# IT/EHR Workgroup

## FIMC Advisory Committee – North Central Accountable Community of Health

MEETING NOTES

1:00 PM – 2:30 PM August 8, 2017

**Attendance:** Tamara Burns, Rosa Geurrero, Loretta Stover, Kathleen Boyle, Isabel Jones, Whitney Howard, Megan Gillis, Lorena Miramontes, Ruth Bush, Corey Cerise, Gerri Mills, Duane Duncan, Darla Boothman, Edith Medina, Ashley Porter, Rebecca Arnold, Colette Rush, Christal Eshelman
**Via phone**: Misty Morris, Jane Morton, Donnell Barnett, Alice Lind, Jason Bergman, Lani Spencer, Thomes Fahner
**Notes**: Teresa Davis

**Technical Assistance RFP Update** RFP went out to bring on a Technical Assistance Contractor. XPIO Health has been selected. They have provided a very similar TA for SW Washington. XPIO has worked in multiple BHO regions as well. The contract will now go to CMMI for final approval. HCA is hoping for a start date in September to begin working with providers. They plan to offer 150 hours of TA for each provider until January. If there is a need after January, providers can talk to the BHO about that closer to January.

***Assumptions:***

- Hoping each provider will have decided what EHR they will be using
- Providers establish a point of contact – Isabel or XPIO will send an email asking for it
- Providers be open to system testing
- Provide reasonable access to system

**Answers to MCO Questions**
*See attached Question and Answer Document*

Additional Clarifying Items:

*Q 1 - What is meant by reporting codes? Additional clarification needed to ensure we accurately respond to the question.*
*A* - 1100 code is a local code, there are other codes that each agency uses for tracking.

*Q 1 - What services are being provided that are not currently reimbursed? Examples would be helpful*
A - Transportation code, There are CPTC Codes. There is a transportation program that is offered through HCA that providers should be using for transportation. Jason will reach out to arrange a meeting with transportation team. Will need to talk to the MCO's about reimbursement of non-Medicaid claims.

Q 2 – *Do billing and rendering NPI need to be registered with the state?*

A - Will need to do more research on how this will work. Looking for input as to if they can use their agency NPI as the rendering NPI instead of each provider. Corey Cerise from Molina has tried to research if this is allowable and has not been able to get an answer. Isabel will discuss internally with HCA and make an agenda item for one of the implementation calls with North Central.

Q 3 - *Do all three of the MCO's use Office Ally and Payerpath as a clearinghouse?*
A - All three MCO's will check.

Q 5 – *Neuro psych testing coming to some providers that are adding psych services. They need to know more around prior authorizations at the time of appointment.*

Q 6 - *MCOs would like additional information on what services are provided that would warrant an ABN or specifically what providers are concerned about.*
A - Adverse Benefit Notice – New CMS rules (notice that is sent for denial or reduced benefit).

Q 8 - *Do MCO's have specific taxonomy that we need to use?*
A - It would depend on the provider that is rendering service.

**NetSmart**

- BHO will be funding the quote for the extract (read only)
- Timeframe: Once quote is signed it will take 5-6 weeks to get test file
- Agency will need to have SQL capabilities
- Agency will be responsible for testing
- This will be read only data
- The BHI has received request for extraction from all but the Center
- For audit purposes, providers will need a letter or something that states all data was returned from NetSmart.
- Will there be a contact point for new EHR to contact NetSmart? Contact Rosa for everything NetSmart related.

**MCO Updates**: MCO's are collaborating a list of commonalities. Do people want a companion to the companion guide? Yes

**Next Steps:**
- Companion guide completed by MCO's
- Isabel – Internal discussion with HCA about NPI registration
- Jason arrange meeting with transportation team
- There is a workgroup that is addressing Senate Bill 5779 – if you would like to be on the list for that workgroup, email Colette Rush Colette.rush@hca.wa.gov

