Welcome to CareOregon's Billing and Admin Meeting!

February 29, 2024

careoregon.org
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Thank you for joining us!

Please help us have a successful meeting:

There will be time reserved for Q&A at the end of the meeting.
Questions can be submitted in chat throughout the meeting.

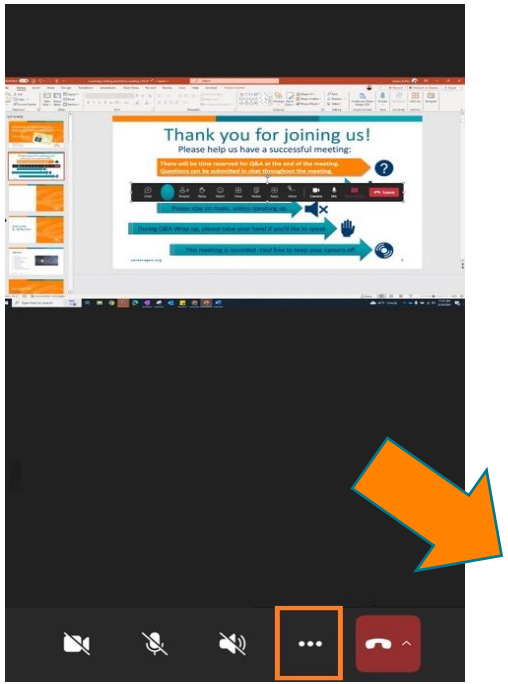
Include your name & organization in your Q+A messages / questions

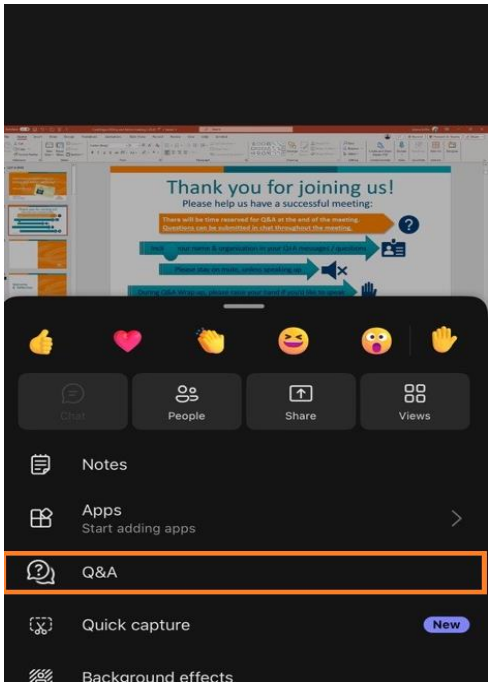
Please stay on mute, unless speaking up

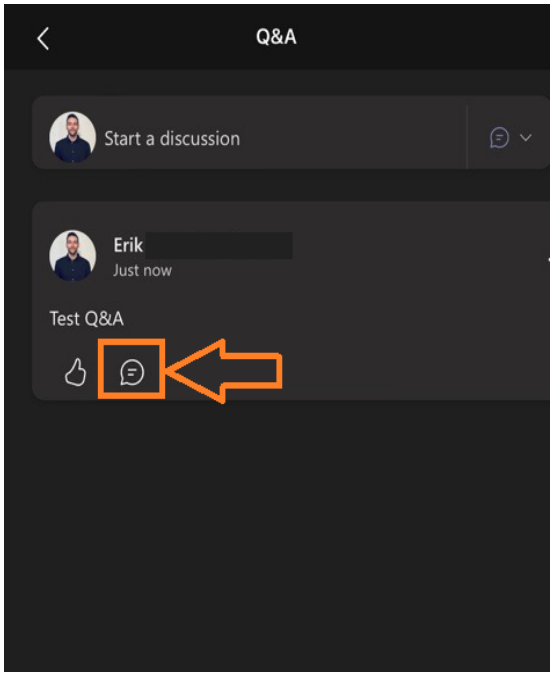
During Q&A Wrap up, please raise your hand if you'd like to speak

