PES Virtual Payer Panel Transcript

April 16, 2020

The following information is intended for education and training purposes only.

Moderator (00:00:01):

Hello everybody. Welcome to the Provider Education Summit's Virtual Payer Panel. Before we begin, let's go over a few housekeeping items. If you're on the line and have not yet connected to the webinar, click the link in your confirmation email. Your browser may prompt you to download and run a file. When you're connected, you should see the welcome slide on your screen. You'll be using Zoom's Q&A function to send in your questions. Please take a moment and find the chat bubble icon near the bottom and center of the webinar screen. When you type in a question, please let us know if the question is for a specific panelist or for everyone. Once a question is submitted, everyone will be able to see it. If you agree with a question and would like to see it answered, you can up-vote the question by clicking the "thumbs up" icon on the left.

Moderator (00:00:49):

You can also comment on the question if you would like to add information, we will be prioritizing the questions that have more interest around them, so make sure to up-vote your favorites. If you submitted a question ahead of time through our survey, we have those questions entered and we'll be going through those as well. When you submit questions, please keep them short, clear and professional. Any questions that are unprofessional or antagonistic will be dismissed by the moderators. Also, before submitting one of your own check to see if someone else has submitted a similar question that you could up-vote. This will help the topics you care about rise to the top of the list. If we run out of time before all questions are answered, we will save the remaining questions and get answers from the panelists. Offline answers will be included in a follow-up communication to all registered attendees.

Moderator (00:01:39):

The main sponsor for the Virtual Payer Panel is Med USA. Med USA has provided RCM services in Utah for over 40 years. They offer solutions for credentialing, billing and coding, a fully certified EHR and PM, and more. Currently they do offer medical marketing help to push telemed visits during the COVID-19 crisis and they welcome any questions you might have. Med USA would like to thank you for your tireless efforts during this difficult time. The additional sponsor for this today is UHIN. Sponsorships for this event are funding the purchase of gift cards to local businesses. At the end of the event, we will randomly select several attendees who are still connected to receive these gift cards, so stick around and help us support these small businesses. This virtual event is being recorded and a copy will be made available to all attendees after the event. Now it's time to begin. I'm going to give each panelist organization an opportunity to introduce themselves and make any major announcements their organizations may have. Once we've gone through all of the panelists, we will begin answering questions. Panelists, I'm going to have you raise your hands if you are going to be the rep for your organization making your announcements. I'm going to start with Marie Baker. Marie, go ahead and unmute yourself.

Marie - United Healthcare (00:02:58):

Hi, thank you Sara, I appreciate it. My name is Marie Baker and I'm the Director of Provider Servicing for Utah for United Healthcare. And on the line today, along with myself, I have Lindsey Kelly who's a contracting manager and DeAnn Cruz who is the director of network contracting for Utah. So, thank you for having us, and I appreciate any of the questions and hopefully we can answer them to your satisfaction.

Moderator (00:03:28):

Thank you, Marie. All right, next I'm going to call on Michele Beutler.

Michele - U of U (00:03:37):

I don't know what happened there but that was a good introduction. This is Michelle Butler. I'm the Manager of Provider Relations with University of Utah Health Plans and I have on the line with me Michelle Reilly from our EDI department. And a couple of things about university of Utah: we've had a really big year of growth with Medicaid expansion along the Wasatch front, and in September of 2019 we became the behavioral health administrator for Medicaid and unfunded individuals for Summit County. And in 2021 we are going to be offering a Medicare advantage plan. The network is Advantage U and professional providers that are on our Healthy Premier network were sent contract amendments in March. We're still in the process of sending out facility and ancillary contract amendments. So, if you haven't received one and you're on our Healthy Premier network, look for those to come soon. And we have also gone into a new partnership with Verisys for our credentialing process effective March 10th. They're going to be providing also a monitoring services for providers, check medical contact, newly contracted so versus uses check medic and they will be contacting newly contracted providers or those due for re credentialing with instructions on how to update and share their CAQH records or provide the necessary information for check medic to complete the credentialing process. And we anticipate that our partnership with Verisys will provide a more efficient, transparent credentialing experience. Thanks.

Moderator (00:05:04):

Thank you. All right, next up I'm going to call on Susan Daniels. Susan, go ahead.

Susan - SelectHealth (00:05:12):

Hey, this this is Susan Daniels from SelectHealth. I am the director over the EDI department for SelectHealth. And on the line with me, I have Marianne White, who's the director of our claims department, Damon Carter, who's the manager over our Claims department, and then I also have Angie Fedderson who's the director over our Medical Review and Coding department. So, we're happy to be here and can't wait to get some of your questions and be able to answer those for you.

Moderator (00:05:43):

Excellent. All right, next up. Let's call on Steve Baker.

Steve - Steward (00:05:50):

Hi, this is Steve Baker. I'm the Director of Network Services for Steward Health Choice. We are a managed care Medicaid and Medicare Advantage dual special needs plan. Some of the big announcements that have happened to us over this past year effective January 1st our Medicaid plan was expanded into a statewide offering. So, we are now in all counties in the state and also effective January 1st, due to the Medicaid expansion, we are one of the organizations that is now administering behavioral health benefits for our adult expansion population. So, the legacy members of Medicaid

remain the carve out of the state, but any new members that came onto Medicaid as a result of the expansion, we now administered their behavioral health services.

Moderator (00:06:39):

All right. Thank you, Steve. Next up, let's call on Terri Nehorai.

Terri - Molina (00:06:49):

Thank you, Sara. This is Terri Nehorai. I am the AVP of operations with Molina Health Care, and like Steward, we are one of the ACOs that also offers behavioral health integrated benefits for the five County expansion area. We are a Medicare advantage plan and also have dual eligibles with Medicare and Medicaid as well as Medicaid by itself. Thank you for the opportunity to do this.

Moderator (00:07:26):

Thank you, Terri. All right, next up, let's go with Alan Ford.

Alan - Regence (00:07:33):

Hello. Good afternoon everyone. My name is Alan Ford. I'm the Provider Relations Manager for Regence Blue Cross Blue Shield and we are very excited to be able to talk to you today about some of the exciting things that are happening. Two things that I wanted to talk about. First of all is that a lot of things we're going to be talking about COVID-19 in telehealth can be found on our website, www.regence.Com, that's being updated almost every day. And second of all, wanted to just re-iterate our new preauthorization tool that you can go to Availity and you can get vital information and potentially, you can get instant authorizations. We can talk more about that later. So anyway, thank you. It's really good to be here.

Moderator (00:08:25):

Thank you, Alan. Okay, next person. Let's go to Brenda Hardle.

Brenda - Cigna (00:08:33):

Thanks Sara. Hello everyone. My name is Brenda Hardle. I'm with Cigna Health Care. I'm the Provider Experience Manager supporting the Utah market. I appreciate the opportunity to be here with you today. Hope all is well. We do have updates on our provider portal at cignaforhcp.com relative to both COVID-19 and non -COVID19 billing guide. We offered that directly from our website without a registration. It's got a lot of helpful information on there and we update that weekly. So please check it out if you haven't already. Thanks for the opportunity again.

Moderator (00:09:17):

Thank you. Next, let's go to Brett Gashler.

Brett - DMBA (00:09:24):

Okay. Hello everyone. This is Brett Gashler with DMBA. I am a Contract Manager. On the line with me I also have Sione Fisihetau. He's a Contract Manager in my department as well. And, I have Lisa Varley. She is the Director over our Configuration department. As far as announcements go, in late 2020 we should have our provider portal ready to go. There's a few things that have held it up just a little bit but it should be done towards the end of the year. We'll have all the usual things, claims eligibility, pre-

authorization provider credentialing all of that on there once it's ready to go. So, thank you. Look forward to answering your questions.

