

# Provider Matters – February 2016

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

In this issue:

## Health system transformation

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

## Other provider updates

[From SAMHSA: New resource to help consumers understand parity](#)

[Changes to provider appeals processes start March 1, 2016](#)

[From CMS: Important clarifications concerning QMB balance billing law](#)

[Provider Web Portal password reminders and resources](#)

[Change to electronic data interchange \(EDI\) mailbox access](#)

[TPL reporting on claims and system-generated TPL information requests](#)

[Reminder: Identify and bill TPL first](#)

[Reminder: Monthly payment recovery for OHP newborn claims](#)

## Medicaid Electronic Health Records (EHR) Incentive Program

### Year 2015:

- **For eligible hospitals:** OHA will accept both types of attestations – adopt, implement or upgrade (AIU) and meaningful use (MU) – until **March 31, 2016**.
- **For eligible professionals:** OHA is accepting only AIU attestations until **March 31, 2016**. The health authority expects to begin accepting MU attestations **in late May 2016**.

### Year 2016:

Program year 2016 is the last year to begin the program (coming in under AIU or MU Payment Year 1). Eligible professionals can receive an incentive payment for adopting, implementing or upgrading certified EHR technology in their first year of participation.

### What is the Medicaid EHR Incentive Program?

The program provides federal incentives, up to \$63,750 paid over six years, to certain eligible providers who adopt, implement, upgrade or achieve meaningful use of certified electronic health record technology (CEHRT).

- [Eligible professionals](#) must choose to participate in either the Medicare or Medicaid EHR Incentive Program.
- 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 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.

### For more information

- **About the program:** Please visit the [Medicaid EHR Incentive Program website](#) or contact the Medicaid EHR Incentive Program team at 503-945-5898 (Salem).
- **About EHR Incentive Programs resources:** Please visit the [CMS EHR website](#).
- **About certified EHRs:** Please visit the Office of the National Coordinator (ONC)'s [Certified Health Product Listing website](#).
- **About CMS and ONC rule changes for Program Years 2015-2017:** See the [CMS Final Rule](#) and the [ONC Final Rule](#) (dated October 2015), and ONC corrections and clarifications ([HTML](#) or [PDF](#), dated January 2016).

## From SAMHSA: New resource to help consumers understand parity

The Substance Abuse and Mental Health Services Administration (SAMHSA) has created a new pamphlet, [Helping Consumers Understand Parity, and MH and SUD Benefits](#), for consumers and their providers.

- The pamphlet explains how consumers' mental health and substance use disorder (MH and SUD) benefits are protected and how they can take action if their benefits are denied.
- It also has information about the Mental Health Parity and Addiction Equity Act and how it applies to employer-sponsored health plans, including standards for parity among MH and SUD benefits, and other

physical health benefits.

Individuals and their providers will learn about reasons why some MH and SUD benefit claims are denied, how to file an internal or external appeal if a claim is denied, and how to learn more about parity, MH and SUD benefits, and appeals of denied claims.

## Changes to provider appeals processes start March 1, 2016

Starting March 1, 2016, OHA will accept claim re-determination requests and administrative review requests using the updated [OHP 3085](#) (Claim or Payment Authorization Review Request) form.

- Use the updated form to request review of OHA, CCO or PHP coverage decisions.
- Send only by mail (not fax or email). OHA will no longer accept fax requests on or after March 1.

To learn more, please [read OHA's recent letter about the March 1 changes](#). Information from [the February 16 webinar](#) will be available soon.

## From CMS: Important clarifications of the QMB balance billing law

On February 4, 2016, the Centers for Medicare and Medicaid Services (CMS) revised *MLN Matters Special Edition Article SE1128: [Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary \(QMB\) Program](#)* to include updates for 2016 and the following policy clarifications:

1. All original Medicare and Medicare Advantage (MA) providers –not only those that accept Medicaid – must abide by the balance billing prohibitions.
2. QMB individuals retain their protection from balance billing when they cross state lines to receive care. Providers cannot charge QMB individuals even if they serve them in a different state than the state in which care is rendered.
3. QMBs cannot choose to "waive" their QMB status and pay Medicare cost-sharing. The federal statute referenced above supersedes Section 3490.14 of the "State Medicaid Manual," which is no longer in effect.

To promote compliance with QMB balance billing prohibitions:

### **Determine effective means to identify QMB individuals among your patients.**

- Find out what cards are issued to QMB individuals so you can ask your patients if they have them.
- Use the Provider Web Portal at <https://www.or-medicaid.gov> to verify QMB enrollment for OHP members. (OHP members with QMB will have the MED or BMM benefit plan.)
- If you are a Medicare Advantage provider, ask the plan how best to identify their QMB enrollees.

**Learn what you need to do to seek reimbursement for Medicare cost-sharing.** Different processes may apply to original Medicare and MA services.

- For original Medicare claims, nearly all states automatically receive Medicare-adjudicated claims as "crossover" claims.
- Claims that have crossed over to other payers, such as Medicaid, are noted on the Medicare Remittance Advice.
- Contact these other payers to learn how to seek reimbursement for cost-sharing. The processes may differ from payer to payer or state to state. For example, to seek fee-for-service reimbursement from OHP (Oregon Medicaid), providers must enroll as described on the [OHP Provider Enrollment page](#).

**Make sure that you do not bill or make collection efforts against QMB individuals for Medicare cost-sharing.** This may mean updating your billing software and letting your administrative staff know about this requirement.

