I/T/U Policy, Billing and Updates

Presented 2018
Disclaimer

This presentation was compiled by OHCA Provider Services and Tribal Government Relations.

The information contained within this presentation is intended as a reference only and is current as of November 2018.

Content is subject to change.
Agenda

- SoonerCare Programs
- I/T/U Policies and Rules
- I/T/U Billing Requirements
- Cost-sharing exemptions
- Referrals
- Medical Authorization Using InterQual®
- WebAlerts

I/T/U: Indian Health Service, tribal program, and urban Indian clinics
SoonerCare

- Birth through age 20

- Age 21 and up
SoonerCare Traditional

- SoonerCare Traditional is a state-wide network of providers that includes, but is not limited to, I/T/U facilities, hospitals, family practice doctors, pharmacies, and medical suppliers.
SoonerCare Traditional: Coverage

- Behavioral health
- Certain prosthetic devices
- Dental and orthodontic services
- Diabetic testing supplies
- Durable medical equipment
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) exams and services

**Compensability of services is subject to OHCA’s policies and rules.**
SoonerCare Traditional: Coverage, cont.

- Family planning services
- Home health care services
- Inpatient hospital services (acute care only)
- Laboratory and X-ray
- Long-term care
- Outpatient hospital and surgery services
- Over-the-counter contraceptives
- Pregnancy services

**Compensability of services is subject to OHCA’s policies and rules.**
SoonerCare Traditional: Coverage, cont.

- Prescription drugs
- School-based services
- Smoking and tobacco use cessation counseling products
- Therapy services – physical, speech, and occupational
- Transplant services
- Transportation related to medical emergencies
- Vision services

**Compensability of services is subject to OHCA’s policies and rules.**
SoonerCare Traditional: Provider Portal

<table>
<thead>
<tr>
<th>Coverage Details for Member ID</th>
<th>from 10/02/2017 to 10/02/2017</th>
<th>Back to Eligibility Verification Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective/End dates are shown only for the period of time requested.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verification Number</td>
<td>10/2/2017 - Status: A</td>
<td></td>
</tr>
<tr>
<td>Eligibility</td>
<td>Title 19</td>
<td>10/02/2017</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td></td>
<td>10/02/2017</td>
</tr>
<tr>
<td>EPSDT</td>
<td>Service</td>
<td>Last Exam</td>
</tr>
<tr>
<td>Medical</td>
<td></td>
<td>07/07/2017</td>
</tr>
<tr>
<td>TPL</td>
<td>Carrier Name (Carrier ID)</td>
<td>Policy Number</td>
</tr>
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<tr>
<td>Click to expand</td>
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</tr>
</tbody>
</table>
SoonerCare Choice

- SoonerCare Choice is a managed care model where a member is linked to a primary care provider (PCP) who serves as the “medical home.”
  - PCP’s manage all of the basic health care needs of members, including specialty referrals.
PCP Changes, cont.

• Effective July 26, 2018 OHCA implemented system changes to include I/T/U PCPs in the PCP selection module in Home View and Agency View.

• Real-time PCP changes are also available to members requesting an ITU as their PCP; they will have the ability to make same day changes with a phone call to the SoonerCare Helpline at 1-800-987-7767.
PCP Changes

• OHCA has discontinued the use of the I/T/U-specific PCP Change Form.
45 Mile Radius

• If a member wants to select an ITU as their PCP and the facility is more than 45 miles away from their address, the online system will not allow it. The workaround has always been to call the SoonerCare Helpline.
SoonerCare Choice: Provider Portal
Soon-to-Be-Sooners

- Soon-to-Be-Sooners (STBS) provides coverage of pregnancy-related medical services for pregnant women who would not otherwise qualify for SoonerCare.
  - Women ages 19-64
  - Federal Poverty Level: 134-185 percent
**STBS: Provider Portal**

![Image of Provider Portal]

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### Coverage Details for Member ID

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Coverage Type</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health and Substance Abuse</td>
<td>$</td>
<td>10/11/2017</td>
<td>10/11/2017</td>
</tr>
<tr>
<td>Alien Emergency Services Only</td>
<td>$</td>
<td>10/11/2017</td>
<td>10/11/2017</td>
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<tr>
<td><strong>SOON TO BE SOONERS</strong></td>
<td>$</td>
<td>10/11/2017</td>
<td>10/11/2017</td>
</tr>
</tbody>
</table>

