TRIBAL HEALTH PROGRAM

Billing Guide

July 1, 2016

About this guide*

This billing guide is designed to assist Tribal health care facilities and providers to deliver health care services to eligible clients, and to bill the Medicaid agency for delivering those services. This publication takes effect July 1, 2016, and supersedes earlier guides to this program.

> This Tribal Health Program Billing guide applies to providers in the Indian Health Service (IHS) and in Tribal 638 Facilities. Providers who are not in IHS or in Tribal 638 Facilities should refer to the appropriate program-specific provider billing guide.

This guide is intended to be used in conjunction with all of the following:

- Medicaid State Plan
- Medicaid Washington Administrative Code (WAC)
- ProviderOne Billing and Resource Guide
- Program-specific billing guides

All requirements of the Medicaid State Plan apply to Tribal health care facilities, programs, providers, and clients. This includes, but is not limited to, coverage benefit limitations, prior authorization, and reimbursement requirements and limitations. Refer to Washington Apple Health program-specific billing guides for covered services, prior authorization (PA) requirements, expedited prior authorization (EPA) criteria, and limitations.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

* This publication is a billing instruction.

What has changed?

Subject	Change	Reason for Change
All	Clarified language, fixed broken links, etc.	Housekeeping
Name Change	The agency is changing the name of the Provider Guides to Billing Guides.	Align with the agency's new website redesign launching in August
SUD Services	Removed definitions, codes, and instructions related to the provision of substance-use disorder (SUD) services. This information is now located in the agency's *Substance-Use Disorder Billing Guide (Fee-for-Service Benefits Provided Outside of the BHO Process).*	Information belongs in a different billing guide
Encounter Rates	Updated information under Are pharmaceuticals and drugs included in the encounter payment?	To align with the State Plan
Reference	Added new section Where do I find program-specific policy?	Clarification

How can I get agency provider documents?

To download and print agency provider notices and Washington Apple Health billing guides, go to the agency's Provider Publications website.

Copyright disclosure

Current Procedural Terminology (CPT) copyright 2015, American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Table of Contents

Resources Available **6**

Definitions **7**

Program Overview **11**

Washington Apple Health (Medicaid) and Federally Recognized Tribes 11
What is a Direct IHS Facility or a Tribal 638 Facility? 11
What are the basic requirements for a Tribal health care facility to be eligible for Medicaid reimbursement? 12
How does a Tribal health care facility become an enrolled Medicaid provider? 12
Which providers are eligible for the IHS encounter rate? 13

Client Eligibility **14**

How can I verify a patient's eligibility? 14
Which clients do not qualify for the encounter payment? 15
Are managed care clients eligible for services provided by a Direct Indian Health Service (IHS) Facility or a Tribal 638 Facility? 16

Encounter vs. Fee-for-Service **18**

How do I determine if a service qualifies as an encounter? 18
What are the categories of encounters the agency recognizes? 18
Can services qualify in two different encounter categories? 19
Which types of services do NOT qualify for an encounter payment? 20
Which services and supplies are incidental to professional services? 20
Are pharmaceuticals and drugs included in the encounter payment? 21
How does the agency determine if a claim is eligible for an encounter payment? 21
How are services not eligible for an encounter paid? 22

Billing and Claim Forms **23**

What are the general billing requirements? 23
What additional requirements must Tribal health clinics follow when billing? 23
How do I submit CMS-1500 and Dental ADA claim forms electronically? 24

Medical Services **25**

What is a medical encounter? 25
How many medical encounters are allowed? 26
How do I bill for a medical service encounter? 26
Sample medical encounter claim 27

Dental Services **28**

What is a dental encounter? 28
Where do I find program specific policies? 28

Alert! This Table of Contents is automated. Click on a page number to go directly to the page.

EPA Guidelines ... 28
EPA Criteria Coding List ... 29
How many dental encounters are allowed? ... 29
How do I bill for a dental encounter? ... 30
Sample dental encounter claim ... 31

Mental Health Services ... 32

What is a mental health encounter? ... 32
Where do I find program-specific policy? ... 33
How many mental health service encounters does the agency pay for? ... 33
Expedited prior authorization (EPA) guidelines ... 33
EPA Code and Criteria ... 35
How do I bill for a mental health encounter? ... 36
Sample mental health encounter claim ... 37

Substance Use Disorder and Treatment Services ... 38

What is a substance use disorder (SUD) encounter? ... 38
Who can receive substance use disorder treatment services? ... 38
How many SUD encounters does the agency pay for? ... 39
How do I bill for an SUD encounter? ... 39
What is the payment for an SUD encounter? ... 40
Sample SUD encounter claim ... 41
What is the process for an intergovernmental transfer (IGT)? ... 42

Billing for the Encounter Rate After Other Payers ... 43

Billing for the encounter rate after private insurance ... 43
Billing for the encounter rate secondary to Medicare ... 43
Billing for the encounter rate after Medicaid Managed Care Organization (MCO) payment ... 43

Enrolling/Disenrolling American Indian/Alaska Native Clients from Managed Care or Primary Case Care Management ... 44

Medicaid Administrative Claiming ... 46

Medicaid Administrative Claiming (MAC) ... 46
Purpose of the Washington State MAC Program ... 46
Examples of Reimbursable MAC Activities ... 46

Resources Available

Note: This section contains important contact information relevant to the Tribal Health Program. For more contact information, see the agency's Resources Available web page.

Topic	Contact Information
Tribal health program mental health and substance use disorder treatment services	Behavioral Health Administration **Tribal Liaison** (360) 725-3475
Tribal health program medical or dental services	**Washington Apple Health (Medicaid)** **Tribal Health Program Manager** (360) 725-1649 tribalaffairs@hca.wa.gov

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

"638" Compact – Compact (or Annual Funding Agreement) to carry out self-governance as authorized by Title II, P.L. 103-413, III, P.L. 100-472, which built upon the Self-Governance Demonstration Project and transfers control to Tribal governments, upon Tribal request, over funding and decision making of Federal programs, activities, functions, and services as an effective way to implement the federal policy of government-to-government relations with Indian Tribes.

"638" Contract – A contract between Tribes and the Indian Health Service (IHS) that provides for Tribes to assume responsibility for providing social and health care services to AI/ANs. Authorized by Public Law 93-638, Indian Self Determination Act.

Agency – The Washington State Health Care Authority, which has been designated by the Washington State legislature as the single state Medicaid agency.

American Indian/Alaska Native (AI/AN) - A person having origins in any of the original peoples of North America.

Attestation – Clients self-attest their AI/AN status**.**

Behavioral Health Organization (BHO) – A single- or multiple-county authority or other entity operating as a prepaid health plan with which HCA or HCA's designee contracts for the delivery of community outpatient and inpatient mental health and substance use disorder services in a defined geographic area.

Bureau of Indian Affairs (BIA) – Federal agency under the Department of the Interior responsible for the administration and management of land held in trust by the United States for AI/ANs and Indian Tribes. Developing forestlands, leasing assets on these lands, directing agricultural programs, protecting water and land rights, developing and maintaining infrastructure, providing for health and human services, and economic development are all part of this responsibility taken in cooperation with the AI/ANs.

CMS – Centers for Medicare and Medicaid Services.

