

Provider Matters – August 2014

Monthly updates about claim processing, policy and resources for Oregon Medicaid providers

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Renewing Oregon Health Plan and Healthy Kids benefits

Every year, Oregon Health Plan (OHP) and Healthy Kids members must update their application to make sure they still qualify for health benefits. When it is time to renew their benefits, the Oregon Health Authority (OHA) will send members a letter that lets them know how to renew.

- Most OHP and Healthy Kids members can renew their benefits by filling out a simple form that lets us know if there has been a change in their household information.
- Some members who have had a change or members that signed up through the fast-track process will need to fill out a full application.

Examples of OHP renewal letters, frequently asked questions for clients and more information can be found at www.ohp.oregon.gov

Medicaid Electronic Health Records (EHR) Incentive Program

The Medicaid EHR Incentive program provides federal incentives, up to \$63,750 paid over six years, to certain eligible professionals who adopt, implement, upgrade or achieve meaningful use of certified EHR technology.

For more information, please visit the [Medicaid EHR Incentive Program website](#) or contact the Medicaid EHR Incentive Program team at 503-945-5898 (Salem).

Eligible professionals - Program year 2014 applications being accepted now

Eligible professionals must choose to participate in either the Medicare or Medicaid EHR Incentive Program. If participating in the Medicaid EHR Incentive Program, eligible professionals can submit their attestation now for program year 2014.

Hospitals - Program year 2014 applications being accepted now.

Most but not all of the eligible hospitals in Oregon meet the federal requirements to participate in both the Medicare and Medicaid EHR Incentive Programs.

- Hospitals participating in the Medicaid EHR Incentive Program have until **December 29, 2014**, to submit their attestation to Oregon's Medicaid EHR Incentive Program for program year 2014.
- Hospitals that receive payments under both programs must first attest to Medicare and then, attest for a payment through Medicaid. Once payments begin in Medicare, Hospitals must attest to demonstrating meaningful use **every year** to receive an incentive and avoid a payment adjustment.

New proposed rule for Stage 2 in 2014

Under the current rule for meaningful use, in program year 2014, all participants must adopt EHR technology certified to the 2014 standard. [A proposed CMS rule published on May 23, 2014](#), would provide eligible professionals, eligible hospitals, and critical access hospitals more flexibility in how they use certified electronic health record (EHR) technology (CEHRT) to meet meaningful use.

- For more information on the proposed rule, [please visit the Federal Register website](#).

- To view the CMS press release about the proposed rule, [please visit the online CMS Newsroom](#).

To view a list of systems that have been certified, please visit the Office of the National Coordinator's [Certified Health Product Listing website](#).

Self-attest by September 30 to receive the federal primary care payment increase effective July 1, 2014

So far, 3,165 providers have been deemed eligible for the temporary primary care rate increase available under Section 1202 of the Affordable Care Act.

- Physicians, advance practice nurses and physician assistants who practice General Internal Medicine, Pediatric Medicine or Family Medicine have until September 30, 2014, to [self-attest to have the increase apply to eligible primary care services rendered on or after July 1, 2014](#).
- Providers who have already attested in 2013 **do not need to re-attest** to have the rate increase apply in 2014.
- Newly enrolled providers must wait to attest until **after** their effective enrollment date with Oregon Medicaid.

When attesting, please make sure to use the Oregon Medicaid ID and NPI for the **rendering provider** (not the clinic or group). This allows us to link the attestation to the correct practitioner.

For newly-attesting providers, we will apply the new primary care rate once we review your attestation, obtain any needed corrections, and update your provider record to indicate that you qualify for the increase. Please allow 2-3 weeks for us to process your attestation. Learn more on [our ACA primary care increase Web page](#).

From CMS: Deadline for ICD-10 set for October 1, 2015

On July 31, the U.S. Department of Health and Human Services (HHS) [issued a rule](#) finalizing **October 1, 2015** as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10, the tenth revision of the International Classification of Diseases.

This deadline allows providers, insurance companies and others in the health care industry time to ramp up their operations to ensure their systems and business processes are ready to go on Oct. 1, 2015.

For more information on the rule, [view the press release](#).

Keep up to date on ICD-10

Visit the CMS [ICD-10 website](#) for the latest news and resources to help you prepare; and sign up for [CMS ICD-10 Industry Email Updates](#). You can also [view all past CMS ICD-10 Industry Email Updates](#).

Questions about ICD-10?

Email the DMAP ICD-10 Project at stateoregon.icd10@state.or.us.

Social Security Number field returns to Provider Web Portal eligibility screen

We are happy to let you know that the Social Security Number (SSN) field is back in the search panel of the [Provider Web Portal Eligibility Verification Screen](#). This means you can now perform inquiries using the following combinations:

- Client ID (or SSN) and Birth Date
- Client ID (or SSN), Last Name and First Name
- Client ID (or SSN), Last Name and Birth Date
- Client ID (or SSN), First Name and Birth Date
- Client ID (or SSN), Last Name, First Name and Birth Date
- Last Name, First Name and Birth Date

The screenshot shows a web form titled "Eligibility Verification Request". It features a blue header with a question mark icon and a search icon. The form contains the following fields:

- Client ID: [input field]
- Last Name: [input field]
- First Name: [input field]
- Birth Date: [input field]
- SSN: [input field]
- From DOS: [input field]
- To DOS: [input field]
- Procedure: [input field] [Search]

At the bottom right, there are two buttons: "search" and "clear".

