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OHP Provider Collaboratives to resume in June
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.

We are taking the month of May off, but plan for new monthly collaboratives to resume in June.

In the meantime, you can view past collaboratives on YouTube at https://www.youtube.com/playlist?list=PL7mua_4kMbMq7yxQLGy3LYyfIVqrVZFCoe. Topics so far include:

- Newborn Notification
- 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.

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.

For eligible professionals, Program Year 2014 attestations are due no later than 11:59 pm (PST) on May 31, 2015.

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](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/EHRIncentiveInnovationsInMedicare/). 

- Concurrently, the Office of the National Coordinator for Health Information Technology (ONC) also announced the proposed [2015 Edition certification criteria for health IT products](https://www.healthit.gov/it-providers/2015-edition-certification).

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](https://www.medicaid.gov/EHRIncentiveProgram/), or contact the Medicaid EHR Incentive Program team at 503-945-5898 (Salem).
- **About the CEHRT flexibility option rule:** Please view [the final rule](https://www.federalregister.gov/documents/2015/08/18/2015-18433/medical-records-and-health-care-items-and-services-meaningful-use), or visit the CMS Newsroom to read the [press release](https://www.cms.gov/apps/news/press-releases.cms?category=archive&count=10&search=ICD-10) about the final rule.
- **About EHR Incentive Programs resources:** Please visit the [CMS EHR website](https://www.cms.gov/medicare-coverage-database/).  
- **About certified EHRs:** Please visit the Office of the National Coordinator’s [Certified Health Product Listing website](https://www.healthit.gov/certification).

**From CMS: Five facts about ICD-10**

To help dispel some of the myths surrounding ICD-10, the Centers for Medicare & Medicaid Services (CMS) recently talked with providers to identify common misperceptions about the transition to ICD-10. These five facts address some of the common questions and concerns CMS has heard about ICD-10:

1. **The ICD-10 transition date is October 1, 2015.**  
The government, payers, and large providers alike have made a substantial investment in ICD-10. This cost will rise if the transition is delayed, and further ICD-10 delays will lead to an unnecessary rise in health care costs. Get ready now for ICD-10.

2. **You don’t have to use 68,000 codes.**  
Your practice does not use all 13,000 diagnosis codes available in ICD-9. Nor will it be required to use the 68,000 codes that ICD-10 offers. As you do now, your practice will use a very small subset of the codes.

3. **You will use a similar process to look up ICD-10 codes that you use with ICD-9.**  
Increasing the number of diagnosis codes does not necessarily make ICD-10 harder to use. As with ICD-9, an alphabetic index and electronic tools are available to help you with code selection.

4. **Outpatient and office procedure codes aren’t changing.**  
The transition to ICD-10 for diagnosis coding and inpatient procedure coding does not affect the use of CPT for outpatient and office coding. Your practice will continue to use CPT.

5. **All Medicare fee-for-service providers have the opportunity to conduct testing with CMS before the ICD-10 transition.**  
Your practice or clearinghouse can conduct acknowledgement testing at any time with your Medicare Administrative Contractor (MAC). Testing will ensure you can submit claims with ICD-10 codes. During a special “acknowledgement testing” week to be held in June 2015, you will have access to real-time help desk support. Contact your MAC for details about testing plans and opportunities.

Stay tuned for five more facts about ICD-10: coming to you soon in another CMS ICD-10 Email Update message.

**From CMS: Final opportunity to volunteer for ICD-10 end-to-end testing**

During the week of July 20-24, 2015, a final sample group of providers will have the opportunity to participate in ICD-10 end-to-end testing with Medicare Administrative Contractors (MACs) and the Common Electronic Data Interchange (CEDI) contractor.

**CMS is accepting additional July volunteers from May 11-22, 2015.** Don’t miss your chance to participate in end-to-end testing with Medicare prior to the October 1, 2015 implementation date.
Approximately 850 volunteer submitters will be selected to participate in the July end-to-end testing.
This nationwide sample will yield meaningful results, since CMS intends to select volunteers representing a broad cross-section of provider, claim, and submitter types, including claims clearinghouses that submit claims for large numbers of providers.

Note: Testers who are participating in the January and April end-to-end testing weeks are able to test again in July without re-applying.