Canadian First Nation/Jay Treaty Person - A person born in Canada, having at least 50% aboriginal blood.

Chemical Dependency Professional (CDP) – A person certified as a chemical dependency professional by the Washington State Department of Health under Chapter 18.205 RCW.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Chemical Dependency Professional Trainee (CDPT) – A person certified as a chemical dependency professional trainee by the Washington State Department of Health under Chapter 18.205 RCW.

Client (for SUD services) - A person receiving substance use disorder services from a DBHR-certified agency.

Clinical Family Member (for mental health services only) – A person who maintains a familial relationship with a Tribal member, including:

- A spouse or partner of an eligible AI/AN.
- A person under age 19, or is an incapacitated adult; ***and*** is the natural or adopted child, step-child, foster-child, legal ward, or orphan of an eligible AI/AN.
- A child in common, a foster or custodial child, or an adopted child placed within a family unit in which any member is an eligible AI/AN.
- A non-native woman pregnant with an eligible AI/AN's child. If unmarried, the woman may be a Clinical Family Member if an eligible AI/AN male attests in writing that he is the father of the unborn child, or AI/AN paternity is determined by order of a court of competent jurisdiction.
- A non-native adult who has guardianship, custodial responsibility, or is acting *in loco parentis* (to assume the duties and responsibilities of a parent or acting as temporary guardian) for an eligible AI/AN minor.

Courtesy Dosing – Temporary dosing from another approved Opiate Substitution Treatment facility provided to a patient when they are away from their home clinic.

Direct IHS Facility – A facility that is operated directly by the Indian Health Service (IHS)

Division of Behavioral Health and Recovery (DBHR) – The Division of Behavioral Health and Recovery (DBHR), Department of Social and Health Services, provides support for Mental Health, Substance Use Disorder, and Problem Gambling Services. The public mental health programs promote recovery and resiliency and reduce the stigma associated with mental illness. The substance abuse prevention and substance use disorder treatment programs promote strategies that support healthy lifestyles by preventing the misuse of alcohol, tobacco, and other drugs, and support recovery from the disease of substance use disorder. The problem gambling program mitigates the effects of problem gambling on the family and helps families remain economically self-sufficient without requiring assistance from other state programs. DBHR brings operational elements like medical assistance, substance use disorder and mental health into closer working relationships that serve people more effectively and efficiently than before.

DSHS – Washington State Department of Social and Health Services.

Encounter – An encounter is a face-to-face contact between a health care professional and a Medicaid beneficiary for the provision of medically necessary, Medicaid-defined services from a Direct IHS Facility or Tribal 638 Facility within a 24-hour period ending at midnight, as documented in the patient's record.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Encounter Payment – The agency's payment of the IHS Encounter Rate to Direct IHS Facilities or 638 Tribal Facilities in accordance with the Memorandum of Agreement.

Federally recognized Tribe – Tribal entities acknowledged by the US Government and eligible for funding and services from BIA by virtue of their status as Indian Tribes. Tribes are acknowledged to have the immunities and privileges available to other federally acknowledged Indian Tribes by virtue of their government-to-government relationship with the United States as well as the responsibilities, powers, limitations, and obligations of such Tribes.

Indian Health Service (IHS) – A federal agency under the Department of Health and Human Services, including contracted Tribal health programs, entrusted with the responsibility to assist eligible AI/ANs with health care services.

IHS Beneficiary – An AI/AN who provides proof of being a member in or a descendent of a federally recognized Indian Tribe and who is eligible for services funded by the IHS.

IHS Encounter Rate – The all-inclusive rate for an Encounter at a Direct IHS Facility or 638 Tribal Facility, set forth in the Memorandum of Agreement. The IHS Encounter Rate is published by the federal Office of Management and Budget in the Federal Register on an annual basis.

Memorandum of Agreement (MOA) – The December 19, 1996 memorandum of agreement between the federal Health Care Financing Administration (now CMS) and IHS. The MOA established the IHS encounter rate for payment of Medicaid services provided to AI/AN people on and after July 11, 1996, through Direct IHS Facilities or 638 Tribal Facilities.

Substance use disorder — A problematic pattern of substance abuse leading to clinically significant impairment or distress, ranging in severity from mild, moderate, or severe.

Substance use disorder treatment - Medical and rehabilitative social services provided to an eligible client designed to mitigate or reverse the effects of substance use disorder and restore normal physical and psychological functioning. Drug addiction or drug abuse treatment is characterized by a combination of drug and alcohol education sessions, individual therapy, group therapy and related activities provided to detoxified clients and their families.

Tribal 638 Facility – A facility operated by a Tribe or a Tribal organization, and funded by Title I or Title V of the Indian Self Determination and Education Assistance Act (Public Law 93-638, as amended).

Tribal Substance Use Disorder Treatment Services Program – A qualified Tribal substance use disorder treatment program that contracts with DSHS under the provisions of the MOA.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Tribal organization – Any legally established organization of Indians which is controlled, sanctioned, or chartered by one or more federally recognized Tribes or whose governing body is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; see Section 4(26) of the Indian Health Care Improvement Act, 25 U.S.C. §1603(26).

Washington Apple Health – The brand name for all Washington State medical assistance programs, including Medicaid. The brand name may be shortened to "Apple Health."

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Program Overview

Washington Apple Health (Medicaid) and Federally Recognized Tribes

The State of Washington recognizes Congress's intent to provide Medicaid funds to Indian Health Service (IHS) and Tribal governments for the delivery of Medicaid services to eligible members of federally recognized Tribes. Under the Centennial Accord, the agency supports a government-to-government relationship between Tribes and the State of Washington. The agency partners with federally recognized Tribes to use all possible Medicaid and state health funding to assist Tribes in addressing the health needs of American Indian/Alaska Natives (AI/ANs) and to raise their health status to the highest possible level.

What is a Direct IHS Facility or a Tribal 638 Facility?

Health programs of federally recognized Tribes and Tribal organizations may operate health care facilities in a number of ways. IHS may directly operate one or more health care facilities for a federally recognized Tribe; these facilities are called Direct IHS Facilities in this guide. A federally recognized Tribe may choose to operate a health care facility and receive funds under Title I or Title V of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended); these facilities are called Tribal 638 Facilities in this guide.

Under the Memorandum of Agreement (MOA) between the federal Health Care Financing Administration (HCFA) and IHS. Tribal health care facilities may choose to be designated as one of the following:

- **IHS Facility under the MOA:** A Tribal health care facility that is a Direct IHS Facility or a Tribal 638 Facility may be designated as an IHS facility under the MOA. An IHS Facility under the MOA receives the IHS encounter rate for eligible services provided to Medicaid clients. The encounter rate is an outpatient, per-visit rate that includes all on-site laboratory and X-ray services, as well as all medical supplies incidental to that visit. The encounter rate is published in the Federal Register annually and is retroactive to the first of the year. The agency automatically processes a retroactive claims adjustment each year to ensure payment of the updated rate.

