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DMAP Operations Section

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Authorized Signature

Issue Date: 06/24/2013

Topic: Medical Benefits

Subject: Provider announcement: June 2013 "Provider Matters"

Applies to:

- All DHS employees
- Area Agencies on Aging
- Children, Adults and Families
- County DD Program Managers
- County Mental Health Directors
- Aging and People with Disabilities
- Other (please specify): DHS and OHA staff and others identified on the APD, CAF, AMH and DMAP transmittal lists

Message:

DMAP will post the following [OHP Provider Announcement](#) and send it to subscribers of OHP Provider Announcements, OHP Plan Announcements, and MMIS-What's New eSubscribe lists.

"Provider Matters" is a monthly provider newsletter. This month's issue includes the following updates:

- Contact changes for non-emergency medical transportation authorizations starting July 1, 2013
- Reminder - How to identify coordinated care organization members
- When seeking out-of-area referrals for OHP managed care plan members, contact the managed care plan (MCO or CCO)
- ICD-10 provider survey now available on DMAP's updated ICD-10 Web page
- From CMS - The Role of Clearinghouses in the ICD-10 Transition
- Updated Home Health rates and administrative rules effective July 1, 2013
- Updated Hospice administrative rules effective July 1, 2013

If you have any questions about this information, contact:

Contact(s):	DMAP Client and Provider Education
E-mail:	dmap.distribution@state.or.us

Provider Matters – June 2013

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

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Other provider updates

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Medicaid Electronic Health Records (EHR) Incentive Program updates

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 Web site](#) or contact the Medicaid EHR Incentive Program team at 503-945-5898 (Salem).

2013 program changes

Proposed revisions to the Medicaid EHR Incentive Programs' Oregon Administrative Rules [are now posted for comment](#). The revisions provide greater flexibility in what patient volume time periods may be used and the types of OHP encounters to include in the patient volume calculation.

Timelines for applying for first, second and third year incentives

When to apply depends on which payment period you need to apply for:

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

How to apply

- For first-year payment, providers must first register through Centers for Medicare and Medicaid Services (CMS) and then apply using the Provider Web Portal at <https://www.or-medicaid.gov> to access the online application.
- After the first year, providers only need to apply using the [Provider Web Portal](#).
- A list of the [steps to apply](#) can be found on our website.

Contact changes for non-emergency ambulance transportation authorizations starting July 1, 2013

Starting July 1, hospitals, medical providers and ambulance providers should contact the local transportation brokerage for authorization of non-emergent **ambulance** services, except in the following instances:

- In Clackamas, Multnomah, and Washington counties, continue to contact the DHS branch offices (not the brokerage).
- In Benton, Lincoln and Linn counties, contact the CCO for authorization of services for InterCommunity Health Network (IHN) and Trillium CCO members. For other OHP members, contact the local brokerage.

The authorizing agent (brokerage, branch, or CCO) will complete and submit a 405T (Medical Transportation Order) to DMAP and send a copy to the ambulance company.

Starting July 1, ambulance providers will bill the two CCOs who are responsible for NEMT services (IHN CCO and Trillium CCO) for their enrolled members, and bill DMAP for payment for all other non-emergency ambulance transportation.

To learn more, [read our provider announcement](#).

Reminder - How to identify coordinated care organization members

When using the [Provider Web Portal \(PWP\) eligibility verification screen](#) or [Automated Voice Response](#), please note:

- CCO members who receive both physical and mental health care through their CCO have the code **CCOB** listed for their CCO.
- CCO members who receive physical, dental, and mental health care through their CCO have the code **CCOA** (this option begins July 1, 2013).
- CCO members who only receive mental health services through their CCO have the code **CCOE**.

CCO members will see these same codes on the "Managed care enrollment" page of their [OHP coverage letter](#).

When seeking out-of-area referrals for OHP managed care plan members, contact the managed care plan (MCO or CCO)

If you need to obtain a referral for services outside an OHP managed care plan (MCO or CCO) member's area, please contact the member's managed care plan (MCO or CCO).

Self-attest by June 30 to receive the 2013-2014 federal primary care payment increase effective April 1, 2013

So far, over 2,000 providers have been deemed eligible for the temporary two-year 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 June 30, 2013 to [self-attest to have the increase apply to eligible primary care services rendered on or after April 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.

DMAP will apply the new primary care rate once we receive approval from the federal Centers for Medicare and Medicaid Services (CMS). Please allow 2-3 weeks for us to process your attestation. Learn more on [our ACA primary care increase webpage](#).

ICD-10 provider survey now available on DMAP's updated ICD-10 Web page

We have posted our [new readiness survey](#) for providers on the updated [ICD-10 Web page](#). Please share the survey with the individual in your organization who is responsible for planning, implementing, and/or managing your organization's transition to ICD-10:

<https://survey.emp.state.or.us/cgi-bin/qwebcorporate.dll?idx=DBVMEY>

Your answers will tell us about your progress in preparing to meet the ICD-10 compliance date of Oct. 1, 2014 and help us improve DMAP's outreach efforts. We look forward to hearing from you!

From CMS - The Role of Clearinghouses in the ICD-10 Transition

Practices preparing for the October 1, 2014 ICD-10 deadline are looking for resources and organizations that can help them make a smooth transition. It is important to know that while clearinghouses can help, they cannot provide the same level of support for the ICD-10 transition as they did for the Version 5010 upgrade. ICD-10 describes a medical diagnosis or hospital inpatient procedure and must be selected by the provider or a resource designated by the provider as their coder, and is based on clinical documentation.

During the change from Version 4010 to Version 5010, clearinghouses provided support to many providers by converting claims from Version 4010 to Version 5010 format. For ICD-10, clearinghouses can help by:

- Identifying problems that lead to claims being rejected

- Providing guidance about how to fix a rejected claim (e.g., the provider needs to include more or different data)

Clearinghouses cannot, however, help you identify which ICD-10 codes to use unless they offer coding services. Because ICD-10 codes are more specific, and one ICD-9 code may have several corresponding ICD-10 codes, selecting the appropriate ICD-10 code requires medical knowledge and familiarity with the specific clinical event. While some clearinghouses may offer third-party billing/coding services, many do not. And even third-party billers cannot translate ICD-9 to ICD-10 codes unless they also have the detailed clinical documentation required to select the correct ICD-10 code.

As you prepare for the October 1, 2014 ICD-10 deadline, clearinghouses are a good resource for testing that your ICD-10 claims can be processed—and for identifying and helping to remedy any problems with your test ICD-10 claims.

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. For practical transition tips:

- Read [recent ICD-10 email update messages](#)
- Access [the ICD-10 continuing medical education modules](#) developed by CMS in partnership with Medscape

Updated Home Health rates and administrative rules effective July 1, 2013

To learn more about the July 1 rates, read [our recent letter to home health providers](#).

We will post the July 1 rule revisions on the [Home Health Services provider guidelines page](#).

Updated Hospice administrative rules effective July 1, 2013

We will post the July 1 rule revisions on the [Hospice Services provider guidelines page](#).

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).

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.

