

Medicaid Q & A

MARSHFIELD CLINIC

Question

The July 21, 2008 WPS Medicare list service message contained information regarding the use of taxonomy codes on Medicare claims. It indicated “The Healthcare Provider Taxonomy Codes (HPTC) set is an external non-medical data code set designed for use in classifying health care providers according to provider type or practitioner specialty in an electronic environment (specifically within the American National Standards Institute (ANSI)).

Using taxonomy codes is beneficial and appropriate to use when the NPI corresponds to more than one legacy (PTAN) number. If you use the taxonomy code, it must be valid and used at the rendering provider level. The taxonomy code would be sent in the 2000A/PRV loop unless the provider is also sending a 2310B and/or 2420A loop. If sending a 2310B and/or 2420A loop, the taxonomy code should be sent at that level only. A prepass edit will set.”

We have been told that we have to transmit a taxonomy code with the billing NPI for many of our Medicaid/BadgerCare claims.

Based upon the Medicare information, if we submit that information on our Medicare claims for patients with Medicare and BadgerCare/Medicaid, the Medicare claim will not be accepted and processed. If we submit the claim to Medicare without the taxonomy numbers, Medicare will process and forward the claim to Medicaid, but as I understand it, Medicaid will not accept the claim. Since it hasn't been accepted into the Medicaid system, we won't receive a denial to notify us to submit a Medicaid claim.

If we cannot rely on the Medicaid system to notify us that they did not accept the cross-over claims, we will be forced to generate claims to Medicaid, even if Medicare indicates they have crossed them over. While this may create some problems with duplicate claim submissions, it is really the only alternative that we have to keep from having to implement a costly manual review process.

Are you considering sending the provider some type of notification that the cross-over claims have not been accepted?

Answer

In some instances Medicaid is able to process automatic crossover claims received from Medicare without the taxonomy code for the billing provider.

When a single NPI has been reported for multiple Medicaid legacy provider numbers, creating a duplicate NPI situation, Medicaid uses the taxonomy code and the ZIP+4 code to identify the billing provider. Medicaid can determine the billing provider without the using the taxonomy code when the ZIP+4 code of the billing provider uniquely identifies the provider. The ZIP+4 code of the billing provider on the claim is matched to the ZIP+4 code of the physical address on file with Medicaid. In addition, Medicaid can determine the billing provider without the using the taxonomy code when there is a one-to-one match of the NPI to the Medicaid legacy provider number.

If the two situations above do not exist, a Medicaid designated taxonomy code for the billing provider is needed to identify the provider. When the taxonomy code is needed and we do not receive the taxonomy code we cannot identify the billing provider in order to report paid or denied Medicare crossover claims information on the Remittance & Status report. We do not have a way to notify providers about denied claims when we cannot identify the provider. The EDI help desk can help research Medicare crossover transactions received from the Medicare COBA contractor that denied. If automatic crossover claims do not appear on the Medicaid Remittance & Status report after 30 days of the Medicare processing date, providers should resubmit the claim directly to Wisconsin Medicaid.

Question

We would like you to reconsider the requirement for providers to maintain a separate PIN for every billing provider number, taxonomy, zip plus four and program combination. We anticipate maintaining the number of PINS and passwords required will take an unreasonable amount of time, adding to our cost of providing care.

Answer

Providers do not need to maintain a PIN for every billing provider number, taxonomy, zip plus four and program combination. The PIN is used only one time – when the Provider sets up their Portal Administrator Account. Once a PIN has been used to set up the provider’s Portal Administrator account the PIN can never be used again. Providers must request PINs for every combination noted in the question; however, providers can combine all of their accounts under one Portal Administrator account by using the “Add Org” feature discussed at the August Provider Trainings (note a PDF version, as well as a webcast of this training are available on the Portal). Once the Portal Administrator account is set up, the Provider can use the User ID and password they selected when setting up the account.

Please note that the PIN process helps ensure the security of the Providers ForwardHealth data. Since the PIN is sent to the Provider address we currently have on file, the risk of someone outside the provider’s organization accessing the

providers account is virtually eliminated. Even if an inappropriate request was made for an account (note that the requester would need the NPI, taxonomy, zip plus four and program to even make the request), since the PIN is only sent to the address we have on file, the requester would have to be at the providers location to get the PIN letter that would get them access.

MILE BLUFF CLINIC

Question

Your requirement to have HPTC on claims for Billing and Rendering providers is causing us to incur a tremendous amount of overhead for our Medicare/ Medicaid patients. All of those secondary claims have to be hand keyed into PES software after we send them to Medicare who will then cross them over to MA only to be denied for a lack of taxonomy for the "Billing/Pay-To Provider taxonomy code."

