Transcript for NC Medicaid Managed Care Hot Topics Webinar Series: Medicaid Hot Topics

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Chris Weathington

It's 530 let's get started. Good evening everyone and thank you for participating in this evening's Medicaid managed care back porch chat webinar. I'm Chris Worthington and I'll moderate tonight's webinar, tonight's discussion is produced by North Carolina Medicaid and NC AHEC to support providers across all 100 counties as you seek to adapt and thrive under Medicaid managed care. As a reminder, the back porch chat webinars occur on the third Thursday of the month on a variety of Medicaid managed care hot topics. This collaboration produces educational programming and virtual office hours across a variety of these topics. In addition, a practice support coaches are available to provide one to one assistance directly to practices at no cost. Note also that we will have a virtual office hour session next thursday from 4pm to 5pm to share information on how to support members transitioning to Medicaid direct information regarding the virtual office hours and other webinars are available on our NC AHEC Medicaid Managed Care website. And before I turn it over to Dr. Dowler, let me just read through some brief logistics. If you need technical assistance, just email us at technicalassistanceCovid19@gmail.com. Everyone, other than our presenters is muted in the chat function is turned off, you can ask questions or make comments, either by using the q&a feature on the black bar on the bottom of the webinar screen, or if you're dialing in by sending an email to questionscovid19webinar@gmail.com, the slides are available on the AHEC Medicaid Managed Care website, there is a link to them in the q&a box. We will record this webinar, and add that recording and a written transcript of the of this presentation. And the questions and answers on the NC AHEC website by tomorrow, or as soon as possible. We've learned in past webinars that the presenters will often address your questions during their presentations, we encourage you to wait until the presenters are through with their presentations before submitting a question and please know that for any questions we're unable to get to tonight, we will provide those answers and post on the NC AHEC, a Medicaid Managed Care website, tonight's webinar is running until 6:30pm So just so some of you who may think

that this is going to run a little bit longer. And now I'm going to go ahead and turn this over to Dr Dowler.

Dr. Shannon Dowler

Alright thanks Chris. Thanks for being here tonight, since Hugh left us, at least for the night. We appreciate you being here and that's it. As always thank you for the jammin music, it was particularly fun watching Chris keep trying to talk why the music kept playing. So we appreciate that start to our evening we have a full agenda as always, thanks to all of you that sent questions in advance we wanted to try something a little different this time. And our plan is to get through a bunch of those questions you sent in advance to make sure we answer them tonight. Make sure if you're putting questions in the chat if it's a plan specific question, if you'll put that in there, and then if you want it to be a private question, there's a way that they have where they can answer that question and have it just go to you and not to everybody. So if you have a plan specific question please notate that and if you'd like a private response, put that on there as well. All right, great, we are going to fly through the content. We do have a lot for you today but, as always, we'd like to start off with a little bit of where you are right now. So we've got an audience response question for you. So the first question is regarding contracting. Which of the following is true for your organization, to the best of your knowledge, you're fully contracted with all plans and you're done, you've contracted with everyone you plan to contract with and are done. There are others you want to contract with but you just haven't yet. There are others that you want to contract with but you're having trouble getting people to respond, or you've got a really long way to go, and you're starting to wonder if it's hopeless. So where are you in the contracting space, we'll just leave that up for a couple of seconds, and have Nevin show us the results. All right. Nice, I like it 65% fully contracted and are done, that's terrific. Those of you that are having trouble reaching folks, it looks like a few people had that answer, put that in the chat because in the q&a What plan you're having trouble reaching, they want to hear that tonight, so make sure you let them know that you're having trouble reaching them and you'd like to contract. Alright, we'll go on to the next slide.

I think we've got one more question for you. So it said if you're not fully contracted so for those of you that aren't fully contracted with every plan. I'm curious about what you think out of network is going to feel like how's that gonna impact your office and the beneficiaries you care for. So for those of you that aren't fully contracted or if you are fully contracted but you know people who aren't you get to answer this question as well and you can choose all that apply. You could say, Wait, we're gonna be out of network. Yeah, but but there's a date for that. If you're worried that your organization will decline to schedule or see patients from certain plans until they change plans, or if you'll see them urgently but then ask them to change plans, if you're going to see everybody just do your best to get paid. Your staff stand ready to help members change plans, you're maybe you're not worried about your office but you're actually worried about difficulty accessing hospital services so kind of where's it where are you on this one. And this is one that you can choose all that apply. And so Nevin let us know what people had to say about that. Okay, so a little bit all over the place. You're saying wait, we're gonna go out of network. Um, I have some good news on that today too, so if we're going to the next slide, thanks for that, we have a few more questions we're going to ask you later tonight.

