

Provider Matters – November 2014

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

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Help us spread the word about Oregon Health Plan (OHP) renewals

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. More information about OHP renewals is available at www.ohp.oregon.gov.

Please help us get the word out to OHP members about renewing their benefits. As valued partners, sharing renewal information on your websites, social media accounts, newsletters and directly with members, will have a huge impact. You can find tools such as banner ads, text (for social media, email and newsletter content), posters, and more in the [OHP Partner Toolkit](#). Thank you for your help!

Update - OHP renewal letters and timelines

Since August, OHA has been sending renewal letters to OHP households each month. For those who **do not** respond or reapply, OHP coverage ends as follows:

Renewal letter sent	OHP coverage ends
August 2014	October 31, 2014
September and October 2014	December 31, 2014
November and December 2014	January 31, 2015

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.

Oregon as part of the federal Health Insurance Marketplace

On November 15, 2014, Oregon joined the federal Health Insurance Marketplace at HealthCare.gov. This means that starting November 15, most OHP applicants are now able to apply and receive immediate notification of their Medicaid/CHIP eligibility through HealthCare.gov.

What has changed:

- OHA has a new website for the online OHP application: OregonHealthCare.gov. People who have situations that require special processing will be served better by applying here than through HealthCare.gov. This is especially true for tribal members, pregnant women, refugees and others.
- DMAP has sent notices to plans, providers and pharmacies about [how to address urgent health care needs for OHP applicants deemed eligible through HealthCare.gov](#).

- HealthCare.gov determines Medicaid/CHIP eligibility immediately. OHP providers may accept the HealthCare.gov confirmation letter as proof of eligibility effective for the **application date** listed on page 1.

What stays the same:

- The process for [determining Hospital Presumptive Eligibility \(HPE\)](#), or submitting OHP applications on behalf of HPE-eligible members.
- The process for [submitting Medicaid applications for Oregon correctional facility inmates](#) entering or exiting a hospitalization.

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

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 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 **December 29, 2014**.
- 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.

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](#).

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

So far, over 3,290 providers have been deemed eligible for the temporary primary care rate increase available under Section 1202 of the Affordable Care Act. The increase is only effective for calendar years 2013 and 2014, and [ends December 31, 2014](#).

- Physicians, advance practice nurses and physician assistants who practice General Internal Medicine, Pediatric Medicine or Family Medicine have until December 31, 2014, to [self-attest to have the increase apply to eligible primary care services rendered on or after October 1, 2014](#).
- Providers who have already attested in 2013 or 2014, and who are already receiving the increase, **do not need to re-attest**.

- 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.

If you are a clinic who frequently reports new practitioners using the online attestation form, please make sure we receive your attestation by periodically [clearing your internet cache](#). You only need to do this for the browser and device you use to access the attestation form.

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 transition resources

New Medscape resources offer CME/CE credits

CMS has released three new resources to help small physician practices prepare for ICD-10. These resources also provide continuing medical education (CME) and continuing education (CE) credits to health care professionals who complete the learning modules, and anyone who takes them will earn a certificate of completion. If you are a first-time visitor to Medscape, you will need to create a free account to access these resources.

- [ICD-10: Getting From Here to There -- Navigating the Road Ahead](#) – A video lecture giving providers an overview of ICD-10 and its benefits, the differences between ICD-9 and ICD-10, and the CMS “Road to 10” Tool.
- [ICD-10 and Clinical Documentation](#) – A video discussing the role of documentation and coding in health care and examining why documentation is important for ICD-10.
- [Preparing for ICD-10: Now Is the Time](#) – An expert column exploring the effect ICD-10 will have on systems, the coding process, documentation, and quality reporting. It also provides steps to prepare for ICD-10 implementation.

CMS has created “Road to 10” to help you jump start the transition to ICD-10.

Built with the help of small practice physicians, “Road to 10” is a no-cost tool that will help you:

- Get an overview of ICD-10
- Explore Specialty References

To get started and learn more about ICD-10, visit <http://www.roadto10.org/>.

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.

Reminders about OHP Plus services delivered through nursing facilities

Post-hospital extended care (PHEC) and hospice services to Medicaid nursing facility (NF) residents are **not** considered long-term care (LTC) services. Both services are provided through the OHP Plus benefit package.

PHEC:

This benefit is for Medicaid-only (BMH) members who meet Medicare criteria for a 1-20 day NF placement following a qualifying hospital stay. After day 20, the PHEC benefit ends, and AAA/APD must review for LTC eligibility. To learn more about PHEC eligibility criteria, see [OAR 411-070-0033](#).

