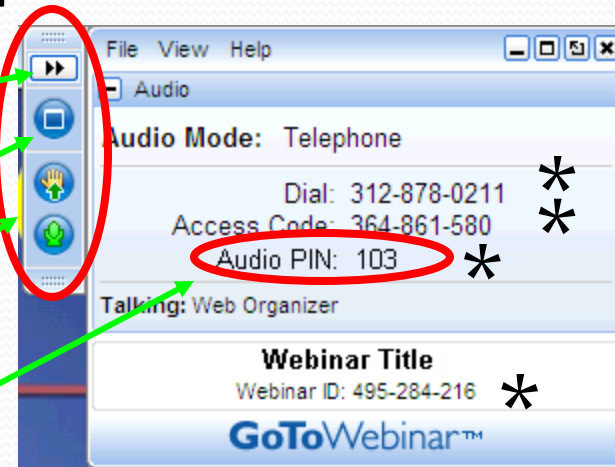


## Using the Attendee Control Panel

- 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.

# **Provider Billing Errors for BAYOU HEALTH Claims Submitted to Shared Savings Plans**

**Molina Medicaid Solutions  
Community Health Solutions  
United HealthCare Community Plan  
Joint Training**

**Webinar #7**

**June 19, 2012**



# **Bayou Health Implementation**

## **A Transition from Legacy Medicaid to Medicaid Managed Care**

**This webinar is the seventh 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.

# Bayou Health Implementation

## A Transition from Legacy Medicaid to Medicaid Managed Care

- Transition Began February 1, 2012 and is now complete statewide
- Approximately 800,000 Medicaid recipients have been transitioned from the existing legacy Medicaid Program to Medicaid Managed Care operated by private insurance companies.
- Pre-Paid Plans – Responsible for all aspects of program, including claims payment.
- Shared Plans – Responsibilities are shared; claims are pre-processed by the shared plans, then transmitted to Molina for final processing and payment.

**This webinar addresses billing issues identified with claims processed for shared plan members.**

# CommunityCARE & KIDMED

- Effective June 1, 2012, the legacy Medicaid CommunityCARE and KIDMED Programs are no longer in existence
- Providers must contact each of the 5 Bayou Health plans to discuss procedures, reports, etc., that were once a part of these programs

# Transition of Waiver Recipients to Bayou Health

- Some Medicaid Home and Community-Based Waiver recipients will now be transitioned to Bayou Health as Phase II
- The tentative date for this transition is July 1, 2012
- These recipients were not included in the initial rollout
- This transition does not change the waiver services currently received by these recipients
- Actual waiver services are 'carved out' of Bayou Health at this time

# Carved Out Services

- Some services are considered 'carved out' of Bayou Health and should still be billed directly to Molina for payment
- Claims for these services that are submitted to a Shared Plan will receive a denial of 313 (Submit to FI not BYU)
- To correct this denial, simply rebill the claim to Molina instead of the health plan
- The following slide contains a list of 'carved out' services for the shared plans
- A list of complete 'carved out' services, prepaid and shared, can be found at the link below
  - [List of Carved Out Services](#)



# Carved Out Services for Shared Plans

The following services continue to be billed to Molina

- Dental
- Pharmacy
- Waiver Services
- Durable Medical Equipment
- Long Term Personal Care Services
- Personal Care Services for Children under age 21
- Hospice
- Emergency and Non-Emergent Transportation Services
- Nursing Facility
- ICF-DD
- Case Management
- Adult Day Health Care
- EPSDT Health Services
- EarlySteps case management and medical services

# Dental Services

- Dental services for recipients – including those in Bayou Health Plans - continue to be submitted to Molina for processing and payment. This includes claims for Oral Surgery
- For instances where the dental/oral surgery procedure must be done in a hospital setting (outpatient or inpatient), the hospital claim must be submitted to the appropriate Health Plan

# Only LA Medicaid Enrolled Providers

- Providers billing claims for Shared Plan members **MUST** be enrolled as Louisiana Medicaid providers.
- Being contracted/affiliated with the Shared Plan for commercial business does not constitute a provider as being enrolled as a Louisiana Medicaid provider.
- Once enrolled, the NPI or NPI/tie breaker code combination registered with Medicaid must be used to bill claims for Medicaid members enrolled in Shared Plans.
- Claims submitted by non-Medicaid enrolled providers are not processed because the provider is not enrolled with Medicaid.