Moderator (00:10:12):

Thank you very much. We're nearly done. Let's go now to Andrea Garry.

Andrea - Aetna (00:10:22):

Hi, this is Andrea Garry. I'm the Senior Network Manager for Aetna and I just wanted to update that on aetna.com we have a robust provider portal for anything COVID-19 related and it is updated daily. Also, Aetna is transitioning from NaviNet to Availity as our new provider portal beginning May 1st. Look forward to talking to you more. Thank you.

Moderator (00:10:48):

Excellent. Okay, let's now go to Jenna Murphy.

Jenna - PEHP (00:10:57):

Hi, this is Jenna Murphy with PEHP. I'm a Provider Relations Specialist, and we also have Sandra Hanson from our EDI department today to answer any of your questions. We do have a lot of good information that is constantly updated as needed on our website especially with the COVID-19. If you go to our provider page that's front and center so you can get any information you need there. Looking forward to answering all your questions today.

Moderator (00:11:30):

Thank you very much. Okay, we have not heard yet from EMI Health. Does someone from EMI want to unmute and introduce yourself? They may be having some audio issues. If you're from EMI, I am not able to hear you. Let's move on for just a second. EMI, go ahead and keep trying to connect. Let's go to Lori Weber.

Lori - Noridian (00:11:59):

Hello everyone. And thank you Sara. I'm Lori Weber from Noridian Traditional Medicare Part B with the Provider Education Department for the States of Idaho, Wyoming, Oregon, and Utah. For the COVID-19 updates along with the Noridian and CMS websites, I want to let you know that hope that you've either attended or are registering for one of our [inaudible] complete Medicare telehealth, Virtual visits, presentations along with the accelerated payment program. So, we appreciate the provider community and your tireless efforts with your patients our Medicare beneficiaries. Thank you, Sara.

New Speaker (00:12:43):

Absolutely. Lori. All right, let's try once again and see if we can get EMI on the line. Tiffany or any of the others from EMI, can you talk?

Patty - EMI Health (00:12:54):

Hi, this is Patty. Can you hear me?

Moderator (00:12:56):

We can hear you, Patty.

Patty - EMI Health (00:12:58):

Okay, great. Sorry, I'm not sure what's going on. Tiffany's having some difficulty with her audio. So, I don't have anything prepared. I just want to let you know we are here and all your different reps are listening and we will be happy to answer any questions.

Moderator (00:13:15):

All right, fantastic. So, we have done introductions for all of the panelists who are here. What we're going to do at this point is begin answering questions. As a reminder, the ones that are voted to the top are the questions that we're going to prioritize first. So, make sure you look through all of the questions, up-vote your favorites, and if you don't see something you're interested in, go ahead and submit that as a question of your own. As another reminder, please keep your questions short, clear and professional. And don't be afraid to up-vote the ones that say they are from the moderator. These were questions that were entered in a pre-event survey and so these were ones that we had our panelists research ahead of time. So, if those are interesting to you, absolutely up-vote them. To start off with, the actually highest voted one so far has asked whether we are going to provide contact information for the panelists. I can just actually go ahead and let you know we can contact the panelists and ask them which contact information is going to be best for you guys for any kind of follow-up, and we will get that out to you in a follow-up email. So, I'll take that on as an action item from the moderator side.

Moderator (00:14:26):

The next biggest question, it says, "Which are the most common errors that keep claims from processing?" This is something that comes up a lot and typically there's a couple of things that are going to be kind of the same across the board. So, I'm going to ask a panelist to raise their hand if they would like to give the first stab at the answer and then we'll have additional panelists chime in as they think of additional things that they want you guys to know about biggest errors. Okay, Sandra, go ahead.

Sandra - PEHP (00:15:01):

Sorry, I forgot to unmute after I raised my hand. With electronic claims our biggest error is that your trading partner number or your submitter ID has changed, and we have not been notified or we were notified to change one when in reality we should not have changed it. And the clearinghouses are always sending us mass emails of, you know, providers that they want us to move over to their trading partner number. And that's not always exactly right. So if your claims are rejecting or you're not seeing them get paid, please, please be checking your 277CAs, because if they're coming in and your submitter ID is not what we have you set up on in our system, it will front end reject and we will send you that message in a 277CA. Other errors that we see are invalid member ID. I know PEHP has a really long member ID and quite often one number will be missing, or they'll be transposed. And so those will reject. And then the other one would be date of birth. When] the date of birth you have in your system is different than we have in our system. So, we will reject those up front. Again, all of these are rejected in the 277CA.

Moderator (00:16:32):

Thank you, Sandra. It looks like Andrea also wants to add to that. Andrea, go ahead.

Andrea - Aetna (00:16:37):

Thank you. For Aetna, for the state of Utah, the most common errors are missing information on the claim, incorrect information with the claim, incorrect billing based on our policies, lack of authorization

for services that require it and lack of referral on a referral based plan. So, I suggest you call our PSO department prior for the authorization and referrals and they'll tell you whether or not it's required for that member's plan to have an authorization or referral in place. Thank you.

Moderator (00:17:15):

Thank you. And it looks like Steve Baker would also like to add to that. So, Steve, your turn.

Steve - Steward (00:17:21):

Thanks Sara. Yeah, just to add onto that, one thing that we see being a Medicaid and Medicare plan primarily is eligibility. So it's always best practice to check the eligibility of your, your patients as they come in, especially with Medicaid simply because that can change on a month to month basis very readily, whether it's with the state fee-for-service or with another ACO in the state or they've gone off Medicaid. We do see a lot of denials, claims for services that were submitted to us when that member was actually no longer eligible for our plan.

Moderator (00:17:58):

Thank you for that. Damon. You're up next.

Damon - SelectHealth (00:18:03):

This is Damon from SelectHealth. I would agree with the eligibility issues as being a common thread for us as well. I'd also add to that as well as coordination of benefits, information lacking or not submitted to us with the claim. I'd encourage providers offices to verify with our member services department, on our provider portal as well. Just encouraging them to make sure that all of that information is received from the, from the patient as well and prior to submitting claims.

Moderator (00:18:36):

All right. Thank you. Marie, I see your hand. Go ahead.

Marie - United Healthcare (00:18:41):

I agree with what everyone else has said. The one thing that I would like to add is the wrong modifiers or no modifiers were appended when they needed to be.

Moderator (00:18:54):

Okay. Thank you. Brenda, you'll be the last one.

Brenda - Cigna (00:18:59):

Okay. Thank you, Sara. So, for Cigna, I also agree with the other comments, but I just want to add that in the event that there are claims that are pended for external reasons, meaning again, I think somebody had mentioned modifiers. So, if we're looking for additional documentation to process that or finalize that claim that information can be found on our website as well if there's an external pend. So, I just wanted to add that. Thank you.

Moderator (00:19:24):

Thank you. All right. The next question is, "What are the procedure codes with modifiers that should be used for phone visits for each insurance company?" So, who would like to be the first one to go for that question? Okay. Brenda, I saw your hand first. Go ahead.

Brenda - Cigna (00:19:45):

Okay, thank you. So, for the, for the telephone visits we're accepting the G2012 code and that will be for both medical and behavioral as well.

Moderator (00:19:59):

Okay. And then Lisa, I also see your hand up.

Lisa - DMBA (00:20:03):

So, for the telephone evals, we are allowing 99441 99443. And according to AMA billing guidelines, they are required to use location two, modifier 95.

Moderator (00:20:21):

All right. And then Steve, it looks like your hand is up. You're next.

