Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Department of Social and Health Services
Health and Recovery Services
Administration (HRSA)

Tribal Health Program

Billing Instructions for
Tribal Health Programs and Indian Health
Services Providers

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About this publication

This publication incorporates the previous *Indian Health Services Billing Instructions*, dated September 2000 and Numbered Memorandum: 03-88 MAA, 04-62 MAA, 05-72 MAA, and 05-80 MAA, and 06-79.

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Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

HRSA's Billing Instructions and Numbered Memoranda

To obtain HRSA's provider numbered memoranda and billing instructions, go to HRSA's website at http://hrsa.dshs.wa.gov (click **Billing Instructions/Numbered Memoranda** link).

Table of Contents

Table of Contents (continued)

Table of Contents (cont.)

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Important Contacts

A provider may use HRSA's toll-free lines for questions regarding its programs; however, HRSA's response is based solely on the information provided to the [HRSA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern HRSA's programs. **[WAC 388-502-0020(2)]**

How can I use the Internet to…

Find information on becoming a DSHS provider?

Visit Provider Enrollment at:
http://maa.dshs.wa.gov/provrel/index.html
Click **Sign up to be a WA State Medical Assistance provider** and follow the on-screen instructions to find information on becoming a DSHS provider; or

Visit Tribal Provider Resources at:
http://maa.dshs.wa.gov/tribal/

Ask questions about the status of my provider application?

Visit Provider Enrollment at:
http://maa.dshs.wa.gov/provrel/index.html

- Click **Sign up to be a WA State Medical Assistance provider**.
- Click **I want to sign up as a WA State Medical Assistance provider**.
- Click on the link on the left side of the screen, **What happens once I return my application?**

Submit a change of address or ownership?

Visit Provider Enrollment at:
http://maa.dshs.wa.gov/provrel/index.html
Click **I'm already a current provider** to submit a change of address or ownership.

If I don't have access to the Internet, how do I find information on becoming a DSHS provider, ask questions about the status of my provider application, or submit a change of address or ownership?

Call Provider Enrollment at:
800.562.3022 (toll free)

or write to:
HRSA Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

Who do I contact if I have questions on Mental Health?

Mental Health Division Tribal Liaison
360.902.0812
http://www1.dshs.wa.gov/mentalhealth/Tribal_Internet_Map_20060516.shtml

Who do I contact if I have questions on Tribal Health – Medical or Dental Services?

Native Health Program Manager
360.725.1649
http://maa.dshs.wa.gov/tribal/

Where do I call if I have questions on Chemical Dependency Services?

Division of Alcohol & Substance Abuse
Title XIX Coordinator
360.725.3750
http://www1.dshs.wa.gov/dasa/

Where do I send my claims?

Hard Copy Claims:
Division of Healthcare Services
PO Box 9248
Olympia, WA 98507-9248

How do I obtain copies of billing instructions or numbered memoranda?

To view an electronic copy, visit HRSA on the web at: http://hrsa.dshs.wa.gov (Click **Billing Instructions/Numbered Memoranda**)

Who do I contact if I have questions regarding…

Payments, denials, general questions regarding claims processing, HRSA managed care organizations?

Visit the Customer Service Center for Providers on the web at: http://maa.dshs.wa.gov/provrel/index.html (click on "I'm already a current provider")

or call/fax:
800.562.3022 (toll free)
360.725.2144 (fax)

or write to:
HRSA Customer Service Center
PO Box 45562
Olympia, WA 98504-5562

Private insurance or third party liability, other than HRSA managed care organizations?

Division of Eligibility and Service Delivery
Coordination of Benefits
PO Box 45565
Olympia, WA 98504-5565
800.562.6136 (toll free)

Assistance with Electronic Billing?

HRSA/HIPAA E-Help Desk
Toll free: 800.562.3022 (Choose option #2, then option #4) or e-mail: hipaae-help@dshs.wa.gov

ACS EDI Gateway, Inc.
Toll free : 800.833.2051 or
http://www.acs-gcro.com/

How do I find out about Internet Billing (Electronic Claims Submission)?

WinASAP and WAMedWeb
http://www.acs-gcro.com/
Select *Medicaid*, then *Washington State*

All other HIPAA transactions
https://wamedweb.acs-inc.com/

To use HIPAA Transactions and/or WinASAP 2003 enroll with ACS EDI Gateway by visiting ACS on the web at: http://www.acs-gcro.com/docs/wa-home.php?menuItem=enroll

Or by calling: 800.833.2051.

How do I find out about Internet Billing (Electronic Claims Submission)? (cont.)

Once the provider completes the EDI Provider Enrollment form and faxes or mails it to ACS, ACS will send

the provider the web link and the information needed to access the web site. If the provider is already enrolled, but for some reason cannot access the WAMedWeb, then the provider should call ACS at 800. 833.2051.

Where can I view and download rates?

Visit: http://maa.dshs.wa.gov/ProRates

How do I use the WAMedWeb to check on a client's eligibility status?

If you would like to check client eligibility for free, call ACS at 800. 833.2051 or HRSA at 800.562.3022 option #2

You may also access the WAMedWeb tutorial at: http://maa.dshs.wa.govgov/dshs/maa/WaMedWebTutor/

Where can I view the following HRSA client publications?

- Guide for People getting services from Washington State Medical Assistance (#22-530); and
- Healthy Options Guide (#22-542).

Visit HRSA's Client Publications website at:

http://maa.dshs.wa.gov/CustomerPublications/Publicationsalpha.html

Important Numbers

Acute Physical Medicine & Rehabilitation (PM&R) Authorization **(Providers Only)** 800.634.1398
Billing Instructions – Department of Printing 360.586.6360
Fax requests to: 360.568.6361
Casualty questions 800.894.3754
Coordination of Benefits Section 800.562.6136
Disability Insurance 800.562.6074
DME*/Prosthetics & Orthotics Authorization **(Providers Only)** 800.292.8064
Electronic Billing Questions (call this number and press option "2") 800.562.3022
EDI Gateway Enrollment Technical Support 800.833.2051
Fraud Hotline 800.562.6906
HIPAA Help hotline (call this number and press option "4") 800.562.3022
Home Health/Plan of Treatment 360.725.1582
Medical Assistance Customer Service Center (MACSC) 800.562.3022

Option 1: Client - Access to Medical Care, Broker Transportation, Client Complaints or Assistance, Healthy Options Enrollment, Disenrollment, Exemptions, and Interpreter questions
Option 2: Providers
Option 3: Provider Enrollment

Medical Eligibility Determination Services (MEDS) 800.204.6429
Medicare Unit Fax Line 360.664.2186
Pharmacy Authorization **(Providers Only)** 800.848.2842
TAKE CHARGE questions 800.770.4334
Telecommunications Device for the Deaf (TDD) 800.848.5429
*Durable Medical Equipment

List of HRSA Billing Instructions

Access to Baby & Child Dentistry (ABCD)
Acute Physical Medicine & Rehabilitation (Acute PM&R)
Adult Day Health
Ambulance and Involuntary Treatment Act (ITA) Transportation
Ambulatory Surgery Centers
Blood Bank Services
Chemical Dependency
Chemical-Using Pregnant (CUP) Women
Childbirth Education
Chiropractic Services for Children
Dental Program for Clients Age 21 and Older
Dental Program for clients Through Age 20
Diabetes Education Program
Early, Periodic Screening, Diagnosis, and Treatment (EPSDT)
Enteral Nutrition Program
Family Planning Provider
Federally-Qualified Health Centers (FQHC)
First Steps Childcare
General Information Booklet
Healthy Options/Basic Health Plus/SCHIP
Hearing Aids and Services
HIV/AIDS Case Management
Home Health Services
Home Infusion Therapy/Parenteral Nutrition
Hospice Services
Hospital Inpatient
Hospital-Based Inpatient Detoxification
Hospital Outpatient
Kidney Center Services
Long Term Acute Care (LTAC) Program
Maternity Support Services/Infant Case Management
Medical Nutrition Therapy
Neurodevelopmental Centers
Nondurable Medical Supplies and Equipment (MSE)
Nursing Facilities
Occupational Therapy Program
Orthodontic Services
Oxygen and Respiratory Therapy
Physical Therapy
Physician-Related Services (RBRVS)
Planned Home Births and Births in Birthing Centers
Prenatal Diagnosis Genetic Counseling
Prescription Drug Program
Private Duty Nursing for Children
Prosthetic and Orthotic Devices
Psychologist
Rural Health Clinic
School Medical Services for Special Education Students
Speech/Audiology Program
Tribal Health Program
Vision Care Services
Wheelchairs, Durable Medical Equipment & Supplies (DME)

To obtain HRSA's Billing Instructions:
To **view and download**, visit HRSA's web site: http://hrsa.dshs.wa.gov/ and click **Billing Instructions/Numbered Memoranda**.

Definitions & Abbreviations

This section defines terms and abbreviations (includes acronyms) used in these billing instructions.

"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. Allows tribes to:

- Redesign programs, activities, functions, and services of the Bureau of Indian Affairs (BIA);
- Reallocate funds for such programs, activities, functions, or services according to its Tribal priorities;
- Provide such programs, activities, functions, and services, as determined by its Tribal priorities;
- Enhance the effectiveness and long term financial stability of its Tribal government;
- Plan, conduct, consolidate, and administer programs, activities, functions and services, or portions thereof, administered by the Department of the Interior, other than through the Bureau of Indian Affairs (BIA) as provided in the annual funding agreement applicable to such non BIA programs, activities, functions and services; and
- Reduce the Federal-Indian service bureaucracy.

Compact is and shall be enforceable at law and in equity to the same extent and pursuant to the same remedies as provided for in Public Law 93-638 contracts in Title III, Section 303(d) of P.L. 100-472.

"638" Contract – A contract between tribes and the Indian Health Service (IHS) that states tribes will assume responsibility for providing social and health care services to American Indian/Alaska Natives (AI/AN). Authorized by Public Law 93-638, the Indian Self Determination Act.

ADATSA (Alcoholism and Drug Addiction Treatment and Support Act) – A state-funded program to provide chemical dependency treatment and support services for indigent alcoholics and addicts seeking alcohol or drug rehabilitation in Washington State.

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

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 American Indians, Indian tribes, and Alaska Natives. 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 American Indians and Alaska Natives.

Canadian First Nation Medicaid Eligibility – People born in Canada, having at least 50% Aboriginal blood, and who are unable to work or who have lost their job, may be entitled to one or more of the following government benefits: Medicaid, Supplemental Security Income (SSI), Food Stamps, Disability, Social Security, and Medicare. http://www.ptla.org/wabanaki/jaytreaty.htm#Cross%20Border. Refer to the Appendix for further information.

Centers for Medicare and Medicaid Services (CMS) - The agency within the federal Department of Health and Human Services (DHHS) with oversight responsibility for Medicare and Medicaid programs. [WAC 388-531-0050]

Chemical Dependency Professional - Means a person certified as a chemical dependency professional by the Washington State Department of Health under Chapter 18.205 RCW.

Child psychiatrist - A person having a license as a physician and surgeon in this state, who has had graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.

Client - An individual who has been determined eligible to receive medical or health care services under any HRSA program.

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.
- An individual who has not attained 19 years of age, 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 AI/AN woman pregnant with an eligible AI/AN's child. If unmarried, the woman is eligible if the 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 AI/AN 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.

Clinical Social Worker - As defined by Title 42 USC, 1395x(hh), Sec. 1861(hh)(1)) means an individual who:

- Possesses a master or doctor's degree in social work;
- After obtaining such a degree, has performed at least two years of supervised clinical social work; and
- Is licensed or certified as a clinical social worker by the state in which the services are performed, or
- In the case of an individual in a state which does not provide for licensure or certification, has completed at least 2 years or 3,000 hours of post master degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting (as determined by the Secretary of Health and Human Services), and II. Meets such other criteria as the Secretary of Health and Human Services establishes.

Code of Federal Regulations (CFR) – A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Core Provider Agreement - The basic contract between DSHS and an entity providing services to eligible clients. The core provider agreement outlines and defines terms of participation in medical assistance programs.

Counselor – An individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee.

Current Procedural Terminology- (CPT) - Descriptive terms and identifying codes for reporting medical services and procedures. The purpose of CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby serves as an effective means for reliable nationwide communication among physicians, and other healthcare providers, patients, and third parties. Developed by the American Medical Association (AMA).

