

Provider Matters – July 2014

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

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Clarifications about the Provider CCO Change Request process

In April, DMAP introduced the [Provider CCO Change Request Guide](#). Because of the unexpected volume and variety of change requests we have received, we would like to clarify how to use this process.

The Provider CCO Change Request process is only for physical health Primary Care Providers (PCPs) and CCO members. This process is only to help CCO members change to the same CCO as their physical health PCP.

The Provider CCO Change Request form is NOT for:

- **Any providers other than the physical health PCP:** For example, dentists, behavioral health providers, pharmacies
- **Non-CCO members:** Fee-for-service (FFS or “open-card”) members; managed care plan (DCO/FCHP/PCO/MHO) members

For other types of change requests, please read [How to submit other member change requests](#).

For children under age 19, please provide the parent/guardian’s information

For children under age 19, please include the following information in the “Member or Guardian” box of the Provider CCO Change Request form:

- Print the parent/guardian name in the “Member Name” field.
- For in-office requests, also include the parent/guardian signature in the “Member Signature” field.
- For phone requests, also include the date and time of request.

Please wait 3-4 weeks before checking status of a Provider CCO Change Request

Because of the variety of change requests we have received through this process, we have had to take additional time to review the request to either process or redirect to the appropriate staff. Please allow a three- to four-week response time. We appreciate your patience as we work toward a solution.

The Provider CCO Change Request process is not for immediate or urgent requests. For changes that need to happen within the same day or week, members should call their plan/CCO or OHP Customer Service.

Questions?

If you have questions about this new process, please email CCO.ChangeRequest@state.or.us.

How to submit other member change requests

Please refer to the following list of contacts regarding other OHP member change requests. In addition:

- **For urgent prescription issues** – Providers may call the Oregon Pharmacy Call Center (1-888-202-2126).
- **For other urgent health care needs** – Members may call OHP Care Coordination (1-800-562-4620).

When to call member’s CCO View OHA’s full CCO list	When to call OHP Customer Service 1-800-699-9075
Dental plan change for CCOA or CCOG members	Other CCO/plan changes

Health Share of Oregon changes – From one Health Share plan to another Health Share plan

Report other changes for OHP members

- Address change
- Household/income change
- Other health coverage (TPL)
- Pregnancy

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.

- Comments must be submitted by July 21, 2014. To submit, [please visit the CMS website](#).
- 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, over 3,080 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: ICD-10 Basics - Unspecified diagnosis codes, CPT codes, and Version 5010 standards

The Department of Health & Human Services (HHS) expects to release a final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The new compliance date would give providers an extra year to prepare. Now is a great time to brush up on ICD-10 basics as you get ready for the transition.

If you missed the June 4 MLN Connects National Provider Call, *More ICD-10 Coding Basics*, a [written transcript and audio recording](#) are now available.

And for a quick refresher on a few ICD-10 basics where the Centers for Medicare & Medicaid Services (CMS) frequently receives questions, read on!

Unspecified diagnosis codes

In both ICD-9 and ICD-10, sign/symptom and “unspecified” diagnosis codes have acceptable, even necessary, uses.

While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient’s condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the health care encounter. Each health care encounter should be coded to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn’t known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate “unspecified” code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). In fact, unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient’s condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or to conduct medically unnecessary diagnostic testing in order to determine a more specific code.

CPT codes

The transition to ICD-10 does not affect Current Procedural Terminology (CPT) coding for outpatient procedures. Like ICD-9 procedure codes, ICD-10 procedure codes (ICD-10-PCS) are for hospital inpatient procedures only.

Version 5010

You must be using [Version 5010 HIPAA standards](#) in order to conduct electronic transactions with ICD-10. The earlier, Version 4010 HIPAA standards cannot accommodate the longer ICD-10 codes.

Most organizations began using Version 5010 in 2012, when compliance became mandatory under HIPAA. Any providers or organizations still using Version 4010 for electronic transactions are in violation of HIPAA. If you are not certain whether you are Version 5010-compliant, check with your health IT professional or your clearinghouse or billing service.

Find out more about the basics in the *Road to 10*

To find out more about ICD-10 basics and beyond—including how to build an action plan, update your processes, and test your readiness—check out the *Road to 10* resource for small medical practices, available at cms.gov/ICD-10.

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](#).

Questions about ICD-10?

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

June 14 and June 16 Medical Payment Recovery letters about services not covered by Medicare

Earlier this week, DMAP shared [a message from the DHS/OHA Office of Payment Accuracy and Recovery about Medicare billings sent in error](#). We would like to share some more information about these letters:

- The “Medicare billings” were automated letters issued by [OPAR Medical Payment Recovery](#), dated June 14 and June 16, 2014. They incorrectly stated that Medicare is the primary payer for services that Medicare does not cover (for example, nursing facility room and board charges).

- The letters also asked providers to bill Medicare for the services and reimburse DHS for payments made on these claims.

If you received such a letter dated June 14 or June 16 that is specific to services that you know Medicare does not cover, please disregard. 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 again for any confusion this may have caused, and thank you for your patience during this time.

Change in multivitamin coverage effective August 1, 2014

Starting August 1, fee-for-service coverage of most multivitamins will require prior authorization (PA).

- DMAP will only approve PA for individuals with documented nutritional deficiency or a diagnosis associated with nutritional deficiency.
- Upon PA approval, DMAP will only cover a select list of multivitamin products (or their generic equivalent).

If DMAP recently covered one of the select multivitamin products for a particular client, that client will be able to continue getting coverage for the same product until August 1, 2015.

These changes do not affect DMAP's coverage of prenatal or pediatric multivitamins.

You can view the new multivitamin PA criteria on page 114 of DMAP's [Oregon Medicaid PA Criteria](#) (updated July 15, 2014).

Next PERM Provider Education Webinar/Conference Call is July 30

The Centers for Medicare & Medicaid Services (CMS) will host the last of four provider education webinar/conference calls about specific provider responsibilities during the 2014 Payment Error Rate Measurement (PERM) cycle. These sessions feature presentations about:

- The PERM process and provider responsibilities during a PERM review
- Recent trends, frequent mistakes and, best practices
- The Electronic Submission of Medical Documentation, esMD program

You can still join the [July 30](#) session from 3 to 4 p.m. Eastern Standard Time. Once available, presentation material will be posted on [the Providers tab of the PERM website](#).

For detailed information about these sessions, including how to test your computer and audio for session compatibility, [view the 2014 webinar invitation](#).

Reminder: Third-trimester exemptions from CCO enrollment

Last month, DMAP filed [a temporary rule that removes the July 1, 2014 end date for CCO enrollment exemptions for pregnant women in their third trimester](#).

This change is to retain a fee-for-service ("open card") option for pregnant OHP women, based on recommendations from OHA's Licensed Direct Entry Midwife Staff Advisory Workgroup. To learn more, [please read our June letter to maternal health care providers](#).

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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