

# Provider Matters – November 2013

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

In this issue:

## Health system transformation

[Spread the word: "Send the fast-track back!"](#)

[Medicaid Electronic Health Records \(EHR\) Incentive Program](#)

## Other provider updates

[About the Rural Medical Practitioners Insurance Subsidy Program](#)

[Self-attest by December 31 to receive the 2013-2014 federal primary care payment increase effective October 1, 2013](#)

[Providers who qualify for both Oregon and federal primary care rates](#)

[Covered Vaccines for Children codes](#)

[Change to RVU-based professional claim processing begins January 1, 2014](#)

[October 1, 2013 hospice and nursing facility rate updates](#)

[Billing clarifications for nursing facility residents on hospice](#)

[From CMS – Talking to your vendors about ICD-10: Tips for medical practices](#)

[Reminder – The EDMS Coversheet is required in order to process documents sent to central fax numbers](#)

[Reminder – Provider Web Portal and compatible browsers](#)

[Coming soon – DMAP policy pages moving to Oregon.gov](#)

## Spread the word: "Send the fast-track back!"

Do you know someone who received the fast-track letter but hasn't sent it back? This week the Oregon Health Authority (OHA) is mailing a reminder notice to Oregonians who qualify for fast-track enrollment.

If you know someone who receives the letter, please urge them to send the fast-track form back.

So far, about 70,000 Oregonians have already taken advantage of the fast-track option and will be enrolled in health care coverage beginning January 1, 2014. But we know there are more people who qualify. That's why we are sending out about 177,000 reminder notices this week.

You can see a copy of the reminder letter and a fast-track fact sheet at [www.OHP.Oregon.gov](http://www.OHP.Oregon.gov). Also attached are fliers that you can use to spread the word about fast-track enrollment ([English version](#)) ([Spanish version](#)).

### How to enroll

Fast-track eligible Oregonians do not have to fill out an application through Cover Oregon. All they have to do is send the fast-track form back in the self-addressed stamped envelope. It's the easiest and fastest way to get enrolled.

If people prefer to call, they can enroll at 1-800-699-9075. When they call, they should have their letter with them. They will be asked for their case number or client ID printed at the top of their letter.

Fast-track enrollment is available to adult Oregonians who meet qualifications for the Oregon Health Plan (OHP) and who already qualify for either food benefits through the Supplemental Nutrition Assistance Program (SNAP), or health care benefits for children through Healthy Kids/OHP.

Coverage starts January 1, 2014.

Thank you for your help in spreading the word to "**Send the fast-track back!**"

## 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).

### Hospitals - Program year 2013 deadlines approaching

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 Medicare EHR Incentive Program have until November 30, 2013, to attest to demonstrating meaningful use to CMS.
- Hospitals participating in the Medicaid EHR Incentive Program have until December 29, 2013, to submit their attestation to Oregon’s Medicaid EHR Incentive Program.

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.

**Providers - Program year 2012 attestation processing deadlines**

Program staff are still working directly with a handful of providers on outstanding items for program year 2012. If you are currently working with staff on your 2012 attestation, please be sure to submit all remaining documentation and information to staff no later than November 30, 2013.

**Program year 2013 timelines for applying for first, second and third year incentives**

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 have until March 31, 2014, to submit their attestation for program year 2013.

When an attestation may be submitted depends on the individual provider’s experience in the program as shown below:

<b>First-year payment: To adopt, implement or upgrade EHR</b>	<b>Second-year payment: To report meaningful use</b>	<b>Third-year payment: To report meaningful use</b>
Apply now	Apply now	<b>Wait until at least January 1, 2014</b> , after a full 365-day EHR reporting period has passed.

**Looking ahead to program year 2014 and Stage 2 meaningful use**

There are many changes for program year 2014, including the introduction of Stage 2 meaningful use. One key change for all participants, regardless of the meaningful use stage, is that they will need to adopt technology certified to the 2014 standard. A list of systems that have been certified can be found at the Office of the National Coordinator’s [Certified Health Product Listing](#) website.

**About the Rural Medical Practitioners Insurance Subsidy Program**

This program subsidizes the cost of medical professional liability insurance policy premiums to qualified rural medical practitioners.

- DMAP administers the Rural Medical Liability Subsidy Fund, which pays participating carriers up to 80 percent of the premium cost. To learn more, view [DMAP’s administrative rules for this program](#).
- The Office of Rural Health determines eligibility for this program. To apply for a subsidy under this program, [visit the program’s website](#).