Department - The state Department of Social and Health Services (DSHS). [WAC 388-500-0005]

Division of Alcohol and Substance Abuse (DASA) - is the division within HRSA that coordinates efforts to help individuals and communities with problems related to the abuse of drugs and alcohol. DASA contracts with government entities, Tribes, and organizations in the community to provide prevention, treatment, and other support services for individuals with problems related to alcoholism and drug addiction.

Emergency Care - Service provided for a person that, if not received, would likely result in the need for crisis intervention or for hospital evaluation due to concerns of potential danger to self, or to others, or grave disability.

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 an Indian Health Services (IHS) or Tribal 638 facilities within a 24-hour period beginning and ending at midnight. An outpatient contact between a Medicaid beneficiary and more than one health care professional in a single IHS or Tribal 638 facility, within the same 24-hour period, and the services provided are a result of the same diagnosis, constitutes a single encounter.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Expedited Prior Authorization (EPA) A process designed to eliminate the need for live telephone prior authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an EPA number, when appropriate.

Federally Qualified Health Center (FQHC) - A facility that is:

- Receiving grants under section 330 of the Public Health Services Act; or
- Receiving such grants based on the recommendation of the Health Resources and Services Administration within the Public Health Service Act, as determined by the Secretary to meet the requirements for receiving such a grant, or
- A tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (PL93-638).

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. http://factfinder.census.gov/home/aian/indian_entities_11-25.pdf

Fee-for-service – A payment method the Health and Recovery Services Administration (HRSA) uses to pay providers for covered medical services provided to medical assistance clients, except those services provided under HRSA's prepaid managed care programs.

Healthcare Common Procedure Coding System (HCPCS) - Standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

Health Care Financing Administration (HCFA) – See **Centers for Medicare & Medicaid Services.**

Health and Recovery Services Administration (HRSA) – The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Healthy Options program or HO program - HRSA prepaid managed care health program for Medicaid-eligible clients and State Children's Health Insurance Program (SCHIP) clients. [WAC 388-500-0005]

HIPAA- Health Insurance Portability and Accountability Act of 1996 (HIPAA) – An Act that:

- Protects health insurance coverage for workers and their families when they change or lose their jobs;
- Establishes national standards for electronic health care transactions and national identifiers for providers, health plans, and employers; and
- Addresses the security and privacy of health data.

Indian Health Service (IHS) - A federal agency under the Department of Health and Human Services (DSHS) and contracted tribal health programs entrusted with the responsibility to assist eligible AI/AN with health care services.

IHS Beneficiary –AI/AN who provide proof of being a member in or a descendent of an Indian tribe recognized by the U.S. government are eligible for services funded by the IHS. Refer to the Appendix for information on Canadian eligibility.

IHS/OMB Encounter – A face-to-face contact between a health care professional and a Medicaid beneficiary in order to provide Title XIX defined services through an IHS or Tribal 638 facility within a 24-hour period ending at midnight, as documented in the patient's record.

Indian Health Service/Tribal (I/T) - A health facility run by the IHS as a direct service unit, or a Tribal 638 facility run by the tribe.

Internal Control Number (ICN) – A 17-digit claim number appearing on the HRSA Remittance and Status Report near the client's name that is used as a means of identifying the claim.

Managed Care - A comprehensive health care delivery system of medical and health care delivery including preventive, primary, specialty, and ancillary health care services. These services are provided either through a managed care organization (MCO) or primary care case management (PCCM) provider.

Managed Care Organization (MCO) - An MCO is an entity that finances and delivers health care using a specific provider network and specific services and products.

Maternity Support Services (MSS) - Preventive health services for pregnant/postpartum women, including assessment, education, intervention, and counseling provided by an interdisciplinary team of community health nurses, nutritionists and psychosocial workers; childbirth education, and authorization of childcare. Community health worker visits may also be provided.

Maximum allowable - The maximum dollar amount HRSA will pay a provider for a specific service, supply, or piece of equipment.]

Medicaid - The state and federal funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs. [WAC 388-500-0005]

Medical Identification (ID) card – The document that identifies a client's eligibility for a medical program. This card was formerly known as the medical assistance identification (MAID) card or medical coupon.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500- 0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has four parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.]
- "Part C" is the Medicare Risk Contract or HMO program, or Medicare+ Choice created in the **Balanced Budget Act of 1997** and adding other alternative treatment programs for Medicare recipients.
- "Part D" is the Medicare program that will allow Medicare to help pay for prescription drugs. In December of 2003, Congress passed the Medicare Modernization Act, which created this benefit.

Memorandum of Agreement (MOA) – Specifically, the December 19, 1996 memorandum that established the roles and responsibilities of the federal Health Care Financing Administration (HCFA) (now CMS) and the IHS regarding AI/AN individuals. The MOA addresses payment for Medicaid services provided to AI/AN individuals on and after July 11, 1996, through health care facilities owned and operated by AI/AN tribes and tribal organizations, which are funded through Title I or V of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended).

Mental Health Division (MHD) is the division within HRSA that administers the mental health program for the State of Washington. The mental health program:

- Provides inpatient and outpatient care and treatment for people with severe and recurring mental illness, and children with serious emotional disturbance and their families;
- Operates a crisis response system for all of Washington's citizens;
- Develops mental health policy and regulations for providers of public mental health services; and
- Provides inpatient treatment through two adult state-run hospitals and one children's state-run hospital and three contracted children's long-term inpatient facilities.

Mental Health Professional –
(1) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapters 71.05 and 71.34 RCW;
(2) A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;
(3) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986;
(4) A person who had an approved waiver to perform the duties of a mental health professional that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or

Mental Health Professional (Continued) (5) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-0265.

Mid-Level Practitioner – Advanced Registered Nurse Practitioner (ARNP), Certified Nurse Midwife, Woman's Health Care Nurse Practitioner, Physician's Assistant (PA), Psychiatric ARNP, Clinical Social Worker, or Mental Health Mid-Level Practitioner.

National Provider Identification (NPI) - The NPI is a unique identification number for health care providers that will be used by all health plans. Health care providers and all health plans and health care clearinghouses will use the NPIs in the administrative and financial transactions specified by HIPAA. The NPI is 10-position numeric identifier with a check digit in the last position to help detect keying errors. The NPI contains no information about the health care provider such as the type of health care provider or State where the health care provider is located.
http://aspe.hhs.gov/admnsimp/faqnpi.htm

Patient Identification Code (PIC) – An alphanumeric code that is assigned to each Medical Assistance client and which consists of:

- First and middle initials (or a dash (-) if the middle initial is not available);
- Six-digit birthdate, consisting of numerals only (MMDDYY);
- First five letters of the last name (and spaces if the name is fewer than five letters); and

Alpha or numeric character (tiebreaker).

Prepaid Inpatient Health Plan (PIHP) –An entity that:

- Provides medical or mental health services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; and

- Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees.

Primary Care Case Management (PCCM) - A system under which a provider contracts with the state to furnish case management services, which include the provision, coordination and monitoring of primary care to Medicaid clients.

Primary Care Provider (PCP) – A provider who manages, and coordinates medical care for DSHS contracted managed care organizations *or PCCM* enrollees. The PCP must also authorize, in advance, all health care services performed by other providers. The only exceptions to this preauthorization requirement are a medical emergency, and/or services covered by HRSA, not included under the contract with the managed health care provider.

Prior Authorization – A process by which clients or providers must request and receive HRSA approval for certain medical services, equipment, drugs, or supplies, based on medical necessity, before the services are provided to clients, as a precondition for provider payment. Expedited prior authorization and limitation extension are forms of prior authorization.
[Refer to WAC 388-531-0050]

Provider or Provider of Service – An institution, agency, or person:

- That has a signed agreement (Core Provider Agreement) with the Department to furnish care, goods, and/or services to clients; and

- Is eligible to receive payment from the department.
  [Refer to WAC 388-502-0010]

Psychiatric nurse - A registered nurse who has a bachelor's degree from an accredited college or university, and who has had, in addition, at least two years experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional. "Psychiatric nurse" shall also mean any other registered nurse who has three years of such experience.

Psychiatrist - A person having a license as a physician in this state who has completed residency training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and is board eligible or board certified in psychiatry.

Psychologist - A person who has been licensed as a psychologist under Chapter 18.83 RCW.

Remittance and Status Report (RA) – A report produced by the Medicaid Management Information System (MMIS) [HRSA's claims processing system] that provides detailed information concerning submitted claims and other financial transactions.

Regional Support Network (RSN) – A county authority or group of county authorities, or other entities recognized by the Secretary of Social and Health Services for the provision of mental health services. (Chapter 71.24 RCW)

Rehabilitation Case Management – A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include:

- Assessment for discharge or admission to mental health care;
- Integrated mental health treatment planning;
- Resource identification and linkage to mental health rehabilitative services; and
- Collaborative development of individualized services that promote continuity of mental health care.

These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned readmission, and to increase the community tenure for the individual.

Services are provided by or under the supervision of a mental health professional.

Revised Code of Washington (RCW) - Washington State laws.

Social Service Payment System (SSPS) – The payment system DSHS uses to pay for a variety of services that facilitate employment, increase independence, and protect children, the fragile elderly, and disabled children and adults.

Social worker - A person with a master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary.

Staff Supervision – The monitoring of the administrative, clinical, or clerical work performance of staff, students, interns, volunteers, or contracted employees by persons with the authority to direct employment activities and require change.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client.

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Title XXI - State Children's Health Insurance Program- The portion of the federal Social Security Act that authorizes grants to states to initiate and expand the provision of child health assistance to uninsured, low-income children program Title XXI is also called SCHIP.

Tribal 638 Facility – A facility operated by a tribe or a tribal organization, and funded by Title I or V of the Indian Self Determination and Education Assistance Act (Public Law 3-638).

Tribal Chemical Dependency Treatment Services Program–- A qualified tribal chemical dependency treatment program which contracts with the Department of Social and Health Services under the provisions of the December 1996 Memorandum of Agreement between the federal Health Care Financing Administration (now CMS) and Indian Health Services.

Tribal Mental Health Services – A tribal mental health program which enters into an agreement with DSHS under the provisions of the December 1996 Memorandum of Agreement between the federal Health Care Financing Administration (now CMS) and Indian Health Services.

Usual and customary charge - The fee that the provider typically charges the general public for the product or service.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

Washington Medicaid State Plan – The official federally recognized statement describing the nature and scope of Washington State's Medicaid program. The State Plan addresses program administration, Medicaid eligibility, service coverage, and provider reimbursement.

Tribal Health Program

The Department, HRSA, and Federally Recognized Tribes

The State of Washington recognizes the intent of Congress to provide Medicaid funds to Indian Health Service and Tribal governments for the delivery of Medicaid services to eligible members of Federally Recognized Tribes. The Department of Social and Health Services' (DSHS) Health and Recovery Services Administration (HRSA) supports a "government to government" relationship with the Tribes and the State of Washington in order to deliver these services.

HRSA collaborates with Federally Recognized Tribes to use all possible Medicaid services to address the health needs and raise the health status of American Indians/Alaska Natives (AI/AN) to the highest possible level.

Billing Instructions for the Tribal Health Program

These billing instructions explain how the department pays for the Medicaid services provided by tribal health care facilities to eligible clients.

Tribal Health Care Facilities

Under the Health Care Financing Administration/Indian Health Service (HCFA/IHS) Memorandum of Agreement (MOA) dated December 16, 1996, Tribal health care facilities may choose to be designated as a certain type of provider or facility. The designation determines how the department pays for the Medicaid services provided by that provider or facility. This section describes the types of provider or facility that Tribes may chose, and the associated payment structure.

Types of Tribal Health Care Facilities

Tribal facilities may choose to be designated as:

- **IHS and Tribal 638 Facilities:** A health care facility may be designated as one of the following two types of IHS facilities, which are paid the federal IHS encounter rate:

  - ✓ An **IHS facility** which is established, operated, and funded by the IHS; or
  - ✓ A **Tribal 638 facility** which is tribally owned and operated and funded by Title I or V of the Indian Self Determination and Education Assistance Act (Public Law 93-638).

- **Tribal Facilities:** Health care facilities operated by federally recognized Tribes or Tribal organizations which have chosen NOT to be designated as Tribal 638 or IHS facilities. (This includes all facilities that are not listed with DSHS as Tribal 638 or IHS facilities.) These facilities are paid standard fee-for-service (FFS) rates.