This is just an update that RSV season is here, it's here really really early. Turns out all of our best evidence based guidelines did not plan for a pandemic. So as much as we are trying to use evidence to guide us. We had to get a little bit, spontaneous on this one we're seeing RSV rates at the full season rates. This summer, and that's obviously a problem for multiple reasons but it's co occurring with a surge of COVID, as well and so Medicaid get together with the pediatric infectious disease specialists around the state, the department of public health and epidemiology folks all the plan CMOs and we all put our heads together to come up with how we're going to respond to it and so we have open the season RSV season. As of now, so for your at risk, infants who qualify percentages, and we will cover it now, we're going to have the season go through March 31 we anticipate will probably have a very long season, and that we will give up to eight doses if it's appropriate. So just to let you know there's all the informations here and of course you can get the links. When you see the slides later but just making you aware of that. Next slide. Oh good. Another question. All right, what do we have,

Let's see what would make the biggest impact on increasing COVID vaccination rates and your community. So pick the thing that you think would have the biggest impact financial incentives for patients, financial incentives for providers, maybe more off hours vaccine availability evenings and weekends, coordinating information sessions with faith and community based local organizations or mass media outreach or advertisements. What do you think would make the biggest impact in increasing vaccination rates. All right, let's hear we got financial incentives for patients. That's good, I'm glad you think that that's what I think too, so I've been pushing focus on that, but also working with faith and community based organizations, those are that's really helpful. All right, if you go to the next slide. This is just a reminder that you all are so very important in helping folks understand the vaccine. The risks the benefits the alternatives, and I want to make sure that you're getting paid for the work that you're doing and so this is just a reminder it's been out here since June 22, 99401 is vaccine counseling code, it's for physicians, nurse practitioners, physician assistants, and certified nurse midwives can bill for this code, we want you to use it, we want you to use it often, ideally you pair it with offering vaccine in your office, we think that's the most effective way, you counsel in the give them a shot when they say they're ready. We know that's not going to be practical for everybody out there, we sure hope you will we hope that reimbursing you for this hard work will help you spend the time that it takes to do this. Next slide.

All right, we got one more question coming up, let's see what we've got. Has the surge in COVID infections over August impacted your practice, how has the surge, obviously it's impacted your practice choose all that apply. So you're overwhelmed with sick visits, You're having trouble staffing because of sick staff members, your volumes of visits are way down because nobody's coming in, you're shifting back to virtual or telehealth now you're thinking about shifting back to virtual or telehealth or none of these really apply to your practice. So where are you now with the surge. Oh, interesting. So spread, a lot of trouble staffing seems to be a common one, and that is what I have heard from colleagues and friends as well. All right, great. Thank you. We'll go to the next slide.

So this is just an alert in case you missed the memo tailored plans or announced, and we have already started the hard work so we have an entire team working on developing tailored plan so they're ready for launch. Well the work of developing has been happening for three years but the final steps of operationalizing and making it happen. So in less than a year from now we're gonna have tailored plans, this is really important step in our journey divine health, the integration of physical and behavioral health is so important to the department, and we think for our beneficiaries. So just making you aware that's coming so you'll start seeing some of the chats coming up having more information on the tailored plans to give you an idea as well in advance of what you can expect coming. Alright, next slide. So one of the things we heard from folks is they would really like to have more interactive time with the plans and the plan said but we're doing this, and so we said, Great, let's put it together in one place, so that the providers can see where there's office hours are. So this grid tells you for each plan when their office hours are, where you can get on and have an interactive discussion troubleshooting a lot of the times it takes 20 emails to fix something that could happen on one conversation sometimes doing an office hour is really the easiest way to get things done. So making sure you know about these office hours that the plans are offering. Okay, next slide.

All right, this is the money part, electronic payments, so your banking information and nctracks did not transfer to the health plans, we did not give away your banking information which seems totally appropriate. You don't want to be like me and get a call I got a call last night from my eldest son who said hey mom, by the way I paid my tuition today. They said well that's great. What did you pay it with it goes oh your checking account. So then that was followed by rapid emails from the bank and transferring funds but we did not move your banking information to the plan so you've got to do that you have to register your information. So here's the link to this, I feel like most of you probably know this, but just in case you don't hear it is all the plans should offer a free electronic funds transfer option. So, code word free, we know there was a little luckiness early on, that has been fixed, so no one should be charging you for electronic funds transfer if you find that is still happening. We would like you to let us know, we do not think that's happening anymore. Next slide.

All right, guidance for providers experiencing payment issues we have definitely heard the feedback from the field, that the delay in payment has happened for some specialties more than others. There are prompt payment guidelines so there's interest and penalties that'll apply that won't help you now if you're having trouble making payroll because of a delay. So we want to make sure that you have access to hardship payments. This process is in here, the links are in here, it should be through the PHPs you should reach out to the PHPs but if you are not getting what you need, with the hardship payments, we want you to reach out to the provider ombudsman so there's the link, there's the phone number. When it comes to the provider ombudsman we escalate it right away, So if you're having difficulty making payroll, you need a hardship payment but you're not getting resolution, please please please let us know. We don't want that happening. We promise that wouldn't happen. We do not want to happen. All right, next slide. All right audience response question. In what ways can the plans the PHPs best support providers with the rising rates of COVID infections. So what could they do, and this is a choose all that apply. Support members with social resources so food and home care other things, reduce administrative burden Office supports helping out with PP telehealth capabilities, things like that,

supporting vaccine efforts or providing clinical best practice update so these are just some ideas of things plants could do which of these would be meaningful for you and help you in combating the rising rates of COVID infection. So choose all that apply. Let's see what we've got. All right. Not surprisingly, reducing administrative burden so we've got some good news on that at least first, that will help with some of it a little bit later in the chat. Great, great suggestions here. All right. One of the things that we have heard from the plans is that initially there were a lot of the claims that didn't have the provider taxonomies, and it got better and now it seems like it's getting worse again so just remember there's that we have some links on this slide, that help direct your business offices on how to submit your claims and making sure that the taxonomies are on there correctly. So we just put this back in the deck to bring it to your attention because that does seem to be a cause for claims denials, and it's something that's totally avoidable, so we want you to avoid it when at all possible, and it's on the provider side. So, the links are on this slide for you to look at and share with your business office. All right, next slide.

