

# Provider Matters – October 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](http://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 clients, 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!

## Oregon's Health Insurance Exchange for Benefit Year 2015

Health care providers, hospitals and other community partners continue to be instrumental in helping Oregonians enroll in insurance. Oregon will remain a state-based marketplace until the next open enrollment period. However, beginning November 15, 2014, there will be some changes in the way that Oregonians apply for health coverage. Most people will go to [HealthCare.gov](http://HealthCare.gov), the federal marketplace. Those who prefer to apply in-person can find a community partner or agent at [CoverOregon.com](http://CoverOregon.com).

Open enrollment for qualified (private) health plans will occur from **November 15, 2014, through February 15, 2015**. At that time, Oregonians will be able to shop for qualified (private) health plans on the federal exchange. Eligible individuals and families can enroll throughout the year into the Oregon Health Plan.

### How providers and hospitals help

Due to providers' unique relationship with their patients, Cover Oregon and the Oregon Health Authority (OHA) have made it easier for providers to establish enrollment assistance on-site.

- Providers who are enrolled with the Division of Medical Assistance Programs (DMAP) may complete a **Provider Outreach Enrollment Addendum** ([OHA 3128](#)) that serves as their "volunteer agreement" with OHA to provide application assistance at their clinic or hospital. Then, provider-affiliated enrollment assisters must complete a required training sequence and submit a criminal history check, both of which may be arranged by contacting [communitypartner@coveroregon.com](mailto:communitypartner@coveroregon.com).
- Through the **Hospital Presumptive Eligibility** process, OHA authorizes hospitals to determine immediate, temporary eligibility for patients who likely are eligible for the Oregon Health Plan. Any individual seeking immediate medical coverage may qualify, and the hospital is required to provide a full application or refer the individual to a community partner for enrollment assistance. There is no requirement that the individual be admitted to the hospital or be seeking hospital services in order to apply. Even if the individual does not qualify for OHP coverage, OHA will still reimburse the hospital for services rendered during the temporary eligibility period. Please [visit the HPE Web page](#) to learn how to become—or locate—a Hospital Presumptive Eligibility site.

## Questions?

For more information, please contact Betse Thielman, Provider Campaign Coordinator, at [Elizabeth.S.Thielman@state.or.us](mailto:Elizabeth.S.Thielman@state.or.us).

## 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.

### 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 3,275 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 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 **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: MLN Connects™ National Provider Call: Transitioning to ICD-10

Call date and time: Wednesday, November 5; 1:30-3pm ET

To register: Visit [MLN Connects™ Upcoming Calls](#). Space may be limited, register early.

The Department of Health & Human Services (HHS) has issued a [rule](#) finalizing October 1, 2015, as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10.

During the MLN Connects™ National Provider Call, CMS subject matter experts will discuss ICD-10 implementation issues, opportunities for testing, and resources. A question and answer session will follow the presentations.

### Agenda:

- Final rule and national implementation
- Medicare Fee-For-Service testing
- Medicare Severity Diagnosis Related Grouper (MS-DRG) Conversion Project
- Partial code freeze and annual code updates
- Plans for National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
- Home health conversions
- Claims that span the implementation date

*Target Audience:* Medical coders, physicians, physician office staff, nurses and other non-physician practitioners, provider billing staff, health records staff, vendors, educators, system maintainers, laboratories, and all Medicare providers

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

### 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](mailto:stateoregon.icd10@state.or.us).

## Reminders about DMAP provider service options

Earlier this month, we let you know about [our expanded provider service hours](#) (8 a.m. to 5 p.m. Monday-Friday, including lunch hours). We would also like to remind and encourage providers to use our self-service options (the Provider Web Portal <https://www.or-medicaid.gov> and Automated Voice Response at 1-866-692-3864). These options will reduce your wait time on the phones.

- For information about using the Provider Web Portal, [please visit our Provider Web Portal page](#) or [view our Provider Web Portal training videos](#).
- For information about Automated Voice Response, [see our quick reference guide](#).