- **Tribal Federally Qualified Health Centers (FQHC):** Health care facilities operated by federally recognized Tribal organizations which have chosen to be designated as FQHCs. FQHCs are paid FQHC rates, which are determined by considering the costs of medical services, supplies, administration, and case management.

Health Care Facilities Payment Structure

The department pays tribal health care facilities according to their self-designated provider or facility type.

IHS-Recognized Provider

- **IHS and Tribal 638 Facilities:** These facilities are paid for most services through an all-inclusive encounter rate. The encounter rate is an outpatient, per-visit rate which includes all on-site laboratory and x-ray services, as well as all medical supplies incidental to the services provided to the client during the visit. The Federal Office of Management and Budget publishes the encounter rate in the Federal Register each fall; the rate is retroactive to the first of the year. The department automatically processes a retroactive billing adjustment each year to ensure payment of the updated rate. A numbered memorandum is published on HRSA's website that announces the implementation date, along with a postcard that is sent to IHS and tribal facilities.

- **Tribal Facilities:** Health care facilities NOT designated as Tribal 638 facilities are paid the state-determined fee-for-service (FFS) payment rate for services provided. Refer to the appropriate program-specific billing instructions for information about provider and client eligibility, covered services, and payment rates.

- **Tribal FQHCs:** Facilities choosing to be designated as FQHCs for Medicaid payment purposes will receive an encounter payment that is facility based. The cost evaluation for the facilities encounter rate includes medical services, supplies, administrative costs, and case management. FQHCs may elect to have either an all-inclusive rate, which covers all Title XIX Medicaid services, or individual rates for different types of service. For FQHCs choosing an all-inclusive rate, this rate will be applied to each of the encounter codes. For the individual rates, the rates will be applied according to the appropriate encounter code. For information or questions regarding FQHC cost and audit reports, contact the HRSA FQHC/RHC Program Manager at: 360.725.2104 or e-mail at COLLIKM@dshs.wa.gov.

Provider Numbers

Each eligible IHS tribal facility may request a provider number from HRSA based on the encounter or FFS billing category. The facility must use the appropriate provider number(s) to receive payment from HRSA. HRSA issues provider numbers for:

- Medical encounter;
- Medical FFS;
- Dental encounter;
- Dental FFS;
- Mental health encounter;
- Chemical dependency treatment encounter; and
- Various FFS programs (e.g., pharmacy services).

Providers need a core provider agreement (CPA) for each provider number requested. If a facility has different clinic sites, a provider number may be issued for each site if the site is an eligible IHS facility. A facility may bill for services provided at its satellite locations for services provided by facility/clinic personnel.

When adding a new clinic or service, indicate on the upper right hand corner of the CPA application that you are a tribal facility. HRSA's Provider Enrollment Unit will contact the appropriate program manager for coordinated processing of the application. Submit the application to:

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

If a tribal facility wishes to receive a provider number to be paid for providing chemical dependency treatment services to HRSA clients, the tribe must contact the Division of Alcohol and Substance Abuse (DASA). DASA will establish a Medicaid CPA with the tribe. Chemical dependency treatment services must be provided at facilities that meet DASA certification criteria. A separate provider number will be established for each facility at which treatment services are provided. For more information regarding DASA service contracts please contact the DASA Title XIX Coordinator (refer to the Important Contacts Section).

How to Bill

Washington Medicaid uses federally mandated Healthcare Common Procedure Coding System (HCPCS) codes, Current Procedural Terminology (CPT™) codes, and Current Dental Terminology (CDT™) codes. When billing, you *must* submit claims on the appropriate form or on an 837 Health Insurance Portability and Accountability Act- (HIPAA) compliant transaction.

Encounters:

When billing for an encounter, you must use the following when billing for the services in the table below:

- HCPCS procedure code **T1015** (the encounter code for all Indian Health Clinic services);
- The appropriate modifier*; and
- The appropriate ICD-9-CM diagnosis code*.

Note: HRSA requires valid and complete ICD-9-CM diagnosis codes. When billing HRSA, use the highest level of specificity (4th or 5th digits when applicable) or the services will be denied.

Fee-for-Service (FFS):

When billing FFS, you must use the following when billing for the services in the table below:

- The appropriate CPT or CDT procedure code;
- The appropriate modifier*; and
- The appropriate ICD-9-CM diagnosis code*.

Type of Service	Type of Form
Chemical dependency encounters Dental encounters Medical encounter services & FFS Mental health encounters	1500 Claim Form or 837 HIPAA-compliant transaction
Dental FFS services	ADA Dental Form or 837 HIPAA-compliant transaction
Pharmacy services	Pharmacy Statement Claim Form 525-106 or Point-of-Sale (POS) system

*For a list of appropriate modifiers and diagnosis codes, refer to page 3 of the Appendix.

CPT™ is a trademark of the American Medical Association.

HRSA requires separate ICD-9-CM diagnosis codes for psychiatric and dental encounters (see table below).

Type of Provider	ICD-9-CM Diagnosis Code Required
Dental	520-525.9 or V72.2
Psychiatric	290-319

HRSA Managed Care Enrollment/Disenrollment Options

If a client is an AI/AN who meets the provisions of 25 U.S.C. 1603(c)(d) for federally recognized tribal members and their descendants, the client may choose one of the following for their medical or mental health care per WAC 388-538-130:

- Enrollment with a managed care organization (MCO) available in their area;
- Enrollment with an IHS or tribal primary care case management (PCCM) provider available in their area; or
- HRSA's fee-for-service system.

If the client is enrolled in a medical managed care organization and chooses to enroll with or disenroll from a tribal clinic or tribal PCCM, the client must call the HRSA Medical Assistance Customer Service Center (MACSC) at 800.562.3022 (toll free) or fill out a Managed Care Enrollment/Disenrollment Request [DSHS 13-778] at: http://www1.dshs.wa.gov/msa/forms/index.html and send or fax it to:

HRSA-Division of Eligibility and Service Delivery
PO Box 45562
Olympia WA 98504-5562
FAX: 360.725.2144

HRSA Managed Care Programs

HO Program, BH+, and SCHIP: AI/AN clients enrolled in the Healthy Options (HO) program, Basic Health Plus and Maternity Benefits (BH+) program, or State Children's Health Insurance program (SCHIP) must receive their medical care through the state's contracted managed care health plans. The plan in which they are enrolled is identified in the "HMO" column of the client's Medical ID card. A complete list of the contracted health plans, acronyms, and the counties they serve can be found in the Appendix.

If the AI/AN client wants to receive medical services from the IHS or Tribal 638 facility, the client must disenroll from the HO, BH+, WMIP, or SCHIP program by calling MACSC at 800.562.3022 or by filling out a Managed Care Enrollment/Disenrollment Request [DSHS 13-778] at: http://www1.dshs.wa.gov/msa/forms/index.html and sending or faxing it to:

HRSA-Division of Customer Support
PO Box 45505
Olympia WA 98504-5505
FAX: 360.725.2144

The Washington Medicaid Integration Partnership (WMIP) Information: In Snohomish County, clients with an identifier of "MINT" in the HMO column on their Medical ID card are enrolled in a project managed care organization and must receive medical, community mental health, and outpatient chemical dependency treatment services through the managed care organization – Molina Healthcare of Washington. AI/AN Medicaid clients have the option to enroll in the WMIP program, but are not automatically enrolled. If the AI/AN client wants to receive medical services from the IHS or Tribal 638 facility, the client must disenroll from the WMIP program. To enroll or disenroll from this program, please use the Washington Medicaid Integration Partnership Exemption/Disenrollment Request [DSHS 13-737] at: http://www1.dshs.wa.gov/msa/forms/index.html or call MACSC at 800.562.3022. To find out more information on this program go to http://maa.dshs.wa.gov/mip/.

Medicare/Medicaid Integration Program (MMIP) Information:
Clients with an identifier of "EVCP" in the HMO column on their Medical ID card are enrolled in a managed care demonstration program. It is a voluntary managed care program located in King and Pierce Counties. This project was initiated by the Centers for Medicare and Medicaid Services (CMS) through a formal solicitation for proposals. In the spring of 2004, CMS officially awarded Evercare Premier™, part of United HealthCare Insurance Company, the opportunity to implement this project in Washington State.

If the AI/AN client wants to receive medical services from the IHS or Tribal 638 facility, the client must disenroll from MMIP by calling MACSC at 800.562.3022.

GA-U Managed Care:
Clients with an identifier of "CHPG" in the HMO column on their Medical ID card are enrolled in a managed care pilot program. GA-U clients are automatically enrolled if they reside in King or Pierce counties. The standard exemptions for AI/AN clients previously listed apply. For more information please go to http://maa.dshs.wa.gov/GAUMC/.

If the AI/AN client wants to receive medical services from the IHS or Tribal 638 facility, the client must disenroll from GA-U Managed Care by calling MACSC at 800.562.3022 or by filling out a Managed Care Enrollment/Disenrollment Request [DSHS 13-778] at: http://www1.dshs.wa.gov/msa/forms/index.html and sending or faxing it to:

HRSA-Division of Customer Support
PO Box 45505
Olympia WA 98504-5505
FAX: 360.725.2144

Prepaid Inpatient Health Plan (PIHP)
Most Medicaid-eligible persons, including AI/AN, across the state are eligible for state-contracted managed outpatient and inpatient mental health benefits through local Regional Support Networks (RSNs). RSNs are able to determine eligibility using match codes.

AI/AN clients have the option of receiving mental health services from either the RSN/PIHP or IHS or Tribal 638 facilities or both concurrently. No referral or enrollment/disenrollment is necessary.

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Payment Based on Client Eligibility

Clients who are Eligible for Payable Encounter Rate Services

Providers serving clients who present a current DSHS Medical ID card with one of the following identifiers are eligible to be paid the encounter rate if the services are provided at IHS service or Tribal 638 facilities. Limitations for encounter payment for the specific medical service categories are noted in the Medical Service Category column.

Medical ID Card Identifier	Medical Program	Medical Service Category
CNP	Categorically Needy Program	Medical, Dental, and Mental Health services for AI/ANs* and Clinical Family Members Chemical Dependency Treatment for AI/ANs only, unless specifically contracted for non natives
CNP **SCHIP**	Categorically Needy Program – State Children's Health Insurance Program	Medical, Dental, and Mental Health services No Chemical Dependency coverage at the encounter rate. See section D.3
CNP – QMB	CN-Qualified Medicare Beneficiary	Medical, Dental, and Mental Health services for AI/ANs* and Clinical Family Members Chemical Dependency Treatment for AI/ANs only, unless specifically contracted for non natives
LCP-MNP	Limited Casualty Program – Medically Needy Program	Medical, Dental, and Mental Health services for AI/ANs* and Clinical Family Members Chemical Dependency Treatment for AI/ANs only, unless specifically contracted for non natives

Exception: If the client's Medical ID card shows CNP with a POB in the medical coverage group (undocumented pregnant woman), HRSA will pay fee-for-service only.)

Clients who are not Eligible for Payable Encounter Rate Services

Providers serving clients presenting a current Medical ID card with one of the following identifiers are not eligible to be paid the encounter rate for those services:

Medical ID Card Identifier	Medical Program
CNP **Emergency Medical Only**	Categorically Needy Program – Emergency Medical Only
CHP	Children's Health Program (non-citizen children)
Detox Only	DETOX
GA-U **No Out of State Care**	General Assistance – Unemployable
TAKE CHARGE Family Planning	TAKE CHARGE (Reproductive Health Services)
QMB – Medicare Only	Qualified Medicare Beneficiary - Medicare Only

See the *Medicaid Fee-for-Service Program* section for information regarding how providers may get paid for providing services to these clients.

Are clients enrolled in an MCO eligible for payable services provided by an IHS or Tribal 638 facility?

[Refer to WAC 388-538-060 and 095]

YES - Only a limited number of services are eligible for HRSA payment when provided by an IHS or Tribal 638 facility**.** If AI/AN clients choose to receive their medical care through a contracted managed care organization (MCO) in their area, the ONLY reimbursable services provided by the IHS or Tribal 638 facility are:

- Chemical dependency treatment;
- Dental care; and
- Mental health services.