Okay, so the bottom line, we're all in this together. All of us are going to have to be worked together to be successful in this. Ultimately we want our members to have access to services. We want providers to get paid, so that our members have access to services, and we want to work collaboratively and that's exactly what we've done. We have worked really well together I think hearing your feedback these chats have been really important for you, giving us information, your advocacy groups give us lots of information that we can act on your feedback to the provider ombudsman, but there are all sorts of ways we're getting information we're working together to fix things to help the folks in the state who have Medicaid to help the plans provide the services to help riders get what they need, and we're all working together. To that end, we have definitely seen over the last month as COVID rates have risen, as we've seen claims lag a little further than we would like because of some technology issues and other things that, that a lot of folks aren't ready for the next step of managed care. And so the provision that we had made to extend the out of network period, we made the decision to extend it a little bit further. So if you will go to the next slide. This decision was made with the plans. They are have been partners in this all along and has definitely given feedback about what things that might help in the future for us to do and so there's a bulletin that's out now, it probably came out about 20 minutes before the back porch chat started, and that goes into more details but essentially the extensions we put into place in order for the month of August are going to be extended to the end of November, do I think COVID is going to be done by then. Probably not. Sadly, unfortunately, and it's also going to be flu season so we know we've got a lot of illness in our future. But what we do think is we're going to have the technology things really ironed out the claims things really ironed out, contracting completed to we're going to be ready to go fully in December 1. We're committed to that. But we also have committed to supporting you, the providers in the field over these next few months, so please note that we ever changed those flexibilities so out of network providers folks that are not contracted will be reimbursed at that in network rate, and they will follow the same pa requirements, as in network providers. The other thing we did was we decided to extend the time a beneficiary can change their primary care provider, so that they can do that for a longer period of time we've extended that to November 30, because we recognize that folks have been maybe not seeking care because they're worried about COVID and they're not going out or they've been distracted by having COVID And so they haven't done these things. So we extended that the end of the beneficiary change period is still coming up it's 90 days from launch it goes to September 30. But after that time, members can change for cause and it pretty much, I will tell you

that the department is going to look at their for causal reasons it's pretty much any reason that they need to reasonably change their plan and so we're going to be very open to plan changes over these next few months, because we want to make sure that people get the care that they need. We don't want them avoiding care or delaying care. So I think you'll find these as good news. And I will say the caveat, this doesn't apply to concurrent reviews for inpatient hospitalizations, it's really important for the plans and their care managers to know when you've got somebody in the hospital, so they can go on and start preparing for discharge and making sure things are ready. Okay, next slide.

All right, this is the good cop bad cop slide so I work for Dave Richards and who is the good cop, he's always ... chose to work, because I knew I'd get my way most of the time I get to be the bad cop a lot. So one of the things that I just want to make sure that the field understands is how hard we're working at oversight. So, launching managed care does not mean that the folks at DHB the hundreds of folks you have working for you in the Medicaid department have stopped working for you, they are still working for you and we've just shifted a lot of our work to oversight. And so in that commitment to transparency I'm gonna share some data with you tonight and there'll be more coming on a very regular basis. So if you go to the next slide.

This is just our Help Center dashboard we said, we shared this in the last backports chat too we monitor this on a very regular basis to see who's calling us why, And what their needs are. If you go to the next slide is the member dashboard. So we looked at our call centers for all of the plans, and we looked at how many calls they're cancelling, how many calls are answered within 30 seconds, and what their abandonment rate is. And then we looked at the reason for the call so whether they're coming in through the enrollment broker or through the health plans, we pay a lot of attention to this and look for where there are aberrations in the plans have certain dependent they have things they have to provide at a certain level, or else it's a penalty to them and sometimes a significant penalty so the department's paying really close attention to these things. We're also listening to you. So if you go to the next slide, we're also tracking what we're hearing from the providers. So we look at provider calls, we look at the percentage of the calls answered in 30 seconds and the abandonment rate for that as well. And we're also measuring ourselves as well as you so I just want you to know that we are paying attention the provider ombudsman is not getting a lot of calls, which is great, that tells us that the plans are handling your issues, but that is a place for you if your issues are not being handled. Okay, next slide, non emergency transportation is something that flared up early after launch has been your problem. This is something that's probably been one of the bigger impacts to the field, is how people get rides to appointments historically it's been managed by the counties and this changed with the launch with managed care. And so we are looking at this on a regular basis and what we're seeing the data so far is suggesting that we are seeing pretty much close in August, we're on track to be the same number of rides we had prior to launch. July was a little short, we've seen an incredible movement on the part of the vendors that the plants are working with for transportation it's gotten much much better. We are getting far fewer complaints than we were in July. But I don't know if that's just because you're tired of complaining, so if you continue to have problems with transportation. We want to hear about it, so please whether it goes to the member ombudsman or the provider ombudsman, that the plan hasn't resolved the problem for you, please let us know because we want to track these things. Alright, next