If you need password or PIN resets to access either of these options, please email [team.provider-access@state.or.us](mailto:team.provider-access@state.or.us).

## Please call Provider Services or the CCO/plan to resolve claim denials

DMAP has noticed an increase in calls from clients whose providers have advised them to call OHP Client Services and/or DMAP Provider Services to resolve issues with denied claims. Please do not ask clients to resolve billing issues for claims you have billed DMAP or the CCO/plan. Instead, please do the following:

If your claim denial is for a covered service to an OHP client who is not enrolled in a CCO/plan:

1. [Review your Remittance Advice](#) to review the reasons for denial.
2. Research your claim on the Provider Web Portal at <https://www.or-medicaid.gov>.
3. If you still do not understand the reason for denial, contact Provider Services. They can explain the denial and if possible, how to resolve the issue. We have expanded our Provider Services phone hours so that we are available to help with complex denials.

If your claim denial is for a covered service for a CCO/plan member, please contact the CCO/plan.

While we understand frustrations with call wait times and claim denials, researching your claims before calling

Provider Services or the client's CCO/plan can actually save your staff time and is the most direct way to resolve billing issues.

## Provider Web Portal change effective October 27, 2014

Starting Monday, October 27, when you do searches, logins, page refreshes or other activity that requires the Provider Web Portal at <https://www.or-medicaid.gov> to validate the information you enter, the screen will turn gray. The shade of gray may vary depending on the version and type of internet browser you use.

## October 1, 2014 hospice rates now available

DMAP has posted the fee-for-service hospice rates that will be effective for federal fiscal year 2015 (October 1, 2014, through September 30, 2015).

- You can find the rates and other resources on DMAP's [hospice guidelines page](#).
- This is the annual rate change based on federal requirements from CMS.
- To learn more about the October 1, 2014 rates, please [read our recent letter to hospice agencies](#).

## Do not enter daily room rate in Field Locator (FL) 44 of the UB-04

To ensure timely processing of your paper claims, please do not enter your daily room rate in FL 44 (HCPCS/Rates) of the UB-04 claim form.

- Claims with this information in FL 44 will either deny, or suspend until DMAP staff manually remove this rate information from your claim.
- FL 44 is only required on hospital claims for revenue codes that require CPT/HCPCS reporting. The Revenue Code Table (available on DMAP's [hospital guidelines page](#)) lists all codes that require this reporting.

To learn more about how to submit institutional claims to DMAP, please view our [Institutional Billing Instructions](#) (updated October 2014 to include nursing facility billing instructions and new UB-04 PO Box information).

## Reminders about CLIA updates and common lab billing errors

DMAP updates MMIS with new or updated CLIA certifications during each weekend's financial cycle. Delays are rare. If you find that a lab claim has suspended or denied, please research the following options:

- **Was the service billed under the correct provider ID?** Lab services must be billed under the performing laboratory's provider ID. Each laboratory provider ID is linked to the CLIA certificate for that laboratory. [Labs that are waived from CLIA certification requirements](#) are limited in the types of services they can perform and the modifiers they can use.
- **Was the service authorized by the lab's CLIA certification for the dates of service billed?** When billing for services authorized under CLIA, the claim's date(s) of service must correspond to the laboratory's dates of authorization for the services billed.
- **Is the service covered according to DMAP guidelines?** Some lab services require prior authorization, are not covered or only covered as part of a bundled service. For other guidelines for billing laboratory services, please see OAR 410-130-0680 (Laboratory and Radiology) in DMAP's [Medical-Surgical guidelines](#).

## Reminder - DHS/OHA secure email changes

Last month, DHS/OHA changed their secure email service from Tumbleweed to ProofPoint. Access to secure emails through Tumbleweed will end Saturday, November 8.

To help us transition from Tumbleweed to ProofPoint, please **do not** reply to DHS/OHA emails that were sent using Tumbleweed.

- Tumbleweed emails will be dated prior to September 9, 2014, and look like the screenshot below.
- If you still have DHS/OHA email that looks this way, you can still view the message(s), but if you need to reply, please start a new email.



## 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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