## Provider Web Portal password reminders and resources

When logging into the Provider Web Portal at <https://www.or-medicaid.gov>, please remember to make only **two** attempts to enter the correct password. After that, please click the **reset password** button and answer one of your secret questions.

- The answers are case sensitive.
- After you successfully enter the answer to your secret question, click on **reset password** again.

Remember to visit our Provider Web Portal page at [www.oregon.gov/OHA/healthplan/pages/webportal.aspx](http://www.oregon.gov/OHA/healthplan/pages/webportal.aspx) for tools such as videos, step-by-step guides, and the [Troubleshooting the Provider Web Portal](#) quick reference.

## Change to electronic data interchange (EDI) mailbox access

If you are a current Oregon Medicaid provider and directly exchange electronic data batch files with OHA, either incoming (837/claims) or outgoing (835/ERA), OHA is changing the way you currently access your EDI mailbox.

- Effective January 1, 2016, we are transitioning trading partners away from the mailbox URL and will use the host name going forward.
- If you do not have the host name or if you have questions about this change, please have your authorized technical contact send an email to [DHS.EDISupport@state.or.us](mailto:DHS.EDISupport@state.or.us).

**Please note** that this change does not apply to the Provider Web Portal at <https://www.or-medicaid.gov>.

## Third party liability (TPL) reporting on claims and system-generated TPL information requests

On paper claims, if you enter amounts on Line B of FL 54 on the UB-04 claim form, or in box 29 of the CMS-1500 claim form, our system enters those amounts as TPL payments. If we do not have TPL on file for the client on the claim, our system will send you a letter from the DHS-OHA Office of Payment Accuracy and Recovery.

This letter asks the provider to complete a form about the client's TPL information (e.g., insurance company contact information, policyholder information, and policy number) and return it to the attention of the "Project Team."

If you get these letters, please do the following:

- Do not forward these letters to clients to complete. We have found that when clients get these letters, they think we are asking for payment.
- Please review coverage information for the patient and what you reported on the original claim. If the claim is related to Medicare Advantage plan payments, please disregard the letter. If the claim is related to incorrect TPL reporting, please let us know. Otherwise, please complete the form and return it to the Project Team.

If you get these letters due to incorrect TPL reporting, please remember that prior Medicare payments should only be reported on Line A of FL 54 on the UB-04. Prior Medicare payments should never be reported on a CMS-1500. If you need to reflect a prior Medicare payment on a professional claim, submit the claim on the DMAP 505 claim form or on the Provider Web Portal, not the CMS-1500.

## Reminder: Identify and bill TPL first

Oregon Administrative Rule 410-120-1280(8) in our [General Rules guidelines](#) explains TPL policy. Table 120-1280 in this rule lists the codes to use when reporting TPL denials on paper claims. For clients with TPL:

- Bill the TPL first.
- Do not collect TPL coinsurances, copayments or deductibles from the client.
- When billing OHA, clearly list whether TPL paid or denied your claim. Otherwise, we may deny your claim with a message telling you to bill TPL first.
- Do not collect OHP copayments until you see if we deducted a copayment amount from your claim payment. Depending on what TPL paid, the copayment may be less than \$3.
- If you discover that the client has TPL that OHA does not list on the Provider Web Portal, EDI or AVR, please report the new resource to OHA at [www.oregon.gov/OHA/healthplan/pages/tpl.aspx](http://www.oregon.gov/OHA/healthplan/pages/tpl.aspx).

## Reminder: Monthly payment recovery for OHP newborn claims

Every month, OHA recovers a small number of payments made in the preceding month for services to newborns who are now enrolled in an OHP managed care organization (MCO) or CCO.

- Once the birth is reported, we enroll children born to MCO or CCO members in the mother's plan.
- However, depending on when the birth is reported to us, this process may take three or more weeks to complete.

To avoid future recoveries for newborn services:

- Please report births as soon as possible using the [Newborn Notification Form](#). Allow 2-3 weeks for processing.
- [Verify the newborn's MCO or CCO enrollment](#) using PWP, Automated Voice Response or Electronic Data Interchange.
- Once you have verified the newborn's MCO or CCO enrollment, bill the MCO or CCO.

What you will see on the paper remittance advice (RA), electronic remittance advice (ERA) or PWP:

- **On the paper RA:** Adjusted claims will have an ICN beginning with "52". The "Detail EOBs" for these ICNs

will list Explanation of Benefits (EOB) code *EOB 0090 – Service is covered by a managed care plan. Claim must be billed to the appropriate managed care plan.*

- **On the ERA or PWP:** The ERA should list these adjustments as overpayment recoveries. PWP will show the adjustment ICN as a denied claim. In both ERA and PWP, the reason for recovery will be Adjustment Reason Code 24 - *Charges are covered under a capitation agreement/managed care plan.*

To learn more about recovery of overpayments or appeals, please see Oregon Administrative Rules 410-120-1397(7), 410-120-1560 and 410-120-1580 in the [General Rules](#) guidelines.

## Need help?

Find more phone numbers, email addresses and other resources in our [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** – [OHAICD10.help@state.or.us](mailto:OHAICD10.help@state.or.us)
- **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 PA line at 800-642-8635 or 503-945-6821 (outside Oregon).
- **Provider enrollment updates** - Contact [Provider Enrollment](#) (800-422-5047).
- **Provider training videos and past provider collaborative webinars** – [Visit the OHA YouTube channel](#).
- **Provider Web Portal help** - [Visit our Provider Web Portal page](#). If you need a password reset, contact [Provider Services](#) (800-336-6016).