slide. One of the sexy data points I really hope to have some sexy data for you tonight is around claim surveillance we are paying really close attention to what's happening with planes, and we're measuring it from a lot of different places whether they're paid or denied rejections pending claims, we're looking at the reasons for the claims we're looking at it by PHP and we're tracking it over time. Very soon I think in the next week or two, we're gonna have a public facing dashboard that we're you're going to be able to go out and look at this and see it as well. And so as soon as we get, we feel pretty confident that the data is really good. We're gonna put it out there and we're gonna make it available to you to look at as well. All right, next slide. All right now is the time where I get to stop talking so much and hand it over to my amazing and brilliant colleagues. What we're going to be talking about tonight, I asked him to bring the most common claims, and prior authorization denials that they're saying in their plans and to give you some clues some helpful tips on how you can get more claims paid and Services approved the first time around. So with that, we will start with the good Dr. Komives.

Dr. Eugenie Komives

Thank you Shannon. So, the top three claim denial reasons for well care first one is the same taxonomy issue that Shannon mentioned so the taxonomies have to match what's in nctracks. And so we need to make sure that the NC track state is up to date for both rendering and billing provider NPI and taxonomy information. Unfortunately, we will have to reject claims if we don't have the correct or we have missing taxonomies. Second thing is missing modifiers so we follow the North Carolina Medicaid clinical policy billing information with regard to required modifiers. And so, and then in the absence of a specific policy from the department. We actually will follow CMS guidelines. If you have modifier issues or questions, please use that North Carolina provider relations at Wellcare.com mailbox at the bottom, and we are happy to have one of our provider relations specialists or claim specialists, reach out to your practice and help you with any gaps that you're seeing on modifiers. And then the final one is the missing or incorrect NDC codes and these are for the drug claims so for every prescription drug claim that comes in on the medical side we have to have an NBC code in order to pay that claim correctly and so we use NDC codes that are on the state prescription drug list the BL for for drug was so please consult video and make sure you get the NDC codes on there. As far as the most common prior authorization denial reasons so the big one is lack of clinical information and this is improving, we've got some electronic medical record now connectivity with some of the bigger health systems which will facilitate that. But we really do need the clinical information at the time that the authorization is requested in ideal situation. If for some reason you're not able to submit it at that time, then if we request additional clinical or if we request a peer to peer offer peer to peer please respond. Unfortunately, If we don't have the clinical that we need. By the end of our turnaround time periods and sometimes we have to issue a denial, which we really don't want to do because we often have a pretty good idea that if we got the right clinical we could approve the service. So, definitely. Please get that clinical. Second is inpatient level of care. So, we have certainly seen cases where the inpatient stay request does not meet the MCG criteria which is what we use for inpatient, please know that we pay for observation up to 30 hours without an authorization so if you think your patient, our member can be treated in 24 to 30 hours 30 hours and observation isn't severely ill doesn't really need to be in the inpatient setting, then there's really no need for an inpatient authorization you can bill off, and the claim will pay. And then the final one is we've seen some unusual examples of what I think are probably the wrong service being built, or requested so we've seen two requests for personal care services that really look more like home health

aide type services. We've seen requests for private duty nursing that really look like intermittent skilled nursing visits. Unfortunately the service that we have to review is the one that you request. And so, take a close look at the services that are being requested, and again if you have any questions feel free to reach out to us or provider relations mailbox, or you can also call into our UN department if you have any questions, and they should also be able to help. And with that I'm going to turn it over to Michelle.

Dr. Michelle Buckner

Good evening everyone, Michelle Buckner, I'm the Chief Medical Officer for United. And I think what you'll find as the CMOS are talking that many of our issues are either the same or related so as Shannon brought up earlier and Jamie brought up also one of our cup, top claim denial issues are the taxonomies so as Shannon mentioned earlier we had seen a decrease in that it may be picking up again so just want to reiterate the need to make sure that the taxonomies are in there, we've actually seen quite a bit of duplicate claim submission. Most of that was probably right after launch where, you know provider of claims were going through so also want to remind folks that we do have a website where you can track claims so that you're not putting in those duplicate claims so claims may be being paid, but because they're duplicates of course we wouldn't pay twice, and then early on, we were seeing claims come in that were before managed care launch and of course those should have been built to the department so if there is any lag within your claims filing, just realize that if the date of service was prior to seven, one. In most cases that should be billed to the department.

