Tribal Billing Workgroup (TBWG)

September 9, 2015
Mike Longnecker
HCA Tribal Affairs Office

Agenda

- Monthly Data and Analysis
- Non-AI/AN SUDs resolution
- 2015 IHS rate and annual mass adjustment
- Clarification of Providers who are eligible for the encounter rate
- ICD-10 starts October 1st - are you ready?
- FAQ and Open Discussion

July 2015 Claims Data (I/T/U)

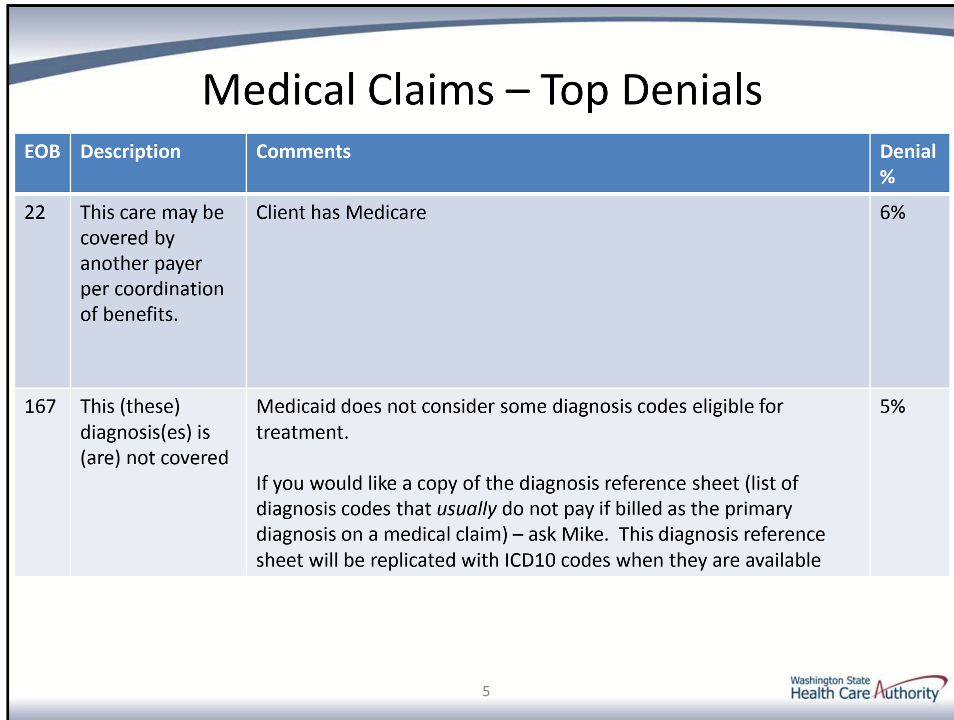
	Dollars	Dollars, Prior TBWG	Clients*	Clients, Prior TBWG*	% Paid	% Paid, Prior TBWG
Totals	$6,558,826	$6,547,126	11,397	11,774	NA	NA
Medical	$1,577,196	$1,586,501	4455	4456	73%	75%
Dental	$712,645	$779,917	2114	2174	81%	84%
MH	$815,936	$899,531	1068	1229	86%	89%
SUDS(CD)	$2,960,207	$2,694,284	1117	1145	83%	95%
POS	$483,129	$533,146	5559	5663	60%	61%
Other FFS	$9,710	$53,747	135	183	14%	6%

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

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)	26%
24	Charges are covered under a capitation agreement managed care plan	Client is Enrolled in one of the Managed Care Plans	15%

* Denial percentages example: Out of the Medical claims that did not pay at the encounter rate, 26% were due to duplicate billing



Medical Claims – Top Denials

EOB	Description	Comments	Denial %
22	This care may be covered by another payer per coordination of benefits.	Client has Medicare	6%
167	This (these) diagnosis(es) is (are) not covered	Medicaid does not consider some diagnosis codes eligible for treatment. If you would like a copy of the diagnosis reference sheet (list of 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	5%

5

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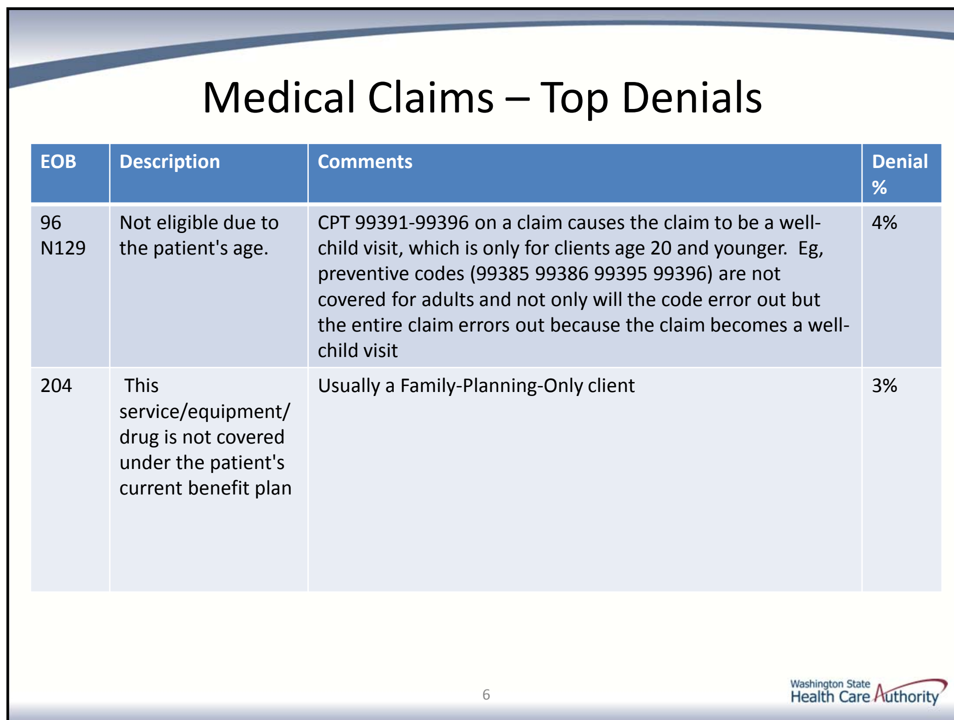