Steve - Steward (00:20:28):

So, both UDOH and CMS has made some allowances with telephonic visits. So currently we are allowing regular E&M codes. So, the 99201 - 99215, to be utilized via telephone provided that again that the service can be performed clinically via the telephone only. Again, the place of service on those would need to be an 02 with the GT modifier.

Moderator (00:20:57):

Thank you. Jenna, do you have anything to add?

Jenna - PEHP (00:21:03):

PEHP is accepting the E&M code visit the 99441 - 99443 and also the same with the GT modifier and 02 place of service.

Moderator (00:21:19):

Thank you. Michelle?

Michele - U of U (00:21:22):

For University of Utah Health Plans, the same thing. We're accepting the 02 - it should be billed with an 02 place of service and we will recognize the 95 modifier. We have a list of the codes that we're allowing telehealth services for on our website, which is Uhealthplan.utah.edu, and we are following the CMS list of codes that are covered.

Moderator (00:21:46):

Excellent. All right, Lori, it looks like you're up next.

Lori - Noridian (00:21:50):

Thank you. And we have the complete presentation as I said earlier, but we are also accepting the telephone assessment and management service codes that are time-based. The 99441 - 99443, the 98966 - 98968, which we never covered before. That's all per the 1135 waiver. Also are accepting the virtual check-in that was mentioned earlier, the G2012 and also the G2010 which is the evaluation of records. Another one that we are accepting what we call online E&Ms. These are the 99421 - 99423 and those are just for the physician community. And then of course, the G2061 - G2063, which is the same sort of a visit, but it's for those non-physicians, like a physical therapist or a clinical psychologist. So, it's the G codes, the HCPCS codes and I can go on and on but I'm not going to. Thank you.

Moderator (00:23:11):

Thank you, Lori. All right, Lisa Varley, you're up.

Lisa - DMBA (00:23:16):

Oh, I lied. Sorry, I should have lowered my hand.

Moderator (00:23:19):

Oh, okay. I lied too, then. You are not up. Let's go with Marie Baker.

Marie - United Healthcare (00:23:26):

Hi. Yes. So, for telemedicine codes, what United is accepting are the regular E&M codes with the 95 modifier and the office visit place of service. And there is a whole list of coding scenarios and the codes that we are accepting on UHCprovider.com under the telehealth for the COVID. And additionally, United Healthcare is waiving all the member cost-sharing for any Telehealth service during this pandemic.

Moderator (00:23:58):

Thank you. Let's see. Let's go with Andrea Garry next.

Andrea - Aetna (00:24:03):

I'm just going to echo what everyone else said, Aetna is doing the same. We have a broad list of telemedicine codes that we're approving with how to bill them on aetna.com under provider tab. Thanks.

Moderator (00:24:20):

Thank you. Let's now go to Angie.

Angie - SelectHealth (00:24:26):

Hello. Can you hear me?

Moderator (00:24:27):

I can hear you.

Angie - SelectHealth (00:24:29):

So SelectHealth, we are allowing the new codes for both digital and telephonic, but we're requiring the code specific to those services be used. And so those are the codes that were mentioned earlier where

we're allowing the physician and the non physician codes both of those. And then for audio, visual, visual telehealth, we have expanded our code lists. CMS released a whole bunch of new codes. We already covered a large portion of those but we have added the additional codes and so we require those with the appropriate modifier and place of service. And we also have additional information for providers on our website.

Moderator (00:25:14):

Thank you very much Terri Nehorai. Let's go to you.

Terri - Molina (00:25:18):

Thank you. For Molina Healthcare, we are allowing the CPT codes 99201 - 99215 with a place of service 02 and 95 modifier. Also, GT modifier is being used.

Moderator (00:25:36):

Okay. And Lisa, your hand is up again. Is this on purpose?

Lisa - DMBA (00:25:42):

Seriously? It doesn't show me as up. No, I keep... Oh my goodness. Sara are we, I know that some of the payers are, talking about their full telemedicine coverage and I just referred to the telephone coverage because I thought that's what we were talking about. So DMBA also has reviewed the expanded telemedicine list from CMS and if it is a covered service under the plan, we are allowing those services to be telemedicine as well. And so, we follow the CPT list as well. That is in the CPT book for approved telemedicine codes. We do require them to be billed with modifier 95 and location 02.

Moderator (00:26:41):

An excellent update. Thank you. Okay, Alan, you are up next.

Alan - Regence (00:26:46):

Thank you. Hey, so for Regence Blue Cross Blue Shield, we have to do it super complicated. So, for all of our commercial plans, we are allowing all of our E&M visits and we are using place of service 11 with a GT modifier. And then for FEP we are doing its place of service 02 with the GT modifier and this is brand new, for those of my team who are listening, we just found out that for MA, it's place of service 11 with the 95 modifier. So again, we had to do it super complicated so if there's any questions, please reach out to me.

Moderator (00:27:32):

Excellent. Thank you, Alan. Okay uh Angie, it looks like your hand is raised, you're next. Angie, are you able to hear me? I see your hand is raised.

Angie - SelectHealth (00:27:46):

Sorry. Right button. Can you hear me now?

Moderator (00:27:50):

I can hear you.

Angie - SelectHealth (00:27:51):

Okay. I just wanted to clarify. As folks are talking about places of service, you know, Medicare came out and said they're going to allow the same places of services as if it was done face-to-face. And so not all these services are in the office, so they're not all going to be allowed with basic service 11. If it's an inpatient service, you know, you'll want to bill their appropriate place of service for inpatient. So just be cognizant of what services being provided, the codes where the patient is when you bill appropriate place of service.

Moderator (00:28:21):

Awesome. Thank you. All right, so let's go ahead and move on to the next question. The next most up-voted question was, "Are all the payers reimbursing for Telehealth visits at the same rates as in person visits during the pandemic?" So once again, we're going to start with whoever wants to go first. Angie, I see your hand first, and then everyone else who wants to chime in with something different, we'll go with you one at a time. So, Angie, go ahead.

Angie - SelectHealth (00:28:50):

So, this is really going to be based on how the provider bills. So, for our government lines of business, Medicare has said that they will allow the same rate as the face-to-face if they choose to bill a place of service as if the visit was face-to-face. If the provider continues to bill places, service 02, it will be paid at the at the facility differential. And so, it would be the lower rate. For our commercial line of business, we're still continuing to require the place of service 02 for telehealth. So, it will be paid at the differential rate.

Moderator (00:29:21):

Thank you, Angie. Steve, I see your hand next.

Steve - Steward (00:29:26):

Thanks Sara. For Steward health choice, we are paying at the regular E&M rates. During the pandemic, during the state of emergency, there will be no difference in the reimbursement rate for telehealth visits.

Moderator (00:29:42):

Thank you. Alan. You're next.

Alan - Regence (00:29:47):

Okay, thank you. Yeah, so we've got a couple of things. Number one as long as the member has the telehealth benefit, we will pay at the at rate parity as long as it's billed with the 11 modifier, sorry, the 11 place of service with the GT modifier. If it's not, if you bill it 02 it will be the, it'll be the rate prior to COVID-19. You can go to our website regence.com and there is a link for all of the groups, all of our self-funded groups that participate and have that telehealth benefit and those that do not.

Moderator (00:30:28):

Thank you, Alan. Marie Baker, you're up next.

Marie - United Healthcare (00:30:33):

Yes, United is pretty much the same. As long as the member has the telehealth benefit. We are paying the office visit reimbursement or the place of service, but it depends on the place of service. So, they should not bill the 02 places service. They should be billing as if it's face-to-face and then they will receive the full reimbursement.

Moderator (00:30:55):

Thank you. Jenna, you're up next.