And then same issues for the common pa denial reasons of course services have to be medically necessary, and I know it can be difficult sometimes as a provider, especially a primary care provider where you support it, a member going or patient going to see a specialty provider and then just trying to figure it out. Sometimes they, there might be as an eye on the patient comes back to you and you want to support them. So to really figure out what are those medical necessity criteria. Remember, we cannot be more restrictive than the state so if there is a state policy, you can certainly check that and if it looks like it should have been covered by the state policy, we as the PHP should be covering it. Now that said, we can be less restrictive so make sure you also check out the United website where you can see all of our clinical policies. And then I think the other thing I want to share is, we have a list of codes by the service categories for what we do PA. And, you know, as we are getting used to the provider community in the state and practice patterns, those lists might change, and hopefully fewer PA, that's our goal. But, you know, starting off it's just hard to know what should be pa and what shouldn't. And so, that list is available for you if you have feedback for us on that, please let us know. The other issue, Genie brought up already is that we don't have all of the necessary clinical information to support the medical necessity review. And, again, often, I know when I was in primary care, especially starting out, you know, I didn't know where to find that information and it wasn't always sort of publicly posted because if they were using, you know melamin or interquad, I didn't know how bad even existed, actually. And so our policies are out there and so make sure you're giving us the necessary clinical information if our staff are calling, it's important to send that information, and if there is a denial though and you feel that additional clinical information is available that we did not consider, you can always ask for a peer to peer, and that's true for all plans so that's another thing that was sort of, I had to learn along the way, is that you know you can call and talk to the medical director, and let them give them more information because often especially what they Maurice I think the all of the information may not have come over to

us. And then, another reason that we've seen some denials is that out of state services so where a person has started care out of state word supporting that from a continuity of care. But, really important for us that if the service is available in state we want to make sure that people don't have to travel far and have close follow up care and so if it's medically necessary for them to go out of state, and that service doesn't exist in it's really specialized in North Carolina, then we're gonna support it but we do definitely review that and of course, out of network as Shannon mentioned, we're going to support that in state and out of network will be treated through the end of November. And so with that, I'm gonna turn it over to Dr. Ogden.

Dr. Michael Ogden

It's all Michael Ogden from healthy blue. Great to talk with everyone this evening. So the, you're going to hear, probably some of the same issues that healthy Blue has been experiencing with our claims denials issues are the most common and most important claims denial issues really related to the NPI and taxonomy mismatches, from the information that's available in C tracks which we all draw from as a source of truth. So we encourage our provider partners to go into NC tracks ensure that the NPI and taxonomy, that's existing in NC tracks is the same that you're submitting to help you believe the second, and I only put two down here because these I think are the more common are the, you know we occasionally are getting. Now occasionally but, but several elements are being submitted without having a PA and, You know, and if it's a service or a procedure or a good that is on our PA list. And there's no pa received. That's one that may cause some difficulty when it goes into the claims processing. Now, Keep in mind also, even though we will not be more restrictive in scope and quantity, or, or in in duration of services that is cut they're covered by, by NC Medicaid, we may end up having more PA or a different PA on a service that you may not have been present in fee for service Medicaid prior to July 1. So it does pay to check it out, we do on our website have a prior authorization lookup tool, which will help you understand not only, you know, is it, am I submitting the correct code. But also, you know, is this something that requires prior authorization or does something that doesn't, you know, as Michelle mentioned, you know, we do have areas that were authorized prior authorization basis by fee for service Medicaid did not prior authorize. So it does pay that, to check that out as far as the most common pa denials, we are having quite a few and it is continuing so folks that are submitting multiple requests for, for the same service in the same patient. This will only delay the process it won't speed it up it's, it's kind of like hitting the elevator button a couple times and expecting the elevator to get there quicker it will actually slow things down. And so we asked single requests and track it on our interface. We also have received requests for some non covered codes. We do have some exceptions, we can apply with EPSDT and in 42 CFR 440 7o for homebased DME. But generally, these are also things that can be discerned when you check out our website and go to our prioritization lookup tool. And then, as was mentioned by my colleagues, we are also seeing several of either we don't get enough information that's documented, or we don't get any information at all. Now, when there's not enough information documented for us to be able to approve it, certainly a peer to peer is something we encourage we like to talk to our provider partners, And oftentimes we can fill in the blanks and approve the service that was initially denied based on the little extra information. Unfortunately, if it's, if it's something that is not submitted at all. If there is, you know, if it's a service that is, you know, submitted for a claim without getting a prior authorization or if it's just submitted without any information at all. We are unable to do a period of periods for no information at all. One of the things I will mention is you know,

certainly when we do our period appears. My word is never the last word. There are several steps after a peer to peer that providers have in order to, to appeal the decision. However, one of the things that we want to make sure that we do when we're submitting appeals is, is get a member consent. You have to ensure that the member is on board with with getting an appeal done, and they can only be beneficial to both you and your and your patient. So with that, I will actually turn it over to my, my colleague, Dr. Lawrence.