**Next Meeting:** September 20th at the Chelan Douglas Health District, East Wenatchee

# NC ACH IT/EHR Workgroup Question Tracker

| Billing Questions From the NC Behavioral Health Agencies | Joint MCO/Beacon Responses |
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| 1. What codes and/or modifiers should providers use for billing claims or conducting encounter submissions? Are they the same codes we are using now? Are there different reporting codes that we can use? Will there be new codes created to reflect the work we are doing now and not getting paid for? | MCO's: Generally speaking, follow the SERI Guide and/or HCA Billing Guides for billing codes and modifiers.<br><br>Beacon: Final provider contracts will detail allowable services, rates, and billing codes.<br><br>*What is meant by reporting codes? Additional clarification needed to ensure we accurately respond to the question.*<br><br>*What services are being provided that are not currently reimbursed? Examples would be helpful.* |
| 2. What do providers need to know regarding provider NPI on claims/encounter submissions? | MCO's: All NPIs must be registered with ProviderOne and an NPI must be present on a claim/encounter submission.<br><br>Beacon: currently does not require registration in ProviderOne, just that CMS guidelines are followed. Beacon plans to consult with HCA on this and may move to be in line with MCO practice.<br><br>*Lesson learned from SWWA: It was new for BH providers to register rendering NPIs in addition to billing NPIs. We encourage providers to ensure the NPIs they plan to use for billing and rendering are registered with the State's ProviderOne system and to allow adequate time to get applications completed, submitted and accepted by the State before 1/1/2018.* |

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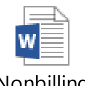
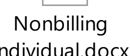
| | *There are a few unusual circumstances that have come up related to services rendered in SW that we have been working with HCA to get clarity on. If NC providers have any concerns about any of their providers, they can let us know the specific scenarios and we will try to get them addressed.*<br>*In general, if a provider has an NPI they should try to get it registered with HCA. Attached are applications to be used if the provider does not plan to bill the State directly for any services ("non-billing application"). If the provider also plans to bill HCA directly they can find forms and information on the HCA website: https://www.hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-provider.*<br> Nonbilling Individual.docx  Nonbilling Organization.docx |
| 3. What is the billing platform to be used? | MCOs and Beacon: All accept claim submissions via: paper or electronic (EDI) claims and via entity's provider portal.<br>Link to Provider Manuals with additional information/detail pertaining to claims:<br>AmeriGroup:<br>Provider Manual: https://providers.amerigroup.com/ProviderDocuments/WAWA_Provider_Manual.pdf<br>Clearinghouse Information: https://providers.amerigroup.com/Pages/edi.aspx<br>Beacon:<br>Provider handbook for SWWA for reference; will be updated for North Central: http://wa.beaconhealthoptions.com/providers/files/WA-State-ASO-Provider-Handbook-Supplemental-Appendix.pdf<br>Provider Portal: https://www.valueoptions.com/pc/eProvider/providerLogin.do<br>Paper claims are sent to: PO Box 1852, Hicksville, NY 11802-1852<br>Coordinated Care:<br>Billing Manual: https://www.coordinatedcarehealth.com/content/dam/centene/Coordinated%20Care/provider/PDFs/508_WA-Provider-Billing-Manual%20Jun%208%202016.pdf<br>Clearinghouse Information: https://www.coordinatedcarehealth.com/providers/resources/electronic-transactions.html |

# NC ACH IT/EHR Workgroup Question Tracker

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| | Molina:<br>Provider Manual (Claims Section): http://www.molinahealthcare.com/providers/wa/medicaid/manual/PDF/08-Claims-2016.pdf<br>Clearinghouse Information: Molina uses ChangeHealth for EDI claims and providers may use that vendor or another vendor who can submit claims through ChangeHealth. http://www.molinahealthcare.com/providers/common/medicaid/ediera/edi/Pages/chinfo.aspx |
| 4. What will be done with clients who are enrolled in ABP with United Healthcare and Community Health Plan of WA? How will these be handled/billed? | All Fee-For-Service (FFS) services would remain FFS for Alternative Benefit Plan clients. For all Managed Care Organization (MCO) benefits managed under United Healthcare (UHC) and Community Health Plan of Washington (CHPW) would be transitioned to one of the three remaining MCOs. |
| 5. Are any services going to require pre-authorization? If so, which ones? | MCOs and Beacon: There will be some services that require prior authorization. While Beacon and Molina have guidelines on what services require prior authorization in SWWA, time is needed to collaborate with AmeriGroup and Coordinated Care. More information will be shared as soon as possible. |
| 6. Will each MCO have their own ABN form, or is a general ABN form acceptable? | MCOs would like additional information on what services are provided that would warrant an ABN or specifically what providers are concerned about.<br><br>*Lesson learned from SWWA: Molina updated their Claims Processing COB guidelines to not require an EOB for those MH and SUD services we know Medicare does not cover and do not require the ABN from. This was implemented for SW Washington due to concerns over getting denials from Medicare for EOB submission. We are not familiar with the ABN form. With the implementation of COBA effective 9/1/2017 we expect this process to be impacted as Molina will receive dual claims directly from CMS.* |