**Who qualifies for this program?**

Physicians and nurse practitioners in [an eligible rural area recognized by the Office of Rural Health](#) who:

- Are not employed by a health facility;
- Hold an active, unrestricted license or certification;
- Are covered by, are individually named in, and pay premiums for, a medical professional liability insurance policy with minimum coverage limits of \$1 million per occurrence and \$1 million annual aggregate; and
- Are willing to serve Medicare and Medicaid patients in at least the same proportion to the total number of patients as the Medicare and Medicaid populations represent to the total number of people in the rural areas of the county of practice.

Practitioners must submit an affidavit to the Office of Rural Health by the end of each calendar year in order to qualify for coverage for the following year.

**What reimbursement is allowed under this program?**

For policy limits not exceeding \$1 million per occurrence and \$3 million aggregate:

<b>Reimbursement percentage allowed</b>	<b>Qualified practitioners</b>
<b>80 percent</b>	Doctors specializing in obstetrics Nurse practitioners certified for obstetric care
<b>60 percent</b>	Doctors specializing in family or general practice who provide obstetrical services

## Up to 40 percent

Doctors and nurse practitioners engaging in one or more of the following practices whose practice is not located in an urbanized area of Jackson County (*i.e.*, Ashland):

- Family practice without obstetrics
- General practice
- Internal medicine
- Pediatrics
- Geriatrics
- Pulmonary medicine
- General surgery
- Anesthesiology

## Up to 15 percent

Doctors and nurse practitioners other than those mentioned above.

## Self-attest by December 31 to receive the 2013-2014 federal primary care payment increase effective October 1, 2013

So far, approximately 2,770 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, 2013, to [self-attest to have the increase apply to eligible primary care services rendered on or after October 1, 2013](#).
- 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](#) (please note the new URL of [www.oregon.gov/OHA/healthplan/pages/pcp-rates.aspx](http://www.oregon.gov/OHA/healthplan/pages/pcp-rates.aspx)). We have recently updated this page to include a separate section for rate changes and to add links to the Oregon Administrative Rules that relate to the increase.

## Providers who qualify for both Oregon and federal primary care rates

Recently, DMAP updated provider records for providers who qualify for both the Oregon primary care rate and the federal primary care rate. The change was to allow the higher federal rate to take the place of the Oregon rate.

When this happens, providers may receive a letter saying that their Oregon primary care contract has been terminated. If you receive this letter, please know that you are still a valid Oregon Medicaid provider, and you will be receiving the higher federal primary care rate. When the federal rate increase ends, your Oregon primary care contract will be reinstated.

## Covered Vaccines for Children codes

Table 130-0255-1 Vaccines for Children in [DMAP's Medical-Surgical Services rules](#) does not contain CPT codes 90672, 90644, and 90686. However, DMAP **does** cover these codes and is working to get the table corrected to include them.

## Change to RVU-based professional claim processing begins January 1, 2014

This is a reminder that beginning January 1, 2014, DMAP will assign Facility and Non-Facility Relative-Value Unit (RVU) weights according to Place of Service (POS), not procedure code.

This change will only affect professional (837P and CMS-1500) RVU-based claims. Once we begin processing RVU-based professional claims according to POS:

- Professional services performed in a Facility (*e.g.*, hospital or ambulatory surgical center) will be paid at a lower rate.
- Professional services performed in a Non-Facility setting will stay the same rate.

To learn more, [please review our October 24 letter about this change](#).

## October 1, 2013 hospice and nursing facility rate updates

The [October 1, 2013 hospice rate letter](#) includes increases for both hospice rates *and* nursing facility rates. For more information about October 1 changes to nursing facility rates, please see [Aging and People with Disabilities Division's October 1 letter to nursing facilities](#), available on [APD's Administrator Alerts page](#).

## Billing clarifications for nursing facility residents on hospice

### Bill room and board for hospice Date of Discharge:

The day a nursing facility (NF) resident is discharged from hospice services or revokes their hospice election is the hospice date of discharge. The NF should bill the hospice for room and board for that date.

### Do not bill room and board for NF Date of Discharge:

The NF should not bill the hospice for room and board for the NF date of discharge (the date a NF resident leaves the facility).

### Patient Liability for NF residents on hospice:

Recently, we have heard concerns about how DMAP deducts the resident's Patient Liability amount for NF room and board when the resident is discharged from hospice during the month. When this happens:

- The NF bills the hospice for the full NF charges for the days the resident was on hospice.
- The hospice then bills DMAP to be reimbursed for the room and board charges paid to the NF (Revenue Codes 658, 191, 192, or 199).
- DMAP only deducts the Patient Liability amount from the NF room and board charges.
- DMAP deducts this amount on the **first** NF claim received for the resident for that month. For example, if DMAP receives the NF claim before the hospice's NF claim, then the Patient Liability will be deducted from the NF payment.