Dr. Lawrence

Hey, Good evening everyone, William Lawrence from Carolina complete health. Let's see number one in terms of most common claims denials, as has been said is the taxonomy mismatch or missing issue, so I won't belabor that because we've talked about the solutions to that one. A second common descriptor that we see in claims denials is service a service modifier combo now don't be skeptical. Now that one clearly there are some situations, as my colleagues have described were missing modifiers or inappropriate modifiers are used, but if you see that denial reason on Carolina complete health claims. It also represents, to some degree, an area that's somewhat of a catch all category too. So one of the most common reasons that falls into that particular descriptor for us, may be claims that might be considered bundled into other paid service claims or for which no additional reimbursement is generally warranted. Some examples of that would be categories like handling of a specimen for transfer from office to lab, are some of the basic screening tests for visual acuity that don't have additional payment. So if you find that you're encountering that descriptor in many of your denied claims, we recommend you outreach to our Carolina complete health provider relations team, or some further assistance. Another frequently seen claims denial in our files have been billing NPI plus taxonomy not on a Medicaid file on that active on service states that is actually another one that was quite frequent and in some cases you may find that data not being there. However for providers who in the past may have seen that claim denial reason are descriptive frequently and look back and said you know what this I'm using the right NPI, using the same information I've used before. That was a frequent denial for us early on, but was found to be due to a prior system technicality that has actually now been fixed, so you should not be seeing that very often at this point. And if you do see or find that you have frequent instances of that descriptor in your denials, please again reach out to our provider relations colleagues for some assistance. In terms of common pa prior authorization denials, similar to my colleagues impatient, you know, new admits or concurrent reviews are one of the frequent areas where we'll see denials and in most cases it is because we have a lack of clinical information, of which a medical necessity decision can be made with pharmaceutical prior authorizations, you know, The vast majority of claims denials on pharmacy usually related to something that happens at point of sale. Well, or actual pharmaceutical prior authorization cases that are conditions of review, the usual reason probably three quarters of denials for pharmaceutical agents are usually because there's been no evidence of failure to try the preferred agents, which are already a part of the existing Medicaid policies. So that is the usual reason for those. And then a third while not a high volume service. We get a lot of lumbar spine MRI imaging studies requested that end up being denied and the most usual reason for that is not showing the clinical evidence, particularly around conservative care for those conditions prior to escalating to that level of imaging. So those are some of our common ones and some of the things that we can do the big stones, I will turn it over to Dr Cheely from AmericaHealth Caritas.

Dr. Cheely

Thank you Dr. Lawrence, I may keep my comments somewhat brief because you all will note similar themes that others have identified as well I think we have also seen the issues with taxonomy impacting denial rates as well. Dr Bucknor also mentioned that probably earlier on for us also we saw issues with duplicate claims impacting denials one thing others haven't mentioned that we've suspected maybe part of providers getting used to the move to manage Medicaid is, is just the reminder that Medicaid remains the payer of last resort, with the exception of EPSDT but we had seen some members who also had third party insurance, where Medicaid was built before the third party insurance so just a gentle reminder for office staff that asking for supplemental insurance and billing Matt insurance first is typically the correct order of operations as it was in Medicaid fee for service in the past as well. And then in terms of our prior authorization denials reasons you'll also see some common themes here are medical necessity criteria we've typically matched what exists in the North Carolina DHHS clinical coverage policies. So we'll just offer the reminder please reference those policies and be sure that your documentation matches the criteria that's present in those policies. We also rely heavily on interCall if you're billing a code that's not present in a policy. We have a tool that's available through our provider portal or our you staff can provide the relevant Interpol criteria or direct you if there's an AmeriHealth clinical policy to refer to for the criteria. And then we also have seen circumstances where pa gets submitted without clinical information or with within adequate documentation and so number two in my mind kind of dovetails with number one. If you identify the criteria and ensure that your documentation is recent and matches the, the criteria that's really kind of the best practice to ensure that pa are going to pass muster. Number three I did just want to take a moment to mention Dr. Lawrence mentioned this as well. We've seen, I think a number of office staff who were trying to be prepared and downloaded the generic pharmacy prior authorization request form for for pharmaceuticals, without maybe recognizing that there are a number of agents that have specific state required criteria that has met each PHP creates agent specific pa forms and so it's really important to use that specific pa form to ensure that that you're checking the appropriate criteria for the appropriate drug as well so just a gentle reminder to please look for the, the associated form rather than submitting a generic pharmacy pa form, in those situations. And that's all I have.

Dr. Shannon Dowler

All right, thank you everybody thanks for all that information and there's been a bunch of questions that have been answered in the chat and more stuff coming in. We are going to get to some questions and answers. I did want to make sure that you all of you out there that take the time to listen to this backwards chat and pipe in and give us information as well as your associations your voice really does matter, so many things we have identified that were a little glitchy in the beginning, we've been able to fix them at been from feedback directly from you guys and others like you so please keep the information coming. I can't stress enough if you don't get resolution for things through the plan directly go through the provider ombudsman. We don't know when things don't work unless you tell us and so it's something this big such a massive change is not going to be perfect. Ever. But we're trying to fix things rapidly when we find them. And so thank you, your voice makes a difference, it really has directly impacted things. Okay, next slide. So we've got some questions that we are going to put out there. Let's

see if I can. So the first one this is pretty little but Genie, the first question is we have a PHP, stating that their credentialing information in their system is from data provided by nctracks and 2019 not from 2021 when they initiated and signed a contract, why would they have 2019 in their system. So can you talk about that?

Dr. Eugenie Komives

Sure Shannon things. So, the North Carolina DHHS has instructed the health plans that we are not to, that we are to rely on the Medicaid credentialing in nctracks, so we're not separately credentialing the providers for Medicaid and HealthChoice at this time. And we received the files from nctracks on a daily basis without data provider data and information, but any data that's outdated in nctracks, I think, is really there because that's the information that Medicaid, as in the system, so.