Jenna - PEHP (00:31:01):

PEHP will cover the telehealth visits when they're billed with the 95 modifier and 02 place of service. We pay at 90% the in-office fee, unless the services are related to the diagnosis of COVID-19, then they will be covered at 100%.

Moderator (00:31:23):

Thank you. Michele Beutler? You're up next.

Michele - U of U (00:31:27):

So, for university of Utah health plans, we are reimbursing at the same rate that we would for an office visit, or in an office. And it would be those codes again that are listed out on our website that CMS is covering.

Moderator (00:31:42):

Thank you. Brenda, you are up.

Brenda - Cigna (00:31:48):

Okay, thank you. So, for Cigna it's the same on the fields. For the telehealth it is paid at the same reimbursement rate as an office or a face-to-face visit. We just ask that those be billed with a place of service. 11. Thank you.

Moderator (00:32:05):

Thank you. All right. Terri, you're up.

Terri - Molina (00:32:09):

Thank you. For Molina Healthcare, we are reimbursing the same rate as a face-to-face visit and bill the appropriate place of service code.

Moderator (00:32:21):

Okay. Thank you. All right, so Brett Gashler, you're up.

Brett - DMBA (00:32:27):

For DMBA we also reimburse at the same rate as long as it's billed appropriately.

Moderator (00:32:33):

Thank you. All right. Are there any other panelists who would like to put some additional information in? Lori, it looks like your hand is up.

Lori - Noridian (00:32:50):

I'm sorry. I just wanted to say that exactly what everyone else is saying. There is a small caveat that even if the, let's say that the physician was doing a telehealth visit from their home or making a phone call, we've been asked, do they use a different place of service? No - continue to use the same place of service as if they were calling or performing telehealth from their office. So, I just wanted to make that. Thank you.

Moderator (00:33:23):

Thank you. All right, moving on. We do have a quick update. It looks like there are some questions coming in about whether Utah Medicaid could send a representative. Unfortunately, they were not. As you might imagine, they're fairly busy at the moment. So, we're wishing them well and if you have questions for them, we can try and send those on to our contacts over there. But they are not officially part of the panel today. The next question is specifically for Aetna. So, Aetna reps, go ahead and get ready. Your question is, "will fee schedules be available on Availity as they currently are available on NaviNet when you switch over?" So whichever Aetna person would like to try and answer that, please go for it.

Andrea - Aetna (00:34:04):

This is Andrea. Yes, they are. They will be available on Availity and you can get it now. It's up and running.

Moderator (00:34:12):

Oh, fantastic. Is there anything they need to know about getting it right now?

Andrea - Aetna (00:34:16):

They just have to be able to log in, and the Aetna site is already ready.

Moderator (00:34:21):

Excellent.

Andrea - Aetna (00:34:22):

Register under the Aetna [site].

Moderator (00:34:25):

Thank you for that. Okay. The next question is for Cigna, specifically. Cigna, "Are there plans to up reimbursement rates in Utah?"

Brenda - Cigna (00:34:39):

So, so what Cigna does is we review our fee schedules annually. That typically occurs at the end of April, 1st of May. And then we make adjustments as necessary.

Moderator (00:34:54):

Okay. Thank you. It looks... Oh, was there additional on that? ...I Guess not. All right. This is for Cigna, United Healthcare and Aetna. So, we'll go with whoever raises their hand first. For Cigna, United healthcare and Aetna, can you talk about the 90 days to bill claims? And let's go with Andrea first.

Andrea - Aetna (00:35:22):

Well, I think we need a little more understanding of what they mean by 90 days to bill claims. It's dependent on their contract of how many days they have to submit claims. So, if somebody, whoever, I think it's Andrea that submitted the question. If she could clarify what she means by 90 days to bill claims in 90 days.

Moderator (00:35:43):

I suspect it's a timely filing thing that uh...

Andrea - Aetna (00:35:47):

Right. So, they have to look at their contract. It's 120 days. So, I'm unclear...

Moderator (00:35:58):

So, we can try and get some additional detail. But it does sound like it's contract dependent for Aetna. Maria, do you want to address this from the United Healthcare perspective next?

Marie - United Healthcare (00:36:08):

Sure ,and I agree with the previous answer that yes, it depends on their contract, but if the question is specific to COVID we have extended our timely filing policies for any claim that has occurred from January 1st through June 30th and that has been billed by June 30th, we will waive timely filing.

Moderator (00:36:39):

Wonderful. And then Brenda, how about from the Cigna perspective?

Brenda - Cigna (00:36:45):

Okay. Thank you. So, I would agree also. It is contract driven on the timeliness. Cigna standard is typically 90 days, but during the COVID-19 crisis, we have extended the timely filing for an additional 90 days. So that information is also posted on our website cignaforhealthcareprofessionals.com.

Moderator (00:37:09):

Excellent. Thank you very much. Okay. It looks like we have some more questions that are rolling in. Thank you everyone for doing all that excellent upvoting. This next one is specifically for PEHP, PEHP, are you allowing private clinics to bill for telemedicine visits, or are those visits only available to members through the Intermountain Connect Care or the Healthy U Telemed service? So, whoever from PEHP would like to answer that, please go ahead.

Jenna - PEHP (00:37:38):

Yes, this is Jenna from PEHP. We are allowing private clinics to do telemedicine during this time. There's no special forms or anything they need to fill out. They just need to bill, as we've mentioned before, with the GT modifier and the 02 place of service. And of course, with the HIPAA compliant medium and

anything that can't be done over video obviously wouldn't be able to be billed. But anything that can, we are allowing at this time.

Moderator (00:38:13):

Excellent. Thank you. The next question is for all panelists. So, we'll do the same thing again where the first panelist to answer gives the baseline response and everyone else can chime in if they've got something different. The question is in two parts. The first part is, "Can you speak to the non-medical personal care benefit offering, if any that you have or will be offering in the future as part of your Medicare advantage plans?" And then the second part is, "Will you be contracting directly with personal care agencies not contracted with Medicare, or will you only be contracting with Medicare certified home health/hospice agencies?" So, panelists, if any of you need me to read that again, I can, or you can just start raising your hands to answer. Terri, looks like you decided to go first though. Go for it.

Terri - Molina (00:39:12):

So, for our Medicare line of business at this point, personal care services are not part of the benefit. However, we are exploring that option in the future. If we decide to include that as part of the Medicare benefit, it would need to be a certified provider with Medicare.

Moderator (00:39:36):

Okay. Thank you. Terri. Is there anyone that this question applies to who has a different answer? I'm not seeing any hands raised amongst the panelists, so we'll let that stand as the definitive answer for the moment. Panelists, if you have any updates later, we can get those to the attendees. All right. The next question is for DMBA. DMBA, when you open your portal later this year, will this open DMBA for new providers and groups to contract/ credential with them? Also, for behavioral health providers too. So, whoever would like to take that from DMBA go ahead and unmute. Oh, Sione, I see you, go ahead.

Sione - DMBA (00:40:27):

Yeah, I'll take that one. So, the portal is not contingent upon whether or not we'll open our panel or not. So, we are still taking case by case basis depending - and this is for medical and behavioral health - but our, our panel has been closed for years and we're still evaluating that on a case by case basis. But the portal will no way affect whether or not that panel is open.

Moderator (00:40:56):

Okay. Thank you, Sione. All right. It looks like the next question is specifically for Regence. The question is, "We do not have the ability to send EOBs as secondary payer to you electronically. I have tried using Availity to add in the COB information with no luck. Is there any other way to submit these?"