DMAP policies, rules and guidelines now available at www.oregon.gov

This month, DMAP finished moving all of its policies, rules and guidelines content from [the Department of Human Services \(DHS\) website](#) to [the OHP website](#). We hope you enjoy having all DMAP provider resource content on the same website.

- Please update your Internet bookmarks or favorites as needed.
- Starting September 1, visitors to the old DHS pages will automatically redirect to the new OHP pages.

The OHP pages also include a new policy page for the [Behavioral Health program \(chapter 410, division 172\)](#). This program covers the policies for Medicaid-covered behavioral health services on and after August 1, 2014. For services rendered before August 1, please continue to refer to the [Addictions and Mental Health Division's OARs](#) (chapter 309, division 016).

Reminders about OHP eligibility

It has come to our attention that some providers believe that OHP clients only have OHP coverage when they are enrolled in a coordinated care organization (CCO) or other type of OHP health plan. However, depending on where they live, some OHP clients still need to access covered services on a fee-for-service (FFS, or "open-card") basis.

We hope the following reminders make clear how to determine whether clients have OHP benefits and what it means if you find that a client is not enrolled in a CCO/plan. You can also [view resources about OHP eligibility verification on the OHP website](#).

Benefit plan indicates OHP coverage

When verifying eligibility, please remember that the client's benefit plan indicates the level of coverage available for that client. This information is in the "Benefit Plan" section of the [Provider Web Portal Eligibility Verification Screen](#).

- **BMH (OHP Plus)**. This plan offers comprehensive coverage. View the [OHP benefits chart](#) for a quick reference or refer to Oregon Administrative Rule (OAR) 410-120-1210(4)(a) in [DMAP's General Rules](#).
- **BMD, BMM (OHP with Limited Drug)**. This plan offers the same benefits as OHP Plus, except that OHP Plus drug coverage is limited only to drugs that are not already covered by Medicare Part D. See OAR 410-120-1210(4)(b). People with BMM also have their Medicare coinsurance and deductibles paid by DMAP as described in OAR 410-120-1210(4)(c)(C).
- **CWX (CAWEM Plus)**. This plan offers the same benefits as OHP Plus, except for hospice care, sterilization, abortion and Death with Dignity services. See OAR 410-120-1210(4)(e).

Identifying fee-for-service ("open-card") clients and CCO/plan members

The "Managed Care" section of the [Provider Web Portal Eligibility Verification Screen](#) shows any CCO/plans the client is enrolled in. When any plan(s) show in this area, this means the CCO/plan covers the service. If there are no plans in this area, DMAP covers the service on a FFS basis.

Plan type displayed	Who is responsible for payment?		
	Behavioral health care	Dental care	Physical health care
CCOA	CCO	CCO	CCO
CCOB	CCO	DMAP or DCO	CCO
CCOE	CCO	DMAP or DCO	DMAP, FCHP or PCO
CCOG	CCO	CCO	DMAP, FCHP or PCO
None listed	DMAP	DMAP	DMAP

How to view service types covered for OHP benefit plans

If you do not know what a specific benefit plan covers, click on the OHP benefit plan in the "Benefit Plan" section of the [Provider Web Portal Eligibility Verification Screen](#).

- Covered service types and copayment information will display in the "Service Type Coverage and Copay" section. Some covered services may state there are limitations; refer to OAR 410-120-1210 in DMAP's [General Rules](#) for benefit plan limitations, as well as the specific guidelines for the service type (e.g., [Dental Services guidelines](#) for dental limitations).
- Non-covered service types will not display.

To view service-specific coverage information, you will need to use the [Benefits and HSC List inquiry](#) for FFS clients, or contact the CCO/plan for CCO/plan members.

Reminders about CWX (CAWEM Plus) coverage

We have heard of some confusion about the CWX (CAWEM Plus) benefit.

- **CWX (CAWEM Plus) offers the same benefits as OHP Plus**, except for hospice care, sterilization, abortion and Death with Dignity services. See OAR 410-120-1210(4)(e) in DMAP's [General Rules](#).
- **CWM (CAWEM)** covers only emergency and labor/delivery services.

Both CAWEM Plus and CAWEM clients receive services on a FFS ("open-card") basis. CAWEM Plus benefits end the day after the client's pregnancy ends. To learn more about CAWEM Plus, [read this letter](#).

Below is an example of what the [Provider Web Portal Eligibility Verification Screen](#) displays for a CAWEM Plus client.

When you first enter the eligibility information, the "Service Type Coverage and Copay" section is blank. A message underneath the "Benefit Plan" section asks you to "Select a Benefit Plan row to see the Service Type Coverage and Copay rows."

