

# Provider Matters – January 2015

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

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## WEBINAR: Reimbursements for OHP-eligible people who do not yet appear in MMIS

Please join the Oregon Health Authority [Friday, January 30 from 10 AM to 11 AM](#) to learn how to verify Oregon Health Plan (OHP) eligibility for people with urgent health care needs, but who do not yet appear in the OHP eligibility system (the Medicaid Management Information System, also known as MMIS, and the Provider Web Portal, or PWP).

**Join us January 30, 2015**

**10 AM to 11 AM**

**[Register Today!](#)**

### Background

Right now, Oregonians can apply for OHP online through HealthCare.gov. If they qualify for OHP, HealthCare.gov will issue [an immediate notification of eligibility](#). However, MMIS and the PWP may not reflect eligibility information for two weeks or more.

Similarly, most hospitals are using the [Hospital Presumptive Eligibility process](#) to determine an individual's immediate temporary eligibility for OHP. The hospital provides [an HPE Approval notice](#) to individuals whom it presumes eligible. However, it may take up to five days for the approved individual to appear in MMIS or the PWP.

In order to obtain health care services prior to appearing in MMIS, patients can show either their [HealthCare.gov confirmation letter](#) or [HPE Approval notice](#) to providers and pharmacies. Providers will be reimbursed for services rendered to patients showing either of these documents on a fee-for-service basis. This training gives an example of each approval letter and outlines coverage information, coverage limitations, Oregon Health Authority responsibilities, and the process for provider reimbursement for services to these OHP-eligible patients.

**[Register today!](#)**

## Reminder: Oregon as part of the federal Health Insurance Marketplace

Now that Oregon is part of the federal Health Insurance Marketplace at [HealthCare.gov](#), please keep the following changes in mind:

- **Where to direct people to apply for OHP:** People who want to apply for OHP should visit [OregonHealthCare.gov](#) to find out the best way to apply. [OregonHealthCare.gov](#) will invite tribal members, pregnant women, refugees and other people whose situations require special processing to apply on their website; other people will be directed to [HealthCare.gov](#) to apply.
- **Serving OHP members who are not yet in our eligibility system:** Plans, providers and pharmacies may

still refer to this recent announcement about [how to address urgent health care needs for OHP applicants deemed eligible through HealthCare.gov](#). Also make sure to [join our January 30 webinar to learn more](#).

To learn more about the transition to HealthCare.gov, [visit our Medicaid 101 page](#).

## Reminder: OHP renewal letters

Every year, OHP and Healthy Kids members must update their information to make sure they still qualify for health benefits. Not everyone will renew at the same time. When it is time to renew benefits, OHP will send a letter telling how to renew.

**Please encourage members to respond with their renewal paperwork as soon as possible so that their coverage continues.** For most households, the paperwork is [a simple 2-page form](#). If their coverage ends, they will need to reapply using the full OHP or HealthCare.gov application.

If members have questions or believe their coverage ended in error, they should call OHP Customer Service at 1-800-699-9075. More information about OHP renewals is available 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 and 2015 applications being accepted now.

Eligible professionals must choose to participate in either the Medicare or Medicaid EHR Incentive Program.

For professionals participating in the Medicaid EHR Incentive Program:

- Program year 2014 attestations are due no later than **May 31, 2015**.
- Program year 2015 attestations can be submitted starting **January 1, 2015**.

### Hospitals - Program year 2014 and 2015 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.

For hospitals participating in Oregon's Medicaid EHR Incentive Program:

- Program year 2014 attestations are due no later than **January 31, 2015**.
- Program year 2015 attestations can be submitted starting **October 1, 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.

### Medicare to Medicaid program switch

Providers will have until **February 28, 2015** to switch from Medicare to Medicaid for their EHR Incentive Program participation. Per CMS rule 42 CFR 495.10, all program switches can occur one time, and only **for a payment year before 2015**.

### Final rule published to determine your CEHRT participation options for Program Year 2014

The Centers for Medicare and Medicaid Services (CMS) has released a [final rule](#) that allows providers participating in the EHR Incentive Programs to use the 2011 Edition of certified electronic health record technology (CEHRT) for calendar and fiscal year 2014.