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4345 N Lincoln Blvd, OKC | 405-522-7300 | okhca.org
Mental Health and Substance Abuse Services

- Mental Health and Substance Abuse Services (MHSAS) is behavioral health coverage for Oklahoma Department of Mental Health and Substance Abuse Service (ODMHSAS) contracted providers only.
  - This is **not** medical coverage.
  - Qualifications for this program are different than SoonerCare.
  - Some may qualify for this program and not SoonerCare.
SoonerPlan

• SoonerPlan is Oklahoma’s family planning program for eligible men and women who are not enrolled in regular SoonerCare services.
• To be eligible, an individual must:
  – Be age 19 or older
  – Be an Oklahoma resident
  – Be a U.S. citizen or qualified alien
  – Have income at or below 133 percent FPL
SoonerPlan: Coverage

Coverage includes:

• Birth control information and supplies;
• Office visits and physical exams related to family planning;
• Laboratory tests related to family planning services, including pregnancy tests, pap smears and screening for some sexually transmitted infections…
SoonerPlan: Coverage, cont.

- Tubal ligations for women age 21 and older;
- Vasectomies for men age 21 and older; and
- Gardasil for males and females through age 26.

**All services are paid in accordance with current SoonerCare policy and some services may require completion and submission of the Sterilization Consent Form**
SoonerPlan: Policy Update

• In 2016 a comprehensive review of OHCA policies related to Long Active Reversible Contraceptives (LARC) was conducted.

• In 2017 OHCA changed the LARC policy.
SoonerPlan: Policy Update , cont.

• Previous Language
  – Long acting reversible contraceptives (LARC) are reimbursable once per recipient as per the recommendation noted in the package insert for each respective device. For intrauterine and implantable devices, if removal and/or re-implantation at the same or different incision site is performed prior to the typical duration noted in the device’s package insert, reimbursement is available for the removal only.

• Current Language
  – Family planning services and supplies are covered for individuals of childbearing age as medically appropriate and medically necessary.
SoonerPlan: Billing

Billing for Codes and Services

WebAlerts

SoonerPlan will pay for the following services:

- Birth control information and supplies
- Office visits and physical exams related to family planning;
- Laboratory tests related to family planning services, including pregnancy tests, Pap smears and screening for some sexually transmitted infections;
- Tubal ligations for women age 21 and older;
- Vasectomies for men age 21 and older; and
- Gardasil for males and females through age 26.

Tubal ligations and vasectomies are paid in accordance with current SoonerCare policy and require the Sterilization Consent form.

Medically necessary office visits related to family planning are unlimited for SoonerPlan members younger than 21.

For SoonerPlan members 21 and older, medically necessary office visits and physical exams related to family planning (birth control) are limited to four per month except for the initial visit code. For 99202, the limit is two per month.

Copayments do not apply for any family planning service, device, prescription or over-the-counter product.

Billing

Claims for family planning services can be billed electronically or by using the appropriate paper claim form. You should use your SoonerCare fee-for-service provider number when submitting these claims.

Coverage for this program is limited to the use of listed diagnosis codes. Please be advised these diagnosis codes are subject to change. These are effective October 1, 2015. For claims billed with dates of service prior to Oct. 1, use the new ICD-10 codes. For claims with dates of service before Oct. 1, use ICD-9 codes.

The following CPT codes are covered seesoonerplan.com in this program and are reimbursed at the current SoonerCare Fee-for-Service rate:

- SoonerPlan CPT Codes

Please be advised that these CPT codes are subject to change.
### SoonerPlan: Provider Portal

#### Coverage Details for Member

**Eligibility Verification**

*Eligibility Verification* > *Coverage Details*

**From 10/11/2017 to 10/11/2017**

Effective/End dates are shown only for the period of time requested.

**Verification Number:** 10/11/2017 - Status: A

#### Table: Coverage Details

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Emergency Transportation</td>
<td>10/11/2017</td>
<td>10/11/2017</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td>10/11/2017</td>
<td>10/11/2017</td>
</tr>
<tr>
<td><strong>FAMILY PLANNING</strong></td>
<td>10/11/2017</td>
<td>10/11/2017</td>
</tr>
</tbody>
</table>

**TPL**
Oklahoma Cares

Eligibility Requirements:
- Be screened under NBCCEDP and have an abnormal screen, requiring further diagnosis and/or treatment services
- To find a NBCCEDP screener, please call:
  - OSDH: (866) 550-5585
  - Cherokee Nation (877) 458-4491
  - Kaw Nation: (580) 362-1039 ext. 228

NBCCEDP: National Breast and Cervical Cancer Early Detection Program
 Covered services include:

• Breast and cervical cancer and pre-cancer diagnosis and treatment

• SoonerCare coverage that includes the *full range* of services

• Eligibility will show Title 19
I/T/U Policies and Rules
I/T/U Policies and Rules

- Go to www.okhca.org
- Select “Policy” from within the provider box
- Select “Oklahoma Health Care Authority Medicaid Rules”
I/T/U Policies and Rules, cont.