Benefit Plan						
Benefit Plan	Effective Date	End Date	Remaining Out Of Pocket	Remaining Deductible	PERC Code	
CWX - CAWEM Plus	08/06/2014	08/06/2014		\$0.00	CX	

Select a Benefit Plan row to see the Service Type Coverage and Copay rows.

When you click on the "Benefit Plan" line that lists the CWX benefit, a list of the service types CWX covers then appears.

Benefit Plan						
Benefit Plan	Effective Date	End Date	Remaining Out Of Pocket	Remaining Deductible	PERC Code	
CWX - CAWEM Plus	08/06/2014	08/06/2014		\$0.00	CX	

Select a Benefit Plan row to see the Service Type Coverage and Copay rows.

Service Type Coverage and Copay						
Benefit Plan	Effective Date	End Date	Service Type	Coverage	Copay	
CWX - CAWEM Plus	08/06/2014	08/06/2014	MEDICAL CARE	ACTIVE		
CWX - CAWEM Plus	08/06/2014	08/06/2014	CHIROPRACTIC	ACTIVE	\$0.00	
CWX - CAWEM Plus	08/06/2014	08/06/2014	DENTAL CARE	ACTIVE		
CWX - CAWEM Plus	08/06/2014	08/06/2014	DIAGNOSTIC X-RAY	ACTIVE	\$0.00	
CWX - CAWEM Plus	08/06/2014	08/06/2014	HOSPITAL	ACTIVE	\$0.00	
CWX - CAWEM Plus	08/06/2014	08/06/2014	HOSPITAL - INPATIENT	ACTIVE	\$0.00	
CWX - CAWEM Plus	08/06/2014	08/06/2014	DIAGNOSTIC LAB	ACTIVE	\$0.00	
CWX - CAWEM Plus	08/06/2014	08/06/2014	HOSPITAL - OUTPATIENT	ACTIVE	\$0.00	
CWX - CAWEM Plus	08/06/2014	08/06/2014	MATERNITY	ACTIVE	\$0.00	
CWX - CAWEM Plus	08/06/2014	08/06/2014	AUDIOLOGY EXAM	ACTIVE	\$0.00	

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Reminders about National Drug Code reporting for physician-administered drugs

DMAP is required to collect Medicaid drug rebates on medical (CMS-1500) and institutional (UB-04) claims for outpatient drugs that are part of the [Medicaid Drug Rebate Program](#). To meet this requirement, you must include National Drug Code (NDC) information, the NDC's correct [Unit of Measure \(UOM\)](#) and NDC quantity whenever you bill DMAP for drug procedure codes.

- The NDC reported must be for the actual drug administered, as labeled on the drug packaging.
- In all claim formats, enter the NDC in 5-4-2 format, with no dashes.
- To find out how to enter the NDC, UOM and NDC quantity on Provider Web Portal, CMS-1500 and UB-04 claims, please read our [National Drug Code reporting tips](#).

Questions and answers, webinar slides, and other resources about NDC reporting are also available on DMAP's [NDC reporting page](#).

Reminder – Billing for Vaccines for Children administrations

OHP (Medicaid and CHIP) is generally the payer of last resort. However, Medicaid and CHIP are **not** considered the payer of last resort for administration of [Vaccines for Children](#) (VFC) vaccines, as stated in OAR 410-130-0255(8) of DMAP's [Medical-Surgical rules](#). This rule is to ensure provider payment for administration of these vaccines for all OHP clients, including those with Third-Party Liability (TPL, or other health coverage).

When billing for VFC administrations to OHP clients:

- If the client is enrolled in a CCO/plan for physical health services, bill the CCO/plan.
- If the client is not enrolled in a CCO/plan for physical health services, bill DMAP.
- If the client has TPL, also bill the TPL when possible.

DMAP's current reimbursement rates are available on the [OHP fee schedule page](#). For CCO/plan rates, contact the CCO/plan. To learn more about billing for immunizations, please visit the Public Health Division's [Immunization Billing Resources page](#).

Need help?

Find more phone numbers, e-mail addresses and other resources in DMAP's [Provider Contacts List](#).

Claim resolution - Contact [Provider Services](#) (800-336-6016).

Direct deposit questions – Contact the DHS/OHA EFT Coordinator (503-945-6872).

Electronic Data Interchange (EDI), the EDI Trading Partner Agreement, EDI mailbox help, and the 835 ERA - Contact [EDI Support Services](#) (888-690-9888).

ICD-10 transition questions – Contact the [ICD-10 Project Team](#).

Pharmacy and prescriber questions (for technical help and fee-for-service prescription PAs) - Contact the Oregon Pharmacy Call Center at 888-202-2126. You can also fax PA requests to 888-346-0178.

Prior authorization status – Call the DMAP PA Line at 800-642-8635 or 503-945-6821 (outside Oregon).

Provider enrollment updates - Contact [Provider Enrollment](#) (800-422-5047).

Provider Web Portal help and resets - Contact [Provider Services](#) (800-336-6016).

Help us improve future announcements:

[Click here](#) to answer six survey questions about this provider announcement.



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