Medical Claims – Top Denials

EOB	Description	Comments	Denial %
96 N129	Not eligible due to the patient's age.	CPT 99391-99396 on a claim causes the claim to be a well-child visit, which is only for clients age 20 and younger. Eg, preventive codes (99385 99386 99395 99396) are not covered for adults and not only will the code error out but the entire claim errors out because the claim becomes a well-child visit	4%
204	This service/equipment/ drug is not covered under the patient's current benefit plan	Usually a Family-Planning-Only client	3%

6

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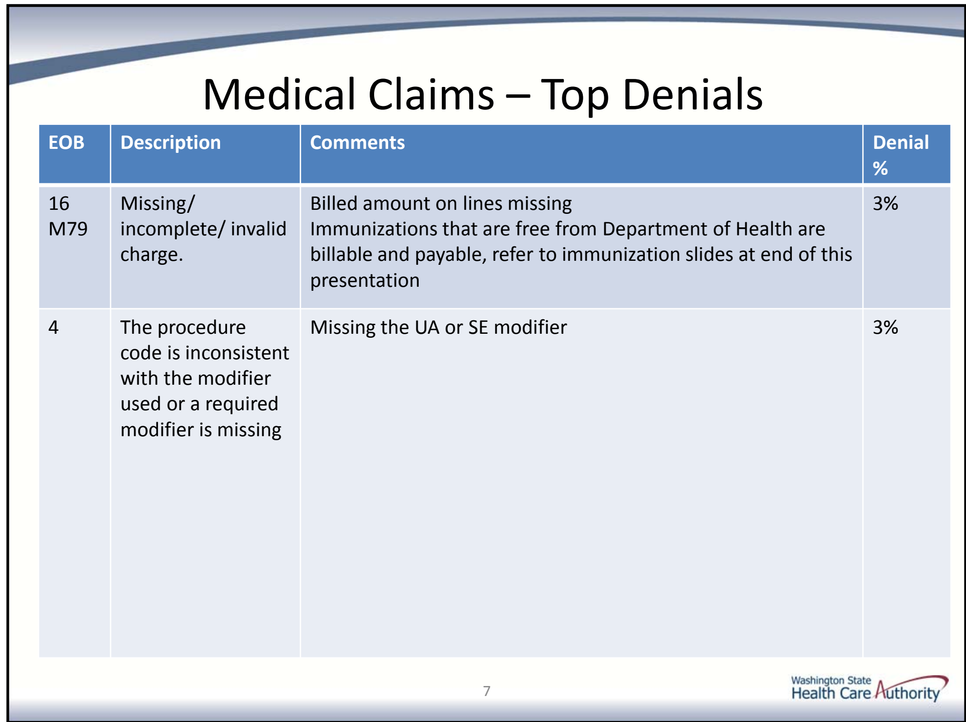
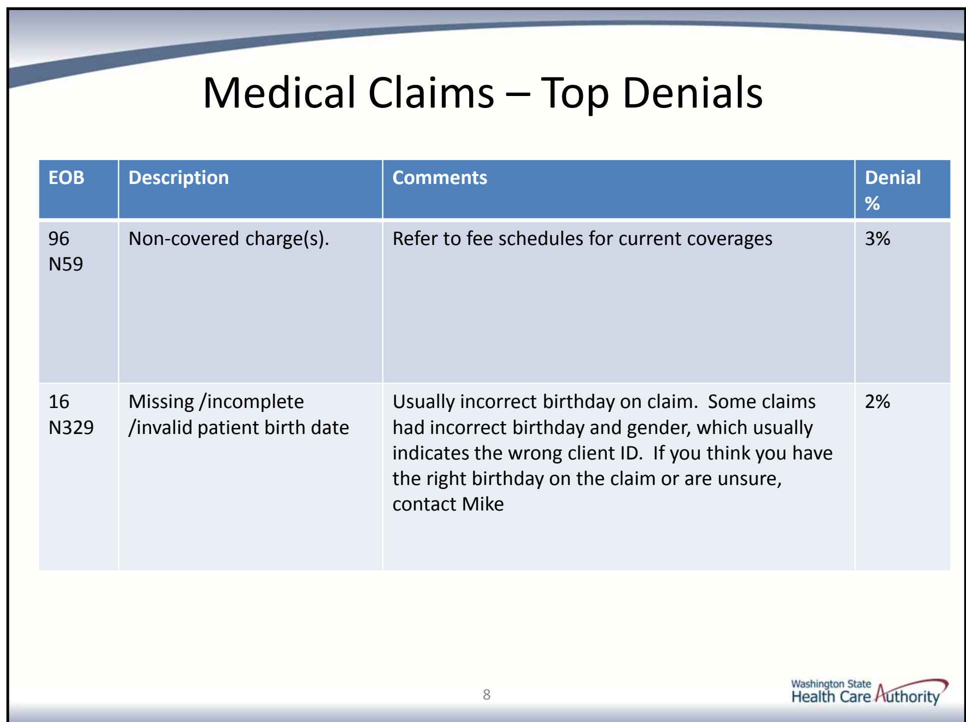
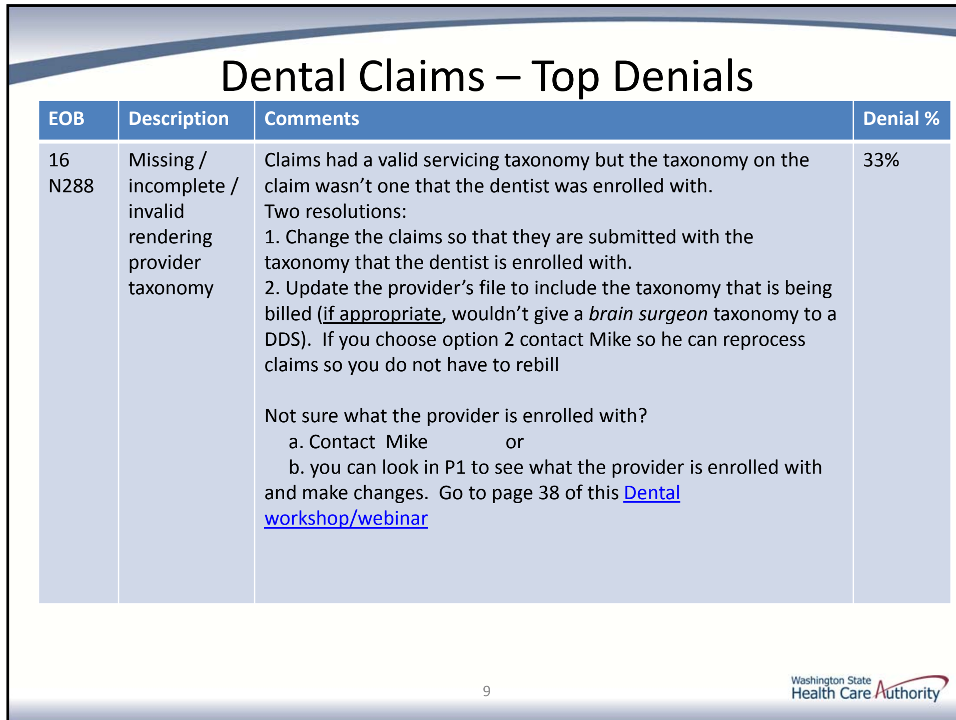