# Billing Shared Plan Claims for Medicaid

All claims submitted to the Shared Plans will continue to follow the guidelines set by legacy Medicaid Program.

Examples:

- NPIs – Billing/Attending
- Claim data including modifiers
- Claim format/forms (electronic/paper)

Providers should bill as previously required by Medicaid.

# Medicaid vs. Commercial Insurance Guidelines

DO NOT change your system to accommodate billing guidelines for commercial insurance.

- Bill claims as previously billed to Medicaid.
- Requirements have not changed for billing claims for Medicaid Recipients.

Examples of Identified Errors:

- NPIs submitted incorrectly;
- Taxonomy codes not included on claims where required;
- Authorization Numbers (PA/Precertification) are Missing or Invalid causing 191 and 161 denials;
- Rehabilitation Centers and Ambulatory Surgical Centers entering attending provider numbers on claims.

# Submitting Correct NPIs

- If claims are submitted to the Shared Plans with an NPI/NPIs that are **different** from those registered for the Medicaid provider number billing the services, the claims are not processed.
- The claims do not appear on a remittance advice because the billing NPI (or NPI/tie breaker combination) is not on the LA Medicaid provider file.
- This error continues to cause thousands of claims to fail for processing and final adjudication.
- Providers must ensure that correct NPIs/NPI and Tie Breaker (when applicable) are submitted.
- **Individual Providers who have both individual and organizational/business entity NPIs should register both NPIs with Molina Provider Enrollment.**

# Importance of Providing Molina with Current & Accurate Provider Information

- It is the provider's responsibility to ensure that correct information is always present on the Medicaid provider file.
- It is the provider's responsibility to ensure that the correct billing NPI is submitted on claims – which ensures that they are processed and appear on a remittance advice (RA).
- Providers that have chosen to use 1 NPI for multiple Medicaid provider numbers MUST ensure that the correct NPI/Tie Breaker combination is submitted for the correct Medicaid provider number.

# Unprocessed EDI Claims

## The 'Black Hole'

- We continue to have claims that are not being processed due to NPI issues (i.e. going in the 'black hole')
- Ongoing Problems Include:
  - Billing with an NPI that is NOT on the Medicaid file
  - Billing with an incorrect Tie Breaker where 1 NPI is being used for multiple Medicaid ID numbers
  - Using NPIs from closed Medicaid ID numbers (i.e. using an incorrect NPI for the Medicaid ID number)
  - Incorporated Individual physicians should report both the individual NPI and the organizational/business entity NPI to Molina Provider Enrollment (225-216-6370 Option 2)



# EPSDT Screenings and General Claims Submissions

- While the periodicity schedule will not change, certain policies and procedures will change and may differ depending on the Health Plan.
- It is very important that you contact each plan to determine the requirements.
- All claims for BAYOU HEALTH members must be submitted to the Health Plan in which the patient is enrolled on the date of service.