Since the NF initially collects the patient liability directly from the patient or their family, and the amount deducted by DMAP is related to NF charges, it does not matter which payment the Patient Liability is deducted from.

## From CMS – Talking to your vendors about ICD-10: Tips for medical practices

An important step in preparing for the change to ICD-10 is to talk with any software vendors, clearinghouses, or billing services you use to be sure they are ready to provide the support you need. Your vendors will need to have products and services on a schedule that allows adequate time for you to conduct testing.

### Start the conversation with your vendors

Talk with your vendors now to be sure that you can count on them to:

- Have fully functional, compliant products and services ready in plenty of time to allow for thorough ICD-10 testing
- Help you avoid potential reimbursement issues and interruptions to workflow

Ask your vendors to establish a comprehensive approach that will deliver compatible products when you need them. Points to consider discussing with your vendors include:

- System upgrades/replacements needed to accommodate ICD-10
- Costs involved and whether upgrades will be covered by existing contracts
- When upgrades or new systems will be available for testing and implementation
- Customer support and training that they will provide
- How their products and services will accommodate both ICD-9 and ICD-10 as you work with claims for services provided both before and after the transition deadline for code sets

Talking to your vendors now about ICD-10 will help ensure that your transition goes smoothly.

### Keep up to date on ICD-10

Visit the CMS [ICD-10 website](#) for the latest news and resources to help you prepare for the **October 1, 2014** deadline; and sign up for [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).

## Reminder – The EDMS Coversheet is required in order to process documents sent to central fax numbers

The EDMS Coversheet ([DHS 3970](#)) is required as the only cover sheet for faxing the following types of documents:

- **Provider enrollment requests or follow-up documentation (503-378-3074)** – Fax the 3970, followed by the [required forms and documentation for your provider type](#). Include your NPI or application tracking number.

- **Prior authorization (PA) requests or follow-up documentation (503-378-5814 and 503-378-3435)**  
– Fax the 3970, followed by the required forms and documentation [for your program](#). Include your NPI, the patient's Oregon Medicaid ID and prior authorization number.
- **Claim documentation (503-378-3086)** – Fax the 3970 and documentation. Include your NPI and claim ICN.

**Use a separate coversheet for each request.** For example, if you fax two enrollment requests under one coversheet, only the first enrollment request will enter our system correctly.

**If you fax documents without this coversheet,** DMAP will not process them or return them for correction.

## Reminder – Provider Web Portal and compatible browsers

The Provider Web Portal (PWP) at <https://www.or-medicaid.gov> supports the following internet browsers:

- Internet Explorer 6
- Internet Explorer 7 (Service Pack 2)
- Internet Explorer 8 and 9 ([compatibility mode](#))
- Mozilla Firefox 2.0

**PWP does not currently support Internet Explorer 10.** If you have problems using PWP in Internet Explorer 10, you can downgrade to Internet Explorer [8](#) or [9](#) in order to enable compatibility view with the Provider Web Portal.

## Coming soon – DMAP policy pages moving to Oregon.gov

Soon, the provider guidelines pages at [www.dhs.state.or.us/policy/healthplan/main.html](http://www.dhs.state.or.us/policy/healthplan/main.html) will move to the main OHP website at [www.oregon.gov/OHA/healthplan/pages/policies.aspx](http://www.oregon.gov/OHA/healthplan/pages/policies.aspx).

What is changing:

- The main changes will be where the pages are located and the look of the pages.
- You will also see all pertinent supplemental information for each program, including general claim and prior authorization handbooks, and all forms used in each program.
- For best viewing, you will need Internet Explorer 8 or higher.

What is not changing:

- The organization and the types of rule information posted to each program's page will stay the same.

Please feel free to review the new pages at [www.oregon.gov/OHA/healthplan/pages/policies.aspx](http://www.oregon.gov/OHA/healthplan/pages/policies.aspx). You can share your feedback about these changes by emailing us at [dmap.distribution@state.or.us](mailto:dmap.distribution@state.or.us).

## 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).

**EDI and the 835 ERA** - Contact [EDI Support Services](#) (888-690-9888).

**Direct deposit information and provider enrollment updates** - Contact [Provider Enrollment](#) (800-422-5047).

**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 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.



DMAP CAPE  
13-516 11/13