

Provider Matters – June 2015

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

In this issue:

Health system transformation

[Oregon Patient-Centered Primary Care Institute – June 23 health literacy webinar](#)
[Medicaid Electronic Health Records \(EHR\) Incentive Program](#)

Other provider updates

[From CMS: New videos – ICD-10's impact on inpatient hospital payment and Medicare testing plans](#)
[From DMAP: Getting ready for ICD-10](#)
[Physician-administered drug billing for Hydroxyprogesterone Caproate](#)
[Newborn notification form update](#)
[Reminder: Do not bill patients for services covered by Medicaid or Medicare](#)
[Reminder: Mail all standard paper claims to PO Box 14955, Salem](#)
[Reminder: Monthly payment recovery for OHP newborn claims](#)

Oregon Patient-Centered Primary Care Institute – June 23 health literacy webinar

Health literacy is the degree to which patients can receive, understand and use the information provided to them by their healthcare providers. Many in primary care are learning how important it is to address health literacy in the practices as part of providing appropriate care. Learn more about health literacy and how you can address it.

Date: June 23, 2015

Time: 8:00 a.m. PST

Link to register: <http://www.pccpi.org/resources/webinars/health-literacy-key-patient-centered-communication>

About the Oregon Patient-Centered Primary Care Institute

Institute programs and resources help practices meet the standards of the [Oregon Health Authority's Patient-Centered Primary Care Home \(PCPCH\)](#) recognition program, and achieve the [Triple Aim](#). Through partnerships with Oregon's most experienced and knowledgeable technical assistance organizations and content experts, the Institute helps practices develop robust systems to ensure coordinated, accessible, comprehensive and patient-centered care.

To view the Institute's resources and sign up for email updates, visit <http://www.pccpi.org/resources>.

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).

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

- o a payment through Medicaid.
- o 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](#).

From CMS: New videos – ICD-10's impact on inpatient hospital payment and Medicare testing plans

These MLN Connects videos were recorded from presentations at the CMS ICD-10 Coordination and Maintenance Committee on March 18, 2015:

- [Estimating the Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments](#): Run time: 29 minutes
- [Medicare's Testing Plan for ICD-10 Success](#): Run time: 7 minutes

From DMAP: Getting ready for ICD-10

As you know, the ICD-10 deadline of October 1, 2015 is drawing near. This deadline is for all providers, payers and trading partners, including the OHP (Oregon Medicaid).

- If you bill through a clearinghouse, managed care organization (MCO) or coordinated care organization (CCO), please contact them to learn about how ICD-10 will change how you bill with them.
- If you directly bill DMAP, read [our recent update about OHP and ICD-10 readiness](#) to learn what you need to do.

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.

Physician-administered drug billing for Hydroxyprogesterone Caproate

When billing for Hydroxyprogesterone Caproate, please remember to only bill as follows:

- For Makena, bill using code J1725 and National Drug Code (NDC) 64011024301.
- For all compounded Hydroxyprogesterone Caproate, bill using code J3490 (*or Q9977 for dates of service on and after July 1, 2015*) and the appropriate NDCs used in the compound.
- Do not bill J3490 or Q9977 with Makena's NDC (64011024301).

To learn more about billing DMAP for physician-administered drugs, view the NDC reporting tools on the [Medical-Surgical provider guidelines page](#).

Newborn notification form update

We have updated the Newborn Notification form (DMAP 2410 – [Word](#) and [PDF](#)), based on feedback we received during the [Newborn Notification Provider Collaborative](#). It now contains:

- Updated instructions asking providers to complete all fields or enter "N/A." Blank fields will delay processing.
- Newborn status fields to mark off with checkboxes and enter the effective date, if requested. This includes a new reporting status of "Discharged with birth parent."

To learn more about newborn notification, [view the video of our April 2015 Provider Collaborative webinar](#).

Reminder: Do not bill patients for services covered by Medicaid or Medicare

We continue to receive calls from Oregon Health Plan (OHP) members and Qualified Medicare Beneficiaries (QMBs)

about bills they have received for services covered by Medicare Part A or B or by Oregon Medicaid.

- **For Medicare Part A and B services and cost sharing**, please remember that [Section 1902\(n\)\(3\)\(B\) of the Social Security Act](#), as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits all Medicare physicians, providers and suppliers from billing Qualified Medicare Beneficiaries (QMBs) in this way. The Medicare payment (and Medicaid payment, if any) is considered payment in full. In [our eligibility system](#), QMB members have the MED or BMM benefit plan.
- **For Medicaid-covered services**, the Medicaid payment is considered payment in full.

By enrolling with DMAP and signing the Oregon Health Authority's [Provider Enrollment Agreement](#), Oregon Medicaid providers agree to "accept the Authority's payment for any care, service, equipment or supplies as payment in full, and agrees not to make any additional charge to a Recipient except that specifically allowed by OHA Rules."

As outlined in [Oregon Administrative Rule 410-120-1280\(1\)](#), enrolled providers must not seek payment from OHP members for any services covered by OHP, whether through DMAP or a contracted health plan (e.g., CCO).

Medicare providers who balance bill QMB patients may be subject to sanctions based on federal requirements established in [Sections 1902\(n\)\(3\)\(C\)](#) and [1905\(p\)\(3\)](#) of the Social Security Act. Medicare providers who violate these billing restrictions are violating their Medicare provider agreement.

To learn more about how to identify QMB members using Oregon Medicaid eligibility systems and what Oregon Medicaid covers for these members, review our [Reminders about billing for services to QMBs](#).

Reminder: Mail all standard paper claims to PO Box 14955, Salem

We have been receiving many standard paper claims at our 500 Summer Street address that we cannot process at that address. Instead, these claims are mailed to our claim processing center for handling. This delays processing of these claims by at least one business day.

To avoid delays, please mail **all** standard paper claims (*ADA 2012, CMS-1500, DMAP 505, NCPDP UCF 5.1 and UB-04 claims*) directly to our claim processing center at PO Box 14955, Salem, OR 97309.

Please mail **only** the following types of claims to 500 Summer Street:

- Out-of-state claims – From any providers located more than 75 miles beyond the Oregon border
- Claims over one year old
- Claim appeals or reconsiderations (for administrative errors, requests to re-determine coverage decisions)
- Claims related to payment for prior-authorized, covered transplant services

To learn more about where to mail claims, please review our [Provider Contacts List](#) (updated April 2015).

When you bill electronically, you don't need to worry about mailing addresses. To learn more about paperless billing, visit www.oregon.gov/OHA/healthplan/pages/ebp.aspx.

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](#) (updated 4/30/15).

- **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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