Provider Matters – January 2016

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

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Provider Collaborative - *Oregon Eligibility (ONE) System Launch - overview and updates*

Please join the Oregon Health Authority (OHA) Thursday, February 4, 2016, from 10 to 11 a.m. for a webinar about the Oregon Eligibility (ONE) system.

- As of February 6, 2016, new clients will be able to apply for Oregon Health Plan (OHP) coverage directly through ONE. Applicants' eligibility information will be transferred from ONE to the Medicaid Management Information System (MMIS) to enroll members in OHP and issue a coverage card.
- The ONE worker portal for OHA staff launched December 15, 2015, and things are going very well for staff who enter, manage or give status information to Oregonians.

Colette Gillies, regional outreach coordinator for Southern Oregon, will present information on ONE. Colette has played a first-hand role as part of the ONE development team and is familiar with ONE's Applicant Portal design, functionality and training.

Link to register:
https://attendee.gotowebinar.com/register/4400032601023390977

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

Medicaid Electronic Health Records (EHR) Incentive Program

Program Year 2015 attestation timelines

- **2015-2017 modifications for meaningful use** (found in the CMS Final Rule): We anticipate opening the Medical Assistance Provider Incentive Repository (MAPIR) to accept these attestations for both eligible professionals and eligible hospitals **in May 2016**.
- **2015 Adopt, Implement, Upgrade (AIU) attestations:** We are currently accepting these attestations for providers participating in their first year of 2015. Applications will be accepted until **March 31, 2016.**

CMS and ONC Release rule changes for EHR Program Years 2015-2017; Stage 3 Requirements and 2015 Edition Certification Criteria
On October 16, 2015, CMS and ONC released final rules that simplify requirements; add new flexibilities for providers to make electronic health information available when and where it matters most; and enable health care providers and consumers to readily, safely, and securely exchange that information.

To find out more about these rule changes, please view the CMS Final Rule and the ONC Final Rule.

Corrections and clarifications to 2015 Edition Final Rule
On December 11, 2015, the ONC issued a Federal Register notice (HTML) (PDF) to provide corrections such as cross-

references and citation omissions, and clarifications for the final rule entitled "2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications." These corrections and clarifications will eliminate confusion and ambiguity, permitting stakeholders to better understand, implement, and comply with the final rule. The final rule and notice are effective January 14, 2016.

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 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.

Accountable Health Communities Model application

The Accountable Health Communities Model is the firstCMS Innovation Center model to focus on the health-related social needs of Medicare and Medicaid beneficiaries, including building alignment between clinical and community-based services at the local level. The goal of this model is that beneficiaries struggling with unmet health-related social needs are aware of the community-based services available to them and receive assistance accessing those services.

- Under the model, $157 million in federal funds will support up to 44 bridge organizations, which will deploy a common comprehensive screening assessment for health-related social needs among all Medicare and Medicaid beneficiaries accessing care at participating clinical delivery sites.
- The model aims to identify and address beneficiaries' health-related social needs in at least the following core areas:
    - Housing instability and quality;
    - Food insecurity;
    - Utility needs;
    - Interpersonal violence; and
    - Transportation needs.

To measure the effectiveness of the model on total cost of health care utilization and quality of care, the primary evaluation will focus on reduction in total health care costs, emergency department visits, and impatient hospital readmissions.

Eligible applicants are community-based organizations, hospitals and health systems, institutions of higher education, local government entities, tribal organizations, and for-profit and not-for-profit local and national entities with the capacity to develop and maintain a referral network with clinical delivery sites and community service providers.

CMS anticipates announcing awards in the fall of 2016.

Applications are due March 31, 2016. To submit an application, go to https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=55237.

Applications require a memorandum of understanding (MOU) from the state Medicaid agency. To request an MOU, contact Jennifer Valentine, Operations and Policy Analyst, Health Systems Division, at jennifer.b.valentine@state.or.us.

Letters of intent are encouraged, but not required. Interested applicants may submit a non-binding letter of intent until February 8, 2016, at http://innovationgov.force.com/ahc.

