

Integrated Managed Care Operations – North Central (Chelan, Douglas, Grant counties) Co-Hosted by:



Agenda

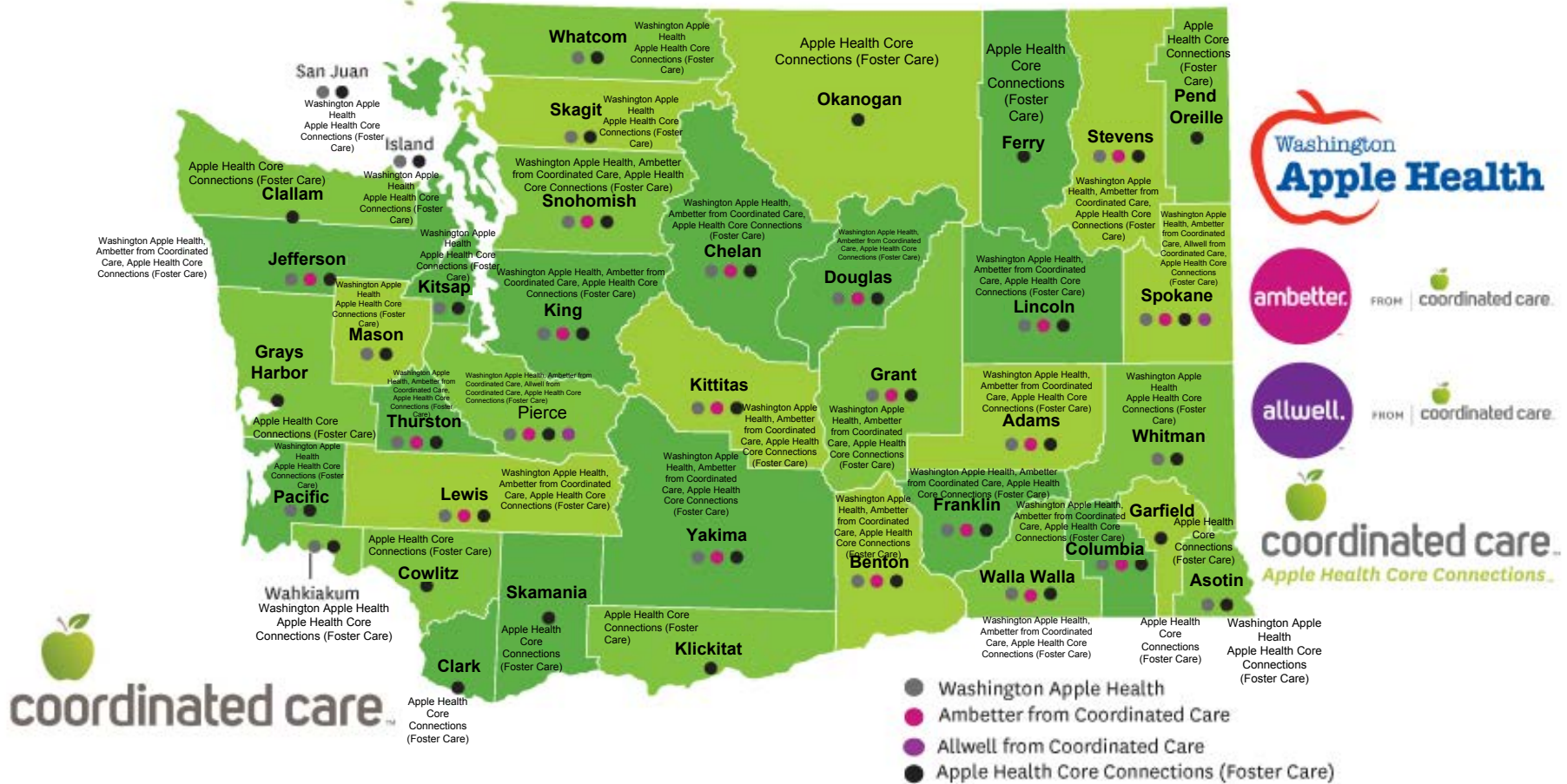
- MCO/BH-ASO Overviews
- IMC Overview
- Partnering with MCOs and the BH-ASO
 - Credentialing
 - Access to Care & Access Standards
 - Websites, Portals & Directories
 - Claims and Billing
 - Prior Authorizations
 - Resources
- Questions and Answers

Coordinated Care of WA

Mission Statement: To be the **highest quality** health plan in Washington, and the **health plan of choice** for members and providers.



Coordinated Care: We've Got You Covered



Beacon is Committed to Strong Partnership with Washington State

Strong Medicaid and Non-Medicaid Experience

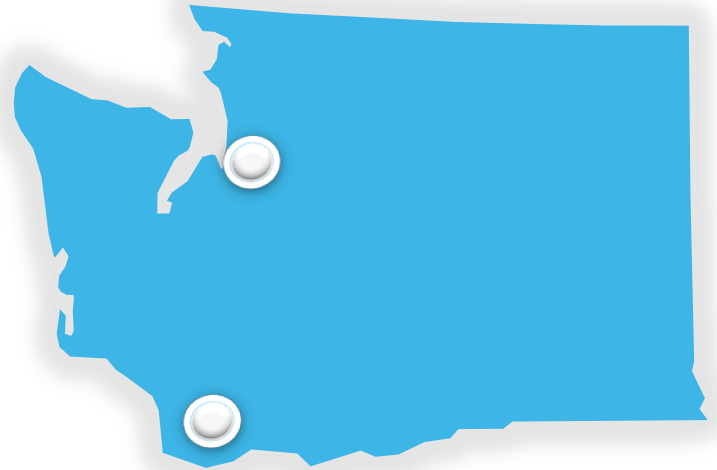
- Implemented the first BH-ASO in partnership in Clark and Skamania Counties in ~90 days
- Manage the crisis system access and coordination contracts with the IMC MCOs, county governments, key providers and other community stakeholders

Dedicated Local Team

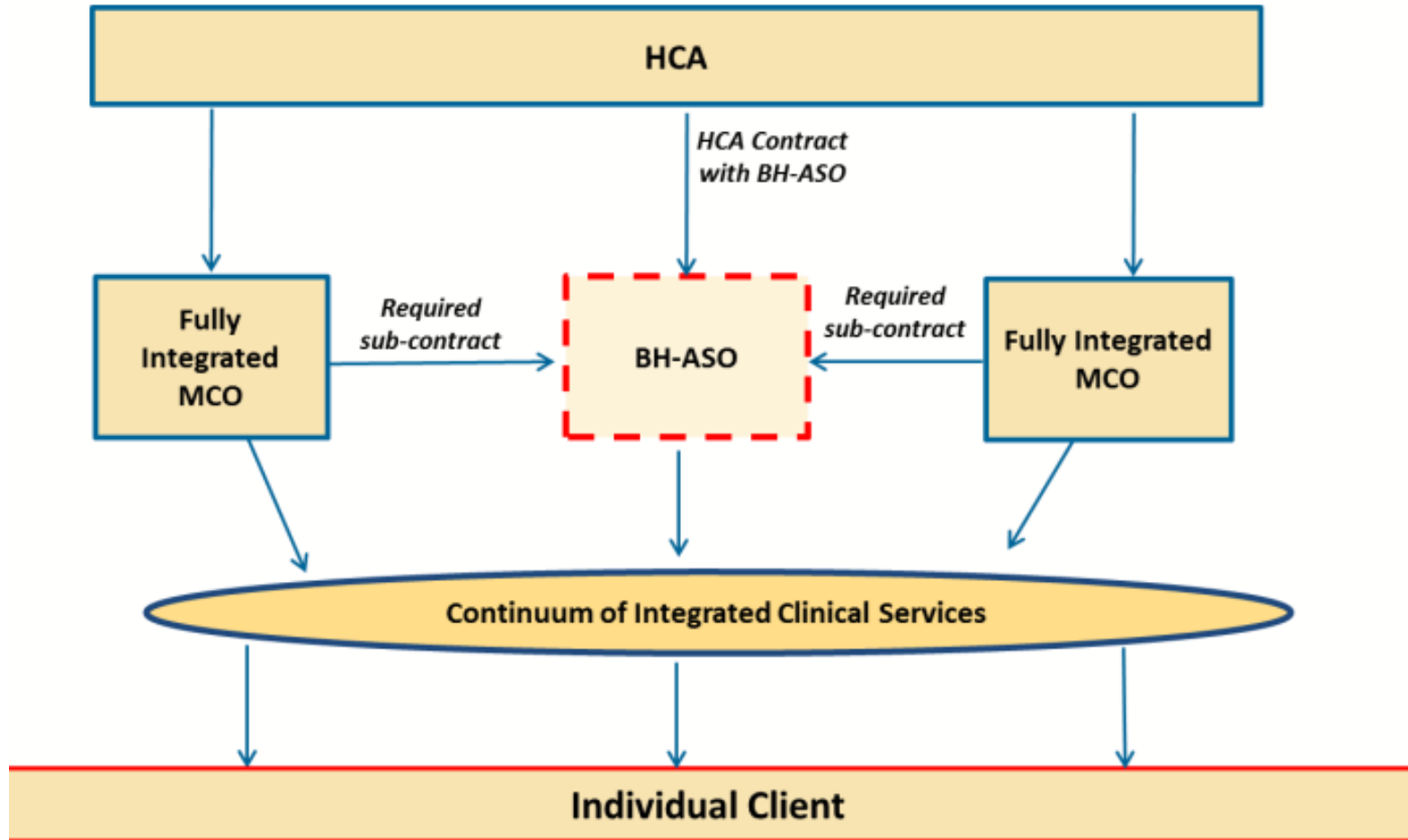
- BH-ASO staff in Vancouver, Washington
- Expansion plans to hire in North Central

Military, Commercial, Employer Experience

- Military contract served out of Bellingham, Washington
- Boeing MHSUD and EAP contract