• Select “Chapter 30” for Medical Providers Fee For Service

• Select “SubChapter 5” for Individual Providers and Specialties

• Select “Part 110” for Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us)
Part 110: I/T/U Policy Breakdown

- **Section 1085**: General provisions
- **Section 1086**: Eligible I/T/U providers
- **Section 1087**: Terms and definitions
- **Section 1088**: I/T/U provider participation requirements
- **Section 1089**: I/T/U multiple sites
- **Section 1090**: Provision of other health services outside of the I/T/U encounter
- **Section 1091**: Definition of I/T/U services
- **Section 1092**: Services and supplies incidental to I/T/U outpatient encounters

- **Section 1093**: I/T/U visiting nurses services
- **Section 1094**: Behavioral health services provided at I/T/Us
- **Section 1095**: I/T/U services not compensable under outpatient encounters
- **Section 1096**: I/T/U off-site services
- **Section 1097**: Billable I/T/U encounters
- **Section 1098**: I/T/U outpatient encounters
- **Section 1099**: I/T/U service limitations
- **Section 1100**: Inpatient care provided by IHS facilities
Outpatient Encounters

• “An I/T/U encounter means a face to face or telehealth contact between a health care professional and an IHS eligible SoonerCare member for the provision of medically necessary Title XIX or Title XXI covered services through an IHS or Tribal 638 facility or an urban Indian clinic within a 24-hour period ending at midnight, as documented in the patient's record.”

317:30-5-1098 I/T/U outpatient encounters
Outpatient Encounters, cont.

Examples include but are not limited to:

- Medical and diagnostic services
- Behavioral health services
- Dental services
- Vision services
- Physical, occupational and speech therapy
- Podiatry
- Visiting nurse services
- Smoking and tobacco use cessation counseling

317:30-5-1098 I/T/U outpatient encounters
Outpatient Encounters, cont.

- “More than one outpatient visit with a medical professional within a 24-hour period for distinctly different diagnoses may be reported as two encounters.”

- “I/T/U outpatient encounters for IHS eligible SoonerCare members whether medical, dental, or behavioral health, are not subject to prior authorization.”

317:30-5-1098 I/T/U outpatient encounters
Services Outside of the Encounter Rate

317:30-5-1090 Provision of other health services outside of the I/T/U encounter

[Revised 09-01-17]

(a) Medically necessary SoonerCare covered services that are not included in the I/T/U outpatient encounter rate may be billed outside the encounter rate within the scope of the SoonerCare fee-for-service contract. The services will be reimbursed at the fee-for-service rate, and will be subject to any limitations, restrictions or prior authorization requirements.
Services Outside of the Encounter Rate, cont.

Examples include but are not limited to:

• Durable medical equipment
• Glasses
• Ambulance
• Home health
• Inpatient practitioner services
• Non-emergency transportation
• Behavioral health case management
• Psychosocial rehabilitative services
• Psychiatric residential treatment facility services
I/T/U Billing Requirements
**Encounter Rate**

- The annual OMB rate for covered encounters paid to contracted I/T/U providers is established by the Office of Management and Budget (OMB), and is published in the Federal Register.

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Outpatient Rate (per encounter)</th>
<th>Inpatient Rate (per covered day)</th>
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</thead>
<tbody>
<tr>
<td>2015</td>
<td>$350</td>
<td>$2,443</td>
</tr>
<tr>
<td>2016</td>
<td>$368</td>
<td>$2,655</td>
</tr>
<tr>
<td>2017</td>
<td>$391</td>
<td>$2,933</td>
</tr>
<tr>
<td>2018</td>
<td>$427</td>
<td>$3,229</td>
</tr>
</tbody>
</table>
I/T/U Revenue Codes

• Contracted I/T/U providers bill with revenue codes for compensable services:
  – 512: Dental
  – 513: Behavioral Health
  – 519: Medical
  – 528: Off-Site Services

OHCA 2018-13
Third Party Liability

317:30-3-24 Third party resources

As the Medicaid agency, OHCA is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized.

– Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act.
Third Party Liability

- EXAMPLES OF TPL
  - Medicare
  - Private health insurance
  - Tricare
  - Casualty/tort settlements
  - Worker’s compensation
Step 1—Primary Paid
### COMMERCIAL INSURANCE—PROFESSIONAL

#### Step 2—Primary Paid

<table>
<thead>
<tr>
<th>#</th>
<th>ICD Version</th>
<th>Diagnosis Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **ICD Version**: [Select or Enter]
- **Diagnosis Code**: [Select or Enter]

**Other Insurance Details**

- **TPL Amount**: [Enter the primary insurance payment amount]

- **Back to Step 1**
### Step 1—Primary Denied

**Claim Type:** Professional

**Provider Information**
- **Billing Provider ID:** 0123456789
- **ID Type:** NPI
- **Name:** Bob SoonerCare, MD
- **SC Provider Number:** 100000000D

**Patient Information**
- **Member ID:** 
- **Last Name:** 
- **First Name:** 
- **Birth Date:** 

**Claim Information**
- **Date Type:** 
- **Accident Related:** 
- **Patient Account Number:** 
- **From Date:** 
- **CLIA Number:** 
- ***Other Insurance:** Denied
- **Date of Current:** 
- **Expected Delivery Date:** 
- **To Date:** 
- **HMO Copay:** No
- **Total Charged Amount:** $0.00

**Buttons:** Continue, Cancel
Billing Question

• Do I/T/U providers bill the global delivery fee for pregnancy-related services?
  – An I/T/U facility should not be billing the global delivery fee.
  – Because I/T/U providers are paid an encounter rate, the facility should be billing for each visit a patient has at the clinic during her antepartum and/or postpartum care.
  – Upon delivery of the child, the appropriate delivery-only CPT should be billed.
317:30-3-11 Timely filing limitation

• Providers must submit all claims no later than 12 months from the date of service. Federal regulations provide no exceptions to this requirement.
  – *In the event that a problem exists (such as a pending eligibility determination), the provider must still file the claim within timely guidelines.*

• For dates of service provided on or after July 1, 2015, the timely filing limit, for SoonerCare reimbursement, is six (6) months (183 days) from the date of service.
Timely Filing, cont.

• Payment will not be made on claims when more than six (6) months have elapsed between the date the service was provided and the date of receipt of the claim by the Fiscal Agent.

• To be eligible for payment under SoonerCare, claims for coinsurance and/or deductible must meet the Medicare timely filing requirements.
Timely Filing, cont.

- All claims more than 183 days old require proof of timely filing:
  - Printout of the entire claim from the Provider Portal, including the Internal Control Number (ICN), and/or
  - The ICN from the Remittance Advice (RA), and/or
  - A date stamp on a paper claim returned by OHCA or DXC
Cost-Sharing Exemptions
Cost Sharing Exemptions

• Any person applying for SoonerCare self-declares their race and/or ethnicity.

• A SoonerCare member is recognized as AI/AN when they have had a claim filed by an I/T/U facility.
Cost Sharing Exemptions, cont.

• The effective date used to determine a member’s copay exemption is the date the claim is verified, not the date of service on the claim.

• **Member Letter:** 2012-02
Member Letter 2012-02, cont.

OHCA 2012-02
April 26, 2012

RE: Co-Pays for American Indian SoonerCare Members

Dear SoonerCare Member,

American Indian SoonerCare adults and children with a contract health referral are not to be charged a co-pay for any SoonerCare covered service, including dental and pharmacy. A contract health referral is for medical/dental care provided away from an IHS (Indian Health Service) or tribal health care facility.

Additionally, American Indian SoonerCare members that receive services from Indian Health care providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization-I/T/U) are also not to be charged a co-pay.
Referrals
Referrals

- Effective **September 1, 2017**, non-I/T/U PCP’s transitioned to a paper referral process.
  - **Provider Letter 2017-09**

- Options for paper referrals include:
  - SC-10 paper referral form or
  - An alternate paper referral method.
Referrals, cont.

- I/T/U PCP’s are the only provider type to retain the ability to submit a new electronic referral after September 1, 2017.
- The attestation box on an electronic referral should only be check marked by I/T/U’s actively participating in the 100 percent FMAP initiative.
  - Requires a signed Care Coordination Agreement (CCA) between the I/T/U provider and the specialist.