- **Federally Qualified Health Center (FQHC):** A Tribal health care facility may be designated as an FQHC under the MOA if it meets federal requirements. Each FQHC receives an encounter rate specific to that FQHC, from the agency, for eligible services provided to Medicaid clients. For more information regarding FQHCs, see the agency's Federally-Qualified Health Centers Billing Guide.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

- **Tribal health care facility:** A Tribal health care facility may be designated as a fee-for-service (FFS) Medicaid provider instead of an FQHC or IHS Facility under the MOA. These Tribal health care facilities receive standard FFS rates for eligible services provided to Medicaid clients and do not receive an encounter rate. Refer to the appropriate Washington Apple Health program-specific billing guide for information about provider and client eligibility, covered services, and payment rates.

The agency allows only Direct IHS Facilities and Tribal 638 Facilities that have chosen to be designated as IHS Facilities under the MOA, as indicated on the IHS Facilities List provided by IHS to CMS, to participate in the Medicaid Tribal Health Program and receive the IHS encounter rate.

What are the basic requirements for a Tribal health care facility to be eligible for Medicaid reimbursement?

To be eligible for Medicaid payments, a Tribal health care facility must:

- Meet state and federal requirements for Medicaid (including Section 1911 of the Social Security Act);
- Meet all Washington state standards for licensure except that servicing providers at Tribal health care facilities may be licensed by any state; and
- Be approved by the agency.

How does a Tribal health care facility become an enrolled Medicaid provider?

Providers, including Direct IHS Facilities and Tribal 638 Facilities, must submit a *Core Provider Agreement* (CPA), HCA 09-015, for each National Provider Identifier (NPI) number registered.

Satellite locations must be identified on the main facility CPA or on a separate CPA. For more information regarding CPAs, see the agency's ProviderOne Billing and Resource Guide.

Submit applications for Medicaid provider enrollment to:

Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562
Attn: Tribal Enrollment Coordinator

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Which providers are eligible for the IHS encounter rate?

See the Definitions section for the definition of **Encounter**.

To be eligible for the IHS encounter payment, health care professionals must meet all of the following:

- Meet the applicable training and/or licensure requirements for providing services under state and federal laws, rules, and regulations
- Be listed as a performing provider under a Direct IHS Facility or a Tribal 638 Facility that has a signed CPA with the agency. The following providers do not need to be listed as a performing provider:
  - ✓ Chemical Dependency Professionals (CDPs) or Chemical Dependency Professional Trainees (CDPTs) because the agency does not enroll CSPs or CDPTs
  - ✓ *Locum tenens* as long as they are currently listed under any other billing group
- Perform services within the scope of their practice
- Be one of the following:
  - ✓ Advanced Nurse Practitioner
  - ✓ Audiologist
  - ✓ Chemical Dependency Professional or Chemical Dependency Professional Trainee (within Certified Chemical Dependency Treatment Facilities)
  - ✓ Dentist
  - ✓ Mental Health Professional (MHP), which includes:
    - ➢ Psychologists
    - ➢ Psychiatric Advanced Registered Nurse Practitioners (P-ARNP)
    - ➢ Psychiatric mental health nurse practitioners-board certified (PMHNP-BC)
    - ➢ Independent Clinical Social Workers or Licensed Advanced Social Workers
    - ➢ Mental Health Counselor
    - ➢ Marriage and Family Therapists
  - ✓ Nurse Midwife
  - ✓ Occupational Therapist
  - ✓ Optometrist
  - ✓ Physician (including Naturopathic Physician)
  - ✓ Physician Assistant
  - ✓ Physical Therapist
  - ✓ Podiatrist
  - ✓ Speech-Language Pathologist

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Client Eligibility

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

To verify eligibility, follow this two-step process:

Step 1. **Verify the patient's eligibility for Washington Apple Health.** For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's current ProviderOne Billing and Resource Guide.

If the patient is eligible for Washington Apple Health, proceed to **Step 2**. If the patient is not eligible, see the note box below.

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's Scope of Categories of Service Table.

Note: Patients who wish to apply for Washington Apple Health can do so in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org

2. By calling the Healthplanfinder Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)

3. By mailing the application to:

   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Healthplanfinder Customer Support Center.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Which clients do not qualify for the encounter payment?

Clients identified in ProviderOne with the following recipient aid category (RAC) codes are enrolled in a state-only program and services provided to these people do not qualify for the encounter payment:

RAC Code	Medical Coverage Group Codes
1040	F99
1056, 1057, 1176, 1177 only	K03
1060, 1062, 1179, 1180 only	K95
1060, 1062, 1179, 1180 only	K99
1077, 1078, 1081, 1082, 1158-1161, 1182-1185 only	L04
1190-1195 only	L24
1085, 1087, 1155, 1157, 1186, 1187 only	L95
1085, 1087, 1090, 1092, 1155, 1157, 1186, 1187, 1188, 1189	L99
1206, 1207 (SUD encounters only)	N13
1208	N21
1210	N25
1211	N31
1212, 1213	N33
1097, 1098 only	P05
1099, 1100	P06
1112, 1113	S03
1119, 1120	S07
1034, 1123	S30
1125, 1127	S95
1125, 1127	S99
1214	A01
1215	A01
1216	A05

The agency pays for services to clients with these RAC codes at the standard fee-for-service rates without an encounter payment.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Are managed care clients eligible for services provided by a Direct Indian Health Service (IHS) Facility or a Tribal 638 Facility?

[Refer to WAC 182-538-060 and 095 and WAC 284-43-200]

Yes. When verifying eligibility using ProviderOne, if the client is enrolled in an agency-contracted managed care organization (MCO), managed care enrollment will be displayed on the *benefit inquiry* screen in ProviderOne. The MCO is the primary payer for medical services for Washington Apple Health clients. The remaining balance of the IHS encounter rate may be billed to ProviderOne for American Indian/Alaska Native (AI/AN) clients.

The following services provided by Direct IHS Facilities or Tribal 638 Facilities may be billed directly to the agency:

- Substance use disorder treatment (for both AI/AN and non-AI/AN clients)
- Dental care (for both AI/AN and non-AI/AN clients)
- Mental health services (for AI/AN clients and for non-AI/AN clients who meet the definition of Clinical Family Member)

Send claims to the clients MCO for payment. MCOs are required to pay for covered services regardless of whether or not the Tribe is contracted with the MCO if the client is AI/AN. However, if the client is non-native, call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited circumstances as described in WAC 182-502-0160.

Note: Clients enrolled in an agency-contracted behavioral health organization (BHO) are eligible for fee-for-service substance use disorder (SUD) treatment services that are provided through a tribal clinic. These clients are also eligible for SUD treatment services:

- Through their regional Behavioral Health Organization (BHO), except in the southwest Washington (SW WA) region (Clark and Skamania counties). To access these services through the BHO, use the BHO Contacts for Medicaid Services information found here.
- Through the agency-contracted MCO for clients who reside in SW WA.

Note: To prevent billing denials, check the client's eligibility **before** scheduling services and at the **time of the service;** also, verify proper plan authorization or referral. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Primary Care Case Management (PCCM): If a client has chosen services with a PCCM, this information will be displayed on the *benefit inquiry* screen in ProviderOne. These clients must obtain or be referred for services via one of the health care professionals in the client's PCCM clinic. The PCCM provider is responsible for coordination of care just like the Primary Care Provider (PCP) would be in a managed care plan. Clients do not need a referral from a PCCM to be able to receive emergency or women's health care services.