Exception: HO, BH+, GA-U Managed Care, MMIP, PCCM, and PIHP clients do not have to obtain a referral from their PCP when seeking chemical dependency, dental and mental health services. An AI/AN client enrolled in the WMIP program must obtain a referral from their PCP for mental health services, but not for chemical dependency treatment (see page C.3) or any other non-covered benefit.

Clients may contact their plan by calling the telephone number located on their DSHS Medical ID card. For a list of contracted MCO acronyms that appear on the Medical ID card, websites and telephone numbers, see the Appendix.

AI/AN clients who wish to receive all services through a Tribal facility can request to be disenrolled from managed care by calling MACSC at 800.562.3022 or by filling out a Managed Care Enrollment/Disenrollment Request [DSHS 13-778] at: http://www1.dshs.wa.gov/msa/forms/index.html and sending or faxing it to:

HRSA-Division of Eligibility and Service Delivery
PO Box 45505
Olympia WA 98504-5505
FAX: 360.725.2144

To prevent billing denials, please check the client's DSHS Medical ID card prior to scheduling services and at the time of service to make sure the services provided will be paid by HRSA or the MCO.

Chemical Dependency Treatment Services: Chemical dependency treatment services are not covered services under the HO, BH+, SCHIP, and MMIP programs. Clients need no referral from a PCP to be able to receive an assessment or treatment. Refer to the clients DSHS Medical ID card to determine billing capability and appropriate Chemical Dependency Treatment contract.

Dental Care Services: HRSA managed care does not cover dental services. Dental services may be covered FFS regardless of managed care eligibility. Clients who are enrolled in an HRSA MCO **are eligible for all Medicaid-covered dental services and the ABCD Children's Dental Program.** Refer to the client's DSHS Medical ID card to determine appropriate program coverage and billing capability.

Mental Health Services: Mental Health Services in Washington State are provided under a managed care system administered by Regional Support Networks (RSNs). AI/AN clients may receive outpatient services provided through IHS or Tribal 638 facilities in place of the RSN. No referral is necessary. A tribal clinic may also bill for Mental Health services provided to a non native qualified under the "Clinical Family" definition.

PCCM: For the client who has chosen to obtain medical care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a managed care organization setting. **Please refer to the client's Medical ID card to find out who the client's PCCM is**.

A provider generated printout of the Medicaid Client Eligibility Inquiry Response (270-271 Transaction) from the WAMedWeb would indicate whether the client was a PCCM client (see page A.3 for more information on the WAMedWeb).

Note: Women enrolled with a PCCM **DO NOT** need a referral from their PCCM for women's health care services to be paid to a provider other than the clinic where the woman is enrolled. Women enrolled in a PCCM cannot self-refer for women's health care services. Send PCCM claims for services to HRSA-**Division of Program Support (**see *Important Contacts* section**)**. For more information, see page H.2 – *How do I bill for services provided to PCCM clients?*

Note: If you treat a client who is enrolled with a PCCM and you are not the client's designated PCCM/PCP, or the client was not referred to you by the PCCM/PCP, you may not receive payment. Contact the PCCM/PCP to get a referral. Newborns of clients who are connected with a PCCM are FFS until the client chooses a PCCM for the newborn. **Bill all services for the newborn to HRSA.**

Encounters

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

For a health care service to qualify as an encounter, it must meet all the following criteria. The service must be:

- Medically necessary.
- Face-to-face.
- Identified in the Medicaid State Plan as a service that is:

  - ✓ Covered by HRSA;
  - ✓ Performed by a health care professional eligible for payment under the encounter rate; and
  - ✓ Performed by a health care professional within their scope of service.

- Documented in the client's file in the provider's office.

- Performed in the health care facility or at any other location in which tribal facility-supported activities are performed by eligible clinic staff. Services provided in any other location must meet the applicable regulations for the services provided. Client records must be maintained by the primary health care facility to ensure HIPAA compliance.

Types of Encounters

The Washington State Medicaid State Plan recognizes four types of encounters:

- Medical;
- Dental;
- Mental health; and
- Chemical dependency.

Each facility is limited to the billing of one type of encounter, per facility, per day, per client, regardless of the services provided, unless a client returns due to an emergency.

Example:

- A physician may not bill for a medical encounter and a psychiatric encounter for the same client on the same day. They are both medical encounters.
- A dental encounter and a physician encounter may be billed on the same day by using separate provider numbers.
- In addition, if a client visits different health centers, more than one encounter will be allowed if the providers have different billing numbers. A facility may bill for a second encounter if a client returns due to an emergency.

Services That Fall Under Two Encounter Categories -Although certain services, such as medication management, may fall under two different types of encounters, only a single service may be billed for a visit. Billing for the same service under a different type of encounter is considered duplication of payment.

Serving Multiple Clients Simultaneously - When an individual provider renders services to several clients simultaneously, the provider may count each client as a separate encounter if the provision of services is documented in each client's health record. This policy also applies to family therapy and family counseling sessions. **Bill services separately for each client on separate claim forms.**

Who is eligible to perform encounter services?

HRSA considers an eligible health care professional to be an individual who:

- Meets the training and/or licensure requirements for providing services under the state or federal requirements;
- Is listed as a performing provider on a signed Core Provider Agreement; and
- Is performing services within the scope of their practice under state law.

HRSA considers the following occupations to be health care professionals for the purposes of billing encounter services:

- Advanced Nurse Practitioners;
- Audiologists;
- (Chemical Dependency Professional within) Certified Chemical Dependency Treatment Facilities;
- Dentists;
- Mental Health Professionals;
- Nurse Midwives;
- Occupational Therapists;
- Optometrists;
- Physicians;
- Physician Assistants;
- Physical Therapists;
- Podiatrists;
- Psychiatrists; and
- Speech-Language Pathologists.

Types of services that do NOT qualify as Encounters

The following services are not paid as an encounter. HRSA pays for the following services under the fee-for-service (FFS) system. See the *Medicaid Fee-for-Service System* section for information on FFS programs.

- Health services provided to clients presenting Medical ID cards with one of the following identifiers:

Medical ID Card Identifier	Medical Program	Medical Service Category
ADATSA	Alcoholism & Drug Addiction Treatment & Support Act	Chemical dependency treatment services may be billed only through a specific contract with DASA
CHP	Children's Health Program (non-citizen children)	**Chemical dependency treatment services may be billed** ONLY if specifically contracted with the county entity to provide the services. Services are paid at the fee for service rate.
CNP SCHIP	Children's Health Insurance Program	Chemical dependency treatment services may be billed only if specifically contracted with the county entity to provide the services. Services are paid at the fee for service rate.
GA-U No out of state care	General Assistance – Unemployable	**Medical and dental encounters are not covered.** Chemical dependency treatment services may be billed only through a specific contract with DASA
QMB Medicare Only	Qualified Medicare Beneficiary – Medicare Only	
LCP-MNP Emergency Medical Only	Limited Casualty Program – Medically Needy Program Emergency Medical Only	This is a Medicaid program in which the scope of care is limited to hospital-based services relating to an emergency medical condition.
Take Charge	TAKE CHARGE – Family Planning Program	Medical care services cannot be billed as encounters and clinics will need a program specific provider number to bill for client services.

- Blood draws, laboratory tests, and/or x-rays, are bundled in the encounter fee and are considered as part of the encounter service. Otherwise, these services are reimbursable at the standard FFS rate.

- Health services provided to GA-U, some SCHIP, CHP, and ADATSA.

- Case management services.

Clinic-Related Activities NOT Covered by HRSA

The following circumstances are NOT covered by HRSA and MUST NOT be billed either as an encounter or under the FFS system:

1. Participation in a community meeting or group session that is not designed to provide health services.

   Examples: Informational sessions for prospective users, health presentations to community groups, school classes, PTAs, etc., or informational presentations about available health services.

2. Health care services provided as part of a large-scale effort. Providers must not provide a free and in-kind service to the community and only bill Medicaid-eligible people.

   Examples: Mass-immunization program, a vision or dental screening program, or a community-wide service program (e.g., a health fair).

Medical Service Encounter

Qualified health care practitioners may only bill for services that are within the scope of the practitioner's license. Medicaid-covered services are listed in the corresponding billing instructions for the varying providers. A medical service encounter is a service provided by a Tribal facility using the following practitioners. Refer to the HRSA's billing instructions web site at: http://maa.dshs.wa.gov/download/BI.html:

Providers eligible to bill the encounter rate for services provided	Refer to the Billing Instructions for a list of Medicaid covered services
Physicians, Physician Assistants, Advanced Nurse Practitioners	*Physician –Related Services Billing Instructions*
Nurse Midwives	*Planned Home Births and Births in Birthing Centers Billing Instructions*
Podiatrists	Section E: Podiatric Services in the *Physician – Related Services Billing Instructions*
Optometrists	Section D: Vision Care Services In the *Physician –Related Billing Instructions*
Psychiatrists	Section E: Psychiatric Services in *Physician – Related Services Billing Instructions*
Speech-Language Pathologists & Audiologists	*Speech/Audiology Program Billing Instructions*
Physical Therapists	*Physical Therapy Program Billing Instructions*
Occupational Therapists	*Occupational Therapy Billing Instructions*

How do I bill for a medical service encounter?

Facilities must:

- Bill using a medical encounter provider number.
- Submit an 837P HIPAA-compliant transaction or complete the1500 claim form. (See *Completing the 1500 Claim Form* and attached sample)
- Use HCPCS code T1015 with the appropriate AI/AN or non-native identification modifier (see table below) for **an all-inclusive, medical service visit/encounter, place modifier** in field 24D on the 1500 claim form (see example below)
- Use the appropriate ICD-9-CM diagnosis code for the service provided.

Client	HCPCS Code and Modifier	ICD-9-CM Diagnosis Code
AI/AN	T1015-UA	As appropriate
Non-native	T1015-SE	As appropriate

Note: HRSA allows 12 psychiatric encounters per calendar year. A claim with a primary ICD-9-CM diagnosis within the range of 290-319 will count as a psychiatric encounter. When billing for medication management, if the primary diagnosis is in the 290-319 range, then it will count as one psychiatric encounter. Please use ICD-9-CM diagnosis V58.83 (encounter for therapeutic drug monitoring) for medication management encounters. Medication management is not subject to the 12 visits per calendar year limitation.

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

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

Example: If a client comes in for a routine medical visit, it is considered one encounter, regardless of how many providers the client sees in the course of the visit. However, if the client leaves and returns for emergency care, that is a second diagnostic episode and a second encounter may be billed. Use field 19 on the 1500 form or the *Comments* field when billing electronically to indicate that it is a separate encounter and the time of the initial and subsequent visit. Documentation must be present for all encounters.

Psychiatric Service Encounter

Qualified practitioners may only bill for services that are within the scope of the practitioner's license. Medicaid covered services are listed in the corresponding billing instructions for the varying providers. A psychiatric service encounter is a specialized medical service provided by a Tribal facility using a psychiatrist. (Bill medication management as a medical encounter)

HRSA limits outpatient psychotherapy and electroconvulsive therapy in any combination to one hour per day, per client, for up to a total of 12 hours per calendar year (this includes family or group psychotherapy).

Providers eligible to bill the encounter rate for services provided	Refer to these Billing Instructions for Medicaid covered services
Physicians, Physician Assistants , Advanced Nurse Practitioners	*Physician –Related Services Billing Instructions*
Psychiatrists	See **Psychiatric Services** section in the *Physician –Related Services Billing Instructions*

How do I bill for a psychiatric services encounter?

Facilities must:

- **Bill using a medical encounter provider number.**
- Submit an 837 HIPAA-compliant transaction or complete the 1500 claim form. (See *Completing the 1500 Claim Form* and attached sample).
- Use HCPCS code T1015 with the appropriate AI/AN or non-native identification modifier (see table below) for **a psychiatric services visit/encounter, all-inclusive** in field 24D on the 1500 claim form (see the following example)
- Use ICD-9-CM diagnosis codes 290 through 319 (mental disorders).

Note: HRSA allows 12 psychiatric encounters per calendar year. A claim with a primary ICD-9-CM diagnosis within the range of 290-319 will count as a psychiatric encounter. When billing for medication management, if the primary diagnosis is in the 290-319 range, then it will count as one psychiatric encounter. Please use ICD-9-CM diagnosis V58.83 (encounter for therapeutic drug monitoring) for medication management encounters. Medication management is not subject to the 12 visits per calendar year limitation.

