

Biller's Meeting Q&A

February 19, 2009

Q: Is the new Pending Report replacing the old version?

A: Yes.

Q: What about claims that are pended for "No Clinical Update", but do not require a clinical update based on the service?

A: This denial will be received on any service, as long as the registration is pending a clinical update. We require a clinical update for the registration event, so we know the member is still active with the provider.

Q: In regards to the COB Specialty Form, if the form was signed/dated in Jan 2009...when will we need to update those letters?

A: At this time, we are not requiring an update of these forms. They can be reused as needed, but please ensure a copy is submitted with *each* claim.

Q: In regards to the COB Specialty Form, can a clinician sign the letter?

A: Yes.

Q: What services could be denied as "Units Exceeded"?

A: Any service that requires pre-authorization.

Q: Are annual limits being tracked in the system, or do the Billers need to track them?

A: We encourage Billers to track the rendering of services with annual limits. Although the Care Management staff is doing so we encourage you to track them as well.

Q: In completing box 22 for timely filing consideration, isn't this the opposite of what we have been directed to do in the past?

A: No, this only pertains to claims that need to be considered for overriding of timely filing, based on a previous submission. Box 22 does not need to be filled in for "Corrected" claims, unless timely filing is of concern. Although box 22 can be filled in when it is not necessary, we would prefer that you reserve it for use when timely filing is involved.

Q: What about when COB is involved and timely filing is an issue, due to a delay in processing by the primary? In this example, the claim has not been filed with KHS previously.

A: In this instance we will utilize the date of the primary carrier's EOB, so box 22 is not used.

Q: Are Crisis services only provided by CMHC's?

A: Yes.

Q: Has the system issue involving units not being paid for Crisis services been corrected?

A: No, the system has not yet been corrected. However, we will be re-adjudicating the claims involved upon correction of the system.

Q: The [Crisis Services] code changes just summarized by Jennifer do not appear to be included in the Provider Notice 2.7?

A: The Provide Notice update in the January Provide Notice, 2.7 was directed to clinicians. We have provided details below in regard to the changes for the Billers. These details have been published in the March Provider Notice, 2.8:

**CRISIS INTERVENTION BILLING CHANGES**

- A) EFFECTIVE MARCH 1, 2009, THERE WILL NO LONGER BE TIME FRAMES FOR HOW LONG A CRISIS SERVICE PLAN MAY CONTINUE.**
- B) CRISIS SERVICES MAY BE PROVIDED AT ANY LEVEL FOR THE DURATION NEEDED TO STABILIZE THE MEMBER OR REFER THEM TO A HIGHER LEVEL OF CARE.**
- C) CRISIS ATTENDANT CARE, CRISIS CPST AND CRISIS PSYCHOTHERAPY ARE IDENTIFIED BY SERVICE TYPE, NOT PROVIDER EDUCATION.**
- D) THESE SERVICES ARE OPEN TO COMMUNITY MENTAL HEALTH CENTER PROVIDERS.**
- E) MULTIPLE PROVIDERS MAY BILL FOR CRISIS INTERVENTION SERVICES AS LONG AS IT IS MEDICALLY NECESSARY AND DOCUMENTED IN THE MEMBER'S RECORD.**
- F) ON-GOING CRISIS CODES (H2015 AND H2015-HK) ARE NO LONGER VALID FOR SERVICES PERFORMED AFTER 02/28/2009.**
- G) DATES OF SERVICE PRIOR TO 02/28/2009 WILL STILL BE ACCEPTED BY KHS WITH ON-GOING CRISIS CODES. NORMAL TIMELY FILING LIMITATIONS APPLY.**
- H) EMERGENT CRISIS INTERVENTION CODES WILL REMAIN AS H2011, H2011-HK, AND H2011-HO.**
- I) THE REIMBURSEMENT RATE WILL REMAIN THE SAME FOR THESE THREE CODES.**
- J) PROVIDER NOTICE 2.7 DATED JANUARY 30, 2009 HAS MORE INFORMATION.**
- K) PLEASE DIRECT QUESTIONS REGARDING THESE SERVICES TO CAROL NEEDLEY AT 785-575-9373 OR [CNEELEY@KHS-KS.ORG](mailto:CNEELEY@KHS-KS.ORG).**

Q: Is there an update on the diagnosis pointer issue for 837 submissions?

A: Currently, it appears this issue could be corrected in April or early May.

Q: Is the diagnosis pointer issue for 837 submissions still happening?

A: Yes.

Q: Will KHS re-adjudicate these claims once the diagnosis pointer issue within 837 submissions is corrected? Or, will Billers need to resubmit?

A: We will provide direction upon correction of the system issue.

Q: If we are submitting claims for a provider that has not yet been credentialed by KHS, but we need to submit the claim just to show the encounter (no money is owed based on the primary covering the charge in full), how should we submit those claims?

A: We would suggest waiting for the provider to be credentialed before performing/billing any charges. Upon KHS approval of the credentialing application, the effective date will be the received date of the application, as long as all necessary items were supplied at that time. A provider may request information about the status of their application at any time by contacting the Credentialing Coordinator at 1-866-547-6457.

Q: If we receive a denial that we suspect is in regards to a non-credentialed provider, should we contact Michele Johnson?

A: If your question stems from the denial, we would prefer you contact Becky Schuetz, Daniel Dubois, or Jennifer Roberts. If you would like to check the status of the credentialing request, you may contact the Credentialing Coordinator at 1-866-547-6457.

Q: If we receive confirmation that the credentialing has been approved after we receive the denial, do we need to resubmit those claims?

A: Yes, if the date of service is after the effective date of the credentialing approval. The effective date is the date in which KHS receives all items required for consideration of credentialing, not the approval date.

Q: In regards to SED Patient Liability, there were claims recouped in April *and* May...will you be reviewing both months for re-adjudication and potential payment?

A: Yes.

Q: Is there a specific denial code for the patient liability portion?

A: Yes, it states, "Monthly Medicaid patient liability amount"

Q: Going forward, will KHS deny these claims as patient liability?

A: No, our plan is to manage this on the post-payment side.

Q: Do you know if SRS has sent the patient liability letters to the patients? If yes, when were they sent?

A: The patient liability information is sent to the member with the notification of waiver eligibility approval.

Q: Even though KHS is paying for the patient liability at this time, can we still bill the patient if we know they will actually pay for the liability in the end?

A: Yes you may. This would be an internal process for your center/provider to determine.

Q: Does the original patient liability stay put in eCura, or does it move like Spenddown amounts?

A: Patient liability is set to the flat amount and does not change in the system, unlike the Spenddown amounts that do change with claims submission.

Q: If we have pended claims waiting for clinical updates, how do we confirm that the update made has been accepted by the system?

A: The claims will be gone from the pended status after the next adjudication run (which usually occurs daily).

Q: What is the status of the timing out issue on eCura?

A: InfoMC has identified a discrepancy between the application timeout procedure and the server timeout procedure. We anticipate a fix being added to the system in early April.

Q: Is there an update on the status of being able to edit COB claims online, and Phase III of online adjustments?

A: These items are still in the development stage. We will attempt to provide details on the expected timeline at the next Biller's Meeting on March 19<sup>th</sup>.

Q: We are receiving 'DOS not authorized' denials for the new injection administration code, 96372?

A: This issue has been corrected.