Welcome to CareOregon's Billing and Admin Meeting!

October 31st, 2024

careoregon.org
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CareOregon

Thank you for joining us!

Please help us have a successful meeting:

Questions can be submitted in the Q&A throughout the meeting.

Include your name & organization in your comments and 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

Welcome

CareOregon

Agenda

- ❑ Electronic Payment Delay – 10/31
- ❑ Behavioral Health Credentialing
- ❑ QDP 2.0
- ❑ UM / Auth submission via Connect
- ❑ Telehealth Guidance Updates
- ❑ Training and Resources
- ❑ Q+A

ACH Payment Delay – Today 10/31

- Electronic payments scheduled for today and managed by Zelis (including through ePayment Center) have not yet deposited in provider accounts.
- CareOregon is working diligently with Zelis to rectify this issue.
- Timeline for resolution is unknown

Credentialing

Holly Ott: Credentialing Manager

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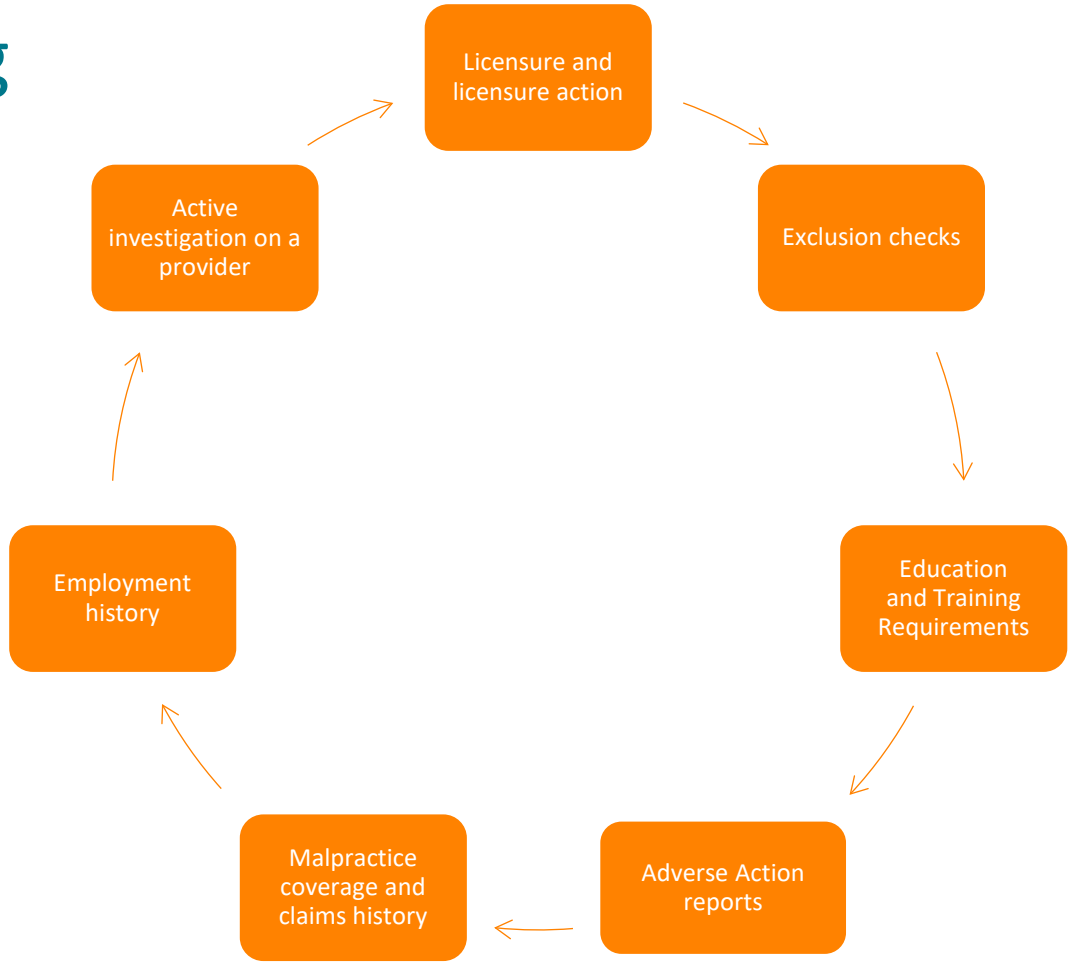
CREDENTIALING 101