# Billing EPSDT Screenings

## (Correction from 6/5/12 Information)

- Going forward – the EP Modifier **will continue to be used as previously submitted. Append the EP Modifier to:**

The RHC/FQHC T1015 encounter code when billing screenings

**The Vision Screening code 99173**

- Do not use the EP modifier on any other screening services
- Other Modifiers used for billing screening services should continue to be used where appropriate

# Durable Medical Equipment

- Claims for DME must continue to be authorized and submitted directly to Molina Medicaid Solutions (Legacy Medicaid) for recipients enrolled in a Bayou Health shared plan
- DME claims for recipients enrolled in a prepaid plan must go directly to the pre-paid plan

# Home Health – PA – CHS

- Routine home health services prescribed by a physician for only one skilled nursing visit per day or less does not require prior authorization and no further action is needed when services are provided by an agency listed in the Medicaid Provider Directory
- A prior authorization is required whenever the prescription of the physician includes multiple daily visits.
  - Multiple visits in the same day are usually associated with IV therapy but prescriptions can also be for three or more hours per day to care for a recipient age birth through 20 meeting the criteria for this care.

# Home Health – PA – UHC

- Prior authorization may be obtained 24 hours per day/ 7 days a week:
  - Phone number is **1-866-604-3276**
  - Fax number is **1-877-271-6290**
  - Provider web portal

# Newborn Baby Health Plan Eligibility

- If a Mother is not enrolled in a Bayou Health Plan on her newborn's date of birth, the newborn's birth will be covered by Legacy Medicaid
- Check the Mother's eligibility for the month of birth. If the Mother is in a Health Plan, the baby will be covered by that Health Plan for the month of birth.
- Check the babies eligibility to make sure they have been listed on the Medicaid file.
- Refer to Bayou Health Informational Bulletin 12-5 dated February 16, 2012 for complete details.

# Rehabilitation Center Claims

- **Do not enter Attending Provider Numbers on Rehabilitation Center claims.**
- **Even when billing on the CMS-1500 claim form the attending provider number should be left blank.**

## **Denial/Edit 202 – Provider Cannot Submit This Type Claim**

Note: Rehab claims submitted directly to Molina for Non-Bayou Health recipients should continue to be billed on the state assigned form-102.

# Vision Service

## Members Enrolled in a Shared Savings Health Plan

- For eye wear, continue to follow legacy Medicaid fee-for-service policy and requirements.
- When indicated Prior Authorization can be obtained from the Molina Prior Authorization Unit at 1-800-488-6334; ePA [www.lamedicaid.com](http://www.lamedicaid.com); or Fax 225-929-6803.
- Claims for the vision exam and other vision services provided by an ophthalmologist, optometrist, or optician must be submitted to the patient's Health Plan for pre-processing and the Health Plan will then submit to Molina.
- Claims for eye wear shall continue to be billed and submitted directly to Molina as they were prior to Bayou Health.



# Vision/Optical Services

- Claims for the medical services by the ophthalmologist or optometrist (actual eye exam and/or other related medical services) are billed to the shared plans
- Claims for the eyewear (frames, lenses, etc.) are billed to Molina
- Some claims for eyewear have been denied incorrectly.
- The logic is corrected which should prevent claims submitted to Molina beginning June 18, 2012 from denying in error
- Denied claims will be recycled tentatively for the RA of 7/3/12
- Eyewear claims that were initially submitted through the shared plan will deny again with edit 313 and must be submitted directly to Molina for consideration

# Authorizations

- Authorizations are still required on Facility claims as previously submitted to legacy Medicaid.
- We have seen claims submitted without authorizations causing edit 161 and 191.
  - Edit 161 - HOSP STAY REQUIRES PRECERTIFICATION
  - Edit 191 - PROCEDURE REQUIRES PRIOR AUTHORIZATION

Example of services we continue to see needing authorization:

Revenue Code 420 and Revenue Code 430  
(for authorization of outpatient rehabilitation services)

# Hospital RUM Services Provided In Conjunction with ER Visit

- The issue causing RUM procedures to deny with edit 191 when provided in the ER on an emergent basis has been corrected.
- The logic change should prevent denial of claims submitted from June 18, 2012 forward.
- Claims denied in error are being recycled.
  - Claims for procedure codes 74176, 74177, and 74178 were recycled first and in two recycles.
  - Claims for the remaining procedure codes are being recycled and the tentative recycle date is the 7/3/12 RA