Role of the Behavioral Health ASO



The BH-ASO Will Provide a Series of Services that Supplement Those Provided by the Managed Care Plan

Maintain and Administer Crisis Services

- Maintain 24/7/365 regional crisis hotline
- Provide mental health crisis services, including mobile outreach team
- Administer Involuntary Treatment Act
- Administer Chemical Dependency Involuntary Commitment Act

Manage SUD and MH braided Funding Benefits

- Proviso funds
- Federal Block Grant (MHBG & SABG)
- Criminal Justice Treatment Account
- Dedicated Marijuana Account
- Jail Transition Services
- State General Funds

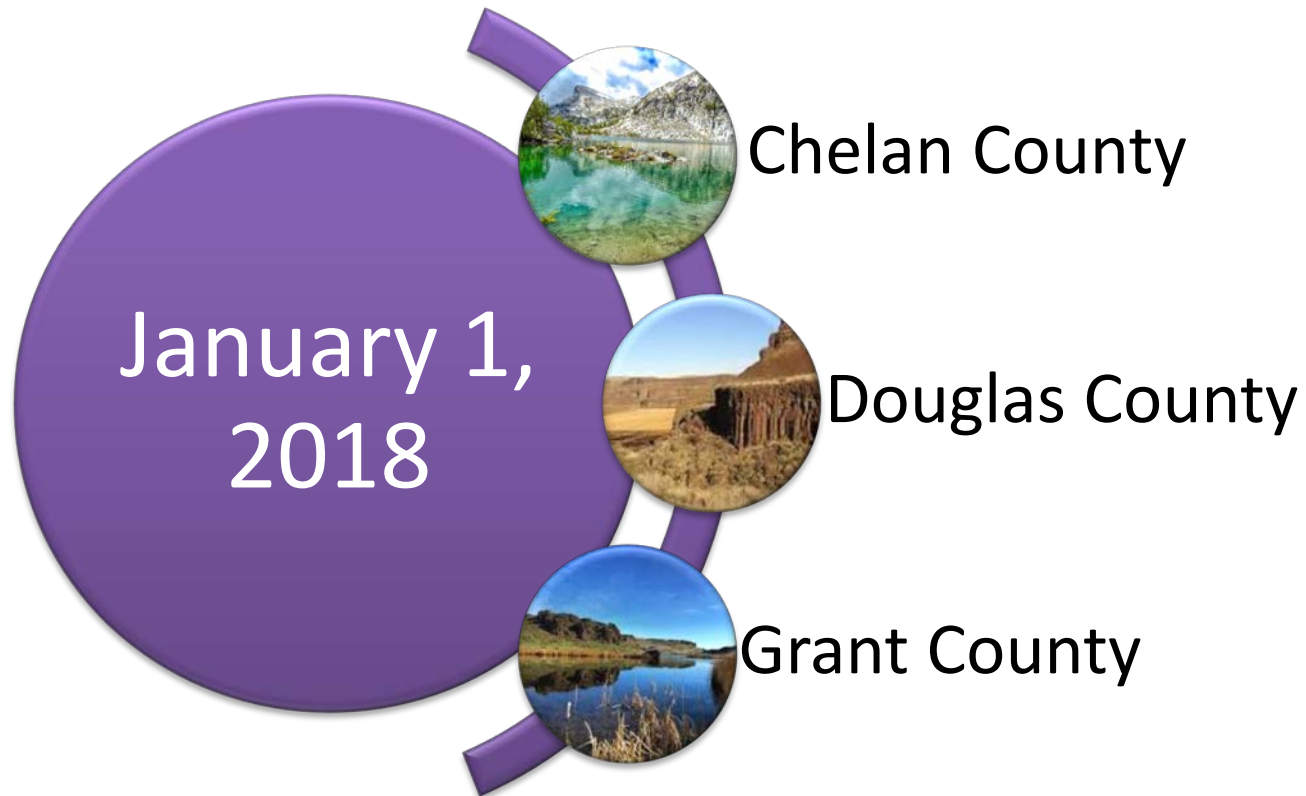
Admin support, financial support and miscellaneous

- Behavioral Health Ombudsman
- FYSPRT & CLIP
- State hospital liaison and Peer Bridger

IMC Overview



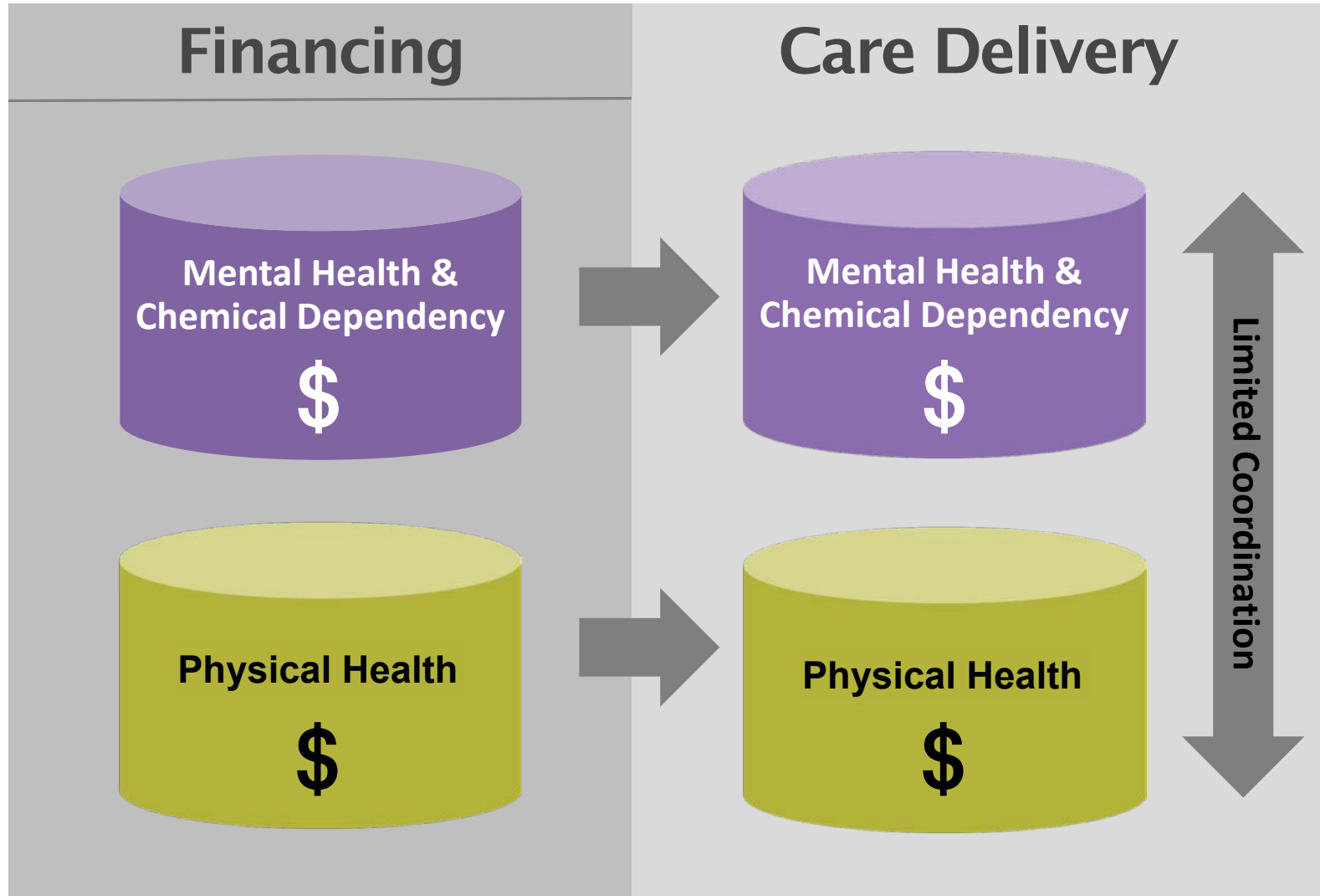
North Central IMC Go-Live



NOTE: Medicaid members in surrounding counties will remain Apple Health with Apple Health benefits.