This meeting is recorded -Feel free to keep your camera off

How To: Q+A on a Mobile Device







Welcome & Reflection

Agenda

- ✓ PH Tech/CIM
- ✓ CHANGE HEALTHCARE UPDATES
- ✓ PAYMENT DELAYS
- ✓ BRIDGE PLAN OVERVIEW
- ✓ LPC/LMFT UPDATES
- ✓ QDP UPDATES
- ✓ BHSI SPOTLIGHT
- ✓ GUIDANCE REVIEW
- ✓ PROVIDER ENGAGEMENT DISCUSSION

PH Tech/CIM

Rachel Ganzon

Account Manager, Ayin Health Solutions

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General Updates

Selena Griffin: Interim Provider Relations Manager
Jane Speyer: Director, Claims Operations
Erik Carter: Network Operations Manager

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CHANGE HEALTHCARE UPDATE

Change Healthcare identified a significant event on February 21st that caused them to disconnect their systems temporarily to protect sensitive data for members and providers. At this time, the issue has not been resolved. We are working to establish an alternative connection to receive electronic claims.

This is a nationwide issue and not isolated to CareOregon

- CareOregon has not received electronic claim files (professional, facility, or dental) from our clearinghouse, Change Healthcare, since February 20th.
- We understand that this may affect the timeliness of claims submissions and CareOregon will work to resolve any issues with timely filing that may arise.
- CareOregon's incident management team has been deployed and is monitoring the situation on a daily basis.
- Please use the Smartsheet link (in Q&A area of this meeting) to tell us who your EHR, Clearinghouse, & informatics point of contact are to help us in exploring interim solutions.

CHANGE HEALTHCARE UPDATE

If Change Healthcare is currently your only option for claim submissions:

FTP Site (*File Transfer Protocol Site)*

- Providers with the ability to log-in to a secure FTP site (hosted by CareOregon's EDI partner) can deliver an 837 claim file containing only CareOregon billed claims.
- Once the 837 files are processed, a claim response file will be delivered to the sFTP site for retrieval (999 and 277CA).

Secure Online Portal

- Providers with the ability to deliver an x12 837 claim file with only CareOregon claims can also deliver those files via a secure online Portal (hosted by CareOregon's EDI partner). Once the 837 files are processed, claim "acceptance" or "rejection" feedback will be available on the portal.

If using a clearinghouse outside of Change Healthcare:

Clearinghouses in contact with VisibilEDI to redirect CareOregon claims for processing

Availity	Claim.MD	OfficeAlly

Potential Clearinghouses being contacted to establish a CareOregon claim file redirection

Ability	EDI-Health Group (Dental)	Experian Health	Vyne Dental
Quadax	Trizetto (EDI Gateway)	Waystar/Zirmed	Dentrix

No changes to the current CareOregon payment remit process

PAYMENT DELAYS

Timeline of discovery and resolution	
January 24th	Discovered RA issue for 1/23 paid date *For example, the **Disallowed** amount was printed in the **Interest field** on the RA.*
January 30th	To implement fix, held off on sending payment file to vendor until assured the payments and remittance advice could be processed correctly
February 2nd	Corrections made and implemented into production.
February 5th	Medicare claims/QNXT-based APMs with 01/30 paid date: -Payments processed & released successfully with payment expected by 02/09 -Paper checks were mailed by 02/07
February 6th	Medicaid claims/QNXT-based APMs with 01/30 paid date: -Payments processed & released successfully with payment expected by 2/13 -Paper checks were mailed by 02/08
Short-Term Improvements	- Testing plan & "Major Incident Management" process with our vendor - Implemented improved decision-making protocol for future payment delay risks
Long-Term Improvements	- Ensuring we're sending over more complete data of 835 detail (CARCs, for example)

