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.

- Serving over 250,000 Washingtonians
- Coverage includes Medicaid, Foster Care, Health Benefit Exchange
- 360 Employees statewide with offices in Seattle, Wenatchee, Tacoma & Yakima
- NCQA Accreditation accredited as COMMENDABLE
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

- HCA
  - Fully Integrated MCO
  - BH-ASO
    - Required sub-contract
  - Fully Integrated MCO

Continuum of Integrated Clinical Services

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

<table>
<thead>
<tr>
<th>Maintain and Administer Crisis Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Maintain 24/7/365 regional crisis hotline</td>
</tr>
<tr>
<td>• Provide mental health crisis services, including mobile outreach team</td>
</tr>
<tr>
<td>• Administer Involuntary Treatment Act</td>
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<tr>
<td>• Administer Chemical Dependency Involuntary Commitment Act</td>
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<table>
<thead>
<tr>
<th>Manage SUD and MH braided Funding Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Proviso funds</td>
</tr>
<tr>
<td>• Federal Block Grant (MHBG &amp; SABG)</td>
</tr>
<tr>
<td>• Criminal Justice Treatment Account</td>
</tr>
<tr>
<td>• Dedicated Marijuana Account</td>
</tr>
<tr>
<td>• Jail Transition Services</td>
</tr>
<tr>
<td>• State General Funds</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Admin support, financial support and miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Behavioral Health Ombudsman</td>
</tr>
<tr>
<td>• FYSPRT &amp; CLIP</td>
</tr>
<tr>
<td>• State hospital liaison and Peer Bridger</td>
</tr>
</tbody>
</table>
IMC Overview
North Central IMC Go-Live

January 1, 2018

Chelan County
Douglas County
Grant County

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

<table>
<thead>
<tr>
<th>Financing</th>
<th>Care Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
<td>Physical Health</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Chemical Dependency</td>
<td>Chemical Dependency</td>
</tr>
</tbody>
</table>

Integrated Services
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?

Better medical care and outcomes for people living with chronic mental illness

Better identification and treatment of behavioral health conditions in primary care

Better integration of fragmented system through care coordination – no falling through cracks

Better inclusion of Social Determinants of Health

Triple Aim

Better health outcomes

Lower total cost of care

Better Patient/Provider experience
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.

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

<table>
<thead>
<tr>
<th>MCO</th>
<th>Credentialing Source</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup</td>
<td>• ProviderSource (OneHealthPort)</td>
<td>All credentialing correspondence and materials can be submitted to:</td>
</tr>
<tr>
<td></td>
<td>• CAQH</td>
<td><a href="mailto:WACredentialing@Amerigroup.com">WACredentialing@Amerigroup.com</a></td>
</tr>
<tr>
<td>Coordinated</td>
<td>• ProviderSource (OneHealthport)</td>
<td>All credentialing correspondence and materials can be submitted to:</td>
</tr>
<tr>
<td>Care</td>
<td>• CAQH</td>
<td><a href="mailto:CONTRACTING@CoordinatedCareHealth.com">CONTRACTING@CoordinatedCareHealth.com</a></td>
</tr>
<tr>
<td>Molina</td>
<td>• ProviderSource (OneHealthport)</td>
<td>All credentialing correspondence and materials can be submitted to:</td>
</tr>
<tr>
<td></td>
<td>• CAQH</td>
<td><a href="mailto:MHWProviderContracting@MolinaHealthcare.com">MHWProviderContracting@MolinaHealthcare.com</a></td>
</tr>
</tbody>
</table>
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
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.

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Appointment Wait Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care Appointment</td>
<td>Within 30 calendar days of request</td>
</tr>
<tr>
<td>Second Opinions</td>
<td>Within 30 calendar days of request</td>
</tr>
<tr>
<td>Routine Primary Care</td>
<td>Within 10 calendar days of request</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>24 hours/7 days</td>
</tr>
<tr>
<td>After-Hours Care</td>
<td>Available by phone 24 hours/seven days</td>
</tr>
<tr>
<td>Office Waiting Time</td>
<td>Should not exceed 30 minutes</td>
</tr>
<tr>
<td>Care Transitions – PCP Visit</td>
<td>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</td>
</tr>
<tr>
<td>Care Transitions – Home Care</td>
<td>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</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Behavioral Health Appointment Types</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life threatening</td>
<td>Immediately</td>
</tr>
<tr>
<td>Non-life threatening</td>
<td>Within 6 hours</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Routine care</td>
<td>Within 10 calendar days</td>
</tr>
</tbody>
</table>
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/HCPCS
- EDI Claims Submission
- Grievance Process
Coordinated Care’s Directory, including Behavioral Health Providers, can be found online at: [https://providersearch.coordinatedcarehealth.com/](https://providersearch.coordinatedcarehealth.com/)

In the upper right hand corner, select “Coordinated Care Medicaid”
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
Coordinated Care ID Cards