To volunteer as a testing submitter:
- Volunteer forms are available on your MAC website
- Completed volunteer forms are due May 22
- CMS will review applications and select additional July testers
- The MACs and CEDI will notify the volunteers selected to test and provide them with the information needed for the testing by June 12

If selected, testers must be able to:
- Submit future-dated claims
- Provide valid National Provider Identifiers (NPIs), Provider Transaction Access Numbers (PTANs), and beneficiary Health Insurance Claim Numbers (HICNs) that will be used for test claims. This information will be needed by your MAC for set-up purposes by the deadline on your acceptance notice; testers will be dropped if information is not provided by the deadline

Any issues identified during testing will be addressed prior to ICD-10 implementation. Educational materials will be developed for providers and submitters based on the testing results.

For more information:
- 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”

From CMS: MLN Connects National Provider Call - Preparing for ICD-10 Implementation and New ICD-10-PCS Section X — Registration now open

It’s not too late to get ready for ICD-10 implementation on October 1, 2015. During this MLN Connects National Provider Call, CMS subject matter experts will present strategies and resources to help you prepare. Also, learn about ICD-10-PCS Section X for new technologies, which will be used by hospitals. A question and answer session will follow the presentations.
- Date: Thursday, June 18; 1:30-3pm ET
- How to register: Visit MLN Connects® Upcoming Calls. Space may be limited, register early.

Agenda:
- National implementation update and preparation strategies
- ICD-10-PCS Section X for new technologies
- Testing update
- Provider resources

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.
Hospice providers: Updated resources for hospice-nursing facility coordination

DMAP has updated the Hospice Services Provider Guide with information to help with coordination for hospice patients who reside in nursing facilities. An updated Hospice-Nursing Facility Quick Guide is also available.

- These tools will provide additional support to hospices that have contracts with nursing facilities.
- Regular communication between the hospice and their contracted nursing facilities is important to maintain good relationships, understanding, and address issues as they arise.

You can find these tools and other resources on DMAP’s Hospice Services provider guidelines page.

Common claim denial reasons to avoid

DMAP continues to deny fee-for-service (FFS) claims for the following easily corrected reasons. To learn more about other common errors and how to fix them, see our Top FFS Billing Errors and Resolutions.

- **Service is covered by a CCO/Plan** – Verify both OHP eligibility and CCO/plan enrollment. Bill the CCO/Plan for services to CCO/Plan members. DMAP does not pay for services covered by the CCO/plan.
- **Client’s name and ID number disagree; client’s ID is not in our records; client’s name is missing** – These may happen when you enter a number instead of a letter (e.g., a zero instead of an “O”), or do not enter the client’s name and ID number as written on the client’s Oregon Health ID card; or when your paper claim does not correctly align the name and ID number on the form. See the billing instructions for your claim type for more tips and to learn which fields need specific alignment.
- **Diagnosis code not valid for the date of service; diagnosis code is missing or invalid** – On paper claims, this may happen when your paper claim does not correctly align diagnosis codes as listed on current, commercially available claim forms. To learn more, read our article about incorrect CMS-1500 diagnosis pointers in the June 2014 issue of Provider Matters.

We hope this information helps you successfully bill for services to OHP clients. Other resources and billing guides are also available on the How to submit claims to DMAP page.

Reminder: EDMS Coversheet is required for all documents sent to central fax numbers

Please make sure all your requests get to DMAP staff for processing by including the EDMS Coversheet (DHS 3970) as the cover page for the following types of requests:

Provider enrollment - 503-378-3074
- On the DHS 3970, include the provider’s NPI; for enrollments you begin in the Provider Web Portal, also include the Application Tracking Number (ATN).
- Send forms and documentation required for the specific provider type (see the Provider Enrollment page).

Prior authorization - 503-378-5814 (routine) or 503-378-3435 (urgent or immediate)
- On the DHS 3970, include provider’s NPI and the client ID. For existing authorizations, also include the PA number.
- Send the DHS 3971 and other forms or documentation as outlined in the provider guidelines for the requested services.

Claim documentation or correspondence - 503-378-3074
- On the DHS 3970, include the claim’s Internal Control Number (ICN) and provider’s NPI.
- Send documentation for the claim.

Each request sent to these central fax numbers must be under its own EDMS Coversheet. If you have two prior authorization requests, they must be sent under two different coversheets. If you are enrolling 5 providers, all 5 requests need their own coversheets.

- We do not see the faxes sent to these numbers until they are scanned into our system.
- Unfortunately, only requests sent in under the EDMS Coversheet get scanned into the system. Requests missing this coversheet are destroyed and not returned.
- If you make the effort to complete the required forms and documentation, please make sure to send your request under the EDMS Coversheet so that we can respond to your request.
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 (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.