Provider Matters – April 2015

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

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Health system transformation

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WEBINAR: Join us April 28 for *OHP Provider Collaborative – Newborn Notification*

Please join the Oregon Health Authority (OHA) on Friday, April 28, 2015 at 10:00 AM PDT for a webinar about OHA's process for enrolling newborns into the Oregon Health Plan (OHP).

Join us April 28, 2015
10 AM to 11:30 AM
Register Today!

We hope you will join us for this webinar. Each Provider Collaborative includes time for questions and discussion.

Link to register:
https://attendee.gotowebinar.com/register/4257976791656084993

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

View past OHP Provider Collaboratives on the OHA YouTube channel

OHP serves over 1,000,000 Oregonians, and we couldn't do it without providers who provide quality, accessible care in the communities where our members live. In the spirit of collaboration, mutual learning and transparency, OHA holds monthly webinar-based Provider Collaboratives to address topics of immediate relevance to providers who serve our mutual clients.

Past Provider Collaboratives were recorded and can be accessed via YouTube at https://www.youtube.com/playlist?list=PL7mua_4kMbMq7yxQLGy3LYfIVqrVZFCoe. Topics so far include:

- Retroactive Eligibility
- CCO Topics
- Provider Options to Verify "Atypical" Oregon Health Plan Eligibility

Help us plan future provider collaboratives
We look forward to hearing from you about future topics you would like to explore. To suggest new topics, please contact our Medicaid Program Trainer.

Spread the word about Hospital Presumptive Eligibility

In Oregon's first year of using the Hospital Presumptive Eligibility (HPE) process, 55 hospitals are now certified to approve eligible Oregonians for immediate and temporary OHP coverage.

The next step is making sure local communities know about this new path to eligibility. HPE determinations should be available to any potentially eligible uninsured individuals upon request. Suggestions include:

- Update hospital directories, signage and informational materials so that visitors know where to go for HPE determinations.
- Inform reception and information staff about HPE and how they can help people find an HPE determination site.

Hospitals can also contact their Regional Outreach Coordinator about resources to help applicants complete the full Medicaid/CHIP application (OHA 7210), which must be submitted before the client's HPE eligibility ends (within 2 calendar months of the HPE approval date).

How hospitals can apply to become an HPE determination site
First, please review the HPE roles and responsibilities. If you agree with the obligations outlined for hospitals who participate in the HPE process, fill out the Declaration of Intent and Agreement to Serve as a Hospital Presumptive Eligibility Site and return to OHA by mail, email or fax.

Questions?
To learn more, including topics such as the determination process, HPE coverage, and hospital reporting requirements, review our recent updates and reminders about HPE. Also visit the HPE Web page, and see Oregon Administrative Rule (OAR) 410-200-0105 of DMAP's Client and Community Medical program.

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.

Take action now to ensure Provider Web Portal access
To submit attestations, you need to have access to the Provider Web Portal (PWP) at https://www.or-medicaid.gov. Please take these steps to make sure you are able to submit Program Year 2014 attestations using PWP by May 31:

- New providers need to submit the DMAP 3113 as soon as possible (allow 2-3 weeks for processing).
- Providers who need to update their enrollment information need to use the DMAP 3035 or Provider Web Portal.
- If you need to have your password or PIN reset, please contact DMAP Provider Services at 1-800-336-6016.

CMS and ONC Release NPRMs on Stage 3 Requirements and 2015 Edition Certification Criteria

- The Centers for Medicare and Medicaid Services (CMS) has released a notice of proposed rulemaking (NPRM) for Stage 3, the next step in the implementation of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.
- Concurrently, the Office of the National Coordinator for Health Information Technology (ONC) also announced the proposed 2015 Edition certification criteria for health IT products.

Both proposed rules focus on the interoperability of data across systems, and make the EHR Incentive Programs simpler and more flexible.

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.

Reminder - ICD-10 resources to prepare for October 1, 2015

CMS end-to-end testing:

- MLN Matters® Article #MM8867, "ICD-10 Limited End-to-End Testing with Submitters for 2015"
- MLN Matters Special Edition Article #SE1435, "FAQs – ICD-10 End-to-End Testing"
- 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.

Medicare-Medicaid billing reminder for home health and hospice providers

When billing DMAP for home health and hospice services for clients who have both Medicare Part A and Oregon Medicaid coverage, please remember to bill Medicare first. Medicare payment for these services may be considered payment in full, as explained in *Oregon Administrative Rule (OAR) 410-120-1340(15)* of DMAP's General Rules.

> *(15) Payment for Division clients with Medicare and full Medicaid:*
>
> *(a) The Division limits payment to the Medicaid allowed amount, less the Medicare payment, up to the Medicare co-insurance and deductible, whichever is less. The Division's payment may not exceed the co-insurance and deductible amounts due;*
>
> *(b) The Division pays the allowable rate for covered services that are not covered by Medicare.*

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

DMAP continues to receive many 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.

More information about provider responsibility for claims resolution
OAR 410-120-1560(2) of DMAP's General Rules states that client appeals of actions (such as claim denials) must be handled in accordance with *OAR 410-120-1860 (Contested Case Hearing Procedures)* and *410-120-1865 (Denial, Reduction or Termination of Services)*. These procedures do not include having the client contact Provider Services or Client Services to discuss claim denials you receive.

As a condition of enrolling with DMAP, all providers also complete the Provider Enrollment Agreement (OHA 3975). Enrolled providers agree to Part 3 of the agreement (Accurate Billing), which states, "The Provider is solely responsible for the accuracy of claims submitted, and the use of a billing entity does not change the Provider's

responsibility for the claims submitted on Provider's behalf." This means that the provider, not the client, is responsible for resolving claims issues with DMAP.

Reminder - Claim processing issues for hospitals

DMAP continues to work 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.

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.