# Referral / Authorization Process

## Community Health Solutions

- ❖ Quick Reference: <http://www.louisiana.chsamerica.com/index.php?id=34>
- ❖ Applicable Definitions:
  - **Referral** – Written or verbal approval for a Member to seek and obtain services from a specialist or other provider when the PCP does not offer such service.
  - **Prior Authorization** – Written or verbal approval for a medically necessary service or procedure as defined by the Louisiana Medicaid State Plan.
- ❖ **Referral Policy**: A referral is required to see a specialist or another PCP outside of the practice/group to whom the Member is assigned. Members may be referred to and see any Medicaid enrolled specialists. The referral can be provided by the PCP or can be obtained by calling CHS at 855-CHS-LA4U (855-247-5248).
- ❖ **Prior Authorization Policy**: Refer to CHS website at <http://www.louisiana.chsamerica.com/index.php?id=34> for the list of services and procedures that require Prior Authorization.

**Referrals and Prior Authorizations Questions:**

Care Management Department at 855-CHS-LA4U (855-247-5248)

# Referral / Authorization Process

## UnitedHealthcare (UHC)

- ❖ Quick Reference: <http://www.uhccommunityplan.com/assets/LA-PriorAuthorizationList.pdf>
- ❖ Applicable Definitions
  - **Referral** is the directing of members for services or procedures to be provided by another provider, typically a specialist, when those services are outside the scope of service for the directing provider. Typically referrals are given by the member's primary care physician.
  - **Prior Authorization** is an approval from UnitedHealthcare for service or procedure for a member that is deemed medically necessary and meets the Louisiana Medicaid regulations as a covered service
- ❖ **Referral Policy:** Referral is not required for any covered service.
- ❖ **Prior Authorization Policy:** UnitedHealthcare requires prior authorizations for certain covered services. For a list of services that require prior authorization, refer to the Benefits and Prior Authorization Grid on page 10 of the Provider Manual and the quick reference link provided above. All physicians, facilities and agencies providing services that require prior authorization should call the Prior Authorization Department at 866-604-3267 (available 24/7), in advance of performing the procedure or providing service(s) to verify UnitedHealthcare has issued an authorization number.
- ❖ A Primary Care Physician or specialist can telephone or fax a prior authorization request to UnitedHealthcare Community Plan. A physician or pharmacist reviews all cases in which the care does not appear to meet criteria or guidelines which are adopted by UnitedHealthcare Community Plan's Medical Policy Committee. Decisions regarding coverage are based on the appropriateness of care and service and existence of coverage. Practitioners or other individuals are not rewarded, nor receive incentives for issuing denials of coverage or service.
- ❖ Responses to requests will be answered within two business days for standard requests, and within 72 hours for expedited requests.

### Prior Authorization Questions:

**Intake/Prior Authorization Team: Phone 866-604-3267 / Fax 877-271-6290 (Available 24/7)**

# Ambulatory Surgical Centers

## (Correction to 6/5/12 Information)

- Some ASC claims have processed incorrectly and paid multiple procedure lines instead of being denied as duplicates
- With one exception, ASC facilities can bill Medicaid only one procedure per day per recipient
- We are in the process of correcting logic and systematically voiding incorrectly paid claim lines
- Once it is complete an RA message will advise providers
- Claims for free-standing Ambulatory Surgical Centers are billed as a professional claim (837P or CMS-1500)
- An attending provider number should not be included on the claim form - Payment is for the facility fee
- A new edit will be activated to deny ASC claims when an attending number is submitted on the claim



# Authorizations for Ambulatory Surgery – UHC

- **Prior authorization and pre-certification may be obtained 24 hours per day/ 7 days a week:**
  - Phone number is **1-866-604-3276**
  - Fax number is **1-877-271-6290**
  - Provider web portal
- **Type of information needed for prior authorization requests:**
  - Pertinent Clinical Data
    - Progress Notes
    - Treatment Rendered
    - Tests Performed
    - Lab Results
    - Radiology Results