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| 7. If the MCO is secondary and another payer is primary, how will it accept the secondary billing, by paper and/or electronically? For example, Medicare only accepts secondary claims electronically. | MCOs and Beacon: All accept secondary claims in the same manner as primary billing: paper, electronic or via MCO's provider portal.<br>Links to each entity's Provider Manual with additional info on claims can be found in response to Question #3 above. |
| 8. Will the MCO's require taxonomy numbers on the claims? Currently Medicaid requires taxonomy numbers for providers on claims. | MCOs: Yes, taxonomy is required on claims.<br>Beacon: Taxonomy not required, will be accepted if sent. |
| 9. Are there any codes that would be split billed on a 1500 and a UB? (Technical component of service on 1500 and professional on UB?) | AmeriGroup: Provider contracts address the type of claims form required.<br>Beacon: Claims load as either a unique HCFA or a unique UB.<br>Coordinated Care: Yes, inpatient and residential providers may have reason to bill separately on a 1500 and a UB. Please share specific services/codes that may require split billing from an outpatient provider, and define "technical component of service."<br>Molina: Residential providers can bill on a UB or a 1500.<br>*If you can provide examples of particular concern, we can address.* |

| Question | Response |
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| 10. What will be eligibility checking requirements? Will the new system use 276 and 277's for eligibility checks? – GC sent question to HCA | We received clarification from HCA that the question meant to reference 270/271 for eligibility checks.<br>MCOs: All the MCOs support 270/271 file exchanges through their clearinghouses. Providers should confirm that the clearinghouse they use supports 270/271 and that their clearinghouse can communicate with each MCO's clearinghouse. If so, 270/271 exchange is available.<br>If the provider does not use a clearinghouse they can still check eligibility on the MCO's provider portal or on the HCA ProviderOne system.<br>Beacon: doesn't typically use a 270/271 exchange (not currently used in SW Washington). Beacon uses Eligibility files (834 or custom flat file), client contacts and the ProviderOne website and requests to do the same for North Central. |
| 11. If coverage expires, how will clients reapply for reactivation? Will the process remain the same as it is currently? | If coverage were to expire, clients would have to reapply for coverage as they normally would. The process would remain the same. |
| 12. If a client has CNP and does not have an MCO listed in Provider One, how will these be billed? | They would be billed under Fee-For-Service. |
| 13. Is the fee schedule the same for all the MCO's or different? Who will provide the fee schedules? | MCOs and Beacon: Rates are negotiated between provider and each MCO/Beacon. Please refer to your MCO/Beacon contracts. |

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| 14. Can we receive 837P Companion Billing Guides from each MCO? | Companion Guides are attached:<br>AmeriGroup:<br>Amerigroup companion guide (1<br>Beacon: https://www.beaconhealthoptions.com/pdf/compliance/Beacon_Companion_Guide.pdf<br>Coordinated Care:<br>Centene 837 Companion Docume<br>Molina:<br>edi_comm_molina_companion_guide_5010. |
| 15. Can credentialing be done by agency rather than for each clinical staff? (i.e. bill for all agency service through the agency NPI?) | MCOs and Beacon: Yes, we are able to credential at the agency level where appropriate based on the licensure of the agency. |
| 16. We have been limited to SERI services/reporting codes per the BHO contract. What types of | MCOs: SERI and HCA Billing Guides should be utilized for guidance on claim and encounter submission.<br>Beacon: Will follow SERI. Final provider contracts will detail allowable services, rates, and billing codes.<br>For services not listed in either of those resources, like transportation related to SUD services, providers should consult with each MCO. Please feel free to provide a list of services in question to the group. |

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| other services will the MCO's allow and what are the codes for those services? For example, do the MCO's allow for transportation? How is it reported? How is it reimbursed? | |
| 17. Grant Integrated Services heard from one MCO that it was fee-for-service (FFS), are they all FFS? If not FFS, how does the claims billing/reporting work? Is there a per member/per month rate that is invoiced separately and then all services are reported via an 837 with zero balances? | MCOs and Beacon: Payment methodologies are negotiated individually between the provider and MCO. Please refer to your MCO/Beacon contracts. |
| 18. Do the MCO's (if FFS) provide 835 for payment? If yes, can we get | MCOs and Beacon: Yes, all can provide 835 remittance advice.<br>Please refer to each entity's Companion Guide provided in the response to Question #14 above. |

