Washington State Health Care Authority

Washington Apple Health (Medicaid)

Tribal Health Billing Guide

July 1, 2017

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This billing guide is designed to assist Tribal health care facilities and providers to deliver health care services to eligible clients, and to bill the Medicaid agency for delivering those services. This publication takes effect July 1, 2017, and supersedes earlier guides to this program.

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

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

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

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

* This publication is a billing instruction.

What has changed?

Subject	Change	Reason for Change
Client Eligibility	Effective July 1, 2017, not all Apple Health clients will be enrolled in a BHO/FIMC/BHSO Effective July 1, 2017, AI/AN clients living in the FIMC regions have a change to services available	Policy Update

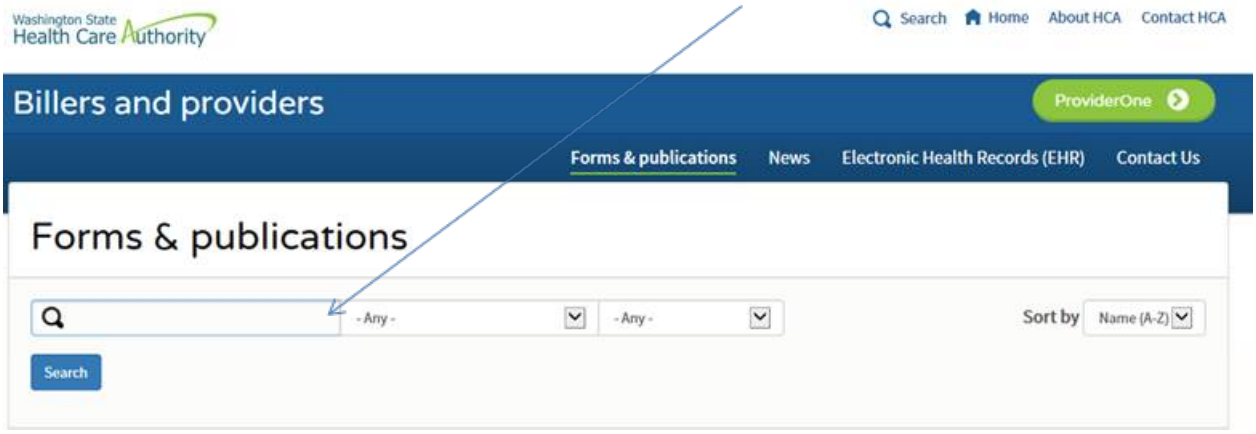
How can I get agency provider documents?

To access provider alerts, go to the agency's Provider Alerts web page.

To access provider documents, go to the agency's Provider billing guides and fee schedules web page.

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and providers web page, select Forms & publications. Type the HCA form number into the **Search box** as shown below (Example: 13-835).



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Resources Available

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

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

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Definitions

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

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

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

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

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

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

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

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

CMS – Centers for Medicare and Medicaid Services.

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

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

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

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

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

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

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

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

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

DSHS – Washington State Department of Social and Health Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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Program Overview

Washington Apple Health (Medicaid) and Federally Recognized Tribes

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

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

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

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

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

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

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

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

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

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

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

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

Providers, including Direct IHS Facilities and Tribal 638 Facilities, must submit a *Core Provider Agreement* (CPA), HCA 09-015, for each National Provider Identifier (NPI) number registered. See Where can I download agency forms?

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

Submit applications for Medicaid provider enrollment to:

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

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Which providers are eligible for the IHS encounter rate?

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

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

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

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Client Eligibility

How can I verify a patient's eligibility?

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

To verify eligibility, follow this two-step process:

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

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

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's Program Benefit Packages and Scope of Services web page.

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

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

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

3. By mailing the application to:

   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

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

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Which clients do not qualify for the encounter payment?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Contact the PCCM/PCP to get a referral

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Effective July 1, 2017, not all Apple Health clients will be enrolled in a BHO/FIMC/BHSO

On July 1, 2017, some Apple Health clients will not be enrolled in a BHO/FIMC/BHSO program. For these clients, SUD services are covered under the fee-for-service (FFS) program.

Effective July 1, 2017, changes to services available to AI/AN clients living in the FIMC regions

Effective July 1, 2017, American Indian/Alaska Native (AI/AN) clients must choose to enroll in one of the managed care plans, either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW) under the FIMC model receiving all physical health services, all levels of mental health services and drug and alcohol treatment coordinated by one managed care plan; or they may choose to receive all these services through Apple Health fee-for-service (FFS). If they do not choose, they will be auto-enrolled into Apple Health FFS for all their health care services.