OHP Bridge/Basic Health Plan (BHP)

Key OHA Decisions for BHP

- BHP Coverage - CCO-administered OHP benefit package
  - **DOES NOT INCLUDE:** HRSN (Health-Related Social Needs), LTSS (Long-Term Services & Supports)
    - *Please note, HRS (Health-Related Services)* ***will*** *be covered!*
- FFS Carveouts - BHP contracts will reflect existing Medicaid FFS carveouts
- BHP Benefit Plan - OHA will create a new, unique benefit plan containing the following:
  - Unique BHP group codes
  - Capitation categories
  - PERCs (Program Eligibility Resource Codes)

OHP Bridge/Basic Health Plan

Payment/Reimbursement Details

- Reimbursement Rates Requirements –
  - Reimbursement rate requirements mirroring existing rules as much as possible
  - **Goal:** To build on existing Medicaid structure to enable CCOs to operate BHP coverage in similar manner to OHP Plus
- BH Adjustments & Directed Payments –
  - BH Rate Adjustments and Directed Payments will be **given priority** to maintain the investment in the state's Behavioral Health system

OHP Bridge/Basic Health Plan

To Be Determined (by OHA)

- PPS Equivalent (WRAP) Direct to Clinic Payments –
  - OHA is conducting further analysis to determine funding and rates for year one
- Unique BHP Codes – Number & values of the group codes, capitation categories, and PERCs
  - We have received these from OHA and are working through them
- Quality Pool -
  - Baseline expectation: All BHP enrollees will receive quality coverage and care
  - OHA & CCOs need more time to collaboratively design bonuses for exceptional quality for this population

LPC & LMFT Medicare Updates

What has changed?

Effective January 1st, 2024 Licensed Professional Counselors (LPC) & Licensed Marriage and Family Therapists (LMFT) will be able to bill Medicare Part B and be reimbursed for approved services, in accordance with Medicare reimbursement rates due to passage of ***Mental Health Access Improvement Act*** by Congress (S.828/H.R.432). This federal law is closing a gap which has historically prevented LPCs and LMFTs from being recognized as Medicare providers.

How do I enroll?

✓As of November 2023, LPCs and LMFTs are now able to enroll as a Medicare billable provider through the Center for Medicaid and Medicare services (CMS). If you are currently a **Medicaid** provider, the following is required:

✓-Obtain a National Provider Identifier (NPI) – nppes.cms.hhs.gov
✓-Complete the Medicare Enrollment Application – may take 60-90 days
✓-Online Application: *pecos.cms.hhs.gov/pecos*
✓-Paper Application: *CMS.gov/medicare/enrollment-renewal*
✓-Select a ***Specialty Designation***

American Association for Marriage and Family Therapy: American Association for Marriage and Family Therapy (aamft.org) or Medicare (aamft.org)

American Counseling Association: American Counseling Association | A professional home for counselors or CMS Releases New Medicare Enrollment Information for Counselors (counseling.org)

LPC & LMFT Medicare Updates

CareOregon recognizes it may take time for LPC & LMFT providers to complete their Medicare enrollment. Please continue to treat our dual members even if your Medicare enrollment is pending

- Claims paid under the CareOregon Medicare Advantage (COA) plan automatically crossover to the CCO plan
- Once Medicare enrollment is complete, notify CareOregon so provider records can be updated. Email: BHProviderDataUpdates@careoregon.org
- Providers **must** bill Medicare first for Members with external Medicare
- For other Medicare Advantage Plans, include primary payer's payment info on the claim. Secondary claims should be billed electronically, if possible
- FFS or Traditional Medicare will send CareOregon a crossover claim – no need to bill CareOregon separately
- We will not require a primary Medicare EOB for LPCs and LMFTs between 1/1/24 & 6/30/24

Medicare rates may be lower than CareOregon rates. To reduce burden on our providers & ensure continued access for our dually eligible members, we are:

Discussing ways to address reimbursement during this transition period for providers who may experience less reimbursement for services provided to Medicare enrollees (e.g. claims adjustments or supplemental payments).

