



Tribal Billing Workgroup (TBWG)

August 12, 2015
Mike Longnecker
HCA Tribal Affairs Office

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Agenda

- Transgender Healthcare Benefit
- Electronic Health Records
- Monthly Data and Analysis
- 2015 IHS rate and annual mass adjustment
- FAQ and Open Discussion

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Washington State Health Care Authority

Medicaid's Transgender Healthcare Benefit

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Transgender Healthcare Benefit

What's covered now?

- ❖ Mental Health Services
- ❖ Hormonal Therapy
 - ❖ Pre-surgical and Post-surgical
- ❖ Puberty -Blocking Therapy

What's new?

Coverage for surgeries to support transition

When?

June 8, 2015

Why the Change?

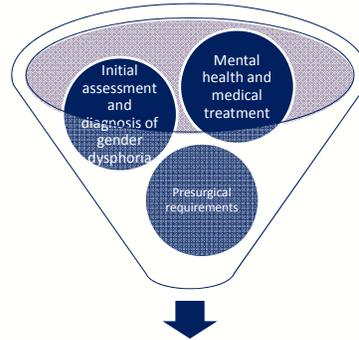
Transgender Healthcare Benefit

Overall Requirements

- Eligible program
- Diagnosis of Gender Dysphoria
- Services provided agency approved provider

Surgical Requirements

- Prior Authorization
- 18 yrs or older
- Psychosocial eval
 - 2 for bottom surgery
 - 1 for top surgery
- Continuous hormone therapy
- Living in gender role



Gender reassignment surgery

Individual considerations will be reviewed on a case by case basis

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Transgender Healthcare Benefit



Questions?

http://www.hca.wa.gov/medicaid/billing/Documents/physicianguides/physician-related_services_mpg.pdf

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Electronic Health Records

**CMS has some changes and deadlines coming,
do not be left out!**

Many tribes are missing out on **free federal incentive funds**.

Contact us if:

- You are not sure where to start
- You had a change in staff or can not log in
- You are not sure you qualify
- Need technical assistance with eMIPP

If you do not have an EHR system, keep in mind there are free and low-cost options available. There is a site, below, that has information on free EHRs.

<http://blog.capterra.com/top-7-free-open-source-emr-software-products/>

You can also do a search for Free EHR List.

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Electronic Health Records

Need EHR help?

Please contact our team at: HealthIT@hca.wa.gov, or:

Holly Givens 360-725-1954 and **Kim Jacobs** 360-725-1031

- **Security or log in issues with ProviderOne?** Please contact: ProviderOneSecurity@hca.wa.gov for assistance with your P1 password or when you have a change in staff resulting in a new System Administrator for your office.

Please remember that if you do not have your own security credentials granting you access to the EHR domain in ProviderOne, our staff is not able to discuss any information with you.

- **CMS EHR Help Desk:** 1-888-734-6433 Option #1
- **CMS Account Security** and to update your accounts contact person: 1-866-484-8049 Option #3
- **Website for Health IT:** <http://www.hca.wa.gov/healthit>

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June 2015 Claims Data (I/T/U)

	Dollars	Dollars, Prior TBWG	Clients*	Clients, Prior TBWG*	% Paid	% Paid, Prior TBWG
Totals	\$6,547,126	\$6,090,334	11,774	11,939	NA	NA
Medical	\$1,586,501	\$1,697,686	4456	4743	75%	74%
Dental	\$779,917	\$808,603	2174	2231	84%	89%
MH	\$899,531	\$954,633	1229	1186	89%	92%
SUDS(CD)	\$2,694,284	\$2,138,754	1145	950	95%	91%
POS	\$533,146	\$486,085	5663	5777	61%	58%
Other FFS	\$53,747	\$4,571	183	187	6%	2%

* Client count will not be the sum from the categories due to 'overlap' (clients can be in more than 1 category)

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Medical Claims – Top Denials