EOB	Description	Comments	Denial %
16 M79	Missing/ incomplete/ invalid charge.	Billed amount on lines missing Immunizations that are free from Department of Health are billable and payable, refer to immunization slides at end of this presentation	3%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Missing the UA or SE modifier	3%



EOB	Description	Comments	Denial %
96 N59	Non-covered charge(s).	Refer to fee schedules for current coverages	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	2%



Dental 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 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 (if appropriate, wouldn't give a *brain surgeon* taxonomy to a DDS). 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 38 of this Dental workshop/webinar	33%

9
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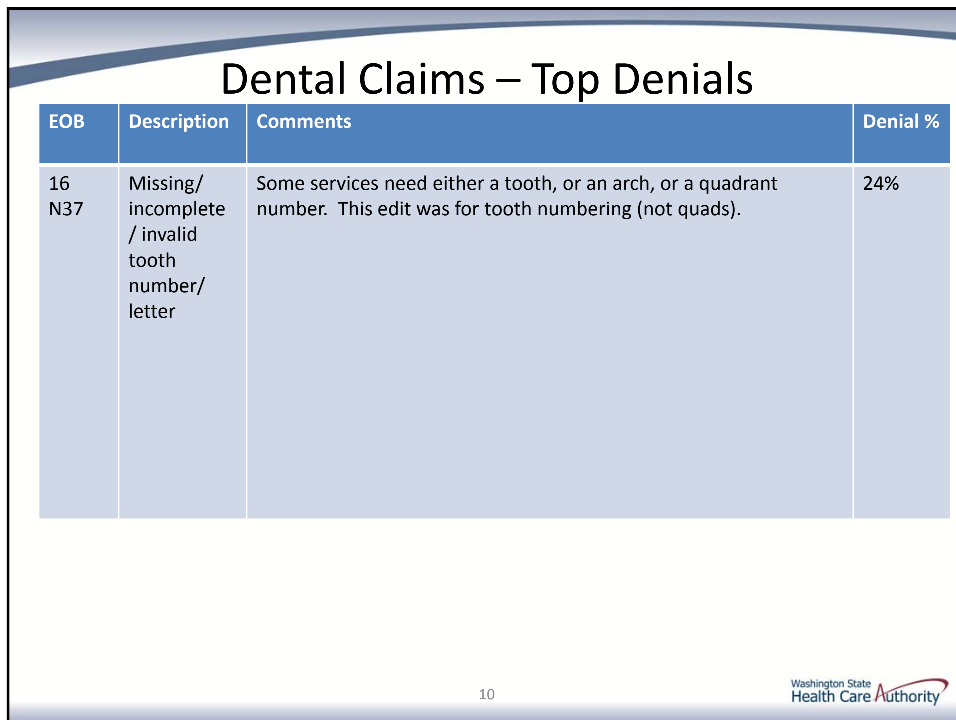

