Multnomah Other Provider Manual

Multnomah Other provides funding for Multnomah County residents who meet income and insurance eligibility requirements. Residents must be signed up for services through one of the contracted Multnomah Other providers. Funding is only available for services from providers who have a contract to provide that service with Multnomah Other. Please note that though Multnomah Other operates much like an insurance carrier, Multnomah Other is not an insurance plan.

While this manual is a comprehensive collection of Multnomah Other policies and procedures, it is not intended to be exhaustive of all requirements. Please contact Multnomah Other staff if there are questions regarding topics not mentioned in this manual. Refer to contracts for any additional requirements. Providers must adhere to all applicable local, state, and federal laws governing provision of services.

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Provider Communications

Program announcements and updates will be provided using three methods:

- **Email:** emails will be sent to the multco-ad-providers email group. Providers are responsible for ensuring that they or their agents have been enrolled in the email group. Contact Addictions staff to request to be added or removed from the email group (refer to Multnomah Other Contact List posted on the AD Provider website, see below).
- **Addictions Provider Resources Website**: Documents and updates will be posted on the AD Provider website: https://www.multco.us/behavioral-health/addiction-provider-resources The most recent forms and documents will be posted here. Make sure to bookmark this helpful site and check it regularly!
- **Addictions Provider Meeting**: Announcements and updates will also be reviewed at the monthly AD provider meeting. The meeting occurs on the 4th Thursday of the month, 8:30am – 10am. The first two meetings of the quarter are dedicated to general and clinical addictions topics. The last meeting of the quarter is dedicated to billing related matters. Meeting notes will be posted on the AD Provider website.

Multnomah Other strives to make reasonable attempts to communicate all changes using all three methods but may not be able to for all messages. Providers are responsible for checking all three methods of communication for updates and changes.

Privacy and Confidentiality

All providers must comply with HIPAA Privacy and Security rules as well as 42 CFR Part 2 Confidentiality of Substance Use Disorder (SAMHSA website) Patient Records and any state regulations regarding privacy and protected health information.

If the information is subject to 42 CFR Part 2 then written consent is required to share information or for re-disclosures, including disclosures for treatment, payment, and health care operations activities. Providers should ensure that their consent forms for 42 CFR Part 2 data allow for disclosures for the purpose of payment and/or health care operations and care coordination activities. In addition, Multnomah County Behavioral Health Division should be listed as a recipient.

Communication regarding members should be sent securely and in compliance with all federal and state laws and regulations (including HIPAA and 42 CFR Part 2) and inadvertent disclosures should be reported to your organization's privacy officer. In addition, HIPAA and state law requires members are notified of breaches.

All disclosures of 42 CFR Part 2 information are required to be labelled with a notice that unauthorized re-disclosure is prohibited.

Documentation Requirements

Providers are required to maintain an accurate medical record for each member who received service(s). All records must be made available upon request or for periodic review/audit and stored in a secure manner.

Providers should be in compliance with all Medicaid requirements and applicable Oregon Administrative Rules (OARs) regarding documentation of the member's service record, in addition to any professional standards applicable to the provider and relevant Multnomah Other contracts.

Ensure that documentation for all encountered services support the rate, including but not limited to the date of service, units of service, type of contact and site of service, individual provider name and all documentation required by the procedure code selected.

MOTS – Measures and Outcomes Tracking System

MOTS is the Oregon Health Authority's electronic database used by behavioral health providers.

Generally, behavioral health providers who are either licensed or have a letter of approval from AMH (Addictions and Mental Health services of the Oregon Health Authority), and receive public funds to provide treatment services are required to report to MOTS. Per the Oregon Health Authority, providers that contract with governmental agencies to deliver mental health and/or substance abuse services are required to report to MOTS.

Please refer to the MOTS page on the Oregon Health Authority website for information on accessing MOTS and additional information: **https://www.oregon.gov/oha//HSD/COMPASS/Pages/MOTS.aspx**

Member Eligibility and Enrollment

All members must be a Multnomah County resident* **AND** be at or below 200% of the Federal Poverty guidelines.

> *Patients who reside in other counties, are receiving SUD Residential Treatment in a facility located in Multnomah County, and have full–time custody of dependent child(ren) or need to reunify with dependent(s) are covered for Child Room and Board through Multnomah Other. These patients may be enrolled in Multnomah Other but are not eligible for any other services.

