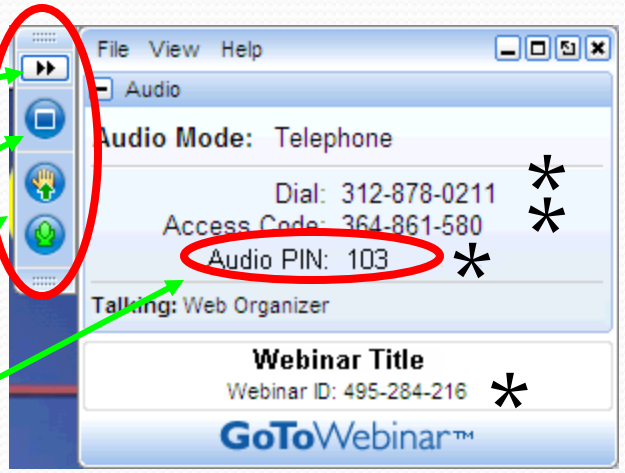
Using the Attendee Control Panel

- Grab Tab
  - Click arrow to open/close Control Panel.
  - Click square to toggle Viewer Window between full screen/window mode.
  - Click hand icon to raise/lower hand.
- **When joining via telephone, be sure to enter on the telephone keypad the Audio PIN noted in your Control Panel.**
- By default, you will be joined into the Webinar muted. Questions will be taken at the conclusion of the presentation.
  - Please use the Hand Icon to raise your hand to ask a question.
  - When the organizer is ready to address your question, your line will be unmuted and you will be cued to ask your question.



The * phone number, Access Code, Audio PIN, and Webinar ID shown are for informational purposes only. Please do not use these numbers.

Bayou Health Shared Plans Joint Training

Molina Medicaid Solutions

Community Health Solutions

United HealthCare Community Plan

Webinar #14

March 5, 2013

Bayou Health Implementation
A Transition from Legacy Medicaid to Medicaid Managed Care

This webinar is the fourteenth in a series of webinars addressing billing issues identified with claims processed for Shared Health Plan members.

Reminders

- At the end of the presentation there will be a question and answer session. For this please make sure that you have dialed into the conference using your audio PIN and raise your electronic hand to ask questions.
- There is a brief survey at the conclusion of this Webinar, Please take a moment to complete it as your feedback is vital for the preparation of the next Webinar.

General Issues

Open Enrollment

- Open Enrollment is a staggered event throughout the state based on the effective date of the original Bayou Health Plan. Region A is now closed; Regions B in progress; & Region C is forthcoming.

GSA Region	Mailing Date	Choice Begins	Choice Ends	Effective Date
GSA A	11/28/2012 – 11/30/2012	12/1/2012	01/30/2013	02/01/2013
GSA B	01/14/2013 – 01/21/2013	02/01/2013	03/27/2013	04/01/2013
GSA C	03/18/2013 – 03/25/2013	04/01/2013	05/30/2013	06/01/2013

Billing

- It is imperative that providers **DO NOT CHANGE** their billing practices from prior to BYU Health's implementation.
- We are seeing providers billing multiple different ways trying to get claims to process.
- Claims billed to the Shared Plans should be billed the same as they were previously billed to Molina Medicaid.

Behavioral Health

- Claims for behavioral health services performed in an emergency room setting were paid in error and were systematically voided on 2/11/13 and 2/19/13.
- Providers receiving these voids should resubmit these claims to Magellan LBHP.
- Claims for behavioral health services in an outpatient setting that were denied in error with edit 555 were recycled and paid on 2/11/13 and 2/19/13.

Billing Recipients for Non Covered Services

- Participation in the Medicaid program requires providers accept the Medicaid payment as payment in full for services rendered to Medicaid recipients.
- Exceptions where Recipients may be billed:
  - Services determined non covered
  - Exceeding service limits for recipients over the age of 21
  - Services rendered after his/her eligibility has ended.
- Providers **may not** bill recipients where billing errors results in a claim denial.