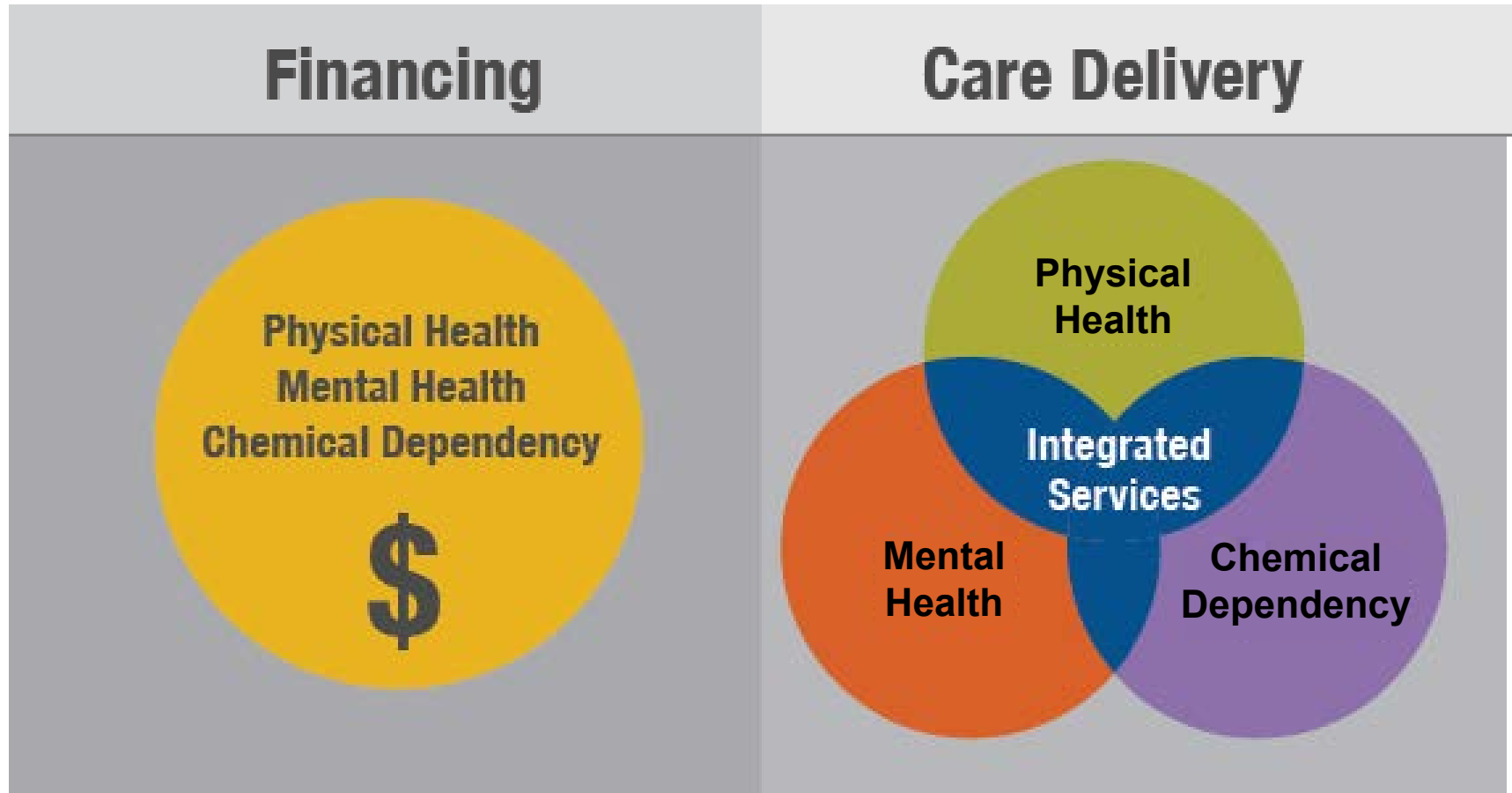
Current State:

Fragmented Financing and Care



Future State:

Integrated Financing = Integrated Care



Two HCA Contracts Cover All Enrollees

Medicaid Covered Services

- Physical Health (e.g. Apple Health)
- Mental Health (MH)
- Substance Use Disorder (SUD)
 - NOTE: MH and SUD = Behavioral Health (BH)

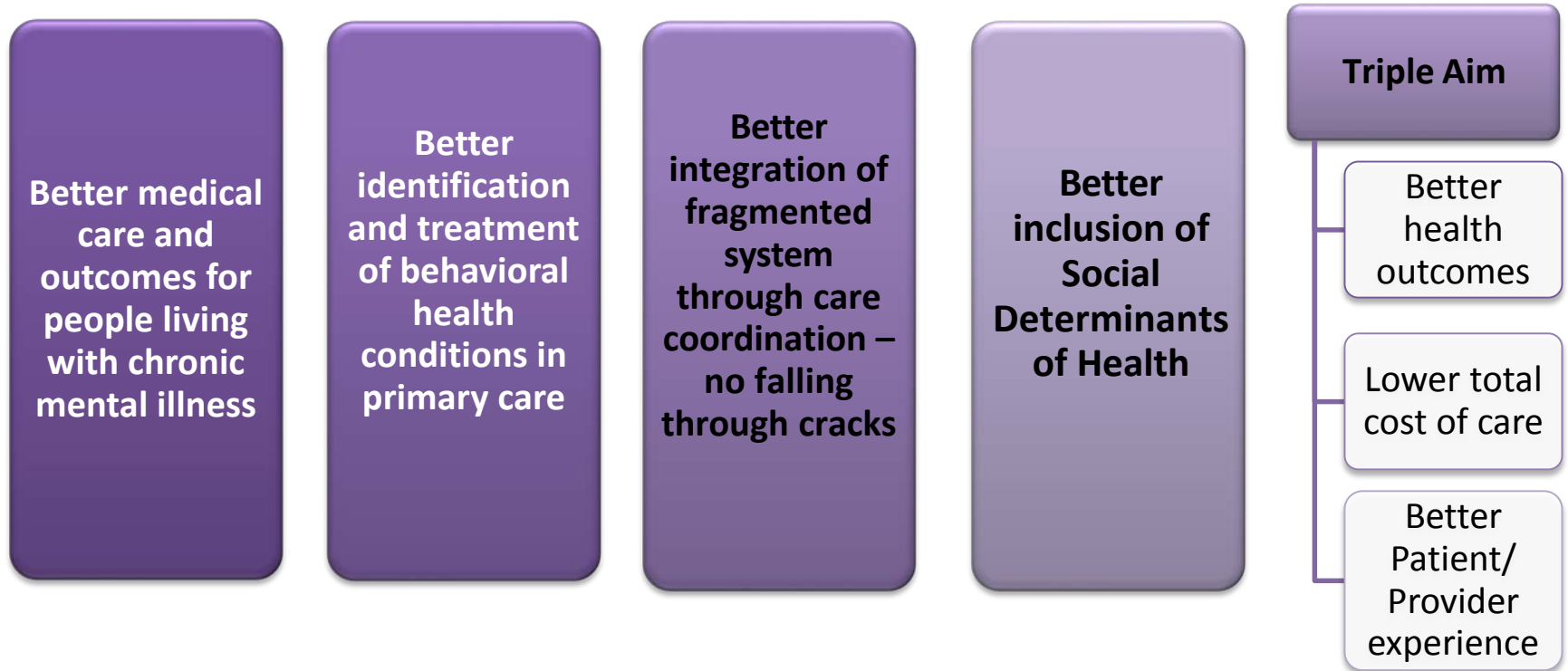
Wrap Around Benefits

- Behavioral Health services **NOT** covered or funded by Medicaid
- These services are funded by General Fund – State dollars
- Examples of services:
 - eg. room & board, sobering services

Enrollees

- Apple Health Medicaid children, families, adults, blind/disabled
- Behavioral Health Services Only (BHSO) members will only receive behavioral health benefits through MCOs. Medical benefits remain Fee-For-Service

What Does Better Look Like?



Provider Network

Primary Care

- Integrated Delivery Systems (Confluence)
- Primary Care Clinics (i.e. Columbia Valley Community Health, Moses Lake CHC, Columbia Basin Health Association)

Mental Health

- State Hospitals--MCOs do not administer this benefit
- Inpatient Psychiatric Hospitals
- Community Mental Health Agencies
- Behavioral Health Providers-Group Practices
- Individual Behavioral Health Providers

Substance Use

- Substance Use Disorder (SUD)/ Chemical Dependency Agencies
- Inpatient and Outpatient Treatment

Behavioral Health Administrative Services Organization (BH-ASO)

- Beacon Health- provides crisis service response 24 hours a day/7 days a week/365 days a year and administers non-Medicaid services to non-Medicaid members

Partnering with MCOs & BH-ASO

- Credentialing
- Access to Care & Access Standards
- Websites, Portals & Directories
- Claims and Billing
- Prior Authorizations
- Resources
 - Member Appeals & Grievance
 - Interpreter Services
 - HCA Transportation Broker
 - MCO Forms
 - Helpful Links



Credentialing



IMC Credentialing

Behavioral health care providers (BHP's) in delivering mental health services in the State of Washington as part of the Integrated Managed Care Model are credentialed according to NCQA requirements and MCO credentialing policies and procedures.

Category/Scenario	Group Practice / Solo Practitioner Contract	Facility (CHMA, Chemical Dependency Agency) Contract
Individual Practitioner Credentialing Required?	Yes	- No (Facility-based non-licensed) - Yes (Licensed, certified or registered with the state of WA who practice independently)
Facility/Location Credentialing Required?	No	Yes
What type of Application is required?	Washington Practitioner Application (WPA) via CAQH or OHP	Facility Application (with supporting licensure)
Are practitioner rosters required?	No (unless group is under a delegated credentialing agreement)	Yes (provider directory when appropriate, member care/referral, claims processing)
Re-credentialing Schedule	3 years / 36 months (or sooner if required by state law)	3 years / 36 months (or sooner if required by state law)

HCA Core Provider Agreement/Provider One ID

MCOs are required to ensure that all contracted providers either have a signed Core Provider Agreement (CPA) with the HCA, or enroll as a 'non-billing' provider (if he/she does not wish to serve fee for service Medicaid clients) but **each provider must have an active NPI number with the HCA to bill independently.**

- 42 CFR 438.602(b) will require all MCO network providers to be enrolled by 1/1/2018
- Both Organizations (Type 1) and individuals (Type 2) NPI's need to be registered
- Requirements and Instructions on enrollment can be found on HCA's website: www.hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-provider
 - Enrollment as a Non-Billing provider is a hard-copy (paper process) at this time.

Lack of compliance with this HCA requirement could impact claims payment so please ensure you are properly registered and obtain the ProviderOne ID!