Members receiving treatment services must ALSO meet one of the following criteria:

- Currently, or will soon be, applying for the Oregon Health Plan
- Have Medicare as their primary insurance
    - Covered by Part A Only **OR**
    - Covered by Part B **AND** receiving only non-MAT services. Medicare Part B MAT clients should be referred to certified OPT providers for treatment.
- Unable to Obtain Insurance
- Underinsured: e.g. unable to afford co-pays/deductible, has reached the maximum benefit allowed under their plan, no in-network providers are available (e.g. distance to in-network provider creates a transportation burden)

Please refer to the Eligibility and Enrollment documentation on the AD Provider website (https://www.multco.us/behavioral-health/addiction-provider-resources) for detailed instructions on determining eligibility, documentation requirements, the enrollment process, and continuing member eligibility after the initial 90 day period.

Authorizations

All Multnomah Other services must have an authorization entered in CIM in order for the service claim to approve.

If the service does not require prior authorization or utilization review, providers may directly enter an authorization into CIM. Authorizations entered within 45 days of the authorization start date will be auto-approved. Authorizations entered after the 45-day window will have a Pend Retro-Authorization

status and plan staff will ask Program to review for consideration. If an extenuating circumstance prevented the authorization from being entered into CIM by the timely entry deadline, send Billing Support (billing.multother@multco.us) a message from the authorization in CIM requesting a waiver. Each request will be reviewed individually.

If an entered authorization is incorrect or needs to be modified (e.g. the wrong procedure code group was selected or the dates changed), please do not enter another authorization in CIM. Send a message through the authorization in CIM to Billing Support (billing.multother@multco.us) for assistance.

Please refer to the CIM Quick Guide on the AD Provider website (https://www.multco.us/behavioral-health/addiction-provider-resources) for instructions on submitting authorizations in CIM and CIM messaging functions.

If the service requires prior authorization or utilization review, refer to the Prior Authorization section below. These authorizations will not auto-approve when entered into CIM by providers, but will be assigned a status of 'Received'.

If the services does not require prior authorization/utilization review and the authorization does not auto-approve, please send a message through the authorization in CIM to Billing Support (billing.multother@multco.us) for assistance. Please do not enter another authorization.

Prior Authorization

Providers must submit/receive an authorization for services for Multnomah Other members. Some authorizations may be entered directly into CIM by contracted service providers and will auto-approve, whereas others require a prior authorization and utilization review by plan staff.

Prior Authorizations which require utilization review include but are not limited to:

- SUD Residential Treatment
- Withdrawal Management authorization extension requests (Note: step downs do not require prior authorization)
- Non-Formulary MAT (Medication Assisted Treatment)

The most recent treatment authorization guidelines and/or service request forms for services requiring prior authorization are available on the Multnomah Other Provider website: https://www.multco.us/behavioral-health/addiction-provider-resources.

Instructions for submitting the prior authorization request are listed in the treatment authorization guideline for the service or on the service request form itself, as well as the submission deadlines. Utilization Review staff will enter the authorization in CIM if the service is deemed clinically appropriate.

Provider entered authorizations into CIM for services that require prior authorization/utilization review will be assigned a status of 'Received'. Plan staff must receive a prior authorization request form and/or clinical documentation for the service for the authorization to be approved by utilization review staff. These should be attached to the authorization in CIM. For questions reach out to billing.multother@multco.us.

Determinations will be made within two weeks upon receipt of the prior authorization request form. If additional information is needed to make a determination, providers must submit the requested

information during this two week period. At the end of the two week period incomplete requests will be issued a determination based on the information already received and may result in a denial.

Provider Fee Schedules/Rate Sheets

The Multnomah Other fee schedule is posted on the AD Provider website: https://www.multco.us/behavioral-health/addiction-provider-resources

Updates to the fee schedule will be posted on the AD Provider website, emailed to members of the multco-ad-providers email group, and discussed at the quarterly AD Provider billing meeting.

Claims Adjudication

Providers are required to submit encounter data for all adjudicated claims. Once a claim has been accepted by PH Tech and is in process or has been adjudicated, the claim is visible and managed in CIM. Adjudicated claims are viewable through the Claim Search area of CIM. Claims are searchable by a wide range of criteria: member, provider, procedure code, etc.

All claims will be adjudicated per current NCCI edits.

Any service provided without an approved authorization in CIM may not be eligible for reimbursement.