Reviewing our COB calculation method to reimburse providers at least up to the Medicaid rate when totaling payments for primary and secondary

For more information on how to become a Medicare provider:
https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers

New QDP Updates

RE-ATTESTATION

- Currently approved Tier 2 providers are not required to re-attest in order to continue receiving Tier 2 rates for 2024
- Currently approved Tier 1 providers are required to attest in order to become Tier 2
- New providers are automatically approved for Tier 1
- If you are a new provider, you are required to attest to be considered for Tier 2 status and rates

TIER 2 RATE INCREASE

Effective 10/1/23 for:

- 90832
- 90834
- 90847
- 90853
- 90882
- H0004
- H0019
- H0036
- T1023

*Separate from recently announced OHA rate increases

OTHER QDP UPDATES

- Uncredentialed (not to be confused with "uncontracted") providers at a contracted organization are eligible to receive contracted ICD provider rates
- Updated fee schedules effective 01/01/2024 are live in Connect
- Updated list of providers who are Tier 1/Tier 2 can be found in Connect

CLSS / ICD Billing Review

QDP Modifier Reminders and Updates

- All CLSS & ICD modifiers must be listed on a single line (up to 4)
  - *List pricing modifiers first*
  - *Claims submitted with modifiers on multiple lines will need to be (re)submitted as a corrected claim with modifiers listed on a single line.*
- Effective 10/1 CLSS payments are now claims-based (Q3 reporting not required)
  - *If you are a sign language or bilingual provider with a case rate or capitation agreement – ICD/CLSS add-on payment(s) will continue via checks/EFT.*
- Updates to the OHA BHDP/QDP rate increase can be found on the OHA's Behavioral Health Rate Increase webpage (*including Fall 2023 webinars).*

Behavioral Health Systems Integration (BHSI)

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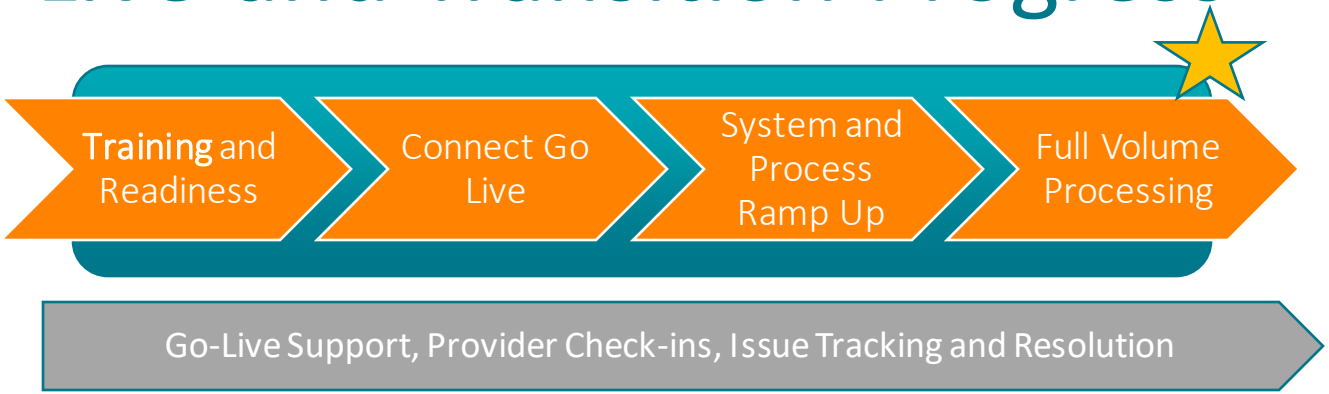
Go-Live and Transition Progress