Client	HCPCS Code and Modifier	ICD-9-CM Diagnosis Code
AI/AN	T1015-UA	290-319

Non-native	T1015-SE	290-319

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

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

Example: If a client comes in for a routine therapy visit, it is considered one Psychiatric encounter, regardless of how many providers the client sees in the course of the visit. If a client is seen by the psychiatrist for psychotherapy and also sees a provider for medication or medical management, it is considered to be one medical encounter visit. However, if the client leaves and returns for emergency care, that is a second diagnostic episode, then a second encounter may be billed. Use field 19 on the 1500 Claim Form or the *Comments* field when billing electronically to indicate that it is a separate encounter and the time of the initial and subsequent visit. Documentation must be present for all encounters.

Dental Services Encounter

A Tribal facility may bill HRSA for dental services provided to a client, for the purpose of prevention, assessment, or treatment of a dental problem, including restoration. The Tribal facility will need a dental encounter provider number.

Qualified practitioners may only bill for services provided that are within the scope of the practitioner's license. Medicaid covered services are listed in the corresponding billing instructions for the varying providers. Dental providers can find more detailed information regarding dental programs, prior authorization, and patient release forms at:

- **Dental Program for Clients Age 21 and Older**
- **Dental Program for Clients Through Age 20**

A dental service encounter is for services provided by a Tribal facility using the following practitioners:

Providers eligible to bill the encounter rate for services provided	**Refer to these Billing Instructions for Medicaid covered services**
Dentists	*Dental Program for Clients Age 21 and Older* *and* *Dental Program for Clients Through Age 20*, and the *Orthodontic Billing Instructions*

How do I bill for a dental services encounter?

Facilities must:

- **Bill using a dental encounter provider number.**
- Submit an 837 HIPAA-compliant transaction or complete the 1500 Claim Form. (See *Completing the 1500 Claim Form* and attached sample).
- Use HCPCS code T1015 with the appropriate AI/AN or non-native identification modifier (see table below) for **a dental services visit/encounter, all-inclusive** in field 24D on the 1500 claim form (see the following example)
- Use ICD-9-CM diagnosis codes 520 through 525.9 or V72.2.

Client	HCPCS Code and Modifier	ICD-9-CM Diagnosis Code
AI/AN	T1015-UA	520-525.9 or V72.2
Non-native	T1015-SE	520-525.9 or V72.2

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

Exception: If, due to an emergency, the same client returns on the same day for a second visit and has a different 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 field 19 on the 1500 form or the *Comments* field when billing electronically to indicate that it is a separate encounter and the time of the initial and subsequent visit. Documentation must be present for all encounters.

Mental Health Encounter

A mental health encounter is a medically necessary, face-to-face contact between a mental health provider and a client during which services are provided.

Services are provided to adults and children for whom mental health services are determined to be medically necessary. These services must be provided to reach the goals of an Individualized Service Plan. Medical necessity is determined by a mental health professional. All state plan modality services are accessible based on clinical assessment, medical necessity, and individual need. Individuals will develop, with their mental health care provider, an appropriate Individual Service Plan.

Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional. Tribal facilities may choose to provide services to "clinical family members".

The following are services that may be provided as a Mental Health encounter:

- Brief Intervention Treatment;
- Crisis services;
- Day Support;
- Family treatment;
- Freestanding Evaluation and Treatment;
- Group treatment services;
- High Intensity Treatment;
- Individual Treatment Services;
- Intake evaluation;
- Medication Management;
- Medication Monitoring;
- Mental Health Services provided in Residential settings;
- Peer Support;
- Psychological Assessment;
- Rehabilitation Case Management;
- Special population evaluation;
- Stabilization Services; and
- Therapeutic psycho-education.

To see a table listing modalities and eligible providers, refer to the table in the Appendix.

Who is eligible to bill the mental health encounter?

To receive the mental health encounter rate, the tribal program must:

- Be on the IHS facility list and identified to provide behavioral health services;
- Have a Core Provider Agreement for Mental Health Services with HRSA; and
- Be billing HRSA for services provided by a mental health professional or where applicable, registered staff under the direct supervision of a mental health professional.

Included in the category of mental health professionals (as defined in WAC 388-865-0150) are the following:

- Psychiatrists;
- Psychologists;
- Social workers;
- Child psychiatrists;
- Psychiatric nurses; and
- Counselors.

Refer to WAC 388-865-0265, RCW 71.05, and RCW 71.34 for more information about mental health professionals and licensure requirements.

Supervision

Staff supervision is the monitoring of administrative, clinical, or clerical work performance of staff, students, interns, volunteers, or contracted employees by persons with the authority to direct employment activities and require change. When supervision is clinical in nature, it occurs regularly and may be provided without the consumer present or may include direct observation of the delivery of clinical care. Supervisory activities include the review of all aspects of clinical care, including but not limited to:

- Review of assessment;
- Diagnostic formulation;
- Treatment planning;
- Progress toward completion of care;
- Identification of barriers to care;
- Continuation of service; and
- Authorization of care.

How do I bill for a mental health encounter?

Facilities must:

- **Bill using a mental health provider number.**
- Submit an 837 HIPAA-compliant transaction or complete an1500 claim form. (See *Completing the 1500 Claim Form* and attached sample).
- Use HCPCS code T1015 with the appropriate AI/AN or non-native identification modifier (see table below) for **a mental health services visit/encounter, all-inclusive** in field 24D on the 1500 claim form (see example below).

Client	HCPCS Code and Modifier	ICD-9-CM Diagnosis Code
AI/AN	T1015-HE	As appropriate
Non-native*	T1015-SE	As appropriate

HRSA covers **one mental health encounter per client, per day** (regardless of how many procedures are done or how many providers are seen).

Example: If a client comes in for a routine therapy visit, it is considered one Mental Health encounter, regardless of how many providers the client sees in the course of the visit. However, if the client leaves and returns for emergency care, that is a second diagnostic episode then a second encounter may be billed. Use field 19 on the 1500 form or the *Comments* field when billing electronically to indicate that it is a separate encounter and the time of the initial and subsequent visit. As always, documentation must be present for all encounters.

Chemical Dependency Encounter

A chemical dependency encounter is a face-to-face contact between a qualified Chemical Dependency Professional (CDP) and a Medicaid beneficiary during which services are provided for outpatient alcohol and/or drug treatment services as defined in Chapter 388-805 WAC.

Who is eligible to bill for a chemical dependency encounter?

Services must be provided by a CDP certified by the Department of Health under RCW 18.205 (or a CDP trainee) and as defined in Chapter 388-805 WAC. Services must be provided by a tribal treatment facility approved by DASA pursuant to Chapter 388-805 WAC and RCW 70.96.A. To be paid for chemical dependency treatment services, the tribe must have a Core Provider Agreement with DASA to provide these services.

Payment for a Chemical Dependency Encounter

HRSA pays Tribal facilities the full encounter rate for chemical dependency treatment services provided to Medicaid AI/AN clients. HRSA pays Tribal facilities that provide chemical dependency treatment services to non AI/AN Medicaid clients at the encounter rate if the Tribe provides and certifies the required State matching funds. HRSA pays only the federal portion of the encounter rate for each encounter provided to non-AI/ANs. The Tribe must certify the required State match portion of the encounter rate to be eligible to receive the federal portion from HRSA.

Tribes may contract with county governments to provide chemical dependency treatment services to non-AI/AN Medicaid clients. Tribes that choose to contract with county governments are paid at the usual and customary Fee for Service rates paid to any other provider. Refer to the county DASA contract.

Tribes may choose to contract with county governments to provide chemical dependency treatment services to non-AI/AN Medicaid clients and receive the federal portion of the encounter rate for each encounter if the tribe:

- Accepts only the state match portion of the service provided based on the FFS payment from the county;
- Accepts only the federal portion of the encounter rate for each encounter provided to the non AI/AN; and

- Certifies the difference between:

  ✓ The state match portion received through the county billing based on the FFS payment; and

  ✓ The state match portion of the encounter rate required to be eligible to receive the federal portion of the encounter rate.

Examples: (1) The Tribe provides an assessment for a non-AI/AN. The Tribe receives the state match portion of the FFS payment in the amount of $45.61. The state match portion of the encounter rate is $111.50. The Tribe certifies the difference of $65.89 to be able to receive the federal portion of the encounter rate.

(2) The Tribe provides group therapy for a non-AI/AN for two hours and an individual session for one hour. The Tribe receives the state match portion of the FFS payment in the amount of $17.84 for the group therapy and $28.40 for the individual session for a total of $46.24. The state match portion of the encounter rate is $111.50. The Tribe certifies the difference of $65.26 to be able to receive the federal portion of the encounter rate.

The facility may only bill for those services defined in their DASA Medicaid Core Provider Agreement. DASA and/or the counties contract with tribes for services to Medicaid beneficiaries who are not AI/AN. Refer to the DASA Medicaid Core Provider Agreement.

Services that fall under two encounter categories: If a health care professional who is dually certified as a CDP and a mental health professional provides a service, you may bill the service only as one encounter. Billing for the same service under a separate category is considered duplication of payment.

How do I bill for a chemical dependency encounter?

Facilities must:

- **Bill using a Chemical Dependency (CD) provider number.**

- Submit an 837 HIPAA-compliant transaction or complete the 1500 claim form. (See *Completing the 1500 Claim Form* and attached sample).

- Use HCPCS code T1015 with the appropriate AI/AN or non-native identification modifier for **a Chemical Dependency Treatment visit/encounter, all-inclusive** in field 24D on the 1500 claim form (see example).

Client	HCPCS Code and Modifier
AI/AN	T1015-HF
Non-native	If the tribe is able to bill the service, the code is included in the DASA contract.

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Medicaid Fee-for-Service System

The Medicaid Fee-for-Service (FSS) system is a payment method HRSA uses to pay providers for covered medical services provided to medical assistance clients, except those services provided under HRSA's prepaid managed care organizations (MCOs) or as encounter services. Other Medicaid services are available outside of HRSA (e.g., personal care services, children's therapeutic, COPES, etc.).

Dental [Refer to Chapter 388-535 WAC]

Please see the current *Dental Billing Instructions* for covered services and appliances for children and adults at
Dental Program for Clients Age 21 and Older and
Dental Program for Clients Through Age 20

The dental FFS number allows Medicaid providers to bill for dental services and appliances not covered under the encounter rate (e.g., denture services).

Clients - 20 years of age and younger

HRSA covers only one maxillary denture and one mandibular denture per client in a 10-year period **and considers that set to be the first set**.

HRSA **does not require prior authorization for the first set of dentures.** (See exception for laboratory and professional fees for dentures and partials, page D.36 of HRSA's current *Dental Billing Instructions*.)

Clients - 21 years of age and older

HRSA covers the following for eligible adults **with prior authorization**:

- Only one complete maxillary and one complete mandibular denture per client in a ten year period, when constructed after the client had been without teeth for a period of time; or
- Only one immediate maxillary denture and one immediate mandibular denture allowed per client, per lifetime, and only when constructed prior to the removal of the client's teeth.

The dentures must be of an acceptable structure and quality to meet the standard of care. HRSA does not cover transitional dentures.

Diabetes Education Program

Application Process

1. Obtain a Diabetes Education Program Application and Reference List from:

   Health Promotion Specialist
   Diabetes Prevention and Control Program
   Department of Health
   PO Box 47855
   Olympia, WA 98504-7855
   (253) 395-6758

2. Provide all of the following documentation with the application:

   a) Primary Health Care Advisor;
   b) Referral process;
   c) Qualifications of, and continuing education gained by, the teaching team; and
   d) Curriculum outlined by module.

   For more information on the application process, program requirements for initial application and billing/payment information, and issuance of the Diabetes Education Provider number, please refer to the Diabetes Education Program on the HRSA Provider Publications web site at: http://maa.dshs.wa.gov/download/Memos/2005Memos/05-41%20maa%20Diabetes_Ed.pdf

Durable Medical Equipment (DME)

What is the purpose of the Wheelchairs, DME, and Supplies Program?
[Refer to WAC 388-543-1100]

HRSA's Wheelchair, DME, and Supplies program makes accessible to eligible HRSA clients the purchase and/or rental of medically necessary DME equipment and supplies when they are not included in other payment methodologies (e.g., inpatient hospital DRG, nursing facility daily rate, HMO, or managed health care programs). The federal government deems DME and related supplies as optional services under the Medicaid program, except when:

- Prescribed as an integral part of an approved plan of treatment under the home health program; or
- Required under the early and periodic screening, diagnosis, and treatment (EPSDT) program.

