left corner of each slide will contain either I/T (impacts IHS and Tribal) or I/T/U (impacts IHS, Tribal and Urbans) or U (only impacts Urban)
- 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.