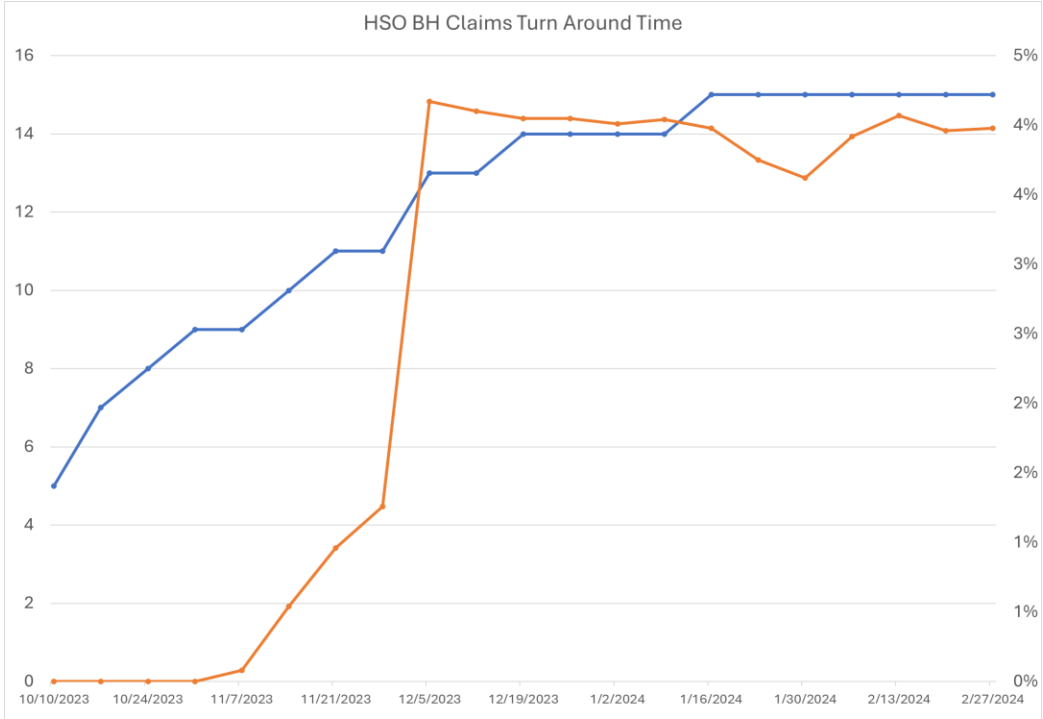


- We are up and running on new systems and processes!
- Our claims team has some data to share today about claims processing times
- Claims and system issues are being tracked closely as identified, and moved to resolution as quickly as possible

We appreciate your partnership and patience as we move through the go-live and transition process!

Claim Statistics

- Average TAT for claim payment has stabilized at 15 days
- 96% of clean claims are paid within 30 days (exceeding our goal to pay 90% of claims within 30 days)
- Current volume of pended clams in low due to Change Healthcare Incident
- Once the flow of claims to us is restored, our top priority wil be getting them paid as quickly as possible.



Top Claim Denial Reasons

Denial Reason – January 2024	% of all Denials
Provider Issue (OHA Enrollment 50%, Missing Rendering Provider 33% Provider not eligible to bill service 4%, Missing or invalid NPI 3%)	29%
Duplicate Claim or Service	25%
Authorization Issue	14%
Noncovered service or exceeds benefit limits	11%
COB Denial	8%
Bundled payment	8%
Coding Error – Procedure or Modifier code	3%