Effective January 1, 2017, some fee-for-service clients who have other primary health insurance were enrolled into managed care

On January 1, 2017, the agency enrolled some fee-for-service Apple Health clients who have other primary health insurance into an agency-contracted managed care organization (MCO).

This change did not affect all fee-for-service Apple Health clients who have other primary health insurance. The agency continues to cover some clients under the fee-for-service Apple Health program, such as dual-eligible clients whose primary insurance is Medicare.

For additional information, see the agency's Managed Care web site, under Providers and Billers.

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Effective April 1, 2016, important changes to Apple Health

These changes are important to all providers because they may affect who will pay for services.

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client's Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. See the Southwest Washington Provider Fact Sheet on the agency's Regional resources web page.

New MCO enrollment policy – earlier enrollment

Beginning April 1, 2016, Washington Apple Health (Medicaid) implemented a new managed care enrollment policy placing clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This policy eliminates a person being placed temporarily in fee-for-service while they are waiting to be enrolled in an MCO or reconnected with a prior MCO.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health Managed Care.

Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Clients currently in fee-for-service or currently enrolled in an MCO are not affected by this change. Clients in fee-for-service who have a change in the program they are eligible for may be enrolled into Apple Health Managed Care depending on the program. In those cases, this enrollment policy will apply.

How does this policy affect providers?

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's Get Help Enrolling page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's new policies.

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Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs will replace the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the Mental Health Services Billing Guide. BHOs use the Access to Care Standards (ACS) for mental health conditions and American Society of Addiction Medicine (ASAM) criteria for SUD conditions to determine client's appropriateness for this level of care.

Fully Integrated Managed Care (FIMC)

Clark and Skamania Counties, also known as SW WA region, is the first region in Washington State to implement the FIMC system. This means that physical health services, all levels of mental health services, and drug and alcohol treatment are coordinated through one managed care plan. Neither the RSN nor the BHO will provide behavioral health services in these counties.

Clients must choose to enroll in either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW). If they do not choose, they are auto-enrolled into one of the two plans. Each plan is responsible for providing integrated services that include inpatient and outpatient behavioral health services, including all SUD services, inpatient mental health and all levels of outpatient mental health services, as well as providing its own provider credentialing, prior authorization requirements and billing requirements.

Beacon Health Options provides mental health crisis services to the entire population in Southwest Washington. This includes inpatient mental health services that fall under the Involuntary Treatment Act for individuals who are not eligible for or enrolled in Medicaid, and short-term substance use disorder (SUD) crisis services in the SW WA region. Within their available funding, Beacon has the discretion to provide outpatient or voluntary inpatient mental health services for individuals who are not eligible for Medicaid. Beacon Health Options is also responsible for managing voluntary psychiatric inpatient hospital admissions for non-Medicaid clients.

In the SW WA region some clients are not enrolled in CHPW or Molina for FIMC, but will remain in Apple Health fee-for-service managed by the agency. These clients include:

- Dual eligible – Medicare/Medicaid
- American Indian/Alaska Native (AI/AN)
- Medically needy
- Clients who have met their spenddown
- Noncitizen pregnant women
- Individuals in Institutions for Mental Diseases (IMD)

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- Long-term care residents who are currently in fee-for-service
- Clients who have coverage with another carrier

Since there is no BHO (RSN) in these counties, Medicaid fee-for-service clients receive complex behavioral health services through the Behavioral Health Services Only (BHSO) program managed by MHW and CHPW in SW WA region. These clients choose from CHPW or MHW for behavioral health services offered with the BHSO or will be auto-enrolled into one of the two plans. A BHSO fact sheet is available online.

Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18th birthday

American Indian/Alaska Native (AI/AN) children will not be auto-enrolled, but may opt into CCW. All other eligible clients will be auto-enrolled.

AHCC complex mental health and substance use disorder services

AHCC clients who live in Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will use the BHO Access to Care Standards to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.

AHCC clients who live outside Skamania or Clark County will receive complex mental health and substance use disorder services from the BHO and managed by DSHS.

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Contact Information for Southwest Washington

Beginning on April 1, 2016, there will not be an RSN/BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to an individual who is not eligible for or enrolled in Medicaid.