- ✓ Credentialing is the process that verifies a provider's qualifications, licensure, and background
- ✓ It typically takes up to 30-60 days to complete credentialing. In some cases, it may take up to 90 days
- ✓ Credentialing is different than contracting. For CareOregon, credentialing is a required part of the contracting process. Contracting cannot be completed until credentialing is complete and approved
- ✓ Recredentialing is required every 36 months
- ✓ If licensure issues or identified adverse actions occur between credentialing cycles, the provider may be reviewed or terminated based on the severity of the issue
- ✓ BH Organizations that bill as a type 2 NPI need to have their organization credentialed as a facility when going through a new contract process, in addition to the individual practitioners working at the organization
- ✓ Monthly rosters are required to ensure CareOregon has an up to date record of all practitioners practicing at contracted organizations

Credentialing



De-delegation of Credentialing

Delegated credentialing is the process in which the health plan delegate the credentialing functions to the organization

When CareOregon took over the BH Benefit from Healthshare, delegation agreements where in place for some organizations, primarily those with a Certificate of Approval

In Q3 of 2024, these providers were notified by mail that CareOregon would be amending contracts and taking back credentialing in house

Credentialing Reminders

- If you are a provider with delegated credentialing, you should have received a letter. Please send us your applications
- Further credentialing questions? Contact: Credentialing@careoregon.org
- Send providers rosters monthly to: BhProviderDataUpdates@careoregon.org

QDP 2.0

Cody Carlson: Program Manager – Provider Contracting

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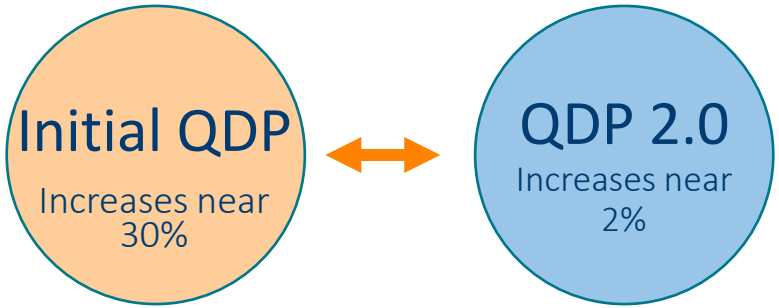
Qualified Directed Payments (QDP)

- Legislatively directed rate increases for outpatient behavioral health services
- In 2023, OHA developed increased rates for
  - Culturally and Linguistically Specific Service (CLSS) designation
  - Integrated Co-Occurring Disorder (ICD) designation
  - Tiered rate structure based on percentage of Medicaid members served



Qualified Directed Payments 2.0

1. 2024 rate increases will apply to both Out of Network Fee Schedule and Contracted Fee Schedules
2. Updated fee schedules will be released soon with tabs indicating 1/1/24 – 6/30/24 rates **and** 7/1/2024 rates
3. Check for Connect / OneHealthPort for the most updated fee schedules
4. Retro processing of claims to 1/1/24 dates of service will occur. No need to hold submission of corrected claims.

Usual, Customary and Reasonable Rates

Hot tip!

The Federal Register provides good references regarding customary charges for healthcare providers. For example, 42 CFR 405.503 states that customary charges refer to the uniform amount which the individual physician or other person charges in the majority of cases for a specific medical procedure or service. The Federal Register also provides appropriate and inappropriate examples of billing a patient less than, or more than, their prevailing (customary) rate.

- What is Usual, Customary and Reasonable?

  The American Medical Association (AMA) adopts a policy w/the following definitions:

  - "Usual; fee means that fee usually charged, for a given service, by an individual physician to their private patient (i.e., his own usual fee);
  - A fee is 'customary' when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and
  - A fee is 'reasonable' when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans.

- How do providers know/determine UCR?