Medical Documentation

- The health plans now have the capability to submit medical documentation to Molina when appropriate to price/pay claims
- If a claim has been received by Molina without the appropriate medical documentation the provider will receive the edit/denial of 189
- To correct this issue simply rebill the claim to the appropriate health plan with applicable medical documentation attached

NCCI Edits

- Effective 01/01/13, CMS released NCCI procedure-to-procedure editing that precluded payment for a preventive visit when billed with immunization administration on the same date of service.
- However, CMS reconsidered their position and has decided to permit states to deactivate these edits should they choose to do so.
- LA Medicaid will soon be implementing the 2013 Q1 NCCI edits; however, the code pairs specific to preventive services and immunization administration will be deactivated as CMS permits for L**egacy and Shared Plan** claims.
- It is LA Medicaid's expectation that appropriate immunizations are to be given at the time of the preventive visit to avoid missed opportunities in both preventive care and immunizations.

Transition of Provider Enrollment Functions from Molina to CNSI

- Effective February 28, 2013, the contract for all Provider Enrollment functions transitioned from Molina Medicaid Solutions to CNSI.
- All Provider Enrollment requests must be directed to the new contractor, CNSI/Noridian.
- Please contact Noridian at 888-780-7858 for all Provider Enrollment requests.
- For information about the Medicaid enrollment/re-enrollment process, go to the PRISM website:

  www.medicaid.la.gov/PRISM
  Select "Contact Information"
  Select "Request More Info"

  Complete the form and "Submit" at the bottom of the page. Your inquiry will be sent directly to a PRISM representative who will promptly respond to you.
- PRISM Address Contact Information

  PRISM Provider Enrollment
  P.O. Box 91108
  Baton Rouge, LA 70821-9108

New Sterilization Consent Form

- The Office of Population Affairs (OPA) has updated the Sterilization consent form. It can be found at:

  http://www.hhs.gov/opa/order-publications/#pub_sterilization-pubs

  or a downloadable fillable PDF version can be found on Lamedicaid.com at the following link:

  http://www.lamedicaid.com/provweb1/Forms/consent-for-sterilization-english-updated.pdf

- The form with the expiration date of 12/31/12 will be accepted until April 1, 2013.

- **The updated form with expiration date 10/31/2015 will be required for dates of service April 1, 2013 forward**.

RUM Authorizations

- Effective with dates of service 1/1/2013 the Radiation Utilization Management program was eliminated from Legacy Medicaid
- Prior Authorizations for recipients on Legacy Medicaid are no longer required
- If the recipient has a Bayou Health Plan, then the plan is responsible for the authorization for those services

Timely Filing

- Some Bayou Health claims are now denying for timely filing.
- Providers should submit shared plan claims with documentation supporting proof of timely filing to the appropriate shared plan.
- Providers should submit legacy Medicaid claims with documentation supporting proof of timely filing to Molina.
- The documentation required to support proof of timely filing has not changed.

BYU Dental

- The Louisiana Medicaid Dental Program implementation into Bayou Health has been postponed indefinitely.

- Continue to monitor updates regarding this and other Bayou Health related issues at:

www.makingmedicaidbetter.com

LaCHIP Affordable

- Effective January 1, 2013 the LaCHIP Affordable Plan is no longer administered by the Office of Group Benefits.
- Recipients eligible under the LaCHIP Affordable Plan were moved to either a Bayou Health Plan, Magellan, or legacy Medicaid as appropriate.
- All claims with date of service January 1, 2013 forward should be billed to the respective Bayou Health Plan the recipient is linked to, Magellan, or Molina instead of OGB.
- Services 'carved out' of Bayou Health should be billed to Molina.