Dental Claims – Top Denials

EOB	Description	Comments	Denial %
16 N37	Missing/ incomplete / invalid tooth number/ letter	Some services need either a tooth, or an arch, or a quadrant number. This edit was for tooth numbering (not quads).	24%

10
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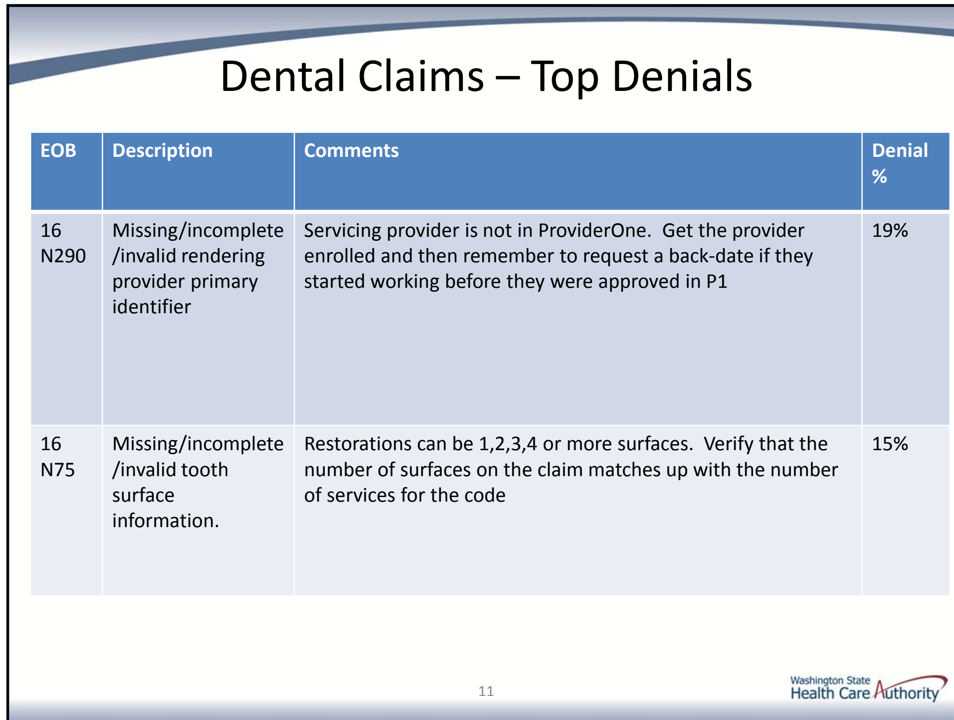
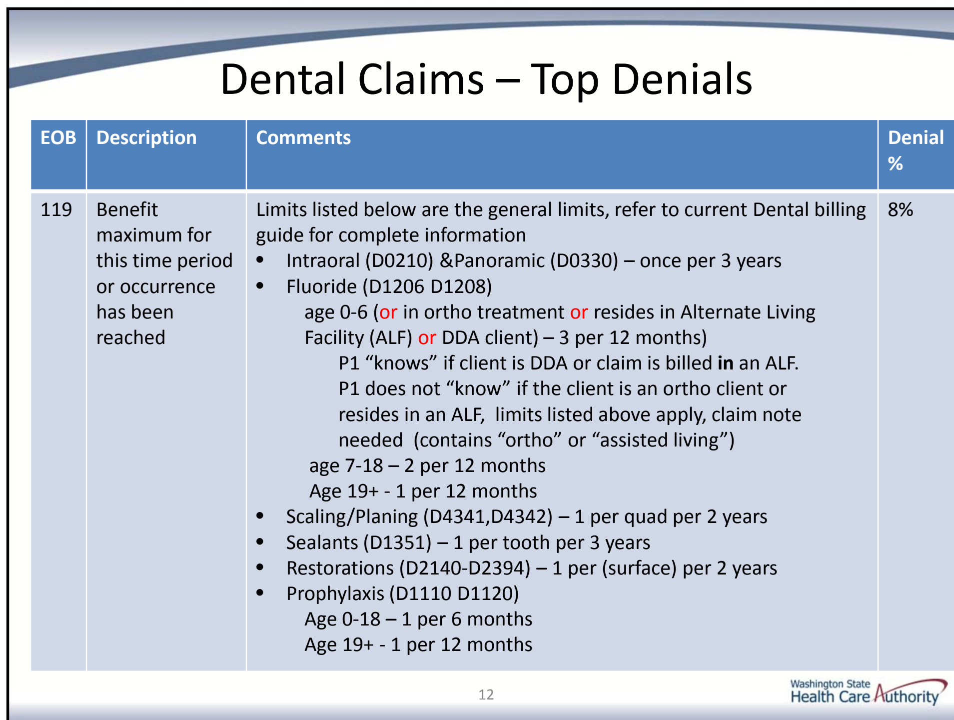