The PCCM contract was developed as an alternate resource for federally recognized Tribal members who are eligible for Medicaid Managed Care and for care at Direct IHS Facilities or 638 Tribal Facilities. This contract is available to Tribes interested in providing case management services to federally recognize Tribal members eligible for managed care. The contract allows the clinic to bill the encounter rate for treatment services to Medicaid-eligible clients and be paid for case management services.

Tribes may participate in PCCM or Medicaid Administrative Claiming (MAC). To avoid duplication of services and payment, tribes must participate in only one of these two programs.

For more information, call (360) 725-1649.

Note: You may not receive payment if the client is enrolled with a PCCM/PCP and any of the following apply:

- You are not the client's designated PCCM/PCP
- The client was not referred to you by one of the health care providers at the PCCM clinic/PCP
- You are not providing emergency care or women's health services

Contact the PCCM/PCP to get a referral

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Encounter vs. Fee-for-Service

How do I determine if a service qualifies as an encounter?

The agency pays Direct IHS Facilities and Tribal 638 Facilities participating in the Medicaid Tribal Health Program the IHS encounter rate for services that meet all of the requirements for the encounter rate in this billing guide. For a health care service to qualify as an encounter, it must meet all the following criteria.
The service must be:

- Medically necessary
- Conducted face-to-face
- Identified in the Medicaid State Plan as a service that is both of the following:
  - ✓ Covered by the agency
  - ✓ Performed by a health care professional within their scope of service
- Documented in the client's file in the provider's office. Client records must be maintained by the primary health care facility to ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Performed in the health care facility identified on the IHS facility list or at satellite or Branch locations where Tribal health care facility-supported activities are performed by qualified staff who are eligible for the encounter rate (see page 13).

What are the categories of encounters the agency recognizes?

The agency recognizes four categories of Tribal encounters:

- Medical
- Dental
- Mental health
- Substance use disorder

Note: The agency pays for up to one of each categorical encounter per day unless the client has an emergency. See the Medical, Dental Services, Mental Health, or Substance Use Disorder sections in this billing guide.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Can services qualify in two different encounter categories?

Yes. The IHS encounter category for a billed service is based on the Washington Apple Health program-specific billing guide that describes the service. Some providers are licensed to provide services described in multiple billing guides that translate to multiple permitted encounter categories. For example, psychiatrists are licensed to provide services found in both the Mental Health Services Billing Guide and the Physician-Related Services/Health Care Professional Services Billing Guide, which translate to either a mental health encounter or a medical encounter. In these situations, the Tribal health program may choose one of the permitted encounter categories based on the billing taxonomy the Tribal health program uses on the claim. No service performed may be billed more than once.

Clinics may not:

- Develop clinic procedures that routinely involve multiple encounters for a single date of service
- Unbundle services that are normally rendered during a single visit for the purpose of generating multiple encounters
- Ask patients to make repeated or multiple visits to complete what is considered a reasonable and typical office visit, unless it is medically necessary. Medical necessity must be clearly documented in the patient's record.

Examples:

- Services with: (a) more than one health professional for the same or related diagnoses within the same encounter category; or (b) the same health professional that take place on the same day, at a single location, and for the same or related diagnoses within the same encounter category constitute a single encounter.
- A servicing provider may not bill for a medical encounter and a mental health encounter for the same client on the same day unless the services have unrelated diagnoses. The servicing provider must then use unrelated servicing provider taxonomies with different specialty types, as appropriate for the service.
- A dental encounter and a physician encounter may be billed on the same day.
- A facility may bill for a second encounter if a client returns due to an emergency.

Note: Billing for the same service under a different type of encounter is considered duplication of billing.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Which types of services do NOT qualify for an encounter payment?

The following services do not qualify for an encounter payment:

- Blood draws, laboratory tests, and/or X-rays – these services are bundled into the same categorical encounter rate if they are provided within the same 24-hour period as the encounter-eligible service. If these services are provided outside of that 24-hour period, they are reimbursable at the standard fee-for-service (FFS) rate.

  For example: A dental X-ray is bundled into the dental encounter rate if the patient receives an encounter-eligible dental service within the same 24-hour period. A dental X-ray is never bundled into a medical encounter rate. A dental X-ray that is provided without an encounter-eligible dental service is reimbursed through FFS.

- Drugs or medication treatments provided during a clinic visit. See also Pharmaceuticals and Drugs Separate from Professional Services.

- Courtesy dosing (see Definitions)

- Case management services (for example, HIV/AIDS case management)

- Maternity Support Services or Infant Case Management

Which services and supplies are incidental to professional services?

Services and supplies incidental to the professional services of encounter-level practitioners are included in the encounter rate paid for the professional services when the services and supplies are:

- Administered as part of the practitioner's professional services (for example, pharmaceuticals and drugs given by injection, oral, or topical delivery as part of a clinical visit)

- Furnished as an incidental, although integral, part of the practitioner's professional services (for example, professional component of an X-ray or lab)

- Of a type commonly furnished either without charge or included in the encounter bill

- Of a type commonly furnished in a provider's office (for example, tongue depressors, bandages, etc.)

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

- Provided by center employees under the direct, personal supervision of encounter-level practitioners

- Furnished by a member of the center's staff who is an employee of the center (for example, nurse, therapist, technician, or other aide)

Are pharmaceuticals and drugs included in the encounter payment?

No. Pharmaceuticals and drugs are not included in the encounter rate, but they are reimbursable through fee-for-service. Pharmaceuticals, drugs, IUDs, and contraceptive implants must be billed on a separate claim from the encounter claim to avoid bundling the items into the encounter payment.

How does the agency determine if a claim is eligible for an encounter payment?

The agency determines a claim to be encounter eligible (i.e., a claim meets the requirements for IHS encounter rate eligibility) when all of the following conditions are true:

- The client's recipient aid category (RAC) code is encounter-eligible.
- The claim is billed by a Direct IHS Facility or 638 Tribal Facility.
- The claim is billed on a professional (837P/CMS-1500) or dental (837D/ADA) claim.
- The billing taxonomy on the claim is one of the taxonomy codes listed in this guide.
- The servicing provider type is listed in this guide as eligible to receive the encounter rate.
- HCPCS code T1015 must be billed on a service line on the claim.
- The appropriate American Indian/Alaska Native (AI/AN) or non-native modifier EPA or claim note is billed on the claim (see instructions below for each category of encounter).
- The claim has at least one line for a service that is correctly billed and eligible for payment for the same date of service as indicated for the T1015 line. If the claim that is correctly billed has only one or more of the following services and the T1015 line, the claim will not be eligible for the encounter payment:

  - ✓ 36400-36425
  - ✓ 36511-36515
  - ✓ 38204-38215
  - ✓ 70000-79999
  - ✓ 80000-89999
  - ✓ 90281-90749
  - ✓ 99441-99443

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

- ✓ D0210, D0220, D0230, D0240, D0270, D0272, D0273, D0274, D0321, D0330, D0340, D0350, D0460, D0501
- ✓ H0030
- ✓ All J codes
- ✓ P3000-P3001
- ✓ All Q codes
- ✓ All S codes (except S9436 and S9445-S9470)
- ✓ T1017

How are services not eligible for an encounter paid?