Alan - Regence (00:41:19):

Good question. So, what I'm going to do is I want to refer this individual to our website. So, on our website you can go to if you go to our claims portion, "claim submission and benefit coordination," there is a whole section on how to submit information for coordination of benefits. So, I'm going to just leave it at that. It definitely is in there. And if it's not please feel free to contact me and we can talk more through it. Alan.Ford@regence.com.

Moderator (00:42:06):

Thank you, Alan. And if you'd like to send us that link to UHIN, we'll make sure to include that in the notes that go out to everybody. Perfect. Okay, so let's go ahead and move on. It looks like the next most up-voted question, it says, "We've reviewed modifiers for phone calls. Can you also review the telehealth modifiers and place of service? Are they the same for Medicare, Medicaid and federal and commercial plans? Noridian said at first to use GT modifier with place of service 02 but now you're saying to use 95 modifier with 11 place of service." We need a little clarification on that. Who on the panel would like to take that first? Lori looks like you're up.

Lori - Noridian (00:42:53):

Hello. What they're speaking of is, is your traditional telehealth visits that had to have audio visual, and had to meet all these requirements on both the patient's eligibility and the physician or practitioner. Those were billed or are billed with place to service 02 and back in the day we also accepted GT modifier. That is no longer needed because the 02 tells us and our system that this was a telehealth visit. For the COVID-19 and everything that's come from that, and I believe I might have spoke to that a little earlier, it's going to be place of service 11. Much like Regence, we like to cause issues and so you'll use place of service 11 with the 95 modifier, which we never in traditional Medicare recognized before, but we'll now recognize that. For these telehealth visits. So hopefully that helps.

Moderator (00:44:08):

Thank you. Are there any panelists who want to add to that answer with any additional information or anything that your organization is doing different? Okay. Steve Baker, I see your hand. Go ahead.

Steve - Steward (00:44:23):

So, with Steward Health Choice, on our Medicaid network we are keeping it relatively simple because we're Medicaid and sometimes things are a bit more archaic. So, we are staying with the place of service 02 and you can utilize either the GT or the 95 modifier. The 95 modifier will constrict what it's able to be used on a little bit more than GT does. But really, we'll accept either modifier so long as place of service is 02.

Moderator (00:44:54):

Thank you. Alan. I see your hand as well. Go ahead.

Alan - Regence (00:44:58):

Hey, I just wanted to clarify this. I had said this earlier, but for FEP claims you want to use the 02 place of service with the GT modifier for commercial. It's still 11 place of service with the GT modifier and for Medicare it is the 11 place of service with the 95 modifier.

Moderator (00:45:24):

Thank you, Alan. All right, Terri, it looks like you're next.

Terri - Molina (00:45:30):

Thank you. Just for clarity, Molina does require the 02 place of service. And the modifier isn't as important in our system right now until we receive further guidance from the state. But 02 is a requirement.

Moderator (00:45:50):

Thank you. Lisa Varley, I see you.

Lisa - DMBA (00:45:55):

And this is legit. I really did raise my hand this time. So just so there's no confusion for telemedicine services. Location 02 is required, but we will accept either GT or 95. The AMA guidelines that came out for the COVID billing stuff, they have primarily referenced 95 and 02. And so, we are, that's kind of the information we're giving out, but we will also accept the GT.

Moderator (00:46:29):

Thank you. Michele Beutler? It looks like you're next.

Michele - U of U (00:46:35):

Same with University of Utah Health Plans, the place of service 02, you can submit the modifier 95 or GT but it's not required.

Moderator (00:46:44):

Okay. Thank you. And then Marie Baker

Marie - United Healthcare (00:46:48):

And for United we're accepting that 11 places service along with the 95 modifier.

Moderator (00:46:59):

Excellent. Are there any other panelists who have additions that they would like to make? Okay. Not seeing any other hands. We're going to go ahead and move forward. This next question is specifically for Molina. When people are calling in with a question, it says, "very often we are being given different information from different reps. What is being done for the training so all reps have the same information?"

Terri - Molina (00:47:26):

Thank you. So, our configuration team - operations team - is meeting now almost daily with the provider services reps to make sure that the communication remains consistent within the organization. But if you do have questions and would like to receive answers to those questions, please refer your questions to the Molina Healthcare of Utah Provider Services request email. That's mhuproviderservicesrequest@molinahealthcare.com.

Moderator (00:48:09):

Thank you very much. And Terri, if you can send us that email, we can make sure to include that in our follow-up as well in case people didn't get a chance to write that down.

Terri - Molina (00:48:20):

Absolutely.

Moderator (00:48:21):

Thank you. All right. So, it looks like the next question is specifically for United Healthcare. United Healthcare, can you explain your relationship with Optum? Is there a separate contracting and credentialing for providers with Optum?

Marie - United Healthcare (00:48:40):

Explain the relationship with Optum... So, you have the United Health group, which is our organization. And then [inaudible] health group is Optum and then there's United Healthcare. So, the Optum is [inaudible] entity. It is, our physical speech, occupational therapy arm, it is our technological arm. So, if you're asking specifically if there should be a separate contract for behavioral health and or therapies, then yes. It's also our pharmacy arm. So yes, there would need to be a separate contract with Optum if you are offering any of those services, if that makes sense.

Moderator (00:49:34):

All right, thank you. Okay, so let's go ahead and go to the question. "If A patient comes in for a well child checkup and has warts or skin tags they want removed, can we bill and have this paid in the same day? Do they need a modifier?" And this is just a general question. So again, whoever on the panel wants to take it first, Angie, I see your hand and then we'll take anyone who wants to add to it again later.

Angie - SelectHealth (00:50:01):

From a SelectHealth perspective, we would pay both in the same day, but we would require a modifier on the office visit.

Moderator (00:50:11):

Okay. And is there additional information? Oh, it looks like Lori has a hand up. Lori, go ahead.

Lori - Noridian (00:50:22):

If you're billing Medicare for this, you would bill the non-covered routine exam. That is the patient's responsibility because we don't cover those. And then you would bill on another line, the skin tag removal code, which I believe is 11200 and that would cover up to 15 lesions or warts or skin tags. Thank you.

Moderator (00:50:49):

Thank you. Are there any other panelists who want to add to this? I'm not seeing any other hands at the moment. Submitters of questions, if you wanted to hear this from a specific panelist you can also resubmit naming a specific panelist you'd like to hear from as well. Just want to remind you that as an option. Okay. And interestingly, the next question is for a specific panelist. Molina. It says, "we're having a problem with claims that are secondary to a Molina Medicare plan denying as a duplicate from the primary when it's crossing to Molina Medicaid. How can this be resolved?"

Terri - Molina (00:51:33):

Okay. So that website that I gave you earlier would be where you'd be able to actually get some help from your Provider Relations Representative on the claims. For claims that have a primary to Molina Medicaid, we would need that EOB from the primary for us to process the claim as a Medicaid secondary. If it is a dual eligible where they have both Molina Medicare and Molina as Medicaid, we should be able to process that claim without any contradictions within our own system. If the claim is

not payable on the Medicare side, it should automatically cross over onto the Medicaid side of our system and process as an eligible benefit if that is applicable.

Moderator (00:52:39):

Wonderful. All right. The next question is specifically for DMBA. "When Do you predict your provider portal will be up and running and what will be the features of your website?" And whoever wants to take that from DMBA go ahead and unmute yourselves and just go for it.

Brett - DMBA (00:53:01):

This is Brett. That's a great question. So, our initial hope was to have the portal completed mid-year, but we've run into just a couple of hiccups. So, it'll most likely be towards the end of the year. We don't have a specific date to give, but once that gets a little bit closer, once it's closer to completion, we'll send out communication to our provider partners on when it'll officially open up. So, your second question, what features will we have? We should have pretty much anything, any information that you'll need. So, benefits, eligibility, claim status, you can submit pre-authorizations. You can also request, to submit providers for your group to be credentialed. So, it'll be, there'll be a whole host of things that you can, you can do on the portal.