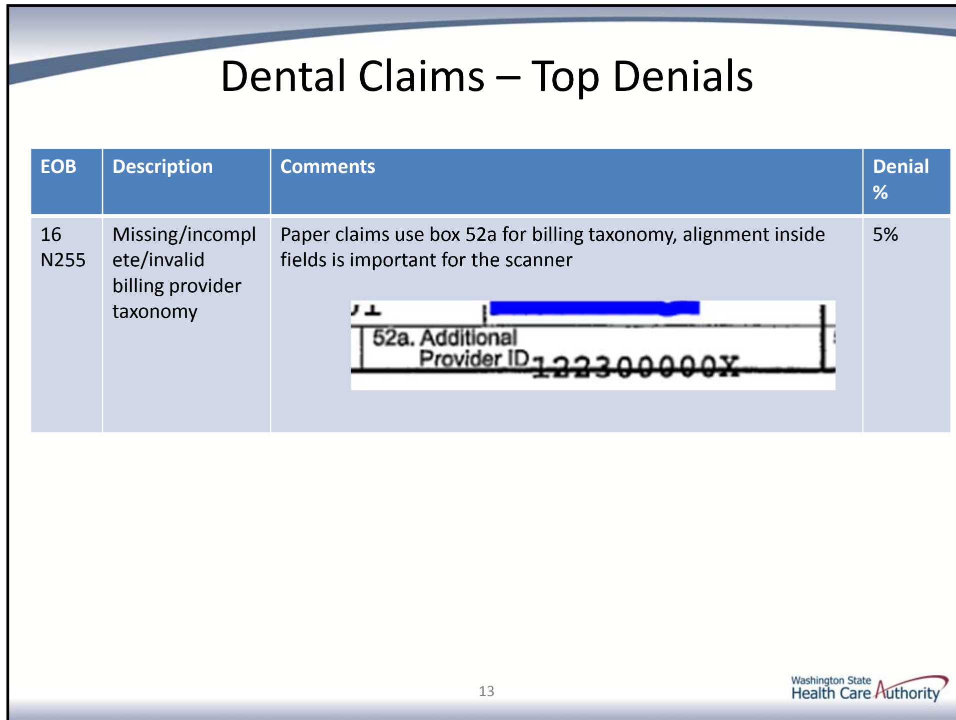
Dental Claims – Top Denials

EOB	Description	Comments	Denial %
16 N290	Missing/incomplete /invalid 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	19%
16 N75	Missing/incomplete /invalid tooth surface information.	Restorations can be 1,2,3,4 or more surfaces. Verify that the number of surfaces on the claim matches up with the number of services for the code	15%



Dental Claims – Top Denials

EOB	Description	Comments	Denial %
119	Benefit maximum for this time period or occurrence has been reached	Limits listed below are the general limits, refer to current Dental billing guide for complete information • Intraoral (D0210) &Panoramic (D0330) – once per 3 years • Fluoride (D1206 D1208) 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) Age 0-18 – 1 per 6 months Age 19+ - 1 per 12 months	8%



Dental Claims – Top Denials

EOB	Description	Comments	Denial %
16 N255	Missing/incomplete/invalid billing provider taxonomy	Paper claims use box 52a for billing taxonomy, alignment inside fields is important for the scanner	5%

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Dental Claims – Top Denials

EOB	Description	Comments	Denial %
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.	5%
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	2%

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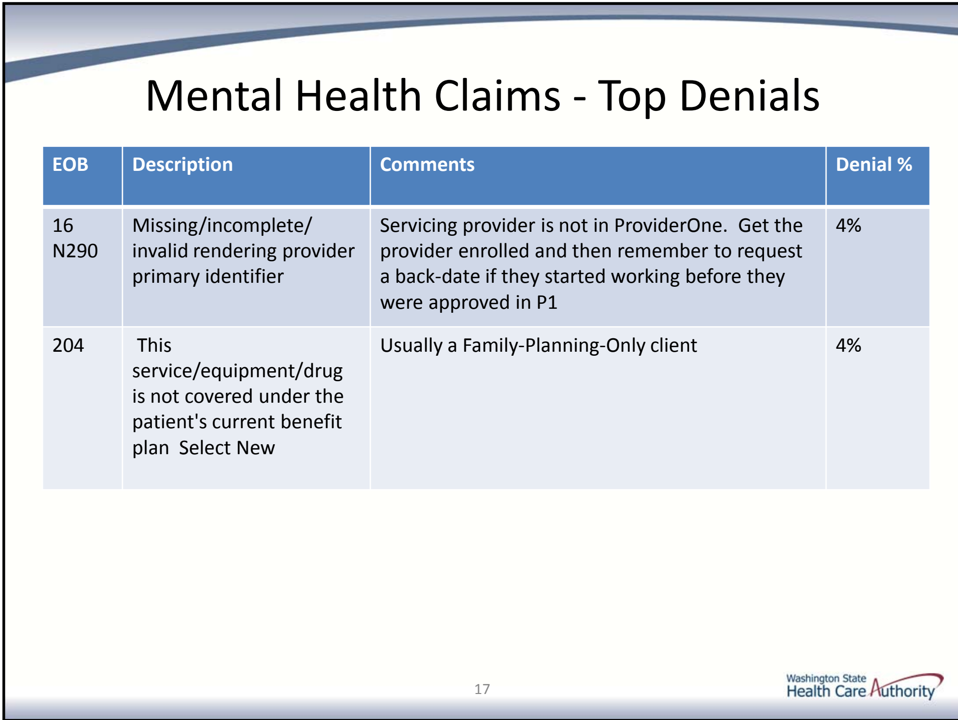
Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing Claim was either a complete rebill (24%) or Claim was a partial rebill (16%) or Encounter already paid and a second encounter (same category) was billed (4%)	44%
24	Charges are covered under a capitation agreement managed care plan	Client is Enrolled in one of the Managed Care Plans	29%