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| the 835 Companion Guide for setup? | |
| 19. The MCO's have "provider portals"- what is the purpose of the provider portals? Is this where our batches will be submitted? | AmeriGroup: The AmeriGroup Portal offers provider a single source of needed information for providers – it is optional for providers to use the portal. The portal does allow for checking eligibility, submitting claims/encounters, and authorizations.<br>Beacon: Beacon portal is ProviderConnect where all provider communications should be made, including authorization requests, eligibility inquiries, claims submissions (single claim or EDI).<br>Coordinated Care: Through Coordinated Care's secure provider portal we can:<br>• Check member eligibility<br>• View Members' health records<br>• View the PCP panel<br>• View and submit claims and adjustments<br>• View payment history<br>• View and request prior authorizations<br>• View member gaps in care<br>• View quality scorecard<br>• Contact Coordinated Care representatives securely and confidentially<br>• Access policies and procedures for medical necessity<br>Molina: The provider portal is on Molina's website and allows a provider to: view claim status, submit a claim, view member eligibility, PCP assignment, PCP panel information, request prior authorizations, access policies and procedures for medical necessity, missed services reports. Only claims to be paid FFS should be submitted through the Portal. |
| 20. What is the earliest date MCO's will be ready for testing claims and payment batches? | AmeriGroup: TBD<br>Beacon: Anticipating to be ready for test claims in mid-November.<br>Coordinated Care: Will receive test claims and payment batches in October.<br>Molina: Anticipate test environment will be ready to load test 837 files Mid-November. |

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| 21. Following our Qualis reports, what is the MCO timeline for things to occur? | MCOs and Beacon: Timelines are still in development. |
| 22. Do the MCO's have monthly provider meetings for quality, reporting, billing, etc.? | AmeriGroup: Yes – for all of these topics- frequency and content of the meetings is a collaborative effort between Amerigroup and our providers.<br>Beacon: Will set upstanding meetings at frequency based on input from providers<br>Coordinated Care: Meeting frequency can be established to meet the needs of the providers, and weekly meetings will be offered during the first 90 days after implementation to resolve any billing/claim needs.<br>Molina: There will be bi-weekly meetings for providers as we move toward implementation. The frequency will be adjusted as we approach go-live, as needed to accommodate provider needs. Topics in this call will cover reporting, billing, and encounters. We are still developing the quality meeting structure, as it relates to BH providers. We will have more information to share over the coming weeks. |
| 23. Will the new Behavioral Health Codes-96150 to 96155 be included in the CPT codes for the new insurances? | MCOs: Pending HCA's inclusion of the codes.<br>Beacon: Code is not covered/paid by Beacon. |
| 24. Are we going to be required to report the same demographic information currently required by the DBHR? | No. At this time, the DSHS Data Dictionary requirements are not included in the MCO contracts, and therefore the MCOs do not pass those requirements on to the BH providers. HCA is exploring a long term solution to collecting data that is necessary for SAMHSA reporting, with a focus on standardizing the process, leveraging existing data sources (P1, etc.), and minimizing the reporting burden. |
| 25. Will we have to send demographic | See question 24. |

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| information to each insurance separately? If yes, what form would they like it in? (On the service when it is submitted, or an end of the month report?) | |
| 26. Do each of our providers need to be credentialed again with the Guarantors as of January 1, 2018? | MCOs: Providers already contracted and credentialed with an entity will not be required to take additional action.<br>Beacon: Providers contracting with Beacon will need to be credentialed with Beacon. |
| 27. Right now we have to report the license of each location that our provider's see a client on the encounter. Will that continue for each insurance? | MCOs: Location licensure is not required on claim/encounter submission. |
| 28. Right now crisis services are set up with DMHP's and overseen by one agency. Will this change after January 1, 2018? | Beacon: No. |

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| 29. Will our agency be able to provide crisis services in a primary care setting? | MCOs: We believe those conversations need to take place with Beacon.<br>Beacon: Further discussion needed; a mobile crisis intervention could occur in a primary care setting which would be reimbursed by Beacon. However, interventions performed within existing scope of providers should be billed to the patient's primary insurance. |