My question is, are the state Medicaid's going to eventually get compliant with the 4010/4010A1 837P format or do we have to incur all this extra overhead cost until the 5010 version comes out in hopes that two different HPTC codes will be accepted in that standard format? (We do know that Medicare has said that they will not accept a claim that varies from the standard version now.)

Answer

In July 2007, CMS published FAQ 8585 stating that it was permissible for entities to report a taxonomy code in the loop labeled as "PRV 2000A" (Billing/Pay to Provider Specialty Information) even though the Version 4010/4010A1 837P Implementation Guide only permits the use of this loop when the Billing Provider is the same as the Rendering Provider reported in the 2310B loop. CMS recognized the solution provided in the July 2007 FAQ 8585 was inconsistent with the Implementation Guide and updated the FAQ on June 30, 2008. The FAQ reads as follows:

Question: May the Billing Provider Loop for the X12 837P (professional claim) be used to report a provider Healthcare Provider Taxonomy Code (HPTC) for a non-individual (e.g., a group practice) provider when the usage notes in the adopted Version of the Implementation Guide (4010/4010A1) state that the Billing Provider Loop of the 837P (PRV2000A) may only be used to report a provider HPTC when the Billing Provider is the same as the Rendering Provider reported in the Rendering Provider loop (2310B)? In most situations, the Billing Provider and the Rendering Provider are not the same.

Answer: The Healthcare Provider Taxonomy Code (HPTC) that is permitted for certain situations in the 4010/4010A1 837P Implementation Guide is a 10-character alphanumeric administrative code that identifies the health care provider type, classification, and, for some classifications, the area of specialization of health care providers. The code set is maintained and updated by the National

Uniform Claim Committee (NUCC). Health care providers may have more than one HPTC depending on their classifications and specializations, and select their own HPTCs from a list of available codes that is published by the Washington Publishing Company (available at www.wpc-edi.com/taxonomy.) While HPTCs are not health care provider identifiers, they do identify provider type, classification, and/or specialization, which is information that is often needed by health plans to determine claim reimbursement and subscriber benefits.

The Version 4010/4010A1 of the 837P Implementation Guide (for professional claims) states that it is not compliant to send the HPTC in both the Billing/Pay-to Provider Specialty Loop (PRV 2000A) and in the Rendering Provider Identifier loop (2310B), except in certain situations. Only when the Billing and Rendering Provider are the same is it permissible to report the HPTC in the Billing Provider Loop (2000A). The inability to report a Billing Provider's type, classification, or specialization, except when the Billing/Pay-to Provider is the same as the Rendering Provider, can burden health plans with the need to suspend claims, telephone providers for the additional information, and, in some cases, incorrectly adjudicate claims because needed information is not permitted by the IG to be submitted on the original claim.

This problem with the 4010/4010A1 837P Implementation Guide arose with the implementation of the NPI because the NPI does not contain intelligence about the type, classification, or specialization of the health care provider it identifies; whereas the previously used legacy identifier numbers often did. In order to obtain health care provider type, classification, or specialization information, some health plans are requesting submission of the HPTC in the Provider Specialty Loop (PRV 2000A) when the Billing Provider and Rendering Provider are not the same, even though this is inconsistent with the instructions in the Implementation Guide. For example, an Acute Care Testing medical group may have a number of different specialty providers within the group. In order to adjudicate a claim, a health plan may need to identify the specialty of the billing provider with a taxonomy code in the Loop 2000A PRV segment, even though, according to the 837 P 4010/4010A1 Implementation Guide, this segment is not used when the Billing or Pay-To Provider is a group and the individual Rendering Provider is identified in Loop 2310B.

There is an incompatibility between the 4010/4010A1 Implementation Guide requirements and the business need of the Billing Provider's type, classification, specialization. Therefore, until the adoption of a new Version of the professional health care claims transaction standard that corrects this problem, CMS will exercise enforcement discretion if HPTCs are reported for Billing Providers in the 837P claims transactions where the Billing Provider and the Rendering Provider are different. Each complaint will be evaluated on a case-by-case basis.

