

Provider Matters – December 2013

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

In this issue:

Health system transformation

[People with OHP Standard benefits will have OHP Plus benefits starting January 1, 2014](#)

[Spread the word: "Send the fast-track back!"](#)

[Medicaid Electronic Health Records \(EHR\) Incentive Program](#)

Other provider updates

[Starting February 1, 2014, please use Q0090 \(not J3490\) to bill for Skyla™](#)

[Use new Agreement to Pay form before providing non-covered services to OHP clients](#)

[DMAP to accept 2/12 version of the CMS-1500 starting January 6, 2014](#)

[Delay in ADA 2012 claim form updates](#)

[Paper claims are seldom required – Bill electronically whenever possible](#)

[Self-attest by December 31 to receive the 2013-2014 federal primary care payment increase effective October 1, 2013](#)

[If you have qualified for the federal primary care payment rate in the past, but believe you are no longer eligible, please let us know](#)

[Patient liability for nursing facility \(NF\) residents on hospice](#)

[From CMS: MLN Connects™ videos on ICD-10](#)

[Quality Corner – New Self-Management Alliance website](#)

People with OHP Standard benefits will have OHP Plus benefits starting January 1, 2014

Adults with OHP Standard (KIT) health benefits will start receiving OHP Plus (BMH) benefits on January 1, 2014. This means approximately 60,000 more adults will have coverage for the following:

- Routine dental care, including cleanings, fillings and extractions
- Physical, occupational and speech therapy
- Non-emergent medical transportation for covered health care services

Last month, we sent adults with OHP Standard benefits [a letter about this change](#). To learn more about other 2014 changes, [visit the OHP 2014 page](#).

Spread the word: "Send the fast-track back!"

If you know someone who has received an OHP fast-track letter, please urge them to send the fast-track form back.

Fast-track enrollment is available to adult Oregonians who meet qualifications for the Oregon Health Plan (OHP) and who already qualify for either food benefits through the Supplemental Nutrition Assistance Program (SNAP), or health care benefits for children through Healthy Kids/OHP.

You can see a copy of the fast-track letter and read the fast-track Q&A at www.OHP.Oregon.gov.

How to enroll

Fast-track eligible Oregonians do not have to fill out an application through Cover Oregon. All they have to do is send the fast-track form back in the self-addressed stamped envelope. It's the easiest and fastest way to enroll in the Oregon Health Plan.

If people prefer to call, they can enroll at 1-800-699-9075. When they call, they should have their letter with them. They will be asked for their case number or client ID printed at the top of their letter.

Coverage starts January 1, 2014. Thank you for your help in spreading the word to "**Send the fast-track back!**"

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).

Hospitals - Program year 2013 deadline approaching

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, 2013, to submit their attestation to Oregon's Medicaid EHR Incentive Program.
- Hospitals that receive payments under both programs must first attest to Medicare (deadline was November 30, 2013) 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.

Program year 2013 timelines for applying for first, second and third year incentives

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 have until March 31, 2014, to submit their attestation for program year 2013.

When an attestation may be submitted depends on the individual provider's experience in the program as shown below:

First-year payment: To adopt, implement or upgrade EHR	Second-year payment: To report meaningful use	Third-year payment: To report meaningful use
Apply now	Apply now	Wait until at least January 1, 2014 , after a full 365-day EHR reporting period has passed.

Looking ahead to program year 2014 and Stage 2 meaningful use

There are many changes for program year 2014, including the introduction of Stage 2 meaningful use. One key change for all participants, regardless of the meaningful use stage, is that they will need to adopt technology certified to the 2014 standard. A list of systems that have been certified can be found at the Office of the National Coordinator's [Certified Health Product Listing](#) website.

Starting February 1, 2014, please use code Q0090 (not J3490) to bill for Skyla™

This year, the Centers for Medicare and Medicaid Services (CMS) updated the HCPCS code set to include a specific code for the Skyla™ contraceptive device: Q0090 – *Levonorgestrel-Releasing Intrauterine Contraceptive System (SKYLA), 13.5 mg*.

DMAP plans to open Q0090 for payment in mid-January 2014. We will accept both J3490 and Q0090 for billing Skyla™ until January 31. Starting February 1, we will deny claims for Skyla™ billed under code J3490.

Use new Agreement to Pay form (DMAP 3165) before providing non-covered services to OHP clients

Before providing OHP clients non-covered services that they agree to pay for, please complete the new DMAP 3165 form ([Word](#)) ([PDF](#)), or a facsimile containing the elements in this new form.

- Both you and the patient (or patient's representative) must review and sign the form before the non-covered service is provided.
- You must also keep the completed form on file and give the client a copy of the completed form (see Oregon Administrative Rule [410-120-1280 – Billing](#)).
- Having patients review and sign the form is an assurance that OHP clients are informed and understand what they are agreeing to before you give them, or bill them for, a service not covered by OHP.

Remember that OHP coverage depends on the client's benefit package and whether the treatment is covered for the client's specific health condition according to the [Prioritized List of Health Services](#).