To learn more, read the CMS press release or visit the CMS Innovation Center website. If you have questions about applying, please contact Jennifer Valentine at jennifer.b.valentine@state.or.us.

Reporting prior payments on UB-04 paper claims

When reporting a prior Medicare or third-party liability (TPL) payment on a UB-04 paper claim form, please make sure you enter the payment information on the correct line. There are three lines in Field Locator 54 (A, B and C). They should be completed as follows:

- Line A: Medicare payment information
- Line B: TPL payment information
- Line C: Leave blank

To learn more, please refer to the Institutional Billing Instructions on the OHP Billing Tips page at www.oregon.gov/oha/healthplan/Pages/billing.aspx. The instructions give you step-by-step instructions for how to complete the UB-04 paper claim form, as well as how to submit these claims on the Provider Web Portal at https://www.or-medicaid.gov.

If you need help completing a claim form, you can also call Provider Services at 1-800-336-6016.

Place of service codes for labor and delivery services

Providers who deliver births in a hospital need to use the *21 - Inpatient Hospital* Place of Service code when billing for labor and delivery services.

If you use any other Place of Service code when billing for labor and delivery services, the claim will be denied because prior authorization is required for out-of-hospital births.

Starting January 11, new "APM" plan type on eligibility and enrollment verifications

Starting January 11, 2016, you will see the following changes on the Provider Web Portal (PWP) Eligibility Verification screen at https://www.or-medicaid.gov:

- The Managed Care panel is now named the "Managed Care/Primary Care Home" panel.
- If an OHP client is enrolled with a federally qualified health center (FQHC) or rural health clinic (RHC) as a primary care home, this panel will display a line for the "APM" plan type.

The APM plan type is only informational. It identifies the patients who are enrolled with the FQHC or RHC as the primary care home, and whose services are paid according to an alternate payment methodology (APM). It does not change any existing requirements for eligibility verification, service authorization, or referral and does not indicate the assigned primary care provider (PCP) for coordinated care organization (CCO) members.

To learn more about this change, read our letter to OHP providers and CCOs.

Call the Oregon Pharmacy Call Center for help coordinating benefits for fee-for-service prescriptions

The Oregon Pharmacy Call Center is committed to helping coordinate benefits for OHP members who have both OHP and other health coverage, such as private insurance.

When an OHP member has private insurance, the private insurance is the primary payer. OHP is the payer of last resort.

- The prescriber should first obtain prior authorization from the primary payer and make sure the prescription is covered by that payer's formulary.
- The pharmacy should bill the commercial insurance first, and then bill OHP as secondary payer.

If OHP denies payment because prior authorization is required, please call the Oregon Pharmacy Call Center at 1-888-202-2126. The call center will review and override the prior authorization requirement if appropriate.

Questions?

- **About pharmacy point of sale and prior authorizations for fee-for-service prescriptions:** Call the Oregon Pharmacy Call Center at 1-888-202-2126.
- **About physical health prescriptions for patients in a CCO:** Contact the CCO.

Reminder: Monthly payment recovery for OHP newborn claims

Every month, OHA 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, we enroll children born to MCO or CCO members in the mother's plan.
- However, depending on when the birth is reported to us, 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 Newborn Notification Form. Allow 2-3 weeks for processing.
- Verify the newborn's MCO or CCO enrollment using PWP, Automated Voice Response or Electronic Data Interchange.
- Once you have verified the newborn's MCO or CCO enrollment, bill the MCO or 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 the General Rules guidelines.

Need help?

Find more phone numbers, email addresses and other resources in our 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** – OHAICD10.help@state.or.us
- **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 PA line at 800-642-8635 or 503-945-6821 (outside Oregon).
- **Provider enrollment updates** - Contact Provider Enrollment (800-422-5047).
- **Provider training videos and past provider collaborative webinars –** Visit the OHA YouTube channel.
- **Provider Web Portal help -** Visit our Provider Web Portal page. If you need a password reset, contact Provider Services (800-336-6016).