HRSA may reduce or eliminate coverage for optional services, consistent with legislative appropriations.

Application Process and Billing/Payment Requirements

For more information on the application process, program requirements for initial application, and billing/payment information, please refer to HRSA's *Wheelchairs, DME, and Supplies Billing Instructions* on the HRSA Provider Publications web site located at http://fortress.wa.gov/dshs/maa/download/BI.html

Bill for these services using your pharmacy provider number.

HRSA-Approved Family Planning Provider Programs

[Refer to Chapter 388-532 WAC]

- Reproductive Health Services
- Family Planning Only Services
- TAKE CHARGE Services

How does HRSA define reproductive health services? [WAC 388-532-001]

HRSA defines reproductive health services as those services that:

- Assist clients to avoid illness, disease, and disability related to reproductive health;
- Provide related and appropriate, medically-necessary care when needed; and
- Assist clients to make informed decisions about using medically safe and effective methods of family planning.

The goal of the Reproductive Health Services Program is to reduce unintended pregnancies by offering family planning services to an expanded population. The program will increase access to family planning (birth control) services for eligible persons who do not have health insurance coverage for these services and for whom an unintended pregnancy might make it difficult to attain self-sufficiency and/or to remain self-sufficient.

Billing/Payment Requirements

A TAKE CHARGE provider must:

- Have a current HRSA core provider agreement to provide family planning services;

- Sign the supplemental TAKE CHARGE agreement to participate in the TAKE CHARGE demonstration and research program according to HRSA's TAKE CHARGE program guidelines;
- Complete and submit a TAKE CHARGE application agreeing to the: Administrative practices; Evaluation and Research Responsibilities; and Clinical Practice Standards; and Participate in HRSA's specialized training for TAKE CHARGE prior to providing TAKE

CHARGE services. For contract information contact the Take Charge Program Manager at:

TAKE CHARGE Program Manager
Family Services Section
PO Box 45530
Olympia, WA 98504-5530
360.725.1652

For more information on the application process, program requirements for initial application and billing/payment information please refer to HRSA's current *HRSA-Approved Family Planning Provider Billing Instructions* on the HRSA Provider Publications web site located at http://fortress.wa.gov/dshs/maa/download/BI.html.

First Steps/Maternity Support Services

[Refer to Chapter 388-533 WAC]

The purpose of the integrated Maternity Support Services (MSS)/Infant Case Management (ICM) program is to provide enhanced support services to eligible pregnant women through the maternity cycle and for eligible families through the month of the infant's first birthday. The purpose of the enhanced services is to improve birth outcomes and respond to clients' individual risks and needs. This program is collaboratively managed by the Department of Health (DOH) and HRSA.

Application Process

For a Tribe to bill for MSS, the agency must be approved by DOH, Community and Family Health, and must meet the billing policy and eligibility requirements as specified in HRSA's current *Maternity Support Services/Infant Case Management Billing Instructions*. A maternity support services encounter is a face-to-face encounter between an MSS provider and a client during which MSS services are provided. MSS includes assessment, development, implementation and evaluation of plans of care for pregnant women and their infants for up to two months postpartum.

For more information on the application process, program requirements for initial application, and billing/payment information, please refer to HRSA's current *Maternity Support Services/Infant Case Management Billing Instructions* on the HRSA Provider Publications web site located at http://fortress.wa.gov/dshs/maa/download/BI.html .

Medical Fee-for-Service

The medical FFS number allows Medicaid providers to bill for ancillary services not covered under the encounter rate (e.g., laboratory services not provided during an encounter visit and eligible services for GA-U clients).

HRSA also pays for services under the state's Medical Care Services (MCS) program which includes the:

- General Assistance - Unemployable (GAU); and
- Alcohol and Drug Addiction Treatment and Support Act (ADATSA) programs.

Covered services under these programs are limited and are not eligible for the federal encounter rate. A review of the covered services is available at the Medical Eligibility Website at http://maa.dshs.wa.gov/Eligibility/OVERVIEW/MedicalOverviewCoveredServices.htm. Please see the appropriate set of HRSA billing instructions for more information. Tribal facilities must submit a Core Provider Agreement and receive a medical FFS number in order to bill for covered services under these programs. For more information, visit HRSA's Tribal web site at: http://maa.dshs.wa.gov/tribal/

Application Process and Billing/Payment Requirements

For more information on the application process, program requirements for initial application, and billing/payment information, please refer to the appropriate HRSA billing instructions for the service on the HRSA Provider Publications web site located at http://maa.dshs.wa.gov/download/BI.html .

Nondurable Medical Supplies and Equipment (MSE)

What is the purpose of the Nondurable MSE Program?
[Refer to WAC 388-543-1100 and 388-543-2800 (4)]

HRSA's Nondurable MSE program is designed to allow eligible HRSA clients to purchase medically necessary MSE that are not included in other payments, such as inpatient hospital Diagnosis Related Group (DRG), nursing facility daily rate, Health Maintenance Organization (HMO), or managed care organizations (MCO). The federal government considers MSE as optional services under the Medicaid program, except when:

- Prescribed as an integral part of an approved plan of treatment under the Home Health Program; or

- Required under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

HRSA may reduce or eliminate coverage for optional services, consistent with legislative appropriations. HRSA categorizes MSE as follows:

- Antiseptics and germicides;
- Bandages, dressing, and tapes;
- Blood monitoring/testing supplies;
- Braces, belts, and supportive devices;

- Decubitus care products;
- Ostomy supplies;
- Pregnancy-related testing kits and nursing equipment supplies;
- Supplies associated with transcutaneous electrical nerve stimulators (TENS);
- Syringes and needles;
- Urological supplies (e.g., diapers, urinary retention catheters, pant liners, and doublers); and
- Miscellaneous supplies.

Application Process and Billing/Payment Requirements

For more information on the application process, program requirements for initial application, and billing/payment information, please refer to HRSA's *Nondurable MSE Billing Instructions* on the HRSA Provider Publications web site located at http://maa.dshs.wa.gov/download/BI.html.

Bill for these services using your pharmacy provider number.

Pharmacy Services [Refer to Chapter 388-530 WAC]

The goal of the Prescription Drug Program is to provide quality pharmaceuticals and pharmacy services to clients served by HRSA. This program is governed by federal regulations and provides coverage for pharmaceuticals manufactured by companies who have signed a federal rebate agreement.

This may entail any of the following:

- Covering drugs without prior authorization;
- Requiring that the drug be prior authorized; or
- Not covering certain drugs.

The specific details are included in HRSA's *Prescription Drug Program Billing Instructions*. The Pharmacy Provider number can also be used to bill for eligible DME and nondurable MSE products. It is HRSA's goal to assist the prescriber, the pharmacy, and the client with well coordinated services.

Application Process and Billing/Payment Requirements

For more information on the application process, program requirements for initial application, and billing/payment information, please refer to HRSA's *Prescription Drug Program Billing Instructions* on the HRSA Provider Publications web site located at http://fortress.wa.gov/dshs/maa/download/BI.html.

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State-Funded Programs

The Medical Care Services (MCS) program is the state-funded medical program which provides limited medical benefits to persons eligible for the Alcohol and Drug Addiction Treatment and Support Act *(*ADATSA) and General Assistance Unemployable (GA-U) program. Covered services under these programs are limited and are not eligible for the Federal encounter rate. A review of the covered services is available at the Medical Eligibility Website at http://maa.dshs.wa.gov/eligibility/overview/medicaloverviewcoveredservices.htm. MCS does not cover medical care out-of-state.

Chemical Dependency Treatment for GA-U and ADATSA Clients

ADATSA is the state-funded program that provides shelter and/or medical benefits, treatment, and support for persons incapacitated from gainful employment due to drug or alcohol abuse. Eligible persons receive limited medical coverage. Only medical is available to persons waiting to get into treatment.

A Tribal facility may provide services to GA-U and ADATSA clients only if the tribal facility maintains a specific (separate) contract with DASA to provide services to these populations. Chemical dependency treatment services are not covered medical care services (not included in the benefits package) under the State-funded medical programs for these two populations. DASA pays tribes at a negotiated rate for chemical dependency treatment services for GA-U and ADATSA clients if the tribe has a contract with DASA to provide the services for these populations.

A Tribal facility may provide services for GA-U clients under the Government-to-Government contract with DASA if the tribal facility has a certified chemical dependency treatment program and chooses to exercise the option of using this funding to provide treatment services. Bill services for GA-U clients directly to DASA using the A-19 invoice with supporting documents as required by contract.

A Tribal facility may provide services for ADATSA clients under a specific ADATSA contract with DASA if the tribal facility has a certified chemical dependency treatment program. Bill services for ADATSA clients directly to DASA using the A-19 invoice with supporting documents as required by contract.

For more information on the application process, program requirements for initial application, and billing/payment information, please contact the DASA Regional Administrator for your area.

> **Note:** Tribal facilities may make directs referrals to residential treatment services for GA-U, TANF, and SSI clients without going through the ADATSA referral process.

Dental

The Dental FFS number allows payment for the limited coverage for dental-related services provided under state-only funded programs. Clients who receive MCS under the following state-funded only programs receive the limited coverage described below:

- GA-U.
- ADATSA - GA-W.

HRSA covers the dental-related services described and limited in these billing instructions for clients eligible for GA-U or GA-W only when those services are provided as part of a medical treatment for:

- Apical abscess verified by clinical examination and radiograph(s), and treated by any of the following:
  - ✓ Palliative treatment (e.g., open and drain, open and broach).
  - ✓ Tooth extraction.
  - ✓ Root canal therapy for permanent anterior teeth only.
- Tooth fractures (limited to extraction).
- Total dental extraction prior to and because of radiation therapy for cancer of the mouth.

The Dental FFS number may only be used to bill dental codes using the ADA dental form.

Medical

Please see HRSA's current *General Information Booklet*, *Physician-Related Services Billing Instructions*, or other appropriate HRSA billing instructions for more information. See page A.5 for a listing of current HRSA provider billing instructions or download them from HRSA's Provider Publication's web site at: http://maa.dshs.wa.gov/download/BI.html or call MACSC at 800.562.3022 to request a paper copy.

State Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP) is jointly financed by the federal and state governments and is administered by the state. Within broad federal guidelines, each state determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. Under SCHIP, the federal government provides a capped amount of funds to each state on a matching basis. Federal payments under title XXI to states are based on state expenditures under approved plans. Washington State exempts premiums for AI/AN SCHIP clients of federally recognized tribes.

Title XXI of the Social Security Act (SCHIP authorization) does not have 100% federal match provisions for SCHIP services provided to AI/AN children by tribal facilities. States can claim the enhanced SCHIP match rate (currently 65% for Washington) for such services.

Note: Bill HRSA for medical, dental, and mental health services provided to clients who have an SCHIP identifier on their Medical ID card the same way you would bill for any other Medicaid-eligible client.

Chemical Dependency

The Division of Alcohol and Substance Abuse (DASA) uses the regular fee-for-service (FFS) payment rate for SCHIP clients.

Tribal facilities may contract with county governments to provide chemical dependency treatment services for SCHIP clients. Tribal facilities that choose to contract with county governments for SCHIP clients will be paid at the standard FFS rate.

The Tribal facility may also contract directly with DASA to provide services to SCHIP clients. Tribal facilities may provide chemical dependency treatment services for SCHIP clients who are AI/AN and non native clients if the Tribe provides and certifies the non-federal matching funds.

Note: Bill HRSA for services provided to clients who have an SCHIP identifier on their Medical ID card according to the DASA contract.

Medical and Dental

As part of its policy to treat SCHIP programmatically the same as Medicaid, HRSA uses the Medicaid encounter rates to pay Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) for permissible Title XXI services provided to SCHIP children. HRSA uses the Medicaid encounter rates to pay tribal facilities for permissible Title XXI services provided to SCHIP AI/AN and non native children who are not enrolled in managed care.

AI/AN clients enrolled in SCHIP have the option to receive their medical care through the state's contracted MCOs. The MCO in which they are enrolled is identified in the "HMO" column of the client's Medical ID card.