  Data can be divided into three categories

  1. Data obtained from healthcare claims submitted to commercial and government payers
  2. Data obtained from claims submitted to commercial, government, and private payers.
  3. Data submitted to government payers

- Why UCR and not fee schedule rate?
  - Data from billed rates informs rate setting
  - For retro-reprocess (CO can only pay up to billed amount)
  - OHA and CO directives

Authorization & Notifications of Treatment

Paul Peynado Clinical Operations Supervisor – Behavioral Health

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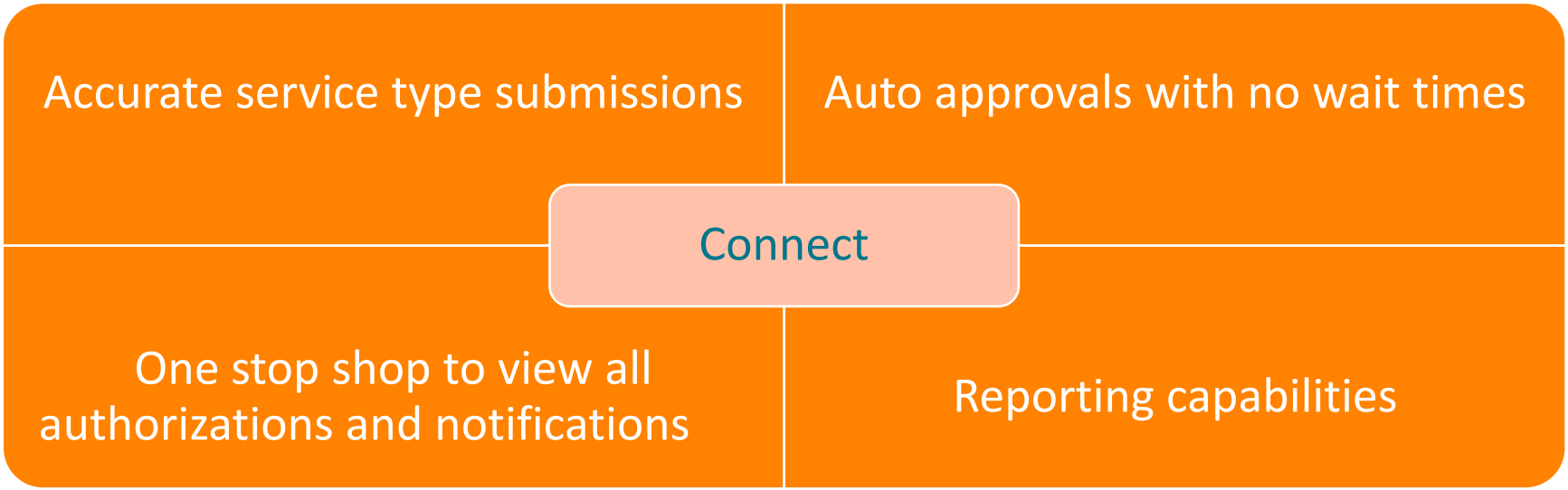
Updates

Effective Jan 1st, 2025 all Authorization and NoT requests must be completed in Connect. Faxed authorizations and notification will no longer be accepted



Requesting an Auth or NoT in Connect

CareOregon Connect is our online provider portal.

Use to:

- ✓ Check member eligibility
- ✓ **Request Notifications of Treatment numbers**
- ✓ Check status for claims & review remittance advice
- ✓ Use code lookup
- ✓ …and more!

Access Connect on our CPCCO + JCC websites.

Jackson Care Connect

Billing Updates & Guidance

Jonique Dietzen: Director, Payment Integrity

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Telehealth Billing Guidance

Modifier Required on ALL Telehealth Claims

- Use of One of the following Modifiers is required:
  - 95, G0 (G+zero), GQ, GT – Audio and Video Communications
  - 93, FQ – Audio Only Communications
- OAR 410-120-1990 requires a modifier even when POS 10 or 02 is used to bill Telehealth Services
- Which BH services are allowed via telehealth
  - Services on the Oregon Behavioral Health Fee Schedule with allowable modifier GT
  - Services listed by the Health Evidence Review Commission (HERC) guideline Note A5
  - Services listed by CMS as payable via telehealth List of Telehealth Services | CMS
- Previously the place of service (10 or 02) was sufficient to indicate a telehealth service

