The Provider Perspective

South Carolina Department of Health & Human Services

palmetto**hit** network

Improving Patient Care Through Health Information Technology.

The SCDHHS is partnering with the SC Area Health Education Consortium (AHEC) to share news about what the new health information technology means to you.

Doctors, Hospitals Eligible For HIT Incentive

The American Recovery and Reinvestment Act (ARRA) of 2009 set aside more than $20 billion for the nationwide development of health information technology infrastructure. The ultimate goal of the federal investment is to allow for the secure flow of patient records and clinical data among multiple health care providers, leading to improved care coordination, reduced medical errors and greater efficiency.

A key component of the effort is to aid individual provider practices and hospitals in taking the necessary steps to adopt and upgrade certified electronic health record (EHR) technology.

Under ARRA, and the enabling HITECH Act, certain Medicare and/or Medicaid providers will be eligible to receive incentive payments over six years. Provider eligibility will be determined partly on the ratio of Medicaid patients to the total number of patients.

Eligible providers will eventually have to demonstrate that they are using EHRs in a way that achieves specified clinical goals, a process referred to as "meaningful use." While the final meaningful use criteria have not yet been defined by the federal Centers for Medicare and Medicaid (CMS), they will help achieve the following goals:

- improve quality, safety, and efficiency of health care delivery,
- reduce health care disparities,
- engage patients and families,
- improve care coordination,
- improve population and public health, and
- ensure adequate privacy and security protections for personal health information.

Importantly, some Medicare providers will begin to incur financial penalties if they don't become meaningful users by 2015.

Want to Learn More Now?
A wealth of information about HITECH can be found online.

ABOUT THIS **S**ERIES. Many physicians and hospitals that participate with the Medicare/Medicaid programs may soon be eligible for incentive payments if they adopt health information technology (HIT). SCDHHS wishes to share information with providers about these incentive payments and how to qualify. Since not all providers are familiar with this initiative, we begin with a broad overview of the HIT incentive program. More detailed information will be shared in subsequent issues of Provider Perspective. Thank you for your attention to this important topic.

South Carolina Department of
Health & Human Services

Warning: Hard Copy Remittance Packages Are Being Discontinued Now

The South Carolina Department of Health and Human Services (SCDHHS) offers the ability to view remittance packages electronically. The new electronic process allows providers to access remittance advices and associated edit correction forms (ECFs) through the South Carolina Medicaid Web Based Claims Submission Tool (Web Tool). In addition, providers have the ability to change their own passwords. Providers can view, save, and print their remittance advice(s) but not a remittance advice belonging to another provider.   Remittance advices and ECFs for the most recent twenty five (25) weeks are available.

EFFECTIVE FEBRUARY 15, 2010, SCDHHS BEGAN THE PROCESS OF DISTRIBUTING REMITTANCES ELECTRONICALLY THROUGH THE WEB TOOL. Each week, SCDHHS will discontinue the hard copy remittance package for a group of providers until all hard copy remittance packages are discontinued.

Distributing remittance advices and associated ECFs through the Web Tool is a more cost-effective and secure manner for providers to receive this information. Also, providers will be able to access this information earlier. Paper remittance packages are mailed on Friday, which means that they are not available to providers until days later. Electronic remittance packages will be available no later than Friday.

Providers that currently use the Web Tool can access this new feature now. Providers that already have a Trading Partner Agreement (TPA) on file but are not current users of the Web Tool can contact the Electronic Data Interchange (EDI) Support Center at 1-888-289-0709 to register for a Web Tool User ID. All other users that do not have a TPA on file must complete and return the SC Medicaid TPA Enrollment Form to: **SC Medicaid TPA, P.O. Box 17, Columbia, S.C. 29202.**

The TPA outlines the requirement for electronic transfer of Protected Health Information (PHI) between SCDHHS and the provider. It can be accessed at http://www.scdhhs.gov/hipaa/Forms.asp or by calling 1-888-289-0709. Providers that are not sure if they have a TPA on file or have questions regarding the agreement, can contact the EDI Support Center at 1-888-289-0709.

If a provider utilizes a billing agent, and elects to have the billing agent access their electronic remittance package, both the provider and the billing agent must have a TPA on file. The provider's TPA must name their billing agent. The billing agent's TPA must include the provider's name and Medicaid number. To learn more about this new feature and how to access it, visit the SC Medicaid provider web site at: http://www.scmedicaidprovider.org. For a schedule of Web Tool training dates, click on "Training Options".

