

Provider Matters – March 2015

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

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WEBINAR: Join us March 27 for OHP Provider Collaborative – Retroactive Eligibility

Please join the Oregon Health Authority (OHA) on [Friday, March 27, 2015 at 10:00 AM PDT](#) for a webinar about OHA's retroactive eligibility process: assisting clients seeking retroactive assistance for medical bills within the last 90 days.

Join us March 27, 2015

10 AM to 11 AM

[Register Today!](#)

We hope you join us for this webinar to discuss improvements to the process for submitting retroactive medical eligibility requests.

Link to register:

<https://attendee.gotowebinar.com/register/100000000065862739>

After registering, you will receive a confirmation email containing information about joining the webinar.

[View System Requirements](#)

Medicaid Electronic Health Records (EHR) Incentive Program

Medicaid attestation timelines and CEHRT requirements

Program Year 2015 attestations are being accepted now for all eligible [hospitals](#) and [professionals](#).

- Please report using 2014 Edition certified electronic health record technology (CEHRT).

For eligible professionals, Program Year 2014 attestations are due no later than 11:59 pm (PST) on **May 31, 2015**.

- You may report using the 2011 Edition, a combination of the 2011 and 2014 Editions, or the 2014 Edition.

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 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 the CEHRT flexibility option rule:** Please view [the final rule](#), or visit the CMS Newsroom to read the [press release](#) about the final rule.
- **About EHR Incentive Programs resources:** Please visit the [CMS EHR website](#).
- **About certified EHRs:** Please visit the Office of the National Coordinator's [Certified Health Product Listing website](#).

From CMS: Participate in ICD-10 Acknowledgement Testing Week: June 1-5, 2015

To help you prepare for the transition to ICD-10, the Centers for Medicare & Medicaid Services (CMS) offers acknowledgement testing for current direct submitters (providers and clearinghouses) to test with the Medicare Administrative Contractors (MACs) and the Durable Medical Equipment (DME) MAC Common Electronic Data Interchange (CEDI) contractor anytime up to the October 1, 2015, implementation date.

CMS previously conducted two successful acknowledgement testing weeks in [March 2014](#) and [November 2014](#). These acknowledgement testing weeks give submitters access to real-time help desk support and allow CMS to analyze testing data. Registration is not required for these virtual events.

Mark your calendar for June 1 through 5, 2015

How to participate

Information is available on your [MAC](#) website or through your clearinghouse (if you use a clearinghouse to submit claims to Medicare). Any provider who submits claims electronically can participate in acknowledgement testing.

What you can expect during testing:

- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected in the system.
- Test claims will be subject to all current front-end edits, including edits for valid National Provider Identifiers (NPIs), Provider Transaction Access Numbers (PTANs), and codes, including Healthcare Common Procedure Coding System (HCPCS) and place of service
- Testing will not confirm claim payment or produce a Remittance Advice (RA)
- MACs and CEDI will be staffed to handle increased call volume during this week

Testing tips:

- Make sure test files have the "T" in the ISA15 field to indicate the file is a test file
- Send ICD-10 coded test claims that closely resemble the claims that you currently submit
- Use valid submitter ID, NPI, and PTAN combinations
- Use current dates of service on test claims (i.e. October 1, 2014 through March 1, 2015)
- Do not use future dates of service or your claim will be rejected

Not sure what type of testing you are eligible to participate in?

[MLN Matters® Special Edition Article SE1501](#) explains the differences between acknowledgement and end-to-end testing with Medicare.

Other resources:

- [MLN Matters Article MM8858](#), "ICD-10 Testing - Acknowledgement Testing with Providers"
- [MLN Matters Special Edition Article SE1409](#), "Medicare FFS ICD-10 Testing Approach"

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.

2015 rates for some RVU-based codes corrected March 11, 2015

When we updated our claims processing system with [Relative-Value Unit \(RVU\) weight-based rates for 2015](#), the wrong Resource Based Relative Value Scale (RBRVS) amounts were loaded for about 5,600 codes. This means that for professional claims billed to DMAP with dates of service on or after January 1, 2015, some of the 5,600 codes may

have incorrectly paid at a higher or lower rate than the one described in the posted [fee-for-service \(FFS\) fee schedule](#). We corrected this system error on March 11, 2015, so that the affected codes now reflect the rates in our posted fee schedule.