Billing Updates & Resources

Topic	Current Status	Provider Guidance
Allowable services by Peer Support Specialists	CareOregon is limiting reimbursement for Peer Support Specialists to services approved by the state as being within their scope of practice and eligible for reimbursement. Clinics require a Certificate of Approval for approved oversight of Peer Support Specialists	Oregon Health Authority : OHP Fee-for-Service Fee Schedule : Oregon Health Plan : State of Oregon Registry - MHACBO
Corrected MUE limits for BH and MH services	Psychotherapy can now be billed with multiple units to cover encounters lasting more than 89 minutes Most Individual and Group counseling services are covered up to 4 hours. Per Diem services limited to 1 unit per day.	Services billed in excess of the Medically Unlikely limits can be reconsidered with clinical documentation that supports both a. Accuracy of coding b. Medical necessity

Billing Updates & Resources

Topic	Current Status	Provider Guidance
ABA Concurrent billing policy & questions (regarding OHA January policy)	Behavior treatment by a technician covered up to 8 hours. Behavior treatment by a physician/health care professional covered up to 6 hours. If 8 hours of technician services are billed, only 1 hour of treatment by a physician/health care professional will be covered. Time must be spent 1:1 between the service provider and the client, otherwise it should be billed as a group service.	Concurrent billing for Applied Behavior Analysis (ABA) codes

Training and Resources

Maig Tinnin: Behavioral Health Provider Relations Specialist Supervisor

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REMINDERS

	Summary	Resource

Organizational Provider Roster Monthly Update	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

Billing "Pay-To" NPI 1 vs. NPI 2	**NPI 1**: is an individual code and is used if the provider is billing for themselves with a TIN or SSN aka billing direct **NPI 2**: is an organizational code and is used if the provider is a group with multiple providers under the same TIN	

REMINDERS

	Summary	Resource
Secure Messaging	**Send us a Secure Message in Connect!** You can also: • Check eligibility • Check the status of an authorization • Check the status of claims • Check member benefits • Submit a PIF • Apply for a DMAP ID	**Secure Messaging Tutorial on CareOregon Website** https://www.careoregon.org/docs/default-source/providers/physical-health-providers/secure-messaging-in-connect.pdf?sfvrsn=9ba9522b_1
HSO BH Directory	We are excited to announce the launch of the new Health Share of Oregon Behavioral Health directory. This project has been a long time in the making, and while there is still more to refine, we've successfully implemented significant improvements in data accuracy and integration with our internal systems. Members and providers can now more easily access and navigate the directory at www.careoregon.org or through the Health Share of Oregon website at www.healthshareoregon.org.	For any updates or questions, please submit an inquiry using the Message Center in our CareOregon Connect online provider portal or contact our Provider Customer Service team at 800.224.4840 (option 3). We're looking forward to adding more enhancements and features soon!

REMINDERS

Medicare Demystified

A workshop for CareOregon Behavioral Health providers

CareOregon - Metro area behavioral health providers

More behavioral health resources

Please carefully review all procedures before rendering any services to members. CareOregon's policies, procedures and authorization requirements are described above in "Guidelines for serving members." You also may find additional resources for doing business with CareOregon in the tabs located below.

After 10-1-2023 Dates of service | Before 10-1-2023 Dates of service

- Behavioral Health Provider Manual (post 10/1/23 only)
- Utilization management handbook and forms (post 10/1/23 only)
- Claims and Billing Resources (post 10/1/23 only)
- Provider Data Management Forms (post 10/1/23 only)
- **Additional provider tools and resources (post 10/1/23 only)**

  - CIM / OneHealthPort / Connect MMIS Guide
  - BHSI Online Resource Diagram
  - BHSI Who To Contact For Help? Quick guide
  - Metro Area Behavioral Health Credentialing Resources
  - Metro Area Behavioral Health Non CoA Credentialing
  - CareOregon Credentialing Checklist
  - EDI Training Opportunity Handout
  - HSO Provider peer FAQ
  - HSO Narrative Access Report
  - Care Coordination for Certified Community Behavioral Health Clinics FAQ
  - Medicare Demystified training