Moderator (00:53:54):

Very exciting. Okay. The next question says, "How do we determine which insurance companies require modifiers for DME? Some insurances seemed to want a modifier such as NU or LT or RT, and others do not pay if there is a modifier." This is a general question. So, it looks like Lori is first and then afterwards we'll take additions to that answer. So, Lori, go ahead.

Lori - Noridian (00:54:22):

Okay, Sara, I don't represent the durable medical equipment department. Noridian does have the contract for half of the US and we have on our DME web pages, all this information. And also, I would register and attend any of their presentations that apply to you. They do everything from oxygen to prosthetics to polysomnography, etc. So, I would really advise you to go to that website and that would be noridianmedicare.com/DME. Thank you.

Moderator (00:55:01):

Thank you. And are there any panelists who want to cover this from the non-Medicare side? Okay, Marie, I see your hand first.

Marie - United Healthcare (00:55:13):

So, for United Healthcare, so my suggestion would be to go to uhcprovider.com and look at the policies and procedures specifically around DME. I do know that we do ask for modifiers, but I'm not going to say that I can specifically answer each individual question, but we do have the policies and procedures posted and you don't even have to be I contracted provider to be able to access them.

Speaker 12 (00:55:44):

Thank you. Lisa Varley it looks like you're next.

Lisa - DMBA (00:55:49):

So DME is a little tricky and that is that some DME you purchase, you know, right off the bat. Some DME requires rental. Some DME requires pre-auth and so it really varies on the piece of equipment that they are obtaining. Most often it would require a modifier indicating if it's a rental that they are submitting, then we would require a modifier RR. If it's a purchase, then we would require the NU modifier. And I believe, well, Brett or Sione might have to answer this, we may have a list of DME that requires pre-authorization posted. If it is not currently on our provider site of our website today, I would assume that we would have something similar to that on the portal. Don't hold me to it.

Moderator (00:56:47):

All right, sounds good. Angie, it looks like you're next.

Angie - SelectHealth (00:56:52):

Yes. so, I agree with what's been said. Modifiers are required for to know if it's rentals versus purchases. Left and right modifiers are important from a SelectHealth standpoint because we do have limits on certain items and so we want to make sure, you know, if we allow only one in a certain period of time, that would be one for the right and one for the left. So, it'd be important to bill those anatomic modifiers as well.

Moderator (00:57:21):

All right. Thank you very much. Are there any other panelists who would like to add to this?

Moderator (00:57:29):

Okay. So, I guess we'll go ahead and move on. The next question is specifically for SelectHealth and Molina. It says, "With regards to the Medicaid expansion, what is the appropriate way to bill? We have received instruction to both hold off on submissions and to bill the same as billing Medicaid, but those claims are still not processing correctly." So, between SelectHealth and Molina, whoever wants to take it first, go ahead and raise your hand. Okay. Terri you're up first.

Terri - Molina (00:58:00):

I'm assuming that this question is coming from a behavioral health provider. And we have had a couple of issues both within our systems and educating behavioral health providers on how to submit claims. The system errors have been rectified and you should see your claims being processed at this time correctly per the state guidelines, and we will be re reprocessing and have been reprocessing any claims that were adjudicated inappropriately. In addition, we are contacting specific providers to assist with electronic billing issues that they may be having, especially if they are using UHIN clearinghouses and are new to billing Molina and need some assistance in billing test files or any assistance related to getting their claims electronically over to Molina if you have not had that ability or need previously.

Moderator (00:59:19):

Excellent. And a Damon, it looks like you're going to be doing the SelectHealth portion. Go for it.

Damon - SelectHealth (00:59:26):

Yes. just a similar update to that we are working through and worked through some of the contracting issues and set up issues. I know the question was if they need to continue to hold off on filing claims, submitting claims, you're okay to now start submitting claims for those any of the claims that have been

processed incorrectly or denied incorrectly. We are escalating this as a top priority to get those claims adjusted and reimbursement sent out. We anticipate having that done the first of next week. And so, we are working tirelessly to get that issue resolved and keep the claims submitted as well. [Inaudible] Reimbursement submitted for those claims, the appropriate way to develop [inaduble] as well, just to be the same recommendation we have for as I mentioned before, the state recommendations and following those guidelines. I know a lot the times for our contracts, the billing provider should be the facility, with the individual provider mostly as the rendering physician. Which I believe is typical how it's been billed in the state in the past. So, the solution we put in place would allow for that to happen. And reimbursements would be received with that information.

Moderator (01:00:43):

Thank you. And then I also see Steve's hand up. Steve, do you want to add to that?

Steve - Steward (01:00:49):

Yeah, I don't want to be left out of the Medicaid party here, since the other three plans that have spoken to it. So, we've certainly had some, some of the same issues. Just want to let all the providers out there know that we have resolved those as well. Any claims that had been denied have been reprocessed at this point and correctly. We've worked tirelessly with our reimbursement services and our claims adjudicators and adjusters to make sure that all of that gets resolved. In addition, we know that there have been some providers that were reimbursed for a claim, but not at the specified PNHP fee schedule rates rather at 100% of the standard Medicaid traditional rate. And those are in the process of being reprocessed currently. So, within the next week or two, those should be resolved as well.

Moderator (01:01:38):

Excellent. Thank you for speaking up. Okay. We're going to move on to the next question, which is specifically for Aetna. Aetna, "For claims that deny the 97140 as mutually exclusive to the 97530 with the 59 modifier. Can we submit medical records with the claim to avoid the denials?"

Andrea - Aetna (01:02:02):

I would say yes, please submit medical records because this is one that does deny quite often, but I'm not going to confirm that it would stop a denial from happening. It's all based on necessity. So, it would help in the review process if you did submit those records.

Moderator (01:02:22):

Excellent. Thank you. The next question is specifically for the U of U. "Are You allowing telehealth by physical therapists for both Health Premier and Healthy U? If so, what modifier and place of service should they use?

Michele - U of U (01:02:38):

So, on that if they could just shoot me over an email with that question, whoever asked that specific question, we can get that answered. Michele.Beutler@Hsc.Utah.Edu.

Moderator (01:02:59):

Okay. Thank you. And if we need to facilitate getting any people contacted afterwards - so for any of the people on the line listening, if you're being advised to contact a panelist and you don't catch their contact info - just notify UHIN and we will get you in touch with the right people. Thank you.

Moderator (01:03:22):

Okay. So, the next question is specifically for Regence Blue Cross Blue Shield. It says, "We are still seeing denials for physical therapy evaluations," and then it lists three codes, "97161, 97162, and 97163, etc. that are billed "in conjunction with 97530. We were told that CMS retracted this rule and we can bill both CPTs together. How do we get all of our claims reviewed and evaluations reprocessed?" So, Regence?

Alan - Regence (01:04:11):

Yeah. So, Brittany. Let's talk about this offline. Alan.Ford@regence.com. We'll need to look at this one a little bit more.

Moderator (01:04:27):

Okay, excellent. The next question then is a general question. It says, "How do we know when to bill the 02 place of service versus 11 place of service?" So, who on the panel would like to take the first stab at this? Okay, Lisa, you're up first.

Lisa - DMBA (01:04:50):

So, for DMBA, any telemedicine, we require location 02 and an appropriate telehealth modifier.

Moderator (01:05:04):

All right. And it looks like we also have Jenna. Jenna, you also have something to add to this?

Jenna - PEHP (01:05:11):

Um my answer is actually the same as what was just shared, just any telehealth has to have that GT modifier and 02 place of service.