EOB	Description	Comments	Denial % *
18	Exact duplicate claim/service	Duplicate billing. I did notice some claims that were partial-duplicates. If a claim is paid or partially paid it would need to be adjusted in order to make any changes (adjusting also automatically proves timeliness too)	37%
24	Charges are covered under a capitation agreement managed care plan	Client is Enrolled in one of the Managed Care Plans	14%

* Denial percentages example: Out of the Medical claims that did not pay at the encounter rate, 37% were due to duplicate billing

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Medical Claims – Top Denials

EOB	Description	Comments	Denial %
167	This (these) diagnosis(es) is (are) not covered	<p>Medicaid does not consider some diagnosis codes eligible for medical treatment.</p> <p>NOTE: Office visits for prescribing Campral, ReVia, Vivitrol, Buprenorphine, Suboxone are covered – refer to physician guide for criteria. Office visits for Buprenorphine/naloxone are also carved out of Managed Care (bill P1 directly for clients enrolled in Managed Care). Claim note of “bupren” or “suboxone” helps avoid denial errors</p> <p>If you would like a copy of the diagnosis reference sheet (list out diagnosis codes that usually do not pay if billed as the primary diagnosis on a medical claim) – ask Mike. This diagnosis reference sheet will be replicated with ICD10 codes when they are available</p>	9%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	The AI/AN or non-AI/AN modifier was missing	7%

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Medical Claims – Top Denials

EOB	Description	Comments	Denial %
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage	6%
22	This care may be covered by another payer per coordination of benefits.	Client has Medicare	3%

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Medical Claims – Top Denials

EOB	Description	Comments	Denial %
31	Patient cannot be identified as our insured	Client ID usually invalid but sometimes there is a space after the "WA". If rebilling in the P1 screens the space issue gets automatically fixed (P1 screens ignore the space and if client ID is invalid you will get an error popup before submitting the claim)	3%
16 N288	Missing / incomplete / invalid rendering provider taxonomy	<p>Claims had a valid servicing taxonomy but the taxonomy on the claim wasn't one that the servicing provider was enrolled with.</p> <p>Two resolutions:</p> <ol style="list-style-type: none"> 1. Change the claims so that they are submitted with the taxonomy that the Dr. is enrolled with. 2. Update the provider's file to include the taxonomy that is being billed (if appropriate, wouldn't give a <i>brain surgeon</i> taxonomy to an FP physician). If you choose option 2 contact Mike so he can reprocess claims so you do not have to rebill <p>Not sure what the provider is enrolled with?</p> <ol style="list-style-type: none"> a. Contact Mike or b. you can look in P1 to see what the provider is enrolled with and make changes. Go to page 217 of this Medicaid webinar 	2%

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Medical Claims – Top Denials

EOB	Description	Comments	Denial %
23	The impact of prior payer(s) adjudication including payments and/or adjustments	Either the claim was a Medicare crossover and Medicare paid more than the HCA allowed (usually only on FFS claims) or claim had private insurance and the Coordination of Benefits folks determined that claim is not payable	2%
16 N329	Missing /incomplete /invalid patient birth date	Usually incorrect birthday on claim. Some claims had incorrect birthday and gender, which usually indicates the wrong client ID. If you think you have the right birthday on the claim or are unsure, contact Mike	1%

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Dental Claims – Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing	16%
119	Benefit maximum for this time period or occurrence has been reached	<p>Limits listed below are the general limits, refer to current Dental billing guide for complete information</p> <ul style="list-style-type: none"> • Intraoral (D0210) & Panoramic (D0330) – once per 3 years • Fluoride (D1206 D1208) <ul style="list-style-type: none"> age 0-6 (or in ortho treatment or resides in Alternate Living Facility (ALF) or DDA client) – 3 per 12 months P1 “knows” if client is DDA or claim is billed in an ALF. P1 does not “know” if the client is an ortho client or resides in an ALF, limits listed above apply, claim note needed (contains “ortho” or “assisted living”) age 7-18 – 2 per 12 months Age 19+ - 1 per 12 months • Scaling/Planing (D4341, D4342) – 1 per quad per 2 years • Sealants (D1351) – 1 per tooth per 3 years • Restorations (D2140-D2394) – 1 per (surface) per 2 years • Prophylaxis (D1110 D1120) <ul style="list-style-type: none"> Age 0-18 – 1 per 6 months Age 19+ - 1 per 12 months 	14%