- The rule grants flexibility to providers who are unable to fully implement 2014 Edition CEHRT for an EHR reporting period in 2014 for Meaningful Use due to delays in 2014 CEHRT availability.
- Providers may now use EHRs that have been certified under the 2011 Edition, a combination of the 2011 and 2014 Editions, or the 2014 Edition for 2014 participation.
- Beginning in 2015, all eligible providers **will be required** to report using 2014 Edition CEHRT.

### For more information

Visit the CMS Newsroom to read the [press release](#) about the final rule. For more EHR Incentive Programs resources, visit the [CMS EHR website](#).

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

## From CMS: Get ready now for ICD-10

With less than a year to go before the **October 1, 2015, compliance date**, now is the time to get ready. Whether you're a provider, payer, or other health care entity, it's important to prepare for ICD-10 now.

Visit the [CMS ICD-10 website](#) to learn how to make a plan that fits your needs. By working together, we can make a successful ICD-10 transition.

### Benefits of ICD-10

Foundational to advancing health care, the ICD-10 code set will replace ICD-9 codes for both diagnosis and inpatient procedures. Among its benefits, ICD-10:

- Better captures details about chronic illnesses, identifying underlying causes, complications of disease, and conditions that contribute to complexity of a disease
- Serves as a building block that allows for greater specificity and standardized data to better support patient care and improve disease management
- Improves data for peer comparison and utilization benchmarking and better documentation of patient complexity and level of care to support reimbursement for care provided
- Enhances public health surveillance and reporting—as well as quality measurement and reporting—with robust detail for research and data analysis

Using ICD-10, doctors can capture much more detail, meaning they can better understand important information about the patient's health. And by enabling more detailed patient history coding, ICD-10 can help to better coordinate a patient's care across providers and over time.

### CMS resources can help you get ready

To help you prepare for ICD-10, CMS recently released two new Medscape videos and an expert column. Available on the [CMS ICD-10 website](#), these resources provide guidance about the transition to ICD-10 with a focus on small practices. Continuing medical education (CME) and nursing continuing education (CE) credits are available to health care professionals who complete the learning modules. Anyone who completes the modules can receive a certificate of completion.

The [Road to 10 Tool](#), also available through the [CMS ICD-10 website](#), gives an overview of ICD-10 and answers frequently asked questions. The tool is designed to help small practices jumpstart their transitions. Providers can build an ICD-10 action plan and review tailored clinical scenarios to learn more about how ICD-10 affects their practice.

### Three new MLN Connects™ Videos on ICD-10: Coding for ICD-10-CM – More of the Basics; Medicare Testing Plans; and Home Health Conversion

In [Coding for ICD-10-CM: More of the Basics](#), experts from the American Health Information Management Association (AHIMA) and American Hospital Association (AHA) provide a basic introduction to ICD-10-CM coding. The objective of this video is to enhance viewers' understanding of the characteristics and unique features of ICD-10-CM, as well as similarities and differences between ICD-9-CM and ICD-10-CM. The video covers:

- How to assign a diagnosis code using ICD-10-CM
- ICD-10-CM code structure
- Coding process and examples: Combination codes, 7th character, placeholder "x," excludes notes, unspecified codes, external cause codes
- Resources for coders

These MLN Connects™ videos were recorded from CMS presentations at the ICD-10 Coordination and Maintenance Committee on September 23, 2014.

- [Medicare's Testing Plan for ICD-10 Success](#): Run time: 8 minutes
- [Converting the Home Health Prospective Payment System Grouper to ICD-10-CM](#): Run time: 8 minutes

### Keep up to date on ICD-10

Visit the [ICD-10 Medicare Fee-For-Service Provider Resources](#) web page for Medicare Learning Network® educational materials, including a complete list of MLN Connects videos on ICD-10. 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 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](mailto:stateoregon.icd10@state.or.us).

## From CMS: Results from November ICD-10 Acknowledgement Testing Week

CMS conducted another successful acknowledgement testing week last month. Acknowledgement testing gives providers and others the opportunity to submit claims with ICD-10 codes to the Medicare Fee-For-service (FFS) claims systems and receive electronic acknowledgements confirming that their claims were accepted. While providers are welcome to submit acknowledgement test claims anytime, during the November testing week, testers submitted almost 13,700 claims.

More than 500 providers, suppliers, billing companies, and clearinghouses participated in the testing week.