Services that are not eligible for the IHS Encounter Rate are payable on as FFS using the agency's fee schedules. For information on FFS, refer to the appropriate Fee Schedule.

Note:	Tribal providers are required to include the appropriate AI/AN or non-native designators (i.e., modifiers, EPA numbers, or claim notes as described in the instructions on the following pages for each category of encounter) on all claims.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Billing and Claim Forms

What are the general billing requirements?

Providers must follow the agency's ProviderOne Billing and Resource Guide.

These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments
- What fee to bill the agency for eligible clients
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
- Billing for clients eligible for both Medicare and Medicaid
- Third-party liability
- Record keeping requirements

What additional requirements must Tribal health clinics follow when billing?

All services performed by one or more providers on the same day, under the same category of encounter must be billed on the same claim. This includes any services performed during an encounter-eligible visit that are not encounter eligible. **Example:** Lab services performed during the same visit as an office visit.

- An encounter-eligible service must be billed with HCPCS T1015.

- If reprocessing a service that was denied or not correctly included when the original claim was billed (for example, blood draws, laboratory tests, or x-rays provided within the same 24-hour period as the encounter eligible service), the paid claim must be adjusted. If the original claim is not adjusted to add these services, your additional claim may be denied.

When billing fee-for-service (FFS), **the appropriate American Indian/Alaska Native (AI/AN) or non-native modifiers, EPA, or claim note are required on all claims**.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

How do I submit CMS-1500 and Dental ADA claim forms electronically?

Instructions on how to bill professional claims and crossover claims electronically can be found on the agency's Medicaid Providers Training page under Medicaid 101. Also, see Appendix I of the agency's ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 claim form.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Medical Services

What is a medical encounter?

A medical encounter is an Encounter (see Definitions) by one of the practitioners listed below for services described in the program-specific policies listed below. Service limitations and prior authorization requirements (program-specific policies) apply to all Medicaid clients for applicable Medicaid covered services.

Providers eligible for a medical encounter	Refer to the agency's program-specific billing guides for a list of Medicaid covered services by the provider
Physicians, Physician Assistants, Advanced Registered Nurse Practitioners	• Physician–Related Services/Health Care Professional Services • Chiropractic Services for Children • Diabetes Education Program • Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Program • Family Planning • Medical Nutrition Therapy • Sterilization Supplement
Nurse Midwives	• Planned Home Births and Births in Birthing Centers
Podiatrists	• Physician–Related Services/Health Care Professional Services (see Foot Care Services)
Optometrists	• Physician–Related Services/Health Care Professional Services (see Ophthalmology – vision care services)
Occupational Therapists, Physical Therapists, Speech-Language Pathologists & Audiologists	• Outpatient Rehabilitation • Habilitative Services

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

How many medical encounters are allowed?

The agency covers **one medical service encounter per client, per day** (regardless of how many procedures are done or how many providers are seen).

> **Note:** When the client is seen on multiple days for a maternity service package (e.g., CPT code 59400), add modifier TH to HCPCS code T1015 using the same date of service as the maternity service CPT code. The units on the encounter line must equal the number of days that the client was seen for the encounter eligible services related to the maternity service package. **All maternity-related services are included in the service payment and are not paid as separate encounters.**

Exception: If, due to an emergency, the client returns on the same day for a second visit and has an unrelated diagnosis, a second encounter is allowed. Use modifier 59 on the HCPCS code T1015 line to indicate that it is a separate encounter. The time of the initial and subsequent visit must be in the client's record.

How do I bill for a medical service encounter?

Facilities must follow the agency's program-specific billing guide and do all of the following:

- Bill a professional (837P/CMS1500) claim.
- Bill with an appropriate billing taxonomy (listed below.)
- Add HCPCS code T1015.
- Bill with an American Indian/Alaska Native (AI/AN) or non-native modifier on every line on the claim (after adding all modifiers that may be required by the source program.)

Type of encounter	Billing taxonomy	AI/AN modifier	Non-native modifier
Medical, general	208D00000X	UA	SE
Medical, physical therapy rendered by physical therapist	225100000X	UA	SE
Medical, occupational therapy rendered by occupational therapist	225X00000X	UA	SE
Medical, speech therapy rendered by speech therapist	235Z00000X	UA	SE
Medical, physical therapy, speech therapy, occupational therapy rendered by a physician, podiatrist, ARNP, PAC or specialty physician	208D00000X	UA	SE
Medical, optometrist	152W00000X	UA	SE

> **Note:** All claims must comply with the requirements in the **Billing and Claims Forms** section of this guide.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Sample medical encounter claim

Sample claim – The IHS encounter rate for this example is $100.00					
Date of service	**Procedure code**	**Modifier**	**Billed amount (bill usual and customary)**	**Paid amount**	**Notes**
01/01/2015	99213	UA	$100.00	$38.71	Paid at fee schedule amount
01/01/2015	99211	UA	$100.00	$0	CCI rejected 99211 due to 99213
01/01/2015	T1015	UA	See Note below	$61.29	Balance paid so that claim pays encounter rate
Total amount paid on claim					$100.00
Sample claim – The IHS encounter rate for this example is $100.00					
02/01/2015	99215	UA	$100.00	$76.09	Paid at fee schedule amount
02/01/2015	T1015	UA	See Note below	$23.91	Balance paid so that claim pays encounter rate
Total amount paid on claim					$100.00

Note: The billed amount on the HCPCS code T1015 line does not affect payment on the claim. The HCPCS code T1015 line may be billed at $0 or the encounter rate or any other rate.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Dental Services

What is a dental encounter?

A dental encounter is an Encounter (see Definitions) by a dentist for services described in the program-specific policies listed below. Service limitations and prior authorization requirements (program-specific policies) apply to all Medicaid clients for applicable Medicaid covered services.

Where do I find program specific policies?

Providers eligible for a dental encounter	Refer to the agency's program-specific provider billing guides for a list of Medicaid covered services
Dentists	• Access to Baby and Child Dentistry (ABCD) • Dental Related Services • Orthodontic Services

Dental providers can find more detailed information regarding dental programs, prior authorization, and patient release forms at the agency's Dental Providers web site.

Expedited prior authorization (EPA)

EPA is designed to eliminate the need for written authorization. The agency establishes authorization criteria and identifies EPA with specific codes.

To bill the agency for diagnostic conditions, procedures and services that meet the EPA criteria on the following pages, the provider must bill with **a 9-digit EPA number** (see EPA Criteria Coding List) and enter the EPA in the authorization number field.

EPA Guidelines

The provider must verify that the requirements for use of the EPA number are met. If the EPA number requires medical necessity, then the client's medical record documentation must support the medical necessity and be available upon the agency's request. If the agency determines the documentation does not support the EPA criteria requirements, the claim will be denied and any amounts paid will be recouped.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

EPA Criteria Coding List

EPA code	Service Modality	Criteria
870001305	Dental services	Client is AI/AN
870001306	Dental services	Client is non-native

How many dental encounters are allowed?

The agency covers **one dental encounter per client, per day** (regardless of how many procedures are done or how many providers are seen).