All Multnomah Other claims must be received within the timely filing deadlines. Due to state reporting requirements, all Multnomah Other secondary claims must be received within 45 days of the service date. January to June claims may be corrected before 8/15 if they are submitted within 45 days of the original adjudication date. July to December claims may be corrected before 2/15 if they are submitted within 45 days of the original adjudication date. Claims submitted after the specified dates will be denied. To ensure that providers are able to meet the new timely filing timelines for secondary claims, Multnomah Other will no longer be requiring the primary payer's EOB to be submitted with the Multnomah Other claim to PH Tech. This will enable providers to submit a secondary claim if the primary payer has not adjudicated the claim yet. Providers may submit the secondary claim after billing the primary payer provided the secondary claim is submitted within 45 days of the service date. Providers should attach the primary payer's EOB to the secondary claim if available. Providers may also choose to submit the secondary claim when they submit the primary payer claim if the client meets the criteria for underinsured. If the primary payer EOB was not submitted with the secondary claim it must be sent to Billing Support upon receipt from the primary payer. Providers may email the EOB to Billing Support or attach the EOB in CIM and message Billing Support. Billing Support will review the EOB. Any encounters that do not meet the criteria for underinsured (e.g. the provider received payment from the primary payer) will be reversed.

January to June DUII claims may be corrected or reprocessed by August 15th if submitted within 30 days of the original claim adjudication date. July to December DUII claims may be corrected or reprocessed by February 15th if submitted within 30 days of the original claim adjudication date. All January to June non-DUII claims may be corrected or reprocessed by August 15th if submitted within 45 days of the original claim adjudication date. All July to December non-DUII claims may be corrected or reprocessed by February 15th if submitted within 45 days of the original claim adjudication date.

Providers may submit a timely filing waiver form for claims denied due to timely filing. The Multnomah Other Timely Filing Waiver form can be found on the AD Provider Website (https://www.multco.us/behavioral-health/addiction-provider-resources).

Timely filing waivers will only be considered in the event of extenuating circumstances; some examples are:

- claim was not received by PH Tech within the 45 days,
- claim was denied for missing a modifier and claim had to be resubmitted, but hit the 45 timely filing deadline,
- CPT code for the primary insurance was forgotten to be changed over to HCPCS code for conversion to Medicaid secondary,
- client lost insurance coverage and provider applied for Multnomah Other funding late,
- a client's registration was not completed in time,
- a client's insurance did not start when services first started with provider. For example, client enrolled with SUD services and did not have insurance at the time, new insurance coverage was effective after the service date began,
- technical issues with 837 batch submissions into PH Tech,
- technical issues with new EMR (Electronic Medical Record)/EHR (Electronic Health Record) short staffed) ,

are not considered extenuating circumstances. Please note that funds may no longer be available to pay for services after the timely filing deadline has passed – funding availability is not guaranteed. Each timely filing waiver will be considered individually but may not be approved even under extenuating circumstances.

If there is a question regarding a specific claim, please search for the claim using Claim Search in CIM and use the email link in the upper right hand corner to contact billing.multother@multco.us. Refer to the CIM Quick Guide on the AD Provider website (https://www.multco.us/behavioral-health/addiction-provider-resources) for additional CIM messaging function and document upload information.

Claims Submissions Process

As a reminder, Multnomah Other is the payer of last resort. If the member has other coverage, that carrier must be billed. When Multnomah Other is the secondary payer the primary payer's Explanation of Benefit (EOB) is required. If a member has insurance coverage (not Multnomah Other), the provider **MUST** bill the primary payer (including Medicare, private insurance, etc.) for all services unless

- A member's primary payer is Medicare, there are several codes which are not required to be submitted to Medicare first – these are listed at the bottom of the Multnomah Other fee schedule (in the TPL Note) located on the Provider **website** under Rate Sheet & Billing Updates section. All services not listed in the TPL note must be billed to Medicare.
- Recovery support services – these are listed on the Multnomah Other fee schedule (under the 'For Uninsured Members Only' column, these codes are marked 'No'). If the primary payer is the Oregon Health Plan (OHP) these codes do not need to be billed to OHP first. If the member's primary payer is not OHP/HSO, these codes will need to be billed to the primary payer first.
- If the member has insurance but there is an extenuating reason why the primary insurance should not be billed, please submit the Eligibility for Indigent Services Funding Form – and write in under the 'Other' section the reason to request the waiver. Every request will be considered on an individual basis by plan staff.

When a Multnomah Other member is enrolled for being underinsured, the member's primary insurance must be billed (except for the conditions listed above). Providers may submit the secondary claim after

billing the primary provider as long as they are able to submit the secondary claim within timely filing requirements. Providers may also submit the secondary claim before the primary provider has adjudicated the claim for underinsured members. In this case submit the primary payer EOB directly to Billing Support once the primary payer has adjudicated the claim.

Multnomah Other Claims must be submitted to PH Tech electronically (through use of Electronic Data Interchange, EDI) or using paper forms. Claims are not submitted via CIM – only claims already adjudicated or in process are visible in CIM.

For questions regarding claim processing (where there is no claim number yet) please contact PH Tech provider services at 503-584-2151. If there is a question regarding a specific claim which has been issued a claim number, please contact billing.multother@multco.us.