Note: In July 2007, CMS published FAQ **8585** stating that it was permissible for entities to report a taxonomy code in the loop labeled as "PRV 2000A"

(Billing/Pay to Provider Specialty Information) even though the Version 4010/4010A1 837P Implementation Guide only permits the use of this loop when the Billing Provider is the same as the Rendering Provider reported in the 2310B loop. The July 2007 FAQ **8585** attempted to resolve an issue that arose upon the implementation of the NPI Final Rule, when legacy identifiers could no longer be used in standard transactions. Legacy numbers usually contain intelligence about the providers they identify, such as type, specialization, location. However, the solution provided in the July 2007 FAQ **8585** was inconsistent with the Implementation Guide. The version of the FAQ provided here replaces the original FAQ that was published in 2007.

When Medicaid designed our NPI implementation solution the clarification provided in the July 2007 version of CMS FAQ 8585 was taken into consideration. Industry recommends health plans and trading partners work together on how to proceed in the interim until the updated version of the guide is in place.

Until the 5010 requirements are finalized, it is necessary for providers to resubmit claims directly to Wisconsin Medicaid if automatic crossover claims do not appear on the Medicaid Remittance & Status report after 30 days of the Medicare processing date,

AGNESIAN HEALTHCARE

Question:

Why is Wisconsin Medicaid assigning different taxonomy codes from what was used when the provider signed up for his/her NPI number? We have loaded the taxonomy codes into our system that are consistent with the codes listed in NPPES. Our HMO Medicaid plans are using the taxonomy that is listed in NPPES but Wisconsin Medicaid has assigned a different code. How can we submit one code to all other payers which is consistent with NPPES and a different code to Medicaid? Example: One of our providers is a hospitalist and the taxonomy that is listed for him in NPPES is for a hospitalist; Medicaid assigned the Internal Medicine taxonomy code.

Answer

The taxonomy code designated for use by Medicaid relates to the type of Medicaid certification held by the provider. This may not be the same taxonomy code the provider originally submitted to the National Plan and Provider Enumeration System (NPPES). Not all taxonomy codes are recognized by Wisconsin Medicaid. For example, some taxonomy codes may correspond to provider types not certifiable with Wisconsin Medicaid or they may represent

services not covered by Wisconsin Medicaid. Therefore, it is important providers indicate the taxonomy code required by Wisconsin Medicaid.

NPI FAQ #2356 published by CMS provides guidance to providers and payers on the purpose and use of Healthcare Provider Taxonomy codes for claims submission and processing. WI Medicaid requirements for use of taxonomy codes for billing are consistent with this guidance.

For the situation described in the question, Medicaid assigned internal medicine based on the specialty the provider selected on the certification application. Medicaid does not recognize hospitalist as a provider specialty for Medicaid certification purposes.

PREVEA HEALTH

Question:

Here are our questions in regards to secondary claims being submitted to Medicaid:

In the seminar it was indicated that the new system will not accept claims with any handwritten remarks, white out or staples.

Answer

ForwardHealth will be utilizing Optical Character Recognition (OCR) software for processing 1500 Health insurance claim Forms and UB-04 Claim Forms with the implementation of ForwardHealth interChange. *ForwardHealth Update* (2008 45), titled "Paper Claim Form Preparation and Data Alignment Requirements for ForwardHealth interChange" provided guidelines for submitting claims in order to utilize the efficiencies of OCR processing. This information was also provided in the statewide provider training conducted in July 2008. The purpose of this software is to improve the speed and accuracy of processing paper claims for providers by elimination of manual data entry. The paper submission requirements will help assure document management software can process the claim without manual intervention.

ForwardHealth will continue to accept and process claims that do not follow the OCR guidelines; however, claims that cannot be read by the OCR software will need to be manually keyed from the electronic image of the claim. This may cause additional processing time as the claims will not benefit from the efficiencies of OCR processing.

Question:

Are the primary insurance disclaimer codes (examples below) still going to be required with the new system?

Examples of Disclaimer codes:

OI-P Other Insurance Paid

OI-D Other Insurance Denied

OI-Y Other Insurance Yes

M-6 Recipient not Medicare eligible

M-7 Medicare disallowed or denied payment

M-8 Non covered Medicare service

MMC - Medicare Managed Care (Medicare replacement policies)

Answer:

Yes, these codes are not changing.

Question:

If so, how are we to submit the required disclaimer codes if we are no longer able to hand write or use white out on the claim forms?

Also, how are we to ensure all the required documents that we submit with claims are going to be processed together if we are not able to use staples?

We also have to white out all Medicare payments

Answer:

Please see the answer to the previous question. In addition, ForwardHealth will accept multi-page claims with attached documentation. We have suggested that providers number multi-page claims if there is a concern (e.g., Page 1 or 5). As indicated in the answer to the previous question, this may require manual processing of the claim; however, the claim will be accepted and processed.