- Testers included small and large physician practices, small and large hospitals, labs, ambulatory surgical centers, dialysis facilities, home health providers, ambulance providers, and several other physician specialties.
- Acceptance rates improved throughout the week with Friday's acceptance rate for test claims at 87 percent.
- Nationally, CMS accepted 76 percent of total test claims. Testing did not identify any issues with the Medicare FFS claims systems. This testing week allowed an opportunity for testers and CMS alike to learn valuable lessons about ICD-10 claims processing.

To ensure a smooth transition to ICD-10, CMS verified all test claims had a valid diagnosis code that matched the date of service, a National Provider Identifier (NPI) that was valid for the submitter ID used for testing, and an ICD-10 companion qualifier code to allow for processing of claims. In many cases, testers intentionally included errors in their claims to make sure that the claim would be rejected, a process often referred to as "negative testing."

The majority of rejections on professional claims were common rejects related to an invalid NPI. Some claims were rejected because they were submitted with future dates. Acknowledgement testing cannot accept claims for future dates. Additionally, claims using ICD-10 must have an ICD-10 companion qualifier code. Claims that did not meet these requirements were rejected.

### Mark your calendar for upcoming acknowledgement testing weeks on March 2-6 and June 1-5, 2015.

In addition to the special testing weeks, providers are welcome to submit acknowledgement test claims anytime up to the October 1, 2015 implementation date. Contact your [Medicare Administrative Contractor](#) for more information.

For more information:

- [MLN Matters® Article MM8858](#), "ICD-10 Testing - Acknowledgement Testing with Providers"
- [MLN Matters® Special Edition Article SE1409](#), "Medicare FFS ICD-10 Testing Approach," which also includes information on opportunities for end-to-end testing with FFS Medicare

## From CMS: Volunteer for ICD-10 End-to-End Testing in April — Deadline Extended to January 21

During the week of April 26 through May 1, 2015, a second sample group of providers will have the opportunity to participate in ICD-10 end-to-end testing with Medicare Administrative Contractors (MACs) and the Common Electronic Data Interchange (CEDI) contractor. The goal of end-to-end testing is to demonstrate that:

- Providers and submitters are able to successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims
- Accurate remittance advices are produced

Approximately 850 volunteer submitters will be selected to participate. This nationwide sample will yield meaningful results, since CMS intends to select volunteers representing a broad cross-section of provider, claim, and submitter types, including claims clearinghouses that submit claims for large numbers of providers. Note: testers who are participating in the January testing are able to test again in April and July without re-applying.

### To volunteer as a testing submitter:

- Volunteer forms are available on your [MAC](#) website.
- Completed volunteer forms are due January 21.
- CMS will review applications and select the group of testing submitters.
- By February 13, the MACs and CEDI will notify the volunteers selected to test and provide them with the information needed for the testing.

**If selected, testers must be able to:**

- Submit future-dated claims.
- Provide valid National Provider Identifiers (NPIs), Provider Transaction Access Numbers (PTANs), and beneficiary Health Insurance Claim Numbers (HICNs) that will be used for test claims. This information will be needed by your MAC by February 20, 2015, for set-up purposes; testers will be dropped if information is not provided by the deadline.

An additional opportunity for end-to-end testing will be available during the week of July 20-24, 2015. Any issues identified during testing will be addressed prior to ICD-10 implementation. Educational materials will be developed for providers and submitters based on the testing results.

**For more information:**

- [MLN Matters® Special Edition Article #SE1409](#), "Medicare FFS ICD-10 Testing Approach"
- [MLN Matters® Special Edition Article #SE1435](#), "FAQs – ICD-10 End-to-End Testing"

## From CMS: Share your ICD-10 story

CMS is looking for providers, vendors, clearinghouses, health plans, and others to share ICD-10 success stories and milestone achievements with the health care community. CMS wants to hear how you are preparing your organization for the transition. Some areas of interest are:

- Training and educating staff about the transition
- Clinical documentation improvement
- Coordinating with vendors to update software
- Testing systems within your practice and with clearinghouses and health plans
- Collaborating with other health care organizations on ICD-10

By talking about how your organization is getting ready for ICD-10, you can help others across the country prepare for October 1, 2015. If you are interested in sharing your ICD-10 best practices, [send CMS your story](#).