Community Health Solutions

RUM Prior Authorization

- Effective January 1, 2013, DHH discontinued the requirement of prior authorization for high cost radiology procedures for legacy Medicaid.
- CHS-LA also removed the prior authorization requirement for these services effective February 1, 2013.
- Our Care Management Department will continue to monitor provider utilization of these services to ensure compliance with evidence based guidelines
- CHS-LA may reinstate prior authorization for these services should utilization patterns indicate the need.
- Click here for the DHH Bulletin
- For more detailed information on CHS-LA Referrals and Authorizations, please follow the link below to our website:

http://louisiana.chsamerica.com/index.php?id=70

Professional Claims Rejections: Pre-Cert Requirements

- Rejection Code 123: Required pre-certification is missing or incomplete.
  - If the hospital fails to obtain a pre-cert, the override process is similar to what was in place prior to Bayou Health
  - Fax the following to the CHS Pre-Certification Department (888) 486-6207:
    - Cover letter requesting a Pre-Certification Override
    - Completed CHS Inpatient Pre-Certification Fax Request Form. This form is found on the CHS-LA website at the link below: http://www.louisiana.chsamerica.com/index.php?id=70
    - Hospital Admit summary
    - Hospital Discharge summary
    - Hard copy of the claim

Professional Claims Rejections: Incorrect Place of Service

- Providers who bill an inpatient Place of Service on an outpatient or observation stay should continue to correct their bill and resubmit. These claims will get a Rejection Code 295

- The most common situation where this rejection will be used:
  - Physician rounds in the hospital setting (the claim has POS-21)
  - Hospital bill was submitted for outpatient services (the claim has POS-23, which typically means that the patient was at the hospital only for a period of observation)

- If the visit is an observation stay, the appropriate Place of Service will need to be changed on the professional claim and resubmitted.

Adjustments & Voids

- System reconfiguration put in place for March 1st to process claims sent via **Paper for Adjustments and Voids**.
- Current backlog of paper adjustment and void claims to be re-processed and sent to Molina by March 7, 2013.
- If an Adjustment /Void is being submitted for a claim originally submitted via a CMS 1500 paper claim form, the 213 Professional Adjustment/Void Form is still required.
- If an Adjustment/Void is being submitted for a UB-04 paper claim, it must be submitted on the UB-04 form using the appropriate fields for adjustment/void data.
- Adjustments and Voids submitted **electronically** have been processing successfully since the inception of Bayou Health.
  - We recommend and encourage filing electronically
  - If your office is not familiar with the process of submitting these electronically, please contact our CHS-LA EDI Help Desk:
- EDI Help Desk Phone: **(855) 229-0258**
- Email: **edihelpdesk@chsamerica.com**

TPL Updates for Members Disenrolled from CHS-LA

- We have found that members who have been "disenrolled" from our plan (i.e. the member no longer has active Medicaid or has moved to another Bayou Health plan) are not having identified TPL information sent back to CHS-LA
  - A solution should be in place within approximately 3 weeks.
- If claims are submitted for CHS-LA members that have been "disenrolled" prior to the implementation of this "fix", the claims will be rejected again by CHS-LA advising the provider to update the member's TPL information with HMS.
- CHS-LA will send out notice once this solution has been implemented informing providers they should submit their claims to CHS-LA.
- To verify that this updated process is in place, please contact your CHS-LA Provider Services Representative or our Provider Service Center at (855) 247-5248.

Rejections Related to PCP Referrals

- A system update implemented on February 1st, caused claims that do not need a referral per current policy to reject in error (Rejection Code 278)
  - Examples of claims being rejected in error include:
    - OBGYN – women's healthcare services
    - Urgent care clinic visits
    - Laboratory services
    - Eye Examinations
- The system was updated correcting this problem effective February 21st.

United HealthCare Community Plan

Louisiana Adjustment/Void Process

- Issue – Bill Type (Adjustment/Void)
  - Inappropriate claim rejections due to system adjusting the bill type based on other claim data
  - Louisiana providers may submit an adjustment or void request to UHC Community Plan electronically (preferred) or by paper (if no access to submit electronically) by using resubmission/frequency codes

- Frequency/Resubmission Codes – What are they?
  - 7 – Adjustment Request – Financial adjudication has taken place and the request is to correct the claim
  - 8 – Void Claim – Financial adjudication has occurred and the request is to recoup any payments on this claim by voiding it completely.