Credentialing Process & Inquiries

Each MCO has provided links and reference material for submission of credentialing materials and/or notice of changes below:

MCO	Credentialing Source	Email
Amerigroup	• ProviderSource (OneHealthPort) • CAQH	All credentialing correspondence and materials can be submitted to: WACredentialing@Amerigroup.com
Coordinated Care	• ProviderSource (OneHealthport) • CAQH	All credentialing correspondence and materials can be submitted to: CONTRACTING@CoordinatedCareHealth.com
Molina	• ProviderSource (OneHealthport) • CAQH	All credentialing correspondence and materials can be submitted to: MHWProviderContracting@MolinaHealthcare.com

Credentialing

- Provider Credentialing and Recredentialing
 - Completion of Credentialing Application required for network consideration
 - Nominated Providers will be contacted by Credentialing Department regarding next steps
 - Beacon's online application is available for the initial provider credentialing process
 - Eligible providers are also encouraged to participate with CAQH[®] (Council for Affordable Quality Healthcare)
 - Once credentialed, review CAQH information regularly
 - For more information about CAQH:
 - Visit the CAQH website at <http://www.caqh.org>

Credentialing in ProviderConnect

 **PROVIDERCONNECT**
BEACON HEALTH OPTIONS

[Submit Application](#) [Print current page](#) [Print all pages](#) [Close](#)

1. Provider | 2. Referral | 3. Practice | 4. Education | 5. License/Certification | 6. Insurance | 7. Work History
8. EAP Counselor | 9. Disability Provider | 10. FPD Specialist | 11. Provider Profile | 12. Attestation | 13. W-9

1. PROVIDER INFORMATION

A. DEMOGRAPHIC INFORMATION

Last Name*
TUMNUS

First Name*
PETER

MI

Gender
☐ Female ☐ Male
☐ Unknown

Mailing Address Line 1*
14 BEAVER TRAIL

Mailing Address Line 2
STEC

City*
NARNIA

County

State*
VA

Zip*
12345

Fax: (include area code)*
5555555555 Ext:

Telephone: (include area code)*
5555555555 Ext:

Mobile Phone

Pager

Social Security Number*
123456

Date of Birth*
12/02/1979

Professional Designation or Title*
ABC

Indicate any other name you may have used in the past (e.g., maiden name, etc.)

Internet E-mail address*
ABC.XYZ@HOTMAIL.COM

ValueOptions, Inc. is engaging in an automated approach to managing and maintaining your network Provider file information. As a network Provider this automated system will immediately update any change you submit regarding your practice and billing activities (i.e. address/phone number changes) and will automatically notify you of our need for you to submit updated license renewals and malpractice information.
To take advantage of this paperless and automated system, indicate your preferred method of communication, including the day and the time that is most convenient.

B. COMMUNICATION PREFERENCE:

Please select your preferred method of communication. If you only have one preferred method, please indicate N/A on the other method.

Primary Communication Preference:
Secondary Communication Preference:

DAY/TIME PREFERENCE (check only one for each category)

For Primary Preference			For Secondary Preference		
Day	Time of Day	Time Zone	Day	Time of Day	Time Zone
☐ Monday	☐ 6AM-10AM	☐ EST	☐ Monday	☐ 6AM-10AM	☐ EST
☐ Tuesday	☐ 10AM-2PM	☐ CST	☐ Tuesday	☐ 10AM-2PM	☐ CST
☐ Wednesday	☐ 2PM-6PM	☐ MST	☐ Wednesday	☐ 2PM-6PM	☐ MST
☐ Thursday	☐ 6PM-10PM	☐ PST	☐ Thursday	☐ 6PM-10PM	☐ PST
☐ Friday	☐ 10PM-2AM	☐ AZ/HI/AK	☐ Friday	☐ 10PM-2AM	☐ AZ/HI/AK
☐ Saturday	☐ 2AM-6AM		☐ Saturday	☐ 2AM-6AM	
☐ Sunday			☐ Sunday		

Save

Save & Next

Access to Care & Access Standards



Access to Care Standards

- DSHS Access to Care Standards implemented by DBHR (utilized by BHOs) are lifted January 1, 2018.
- MCOs will utilize medical necessity criteria rather than the DBHR Access to Care Standards. MCOs will now oversee all Medicaid-covered behavioral health benefits, regardless of diagnosis.
- MCOs will continue to utilize industry standard medical necessity decision making guidelines, based on evidence based practices, for determining levels of services.
- MCOs will continue to utilize the federal guidelines American Society of Addiction Medicine (ASAM) criteria for determining levels of substance use disorder services.

Access Standards

Amerigroup, Coordinated Care, and Molina access standards comply with the Healthcare Care Authority (HCA) and the National Committee for Quality Assurance (NCQA) requirements. According to our contracts with HCA and our commitment towards quality improvement, providers must also adhere to these standards.

Type of Care	Appointment Wait Time
Preventive Care Appointment	Within 30 calendar days of request
Second Opinions	Within 30 calendar days of request
Routine Primary Care	Within 10 calendar days of request
Urgent Care	Within 24 hours
Emergency Care	24 hours/7 days
After-Hours Care	Available by phone 24 hours/seven days
Office Waiting Time	Should not exceed 30 minutes
Care Transitions – PCP Visit	Within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program
Care Transitions – Home Care	If applicable, Transitional health care by a home care nurse or home care registered counselor within 7 calendar days of discharge from a substance use disorder treatment program, if ordered by the enrollee’s primary care provider or as part of the discharge plan

Access Standards: Definitions

Statewide Network and Provider Responsibilities:

- **Emergent** - Immediately
- **Urgent** appointments for illness, injuries which require care immediately but do not constitute emergencies (e.g. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services)-within 24 hours
- **Routine care with symptoms** (e.g. persistent rash, recurring high grade temperature, nonspecific pain, fever)-Within one (1) week or five(5) business days; whichever is earlier
- **Routine care without symptoms** (e.g. well child exams, routine physical exams)-Within thirty (30) calendar days
- **Wait times** (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments should not exceed one hour from the scheduled appointment

Behavioral Health Standards

Amerigroup, Coordinated Care, and Molina access standards comply with the Healthcare Care Authority (HCA) and the National Committee for Quality Assurance (NCQA) requirements. According to our contracts with HCA and our commitment towards quality improvement, MCO network of Behavioral health providers must adhere to these standards.

Behavioral Health Appointment Types	Standard
Life threatening	Immediately
Non-life threatening	Within 6 hours
Urgent care	Within 24 hours
Routine care	Within 10 calendar days

SSB 5779 New Children's Mental Health Requirements

- Effective 1/1/2018
- HCA is working with MCOs to ensure:
 - Children receive treatment and appropriate care regardless of referral source;
 - Maintain adequate provider capacity;
 - Follow up to ensure appointments occur;
 - Coordinate with Primary Care Providers;
 - Maintain accurate provider directories; and
 - Educate about the Washington Recovery Help Line.

1-866-789-1511 - <https://www.warecoveryhelpline.org>

Eligibility

- Eligibility should be verified before every service. HCA updates eligibility daily, therefore there could be retrospective or mid-month changes.
- The preferred method of eligibility verification is via each MCO Provider Portal. You can also utilize ProviderOne or each MCO's customer services line.

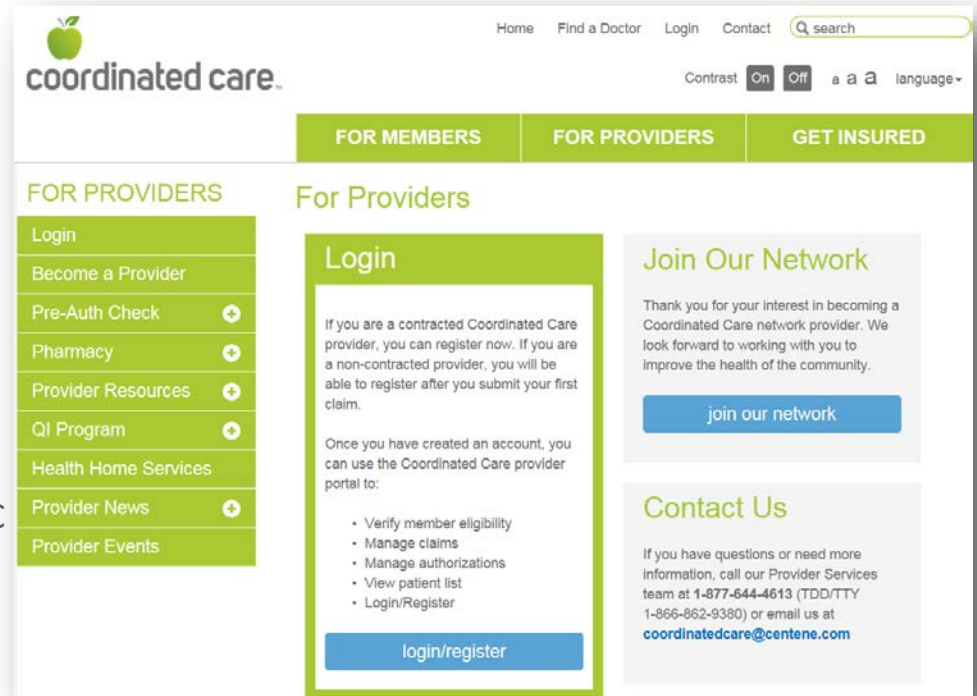
Websites, Portals & Directories



Coordinated Care Website

Provider Resources:

- Contracting & Operational Forms
- Provider & Billing Manuals
- HEDIS Guides
- Clinical & Payment Policies
- Clinical Practice Guidelines
- Provider Newsletters and Announcements
- Preferred Drug List
- Verify Prior Auth requirements by CPT/HCPC
- EDI Claims Submission
- Grievance Process



Coordinated Care Provider Network

Coordinated Care's Directory, including Behavioral Health Providers, can be found online at:

<https://providersearch.coordinatedcarehealth.com/>

In the upper right hand corner, select "Coordinated Care Medicaid"

Menu coordinated care Coordinated Care Medicaid English

Map Satellite United States

Denver Fort Collins Colorado Springs Pueblo Colorado Kansas City Lawrence Kansas Wichita Springfield Missouri Mark Twain National Forest St. Louis Columbia Illinois Springfield Indiana Indianapolis Ohio Columbus Cincinnati Louisville Lexington Kentucky Evansville West Virginia Virginia Richmond Norfolk Virginia Beach Maryland New Jersey Delaware Washington Philadelphia

Google Map data ©2017 Google, INEGI Terms of Use

Welcome to Find a Provider
Use your current location or enter one in.

Use My Location OR Address, Zip code or County
e.g 124 Elm st... Set Location

Find a HealthCare Provider



Quick Name
Search



Detailed
Search



My
Favorites



Enter a starting location

Perform a "Quick Name" Search, or

Detailed Search (Open Weekends,
Accepting new Patients, Patient
Centered Medical Home, etc.)