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Dental Claims – Top Denials

EOB	Description	Comments	Denial %
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Dental claims missing the 870001305 or 870001306 EPA number When reviewing claims I noticed some had the EPA but were processed incorrectly – retrieved data and reprocessed claims that processed incorrectly (about 50)	12%
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage	9%

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Dental Claims – Top Denials

EOB	Description	Comments	Denial %
96 N59	Non-covered charge(s).	Codes varied. Two ways to check dental codes for coverage Dental Billing Guide Dental Fee Schedule	9%
6	The procedure/revenue code is inconsistent with the patient's age	Some dental services are only allowed for children (sealants, hygiene instructions, crowns, posterior root canals) Prophy ages D1110 – 14 years and over, D1120 – 0 through 13 years	8%

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Dental Claims – Top Denials

EOB	Description	Comments	Denial %
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	Some dental services require prior authorization. Refer to the dental billing guide (or ask mike). The Adult Dental EPA numbers (eg 870000002 through 870000033) are no longer needed (as of 01/01/2014)	6%
16 N37	Missing/incomplete/invalid tooth number/letter	Some services need either a tooth, or an arch, or a quadrant number. Most common - scaling/planing (D4341 D4342) needs a quadrant. Refer to Dental tooth, arch, quad numbering slide on the Tribal Affairs website under Quick Reference Sheets for Providers and Billing Offices. RPMS users please contact the Portland Area Office for getting fix in to your system for quadrants/arches	4%

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Dental Claims – Top Denials

EOB	Description	Comments	Denial %
31	Patient cannot be identified as our insured	Client ID usually invalid but sometimes there is a space after the “WA” – P1 treats the space as a value and it makes the ID invalid If rebilling in the P1 screens the space issue gets automatically fixed (P1 screens ignore the space and if client ID is invalid you will get an error popup before submitting the claim)	4%
16 N288	Missing / incomplete / invalid rendering provider taxonomy	Claims had a valid servicing taxonomy but the taxonomy on the claim wasn’t one that the dentist was enrolled with. Two resolutions: 1. Change the claims so that they are submitted with the taxonomy that the dentist is enrolled with. 2. Update the provider’s file to include the taxonomy that is being billed (<u>if appropriate</u> , wouldn’t give an oral surgeon taxonomy to a general dentist). If you choose option 2 contact Mike so he can reprocess claims so you do not have to rebill Not sure what the provider is enrolled with? a. Contact Mike or b. you can look in P1 to see what the provider is enrolled with and make changes. Go to page 24 of this Dental workshop/webinar	4%

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Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
16 N288	Missing / incomplete / invalid rendering provider taxonomy	Claims had a valid servicing taxonomy but the taxonomy on the claim wasn’t one that the MHP was enrolled with. Two resolutions: 1. Change the claims so that they are submitted with the taxonomy that the MHP is enrolled with. 2. Update the provider’s file to include the taxonomy that is being billed (<u>if appropriate</u> , wouldn’t give a <i>brain surgeon</i> taxonomy to an MHP). If you choose option 2 contact Mike so he can reprocess claims so you do not have to rebill Not sure what the provider is enrolled with? a. Contact Mike or b. you can look in P1 to see what the provider is enrolled with and make changes. Go to page 217 of this Medicaid webinar	24%
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage	18%

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Washington State Health Care Authority

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
24	Charges are covered under a capitation agreement managed care plan	Client is Enrolled in one of the Managed Care Plans	14%
18	Exact duplicate claim/service	Duplicate billing	10%

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Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
16 N290	Missing/incomplete/in valid rendering provider primary identifier	Servicing provider is not in ProviderOne. Get the provider enrolled and then remember to request a back-date if they started working before they were approved in P1	7%
A1 N192	Patient is a Medicaid/Qualified Medicare Beneficiary	QMB-only clients are only eligible for fee for service secondary to Medicare	6%