The week of April 6, we plan to reprocess affected 2015 claims to apply the correct payment amounts. Reprocessing information will appear on paper and electronic remittance advices produced for April 10. Adjusted claims will have an ICN beginning with "52".

- **On the paper RA:** The "Detail EOBs" for these ICNs will list Explanation of Benefits (EOB) code *EOB 8136 – DHS initiated adjustments due to processing error*.
- **On the ERA or PWP:** In both ERA and PWP, the reason will be *Adjustment Reason Code 129 - Prior processing information appears incorrect*.

Hospice reminders about billing for nursing facility residents

When billing DMAP for nursing facility (NF) room and board for a hospice client, please remember that NF and hospice discharge dates pay differently.

- **If the client is discharged, transferred, or expires in the NF, the date of discharge, transfer, or death is not a chargeable day.** This means that the NF should not bill the hospice provider for this last NF day, and DMAP will not reimburse the hospice provider for that last day. To learn more about chargeable NF days, please review Oregon Administrative Rule (OAR) [411-070-0050 Days Chargeable](#) (page 31).
- **When hospice ends, the hospice is still paid for the last day of hospice (the date of discharge, revocation or death).** Hospice providers are reimbursed for each day of care (with the exception of payment for physician services). To learn more about billing for hospice services, please review *OAR 410-142-0300 Hospice Reimbursement and Limitations (3)* on page 25 of the current [Hospice Services Rulebook](#).

Claim processing updates for hospitals

DMAP is working on solutions to the following claim processing issues. We will let you know when these issues are resolved.

- 1) We are still waiting to update our system with the Inpatient DRG grouper version 32 effective 10/1/14.
- 2) For outpatient claims paid by the Ambulatory Payment Classification (APC) grouper, clinical lab codes billed using the L1 modifier are not processing correctly.
- 3) The system is paying all inpatient claims according to the date of discharge instead of the admission date. This error mainly affects claims that have outliers.

Thank you for your patience as we continue to work toward system improvements.

New CPT code for chronic care management effective January 1, 2015

If you serve Medicare members with chronic conditions, please review the following information from CMS about Medicare reimbursement for CPT code 99490, effective January 1, 2015:

- **What is covered?** 20 minutes per calendar month of non-face-to-face clinical staff time directed by a physician or other qualified health professional.
- **Who is covered?** Patients with two or more chronic conditions expected to last at least 12 months.
- **What else is required for reimbursement?** Patients must have an established, implemented comprehensive care plan that is regularly monitored or revised.

To learn more, including eligible provider types and other requirements for using this new code, [review material from the Medicare Learning Network's February 18 provider call](#) and their [January 2015 fact sheet about Chronic Care Management Services](#).

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. 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 or MSC 0156 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.

Fee-for-service (FFS) primary care providers - How to request CCO disenrollment for your patients

If you serve OHP members who have been enrolled in a CCO that you are not contracted with, you may contact DMAP's Medical Management Unit to request disenrollment.

- Disenrollment requests are approved only for *medically justified reasons* for continuing care with a specific provider (see OAR 410-141-3060 in [DMAP's Oregon Health Plan - MCO and CCO rules](#)).
- Personal or provider preference is **not** a valid reason to request disenrollment.

If the request is approved, DMAP will end the member's current CCO enrollment so that the member can continue to receive services from you on a FFS ("open card") basis.

How to submit disenrollment requests:

Fax a written request to DMAP's Medical Management Unit at 503-945-6548 (Salem), ATTN: Disenrollment Request.

- The request should state the medical reason the patient needs to continue care with you (e.g., patient is in the middle of treatment).
- Include medical documentation or chart notes that support the request.
- If the request is urgent, mark "Expedited" across the top of the request.

For pregnant members, either you **or** the patient may fax the request.

Questions?

If you have questions about the disenrollment request process: Call DMAP's Prior Authorization Line at 503-945-6821 (Salem) or 1-800-642-8635.

Reminder: CCO PCPs need to use the CCO Provider Change Request process to continue patient care

If you are a part of a CCO and your patient wants to change CCOs to continue seeing you, please continue to use the [CCO Provider Change Request process](#). This process is only for physical health Primary Care Providers (PCPs) and CCO members who want to change to the same CCO as their physical health PCP.

The CCO Provider Change Process 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

Questions?

If you have questions about the CCO Provider Change Request process: Email cco.changerequest@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](#).

- **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 15-103