If a provider does not know which MCO a client is enrolled in, this information can located by looking up the patient assignment in ProviderOne.

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

MOLINA HEALTHCARE	Molina Healthcare of Washington, Inc. 1-800-869-7165

COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009

Beacon Health Options	Beacon Health Options 1-855-228-6502

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Encounter vs. Fee-for-Service

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

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

- Medically necessary
- Conducted face-to-face
- Identified in the Medicaid State Plan as a service that is both of the following:

  ✓ Covered by the agency
  ✓ Performed by a health care professional within their scope of service

- Documented in the client's file in the provider's office. Client records must be maintained by the primary health care facility to ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Performed in the health care facility identified on the IHS facility list or at satellite or Branch locations where Tribal health care facility-supported activities are performed by qualified staff who are eligible for the encounter rate (see page 13).

What are the categories of encounters the agency recognizes?

The agency recognizes four categories of Tribal encounters:

- Medical
- Dental
- Mental health
- Substance use disorder

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

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Can services qualify in two different encounter categories?

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

Clinics may not:

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

Examples:

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

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

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

The following services do not qualify for an encounter payment:

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

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

- Drugs or medication treatments provided during a clinic visit. See also Are pharmaceuticals and drugs included in the encounter payment?

- Courtesy dosing (see Definitions)

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

Which services and supplies are incidental to professional services?

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

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

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

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

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

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

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

Are pharmaceuticals and drugs included in the encounter payment?

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

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

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

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

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

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- ✓ D0210, D0220, D0230, D0240, D0270, D0272, D0273, D0274, D0321, D0330, D0340, D0350, D0460, D0501
- ✓ H0030
- ✓ All J codes
- ✓ P3000-P3001
- ✓ All Q codes
- ✓ All S codes (except S9436 and S9445, S9446 (except when rendered by a Mental Health Provider rendering Maternity Support Services) S9447-S9470)
- ✓ T1002, T1017, T1027
- ✓ T2022

How are services not eligible for an encounter paid?

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

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

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Billing

What are the general billing requirements?

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

These billing requirements include, but are not limited to:

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

What additional requirements must Tribal health clinics follow when billing?

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

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

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

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

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How do I submit claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's Billers and Providers web page, under Webinars.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA Electronic Data Interchange (EDI) web page.

The agency is in compliance with 25.U.S. Code §1621e(h). Tribes and Tribal organizations may continue to submit paper claims if a claim cannot be billed electronically. For information about billing paper claims, see the agency's Paper Claim Billing Resource.

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Medical Services

What is a medical encounter?

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

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

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How many medical encounters are allowed?

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

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

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

How do I bill for a medical service encounter?

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

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

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

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Note: Maternity Support Services claims must also be billed with document level servicing clinic NPI with taxonomy 171M00000X

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

Sample medical encounter claim

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

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

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Dental Services

What is a dental encounter?

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

Where do I find program specific policies?

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

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

Expedited prior authorization (EPA)

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

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

EPA Guidelines

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

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EPA Criteria Coding List

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

How many dental encounters are allowed?

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

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

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

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

How do I bill for a dental encounter?

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

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

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

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

Sample Dental Encounter Claim

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

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

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How do I bill for orthodontic services performed in an IHS/638 facility?

When billing for orthodontic services, IHS/638 facilities must follow the same guidelines as non-IHS/638 providers.

However, orthodontic codes that are considered "global" and cover a specific length of time must be billed at the end of the time indicated. The exception to this is the initial placement of the device, which is billed on the date of service. IHS/638 facilities are reimbursed by an encounter payment and may bill up to the maximum number of encounters shown in the chart below. The chart below illustrates comprehensive treatment timeframes and maximum units allowed during those periods.

	Orthodontic Billing and Encounter Reporting											Total Encounters Allowed
Months from appliance placement date	0	3	6	9	12	15	18	21	24	27	30	
Number of encounters allowed – Comprehensive Treatment (D8080)	0	0	5*	2	2	2	2	2	2	2	2	21
Number of encounters allowed – Limited Treatment (D8030)	0	4*	2	2	2	-	-	-	-	-	-	10

* The date of service on the claim must be the same as the appliance placement date and clinical records must document the number of separate visits

During the first six months (comprehensive treatment) or three months (limited treatment), an IHS/638 facility may bill on the date of the appliance placement for up to one unit and up to a total of five (comprehensive treatment) or four (limited treatment) units. To bill for more than one unit during the first six months (comprehensive treatment) or four months (limited treatment), the provider must see the client and document the encounter in the client's file. If an IHS/638 facility chooses to bill in this manner instead of waiting the full six months (comprehensive treatment) or four months (limited treatment), the latest paid claim must be adjusted each time and another unit added to the line containing the T1015 code. If the claim is not adjusted, the claim will be denied as a duplicate billing.