Post-Live: Issues, Mitigation, Provider Guidance

Since go-live, we are actively monitoring risks and may reach out to you

Issue	Current Status/Mitigation plan	Provider Guidance
NEW: Duplicates	• If performing the same service multiple times a day (such as H0004 or H0005) use an appropriate modifier to indicate it separate and distinct or populate the time of service in the NTE field (Box 19)	• For corrected claims, use frequency code "7" and list the original ICN in REF F8 segment (Box 22)
DMAP Enrollment issues	• Lapses in enrollment will likely result in claim denials.	• Monitor your individual providers enrollment status with OHA.
Missing rendering provider	• Most behavioral health services require a rendering provider – and that provider must be a person, not an organization.	• Report the rendering provider at the claim level, not at the line level
Notification number missing	• Majority of claims denied had multiple notifications on file, but none were listed on the claim. • CareOregon attempts to locate a valid auth/NoT, but if more than one to select from, claim may be denied	• Bill claims with notification number listed • Split service lines into separate claims if multiple notifications apply • Before requesting a Notification of Treatment (NoT) in Connect, confirm there isn't an approved NoT on file.

Reporting Updates

Report	Current Status
Claims Report (Connect) & Risk Corridor	• Claims Report are under development • Risk Corridor reporting anticipated in Q1 of 2024
Authorization Report (Connect) *UPDATED December 2023*	• Connect Enhanced Auth report (UPDATED with Level of Service info!)

Guidance Review

Maig Tinnin: Senior Provider Relations Specialist

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REMINDERS

	Summary	Resource

Delegated Organizational Provider Roster Monthly Update	• Delegated Organizational Provider Roster:
	  • ***A critical tool used by CareOregon's Provider Data team*** *for terming, updating and adding providers.*
	  • *Information provided in the roster is ultimately used to* ***ensure accurate rate assignment*** *for this subset of Providers.*
	• **Providers who signed an agreement with CareOregon to delegate their credentialing** are contractually obligated to send a complete roster.
		• Provider Roster Template:
		  • Updated in October 2023
		  • Located online: Delegated Provider Roster
		  • Please replace old versions!
		• Rosters must be **emailed by the 10th calendar day of each month**. If updates need to be expedited, please send bi-weekly
		• Send to:
		  • BHProviderDataUpdates@careoregon.org

Auth/NoT Not Req'd for Some Providers	• Authorizations/NoTs are **not required** for Providers who meet all the following criteria:
	  • *Hold only one Behavioral Health contract with CareOregon for Health Share members*
	  • *The one contract is for outpatient mental health services*
	  • *The one contract is reimbursed fee-for-service*
	  • *The one contract is NOT for A-C levels of care*
		How do you know if this impacts **YOUR** organization?
		  • Email notification went out in Spring and Fall 2023 to impacted providers.
		  • A list of impacted providers is included in the 10/01/2023 auth/NoT rules/fee schedule in Connect (our online provider portal)

REMINDERS

	Summary	Resource
Med Management Only	• Effective 10/01/23, CareOregon is changing the method of payment for Medication Management services for Case Rate providers. • New method of payment **will be a capitated payment, moving away from fee-for-service (FFS) reimbursement.**	See Section 3 in our BHSI FAQs for additional details and Q&A: BHSI FAQs ****Impacted Providers received an email from Provider Relations on 11/28/23 with additional guidance.*

Telehealth Modifiers	• As of October, 2023:
	  • *Additional modifiers have been added as payable*
	• As of November 24th, 2023:
	  • *Any claims denied with GT, FQ, 93 or 95 modifiers that are appropriate for telehealth were reprocessed by CareOregon*
	  • *Providers do not need to resubmit.*
		Newly published online: Telehealth Billing Guide
		
		See Section 5 in our BHSI FAQs for additional details and Q&A: BHSI FAQs

Fee Schedule Posting	• Rates for October 1st, 2023, and forward:
	  • *Access Contracted Fee schedules via Connect*
	• Rates prior to October 1st, 2023:
	  • *Fee schedules remain in CIM*
		If you need help locating your fee schedule, reach out to:
		
		Provider Relations: MetroBHPRS@careoregon.org
		- OR -
		Provider Customer Service: 800.224.4840 (option 3)