AI/AN may choose to be seen at a tribal clinic for their medical, dental, and mental health services. If the clinic chosen has a PCCM contract the client will be enrolled as a PCCM client. If the clinic does not have a PCCM contract the client is enrolled as FFS. A complete list of the contracted MCOs, acronyms, and the counties they serve can be found in the Appendix.

Mental Health

AI/AN clients may choose to be seen at a tribal clinic for their medical, dental, and mental health services. HRSA uses the Medicaid encounter rates to pay tribal facilities for permissible Title XXI services provided to SCHIP AI/AN children. For non native SCHIP clients requesting services at a tribal facility, the SCHIP client needs to qualify as a "clinical family member" for the tribe to be paid for the service. If the client does not meet the criteria for payment, the clinic should refer the client to the RSN.

Administrative Contract Programs

Medicaid Administrative Match (MAM)

The Medicaid Administrative Match (MAM) program provides payment to public/governmental agencies for administrative-related activities for Medicare/Medicaid eligible people.

Examples of reimbursable activities include: outreach, coordination, and referral of Medicaid eligible individuals to Medicaid services.

For more information, please contact the Administrative Match Unit Manager at 360.725.1647.

You may also visit the MAM web site at:
http://maa.dshs.wa.gov/mam/Index.html

Primary Care Case Management (PCCM)

The PCCM contract was developed as an alternate resource for federally recognized tribal members who are eligible for the Healthy Options (HO) Program and for tribal clinics. This contract is available to tribal clinics interested in providing case management services to federally recognized tribal members eligible for HO. The contract allows the clinic to bill the encounter rate for treatment services and be paid for case management services. PCCM client services are paid at the standard rate.

For more information please call 360.725.1649.

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Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

HRSA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. HRSA has two timeliness standards for initial claims and resubmitted claims.

- ***Initial Claims***

  ✓ HRSA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders HRSA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

  ✓ HRSA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - DSHS certification of a client for a retroactive[2] period; or
  - The provider proves to HRSA's satisfaction that there are extenuating circumstances.

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[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill HRSA for the service.

- ***Resubmitted Claims/Appeals Process***

  Providers may **resubmit, modify, or adjust** any timely initial claim, **except** prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  Note: HRSA does ***not*** accept any claim for resubmission, modification, or adjustment after the time period listed above. HRSA **does** accept additional information for medical review with a resubmitted claim as an appeal when a provider feels the claim was denied in error.

- The time periods do not apply to overpayments incurred by the provider and due to DSHS. After the allotted time periods, a provider may not refund overpayment amounts to HRSA by claim adjustment. The provider must refund overpayment amounts to HRSA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ HRSA does not pay the claim.

What fee should I bill HRSA for eligible clients?

Bill HRSA your usual and customary fee**.**

How do I bill for services provided to PCCM clients?

- When billing on a 1500 Claim Form for services provided to PCCM clients enter the seven-digit, HRSA-assigned identification number of the PCCM who referred the client for the service(s) in field 17a.

- When billing electronically, enter the seven-digit, HRSA-assigned identification number of the PCCM who referred the client for the service(s) in the referring provider field.

How do I bill for clients eligible for both Medicare and HRSA benefits? [Refer to WAC 388-502-0150 (6)]

If a client is eligible for both Medicare and HRSA benefits, and the service is covered by Medicare, **you must *first* submit a claim to Medicare and accept assignment within Medicare's time limitations**. HRSA may make an additional payment after Medicare pays you.

Medicare Part B

Benefits covered under Medicare Part B include:

- ✓ Physician services;
- ✓ Outpatient hospital services;
- ✓ Home health;
- ✓ Durable medical equipment; and
- ✓ Other medical services and supplies not covered under Part A.

If a provider receives a payment or denial from Medicare, but it does not appear on the HRSA Remittance and Status Report (RA), the provider bills HRSA directly with the Medicare EOMB attached.

- If billing Tribal Health encounter codes, indicate "Tribal Medicare" in field 19 of the 1500 Claim Form or in the on-line comments of electronic claims and include the Medicare EOMB. (It is acceptable to combine Medicare paid and denied lines on Tribal Health encounter claims.)

- If Medicare has made payment on a Fee-For-Service (FFS) claim and there is a balance due from HRSA, submit a 1500 Claim Form. Bill only those lines Medicare paid. Do not submit paid lines with denied lines; this could cause a delay in payment. Attach the Medicare EOMB to the 1500 Claim Form.

- If Medicare denies services on a FFS claim, but HRSA covers them, submit a 1500 Claim Form. Bill only those lines Medicare denied. Do not submit denied lines with paid lines; this could cause a delay in payment.

- For electronic billing, bill denied line items and send the Medicare EOB as backup.

- If Medicare denies a service that requires prior authorization by HRSA, HRSA waives the **prior** authorization requirement but still requires some form of HRSA authorization. Authorization or denial of the request is based upon medical necessity.

HRSA's Payment Methodology – Medicare Part B

- On FFS claims, HRSA compares HRSA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no HRSA allowed amount, HRSA uses Medicare's allowed amount.) Medicare's payment is deducted from the amount selected.

- On an Tribal Health encounter claim, HRSA will deduct any payment made by Medicare from the Tribal Health encounter rate and pay the difference.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds HRSA's allowable.

- If there *is* a balance due, payment is made towards the Medicare deductible and/or coinsurance up to HRSA's maximum allowable.

- HRSA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. HRSA *can* pay these costs to the provider on behalf of the client when:

  - ✓ The provider **accepts** assignment; and

  - ✓ The total combined payment to the provider from Medicare and HRSA does not exceed Medicare or HRSA's allowed amount, whichever is less.

QMB (Qualified Medicare Beneficiaries) Program Limitations

For clients who are **Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program** (Clients who have CNP or MNP identifiers on their Medical ID card in addition to QMB):

- If **Medicare and Medicaid** cover the service, HRSA pays only the deductible and/or coinsurance up to Medicare or HRSA's allowed amount, whichever is less.

- If only Medicare covers the service **and Medicaid does not**, HRSA pays only the deductible and/or coinsurance up to Medicare's allowed amount.

- If only Medicaid cover the service **and Medicare does not** and the service is covered under the CNP or MNP program, HRSA pays for the service.

QMB-Medicare Only

For **QMB-Medicare Only** clients (Clients who have QMB ONLY identifiers on their Medical ID card):

- If **Medicare and Medicaid** cover the service, HRSA pays only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.
- If only Medicare covers the service **and Medicaid does not**, HRSA pays only the deductible and/or coinsurance up to Medicare's allowed amount.
- If **Medicare does not** cover the service, HRSA does not pay the service.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical ID card. An insurance carrier's time limit for claim submissions may be different from HRSA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as HRSA's, prior to any payment by HRSA.

You must meet HRSA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding HRSA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by HRSA, or if you have reason to believe that HRSA may make an additional payment, do both of the following:

- Submit a completed claim form to HRSA.
- Attach the insurance carrier's statement or EOB.
- For electronic billing, submit line items and send insurance EOB as backup.

Third-party carrier codes are available in the *General Information Booklet* on HRSA's website at http://maa.dshs.wa.gov/download/BillingInstructions/General_Information_BI.pdf You may also call the Coordination of Benefits Section at 800.562.6136.

What client records must be kept for billing purposes?

[Refer to WAC 388-502-0020]

Enrolled medical, dental, and mental health providers must maintain client records with the following information as appropriate:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination (e.g., diagnosis);
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, **for at least 6 years from the date of service** or longer if required by federal or state law or regulation.

A provider may contact HRSA with questions regarding HRSA's programs. However, HRSA's response is based solely on the information provided to HRSA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern HRSA's programs. [Refer to WAC 388-502-0020(2)]

Rebillings and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

Rebillings

Rebill when:

- **The claim is denied in full**. When the entire claim is denied, check the Explanation of Benefits (EOB) code, then make the appropriate corrections and resubmit your claim on a regular billing form, not the adjustment form.

- **An individual line is denied on a multiple-line claim**. The denied service may be submitted as a rebill on a regular billing form, not an adjustment form.

- **The claim is returned separately.** Occasionally, HRSA is unable to process your claim and will return it to you with a letter stating what information is needed. Correct the information as directed and resubmit your claim.

How to Rebill

- Check any EOB code listed then make your corrections on a copy of the claim OR produce a new claim with the correct information.

- Attach insurance information to the corrected claim and send it to HRSA.

Note: Remember to line out or omit all lines that have already been paid on the claim before sending it back to HRSA. Be sure to adjust the total. If you rebill the claim after the billing time limit has expired, or more than 365 days from the original date(s) of service on the claim, enter the 17-digit claim number in field 22 and/or field 19 (1500 Claim Form). This claim number is proof of your timeliness.

Note: If 60 days (or more) have elapsed since you sent your claim to HRSA *and* it has not appeared on your Remittance and Status Report, resubmit your claim.

Adjustments

Adjust the claim if:

- **The encounter code was omitted or erroneously** reported on a paid claim

- **You were underpaid.** Line items or claims paid at an amount less than the IHS encounter rate maximum allowable constitute an adjustment. (If your charges are less than the maximum allowable, HRSA will pay your claim as billed.)

- You were overpaid. See how to adjust overpayments below.

All **adjustments** must be submitted on the **Adjustment Request form [DSHS 13-715]** which may be obtained on the web at: http://www1.dshs.wa.gov/msa/forms/eforms.html. Use only *one* adjustment request form per claim. Multiple line corrections to a single claim should be submitted on one adjustment request form. Adjustments are processed in two steps:

1. The MMIS locates the claim you wish to adjust. The message *CRE* will appear in the EOB column on the HRSA Remittance and Status Report.

2. The action requested will be completed and the claim processed accordingly.

(Requesting an adjustment does not necessarily mean that your claim will be paid.) The adjusted claim may be denied if HRSA's original payment was correct or if the information provided on the Adjustment Request is incorrect. Be sure proper documentation (e.g., operative report, Remittance and Status Report, etc.) is attached to your adjustment request to avoid another denial or incorrect disposition of your claim.

How to Adjust Overpayments

- Submit an adjustment: HRSA recoups your claim and deduct the excess amount from your future remittance check(s) until the overpayment is satisfied; or

-OR-

- Issue a refund check payable to DSHS: Attach a copy of the Remittance and Status Report showing the paid claim and include a brief explanation for the refund (e.g., insurance payment, duplicate payment).

Do one or the other, not both for the same claim!

Mail this to:

Office of Financial Recovery - Med
PO Box 9501
Olympia WA 98507-9501

Completing the 1500 Claim Form

Refer to HRSA's current *General Information Booklet* for instructions on completing the 1500 Claim Form. You may download this booklet from the HRSA Provider Publications web site located at http://maa.dshs.wa.gov (Billing Instructions/Numbered Memorandum link) or call MACSC at 800.562.3022 to request a paper copy.

Instructions Specific to Tribal Health Providers

Field Number	Instructions
19	When applicable. Indicate "Tribal Medicare" if all of the following apply: • The claim is for secondary payment. • Medicare is the primary payer. • There is a Medicare EOMB attached to the claim. Also note any information that may help with the disposition of the claim.
24B	Enter one of the following Place of Service codes: **Code Number** — **To Be Used For** 05 — Indian Health Service Free-standing Facility 06 — Indian Health Service Provider-based Facility 07 — Tribal 638 Free-standing Facility 08 — Tribal 638 Provider- based Facility 11 — Office 12 — Home
24D	Enter the appropriate Current Procedural Terminology (CPT) or Common Procedure Coding System (HCPCS) procedure code for the services being billed. **Modifier**: Enter the appropriate AI/AN or non-native identification modifier. See table on page D.14.

Completing the 1500 Claim Form for Medicare/Medicaid dual eligibles?

Follow all the instructions previously stated in this section with the addition of:

- In field 19, indicate "Tribal Medicare."
- Attach the Medicare EOMB to your claim.