Detailed Search

Enter Name

Type of Provider

Change your Starting Address or Zip Code

Additional Search Options

Search

Coordinated Care Provider Portal

Provider Resources:

- User Manual
- Check Member Eligibility
- View Member Care Gaps
- View Patient Lists
- View PCP Info & History
- Submit Prior Auth Requests
- Submit, View, and Correct Claims
- Claims Audit Tool
- View Payment History

The screenshot shows the homepage of the Coordinated Care Provider Portal. The header features the 'coordinated care' logo with an apple icon and the 'ambetter. from Coordinated Care' logo. Navigation links for 'Features', 'Join Our Network', and 'CREATE ACCOUNT' are in the top right. A central banner reads 'The Tools You Need Now!' with the text 'Our site has been designed to help you get your job done. Manage all products with ease in one location'. Below this, three main service areas are listed with icons: 'Check Eligibility' (thumbs up icon), 'Authorize Services' (checkmark icon), and 'Manage Claims' (dollar sign icon). On the right side, there is a 'Login' section with fields for 'User Name (Email)' and 'Password', a 'Login' button, and a link for 'Forgot Password / Unlock Account'. Below the login section, there is a 'Need To Create An Account?' section with a 'Create An Account' button and a 'How to Register' section with a 'Provider Registration Video' button.

Coordinated Care ID Cards

IMC

BHSO

AHFC




NAME:
 MEDICAID ID#:
 MEMBER ID#:
 DOB:

RXBIN: 004336
 RXPCN: MCAIDADV
 RXGRP: RX5435

If you have an emergency, call 911 or go to the nearest emergency room (ER).
 Emergency services by a provider not in the plan's network will be covered without
 prior authorization. CoordinatedCareHealth.com




NAME:
 MEDICAID ID#:
 MEMBER ID#:
 DOB:

BEHAVIORAL HEALTH
 SERVICES ONLY
 (BHSO)

If you have an emergency, call 911 or go to the nearest emergency room (ER).
 Emergency behavioral health services by a provider not in the plan's network will be
 covered without prior authorization. CoordinatedCareHealth.com




NAME:
 MEDICAID ID#:
 MEMBER ID#:
 DOB:

Apple Health Core Connections

RXBIN: 004336
 RXPCN: MCAIDADV
 RXGRP: RX5435

If you have an emergency, call 911 or go to the nearest emergency room (ER).
 Emergency services by a provider not in the plan's network will be covered without
 prior authorization. CoordinatedCareHealth.com

IMPORTANT TELEPHONE NUMBERS

Members: ALL Member Services: 1-877-644-4613 TDD/TTY: 1-866-862-9380 24/7 NurseWise: 1-877-644-4613	Providers: Provider Services & IVR Eligibility Inquiry: 1-877-644-4613 Prior Auth: www.CoordinatedCareHealth.com or 1-877-644-4613 Pharmacy: 1-866-716-5099
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Medical and Behavioral Health Claims: Coordinated Care 1145 Broadway, Suite 300 Tacoma, WA 98402 Attn: Claims PO Box 4030 Farmington, MO 63640-4197	Coordinated Care 1145 Broadway, Suite 300 Tacoma, WA 98402 EDI/EFT/ERA please visit Provider Resources at www.CoordinatedCareHealth.com
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IMPORTANT TELEPHONE NUMBERS

Members: Member Services: 1-877-644-4613 TDD/TTY: 1-866-862-9380 24/7 Nurse Advice Line: 1-877-644-4613	Providers: Provider Services & IVR Eligibility Inquiry: 1-877-644-4613 Prior Auth: CoordinatedCareHealth.com or 1-877-644-4613
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Behavioral Health Claims: Coordinated Care Attn: Claims PO Box 4030 Farmington, MO 63640-4197	Coordinated Care 1145 Broadway, Suite 300 Tacoma, WA 98402 EDI/EFT/ERA please visit Provider Resources at www.CoordinatedCareHealth.com
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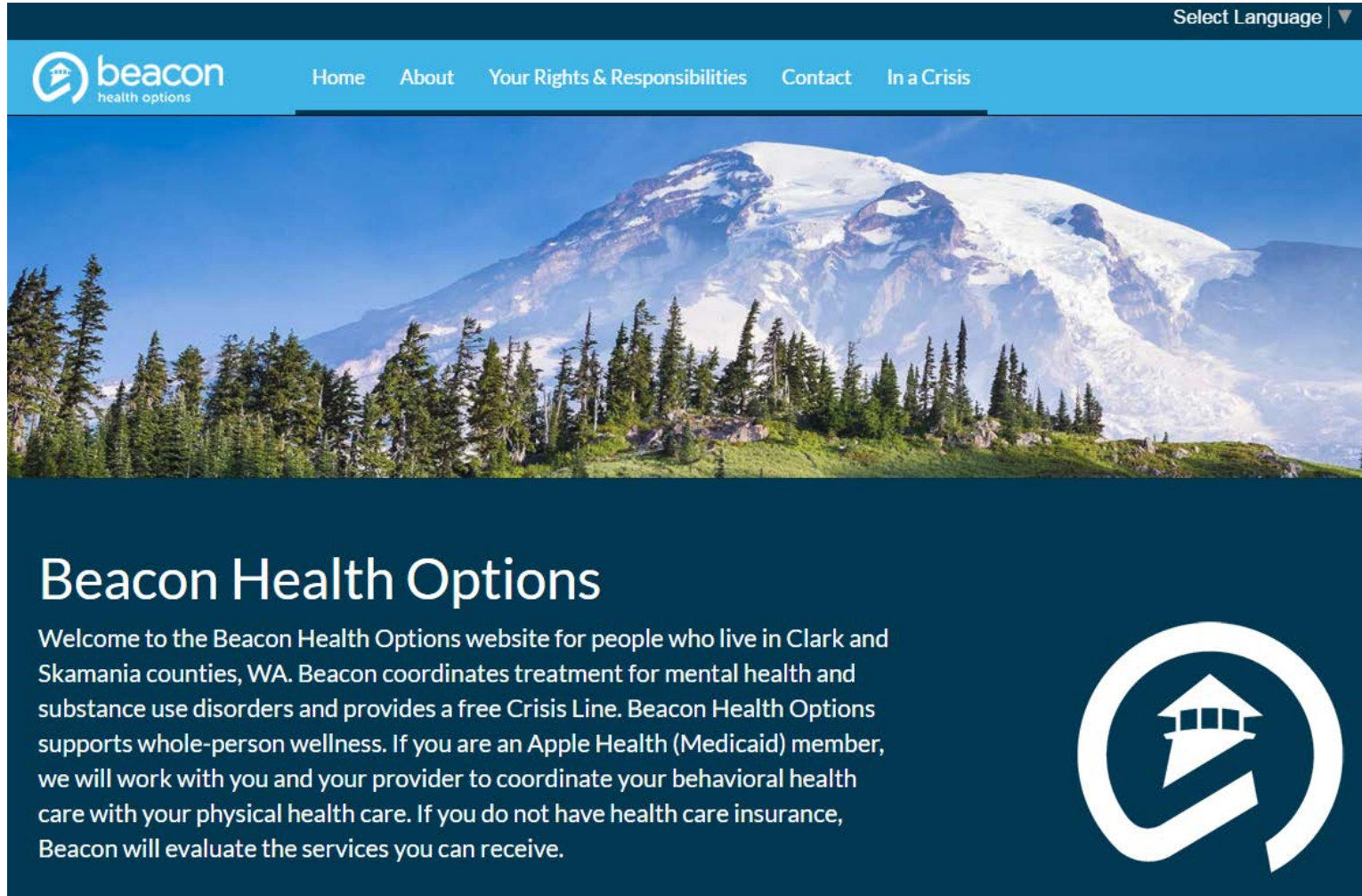
IMPORTANT TELEPHONE NUMBERS