- **Who authorizes PHEC services?** The coordinated care organization or fully capitated health plan (CCO/FCHP) authorizes PHEC for CCO/FCHP members; the local AAA/APD office authorizes PHEC for all other OHP members (including PCO members).
- **Who is responsible for payment (days 1 through 20)?** Who pays depends on who authorized the service and whether the member is enrolled in a CCO/FCHP.
 1. **If the CCO/FCHP authorized the service,** contact the CCO/FCHP.
 2. **If AAA/APD authorized the service,** contact DMAP.
 3. **If there is no authorization on file,** seek authorization from the CCO/FCHP (if the member was in a CCO/ FCHP during the qualifying hospital stay) or the local AAA/ APD office (for all other members).
- **Who is responsible if the member’s enrollment changes?** If the member’s enrollment status changes at any time during days 1-20, providers will need to contact DMAP to make sure the member is returned to the

status that was in effect at the time of the qualifying hospital stay so that their claims can process appropriately.

- **Who is responsible for days 21 through discharge for CCO/FCHP members?** A CCO/FCHP is only responsible for PHEC coverage (days 1 through 20); days 21 forward are LTC services to be billed to DMAP, as long as the AAA/APD office has approved LTC eligibility for the member. Only bill the CCO/FCHP for no more than 20 days; bill DMAP for days 21 forward.

Hospice services for NF residents

Hospice agencies are federally required to reimburse NFs for room and board provided to Medicaid residents receiving hospice services.

- **Who is responsible for payment?** Hospice agencies must bill DMAP for hospice services and NF room and board to all OHP members who elect hospice care (including CCO, FCHP and PCO members).
- **To learn more:** See OAR 410-142-0290(6) of DMAP's [Hospice Services guidelines](#).

Clarifications about LTC eligibility and billing for OHP members

Due to the large numbers of people now eligible for Medicaid due to the Affordable Care Act expansions, you may encounter OHP members seeking LTC services. When this happens, please remember the following:

The local AAA/APD office still determines LTC eligibility for all members

The [local AAA/APD office](#) continues to review and approve LTC service eligibility for all Medicaid members.

- Oregon Administrative Rule (OAR) [411-070-0040\(2\)](#) (*Screening, Assessment, and Resident Review; Pre-Admission Screening*) requires that the local AAA/APD office perform Pre-Admission Screenings before Medicaid members are admitted to an NF.
- APD's Office of Licensing and Regulatory Oversight (ORLO) issued an [Administrator Alert to nursing facility directors](#) reminding them to contact the local office to prior-authorize NF services for Medicaid members.

When billing LTC services to Oregon Medicaid, bill DMAP (not the CCO/plan)

CCOs and physical health plans (FCHP/PCO) are **not** responsible for payment of LTC services. When CCO/Plan members are deemed eligible for LTC services, and you want to bill Oregon Medicaid for these services, you need to bill DMAP, not the CCO/Plan.

- LTC services are **not** included in OHP Plus benefits (benefit package codes BMH, BMD, BMM).
- LTC services are assigned separate benefit package codes (for example, NFC for nursing home services). To view other benefit package codes, view DMAP's [MMIS benefit code descriptions](#).

For a more detailed description of LTC services, please see this [fact sheet about Oregon's Long-Term Care System](#).

Code V2785 re-opened for Ambulatory Surgical Centers

In 2009, DMAP closed HCPCS code V2785 (*Processing, preserving and transporting corneal tissue*) to Ambulatory Surgical Center (ASC) providers.

On Monday, November 17, we re-opened this code for ASC billing. ASCs can re-bill V2785 claims according to DMAP's timely filing guidelines (see [OAR 410-120-1300 – Timely Submission of Claims](#)).

Provider Web Portal – Did you know?

To [adjust a paid claim](#), search for and enter a previously paid claim. Click the **adjust** button, and move your mouse cursor away from the button after you click it.

- When you adjust a claim, you are creating a revised copy of the original claim. Once the copy is submitted, the ICN will change and buttons will also appear on the adjusted copy.
- Four buttons will display on a paid claim: 1) cancel, 2) adjust, 3) void, and 4) copy claim.
- Two buttons will appear on a denied claim: 1) resubmit and 2) cancel.

If your cursor is still where it was when you clicked **adjust** on the original claim, you may accidentally click **void** on the adjustment you just submitted. When this happens, this voids your adjustment and you will have to complete and submit a new claim. Avoid this by moving your cursor to the left after you click the **adjust** button.

Learn more about the Provider Web Portal at www.oregon.gov/OHA/healthplan/pages/webportal.aspx.

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.



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