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	17%
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 (if appropriate, wouldn't give a *brain surgeon* taxonomy to an MHP). If you choose option 2 contact Mike so he can reprocess claims so you do not have to rebill	7%



Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
16 N290	Missing/incomplete/ invalid 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	4%
204	This service/equipment/drug is not covered under the patient's current benefit plan Select New	Usually a Family-Planning-Only client	4%

17

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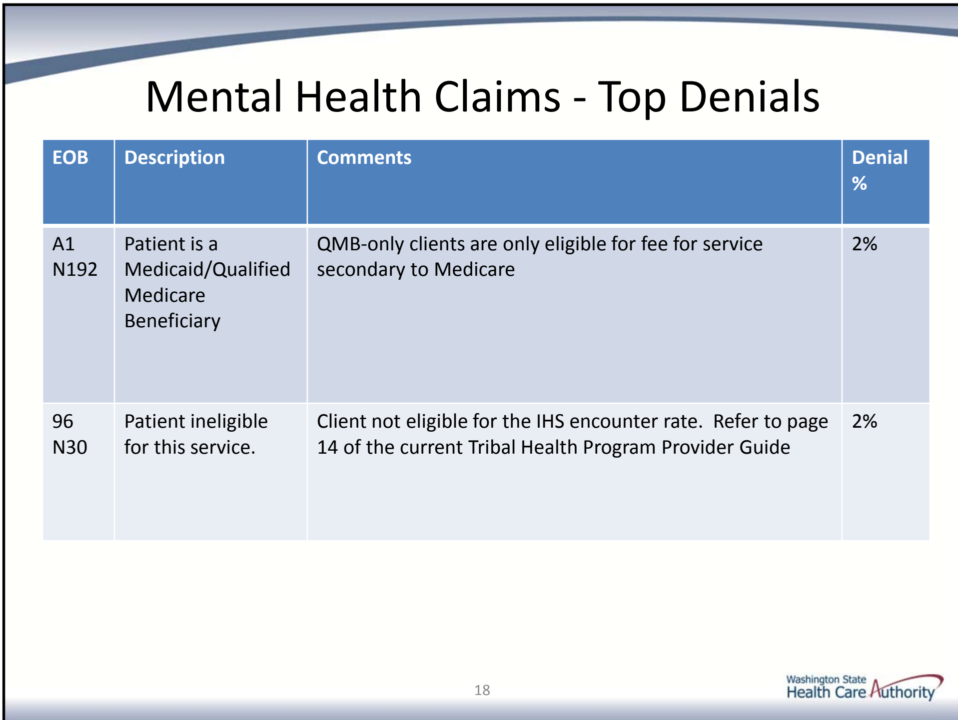

Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
A1 N192	Patient is a Medicaid/Qualified Medicare Beneficiary	QMB-only clients are only eligible for fee for service secondary to Medicare	2%
96 N30	Patient ineligible for this service.	Client not eligible for the IHS encounter rate. Refer to page 14 of the current Tribal Health Program Provider Guide	2%

18

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Mental Health Claims - Top Denials

EOB	Description	Comments	Denial %
167	This (these) diagnosis(es) is (are) not covered	Medicaid does not consider some diagnosis codes eligible for treatment. 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	2%
16 M54	Missing/incomplete/ invalid total charges.	Claims were just a T1015 line	1%

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Substance Use Disorder 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)	74%
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	5%

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Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
170 N95	Payment is denied when performed/billed by this type of provider.	Lab codes are not payable on SUDs claims. Refer to SUDs billing guide for the list of payable codes on SUDs claims	4%
96 N59	Non-covered charge(s).	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).	3%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
A1 N61	Rebill services on separate claims.	**DO NOT REBILL ON SEPARATE CLAIMS.** CD encounters always require the claim note: AI/AN client – SCI=NA Non-AI/AN client – SCI=NN Refer to page 24 of current slides for modifier requirements on SUDs claims	3%
A1 N192	Patient is a Medicaid/Qualified Medicare Beneficiary	QMB-only clients are only eligible for fee for service secondary to Medicare	3%

Substance Use Disorder Claims – Top Denials

EOB	Description	Comments	Denial %
204	This service/ equipment/drug is not covered under the patient's current benefit plan	Usually a Family-Planning-Only client	3%
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage	3%

Non-Native SUDs

- SUDs claims for all clients are working great
- SUDs claims for non-Native clients only pay the federal share of the encounter