Note: When a dental service requires multiple visits on different days (e.g., root canals, crowns, dentures, orthodontics), the service is billed on one claim when the treatment is complete, with the date of service equal to the date of completion. The units billed for the encounter code must equal the number of encounter eligible visits necessary to complete the service.

Exception: If, due to an emergency, a client returns on the same day for a second visit and has an unrelated diagnosis, a second encounter is allowed.

Example: If a client comes in for a routine cleaning and X-rays, it is considered one dental encounter, regardless of how many providers the client sees in the course of the visit. However, if the client leaves, chips a tooth, and returns for emergency care, that is a second diagnostic episode and a second encounter may be billed. Use *Comments* field on the claim to indicate that it is a separate **emergency** encounter and the time of the initial and subsequent visit. Documentation must be in the client records for all encounters.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

How do I bill for a dental encounter?

Facilities must follow the agency's Washington Apple Health program-specific billing guide and do all of the following:

- Bill a dental (837D/ADA) claim
- Bill with the appropriate billing taxonomy - 122300000X
- Add HCPCS code T1015
- Bill with an American Indian/Alaska Native (AI/AN) or non-native EPA number at document level (if the dental service requires further authorization, use the dental authorization number on the claim line)

Type of encounter	Billing taxonomy	AI/AN EPA	Non-Native EPA
Dental	122300000x	870001305	870001306

Note: All claims must comply with the requirements in the **Billing and Claims Forms** section of this guide.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Sample dental encounter claim

Sample claim – The IHS encounter rate for this example is $100.00					
Date of service	**Procedure code**	**EPA**	**Billed amount (bill usual and customary)**	**Paid amount**	**Notes**
01/01/2015	D0150	870001305	$100.00	$24.84	Paid at fee schedule amount
01/01/2015	D0120	870001305	$100.00	$0	Line denied because the agency limits evaluations to one per day
01/01/2015	T1015	870001305	See Note below	$75.16	Balance paid so that claim pays encounter rate
Total amount paid on claim					$100.00
Sample claim – The IHS encounter rate for this example is $100.00					
02/01/2015	D2140	870001305	$100.00	$33.16	Paid at fee schedule amount
02/01/2015	T1015	870001305	See Note below	$66.84	Balance paid so that claim pays encounter rate
Total amount paid on claim					$100.00

Note: The billed amount on the HCPCS code T1015 line does not affect payment on the claim. The T1015 line may be billed at $0 or the encounter rate or any other rate.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Mental Health Services

What is a mental health encounter?

A mental health encounter is an Encounter (see Definitions) by a mental health professional (MHP) or psychiatrist for services described in the program-specific policies listed below. Service limitations and prior authorization requirements (program-specific policies) apply to all Medicaid clients for applicable Medicaid-covered services. Refer to the Mental Health Services Billing Guide for more information.

These services are provided to reach the goals of an Individualized Service Plan. Medical necessity is determined by an MHP/psychiatrist. Services are provided at locations convenient to the client, by or under the supervision of an MHP/psychiatrist. HIPAA compliance must be maintained for all services.

American Indian/Alaska Native (AI/AN) clients may receive outpatient mental health services as follows:

- If the client is enrolled in a managed care organization (MCO) and the client's mental health needs do not meet the Behavioral Health Organization (BHO) Access-to-Care Standard (see below), the client's MCO covers the services.

- If the client's mental health needs meet or exceed the BHO Access-to-Care Standard (regardless of whether the client is enrolled in an MCO), the client's BHO covers the services. BHOs are Washington State's system of mental health managed care for Medicaid clients. BHOs contract with local community mental health clinics to provide both emergency mental health services and ongoing mental health services for people whose needs meet or exceed the Access-to-Care Standard. (See Mental Health Services Billing Guide.)

In addition, AI/AN clients have the choice to receive services through a Direct Indian Health Service (IHS) Facility or a Tribal 638 Facility without regard to the BHO Access-to-Care Standard, because AI/ANs have an elective exemption from Medicaid Managed Care under 42 U.S.C.1396u-2. Claims for AI/AN clients who receive BHO-level services from a Direct IHS Facility or Tribal 638 Facility require expedited prior authorization (EPA). AI/AN clients do not need to disenroll from Medicaid Managed Care to receive care at a Direct IHS Facility or a Tribal 638 Facility, and no referral is necessary.

Non-native clients may receive BHO-level outpatient mental health services at a Direct IHS Facility or Tribal 638 Facility only if the client meets the definition of a Clinical Family Member.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Where do I find program-specific policy?

Providers eligible for a mental health encounter	Refer to the agency's program-specific provider billing guide for a list of Medicaid covered services
Mental Health Professionals	Mental Health Services or Tribal Health (*EPA Guidelines*)
Psychiatrists	Mental Health Services or Tribal Health (*EPA Guidelines*)

How many mental health service encounters does the agency pay for?

The agency covers **one mental health encounter per client, per day** (regardless of how many procedures are done or how many providers are seen), unless the client leaves and returns for emergency care, which is a second diagnostic episode.

Example: If a client has a routine therapy visit, it is considered one mental health encounter, regardless of how many providers the client sees in the course of a 24-hour period.

Note: If a client leaves and returns for emergency care, that is a second diagnostic episode and a second encounter may be billed. Use modifier 59 on the T1015 line to indicate that it is a separate emergency encounter. The time of the initial and subsequent visit documentation must be in the client records.

For mental health services that are below the BHO Access-to-Care standard, refer to the Mental Health Services Billing Guide. For mental health services that are at or above the BHO Access-to-Care standard, refer to the EPA guidelines below for more information.

Expedited prior authorization (EPA) guidelines

EPA is designed to eliminate the need for written authorization. The agency establishes authorization criteria and identifies EPA with specific codes.

To bill the agency for diagnostic conditions, procedures and services that meet the EPA criteria on the following pages, the provider must bill with **a 9-digit EPA number** (see *EPA Criteria Coding List*) and enter the EPA in the authorization number field.

For the following mental health services that are above the BHO Access-to-Care Standard, the Tribal provider must verify that the requirements for use of the EPA number 87001349 are met. This EPA number is applicable only to clients who have an elective exemption from Medicaid Managed Care under 42 U.S.C.1396u-2 or who are Clinical Family Members. For Tribal clinics, the typical basis for the elective exemption under 42 U.S.C. 1396u-2 is that the client is AI/AN.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

In addition, Clinical Family Members are encouraged to receive treatment at Tribal clinics to promote better health outcomes.