Adjustment/Void Process

- UHC will accept form 213 (Professional) & form 202 (Rehabilitation)
- Electronic Submissions for Rehabilitation Services
  - Providers may submit an adjustment or void claim request electronically through a clearinghouse by submitting their claim with bill type ending in
    - 7 – for adjustments
    - 8 – for voids
- Electronic Submissions Via 837P
  - Providers may submit adjustment or void request electronically through a clearinghouse by using frequency/resubmission codes in the appropriate Loop/Segment of the transaction (the information found in Box 22 on the CMS 1500 claim titled Resubmission Code) and must include Molina's original control number in the original reference number box
  - Resubmission codes are 7 for adjustment and 8 for a void

Adjustment/Void Process

- When a provider has to submit an adjustment or void hardcopy the instructions are as follows
  - Rehabilitation Services (202 Form) and Professional Claims (213 Form)
    - Providers are to submit the appropriate completed form to

      LA Health Plan

      P. O. Box 31341

      Salt Lake City, UT 84131-0341

202

213

UB04

1500 Form

Medical Record Disallowed Reasons

- Issue -Failure to review and submit required documentation to Molina
- Medical Records will be required for procedures where Member consent form or medical documentation is required

- Resolution – Adding Two Additional Medical Record Disallowed Codes
  - Disallowed Code 642 – This code is in place today and will be used when a Member consent form is required. If the Member Consent form is NOT submitted with claim, the claim will be denied by UHC Community Plan during preprocessing
  - Disallowed Code 6020 – This code will be used when Medical Records or Manual Pricing are required. If manual pricing is required, typically it will be for unlisted codes requiring manual pricing by Molina or in situations where providers bill a number of units/frequencies above the standard number for the procedure with supporting medical records/clinical evidence. If the Medical Records are NOT submitted with the claim for Manual Pricing, the claim will be denied by UHC Community Plan during preprocessing

Below are examples of what Providers could be required to submit for Manual Pricing:

- Surgical Notes
- Pathology Notes
- Anesthesia Notes
- Other Service Notes
- Lab Notes
- MD office Notes
- Radiology Notes

Medical Review Additional Information

- Current Status
  - Starting 2/4/13, all claims received where Manual Pricing Review 2409 was required, historical documentation will be reviewed and sent to Molina with the current claim submission.
  - For claims received with Medical Records that require Manual Pricing, UHC Community Plan will initiate a process with Molina to transmit attachment information for processing to Molina (processor saves attachments to Molina's FTP site for their review and payment determination).
- Historical Remediation
  - Molina provided UHC a report dated 12/4/12 of pending claims awaiting medical documentation. This list has been reviewed and all medical documentation that had been sent to UHC has been sent to Molina.
  - For claims from 12/4/12 to 2/4/13, Molina will send a listing of pended claims once clean-up is complete.
  - Moving forward, documentation will be sent as received.

Provider Social Security Number Submission

Improper rejection of claims with Social Security Number as TIN.

- Previously, providers were not allowed to submit their SS# as their Tax ID. The claim would be rejected.
- Long Term Resolution deployed as of 2/4/13, UHC Community Plan will accept provider SS# or Tax ID on provider claim submissions.

Third Party Liability (TPL)

- **Issue - Improper rejection of claims involving TPL**
  - Claims rejecting for invalid or missing TPL when submitted. Molina denial edit 273
  - Three major reasons identified for TPL issues.
  1. Provider Keying Error –
     - Provider Education on placement of TPL code and to only submit 6 digits
  2. Keying Error -
     - Claim research was performed on TPL claims, identifying claims where the carrier code was submitted on the claim using a dash. The keying staff entered the claims removing the dash, which is correct, however, the dash was replaced with a space. The claims will then reject at Molina due to the space. The keying staff has been instructed to key the first 6 digits with no spaces. For example, 3001-00 would be entered as 300100
  3. System Error –
     - Information submitted via claim was accurate, however inaccurate when transmitted to Molina. There was a system issue with Cosmos and the claims highway where the carrier code was replaced with the UHC payor ID. Once issue identified, Short Term Resolution was completed 2/6/13 to protect the data not allowing any changes. Long Term Resolution was deployed on 2/16/2013 to correct Cosmos from overlaying the data.