Moderator (01:05:18):

Excellent. So then actually let's do a thing for the panel. If anyone has a different answer, then go ahead and raise your hand and we'll highlight you next. Okay. Laurie, you're first.

Lori - Noridian (01:05:32):

With Noridian, the 02 would be your traditional telehealth and you don't need a modifier, as I stated earlier. With this COVID and the waiver, the 1135 waiver, that's where we want you to use the place of service 11 with the 95 modifier. Hope that helps.

Moderator (01:05:56):

Thank you. All right, Marie, it looks like your hand is up.

Marie - United Healthcare (01:06:01):

I have pretty much the same answer. This is for COVID, only until June 18th of 2020 unless we extend that they should bill without the 02 placing service. Then after the COVID pandemic and the crisis is over, I'm sure that we'll probably go back to the Medicare guidelines.

Moderator (01:06:27):

All right. Thank you very much. Are there any other panelists who want to add to this? All right. Not seeing any hands. We're going to go ahead and move on. This next question, it says it might be for Aetna? There's a question mark there, but it says if NCCI edit pairs are bill with the X modifiers, will they pay upon the first claim review or will they hit the same auto denial as the 59 modifier?"

Andrea - Aetna (01:06:57):

Specifically, to that question we use internal systems as well as nationally recognized vendors to ensure the billing and adjudication of claims is consistent with national standards. Our latest addition is this clinical validation program. It specializes in the most complex and expansive areas of adjudication - I can never say that word, sorry, - performed by specialized nurse coders on less than 3% of the claims. So, if you're seeing denials consistently, I would suggest you maybe reach out to me, I'll get my information to you and get you to the right person to discuss this and go through it.

Moderator (01:07:39):

Excellent. And we'll just make sure to have your contact information in the general contact info that we're sending around to everyone afterwards. Thank you. Okay, next question. It says, "Can you expand on why billing for telehealth diverse differs so heavily from payer to payer?" Is there anyone who would like to take a stab at this? Okay, Laurie, go ahead.

Lori - Noridian (01:08:06):

Hi. Well, in the Medicare world, or at least traditional Medicare, there's tele**health** that we covered, you know, before COVID-19, that had very strict rules about who was eligible to perform and what patients were eligible in those very rural areas. And you had to have this audio visual equipment that was HIPAA compliant. You couldn't just use Skype, and this is all pre-COVID, right? There is also tele**medicine**, which I believe some of the other payers may cover. We don't usually cover phone calls and actual telemedicine, or we weren't covering what we call an e-visit through the portal, through the health care portal or the provider's portal. So, a lot has changed. So, it's actually knowing the difference between telemedicine, telehealth, virtual visits, e-visits or electronic visits, and phone calls. And I don't know if that explains it.

Moderator (01:09:20):

Thank you. Is there anyone else who'd like to add to that? Angie, I see your hand.

Angie - SelectHealth (01:09:27):

I think part of the confusion is the chaos that we're in right now. So, like was previously mentioned before all of this happened, Telehealth really should have been billed with place of service 02. When CMS expanded their coverage and they came out and said, now you can pay differently than what you've paid in the past, I think a lot of payers are trying to figure out how their systems can do that. And so that's probably why you see some of the differences between payers. Some of them saying place of service 11 versus 02 has to do with the payment structures and how those fees are set up, and trying to

get this stuff set up timely. You know, knowing that we've already started receiving claims, to make sure those payments are appropriate.

Moderator (01:10:12):

Thank you. Anyone else who'd like to chime in?

Moderator (01:10:18):

As someone who used to participate on various standard efforts, I'd also like to add - with my hat from those standards experiences - that telehealth is still relatively new as a technology. It's been around for years, but in healthcare, things take more than a few years to kind of settle down, and it hasn't made its way into the standards that have been implemented at a national level. So, the requirements in terms of how to bill with which places of service and which modifiers have never been standardized up to this point, again on a national level. So, we're also kind of dealing with that; because the industry is in a little bit of chaos, as the others have said, on top of an area that just wasn't really included in some of those national rules to begin with. That's something we might see some change in the future, but we'll just kind of have to see.

Moderator (01:11:12):

All right. The next is specifically for PEHP. And the question is, "Is there a fix for the recent issue of receiving NPI error messages on submissions where the provider's NPI group and individual is already in the file? So PEHP, go ahead.

New Speaker (01:11:33):

Uh I'm going to defer to Sandra on that one. So, Sandra, do you want to answer that question?

Sandra - PEHP (01:11:38):

Okay. So, the reason, our system can only have a one-to-one relationship with tax ID, NPI, trading partner. But we have had an issue lately where, you know, it was all set up correctly, but the provider has multiple profiles in our system and they may have a different tax ID and a different trading partner number. This issue is causing it to not find the correct tax ID and trading partner number combination. We have sent it to our programmers to get a fix. But until that is fixed, it may still happen. If we find out about it happening, we're trying to do little fixes to get the claims in, but the biggest problem is just the multiple profiles in our system sometimes are causing a problem. I don't know if that answers the question or not.

Moderator (01:13:04):

Well, it certainly sounds you guys are aware of and working on the fix.

Jenna - PEHP (01:13:11):

I would add that you could contact your Provider Relations Specialist and let them know of a particular claim that that issue is happening on, and they can then work with you one-on-one on that.

Moderator (01:13:26):

Excellent. Thank you. The next question is specifically for the U of U. If we are a Healthy U provider but not a U of U provider, will I still be able to get a login for the website?

Michele - U of U (01:13:42):

Yes. so, in order to get a login for our provider portal, you just need to go to our provider websites. So uhealthplan.utah.edu and when you get to that page, click on "For Providers" and there's a "Link Secure Provider Portal." Click on that. And then if it says no link account, then you click on there and request an account.

Moderator (01:14:09):

Thank you very much. So, the next question is a general one, and it says, "What would you recommend providers do to make things easier for patients?" So, providers, do you have any suggestion - or excuse me, payers - do you have any suggestions for the providers? I think you guys are all thinking hard about this one. Okay, Lisa, I see your hand, go for it.

Lisa - DMBA (01:14:37):

So I'm going to assume that this question, is pertaining to the whole COVID crisis and from our perspective, again, this is the DMBA we felt like allowing the telephone visits 99441 - 99443, those are generally an exclusion under our plan and we felt like opening that up during this crisis period to allow providers to kind of telephone triage their patients to determine whether they really needed an office visit or if they could just kind of consult with them over the phone. And so, we're hoping that that is helping both our members and the providers to manage triaging their patients a little bit better. And so again, those telephone evils are only temporarily covered through this crisis period. We will reevaluate it. Right now they're, they're open for coverage until May 18th and we will, reevaluate come May 18th to see if we need to extend that coverage period. But we're hoping that that can help the provider offices manage their patients a little bit easier without putting their staff at risk as well.

Moderator (01:16:00):

Excellent. Thank you. Jenna, it looks like your hand is also up.

Jenna - PEHP (01:16:04):

And my response to that wasn't necessarily COVID related. It's just a general, helping out your patients. Just making sure you pre-authorize any procedures that need to be. All those forms are available on our website, making sure to refer members to in-network providers and facilities, the labs, radiology or other specialists. And make sure that you have clear expectation in writing if you're performing non-covered services, so that doesn't come up as a surprise to the patients and, if they want to use their out of network benefits, we also suggest that you make sure that that's maybe even written, you have written confirmation that they know that they're using out of network benefits.

Moderator (01:16:56):

Thank you very much. Okay. Brenda, you're up next.