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Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
96 N20	Service not payable with other service rendered on the same date.	CPT code for MH visit had more than 1 unit on the line. Resolution – most CPT's that are not 'per x minutes' must be billed at 1 unit. CPT 90837, 90853 was observed most often	5%
22	This care may be covered by another payer per coordination of benefits.	Client has Medicare	3%

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Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
16 N329	Missing /incomplete /invalid patient birth date	Usually incorrect birthday on claim. Some claims had incorrect birthday and gender, which usually indicates the wrong client ID. If you think you have the right birthday on the claim or are unsure, contact Mike	2%
96 N59	Non-covered charge(s).	Code wasn't covered. MH codes need to be either in the Mental Health Guide or in the Tribal Health Billing guide (Tribal Health guide lists the RSN modalities)	1%

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Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing	23%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	<p>Non-AI/AN claims require certain modifiers on the T1015 line ABP (RAC 1201) – T1015 + SE ABP SSI (RAC 1217) – T1015 + HB All other encounter-eligible clients – T1015 + HX</p> <p>NOTE: non-AI/AN ABP SSI claims are currently not processing correctly (P1 issue) ETA on correction is 08/30/2015</p> <p>AI/AN claims - continue to bill with HF modifier for all client RAC codes</p>	14%

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Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
107	The related or qualifying claim/service was not identified on this claim.	Claim had just a T1015 line.	11%
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage	8%

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Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
96 N59	Non-covered charge(s).	Codes were usually lab codes for UA (UA's are bundled into the daily service rate and are not paid separately)	7%
170 N95	Payment is denied when performed/billed by this type of provider.	Code was either a lab code or a SUDs code but didn't have the HF modifier. Codes payable on SUDs claims are in the SUDs guide and almost always require modifier HF (on the SUDs code).	7%

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Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
11	The diagnosis is inconsistent with the procedure	SUDs claims require that the primary diagnosis be either 303.90, 304.90 (all clients) or 305.00, 305.90 (age 10-20 and/or pregnant clients) ICD10 codes have been posted . Mike will verify when the SUDs billing guide and P1 have been updated	6%
A1 N192	Patient is a Medicaid/Qualified Medicare Beneficiary	QMB-only clients are only eligible for fee for service secondary to Medicare	6%

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Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
16 N255	Missing/incomplete/ invalid billing provider taxonomy	Claims billed with wrong taxonomy (claims didn't have 261QR0405x)	3%
16 N329	Missing /incomplete /invalid patient birth date	Usually incorrect birthday on claim. Some claims had incorrect birthday and gender, which usually indicates the wrong client ID. If you think you have the right birthday on the claim or are unsure, contact Mike	3%

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Substance Use Disorder FAQ

- ICD-10 is scheduled to launch on 10/01/2015
- SUDS claims require that the primary diagnosis be in the approved list of diagnoses
- The list of ICD-10 SUDS codes has been finalized
- Please access the Program Policy Approved Diagnosis Codes website at http://www.hca.wa.gov/medicaid/Pages/approved_diagnosis_codes.aspx
- Information from DSHS indicates that all ICD-10 codes on the website listed above will be accepted on SUDs claims, Mike will verify ASAP when ICD-10 launches

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Non-Native Chem Dep

- CD claims for AI/AN clients are working great
- CD claims for non-Native clients are supposed to pay only the federal share of the encounter

Client RAC	Claim note	Modifier for T1015 line	Date of claim submission (not date of service)	Amount of IHS encounter rate claim pays	Amount of IHS encounter rate for IGT
MAGI (not 1217 or 1201)	SCI=NN	HX	Prior to 10/01/2015	50.03%	49.97%
			On/after 10/01/2015	50%	50%
Alternative Benefit Plan (1201)	SCI=NN	SE	Prior to 01/01/2017	100%	0%
Alternative Benefit Plan, SSI (1217)	SCI=NN	HB	Prior to 10/01/2015	80.01%	19.99%
			On/after 10/01/2015	80%	20%