EDI: EDI is the preferred method for receiving claims submissions. Contact the EDI team at PH Tech (edi.support@PHTech.com) for provider set-up to submit claims electronically or electronic submission issues. Please note that PH Tech uses Office Ally as their clearinghouse and their **Office Ally Payer ID is MLTOT**. All clearinghouse claims must be routed to Office Ally.

Rejected EDI Claims: Rejected claims should have an electronic confirmation message (ECM) that will indicate why the claim was rejected. If you have questions regarding the ECM, please contact edi.support@PHTech.com.

Paper: Paper claims must be submitted on red/white CMS 1500 forms. Photocopied forms will not be accepted. Paper claims should be mailed to:

> Multnomah Other
> PO BOX 5490
> Salem, OR 97304
> *All claims should be addressed to 'Multnomah Other' to ensure proper processing. Please note that multiple carriers send claims to this same PO BOX.

Rejected paper claims: Rejected claims will be sent back with a cover sheet indicating the reason why the claim was rejected. PH Tech does not keep copies of rejected claims.

Claims billed to the Incorrect Carrier

Providers are required to check insurance status on a regular basis for members who are eligible for insurance. Multnomah Other may elect to review member Medicaid coverage status at any time. If it is determined that the member had other coverage on the date of service, Multnomah Other may refund any approved claims and take back funds. This may occur at any point.

Providers will be notified of the claim reversal and may submit a claim to the member's primary insurance. Multnomah Other will not cover services that have been denied by another carrier for administrative reasons, such as failing to meet timely filing deadlines.

How to submit a corrected claim

1. If submitting a corrected claim/encounter by paper, please do not over-write or handwrite changes to the original claim, as these will not be accepted.
2. Create a new claim with applicable changes, noting on the top margin that the claim is a corrected claim.
3. Submit the paper claim as you would a new claim.

4. If submitting a corrected claim through electronic billing, the following loop information should be referred to: Loop 2300 Claim Information
    - Segment CLM05-03 Claim Frequency Type Code - inserting a value of '7' indicates that the claim is a replacement of the original
    - Segment REF-Payer Claim Control Number (these two segments correspond to CMS 1500 form, box 22a and 22b)
        - REF01 – Reference Identification Qualifier, inserting a value of 'F8' indicates Original Reference Number
        - REF02 – Reference Identification or Payer Claim Control Number, the original claim number should be listed

Credentialing/PH Tech set up?

Agencies are responsible for ensuring the credentialing/re-credentialing for the individual practitioners who are providing services to members. Credentialing practices should be in accordance with Medicaid and state regulations.

All providers submitting claims must have their information loaded into CIM in order for their claims to correctly process. The following information should be sent to providercontracting@phtech.com:

- name of provider
- credentials (licensure, QMHA-I,QMHP-C, Credentialed Peer Specialist)
- NPI
- taxonomy
- DMAP number
- effective date of when provider could start billing with agency

A provider who does not have the above information in CIM may have their claims denied. Please note that issues with provider set-up in CIM is not considered an extenuating circumstance for which a timely filing waiver would be approved. Please ensure that new providers have their information submitted to PH Tech as soon as possible.

All updates to this information should also be sent to providercontracting@phtech.com as soon as they are known. Examples include, but are not limited to:

- termination an existing provider
- change in practitioner's name
- change of practice address
- credentialing update

Grievances/Appeals

Per Chapter 309 Oregon Administrative Rules:

> 4) The provider shall post a Grievance Process Notice in a common area stating the telephone numbers of:
> (a) The Division;
> (b) Disability Rights Oregon;
> (c) Any applicable coordinated care organization; and
> (d) The Governor's Advocacy Office.

The provider's grievance policy and process should be reviewed with each member at intake. The provider's grievance policy should comply with Oregon Administrative Rules.

Member complaints should initially be addressed through the provider's grievance procedures. In alignment with the Oregon Health Authority, Multnomah Other encourages providers to facilitate resolution of the grievance at the lowest possible level.

Members may also have access grievance procedures through the following resources:

- Multnomah County Grievance and Complaints Line: 503-988-8600
- Oregon Health Authority Ombudsperson (503-947-2346 or toll free: 877-642-0450)

Provider relation complaints should be addressed to the Addiction Services manager, refer to Multnomah Other Contact List posted on the AD Provider website: https://www.multco.us/behavioral-health/addiction-provider-resources.

Appendices

The following appendices are located on the AD Provider website: https://www.multco.us/behavioral-health/addiction-provider-resources

– Multnomah Other Contact List
– Multnomah Other CIM Quick Guide
– Multnomah Other Common Denial Reasons (CARCs)
– Multnomah Other Eligibility and Enrollment