Rapid Response call notes – 01/30/19

Agenda:

Roll Call by Organization
Client Eligibility or Client Enrollment Issues
Provider Encounter/claims/billing/authorization questions or issues
Crisis System Check-in
Opportunity for any other topics

The updated **HCA Rapid Response Question Tracker** mentioned below is available on the IMC webpage: http://www.betterhealthtogether.org/bold-solutions-content/rapid-response-notes

Outstanding Q/HCA update needed: Guidance on identifying AI/AN clients in ProviderOne?

HCA has tackled on the Question Tracker, question #65 (pg 32). It's a process of elimination to do that identification. If you have specific question about a client's eligibility, you can email hcaintegratedmcquestions@hca.wa.gov.

Outstanding Q/HCA update needed: When new providers come in, whether they're new to our system, we have them fill out a DOH application for agency affiliated or other applicable. Can they provide direct services 60 days from the date of hire, or is it 60 days from pending status with DOH? To even get the ProviderOne application started, we have to have a DOH credential. Can individuals provide services while this process is pending, either under a supervisory oversite with someone who is already fully credentialed with all of the systems, or do we need to wait, or can we provide services with the assumption that they're will be credentialing approval and then upload those with the MCOs once the individual is credentialed. Related Q: Can we have our new clinicians provide services before they get their ProviderOne number?

We continue to update as we get information from the health plans. We have added responses from health plans as we received them. See question #7 (pg 4) on the new HCA Question Tracker.

Outstanding Q/HCA update needed: Crisis services – how do we get paid if we are seeing a patient from outside the region with an IMC provider outside the region. Specifically, we have an adult Coordinated Care patient from Chelan-Douglas. HCA answer 1/23: There are some crisis stabilization services that you would contract directly with the plan. HCA has a meeting later today to work with all the ASOs across the state to figure out how to bill that when patients cross regional boundaries. We're working on developing a process and addressing these questions.

HCA working on directly with the ASOs to come up with a guidance document. Waiting to get feedback from them, then we'll share broadly. See question 64 in updated HCA Question Tracker.

Outstanding Q for MCOs: We have been told that all of the MCO's are using InterQual for their authorizations, however none of them can provide us with any of their "cheat sheets" for how to identify criteria for medical necessity, although HCA told them all that they could. Have you heard about this? We are at a loss, and I'm wondering if other providers have expressed this. (Excelsior)

Coordinated Care –We use InterQual. Any time we've gotten a request for criteria, we've shared that with providers.
Molina – Emailed a response previously (see below). We use InterQual for MH, ASAM for SUD. When we

get a question from a provider around a specific section of that content, because InterQual is proprietary, we are only allowed to release information as it relates to the specific question/need from a provider. Most of us have the ability to take one criteria set - like residential treatment or supervised living or withdrawal management - and send that out to providers in a read-only version. We can certainly do that on request.
All MCOs will be required later this year to make criteria available to providers, so we're working on solutions for that, how to make that available for viewing purposes.

Email from Molina 2/8/19

Not all of the IMC MCOs use InterQual, but we do. Some use MCG and some LOCUS. We all use ASAM for SUD.

HCA may give permission for us to make criteria accessible but our licensure with Change Healthcare (formerly McKesson) that owns InterQual has a slightly more limited perspective. Because the content is proprietary, we can provide it in the least or smallest increments necessary to satisfy the request being made. For example, we can provide a particular subset as it is referenced in a denial letter.
Looking ahead, the WAC language below states that contractors of the state have a deadline to make all criteria available and we are currently looking at potential solutions that will allow us to be compliant with this directive.

Bottom line, for the time being, if Excelsior (or any other provider) requests criteria from us, we can provide it in limited amounts related to their specific need.

WAC language regarding PA effective 11.1.19 including access to criteria.

http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-2050

(4) Effective November 1, 2019, a carrier or its designated or contracted representative must have a current and accurate online prior authorization process. All parts of the process that utilize personally identifiable information must be accessed through a secure online process. The online process must be accessible to a participating provider and facility so that, prior to delivering a service, a provider and facility will have enough information to determine if a service is a benefit under the enrollee's plan and the information necessary to submit a complete prior authorization request. A carrier with an integrated delivery system is not required to comply with this subsection for the employees participating in the integrated delivery system. The online process must provide the information required for a provider or facility to determine for an enrollee's plan for a specific service:

(a) If a service is a benefit;
(b) If a prior authorization request is necessary;
(c) What, if any preservice requirements apply; and
(d) If a prior authorization request is necessary, the following information:
(i) The clinical review criteria used to evaluate the request; and
(ii) Any required documentation.

(5) Effective November 1, 2019, in addition to other methods to process prior authorization requests, a carrier or its designated or contracted representative that requires prior authorization for services must have a secure online process for a participating provider or facility to complete a prior authorization request and upload documentation if necessary. A carrier with an integrated delivery system is not required to comply with this subsection for the employees participating in the integrated delivery system.

Amerigroup – not all MCOs use InterQual, Amerigroup uses Milliman (MCG) for MH and ASAM for SUD. They are very similar.

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Can we get a list of which systems each MCO is using?
The MCO FAQ document (http://www.betterhealthtogether.org/bold-solutions-content/mco-roundup) under authorization tab lists which system each MCO uses. Providers can reach out if you have a question about a certain level to a certain MCO.