Third Party Liability (TPL)

- Resolution - Providers may submit TPL two ways
  1. Electronically
  2. By Paper

- **CMS 1500 TPL Paper Submission**
  - Attach primary EOB
  - Box 9: Member Name
  - Box 9a: 6 digit Carrier Code
  - Plan Network Identification Number
  - Carrier Code is indicated as the network plan identifier on the MEVS response
  - Box 9b: leave blank
  - Box 9c: leave blank
  - Box 9d: Primary Ins. Group Name
  - Box 11d : mark “YES”

1500 Form

Third Party Liability (TPL)

- **UB-04 TPL Billing Paper Submission**
- **FL 61A, B, and C - Insurance Group Name Situational (required if known)**. Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C (other primary insurance) and a WC (Worker Compensation) or an EGHP (Employee Group Health Plan) is involved, it enters the name of the group or plan through which that insurance is provided.

- **FL 62A, B, and C - Insurance Group Number Situational (required if known)**. Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C (other primary insurance) and a WC (Worker Compensation) or an EGHP (Employee Group Health Plan) is involved, it enters the identification number, control number or code assigned by that health insurance carrier to identify the group under which the insured individual is covered.

Third Party Liability (TPL)

- **CMS 1500 and UB Electronic TPL Submissions**
  - Electronic submissions are preferred
  - Electronic TPL claims do not require the primary EOB.
  - Insert the proper Carrier Code where the Insured Policy Number is shown in the grid below
  - Carrier Code is indicated as the network plan identifier on the MEVS response

	Location on Claim	5010 Loop	5010 Segment
Professional Claim	Box 9A	2330B	NM109
Institutional Claim	Box 61A, B or C	2330B	NM109

Facility Claims Billed with Modifiers

- **Issue - Erroneously dropping of required modifiers for facility providers who bill via a UB claim format.**
  - A defect was identified where modifiers were not passing from UHC to Molina.

- **Resolution**
  - Long Term Resolution was deployed 2/16/2013 where manual intervention will not be needed any longer.
  - We have identified the impacted claims and sent to Molina on 2/26/2013.

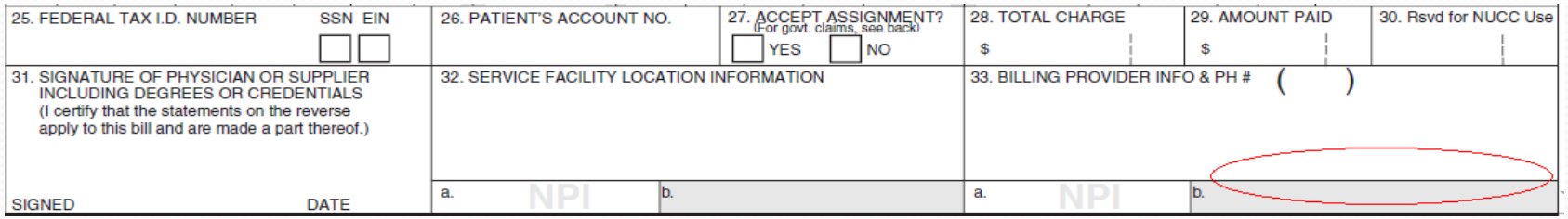
Dropped Digit on Member Medicaid ID#

- **Issue - Occasionally drops last digit when submitting claims to Molina**
  - Cosmos defect identified where the 13th digit is dropped from Cosmos when any changes to a Member record
  - If claims were submitted after the member made updates to their demographics, the claims would have been submitted with 12 digits as the Member Medicaid ID causing the claim to reject at Molina for invalid Member.