IMC

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

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

BHSO

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

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

AHFC

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

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: 1-866-866-9380
24/7 NurseWise: 1-877-644-4613

Medical and Behavioral Health Claims:
Coordinated Care
Attn: Claims
PO Box 4030
Farmington, MO 63640-4197

Behavioral Health Claims:
Coordinated Care
Attn: Claims
PO Box 4030
Farmington, MO 63640-4197

ProMedica
Attn: Claims
P.O. Box 768
Saginaw, MI 48601

ProMedica
Attn: Claims
P.O. Box 768
Saginaw, MI 48601

EDI/EFT/ERA please visit:
Provider Resources at www.CoordinatedCareHealth.com

Providers:
Provider Services & IVR Eligibility Inquiry:
1-877-644-4613
Prior Author: CoordinatedCareHealth.com

Important Telephone Numbers:
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Provider Services & IVR Eligibility Inquiry:
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Prior Author: CoordinatedCareHealth.com

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Coordinated Care
Attn: Claims
PO Box 4030
Farmington, MO 63640-4197

EDI/EFT/ERA please visit:
Provider Resources at www.CoordinatedCareHealth.com
Beacon Health Options Website

Beacon’s website: [www.wa.beaconhealthoptions.com](http://www.wa.beaconhealthoptions.com)

Beacon Health Options

Welcome to the Beacon Health Options website for people who live in Clark and Skamania counties, WA. Beacon coordinates treatment for mental health and substance use disorders and provides a free Crisis Line. Beacon Health Options supports whole-person wellness. If you are an Apple Health (Medicaid) member, we will work with you and your provider to coordinate your behavioral health care with your physical health care. If you do not have health care insurance, Beacon will evaluate the services you can receive.
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”
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:

<table>
<thead>
<tr>
<th>Entity</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup</td>
<td><a href="mailto:waopsrequest@amerigroup.com">waopsrequest@amerigroup.com</a></td>
</tr>
<tr>
<td>Beacon Health</td>
<td>Via Provider Connect website</td>
</tr>
<tr>
<td>Coordinated Care</td>
<td><a href="mailto:Contracting@CoordinatedCareHealth.com">Contracting@CoordinatedCareHealth.com</a></td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td><a href="mailto:MHWProviderInformation.QNXTChanges@MolinaHealthcare.com">MHWProviderInformation.QNXTChanges@MolinaHealthcare.com</a></td>
</tr>
</tbody>
</table>

**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
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. Member’s 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 returned to you will 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 to 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.
• 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:**

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

<table>
<thead>
<tr>
<th>Amerigroup</th>
<th>Coordinated Care</th>
<th>Molina Healthcare</th>
<th>Beacon</th>
</tr>
</thead>
<tbody>
<tr>
<td>800-454-3730</td>
<td>877-331-7154</td>
<td>877-389-1160</td>
<td>877-331-7154</td>
</tr>
<tr>
<td><a href="mailto:ProviderSupport@payspanhealth.com">ProviderSupport@payspanhealth.com</a></td>
<td><a href="mailto:wco.provider.registration@emdeon.com">wco.provider.registration@emdeon.com</a></td>
<td><a href="mailto:corporatefinance@beaconhealthoptions.com">corporatefinance@beaconhealthoptions.com</a></td>
<td></td>
</tr>
</tbody>
</table>
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
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:
Direct Claim Submission
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
- 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/Openings
  - Update Demographic Information
  - Update Roster Information
  - Update ABA Paraprofessional Roster Information
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:** 24 hrs – 72 hrs

Turnaround times are extended if additional information is required. To avoid delays, providers must submit complete information with the initial request.
Amerigroup, Coordinated Care and Molina Healthcare are in alignment on prior authorization for behavioral health services:

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

  - Registration
  - Authorization
  - Discharge
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

• 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:
  - Beacon: http://wa.beaconhealthoptions.com/providers/providers_manual.html
  - Coordinated Care: http://www.CoordinatedCareHealth.com/
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.

<table>
<thead>
<tr>
<th>County</th>
<th>Broker</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Chelan &amp; Douglas</td>
<td>People for People</td>
<td>(509) 248-6793</td>
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<tr>
<td></td>
<td></td>
<td>1-800-233-1624</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TDD/TTY: 800-606-1302</td>
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<tr>
<td>Grant</td>
<td>Special Mobility Services</td>
<td>(509) 534-9760</td>
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<td>1-800-892-4817</td>
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<td>TDD/TTY: (509) 534-8566 or 800-821-7167</td>
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<tr>
<td>Okanogan</td>
<td>People for People</td>
<td>(509) 248-6793</td>
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<td>1-800-233-1624</td>
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<tr>
<td></td>
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<td>TDD/TTY: 800-606-1302</td>
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</tbody>
</table>
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.amerigrou.../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/provman.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