Brenda - Cigna (01:17:00):

So, I would agree with what Jenna said as far as Cigna goes. So, I think it's important with the out of network services that are being rendered if the patient is well aware and has a good understanding of that these are out of network or if these are non-medically necessary services being provided. I think for the most point at patient understanding of what their out of pocket cost is and how it's going to reflect in the benefits. I just wanted to add that, but thank you.

Moderator (01:17:31):

Thank you. All right, I see Marie Baker's name up. Go ahead.

Marie - United Healthcare (01:17:37):

Hi, thanks. And I also agree with what Jenna said because, and you know, keeping up with the members' benefits and utilizing our online tools, including PreCheck MyScript will help immensely with the members. But you know, the one thing that I do want to mention is what we run into a lot at United especially is keep up with your demographics. And I know this is not the time, but post-pandemic. We run into a lot where, you know, members you're trying to select a primary care physician and can't because now our directories show that they're open, but in reality, they've since closed. So, keeping up with those types of demographics, if your phone number changes, if you add additional physicians that, that's always great for us to know about and to actually keep our directories up to date for the members.

Moderator (01:18:36):

Thank you. Steve. I see your hand as well.

Steve - Steward (01:18:43):

I echo what Maria said as far as demographic information that that impacts everything from your claims being paid - so that helps you as the provider as well - along with helping our members to know what sort of primary care providers might be available, what specialists are in network keeping demographics up to date is paramount to us having the most accurate information. In addition to that, I would also recommend for our providers to go into the Steward Health Choice website and look over our PA grid. A lot of confusion between providers and members and us as a payer comes from knowing what services require a prior authorization and which ones don't. While we are a Medicaid plan and we follow the Medicaid fee schedule and we will cover whatever Medicaid covers, we do have differing PA requirements and so it's really vital for providers to understand that and utilize the PA grid that we have available. And that will list every single code where a prior authorization is going to be needed and it is searchable so you don't have to look through the whole thing, you just control left on the, on the PDF and look up the specific code you're looking for. The final recommendation I would make for helping make things easier for our members is utilizing the managed care services that we as a plan offer. We are a managed care Medicaid and Medicare plan and we have a Health Services department full of case managers and nurses that are there to really help our members understand and make the most out of their health care. Anything our providers can do to encourage their patients to utilize those services to respond when we're reaching out on anything, whether it's for an HRA or to perform some sort of preventive service for a HEDIS gap. Anything along those lines. Any encouragement from our providers to our members to utilize the managed care services that we provide to, to respond to any outreach that we have, that's really going to help us and the patients out immensely.

Moderator (01:20:48):

Excellent. And then Andrea, you'll be the last one to respond on this. Go for it.

Andrea - Aetna (01:20:53):

The only thing I would add is encourage your member or patient to call the number on the back of their card. We have concierges for customer service for most of our plan sponsors that will walk them through their benefit. We'll talk to them about out of cost networks and expenses that they might incur.

We'll help them find in plan and take the burden off you from being that quarterback for them. So, I would strongly suggest they call that number on the back of their card. It's a great resource and it helps make them accountable for their health care as well.

Moderator (01:21:32):

Thank you. Okay, we're going to move on to the next question, which is, "How are hospice room and board claims paid by Medicaid MCOs to providers who are Medicaid certified but are not in network with the MCO? Does the facility where the patient resides need to be a network?" So, Medicaid MCOs, whoever wants to take the first stab at it, go ahead and raise your hand. Not seeing any hands yet. So just in case I'm going to read the, oh never mind. I see Steve's hand. Steve, go ahead.

Steve - Steward (01:22:10):

I was actually going to ask if you could repeat the question, I just missed the very first portion of that.

Moderator (01:22:14):

For sure. The question is, "How are hospice room and board claims paid by Medicaid MCOs to providers who are Medicaid certified but are not in network with the MCO? Does the facility where the patient resides need to be in network?

Steve - Steward (01:22:29):

So yes, in that instance, the facility would need to be in network. Obviously as a Medicaid plan, if there's anything that's considered an emergent situation, we're going to reimburse on that. But for routine hospice type care, the facility would indeed need to be in network.

Moderator (01:22:48):

Thank you. Terri?

Terri - Molina (01:22:49):

So, I agree with that answer, however if you are a non-par provider you could always call our prior authorization team to discuss the situation and we would handle that through prior authorization protocol for non-par providers.

Moderator (01:23:16):

Thank you. Are there any other Medicaid MCOs who want to add to this? Okay. Michele, go ahead.

Michele - U of U (01:23:26):

So, I agree with it. It should be at an in network facility, but we do make benefit exceptions if necessary. If there's, a situation where there's shortage of providers and so they would, they would just need to contact our care management department to get an authorization for those services.

Moderator (01:23:46):

Thank you. All right, we're getting close to time here. So, I'm going to go ahead and read the next question. We'll probably get through one or two more. Just as a reminder to everyone, stick around because we're going to give away gift cards at the end and we're pulling from the people who are still in the list of connected attendees when we do the drawing. So, we're in the home stretch. The next

question, it says, "I have several mental health providers wondering if they can go outside, for example, for a walk in nature with their clients since an office visit isn't safe right now, would that be accepted and if so, would billing change at all?" So which payer would like to try answering that? And I'll go ahead and read that again. There are several mental health providers wondering if they can go outside, such as for a walk in nature with their clients since an office visit isn't safe right now. Would that be accepted, and if so, would billing change at all?" Jenna, go ahead.

Jenna - PEHP (01:24:54):

On behalf of PEHP, that would not be covered because that is not a covered benefit to be doing like nature walks. So, it would have to be a telehealth visit.

Moderator (01:25:07):

Thank you. Are there any payers who would like to add to that or who have a different scenario? A different answer? All right, I'm not seeing any hands, so we'll go ahead and let that stand as the answer for now. Again, if there's additional information the payers think of later, we can send that out in the follow-up email. The next question is, "Will there be any leniency on timely filing during this time?" Are there any payers who want to address that? Steve, I see your hand.

Steve - Steward (01:25:49):

Our timely filing's already 365 days, so I'm not sure there's any more that's necessary.

Moderator (01:25:55):

Fantastic. so, then we'll go onto Marie. Marie, go ahead.

Marie - United Healthcare (01:26:02):

Yes, we've extended it for claims that occurred January 1st through June 30th and are submitted by June 30th. We've extended the timely filing by 90 days.

Moderator (01:26:15):

Thank you. And then Michele.

Michele - U of U (01:26:18):

And for the university, ours is also 365 days. So, unless this keeps going for quite some time, then I think we should be good.

New Speaker (01:26:26):

Alright. And then Damon?

Damon - SelectHealth (01:26:31):

First of all, SelectHealth, it'd be the same. Our filing limit is already a year timeframe, but if there's any sort of extenuating circumstances that extend the pandemic or whatever, we look at those cases but for now they remain the year long timely filing limit.

Moderator (01:26:47):

Thank you. And then Lori.

Lori - Noridian (01:26:48):

Exactly what, what the others are saying. We're already at 365 days. I just wanted to bring up that if you're part of the merit based incentive program that is extended an additional month through the 30th of April instead of March 31st for 2019. Thank you.

Moderator (01:27:11):

Thank you. All right, so we are at time now. Just as a reminder to attendees, if you put in a question and it did not get answered, rest assured we are copying those, we're making a note of them, and we're going to be seeing if we can get those questions answered and then emailed out to everybody. So, anyone who is a registered attendee is going to get our follow up communications with additional information. We thank everyone for their participation and most especially for supporting each other through these times. So, if you have any additional questions, please go ahead and send those in. And like we said, we will be sending in additional updates to registered attendees with some of the answers that we couldn't get to today. So, thank you and have a safe and happy rest of your day.