REMINDERS

Auth/NoT # are REQUIRED on Claims

Summary	Resource

• If Authorization/NoT **is required** for service provided:
  • Auth number must be submitted on the claim for appropriate processing/payment
  • Claims must be billed with one authorization number per claim
  • *If there are duplicate/overlapping auths and no auth on the claim, this will result in a claim denial!*
 	
• **Interim Transition Support:**
  • CareOregon has developed an interim solution to attempt to find an auth match if no auth is submitted on claim:
  • *Interim solution in place through June 2024*
  • *Please do not rely on this interim solution!*
  • If you have a high volume (10+) of these specific denials, you may submit a spreadsheet with authorizations to our Provider Relations team for resolution.
  • *Please reach out to Provider Customer Service or Provider Relations for support with this spreadsheet process option*
	Have questions or need support with duplicate or overlapping authorization issues? Please contact:
	
	Provider Relations: MetroBHPRS@careoregon.org
	- OR -
	Provider Customer Service:
	800.224.4840 (option 3)

REMEMBER! *Please ensure you add 1 authorization to each claim (when required) to ensure seamless processing, payment, and to help avoid denials.*

BHSI CHECKLIST

Claims

- ✓Make sure to submit claims with dates of services 10/1 and forward to CareOregon (details also available online):
  - CareOregon EDI#: *93975*
  - Address:
    Claims, CareOregon
    PO Box 40328
    Portland OR 97240
- ✓PH Tech Claims with dates of service prior to 10/1 will continue to go through CIM

Payment

- ✓Ensure you are enrolled for electronic payment through the ePayment Center (administered by Zelis)
- ✓If you are not enrolled in the ePayment Center, please refer to Electronic Payment & Electronic Remittance Advice FAQs (careoregon.org) for details on how to sign-up & how to get assistance.

Authorizations

- ✓Submit authorizations for dates of services 10/1 and forward through ***CareOregon Connect***
- ✓Reference the ***Service Level Crosswalk*** for changes to the service levels in the BHSI FAQs
- ✓Make sure you have setup access to log into ***CareOregon Connect***

Provider Resources: Training & Online Materials

Stay Up To Date! Visit us online at:

CO Metro BH Provider Website

Connect Training
Provider Connect Portal Tutorials

Provider BHSI FAQs
careoregon-bhsi-provider-faqs.pdf

Who to contact when you need help

BHSI Provider Resources, post 10/1/23 go-live

Provider Customer Service

Real-time issue support: Benefits, Eligibility, Auth and Claims questions that can't be answered in Connect Portal

Provider Customer Service: *800.224.4840 (option 3)*

Connect Portal

Eligibility, Claim Status, Claim payment info, Remits, Auth status, Auth submission

CareOregon Website

Provider resources and forms, BHSI FAQ, QDP details and instructions

Provider Relations

Training requests

Issues impacting a large number of claims and/or large dollar amounts

Contracting questions

Metro Bh Provider Relations: MetroBHPRS@careoregon.org

Phone Numbers & more!

Provider Customer Service: *800.224.4840 (option 3)*

Metro BH provider Relations *email: MetroBHPRS@careoregon.org*

BHSI Post-Live Poll

We value your feedback! Please share how things are going since our 10/1/2023 BHSI Go-Live

Rate your experience since go-live on 10/1/23

1 - Poor
2 - Unsatisfactory
3 - Satisfactory
4 - Good
5 - Excellent

BHSI Post-Live Poll

We value your feedback! Please share how things are going since our 10/1/2023 BHSI Go-Live

What areas do you need more support in related to BHSI?

- Auths / NoT
- Claims
- Payments
- Connect system navigation
- None
- If “Other” (or to provide more information on what support you need) please add details here

Questions?

What else do you want to know?

We value your input!

Providers can submit questions or insights to our team of experts here 24/7:

Online Question Intake Form

- No March meeting 
- Next meeting: April 25th, 2024
- Review the slide deck online

Thank you!

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