# Authorizations for Ambulatory Surgery – CHS

- Providers should check the Community Health Solutions website to verify if a prior authorization is required for a procedure
  - <http://www.louisiana.chsamerica.com/index.php?id=34>
  - In the Referrals and Authorizations section



# New/Established Patient

- With the Implementation of Bayou Health, the same guidelines are being followed for the criteria of either a New or Established patient
- The transition from Molina to the health plans, CHS or UHC, does not change this policy
- Claims will run through ClaimCheck (which follows CPT guidelines for this policy) to verify new or established patient
- Claims with a new/established patient conflict will receive the denial of 645

# Sterilization Forms

- For dates of service prior to 8/1/2012 providers may continue to submit the previous version of the Sterilization Consent form
- For dates of service on or after 8/1/2012 providers must use and submit the consent form with an expiration date of 12/1/2012
- Effective immediately, provider should start using the most current form
- The form is located at [www.lamedicaid.com](http://www.lamedicaid.com), link Forms/Files/User Manuals

# Louisiana Behavioral Health Program

- **Note that recipients must meet the clinical requirements established by Magellan in order for providers to service and be paid through LBHP.**
- Emergency Room Claims that have a primary diagnosis code of 290.xx through 319.xx should be submitted to Magellan, both facility and professional claims
- Laboratory and Radiology services that have a diagnosis code of 290.xx through 319.xx are to be billed to the recipients Bayou Health Plan

# Louisiana Behavioral Health Program

- Hospital Inpatient and Outpatient Claims
  - Acute Detoxification Claims (Revenue Codes 116, 126, 136, 146, 156, 202 and 204 with DT (Delirium Tremens) Diagnosis should be submitted to Magellan for claims on date 3/1/2012 or after
  - Inpatient Claims for a hospital with a primary diagnosis of 290.xx through 319.xx should be sent to Magellan, this includes professional, lab and radiology during admission/visit
  - Outpatient Hospital Clinics providing primary care by a provider who is not a Mental Health Professional, should submit these basic claims to the recipients Bayou Health Plan
  - If the primary diagnosis code is something other than 290.xx through 319.xx those claims should be sent to the recipients Bayou Health Plan or Legacy Medicaid, whichever is appropriate

# Louisiana Behavioral Health Program for LEA/EPSDT Services

- OT, PT, ST Services rendered for children billed by Local Educational Agencies will continue to be submitted to and paid by Molina.
- Behavioral health services must be submitted for payment through the SMO.
- There is no billing impact on other providers.

# Behavioral Health Services

- “Basic” Behavioral Health Services
  - Claims for basic behavioral health services for Bayou Health members should be submitted to the Bayou Health Plan.
  - Basic mental health services are defined as those provided by a provider who is not a mental health professional.
  - Mental health professionals include but are not limited to:

Social worker	Marriage and family therapist
Psychiatrist	Psychiatric nurse practitioner
Psychologist	Licensed professional counselors
Mental health clinic	Specialized mental health agencies
Addiction counselor	

# Behavioral Health Services

- **Behavioral Health Services in a RHC**

- Claims for all Rural Health Clinic services should be submitted to the Bayou Health Plan (either Prepaid or Shared).

- **Behavioral Health Services in a FQHC**

- Claims for behavioral health services that are provided in an FQHC should be submitted to **Magellan** if the patient is a member of Community Health Solutions (CHS) or United Healthcare Community Plan (UHC) on the date of service.