Members: ALL Member Services: 1-844-354-9876 Relay 711 24/7 Nurse Advice Line: 1-844-354-9876	Providers: Provider Services & IVR Eligibility Inquiry: 1-844-354-9876 Prior Auth: CoordinatedCareHealth.com or 1-844-354-9876 Pharmacy: 1-800-311-0591
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Medical and Behavioral Health Claims: Coordinated Care Attn: Claims PO Box 4030 Farmington, MO 63640-4197	Coordinated Care 1145 Broadway, Suite 300 Tacoma, WA 98402 EDI/EFT/ERA please visit Provider Resources at www.CoordinatedCareHealth.com
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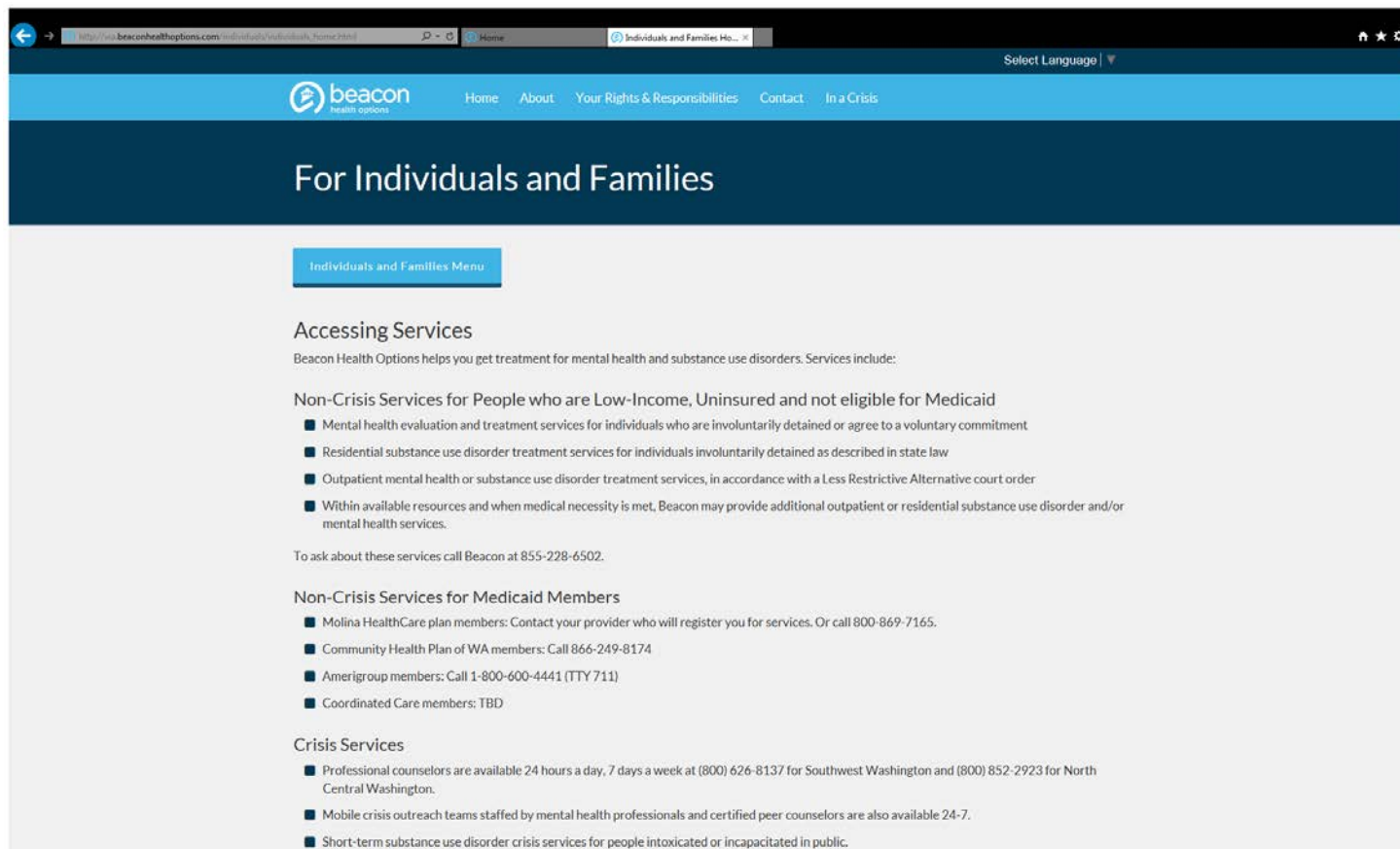
Beacon Health Options Website

Beacon's website : www.wa.beaconhealthoptions.com



Beacon Provider Directory

- Go to www.wa.beaconhealthoptions.com
- Choose “For Individuals and Families”



ProviderConnect - Services

Services of ProviderConnect:

- | | |
|--|--|
| • Verify member benefits and eligibility | • View and print forms |
| • Request and view authorizations | • Access Provider Summary Vouchers (PSV) |
| • Submit claims and view status | • Submit recredentialing applications |
| • Submit updates to provider demographic information | • Submit customer service inquiries |

**INCREASED CONVENIENCE, DECREASED
ADMINISTRATIVE PROCESSES**

How to Access ProviderConnect

- Go to www.wa.beaconhealthoptions.com
 - Choose “For Providers”
 - Choose “Log In”



The screenshot shows the ProviderConnect login interface. At the top, there is a navigation bar with the logo on the left and links for 'ValueOptions Home', 'Provider Home', 'Contact Us', and 'Log In' on the right. The main heading is 'Please Log In'. Below this, a note states: 'Required fields are denoted by an asterisk (*) adjacent to the label.' A grey box contains the instruction: 'Please log in by entering your User ID and password below.' There are two input fields: the first is labeled '*User ID' and the second is labeled '*Password'. Below the password field is a blue link that says 'Forgot Your Password?'. A 'Log In' button is positioned below the input fields. At the bottom, a text box contains a disclaimer: 'The information and resources provided through the Beacon Health Options site are provided for informational purposes only. Behavioral health providers utilizing the Beacon Health Options site ("Providers") are solely responsible for determining the appropriateness and manner of utilizing Beacon Health Options information and resources in providing services to their patients. No information or resource provided through the Beacon Health Options site is intended to substitute for the professional judgment of a behavioral health professional. Providers are solely responsible for determining whether use of a resource provided through Beacon Health Options is consistent with their scope of licensure under applicable laws and ethical standards.' Below the disclaimer, it says: 'It is recommended that you use Internet Explorer when using ProviderConnect. Other internet browsers may not be compatible and may result in formatting or other visible differences.'

Reporting Provider Changes/Updates

Amerigroup, Beacon, Coordinated Care, and Molina providers must give notice **at least 60 days** in **advance** of any provider changes such as:

- Provider Terms
- Provider Adds/Updates
- Tax ID Changes
- Group and/or Individual NPI
- Billing and/or Pay to addresses
- Clinic locations (where services are rendered)

Please submit changes/updates to:

Entity	Email Address
Amerigroup	waopsrequest@amerigroup.com
Beacon Health	Via Provider Connect website
Coordinated Care	Contracting@CoordinatedCareHealth.com
Molina Healthcare	MHWProviderInformation.QNXTChanges@MolinaHealthcare.com

Note: *Claims processing errors, rejections, denials and/or delays are often due to outdated and/or incorrect Provider information in our systems.*

Claims & Billing



Claims / Encounters Submission

Unless otherwise allowed for in your contract with the MCO, you must submit claims or encounters in one of the following ways:

- Electronic Data Interchange (EDI) 837 transaction (*preferred method*)
 - These are done through a clearinghouse
- Direct entry through the MCO's provider web portal
 - These can be done as single claim entry or through a batch upload
- Mailing in a paper claim
 - CMS-1500 for professional claims
 - UB-04 for institutional claims
 - All claim forms must meet CMS printing requirements and be printed in Flint OCR Red, J6983, ink
 - No handwritten claim forms or photocopies will be accepted

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (Self or ID) FECA (LUNG) OTHER (LUNG) (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE (MM | DD | YY) SEX (M | F)

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED (Self | Spouse | Child | Other)

7. INSURED'S ADDRESS (No., Street)

8. PATIENT STATUS (Single | Married | Other)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO: (a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO (b. AUTO ACCIDENT? YES | NO (c. OTHER ACCIDENT? YES | NO)

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. INSURED'S DATE OF BIRTH (MM | DD | YY) SEX (M | F)

13. EMPLOYER'S NAME OR SCHOOL NAME

14. INSURANCE PLAN NAME OR PROGRAM NAME

15. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES | NO) If yes, return to and complete item 9 a-d.

16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM | TO)

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? (YES | NO) \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

22. MEDICARE RESUBMISSION CODE ORIGINAL REF NO

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE (MM | DD | YY) B. PLACE OF SERVICE (CPT/HCPCS) C. TYPE OF SERVICE (CPT/HCPCS) D. MODIFIER E. DIAGNOSIS CODE F. CHARGES G. DAYS (EP/OT) H. PLAN I. ENG J. COB K. RESERVED FOR LOCAL USE

25. FEDERAL TAX ID NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE (8/88) PLEASE PRINT OR TYPE APPROVED CMB-0038-0008 FORM CMB-1001 (12/00) FORM RRB-1000 APPROVED CMB-1215-0005 FORM CMB-1001 (12/00) APPROVED CMB-0038-0008 FORM RRB-1000

Claim versus Encounter

- A claim is a bill for services for one member received for a specific date or date range.
 - Claims are paid a Fee-For-Service amount based on the provider's negotiated contract rate with the MCO.
 - Typically, each covered service provided to the member is individually paid based on an allowable amount.
 - Claims will generate an Explanation of Payment (EOP) detailing the payment or denial to the provider who submitted the claim.
- An encounter is a claim that is processed and paid at zero dollars because the provider has been pre-paid for these services per the terms of their contract.
 - Each line item or service provided is not paid an individual amount but rather the provider is typically paid a capitated amount for any and all services provided during a defined time period.
 - Even if you are under a capitated payment arrangement, you must submit encounter claims for each service provided for documentation and reporting purposes.

Providers are required to submit a claim for each service that is rendered to an MCO enrollee regardless of the provider's claims reimbursement arrangement.

Timely Filing / Clean Claim Definition

- The amount of time you have to file a claim is dependent on your specific contract terms with each MCO. Please refer to your contract and make note of your timely filing deadlines.
 - Timely filing is determined by the number of days between when the MCO receives a **clean claim** from you and the date of service.
 - Claims that are not received within the required timeframes will be denied and will not be paid unless there are extenuating circumstances (these are rare).
 - You must check the member's eligibility on each date of service to make sure you are timely billing the correct payer or MCO. Members can move around between managed care plans.
- Clean Claim – A clean claim is a claim that can be reprocessed without obtaining additional information from the provider of the service, or from a third party. A clean claim contains all the required data elements on the claim form (see each MCO's billing guide for claim form requirements).
- Non-Clean Claim – Non-clean claims include, but are not limited to, those that are rejected for missing data elements, submitted on incorrect forms, contain incorrect data (e.g. wrong member ID, invalid CPT/ICD code, etc.).

Rejected vs. Denied Claims

If you get a notice that your claim was rejected or denied, here is the difference:

Rejected

Does not enter the adjudication system due to missing or incorrect information.

Denied

Goes through the adjudication process but is denied for payment.

When billing electronically, your clearinghouse can send you reports of rejected claims (you may need to request this). You must work this report regularly to resolve the issues and resubmit claims. When sending in a paper claim, if it is rejected, it will be returned to you with a letter explaining the reason for the rejection.

A claim that rejects (non-clean or dirty claim) and does not enter the MCO's claims payment system to be assigned a claim number is not a clean claim and does not count towards timely filing calculations.