Medicare Claim Submission

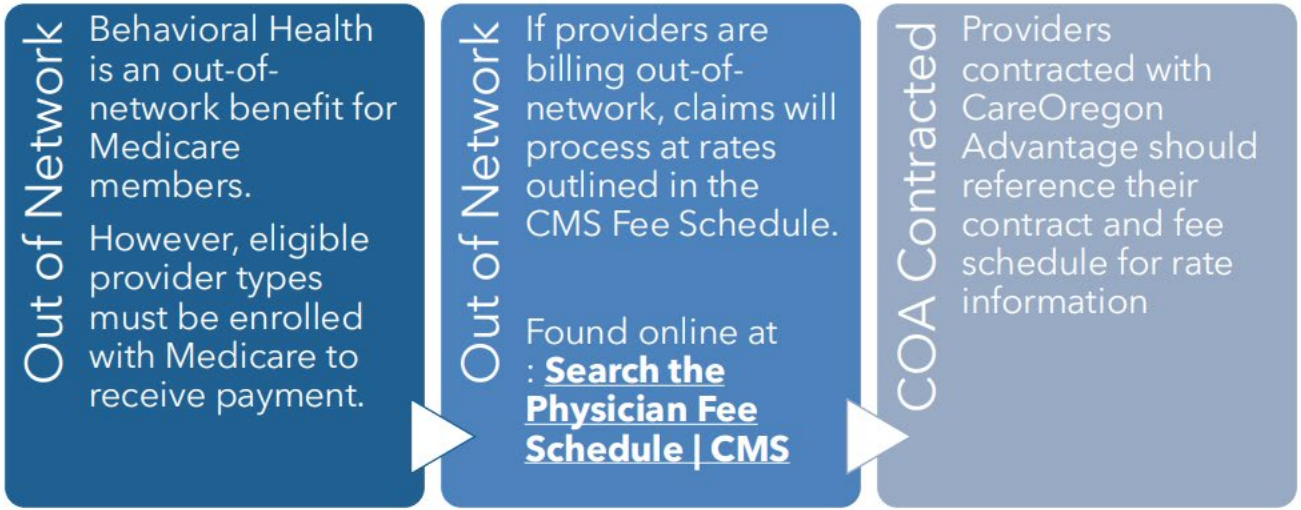
If billing for members with CareOregon Advantage primary coverage: bill CareOregon and a secondary Medicaid claim will be created automatically after the COA benefit processes.

If billing for members with Noridian FFS Medicare, CareOregon will receive a crossover claim automatically

If billing for members enrolled in an external Medicare Advantage plan: bill the primary benefit plan first and then submit secondary claim to CareOregon with the EOB included.

CareOregon Advantage

Medicare Rates & Fee Schedules



CareOregon Advantage

Services Requiring Prior Authorization

For services requiring prior authorization, the auth numbers must be submitted on the claim form for claims to process and pay correctly.

If a member has Non-CareOregon Medicare (e.g. Medicare AB) and OHP secondary with CareOregon, an authorization is **not** required

- The provider can submit claims for secondary costs along with an Explanation of Benefits (EOB) directly to CareOregon without requesting an authorization.

CareOregon Advantage

Services Requiring Prior Authorization continued . . .

If Non-CareOregon Medicare denies payment of services or does not cover a service, and member has secondary OHP with CareOregon, the provider can request that CareOregon pay primary & secondary costs that were not covered by Medicare.

- If it is a service that requires clinical review, the provider will need to submit an authorization request to CareOregon.
- A Behavioral Health Clinician will review the request. If the request is approved, then payment will be rendered.
- Provider will be required to submit an EOB with their claims

CareOregon Advantage

Provider Resources: Training & Online Materials

Stay Up To Date! Visit us online at:

CO Metro BH Provider Website

Meds Ed
https://careoregon.org/providers/meds-ed

Connect Training
Provider Connect Portal Tutorials

Stay Connected

Future topic-specific trainings	**Poll on topic preferences**
Next Billing & Admin Meeting	**January 30th**

Provider Input:

What topic-specific trainings would you like to see us provide next?

- Provider Portal (Connect) Overview & Website Resources
- Member Eligibility and Coordination of Benefits
- Alternative Payment Methods (ex: case rate) & related billing questions

Other ideas? Put them in the Questions section

We value your feedback! Please let us know what is still needed

Who to contact when you need help

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

****NEW* Secure Messaging and Forms**, 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*

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

Thank you!

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