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Completing the ADA Claim Forms

Refer to HRSA's current *General Information Booklet* for instructions on completing the ADA Claim Forms. You may download this booklet from HRSA's website at: http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html

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Appendix

Medical ID Card/Managed Care Indicators and Plan Contact Information

Medical ID Acronym	Plan Name	Plan Phone	Plan Web Site	DSHS Programs
ANH	Asuris Northwest Health Plan	888.344.5587	www.asuris.com	Healthy Options
CHPW CHPP CHPG	Community Health Plan of Washington	800.440.1561	www.chpw.org	Healthy Options Basic Health Plus GAU Managed Care
CUP CUPP	Columbia United Providers	800.315.7862	www.cuphealth.com	Healthy Options Basic Health Plus
EVCP	Evercare Premier	866.266.0636	www.evercareonline.com	Medicare/Medicaid Integration Project
GHC GHP	Group Health Cooperative	888.901.4636	www.ghc.org	Healthy Options Basic Health Plus
KHPP	Kaiser Foundation Health Plan	800.813.2000	www.kaiserpermanente.org	Basic Health Plus
MHC MHCP MINT	Molina Healthcare of Washington	800.869.7165	www.molinahealthcare.com	Healthy Options Basic Health Plus Washington Medicaid Integration Partnership
RBS	Regence Blue Shield	800.669.8791	www.wa.regence.com	Healthy Options

Medicaid State Plan: HRSA Tribal Mental Health Benefit
Tribal Provider Staff Eligible to Bill the Encounter Rate
January 6, 2006

	Benefit/Service Modality	Eligible to Bill Encounter
1	Brief Intervention Treatment	MHPs* or staff registered as counselors under the supervision of an MHP
2	Crisis Services	MHPs* or staff registered as counselors under the supervision of an MHP
3	Day Support	MHPs* or staff registered as counselors under the supervision of an MHP
4	Family Treatment	MHPs* or staff registered as counselors under the supervision of an MHP
5	Freestanding Evaluation and Treatment	Licensed psychiatrists, nurses, or MHPs* or services provided under the direction of same.
6	Group Treatment Services	MHPs* or staff registered as counselors under the supervision of an MHP
7	High Intensity Treatment	MHPs*, mental health care providers**, and peer counselors***
8	Individual Treatment Services	MHPs* or staff registered as counselors under the supervision of an MHP
9	Intake Evaluation	MHPs* only
10	Medication Management	Persons licensed to prescribe and/or administer and review medications.
11	Medication Monitoring	MHPs* or staff registered as counselors under the supervision of an MHP
12	Mental Health Service provided in Residential Settings	Mental health care providers** (including MHPs)
13	Peer Support	Peer counselors*** only
14	Psychological Assessment	Licensed psychologists or persons under the supervision of same
15	Rehabilitation Case Management	MHPs* or staff registered as counselors under the supervision of an MHP
16	Special Population Evaluation	Mental Health Specialists as defined in WAC 388-865-0150
17	Stabilization Services	MHPs* or staff registered as counselors under the supervision of an MHP
18	Outpatient Mental Health rehabilitation Services – Therapeutic Psychoeducation	MHPs* or staff registered as counselors under the supervision of an MHP

* MHPs as defined within this document.

** Mental Health Care Provider means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field, A.A. level with two years experience in the mental health or related fields.

*** Peer Counselor means the individual who: has self-identified as a consumer or survivor of mental health services; has received specialized training provided/contracted by the Mental Health Division; has passed a written/oral test, which includes both written and oral components of the training; has passed a Washington State background check; has been certified by the Mental Health Division; and is registered as a counselor with the Department of Health.

Tribal Billing Codes

Encounter Codes

	Native	Non-Native	Diagnosis Code
Medical Encounter	T1015-UA	T1015- SE	As appropriate
Psychiatric visit using Medical provider number*	T1015-UA	T1015- SE	290-319
Dental Encounter	T1015-UA	T1015- SE	520-525.9 or V72.2
Mental Health Encounter	T1015-HE	T1015- SE**	As appropriate
Chemical Dependency Encounter	T1015-HF	If the tribe is able to bill the service, the code is included in the DASA contract.	**303.90** (alcohol dependency) **304.90** (drug dependency). For youth and pregnant & postpartum women, the following diagnosis codes may be used to distinguish abuse: **305.00** (for alcohol abuse) **305.90** (for drug abuse)

*12 psychiatric visits per calendar year.
**Please refer to the Clinical Family definition in the Definitions section.

Fee-for-Service

	Native	Non-Native	Procedure Code	Diagnosis Code
Medical Fee-for-Service (FFS)	CPT-UA	CPT-SE	As appropriate	As appropriate
Dental FFS *(Use ADA Form)*	CDT	CDT	As appropriate	

Canadian First Nation Medicaid Eligibility

Certain individuals may be entitled to benefits such as Medicaid, Supplemental Security Income (SSI), Food Stamps, Disability, Social Security if they:

- Were born in Canada;
- Have at least 50% Aboriginal blood; and
- Are unable to work or lose their job.

Click on the following hyperlink to read more about *Border Crossing Rights Between the United States and Canada for Aboriginal People:*
http://www.ptla.org/wabanaki/jaytreaty.htm#Cross%20Border.

MEDICAID

What it is: It is a jointly funded, Federal-State health insurance program for low-income and needy people. It covers children, the aged, blind, and/or disabled and other people who are eligible to receive federally assisted income maintenance payments.

Eligibility: In some states people automatically qualify for Medicaid if they qualify for SSI benefits. Other states have their own eligibility rules.

Who to contact: Social Security Administration at **800.772.1213** or the local State Medicaid agency.

The right to this benefit is guaranteed by U.S. law 8 U.S.C. §1612(b)(3).

Crossing the U.S. Border to Live and/or Work

If an individual was born in Canada and has at least 50% Aboriginal blood, he or she has the right to enter the U.S. to live or work. This right is guaranteed by federal statute (8 U.S.C. §1359) and the federal court case *Akins v. Saxbe*, 380 F. Supp. 1210 (D.Me. 1974).

When individuals cross the border with intent to live or work in the U.S., they must be able to prove that they have at least 50% Aboriginal blood. Different U.S. Immigration and Naturalization Service (INS) ports of entry or border crossings may ask for different kinds of documentation. Some ask for more; some for less. At the border, individuals may be asked for **any** or **all** of the following documents:

- A letter from the band office stating that the individuals have at least 50% Aboriginal blood (also referred to as blood quantum).
- The individuals; Certificate of Indian Status Card (the card with the red stripe along the top).
- The individuals' long form birth certificate.
- The individuals' photo ID.
- If the individuals are Haudenosaunee, their Red I.D. Card.
- If the individuals are Inuit, their Inuit enrollment card from one of the regional Inuit lands claim agreements.

If the Social Security Administration is uncooperative about accepting the individuals' letter of quantum or any other piece of the above documentation to prove alien status, refer them to the following regulations from the Social Security Administration's own handbook:

- **SI 00502.105 -** "Exemption from Alien Provisions for Certain Non-citizen Indians"
- **RM 00203.430** - "Evidence for an SSN Card for an Alien Lawfully in the U.S. Without INS Documents"

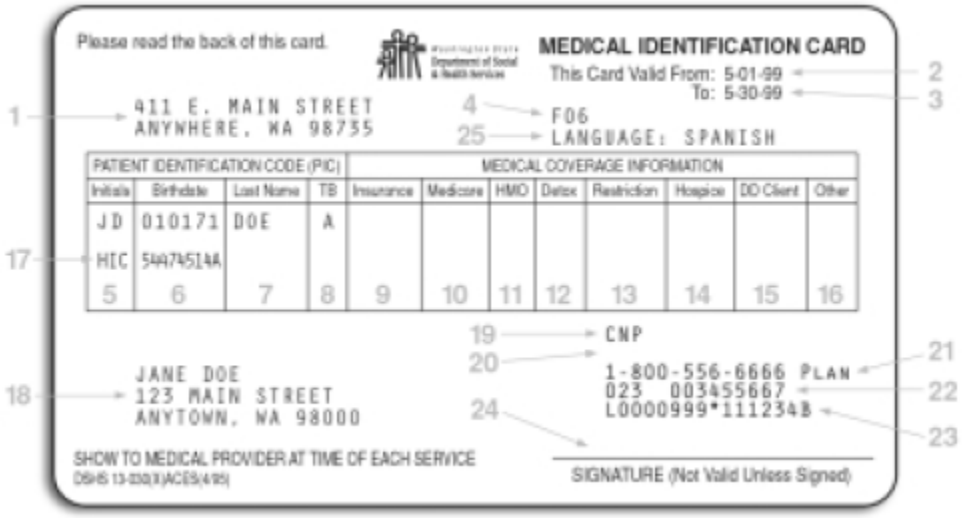
IHS Manual

http://www.ihs.gov/PublicInfo/Publications/IHSManual/Part2/pt2chapt3/pt2chpt3.htm#7

An Indian is not required to be a citizen of the U.S. to be eligible for contract health services (CHS). The Indian (e.g., Canadian or Mexican) must reside in the U.S. and be a member of a tribe whose traditional land is divided by the Canadian border (i.e., St. Regis Mohawk, Blackfeet) or Mexican border (i..e.Tohono O'Odham).

Medical ID Card

Persons who receive medical coverage get a Medical ID card each month. Below is a sample Medical ID card (Medical Coupon):



The codes below are the medical coverage group found in field 4 on the Medical ID card. These codes identify the type of medical assistance the client is receiving. Identification of medical coverage group helps providers to determine the need for additional services such as pregnancy-related First Steps services or if the client is potentially a Healthy Options enrollee.

Medical Coverage Group Codes – Field 4	Medical Coverage Group Definitions
C01, C95, AND C99	Waivered and Community Based Programs such as CAP, COPES
D01, D02	Foster Care, Adoption Support, and Juvenile Rehabilitation Services
F01, F02, F03, F04, and F09	Family Medical
F05, F06, F95, and F99	Children's Medical
F07	CHIP
GO1 and G02	General Assistance
G03, G95, and G99 facility (ALF)	Medical Assistance for a resident of Alternate Living Facility (ALF)
I01	Institution for the Mentally Diseased (IMD)
K01,K03,K95, and K99	Long Term Care – Families
L01, L02, L04, L95, and L99	Long Term Care – Aged, Blind, Disabled
M99	Psychiatric Indigent Inpatient (PII)
P02, P04, and P99	Pregnancy related
P05	Family Planning only
P06	Take Charge Family Planning
R01 R02, and R03	Refugee
S01, S02, S07, S95, and S99	Aged, Blind, or Disabled (SSI) and Breast & Cervical Cancer Treatment
S03, S04, S05, S06	Medicare savings programs
S08	Health Care for Workers w/Disabilities (HWD)
WO1, W02 and W03	ADATSA

Medical ID Card Legend

AREA DESCRIPTION

1 Address of CSO.
2 Date eligibility begins.
3 Date eligibility ends.
4 Medical coverage group described in the table on the previous page.

Patient Identification Code (PIC) Segments Are:

5 First and middle initials *(or a dash if the middle initial is not known).*
6 Six digit birth date, consisting of numerals only *(MMDDYY).*
7 First five letters of the last name *(and spaces if the name is fewer than five letters).*
8 Tie breaker *(an alpha or numeric character).*

Medical Coverage Information

9 **Insurance carrier code** A four character alphanumeric code *(insurance carrier code)* in this area indicates the private insurance plan information.
10 **Medicare** Xs indicate the client has Medicare coverage.
11 **HMO** *(Health Maintenance Organization)* – Alpha code indicates enrollment in an MAA Healthy Options managed health care plan. ***(Managed health care plan is the same as health maintenance organization or HMO)***. This area may also contain the legend PCCM *(primary care case manager)*. The following ACES medical coverage groups, if not otherwise exempt, are required to enroll in Healthy Options: F01, F02, F03, F04, F05, F06, F07, and P02.
12 **Detox** Xs indicate eligibility for a 3 day alcohol or a 5 day drug detoxification program.
13 **Restrictions** Xs indicate the client is assigned to one physician and one pharmacist. The words "client on review" in Field 20 will also indicate restricted clients.
14 **Hospice** Xs indicate the client has elected hospice care.
15 **DD client** Xs indicate this person is a client of the DSHS Division of Developmental Disabilities.
16 **Other** This area is not in use.
17 **HIC** shown here indicates that the client is on Medicare.
18 **Name** and address of client, head of household or guardian.
19 **Medical program** and scope of care indicators.
20 **Other messages** *(e.g., client on review, delayed certification, emergency hospital only).*
21 **Telephone number and name** of PCCM or Healthy Options plan.
22 **Local field office** *(3 digits)* and ACES assistance unit # *(9 digits).*
23 **Internal control numbers** for DSHS use only.
24 **Client's signature** May be used to verify identity of client.
25 **Client's primary language**

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