- Claims for presumptive SSI clients are not paying correctly. Current ETA is August 30, 2015

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2015 IHS encounter rate

- 2015 outpatient per visit/IHS rate (\$350) is in ProviderOne with the exception of non-AI/AN Chemical Dependency claims for ABP SSI (RAC 1217) clients
- Claims previously paid at the 2014 rate (\$342) were sent to P1 System techs in May, 2015 for reprocessing. Current ETA on the mass adjustment is approximately August 30th

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Open Questions and Open Discussion

- Please feel free to ask to be unmuted or use the questions pane
- If you think of questions or issues for the Billing workgroup later please send to Mike or Jessie
- Questions that have “stay tuned” for an answer or “interim” will stay on the log until answered

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Questions Log

Timeliness issues have come up & sometimes clients are retroactively eligible

Timeliness rules are:

1 year from the date of service to get claim billed

Claims that met the 1 year rule can be re-reprocessed until 2 years from the date of services

Secondary claims (from private insurances or Managed Care Organizations) must meet the 1 year timely rule, even if the primary insurance waits 11½ months to process the claim (if claim met the 1 year rule then claim can be re-reprocessed until 2 years from the date of service)

NOTE: we have an exception for the RSN modalities that were not paying (due to coding in P1) from 10/01/2012-04/01/2015. The timely waiver expires on 10/01/2015 – remember to get any outstanding RSN modality claims billed prior to 10/01/2015

Medicare crossover timeliness rules are:

6 months from the Medicare EOB date

Claims that met the 6 month rule can be re-reprocessed until 2 years from the date of service

Retroactively eligible clients (Delayed Certification) have 1 year from the Delayed Certification date for initial timely filing.

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Questions Log

Our ARNP made a home visit, did an exam, and obtained and processed a UA in our lab. This can't be billed as it was not a clinic encounter..... correct?

I need to break this question apart.

- Are ARNP's eligible for the encounter rate? yes, [Tribal Guide](#) (p. 12)
- Where can encounter-eligible services be rendered?
 - The [State Plan](#) (attachment 4) reference - "The definition of an encounter is, "A face to face contact between a health care professional and a Medicaid beneficiary, for the provision of Title XIX defined services *through* an IHS or Tribal 638 facility..." *italics* are mine
 - The current Tribal Billing guide does not support this, we will pursue a change to the billing guide so that it matches the State Plan. The only exception will be for Substance Use Disorder Services (SUDS), SUDS services must be conducted in DSHS approved facilities.
 - The Tribal Affairs office supports providing medically necessary services at locations that are deemed appropriate by the clinician (other factors, such as HIPAA privacy, documenting for medical necessity, appropriateness of the location (eg, a brain surgery would not be conducted in a home setting) apply but are out of scope)
- Which services qualify for the encounter rate?
 - Home E&M's (CPT 99341-99350) qualify for the encounter rate. [Tribal guide](#) (p.20-21)
 Note: labs do not qualify for the encounter rate, however they are bundled into the encounter payment if there is an encounter-eligible service

Therefore, home visits by ARNPs are encounter eligible.

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Questions Log

Descendants do not have the native qualifiers. When tribal assistants are not being allowed to attest is what I am being told (The member is not enrolled in a tribe)

Question sent to Healthplanfinder, this is in regards to AI/AN clients being able to select no managed care. Stay tuned

Is anybody else having trouble with the Medicare crossovers?

A few months ago I shared a typical 1-2-3 fix for the claims that cross over directly from Medicare

Do a "resubmit denied/voided claim" in P1

1. Change the billing taxonomy to an encounter eligible taxonomy (probably 208D00000X)
2. Add the UA or SE modifier to all lines on the claim
3. Add a T1015 + UA or SE line (the billed amount does not matter, the Medicare allowed/paid/coinsurance/deductible will be \$0 on the T1015 line)

Is anybody else getting the P1 error message that says that the charges must match?