Allied Health Professional Program Changes

Effective July 1, 2010, Masters' Level Licensed Independent Practitioners (such as LPC, LMFT, LISW-CP) will be able to enroll as a Medicaid provider and bill directly for therapy services. These services must be authorized by SCDHHS' quality improvement organization (QIO). In order for services to be authorized, the recipient's treating physician must request authorization through the QIO. The physician will be required to identify both the medical necessity for the service and the intended direct service provider. Providers will no longer bill these services under a physician's provider number. Please note: additional information regarding the enrollment process for the Licensed Independent Practitioners and the authorization process will be provided through Medicaid bulletins.

DME Providers

DME Medicaid Certificate of Medical Necessity (MCMN)

As a reminder, the South Carolina Department of Health and Human Services (SCDHHS) has clarified its policy for the DME Medicaid Certificate of Medical Necessity (MCMN) effective for dates of service on or after February 1, 2010. This change will ensure consistency among the six MCMN forms and provide clarity to all required fields. Please refer to section two of the DME Provider Manual for additional information regarding this change.

The revised forms can be found on the SCDHHS website at: http://www.scdhhs.gov

Prior Authorization Submissions

The following information must be submitted with Prior Authorization (PA) requests:

- PA Form (Form 214-available in DME* Provider Manual under FORMS)
- MCMN (available in DME* Provider Manual under FORMS)
- Physician prescription for equipment/supplies ordered
- Any other relevant support documentation to justify medical need of equipment/supplies ordered (if applicable)

 * SCDHHS requires 30 days to review and return the Prior Authorization request. Please note: all requests returned to the provider for additional or corrected information will start a new 30-day process. Each re submission starts the 30-day review period over.

Form Completion Guide for CMS-1500

If you have questions about how to complete the CMS-1500 form, a completion guide is available by visiting http://www.scdhhshipaa.org/internet/hrsm/mdc/medicaid.nsf and clicking on Provider Resources. There are also sample CMS-1500 forms in the DME Provider Manual under FORMS.

Eligibility Verification

Providers have two options to use for eligibility verification.

a) IVR System- To use this sytem, call (888)809-3040. Follow the prompts and use the provider NPI number for identification.

b) SC Medicaid WebTool- Before using this sytem, a provider must sign-up with SCDHHS. To sign up, call the EDI Support Center at (888)289-0709. A trading partner agreement must be on file. To access the WebTool, visit https://webclaims.scmedicaid.com/SCWST/welcome/info.aspx

A Reminder from Program Integrity

Billing Errors that result in overpayment

Federal Medicaid policy requires that providers only bill for necessary medical services and accurately document those services. Failure to do so adds unnecessary costs to the Medicaid program and puts providers at risk for having to pay refunds to SCDHHS and possibly other punitive actions.

To minimize billing errors, SCDHHS encourages all providers to visit http://www.scdhhs.gov/providers.asp to review the provider policy manual and receive policy updates. Providers may also contact their program representatives with any questions about billing.

The following are some recent examples of common billing problems identified by Medicaid Program Integrity staff:

Authorizations for CLTC participants not maintained in client charts.

The service authorization enables the providers to begin CLTC services for Medicaid eligible beneficiaries because it establishes the medical necessity for the service. Without it, no services can be reimbursed by Medicaid. If authorizations for services are missing, the claims paid to the provider result in an overpayment and will be recouped. With the exception of case management, all CLTC services require authorizations.

Prescription and/or Referral from a Physician or Licensed Practitioner of the Healing Arts (LPHA) were missing from medical records.

A physician or LPHA referral for speech services enables the therapist to evaluate or perform therapies, treatment or other clinical activities to the client being referred. This referral is good for one year, and if the client must continue treatment beyond that time, a new referral must be obtained. The referral establishes medical necessity for services and must be obtained prior to performing services that are billed to Medicaid for reimbursement. Services are considered unauthorized without a referral and payments will be recouped.

Initial speech evaluations or annual re-evaluations missing from medical records.

Medicaid policy for speech providers requires an evaluation of a child's dysfunction to determine the existence of a speech disorder. It is required annually if treatment continues and should indicate progress made since the previous evaluation, the need for continued therapy and new or revised treatment goals. The evaluation should include review of available medical history records and must include diagnostic testing and assessment, and a written report with recommendations. If there is no written evaluation and/ or annual re-evaluation report which establishes the initial or continued medical necessity for speech therapy services, those services result in overpayments and will be recouped.