Mental Health Services above the BHO Access-to-Care Standard						
Modality	**HCPCS Code**	**Short Description**	**Provider Type (See legend)**	**EPA (See EPA Code and Criteria Table)**	**Rate**	**Place of Service**
Crisis Services	H0030	Alcohol and/or drug hotline	01, 02, 03, 04, 05, 09, 10, 12	EPA 870001349	$10.00	05, 06, 07, 08
	H2011	Crisis interven svc, 15 min		EPA 870001349	$11.35	05, 06, 07, 08
Day Support	H2012	Behav hlth day treat, per hr	04, 05, 06, 09, 10, 12	EPA 870001349	$31.05	05, 06, 07, 08
Medication Monitoring	H0033 Administration and observation	Oral med adm direct observe	01, 02, 03, 04, 05, 06, 09, 10, 12	EPA 870001349	$8.60	05, 06, 07, 08
	H0034 Training and support	Med trng & support per 15min		EPA 870001349	$22.47	05, 06, 07, 08
Peer Support	H0038	Self-help/peer svc per 15min	06, 14	EPA 870001349	$15.00	05, 06, 07, 08
Stabilization Services	S9484	Crisis intervention per hour	01, 02, 03, 04, 05, 09, 10, 12	EPA 870001349	$11.60	05, 06, 07, 08
Therapeutic psycho-education	H0025	Alcohol and/or drug preventi	01, 02, 03, 04, 05, 06, 09, 10, 12	EPA 870001349	$6.58	05, 06, 07, 08
	H2027	Psychoed svc, per 15 min		EPA 870001349	$12.01	05, 06, 07, 08

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Explanation of Provider Type Codes	
Code	**Definition**
01	RN/LPN
02	ARNP/PA
03	Psychiatrist/MD
04	MA/PhD
05	Below Master's Degree
06	DOH Credentialed Certified Peer Counselor
09	Bachelor Level with Exception/Waiver
10	Master Level with Exception/Waiver
12	Other (Clinical Staff)
14	Non-DOH Credentialed Certified Peer Counselor

EPA Code and Criteria

EPA code	Service Modality	Criteria
870001349	Crisis Services, Day Support, Medication Monitoring, Peer Support, Stabilization services, Therapeutic psych-education	Either: (1) client has elective exemption from Medicaid Managed Care under 42 U.S.C.1396u-2 (e.g., client is AI/AN); or (2) client is a Clinical Family Member.

Note: Modalities listed above are only for clients who have an elective exemption from Medicaid Managed Care under 42 U.S.C.1396u-2.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

How do I bill for a mental health encounter?

Facilities must follow the agency's Washington Apple Health program-specific billing guide and do all of the following:

- Bill a professional (837P/CMS1500) claim
- Bill with the appropriate billing taxonomy - 2083P0901X
- Add HCPCS code T1015
- Bill with an AI/AN or non-native modifier on every line on the claim (after adding all modifiers that may be required by the source program)

Type of encounter	Billing taxonomy	AI/AN modifier	Non-native modifier (for Clinical Family Member)
Mental Health	2083P0901X	HE	SE

Note: All claims must comply with the requirements in the **Billing and Claims Forms** section of this guide.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Sample mental health encounter claim

Sample claim – The IHS encounter rate for this example is $100.00					
Date of service	**Procedure code**	**Modifier**	**Billed amount (bill usual and customary)**	**Paid amount**	**Notes**
01/01/2015	90837	HE	$100.00	$75.30	Paid at fee schedule amount
01/01/2015	90832	HE	$100.00	$0	CCI rejected 99211 due to 99213
01/01/2015	T1015	HE	See Note below	$24.70	Balance paid so that claim pays encounter rate
Total amount paid on claim					$100.00
Sample claim – The IHS encounter rate for this example is $100.00					
02/01/2015	90832	HE	$100.00	$38.28	Paid at fee schedule amount
02/01/2015	T1015	HE	See Note below	$61.72	Balance paid so that claim pays encounter rate
Total amount paid on claim					$100.00

Note: The billed amount on the T1015 line does not affect the payment on the claim. The T1015 line may be billed at $0, or the encounter rate, or any other rate.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Substance Use Disorder and Treatment Services

What is a substance use disorder (SUD) encounter?

An SUD encounter is an Encounter (see Definitions) by a qualified Chemical Dependency Professional (CDP) or Chemical Dependency Professional Trainee (CDPT) under the supervision of a CDP for services described in the program-specific policies listed below. Outpatient alcohol and/or drug treatment services are defined in Chapter 388-877 WAC.

Where do I find program-specific policy?

Providers and clients eligible for a substance use disorder encounter	Refer to the agency's program-specific billing guide for a list of Medicaid covered services
Chemical Dependency Counselors and Chemical Dependency Counselor Trainees	*Substance Use Disorder Billing Guide (Fee-for-Service Benefits Provided Outside of the BHO Process)*

Who can receive substance use disorder treatment services?

Clients must have a Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) diagnosis of substance use disorder, mild, moderate, or severe in order to receive services.

Clients must meet medical necessity criteria as stated in the American Society of Addiction Medicine (ASAM).

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

How many SUD encounters does the agency pay for?

The agency covers **one SUD encounter per client, per day** (regardless of how many procedures are done or how many providers are seen).

How do I bill for an SUD encounter?

Facilities must follow the agency's Washington Apple Health program-specific billing guide and do all of the following:

- Bill a professional (837P/CMS1500) claim
- Bill with billing taxonomy 261QR0405X
- Add HCPCS T1015
- Bill with an American Indian/Alaska Native (AI/AN) or non-native modifier on the T1015 line
- Bill with claim note. Claim note must be entered exactly as listed in the table below.

Client	Modifier on T1015 line	Claim Note (must be written exactly as this)
AI/AN client	HF	SCI=NA
Non-native ABP (RAC code 1201)	SE	SCI=NN
Non-native ABP Supplemental Security Income (SSI) (RAC code 1217)	HB	SCI=NN
Non-native classic Medicaid (All RAC codes except 1201 and 1217)	HX	SCI=NN

Note: All claims must comply with the requirements in the **Billing and Claims Forms** section of this guide.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

What is the payment for an SUD encounter?

The agency pays Tribal health care facilities the full encounter rate for SUD treatment services provided to Medicaid-eligible AI/AN clients.

For Medicaid-eligible non-native clients, the state requires local matching funds equal to the state's portion of Medicaid expenses for SUD treatment services under 42 C.F.R. 433.51. The agency pays Tribal health care facilities the federal portion of the Indian Health Services (IHS) encounter rate (i.e., the Federal Medical Assistance Percentage (FMAP)) for SUD treatment services for non-native Medicaid clients when a Tribe provides the required Tribal funds (local matching funds) equal to the State's portion of the IHS encounter rate (the State Match). The State Match varies depending on whether the Medicaid program covering the non-native client is Classic Medicaid, Alternative Benefit Plan (ABP), or ABP Presumptive SSI (MAGI Adult).

To receive payment for SUD treatment services to non-native clients, the Tribal health care facility must deposit the State Match funds with the Office of the State Treasurer. The Division of Behavioral Health and Recovery (DBHR) within the Department of Social and Health Services (DSHS) draws upon the account to provide the local matching funds. DSHS then reimburses the Tribe the local matching funds and pays the federal portion of the IHS encounter rate. This process is referred to as the Intergovernmental Transfer (IGT) process.

Non-Native Medicaid Category	**State Match Required**	**Which Medicaid category applies to which RAC code?**	**How much does claim pay (federal portion)?**
Classic Medicaid	50%	Any encounter eligible RAC code except 1201 or 1217	50% of encounter rate
ABP	0%	RAC code 1201	100% of encounter rate
ABP Presumptive SSI (MAGI Adult)	15%	RAC code 1217	85% of encounter rate

Note: If a non-AI/AN client has RAC codes 1201 and 1217 for the date of service, the client is deemed retroactively eligible for Supplemental Security Income (SSI) and claims are billed according to RAC code 1217.