Most Common Rejection Reasons

- Missing or invalid required data elements or fields on claim form
 - Missing or invalid member DOB
 - Missing or invalid member ID number
 - Missing provider taxonomy code
 - Missing NPI number
 - Missing service date span
 - Missing CLIA number for lab claims
- Incorrect claim form used
- Photocopy of claim form
- Hand-written claim form
- Unreadable claim form
 - Ink too faded
 - Typing is not fully within the fields; i.e. misaligned
 - Ink bleeds into other fields
 - Font is too small

Corrected Claims

Appropriate when a provider is CHANGING the original claim.

- The amount of time you have file a corrected claim is dependent on your specific contract terms with each MCO. Please refer to your contract and make note of your timely filing deadlines.
- Cannot submit as a corrected claim on a rejection since rejected claims do not enter the system

Corrected Claims can be submitted in the following ways:

- By Paper
 - ❖ Institutional Claims (UB): Must be billed with corrected type of bill (XX7) in field 4, original claim number in field 64 and appropriate frequency code.
 - ❖ Professional Claims (HCFA): Must be billed with original claim number in field 22 along with the appropriate frequency code.
- By EDI
 - ❖ Institutional Claims (UB): Submit with appropriate frequency code.
 - ❖ Professional Claims (HCFA): Submit with appropriate frequency code.
- Web Portal
 - ❖ Corrected claims are submitted by clicking on the original claim, making corrections and submitting

Balance Billing



- Providers must accept payment by **Amerigroup, Coordinated Care or Molina Healthcare** as payment in full.
- Balance billing is not permitted unless the provider and member fully complete and sign an HCA 13-879 form--*Agreement to Pay for Healthcare Services*. *See WAC and HCA Memo in final bullet below for additional information.*
- Services must be rendered within 90 days from signing the HCA 13-879 form, otherwise a new form must be completed and signed.
- The HCA 13-879 form must be translated into the member's primary language if he or she has limited English proficiency, and if necessary, an interpreter must be provided for the member. If an interpreter is used to complete and sign the form, the interpreter's signature must also be obtained.
- All other requirements for the HCA 13-879 form apply, as outlined in WAC 182-502-0160, 42 CFR 447.15, and HCA Memo #10-25.

Claim Reconsiderations

For information regarding what is needed to submit a provider appeal / claim dispute, please visit each MCO's Provider Manual, available online at:

Amerigroup:

https://providers.amerigroup.com/ProviderDocuments/WAWA_Provider_Manual.pdf

Please refer to the Provider Manual for documentation to accompany requests for reconsideration.

Coordinated Care:

<http://www.coordinatedcarehealth.com>

All reconsiderations/claim disputes must be accompanied by the ***Provider Request for Reconsideration and Claim Dispute Form*** included in the Provider Manual. Must be filed within 24 months from the date of the original EOP.

Molina Healthcare:

<http://www.molinahealthcare.com/providers/wa/medicaid/manual/Pages/provman>

Please refer to the Provider Manual for documentation to accompany requests for reconsideration. Submit to:

MHWProviderServicesInternalRep@Molinahealthcare.com

Electronic Funds Transfer & Remittance Advice (EFT/ERA)

Benefits of signing up for EFT/ERA:

- Receive payments automatically in the bank account of your choice
- Receive email notification immediately upon payment
- View/print/save your remittance advice online
- Download an 835 file to use for auto-posting
- Historical EOP search by various methods (i.e. claim number, member name)
- Create custom reports

Amerigroup	Coordinated Care	Molina Healthcare	Beacon
www.Availity.com	www.payspanhealth.com	https://providernet.adminsource.com/Start.aspx	www.payspanhealth.com
800-454-3730	877-331-7154	877-389-1160	877-331-7154
	ProviderSupport@payspanhealth.com	wco.provider.registration@emdeon.com	corporatefinance@beaconhealthoptions.com

Claim Submission – Coordinated Care

Provider Billing Manual: www.coordinatedcarehealth.com

Electronic Claims Submission:

- Coordinated Care Electronic Payer ID: 68069
- Telephone for EDI Assistance: 1-800-225-2573 ext. 25525
- Email contact for EDI Assistance: EDIBA@centene.com

Sign-up to submit claims online via the Provider Portal:

- <http://www.CoordinatedCareHealth.com/>
- Telephone for Provider Services: 1-877-644-4613

To submit paper claims:

Coordinated Care
Claim Processing Department
P. O. Box 4030
Farmington, MO 63640-4197

**Coordinated Care's
timely filing for all
first time Medicaid
claims is 365 days**

Claim Submission- Beacon ProviderConnect

- Accepts claims files from any Practice Management System outputting HIPAA formatted 837 batch files, and from EDI claims submission vendors
- Offers Direct Claims Submission on website for providers who do not have own software or who wish to submit certain claims outside their batch files
 - These claims are processed immediately and you are provided the claim number
 - You may submit batch claims files or Direct Claims interchangeably
- No charge for electronic claims submission
- Access to support:
 - <https://www.beaconhealthoptions.com/providers/beacon/handbook/>
 - EDI Helpdesk: 888-247-9311 between 8 a.m.-6 p.m. ET

Tips for Claim Submission Success

- When submitting any claim, be sure to complete all required fields
 - Providers: Tips for completing the CMS-1500 or UB04 located under [Administrative Forms](#)
 - Direct claim submission: Required fields designated with an asterisk (*)
 - Batch claim submission: Follow the Implementation and Companion Guides located on the [ProviderConnect resource page](#)
 - Beacon Health Options Washington State Provider Handbook:
 - <http://wa.beaconhealthoptions.com/providers/files/WA-State-ASO-Provider-Handbook-Supplemental-Appendix.pdf>

Direct Claim Submission

The screenshot displays the Beacon Health Options ProviderConnect interface. At the top, the header includes the logo, a 'Switch Account' dropdown menu set to '123456-General Account', and navigation links for 'ValueOptions Home', 'Provider Home', 'Contact Us', and 'Log Out'. A left-hand sidebar lists various user functions such as 'Home', 'Specific Member Search', 'Register Member', 'Authorization Listing', 'Enter an Authorization Request', 'Enter a Treatment Plan', 'View Clinical Drafts', 'Enter a Special Program Application', 'Complete Provider Forms', 'Enter a Comprehensive Service Plan', 'Claim Listing and Submission', 'Enter EAP CAF', 'Manage Users', 'Enter an Individual Plan', 'Enter Case Management Referral', 'Enter a Referral', 'Review Referrals', 'Enter Bed Tracking Information', 'Search Beds/Opening', 'EDI Homepage', 'Enter Member Reminders', 'On Track Outcomes', 'Reports', and 'Print Spectrum Release of'. The main content area features a welcome message for 'PETER TUMNUS', a message center notification for '(8 NEW) Message', and a section titled 'WHAT DO YOU WANT TO DO TODAY?'. This section contains several expandable menu items. The 'Enter or Review Claims' menu is expanded, revealing options: 'Enter a Claim' (highlighted with a red box and a red arrow), 'Enter EAP CAF', 'Review a Claim', 'View My Recent Provider Summary Vouchers', and 'PaySpan'. Other visible menu items include 'Link/Unlink Accounts', 'Eligibility and Benefits', 'Enter or Review Authorization Requests', 'Enter or Review Referrals', 'Enter Bed Tracking Information', 'Search Beds/Opening', 'Update Demographic Information', 'Update Roster Information', and 'Update ABA Paraprofessional Roster Information'.

PROVIDERCONNECT
BEACON HEALTH OPTIONS

Switch Account 123456-General Account ValueOptions Home Provider Home Contact Us Log Out

Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization Request
Enter a Treatment Plan
View Clinical Drafts
Enter a Special Program Application
Complete Provider Forms
Enter a Comprehensive Service Plan
Claim Listing and Submission
Enter EAP CAF

Manage Users
Enter an Individual Plan
Enter Case Management Referral
Enter a Referral
Review Referrals
Enter Bed Tracking Information
Search Beds/Opening
EDI Homepage
Enter Member Reminders
On Track Outcomes
Reports
Print Spectrum Release of

Welcome PETER TUMNUS . Thank you for using Beacon Health Options ProviderConnect.

YOUR MESSAGE CENTER (8 **NEW**) Message

Click on inbox to view your messages

WHAT DO YOU WANT TO DO TODAY?

- [Link/Unlink Accounts](#) **NEW**
- ▾ [Eligibility and Benefits](#)
 - [Find a Specific Member](#)
 - [Register a Member](#)
- ▾ [Enter or Review Authorization Requests](#)
 - [Enter an Authorization Request](#)
 - [Enter an Individual Plan](#)
 - [Enter a Special Program Application](#)
 - [Enter a Comprehensive Service Plan](#)
 - [Enter a Treatment Plan](#)
 - [Review an Authorization](#)
 - [Update Monthly Wage Information](#)
 - [View Clinical Drafts](#)
- [Enter Member Reminders](#)
- [Enter Case Management Referral](#)
- ▾ [Enter or Review Claims](#)
 - [Enter a Claim](#)
 - [Enter EAP CAF](#)
 - [Review a Claim](#)
 - [View My Recent Provider Summary Vouchers](#)
 - [PaySpan](#)
- ▾ [Enter or Review Referrals](#)
 - [Enter a Referral](#)
 - [Review Referrals](#)
- [Enter Bed Tracking Information](#)
- [Search Beds/Opening](#)
- [Update Demographic Information](#)
- [Update Roster Information](#)
- [Update ABA Paraprofessional Roster Information](#)

Batch Claim Submission

The screenshot displays the Beacon Health Options ProviderConnect web application. The top navigation bar includes a 'Switch Account' dropdown set to '123456-General Account', and links for 'ValueOptions Home', 'Provider Home', 'Contact Us', and 'Log Out'. The left sidebar contains a list of navigation options, with 'EDI Homepage' highlighted by a red box and a red arrow pointing to it. The main content area features a welcome message for 'PETER TUMNUS', a message center notification for 8 new messages, and a section titled 'WHAT DO YOU WANT TO DO TODAY?' with various action links categorized under dropdown menus.