Dr. Shannon Dowler

Yep, absolutely. So, you've there we've been kind of talking about this for a year, make sure you update your data and nctracks make sure you update your data and then she tracks, the plans get these updates every day. And so that means if it's wrong in the plan system, it's probably because nctracks has old information for you that needs to be updated. Okay, so Michael. Somebody wrote in and said, every day we run into family members usually children who have been assigned to different manners plans, many of which have no idea. We've even encountered a set of twins with different plans, is the state going back on auditing how their algorithm assigned, how they assign members is there a better way for providers to assist patients when they don't understand how to request a change.

Dr. Michael Ogden

And that's a great question and certainly as a practicing pediatrician I can empathize, you know, especially the set of twins. So there's a complex algorithm based on you know zip code based on family relationships based on historical encounters with physicians that were was used for the initial application of the assignment the auto assignment for plan by plan. Here's the solution now, rather than the state going back and auditing how the algorithm is applied. The, the way to address the issue is actually through the enrollment broker, very quick phone call can ensure that you get that patient who may be mismatched with the rest of their family assigned to the, the plan of their choice. And, and certainly, You know having a process within your office to get that done at the point of care when you've got the patient there is probably a best practice.

Dr. Shannon Dowler

Absolutely. Yep. Thanks for that. Okay, Will, why the PHP is that following Medicaid guidelines as far as authorizing therapy treatments for six months. Some are authorizing only three months and that six.

Dr. William Lawrence

Yeah, so that is a frequent question and I think it's important to point out that, you know, one of the features or changes in managed care is that the plans do have the flexibility to utilize prior authorization in a different are more frequent fashion than Medicaid direct may have, but we cannot implement policies as a result, that would be more restrictive and amount duration or scope of care for members names. So to that end, the state's current policy allows up to six months on a given authorization, and that more than that, but it doesn't necessarily guarantee that every request an authorization will be approved for over six months, I think ultimately it's really the goal of all of us to ensure that our members are evaluated for services at a frequency that maximizes their clinical outcomes, and in some cases that period appropriately is six months, but in others it may not be.

Dr. Shannon Dowler

All right, thank you. Um, so let's see here, George, this one and there's like a gazillion questions like this in the chat so this is a hot topic tonight, aren't plans supposed to cover each code in the same way as Medicaid, in other words, if a claim is submitted appropriately encoded as it would have been in Medicaid in June, should each plan be given paying that pain coded the same way in July.

Dr. George Cheely

Yeah. Shannon. This is a hot topic and question that that has come up a lot in our office hours as well. And what I'll say is we and, and based on comments from my colleagues in past forums as well I think we've tried to mirror the details that are present in the North Carolina clinical coverage policies, and we have tried as best we can to orient our systems to those details. And I think the practical reality is there are also a lot of details involved in setting up the systems that plans may not have had access to do it so my first early and often encouragement is to please contact your account executive for AmeriHealth, I think all of the plans would welcome you making outreach, if you've been trying to build a code has paid historically and fee for service but you're either getting a rejection or you're getting a denial, please reach out with the specific claim because that really lets us walk the claim through our system to figure out what the issue is and to be able to give you the most accurate and immediate feedback about what what the issue is that's triggering the denial.

Dr. Shannon Dowler

Yeah thanks George for that explanation and he is absolutely right. The plans literally could not do things the exact same ways because they did not have that all the edits are literally millions of lines of edits and the systems and there was not a way to export that in such a way that we could mandate it the same because everyone uses different systems. No, that does not make it feel better to you in the trenches, we're just trying to do the right thing and getting paid for things the way you always have, and we did talk about this the CMOS and I just yesterday I think about what what can we do, how can we make this better. And we're going to have one of our What if sessions that we had prior to launch with a bunch of physicians from around the state to talk about where places we could align, is it something the

Administrative Simplification group that Will's been leading could work on to try to keep it to create some sort of catalog to simplify this for everybody so we recognize this as a pain point that we, there's not a rapid fix for that right now they're not breaking the rules by having their own coding logic. Michelle, I'm going to move on to the next thing, Michelle. This practice is having trouble with managed care plans covering birth control methods which is not good, especially deppo says we're receiving drug manufacturer labor label does not allow for rebates or the managed care plans not supposed to cover the same CPT ICD 10 says Medicaid.

Dr. Michelle Bucknor

So Shannon this picks up on the thing. We've already been discussing and so the managed care plans are expected especially with the pharmacy program to pay as the state pays this, the pharmacy program is a mandated policy for us to follow as it is, however, as you've mentioned there's a lab, a little background, that it's in there that we don't all have knowledge of and so what I would pick up this one George's recommendation to contact us early and often. And so if you're seeing a specific issue with one PHP contact us often. I don't know if you all know, but the CMOS meet weekly and sometimes more than weekly to address some issues so when we're seeing issues across multiple plants, we have the opportunity to work collaboratively to fix it. So the best thing to do is to reach out to us. Early especially so that we don't see these problems escalate, and we certainly don't want members patients not receiving necessary medication.