New Q: For the record, I have procedure in place to check eligibility of all residents upon referral to treatment, again upon admit, again at the first of the month, and again at the 15th of the month.

That being said, I checked all of our residents' Provider One eligibility information on February 1st to ensure there were no changes to assigned MCOs. One client was admitted in January under AI/AN fee for service and when I checked his Provider One on February 1st, he still had no assigned FIMC care manager. I have a date/time stamped printout to reflect this. However, today he received a letter dated February 3, 2019 indicating he has been enrolled in Molina Healthcare and in Provider One, he now reflects MHC FIMC back-dated to February 1st.

Based on the rapid-response calls, I was under the impression any changes to managed care plans would only take place as of the first of the month – so any change implemented on February 3rd, for example, would not reflect until March 1. Is that not correct? And does this mean we need to be checking the eligibility of all behavioral health clients every day to ensure a change has not been implemented and back dated to the beginning of the month? (New Horizon)

First, very responsibility checking. Good process.

In 99% of cases, that is true that a change made Feb 3 would not reflect until March 1. The 1% would be for example, if you got a referral from someone coming out of Eastern State Hospital, and HCA cannot do anything to pre-assign to a plan and have to wait for client to show up in system. If for example the client is auto-assigned to CHPW, but the Molina liaison has already done all the work with this individual before release, Molina was expecting them, of course we would want to keep them with Molina. That's where somebody on the HCA implementation unit would go in and change the client's plan. That would be a situation where we would backdate the client's assignment to the first of the month to honor what had happened.

Don't think it's necessary to check every day. If you get rejected claims from an MCO, then you would want to take a look at eligibility to see if that had changed in the month. But that is not very common.

Another example of that 1% case would be for AI/AN clients, if there is something that an AI/AN client couldn't get covered thru their FFS network, there would be cases. It's an access to care issue, so if someone cannot access benefits and there is medical necessity and there is a need to get them into a managed care plan to get their needs covered, that would be a case where we would backdate to beginning of the month.

Generally speaking, no, it is not normal for changes to happen in the middle of the month. More likely in the case of someone stepping down from state hospital or potentially for an AI/AN client because that FFS network is smaller. Those would be the two most common situations. So you would not need to be checking every day.

A third scenario would be if they're with BH-ASO and you get an auth from them, and then they're discharged from our hospital, and then another provider signs them up for an MCO. The ASO auth is then no longer good, and even though they have been discharged from your hospital, we have to go back with the MCO and get the auth bc they are retro-ed back to the first of the month. (Providence)
HCA is working on a guidance document with each of the regions' ASOs on this. But yes, this is another

scenario.
Update - HCA ran this question past MCOs:
What happens when MCO enrollment is back-dated and services were already provided and paid for by the ASO? If the MCO is going to cover the services, will they provide a retro-authorization or just honor the authorization given by the ASO?
If a crisis related service, use the process of reconciling twice a year between MCO and ASO. The provider does not need to re-bill.
If a non-crisis related service, the ASO would need to recoup payment, then the provider would need to bill the MCO. MCOs would honor the ASO's authorization for services up to the date that the MCO becomes aware that the client was enrolled with them, assuming that normal rules for medical necessity under Medicaid applied to that authorization. MCOs would then be responsible for confirming ongoing authorization at the point they receive the enrollee on their 834.

How would the provider receive notification about the change in client enrollment in this case so that we can get a new authorization from the MCO, since the ASO one ends when the MCO finds out the client is enrolled with them? Or would they honor the length of the authorization, for example if the MCO finds out about the enrollment on the 15th but the ASO authorization was good thru the end of the month? (New Horizon)
MCOs would treat it as a concurrent review. So they discover that they are responsible for a person who is in a bed. They would reach out to the provider org to say, you have our client in a bed and we'll do a concurrent review to make sure they still qualify and do an authorization. The MCOs can't make you go back and make you figure something out for the days before the MCO was responsible.
So the MCOs would reach out to the provider?
Amerigroup- we just had a case like this in Spokane recently. When the member had been inpatient and when we found out that the person had been retro-ed back to Medicaid back to the first, what we asked the provider to do is submit the clinical information they had submitted previously to the BHO to us, the MCO. We can then process an internal authorization, because we still have to get an authorization into the system for the system to pay. So we just treat it like it's a regular authorization.
If we're not checking ProviderOne every day, how would we know that the enrollment had been retro-ed back to the beginning of the month to submit that clinical information to the MCO?
In this case, when the provider submitted the claim to the original party, the claim was denied because the client had retro-ed to Medicaid. Then the provider looked up eligibility and submitted the claim to the MCO.
How would we know then without checking every day if a client had changed and been backdated, if no one notifies us? In our case, we only knew because the client received a letter.
The MCOs don't get notified either. When you submit the claim and the claim is denied, then you would know and would submit it to the MCO.
Would that also apply to AI/AN, for this particular client? The claim would not have been submitted until March when we did February billing to the state. At that point they would have told us "no, that isn't our client." At that point, would we still be able to backdate the authorization to Feb. 1 and get payment from the MCO for the entire month of services we provided?
In a case like that of retro-eligibility, if you found out after the fact thru the claims process, then yes. You could submit to the MCO the circumstances of what happened, the medical record, and then we would review the hospitalization and all those days for medical necessity and provide authorization as appropriate.