PROVIDERCONNECT
BEACON HEALTH OPTIONS

Switch Account 123456-General Account ValueOptions Home Provider Home Contact Us Log Out

Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization Request
Enter a Treatment Plan
View Clinical Drafts
Enter a Special Program Application
Complete Provider Forms
Enter a Comprehensive Service Plan
Claim Listing and Submission
Enter EAP CAF

Manage Users
Enter an Individual Plan
Enter Case Management Referral
Enter a Referral
Review Referrals
Enter Bed Tracking Information
Search Beds/Opening
EDI Homepage
Enter Member Reminders
On Track Outcomes
Reports
Print Spectrum Release of

Welcome **PETER TUMNUS** . Thank you for using Beacon Health Options ProviderConnect.

YOUR MESSAGE CENTER (8 **NEW**) Message

Click on inbox to view your messages

WHAT DO YOU WANT TO DO TODAY?

- [Link/Unlink Accounts](#) **NEW**
- ▾ [Eligibility and Benefits](#)
 - [Find a Specific Member](#)
 - [Register a Member](#)
- ▾ [Enter or Review Authorization Requests](#)
 - [Enter an Authorization Request](#)
 - [Enter an Individual Plan](#)
 - [Enter a Special Program Application](#)
 - [Enter a Comprehensive Service Plan](#)
 - [Enter a Treatment Plan](#)
 - [Review an Authorization](#)
 - [Update Monthly Wage Information](#)
 - [View Clinical Drafts](#)
- [Enter Member Reminders](#)
- [Enter Case Management Referral](#)
- ▾ [Enter or Review Claims](#)
 - [Enter a Claim](#)
 - [Enter EAP CAF](#)
 - [Review a Claim](#)
 - [View My Recent Provider Summary Vouchers](#)
 - [PaySpan](#)
- ▾ [Enter or Review Referrals](#)
 - [Enter a Referral](#)
 - [Review Referrals](#)
- [Enter Bed Tracking Information](#)
- [Search Beds/Opening](#)
- [Update Demographic Information](#)
- [Update Roster Information](#)
- [Update ABA Paraprofessional Roster Information](#)

INBOX SENT

Prior Authorizations



Prior Authorization (PA) Requests

Prior Authorization of covered services to allow for determination of medical necessity prior to rendering of a service.

Amerigroup, Coordinated Care, and Molina follow HCA contractual requirements on standard and urgent response times as follows:

Standard PA Requests: 5 days – 14 days

Urgent PA Requests: 24hrs – 72hrs

Turnaround times are extended if additional information is required. To avoid delays, providers must submit complete information with the initial request.

High Level PA Overview

Amerigroup, Coordinated Care and Molina Healthcare are in alignment on prior authorization for behavioral health services:

Prior Authorization	Notification and Concurrent Review	Notification Only
• Sub Acute Detoxification/Withdrawal management • Residential Treatment Facility • Partial Hospitalization • Psychological Testing (no PA required for first 2 units of service) • ECT (Electroconvulsive Therapy) & TMS • ABA (Applied Behavior Analysis)	• Inpatient hospitalization for MH and SUD diagnoses • *High Intensity Outpatient/Community Based Services (eg. WISe, PACT) <i>*Coordinated Care only</i>	• High Intensity Outpatient/Community Based Services (eg. WISe, PACT)

Coordinated Care Prior Authorization

Use the Pre-Auth Check Tool on our website to determine if Prior Authorization is required.

- Not a guarantee of payment, please verify benefit coverage/limitations in the HCA guides
- Emergency stabilization services exempt

PA Requests:

- Submit via Secure Web Portal or Prior Auth Fax form on the website
- Standard request have a 5-14 calendar day TAT
- Urgent requests have a 48hr TAT

Covered services by non-network providers:

- When Continuity of Care applies, members are able to access care up to 90 days with previous provider
- PA is required for many covered services, excluding urgent/emergent
- Reimbursed using HCA's fee schedule

Are services being performed in the emergency department or urgent care center or are these family planning services billed with a contraceptive management diagnosis?

☐ Yes ☒ No

Types of Services

YES NO

Is the member being admitted to an inpatient facility?

☐ YES ☒ NO

Are professional services being rendered in the home? (professional services do not include the delivery of DME, orthotics, prosthetics, or supplies).

☐ YES ☒ NO

Are anesthesia being rendered for pain management or dental surgery?

☐ YES ☒ NO

Are oral surgeon services being rendered in office?

☐ YES ☒ NO

Enter the code of the service you would like to check:

Code...

Check

Coordinated Care Inpatient Notification

Hospitals must obtain authorizations for ALL inpatient services.

- Some elective/scheduled admissions – Notification required at least 5 business days prior to the scheduled date of admission.
- Hospitals must notify the Coordinated Care Medical Management department of all admissions via the ER or newborn deliveries within 1 business day.
- Failure to obtain PA may result in administrative claim denials.

Request PA in one of the following ways:

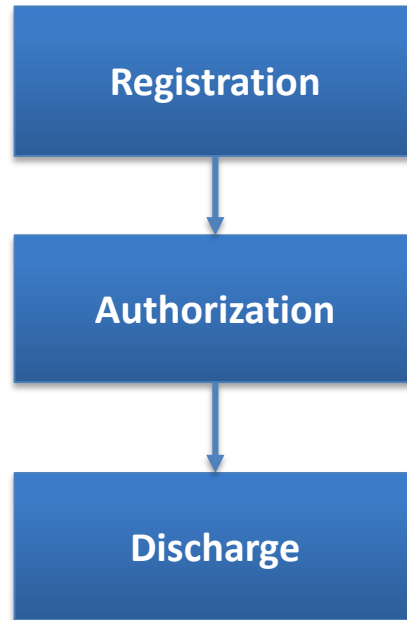
- Submit via Secure Web Portal (pre-scheduled)
- Inpatient Prior Auth Fax form on the website (pre-scheduled)
- Fax via census report to 877-212-6105 (admission notification)

Turn Around Times:

- Standard request = 5-14 calendar days
- Urgent requests = 48hrs

Request for Non-Crisis Services

- At beginning of treatment for individuals, providers must contact the Washington ASO by using ProviderConnect for the following:



Non-Crisis Services that Require Authorization

- Non-Crisis Services that require an authorization include
 - Residential Treatment
 - Intensive Outpatient
 - Day Supports
 - PACT
 - Respite Care
 - Psychological Testing
 - Clubhouse

Authorization Process

- All services can be requested via ProviderConnect and will pend for clinical review*
- If additional information is needed to determine medical necessity, Beacon will outreach telephonically
- Status of authorizations can be found on ProviderConnect
- All requests will be managed within URAC standards
- Registration should be completed prior to requesting authorization to determine individual's eligibility for the funding needed to provide services

*Note: Providers must be fully contracted and credentialed in order to submit authorizations via ProviderConnect

Member Grievance and Appeal • Interpreter Services
• HCA Transportation Brokers • MCO Forms • Helpful Links

Resources



Member Grievance and Appeal

- Member dissatisfaction pertaining to quality of care, the way the member was treated, problems getting care and billing issues can be reported to MCOs. The MCO will confirm receipt of grievance within two business days of receipt. Grievances will be resolved within 45 days and the member will be advised of the resolution.
- A Member or Member Representative may request an appeal for a denied service or authorization within 60 calendar days of the denial. For WISE appeals, please follow WISE Manual (there are different time requirements).

Member Grievance and Appeal

- For more information regarding the Member Grievance and Appeal process please visit each entity's Provider Manual:
 - Amerigroup:
https://providers.amerigroup.com/ProviderDocuments/WAWA_Provider_Manual.pdf
 - Beacon:
http://wa.beaconhealthoptions.com/providers/providers_manual.html
 - Coordinated Care:
<http://www.CoordinatedCareHealth.com/>
 - Molina:
<http://www.molinahealthcare.com/providers/wa/medicaid/manual/PDF/11-Denied-Claim-Review-and-Member-Appeals-2016.pdf>

Interpreter Services

All Amerigroup, Coordinated Care, or Molina members or potential members with a primary language other than English, or who are deaf or hearing impaired, are entitled to receive interpreter services free of charge. Interpreter services shall be provided as needed for all interactions with members including, but not limited to:

- Customer Service
- When receiving covered services from any provider
- Emergency Services
- Steps necessary to file grievances and appeals

Providers of covered outpatient medical services must arrange for interpreter services through HCA's interpreter service vendor CTS Language Link.

- For questions about eligibility for the services, providers can call (800) 535-7358



HCA Transportation Brokers

Medicaid clients may be eligible for non-emergency medical transportation, which can be arranged and paid for Medicaid clients with no other means to access medical care through HCA contracted brokers listed below. 7-14 days advance notice is recommended.

County	Broker	Phone
Chelan & Douglas	People for People	(509) 248-6793 1-800-233-1624 TDD/TTY: 800-606-1302
Grant	Special Mobility Services	(509) 534-9760 1-800-892-4817 TDD/TTY: (509) 534-8566 or 800-821-7167
Okanogan	People for People	(509) 248-6793 1-800-233-1624 TDD/TTY: 800-606-1302

MCO Forms

Form packets will be distributed and include:

- PCP Change
- Release of Information/Authorization for Use and Disclosure of PHI
- Prior Authorization Request
- BH Prior Authorization Request
- Care Management Referral
- Appeal Consent

Helpful Links

- Provider Manuals
 - Amerigroup:
https://providers.amerigroup.com/ProviderDocuments/WAWA_Provider_Manual.pdf
 - Beacon:
http://wa.beaconhealthoptions.com/providers/providers_manual.html
 - Coordinated Care:
<https://www.coordinatedcarehealth.com/providers/resources/forms-resources.html>
 - Molina:
<http://www.molinahealthcare.com/providers/wa/medicaid/manual/Pages/providermanual.aspx>
- WISE Manual-
<https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/WISE%20Manual%20v%201.7-FINAL.pdf>
- SERI: <https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/seri-cpt-information>
- HCA Billing Guides: <https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides>
- HCA 834 Eligibility Guide