- **Resolution -**
  - Long Term Resolution was deployed on 2/16/2013 to prevent dropped digits when the Member record is changed.
  - After successful testing, impacted claims have been identified and were recycled on 2/26/2013.

Taxonomy (Specialty)/ZIP

- **Issue - Provider feedback received that zip codes were being transmitted in the Taxonomy field**.
  - UHC Community Plan confirmed with the keying staff that taxonomy is keyed. Upon research found that provider stamping claims with address stamp that fell below the address line, causing keying staff to submit the zip code as taxonomy.
- Resolution -
  - Long Term Resolution was deployed on February 16, 2013 to instruct keying staff to key the taxonomy



25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ( )		
SIGNED DATE	a. NPI	b.	a. NPI	b.	

* Example above shows where zip codes could be stamped below Box 33 line causing keying staff to populate as Taxonomy.

Additional Discussion Updates

- **PT/OT/ST Evaluations**
  - PT/OT/ST evaluations were erroneously set up to require a PA. Two steps were taken to correct. Benefit configuration was updated and a manual touch of all facilities benefits to update.
  - All affected bills were recycled on 2/26/2013.

- **Bill Type Rejections (i.e. 85X, 21X, 22X, 23X)**
  - UHC accepts the four bill types above for private business that are not accepted by Molina for Medicaid claims.
  - Previously electronic claim files were rejected due to these invalid bill types.
  - Issue Resolved: UHC now front-end rejects claims with one of the four bill types above.

General Information

Informational Bulletin 12-27

- For issues that require escalation, Informational Bulletin 12-27 has provided a flow chart for each of the health plans that include an executive level.
- Each level has an e mail address to an appropriate person that will be able to help with those issues
- Please follow through with each company and allow time to answer before escalating to DHH level

Informational Bulletin 12-27

Current Billing Instructions

Please refer to the Medicaid website below for current billing instructions.

www.lamedicaid.com

Links:

- Provider Manuals

or

- Billing information

Field Visits

- Just a reminder that each company, Molina, CHS and UHC, has Field Analysts in your area available to come to your office and assist with any of the issues you are having.

- If you would like to arrange an on-site visit, please contact your local area Field Analysts or refer to the Provider Relations contact list at the end of the presentation.

- If you continue to have claims payment issues, we strongly encourage you to request a joint visit with the appropriate health plan representative and the Molina representative.

Bayou Health
Noon Conference Call

- Every Wednesday DHH holds a noon conference call for providers to call in and inquiry about issues. The phone number and access code are as follows:

  1-888-278-0296

  Access Code 6556479#

- On Thursdays DHH and Magellan holds a conference call for Behavioral Health providers to call in and inquire about issues. The phone number and access code are as follows:

  1-888-205-5513

  Access Code 827176

Louisiana Behavioral Health Program

- For questions regarding billing of services impacted by the Louisiana Behavioral Health Program:
  - Providers may call 1-800-788-4005
  - Recipients may call 1-800-424-4399
  - Email to: laproviderquestions@magellanhealth.com

Contact Information

Molina Medicaid Solutions
Provider Relations
800-473-2783
225-924-5040

UnitedHealthcare Community Plan of Louisiana, Inc.
Provider Relations
866-675-1607

Community Health Solutions of Louisiana
Provider Relations
855-247-5248

Magellan Behavioral Health
800-424-4399

Hand Test

- Due to confusion over the past few weeks, we are now going to perform a test on raising your electronic hands
  - Please raise your electronic hand located on the left hand side of the webinar toolbar
    - **If you see a red arrow, your hand is raised**
    - **If you see a green arrow, your hand is lowered**
  - Now we will lower all hands and begin to ask questions based on the hand being raised
- Please be aware that we will not have time for all questions that will need to be asked, we do apologize for this in advance

Questions