Note: The Federal Medical Assistance Percentages (FMAP) rate and the State Match (equal to 100% less the FMAP rate) vary quarterly. FMAP examples are from January 2016. The claims processing date determines which FMAP and State Match is applicable.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Sample SUD encounter claim

Sample claim – The IHS encounter rate for this example is $100.00					
Date of service	**Procedure code**	**Modifier**	**Billed amount (bill usual and customary)**	**Paid amount**	**Notes**
01/01/2015	96153	HF	$100.00	$10.92	Paid at fee schedule amount
01/01/2015	99213	HF	$100.00	$0	99213 is not covered in this program
01/01/2015	T1015	HF	See Note below	$89.08	Balance paid so that claim pays encounter rate
Total amount paid on claim					$100.00
Sample claim – The IHS encounter rate for this example is $100.00					
02/01/2015	96154	HF	$100.00	$11.36	Paid at fee schedule amount
02/01/2015	T1015	HF	See Note below	$88.64	Balance paid so that claim pays encounter rate
Total amount paid on claim					$100.00

Note: The billed amount on the T1015 line does not affect payment on the claim. The T1015 line may be billed at $0, or the encounter rate, or any other rate.

Note: Do not bill SUD claims with an individual servicing/rendering NPI/taxonomy.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

What is the process for an intergovernmental transfer (IGT)?

Tribes submitting SUD Medicaid claims for non-native clients must send the Medicaid match to DSHS by the 15th of each month for the previous month's claims using the current FMAP.

Send the local match using one of these three options:

1. **Electronic Funds Transfer (EFT) or Wire transfer**
   Before sending the EFT or Wire transfer, email DSHS with the transfer amount and date. (See the DSHS contact information below.)

   The account number for the agency is: **105000000617**.
   The EFT or Wire routing number is: **026009593**.

2. **Automated Clearing House (ACH) transfer**
   Before sending the ACH, email DSHS with the transfer amount and date. (See the DSHS contact information below.)

   The account number for the agency is: **105000000617**.
   The ACH routing number is: **123308825**.

   DSHS EFT and ACH contacts:
   Melissa Walker Melissa.Walker@dshs.wa.gov
   Adriann Jordan Adriann.Jordan@dshs.wa.gov
   Debra Minton Debra.Minton@dshs.wa.gov

3. **Physical check**

   Note: The process takes longer for payment by check.

   Send to:

   Department of Social and Health Services
   Substance Use Disorders Finance Office
   PO Box 45600
   Olympia, WA 98504-5600

   DSHS will do the following after it receives the Tribe's local match:
   - Send confirmation to the Tribe that funds were received
   - Pay the federal portion for these claims
   - Issue the local match payment to the Tribe within 5 to 7 business days

The facility may bill only for services described in Chapter 388-877B WAC.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Billing for the Encounter Rate After Other Payers

The agency pays Tribal health programs the IHS Encounter Rate differential after other primary payers have paid, such as private insurance, Medicare, and Apple Health managed care plans.

Billing for the encounter rate after private insurance

- Claims must meet all applicable billing and encounter criteria as outlined in this guide.
- For instructions on billing after private insurance, refer to the ProviderOne Billing and Resource Guide.

Billing for the encounter rate secondary to Medicare

- Medicare crossovers require all the same code lines that were billed to Medicare.
- Claims must meet all applicable billing and encounter criteria as outlined in this guide. Typically, this involves adding both of the following to a Medicare crossover claim:
  - ✓ Appropriate American Indian/Alaska Native (AI/AN) or non-native modifiers.
  - ✓ An encounter (T1015) line.

NOTE: Do not include any Medicare allowed amount, paid amount, coinsurance amount, or deductible amount on the encounter (T1015) line.

Billing for the encounter rate after Medicaid Managed Care Organization (MCO) payment

- Claims must meet all applicable billing and encounter criteria as outlined in this guide.
- Indicate the amount paid by the MCO in the insurance field on the claim.
- Add the claim note "AI/AN MC WRAPAROUND."
- Such wraparound payments are only permitted for AI/AN clients.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Enrolling/Disenrolling American Indian/Alaska Native Clients from Managed Care or Primary Case Care Management

An American Indian/Alaska Native (AI/AN) client who meets the provisions of 25 U.S.C. 1603(c) (d) for federally recognized Tribal members and their descendants may choose one of the following for their medical care per WAC 182-538-130:

- Enrollment with an agency-contracted managed care organization (MCO) available in their area
- Enrollment with a Direct Indian Health (IHS) Facility, 638 Tribal Facility, or Urban Indian Federally Qualified Health Center (FQHC) primary care case management (PCCM) provider, if available in their area
- The agency's fee-for-service (FFS) system

The agency processes requests from Direct IHS Facilities or 638 Tribal Facilities to enroll or disenroll Medicaid clients from managed care according to their federal exemption under 42 U.S.C.1396u-2. Requests are processed electronically using the WEBFORM at: http://www.hca.wa.gov/billers-providers/contact-us

To enroll or disenroll an AI/AN Medicaid client from an agency contracted MCO or PCCM, click the above hyperlink. The ***Washington Apple Health (Medicaid)*** webpage will appear.

1. Click the "**Client**" button. The "**Client Web Form**" will appear. Click inside the box next to "**Your Email Address:**" Enter your email address in the box.
2. "Services Card Number:" Enter in the Apple Health (Medicaid) client ID.
3. "First Name," "Last Name," and "Date of Birth:" Enter in the client's name and birthday.
4. "Select Topic:" Choose "Enroll/Change Health Plans" from the drop-down menu
5. "Other Comments:" Enter
   Client is American Indian (or Alaska Native), enrolled in [name of Tribe].
   Please disenroll and exempt from Managed Care enrollment.
   or
   Please enroll in the [Name of Tribe]'s PCCM program.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

6. A "**Thank you for contacting us**" screen will appear with a service request number appearing in red. Record the service request number as proof of having submitted the request.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved

Medicaid Administrative Claiming

Medicaid Administrative Claiming (MAC)

Some of Washington's most vulnerable residents experience difficulty accessing needed health care. Government agencies provide many services to Washington residents on a daily basis, ensuring their overall well-being. Federal funds are available through HCA's MAC program to reimburse government agencies for some of the costs of their allowable Medicaid administrative activities when those activities support provision of services, as outlined in the Medicaid State Plan.

NOTE: Tribes may participate in PCCM or Medicaid Administrative Claiming (MAC). To avoid duplication of services and payment, tribes must participate in only one of these two programs.

Purpose of the Washington State MAC Program

- Provide outreach to residents with no or inadequate medical coverage.
- Explain benefits of Apple Health.
- Assist Washington residents in applying for Apple Health.
- Link residents to appropriate Medicaid covered services.

Examples of Reimbursable MAC Activities

- Informing Washington State Tribal residents about Medicaid.
- Assisting Tribal residents in applying for Apple Heath.
- Arranging transportation in support of Medicaid covered services.
- Linking Medicaid clients or potential Medicaid clients in need of health care services to Medicaid providers.

For more information, see the MAC webpage.

Current Procedural Terminology ® 2015 American Medical Association. All Rights Reserved