**For more detail information on Behavioral Health Services please refer to the Informational Bulletin on the [makingmedicaidbetter.com](http://makingmedicaidbetter.com) website. Bulletin 12-18**

# 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](mailto:laproviderquestions@magellanhealth.com)
- Magellan Conference Call
  - Thursdays at 11:30 am
  - Dial-In Number - 1-888-205-5513
  - Participant Pass Code - 827176



# Common Denials

## **Denial/Edit 187 – Recipient Not Enrolled in a Bayou Health Plan.**

- Provider should verify eligibility on every recipient for every visit to insure claims are being submitted to the appropriate plan.
- If the recipient is not enrolled in a Bayou Health Plan on the date of service, the claims should be submitted directly to Molina Medicaid

# Common Denials

## Denial/Edit 273 – Third Party Code Missing

### Refer to the Carrier Code Listing

- The TPL 6-digit carrier code must continue to be listed in the appropriate field as required by legacy Medicaid.
- The carrier code is returned as a part of the e-MEVS eligibility response-The 6 digit Plan Network Identification Number
- Carrier Codes for Medicare Advantage Plans will be identified with an “H” as the first character in the 6 digit network plan identifier.
- Refer to the TPL listing found on [www.Lamedicaid.com](http://www.Lamedicaid.com) for the correct carrier code.

### Links:

Forms/Files/User Manuals

Online Forms

# Common Denials

## **Denial/Edit 114- Invalid or missing HCPCs**

- Outpatient claims deny for missing HCPCs or invalid HCPCs when required (commonly seen on HR 300 - HR302, HR420, HR430, HR440, HR450, HR490 and HR510)
- Most prevalent are missing HCPCs on HR450 – ER services (99281 to 99285)

# Common Denials

## Denial/Edit 127 – NDC Code Missing or Incorrect

- NDC and accompanying HCPCS are still required when billing for physician administered drugs in the appropriate field of the claim as required by legacy Medicaid.

NDC Format with J codes:

N 4 1 2 3 4 5 6 7 8 9 0 1 U N 1 2 3 4 . 5 6 7 J1000

# Common Denials

**Denial/Edit 299 – Procedure/Drug Not Covered by Medicaid**  
**Denial/Edit 232 – Procedure/Type of Service Not Covered by Program**

Examples of Errors Identified:

- 36415-36416: Venipuncture for physicians and independent labs – specimen collection (routine venipuncture) will be considered integral/incidental to the laboratory procedures performed (RA Message May 18, 2010) This may also cause a 210 denial.
- HR940 – Therapeutic Services - General Classification
- 99000 – Specimen Handling

Refer to the policy and fee schedules listed online at  
[www.lamedicaid.com](http://www.lamedicaid.com)

# Common Denials

## **Denial/ Edit 209 – Group Must Bill for Provider**

- Provider groups must continue to bill as a group and not as an individual physician(s).
- The group NPI that is on the Medicaid file should be entered as the billing number on the claim.
- The individual provider NPI that is on the Medicaid file should be entered as the attending provider number.

Claims should match the same format as previously billed to legacy Medicaid.

# Claim Check/NCCI Edits

Where applicable claims will continue to process through ClaimCheck and NCCI editing.

Examples of Denials/Edits Identified:

- 567 – Procedure incidental to procedure on current claim
- 573 – Procedure incidental to procedure in history
- 759 – CCI: Procedure incidental to procedure in history

# Current Billing Instructions

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

[www.Lamedicaid.com](http://www.lamedicaid.com)

Links:

➤ Provider Manuals/Hospital Services Provider Manual

[http://www.lamedicaid.com/provweb1/Providermanuals/Hosp\\_Main.htm](http://www.lamedicaid.com/provweb1/Providermanuals/Hosp_Main.htm)

or

➤ Billing information/UBo4 Billing Instructions

[http://www.lamedicaid.com/provweb1/billing\\_information/ubo4instructions.htm](http://www.lamedicaid.com/provweb1/billing_information/ubo4instructions.htm)



# 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.

# Bayou Health Noon Conference Call

- DHH holds a Bayou Health conference call Monday through Friday at 12 Noon
- All providers are invited to attend this call whenever possible
- Representatives from DHH, all 5 health plans, and Molina are present on the call
- We encourage you to make this call a part of your business day each day since many provider questions are asked and answered during the call.

1-888-278-0296

Access Code 7299088



# 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