*FMAP: Federal Medical Assistance Percentage*
Referrals, cont.

Create Referral

* Indicates a required field.

Requesting Provider Information

This panel contains provider information.

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>ID Type</th>
<th>NPI</th>
<th>Name</th>
</tr>
</thead>
</table>

Member Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate. Enter a valid phone number (999-999-9999) of the member at which they can be contacted.

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Last Name</th>
<th>First Name</th>
<th>Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Phone Number

Remaining Referral Information

Enter Refer to Provider NPI or click on magnifying glass to search for Provider by ID or Name. Indicate Initial Visit or Ongoing, populate start and end dates, and enter reason. Press Continue to go to the Confirm page.

Referring Provider ID

<table>
<thead>
<tr>
<th>ID Type</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

Alternate Phone

*Refer To Provider ID

<table>
<thead>
<tr>
<th>ID Type</th>
<th>NPI</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Initial Referral

*Ongoing Referral

*Referral Start Date

*Referral End Date

Attestation

 Checkbox: There is a current written care coordination agreement between the Referring Provider and the Refer To provider.

*Refer To Specialty

*Reason for Referral

Submit  Cancel
Referrals, cont.

Alternate Phone

Ext

*Refer To Provider ID

1982883948

Refer To Provider ID not found.

ID Type NPI

Name

Initial Referral Ongoing Referral

*Referral Start Date

*Referral End Date

Attestation

There is a current written care coordination agreement between the Referring Provider and the Refer To provider.

*Refer To Specialty

*Reason for Referral

Submit Cancel
Medical Authorization Using InterQual®
The page will redirect to the InterQual® website if the code entered requires InterQual® review. Click **Accept** to continue.
Select one code on the recommendation screen. If more than one code is required, another line item will need to be entered on the PA. Click OK to continue.
Select **Begin Medical Review** to answer the InterQual® questions.

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**InterQual® Review, cont.**
Select ≥ if the patient is 18 or older.
Select < if the patient is under the age of 18.
The system will not provide additional questions if the incorrect age range is selected.
Comments must be added if **Other clinical information** is selected or if applicable.
Enter the remarks then click **ADD COMMENT**.
Click **View Recommendations** if no questions remain.
Select the **Recommended** procedure if the procedure is listed within the recommendations screen.
Proceed With Not Recommended Service Review should only be selected if the procedure entered is not the same as the recommended procedure.
InterQual® Review, cont.

Select the appropriate **Code** under the **CPT®** tab and click **Complete**.
Completing the medical review will be locked and no further edits can be made. Click Yes to continue.
The following is only a recommendation result, and final determination is to follow. Click OK.
Click the **Save PA Line Item** button to save the review.
• The page is redirected to the Provider Portal and the information entered is saved on the PA request.

• If no additional codes need to be added, click **Submit**.
Click **Confirm** to submit the request.
Authorization Receipt – The Portal will generate a PA number to confirm the request submitted successfully. This does not mean the PA is approved.
PA Submission, cont.

- There are no retro authorizations for therapy services.
- There is a three-day retro limitation for imaging.
- There is a 30-day retro limit for all other services.
- Cancelled or denied PAs are subject to retro limitations and must be submitted as a new request.
PA Submission, *cont.*

- Emergent/Urgent PAs are medical conditions that are defined as loss of life or limb – not due to a scheduling issue.

- For Emergent/Urgent PA requests:
  1. Submit the PA with supporting documentation.
  2. E-mail the [MAUAdmin@okhca.org](mailto:MAUAdmin@okhca.org) with the subject “Emergency PA.”
  3. Include the PA number and reason for the emergency.
  4. Provide a contact name and telephone number.
Web Alerts
Web Alerts

• To make sure you get updates related to the SoonerCare program, please sign up for Web Alerts at [www.okhca.org/webalerts](http://www.okhca.org/webalerts)
  – Anyone can sign up for web alerts.
  – Multiple members of your staff can receive the updated information.
Sign up for OHCA Web Alerts

Be up-to-date on the latest OHCA changes in the areas you care about. We will send you an e-mail each time a change is made in the section(s) you select.

Enter your e-mail address: 

Select one of the following:

- I am a new user.
- I am already registered and want to modify my current subscriptions.
- I want to unsubscribe from all subscriptions.

Continue
Questions
Contact Information

OHCA Tribal Government Relations

www.okhca.org/tribalrelations

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