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Mental Health Services

What is a mental health encounter?

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

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

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

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

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

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

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

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Where do I find program-specific policy?

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

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

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

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

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

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

Expedited prior authorization (EPA) guidelines

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

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

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

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

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

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

EPA Code and Criteria

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

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

How do I bill for a mental health encounter?

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

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

Type of encounter	Billing taxonomy	AI/AN modifier	Non-native modifier
Mental Health	2083P0901X	HE	SE

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

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Sample mental health encounter claim

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

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

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Substance Use Disorder and Treatment Services

What is a substance use disorder (SUD) encounter?

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

Where do I find program-specific policy?

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

Who can receive substance use disorder treatment services?

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

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

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How many SUD encounters does the agency pay for?

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

How do I bill for an SUD encounter?

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

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

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

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

What is the payment for an SUD encounter?

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

For Medicaid-eligible non-native clients, the state requires local matching funds equal to the state's portion of Medicaid expenses for SUD treatment services under 42 C.F.R. 433.51. The agency pays Tribal health care facilities the federal portion of the Indian Health Services (IHS) encounter rate (i.e., the Federal Medical Assistance Percentage (FMAP)) for SUD treatment services for non-native Medicaid clients when a Tribe provides the required Tribal funds (local matching funds) equal to the State's portion of the IHS encounter rate (the State Match). The

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State Match varies depending on whether the Medicaid program covering the non-native client is Classic Medicaid, Alternative Benefit Plan (ABP), or ABP Presumptive SSI (MAGI Adult).

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

Non-Native Medicaid Category	**State Match Required**	**Which Medicaid category applies to which RAC code?**	**How much does claim pay (federal portion)?**
Classic Medicaid	50%	Any encounter eligible RAC code except 1201 or 1217	50% of encounter rate
ABP	5%	RAC code 1201	95% of encounter rate
ABP Presumptive SSI (MAGI Adult)	14%	RAC code 1217	86% of encounter rate

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

Note: The Federal Medical Assistance Percentages (FMAP) rate and the State Match (equal to 100% less the FMAP rate) vary quarterly. FMAP examples are from January 2017. The claims processing date determines which FMAP and State Match is applicable.

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Sample SUD encounter claim

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

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

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

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

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

Send the local match using one of these options:

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

   The account number for the agency is: **153910882346**.
   The EFT or Wire/ACH routing number is: **123000848.**

   DSHS EFT and ACH contact: DSHSDLEFT@dshs.wa.gov

2. **Physical check**

   Note: The process takes longer for payment by check.

   Send to:

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

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

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

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Billing for the Encounter Rate After Other Payers

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

Billing for the encounter rate after private insurance

- Claims must meet all applicable billing and encounter criteria as outlined in this guide.
- For instructions on billing after private insurance, refer to the ProviderOne Billing and Resource Guide.
- To ensure correct payment for the T1015 encounter code, all third-party payment information must be reported at the header claim level only.

Billing for the encounter rate secondary to Medicare

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

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

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

- Claims must meet all applicable billing and encounter criteria as outlined in this guide.
- Indicate the amount paid by the MCO in the insurance field on the claim.
- Add the claim note "AI/AN MC WRAPAROUND."
- Such wraparound payments are only permitted for AI/AN clients.
- To ensure correct payment for the T1015 encounter code, all third-party payment information must be reported at the header claim level only.

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

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

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

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

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

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

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

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Medicaid Administrative Claiming

Medicaid Administrative Claiming (MAC)

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

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

Note: The Community Health Representative (CHR) or other allied staff within the Health Home Lead entity organization has the option of participating in the MAC Program or the Health Home Program. To avoid duplication of services and payment, staff may participate in only one of the two programs, not both.

Purpose of the Washington State MAC Program

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

Examples of Reimbursable MAC Activities

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

For more information, see the MAC webpage.

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