Dr. Shannon Dowler

Yes, thank you. So the next person I'm going to take and this is someone because I because I come from SJC land and in this question. I said we're currently not receiving full PPS rate as an estimate see from any of the PSPS when we attach the T 1015 line item to claims we received denials stating they don't recognize the code and it's not part of the fee schedule, we're not receiving reimbursement for telehealth, can you help. And so whoever wrote this question and for anybody that's experiencing this, that is definitely not okay. There's really clear expectations for the plans on this same process go to the plan, if you don't get resolution on this, go to the provider ombudsman, because this, this just has to be fixed and so if there's a one off exception. They don't know what they don't know so you have to let them know if there's some maybe they've got you enrolled in the wrong category or there's, there's no telling why that's happening but it's not right, and it should not be happening and we want you to fix it so if you don't get what you need from directly from the plan, then go to the provider ombudsman and we are escalating it and investigating it and getting things fixed. Okey doke. Michael could each managed Medicaid plan verify what revenue code is to be billed for skilled nursing facility, room and board. Also if a plan is only paying 90% of the Medicaid right and we have a contract with a company, how do we get this correct.

Dr. Michael Ogden

So that is a two parter, so I'll let me, let me take a stab at the first one. So, when it comes to revenue codes that are built for skilled nursing facilities and room and board, speaking for healthy blue, we follow to be one and then North Carolina clinical coverage policy. I think most of my colleagues do as well. And in that case for skilled nursing, the revenue code is 183 for room and board for custodial level care, the, the revenue code is 100. If a plan is paying 90% of the Medicaid rate, and you have a contract, you really should be being paid what the contract says you should be being paid and if, if you're having issues, especially if it's healthy blue, um, but I'm sure my colleagues would would entertain a conversation as well, if we're paying incorrectly we want to hear from you. And we want to ensure we're we have, we have an opportunity to sit down and get this corrected. We've had a great track record, anybody who's sat down with us and, and communicated their issues we've been able to, for the most, most part solve their problems.

Dr. Shannon Dowler

All right, last question, the field we're going to hit tonight, George, I'm a home care provider and trying to navigate this new managed care system with billing for personal care patients, we were able to submit claims students who tracks on personal care patients for a week previously, and we were compensated on that claim. The following week, with this managed care plan we submit our claims the payment Several weeks later, for small agency this is extremely difficult to maintain payroll, how can the managed care plans be more effective with compensation regarding turnaround.

Dr. George Cheely

Shannon I know this is, this is another topic and question that's come up frequently in our office hours is well, first I can offer a piece of information, which is that the all the health plans are down to pay clean claims within 30 days of receiving the claims so the timeliness may be a little bit different. By virtue of that standard and in what I can say for us is that clean claims that are entered with the AmeriHealth caritas North Carolina Member ID, are able to auto process, and do pay more quickly and so I've been referring people back to our claims and Billing Guide, which is on our website and I suspect of each of my colleagues has a similar type of document to provide some information about what's needed to submit a claim claim and then again similar to what I mentioned for the prior question, contacting your account executive if you're experiencing issues or you're experiencing delays is really kind of the best avenue for us to be able to research what's going on with the claim and to advise you about how the payment can happen more quickly.

Dr. Shannon Dowler

All right. Thank you. So we are really almost at a time, and I think just having I've been kind of scrolling through the chats trying to answer some stuff while other folks were talking and there are a couple things that jumped out at me. Someone put the comment in there, saying that when people said nothing was gonna change they must not admit it. I don't know who said nothing was gonna change with me here but there wasn't me. I spent the last two years trying to help get ready for all the things

that are going to change, and we certainly tried to build protections in there so that the changes were not as drastic and painful as we saw in other states that launched managed care and I will say so far is as painful as this feels to you, it is. From what I can tell, better than what other states have experienced so I'll give that caveat, manage the feature of managed care is managing care so while they have to follow our policies to the in the same scope amount and duration, ultimately, they have to have utilization management that's actually a contractual obligation of utilization management, to manage care, so they're going to have different PA processes that is absolutely a pain point. If things aren't working for you if you've got if you have gone to the provider relations and you can't get an answer, escalate things, the provider ombudsman, um Oh, if you look at the numbers of what's gone through the provider ombudsman it's very small, less than 100. Last month went to the provider ombudsman. So if you're, but I see a lot I see that many people frustrated in the chat that haven't gotten what they need from the plan so if you don't get what you need go to the provider ombudsman, and we'll help the plans want to get this right. So for whatever reason if it's not working, you're hearing it from them. They want to help you get this right, it's in everybody's best interest. And I will tell you all of us I can speak for the CMOS I know we're in these roles right now because we want to be here to make it go well, we want this to be a successful launch, and a successful program in North Carolina, because frankly it's not most states, at least initially. And I think the same is true for our teams. So with that, thank you for doing the hard work that you do. Thank you for doing this transition in the midst of chaos I hope this extension of the AVID network period will recreate a little bit of grace for you and help you do the hard work of responding to a pandemic. Keep the questions coming. Tune in next month to talk more about behavioral health and tailored plans, and we really do want to hear from you so if you're not getting what you need, the provider ombudsman is there for you. All right, thank you everybody Thanks, all the plans for being here tonight.