To learn more, please [read our November letter about the new Agreement to Pay form](#).

DMAP to accept 2/12 version of the CMS-1500 starting January 6, 2014

We are pleased to let you know that starting January 6, 2014, we will be able to accept both the 2/12 and 8/05 versions of the CMS-1500 claim form, with plans to only accept the 2/12 version starting April 1, 2014.

If you need to submit paper claims to DMAP, please make sure you are able to submit the 2/12 version of the CMS-1500 starting April 1. If you also bill a Coordinated Care Organization (CCO) or OHP medical plan, check with the plan on when they will start accepting the 2/12 form.



Delay in ADA 2012 claim form updates

As you may know, starting January 1, 2014, DMAP planned to only accept paper dental claims on commercially available versions of the [ADA 2012 claim form](#). We also planned to update our payment system to accommodate new fields on the 2012 form. These include diagnosis and quantity.

These plans have been temporarily delayed. When we confirm the new date that we will be able to make these changes, we will let you know.

Paper claims are seldom required – Bill electronically whenever possible

Whenever possible, please submit claims electronically using electronic data interchange or the Provider Web Portal at <https://www.or-medicaid.gov>. Billing electronically for **all** your claims is not only faster and results in lower denial rates, but can save you time and money. Paper claims are seldom required.

To learn more about billing electronically with DMAP, please visit our [Electronic Business Practices page](#).

Self-attest by December 31 to receive the 2013-2014 federal primary care payment increase effective October 1, 2013

So far, almost 2,890 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 December 31, 2013, to [self-attest to have the increase apply to eligible primary care services rendered on or after October 1, 2013](#).
- 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](#).

If you have qualified for the federal primary care payment rate in the past, but believe you are no longer eligible, please let us know

Requirements for qualification as a federal primary care provider are not changing for 2014; however, we understand that providers' practices may change.

Please contact [DMAP Provider Enrollment](#) if you used to qualify for the federal primary care payment, but you no longer qualify. Please let them know the date that you no longer qualify, and DMAP will end your eligibility for the increased payments as of that date.

When we end your eligibility for the federal primary care payment, you will receive a termination notice indicating your "Primary Care Federal" provider contract has been ended. If you receive this letter, you do not need to contact Provider Enrollment. You are still a valid Oregon Medicaid provider; the letter just indicates that you will no longer receive the higher federal primary care rate.

Patient liability for nursing facility (NF) residents on hospice

Hospice providers: When billing for NF services for an individual with a Medicaid benefit, review your Remittance

Advice (RA) to see the Patient Liability amount.

If the amount listed on the paper RA is different from what the NF identifies as the Patient Liability amount, tell the Nursing Facility about the discrepancy and request that they coordinate with their local AAA/APD worker to get the Patient Liability amount corrected.

Providers may also work with Vivien Van Hatten with DMAP Provider Services (503-947-5368); however, all updates to the Patient Liability must be done at the local AAA/APD office level."

From CMS: MLN Connects™ videos on ICD-10

Are you ready to transition to ICD-10 on October 1, 2014? MLN Connects™ videos on the CMS YouTube Channel can help you prepare.

- In the "[ICD-10: Implementation for Physicians, Partial Code Freeze, and MS-DRG Conversion Project](#)" video, Pat Brooks and Dr. Daniel Duvall from the Center for Medicare, Hospital and Ambulatory Policy Group discuss the transition to ICD-10 for medical diagnosis and inpatient procedure coding.
- Video slideshow presentations from MLN Connects National Provider Calls:
 - August 22, 2013 – [ICD-10 Basics](#): Keynote presentation by Sue Bowman from the American Health Information Management Association (AHIMA).
 - April 18, 2013 – [Begin Transitioning to ICD-10 in 2013](#): CMS Subject matter experts review basic information on the transition to ICD-10 and discuss implementation planning and preparation strategies.

To receive notification of upcoming MLN Connects videos and calls and the latest Medicare program information on ICD-10, [subscribe](#) to the weekly *MLN Connects™ Provider eNews*. Visit the [Medicare Fee-for-Service Provider Resources](#) Web page for a complete list of ICD-10 articles, products, and videos from the Medicare Learning Network®.

Keep up to date on ICD-10

Visit the CMS [ICD-10 website](#) for the latest news and resources to help you prepare for the **October 1, 2014** deadline; and sign up for [CMS ICD-10 Industry Email Updates](#).

Questions about ICD-10?

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

Quality Corner – New Self-Management Alliance website

The Self-Management Alliance has recently launched a website to be used as a working forum dedicated to making self-management an integral part of health and a priority health care outcome. It supports cross sector dialogue, innovation and a library of tools and resources to help accomplish its integration. To learn more, please visit <http://selfmanagementalliance.org/>.

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).

EDI and the 835 ERA - Contact [EDI Support Services](#) (888-690-9888).

Direct deposit information and provider enrollment updates - Contact [Provider Enrollment](#) (800-422-5047).

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 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.



DMAP CAPE 13-620 12/13