## Only submit claims to DMAP via EDI, Provider Web Portal or mail

DMAP only accepts claims in the following formats:

- **Electronic data interchange (EDI)** – From registered trading partners, through your clearinghouse or HIPAA-compliant office management software. To learn more about EDI, [visit our EDI page](#).
- **Provider Web Portal (PWP)** – This is a free service for enrolled providers. Users can bill claims appropriate to their provider type; verify eligibility and CCO enrollment; submit prior authorization requests; review service-specific Prioritized List and benefit plan coverage; and more. To learn more, [visit our PWP page](#).
- **Original copies of commercially available paper claim forms** – Please do not send black and white copies of forms. Faxed claims are a black and white copy of the original claim form and cannot be processed. [View our Provider Contacts List to learn where to mail paper claims](#)

## How providers may use the OHP Customer Service fax line

Providers may only use the OHP Customer Service fax line at 503-373-7493 (Salem) to submit the following information:

- For members who need to [renew their OHP coverage](#): Completed expedited OHP renewal forms or OHP applications
- For [Hospital Presumptive Eligibility \(HPE\)](#) determination sites: HPE approval and denial letters; OHP applications for HPE-eligible members
- Household changes using the [DMAP 2410 – Newborn Notification](#), [DMAP 720 – AI/AN OHP Enrollment Change Request](#), or [Life Changes Form](#).
- Other information as requested by OHP Customer Service.

**Please do not fax claim forms to OHP Customer Service.** DMAP is unable to process any claims received by fax.

## Rate increase for Mirena® effective November 17, 2014

In December, DMAP increased the FFS rate for Mirena® (HCPCS code J7302 - *Levonorgestrel-releasing intrauterine contraceptive system*) from \$772.65 to \$810.51 effective November 17, 2014.

DMAP will publish this change in the February 2014 [FFS fee schedule](#), but please know that DMAP will process claims at the new rate for dates of service on and after November 17, 2014.

## Medical Payment Recovery letters about services not covered by Medicare

The week of December 7, 2014, some providers received letters from the DHS/OHA Office of Payment Accuracy and Recovery's [Medical Payment Recovery Unit](#) about recent claims for medical services (with an attached report of the claims). The letters incorrectly listed services that Medicare does not cover (for example, nursing facility room and board charges); and asked providers to bill Medicare for these services, then reimburse DHS.

**If you received such a letter in December for services that you know Medicare does not cover, please disregard the letter.** DHS/OHA does not expect you to bill Medicare, and will not attempt to recover payments for these services from your future payments.

DHS/OHA is working on a solution to this issue. Until DHS/OHA solves the problem that created the incorrect letters, this specific letter is no longer going out. However, if you receive other letters from OPAR, please review and respond appropriately.

We apologize for any confusion this may have caused and thank you for your patience during this time.

## Report third party health insurance to DHS/OHA through a new secure Web form

You can now report private health insurance for OHP members at [www.reporttpl.org](http://www.reporttpl.org). When you use this tool, the DHS/OHA Health Insurance Group (HIG) receives the information in a secure, HIPAA-compliant format.

- You will need a current internet browser such as Chrome, Mozilla Firefox or Internet Explorer 8 or higher.
- Every question is important, so please be as thorough as possible. If possible, enter the information with the OHP member present to make sure you have all the information you need.
- After submitting the form, you will receive a confirmation email to track and verify your submission. You can also print a confirmation/summary page for your records.

**Due to HIPAA security requirements, DHS/OHA will no longer accept insurance referrals by fax starting April 1, 2015.** On and after this date, please submit referrals using the new Web form. If you are unable to use the Web form, then you will need to submit the MSC 415H, MSC 0156, or DHS 8708 form by secure email or regular mail.

### Questions?

If you have questions about the new online form and changes to the referral process, contact HIG at 503-378-6233 (Salem) or email [tpr.referrals@state.or.us](mailto:tpr.referrals@state.or.us).

## Reminder: Monthly payment recovery for OHP newborn claims

Every month, DMAP 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, DMAP enrolls children born to MCO/CCO members in the mother's plan.
- However, depending on when the birth is reported to DMAP, 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 [DMAP 2410](#) (Newborn Notification Form). Allow 2-3 weeks for processing.
- [Verify the newborn's MCO/CCO enrollment](#) using PWP, AVR or EDI.
- Once you have verified the newborn's MCO/CCO enrollment, bill the MCO/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 [DMAP's General Rules](#).

## Need help?

Find more phone numbers, e-mail addresses and other resources in DMAP's [Provider Contacts List](#) (updated 9/12/2014).

- **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.



DMAP CAPE 14-795