Non-AI/AN SUDs encounter billing					
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 started paying on 09/01/2015. I will be reviewing claims and reprocessing

2015 IHS encounter rate

- Mass adjustment has been finalized and claims reprocessed
- The IHS encounter rate was entered into P1 early again this year (mid-April), this means that the mass adjustment is smaller than you may have noticed in previous years because claims start paying the new rate right away rather than in August/September

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Providers who are eligible for the IHS encounter rate at I/T clinics

- The services of the following providers are eligible for the IHS encounter rate
- Physicians
- Physician Assistants
- Nurse Midwives
- Advanced Nurse Practitioners (ARNP)
- Speech-Language Pathologists
- Audiologists
- Physical Therapists
- Occupational Therapists
- Podiatrists
- Optometrists
- Dentists
- Chemical Dependency Counselors (and Trainees)
- Psychiatrists
- Psychologists
- Mental Health Professionals (Psychiatric ARNP, Psychiatric Mental Health Nurse Practitioners-Board Certified, Independent Clinical Social Workers, Licensed Advanced Social Workers, Mental Health Counselor, Marriage and Family Therapists)

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Providers who are eligible for the encounter rate at I/T clinics

- The services of providers who are not listed on the previous page are not eligible for the IHS encounter rate, even if the provider is under the supervision of an IHS encounter eligible provider
- Claims are often billed with the supervising provider's servicing NPI, this makes it impossible for P1 to determine if the service was rendered by an IHS encounter eligible provider or under the supervision of an IHS encounter eligible provider
- The services of providers who are not listed on the previous page may be eligible for fee-for-service payments, depending on the HCA program

ICD-10

- ICD-10 coding required beginning 10/01/2015 (date of service)
- Access the HCA ICD-10 Implementation website
  - http://www.hca.wa.gov/Pages/ICD-10_Implementation.aspx
- **Dental claims do not require diagnoses** (ICD9 or ICD10). However, if a diagnosis is on a claim then it needs to be a valid diagnosis & related to the service (eg, a broken toe diagnosis may not be appropriate for a dental visit)
  - Note: the old billing model, prior to 2012 required dental encounters on a HCFA and HCFA claims always require diagnoses
- Do not bill claims that span October 1st, 2015
  - Claim can be for all dates prior to 10/01/2015 or
  - Claim can be for all dates on/after 10/01/2015

ICD-10

- SUDS claims require that the primary diagnosis be in the approved list of diagnoses
- The list of ICD-10 SUDS DSM codes is on the ICD-10 site
- Information from DSHS indicates that all ICD-10 codes on the website listed above will be accepted for SUDs claims, when I am able to confirm the billing codes I will share ASAP

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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

Questions Log

Transgender issues

We have a patient who is transgender who is listed in provider one as male but is listed in our medical record as female. Will claims be paid if sex of patient does not match?

Refer to Physician-Related Services/Healthcare Professional Services Provider Guide.

For Gender to Procedure code mismatch - For a transgender client, providers must include a secondary diagnosis on the claim that indicates the client is transgender (302.85 or 302.6)

For Gender in P1 mismatch to client's identified gender - The provider should check the client's gender in ProviderOne when verifying coverage. If a mismatch is found, the provider should encourage the client to update the gender field to their preferred gender. Client can do this by calling the agency's Medical Eligibility Determination Section toll free 855-923-4633

Transgender Health Website is being updated, please refer to http://www.hca.wa.gov/medicaid/transhealth/Pages/index.aspx

Is there support for the families of Transgender clients?

Yes, in the mental health benefit there are codes for services as follows

Patient only or patient & family – 90832, 90833, 90834, 90836, 90837, 90838, 90847

Family only (patient not present) - 90846

Questions Log

would you also send out the direct link to that CD ICD-10/ICD-9 crosswalk?

Refer to the ICD-10 Implementation site at http://www.hca.wa.gov/Pages/ICD-10_Implementation.aspx

Will claims be processed by date of service for ICD 10. Therefore we would use ICD9 codes for dates of service prior to 10/01?

Yes, coding is based on date of service

Do not bill claims that Span ICD-9 and ICD-10 coding (eg, claim can be prior to 10/01/2015 or after 10/01/2015 but not September and October, 2015

Is a 99211 covered for the encounter rate. Medicare requires the provider be involved in these nurse visits as this is an incident to service so even if the Dr. does not see the patient the nurse has to consult them and get treatment options from them

99211 is an encounter-eligible code, payable if rendered by a physician, PA, ARNP, etc (the list of encounter-eligible providers in the Tribal Health Billing Guide

Questions Log

Timeliness issues regarding coordination of claims did you indicate documentation is required?

Non-Medicare secondary ("crossover") and non-pharmacy (POS) claims have a 1 year/2 year standard

1 year from the date of service to get the initial claim billed

2 years from the date of service for re-reprocessing claims that met the initial 1-year standard

Would Medicaid agree to submitting claims directly without the EOB from the private insurance but add a claim note indicating that the client's insurance doesn't cover the service?