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Questions Log

CD diagnosis requirements

303.9x alcohol dependence, 304.9x drug dependence, 305.0x alcohol abuse, 305.9x drug abuse
5th digits: 0 unspecified, 1 continuous, 2 episodic, 3 in remission

DSM V example

305.00 mild presence of 2-3 symptoms, 303.90 moderate presence of 4-5 symptoms, 303.90 severe presence of 6 or more symptoms
The DSM V does not refer to the fifth digits for coding purposes. Only the ICD-9 or ICD-10 books refer to the use of the fifth digit codes.

The DSM V states

In early remission: After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, "Craving , or a strong desire or urge to use alcohol," may be met.

In sustained remission: After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, "Craving , or a strong desire or urge to use alcohol," may be met.

The ICD book does not have descriptions for: 1 continuous, 2 episodic, 3 in remission

Are there standards the auditors want to use? I would assume In Remission is for a period of 12 months or longer. I have been told this by a commercial ins. company that performed an audit of one patient's chart notes.

Any clarification or input would be appreciated. We really like only using the unspecified codes but want to be compliant for coding and billing

Continued on next page

Questions Log

CD diagnosis requirements, continued

Draft answer - The short answer is, the state is not using ICD-10 codes until October of this year. So the codes would not be accessible to bill until then. ... stay tuned

Questions Log

Spend-down

We're having huge issues with spend-downs, especially the childrens' prior to 10/1/13. Any contact info with be appreciated

Spend-down claims applied to spend-down amount or do we need to send in an invoice to spend down dept?

Who is eligible to request a spend down through HCA? Classic Medicaid is understood, no questions.

Interim update:

- Eligibility Overview for Apple Health (Medicaid) – page 9 - http://www.hca.wa.gov/medicaid/publications/documents/22_315.pdf
- Spenddown Flyer – 2015
- HCA Medicaid Update: Spenddown Webinar - [Session 7 \(Spenddown\)](#) | [Presentation Slides](#)
- Apple Health (Medicaid) Manual: Medically Needy and Spenddown - <http://www.hca.wa.gov/medicaid/manual/Pages/50-500.aspx>

DSHS Customer Service Center can be reached at 1-877-501-2233 for questions regarding SSI-Related Spenddown coverage

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Questions Log

Medicare crossovers

it would be helpful if Medicare would accept T1015 on claims, they are rejecting them. If they accepted T1015 and denied as not covered then it would assist electronic processing of these claims

Contractors are rejecting the claim rather than deny the line.

Medicare requires the correct taxonomy therefore the taxonomies you require for each specialty does not always match up crossovers with T1015 will not process, because MCR will not accept T1015 and rejects claims with T1015 on the claim.

MCR will not allow T1015 to enter their system at all

It isn't necessarily Medicare that won't accept the T1015 but the Fiscal Intermediary Novitas which we are required to use. They set the rules and requirements as they want regardless of CMS regs

Not all tribes use Novitas some use WA state Medicare as well

Stay tuned, In the Interim –

Usually the Medicare crossovers that are received by the agency have 3 items that can be corrected while in the P1 screens doing a "Resubmit Denied/Voided claim":

1. billing taxonomy must be encounter eligible (usually 208D00000x)
note: if you bill Medicare with this taxonomy Medicare should forward to P1
2. appropriate AI/AN or non-native modifiers need to be added
3. T1015 line needs to be added

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Questions Log

Managed Care

Is there a way to get the medical claims to pay directly even if they have an MCO since they are Native and not required to have an MCO?

Stay tuned

Client Delayed Certification

ProviderOne eligibility screen shot of a delayed certification client

Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC-Medicaid	1044	CIP	03/01/2013	12/31/2013	002	[REDACTED]		
MC-Medicaid	1111	CIP	01/01/2012	04/30/2013	002	[REDACTED]		08/13/2013

Message(s): This is the Client's eligibility as of this date, based on information available at this time

Thank you

Send TBWG comments and questions to:

mike Longnecker

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360-725-1315

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360-725-1649