What if the other insurance did not process? Eg, CD coverage may not be covered under some insurers

From HCA's Coordination of Benefits Office: This happens from time to time when the primary insurance carrier does not respond timely to billings. If the insurance company is taking longer to finalize or respond to the claims you have sent them, you can still take the next step and bill HCA to get your claim on file with us (although it will likely be denied to bill the primary carrier). If it is already beyond our one year limit, it is still possible to work this out on a case-by-case basis based on what has happened between you and the primary carrier.

If the services are not covered by the primary and you can provide us with the necessary documentation to prove this, it would be fine to move forward with billing us. It is always best to include the documentation that the primary finally sends you to help us better understand why you were delayed in billing HCA, but in this case, you should be okay by submitting the information that you have.

In order for the system to hold your claim and not auto-reject for timely filing, please include in your comment field: **SCI=Y – COB timeliness consideration – Service(s) not covered by *Ins Co Name**

This should stop the claim and it will be routed over to the COB office where we will review the documentation you have included

33

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Questions Log

We have COB claims that were sent in May to P1 (ML – 90 days out) and are still not paid. Is this issue going to be fixed or will HCA eventually transition all billing to MCOs so this will be a non issue

We strive to have the majority of our claims finalized before they become aged (30days or older). The TPL edits that post and hold a claim are usually farther on the claims 'waterfall' – so we are usually at the end of the line when it comes to getting the claim to finalize out the door as it can post in other areas before coming over to us to work.

Touch base with Mike if you have claims that seem to be taking longer than normal.

Can I say "stay tuned" on whether all billing will transition to the MCOs?

34

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Questions Log

MCO issues

still experiencing payment issues with Coordinated Care not paying the office visit line and getting denied for no prior authorization

United Healthcare is denying all claims for us

We are still having huge issues with Coordinated Care never thought to complain to you about it.

Everybody please chime in – have the MCOs been processing claims quickly/accurately? Have they been responsive to issues? Which MCOs seem better/worse than others?

much better - but not perfect yet :)

Molina says they are working on it

Debra Butler has been a huge help - fairly quick turnover too - with UHC

Questions Log

Are ICD-10 diagnosis codes required on dental claims beginning 10/01/2015?

We do not require an ICD-9 or ICD-10 code, if that changes I will keep everybody informed. If a provider chooses to put an ICD code on their claim, it must be valid to make it through claims processing and if audited must be a valid code for dental services, i.e. a claim with an ICD for broken toe may be questioned if on a dental claim.

How come my dental paper claims are not being processed?

HCA only accepts the 2012 version. Claims submitted on the 2006 version are not being processed or returned (they are discarded)

Descendants do not have the native qualifiers. When tribal assistors 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

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

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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

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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

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 Intemediary 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

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

P1 screen issues?

HCA and DSHS have received reports of providers encountering issues while using ProviderOne using Microsoft's new Edge internet browser, which replaces Internet Explorer in the new Windows 10 release. Most of the issues surround the fact that Edge automatically enables a pop-up blocker.

When using ProviderOne, your browsers pop-up blocker must be disabled. Please refer to the instructions attached to this communication for instructions on how to set the pop-up blocker to off in Edge. In addition, ProviderOne is not yet fully compatible with Edge, so to prevent further issues, you can also enable Edge to open as Internet Explorer 11. Those instructions are also included in the attachment and should be used if there are additional problems encountered while using the system in Microsoft Edge. If you have further questions or concerns, please contact mmishelp@hca.wa.gov.

UPDATE 8/25/15: Finding and using Internet Explorer in Windows 10

Use the Search box on the Taskbar, type in Internet Explorer, right click it and click Pin to Taskbar. Once there, click on the icon and Internet Explorer will launch for the user, bypassing Edge and allowing ProviderOne to be used.

Immunization Billing

- The Department of Health (DOH) supplies free vaccines for children age 0-18, these immunizations require modifier SL and pay an administration fee ($5.96)
- Immunizations for clients age 19 or greater are paid at the fee schedule rate and up to 2 administration fees (admin fees use CPT 90471/90472)

Immunization Billing - Age 0-18

- Refer to EPSDT billing guide, p.24 and the Injectable drugs fee schedule
- Immunizations that are free from DOH will be noted as "Free from DOH" in the EPSDT billing guide/injectable fee schedule
- If the immunization is free from DOH - bill for the administration by reporting the procedure code for the vaccine and add modifier SL (after adding our UA or SE modifier) (e.g., 90686 UA SL). DO NOT bill CPT 90471/90472

- Immunizations do not qualify for the encounter rate
- Immunizations generally happen during office visits (E&Ms or well child visits)
- HCA has policy that office visits do not pay on the same day as an immunization (NCCI type rule) unless modifier 25 is on the E&M code. Modifier 25 on the E&M code indicates that the client was not seen for just the immunization

Immunization Billing – Age 19 and Older

- Refer to Physician billing guide p.149 and the Injectable drugs fee schedule
- Bill for the cost of the vaccine by reporting the procedure code for the vaccine given
- Bill for the administration using CPT 90471 (first vaccine) and 90472 (each additional vaccine)

- Immunizations do not qualify for the encounter rate.
- Immunizations generally happen during office visits (E&Ms)
- HCA has policy that office visits do not pay on the same day as an immunization (CCI type rule) unless modifier 25 is on the E&M code. Modifier 25 on the E&M code indicates that the client was not seen for just the immunization

Washington State Health Care Authority

Thank you

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