


Washington Apple Health (Medicaid)

Tribal Health Billing Guide

April 1, 2018

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 April 1, 2018, 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
<u>How does the agency determine if a claim is eligible for an encounter payment?</u>	HCPCS code T202 changed to T2022	Typographical error – corrected for the appropriate code
<u>What additional requirements must Tribal health clinics follow when billing?</u>	Removed information regarding multiple encounter visits. Replaced with bullets splitting out instructions for billing multiple encounters on the same day by a single provider, a different provider and SUD encounters.	Clarification
<u>How do I determine if a service qualifies as an encounter?</u>	Added bullet to require that an encounter service must comply with Medicaid National Correct Coding Initiative (NCCI) guidelines	Clarification
<u>Which clients do not qualify for the encounter payment?</u>	Added RAC codes 1206 and 1207 for SUD encounters	Inadvertently omitted from this guide

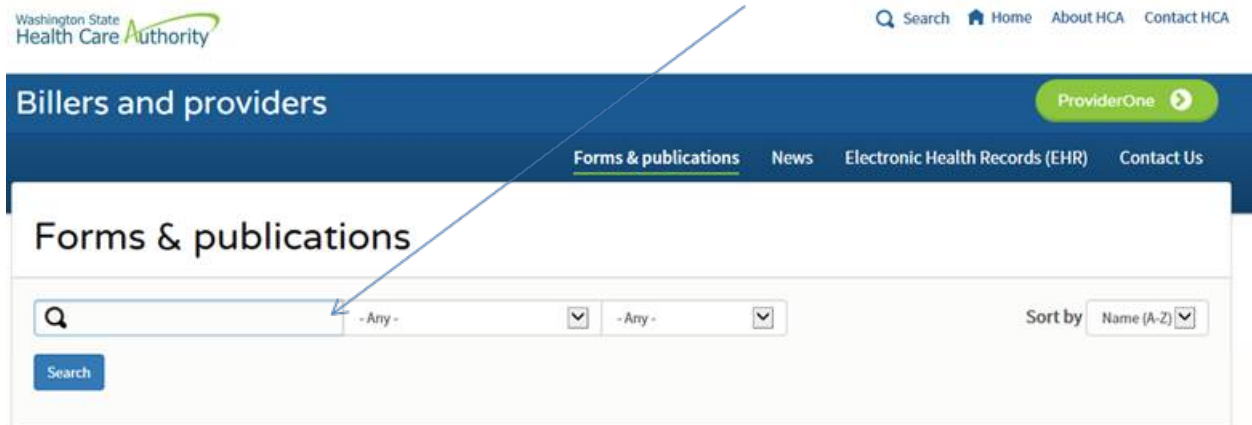
How can I get agency provider documents?

To access provider alerts, go to the agency’s [Provider Alerts](#) webpage.

To access provider documents, go to the agency’s [Provider billing guides and fee schedules](#) webpage.

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and provider's webpage, 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](#) webpage.

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

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) – See WAC [182-500-0015](#)

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.

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 the purposes of this billing guide only) - 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.

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.

Health Care Professional - See [WAC 182-500-0045](#).

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.

Telemedicine - See [WAC 182-531-1730\(1\)](#).

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.

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 – See [WAC 182-500-0120](#).

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](#).

- **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

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 requirements of WAC 182-502-0010
- Be enrolled as a provider with the agency in accordance with the requirements of WAC 182-502-0010 and affiliated with a Direct IHS Facility or a Tribal 638 Facility that is enrolled with the agency
- Perform services within the scope of their practice

Client Eligibility

Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCOs provider network, unless prior authorized or to treat urgent or emergent care. See the agency's [Apple Health managed care page](#) for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has 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.

Is the client enrolled in an agency-contracted managed care organization (MCO), in a behavioral health organization (BHO), or is the client receiving services through fee-for-service (FFS) Apple Health?

Verifying eligibility is a two-step process:

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

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

Step 2. Verify service coverage under the Apple Health client's benefit package. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's [Program Benefit Packages and Scope of Services](#) webpage.

Note: Patients who are not Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org
2. By calling the 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 Customer Support Center.

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) or behavioral health organization (BHO), managed care enrollment will be displayed on the *benefit inquiry* screen in ProviderOne. The MCO or BHO is the primary payer for most Medicaid-covered services for Washington Apple Health clients. With certain exceptions, the remaining balance of the IHS encounter rate may be billed to ProviderOne for American Indian/Alaska Native (AI/AN) clients only; for these exceptions, see [Substance Use Disorder and Treatment Services](#).

The following services provided by Direct IHS Facilities or Tribal 638 Facilities may be billed directly to the agency (regardless of the client's enrollment in an MCO or BHO):

- 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 client's MCO or BHO, as applicable, 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 MCO or 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 BHO, except in the fully integrated managed care regions. To access these services through the BHO, use the BHO Contacts for Medicaid Services information found on [DSHS's BHO page](#).
- Through their MCO for clients who reside in a fully integrated managed care region.

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.

Primary Care Case Management (PCCM). PCCM is a case management program, not an insurance plan. 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 recognized 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

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program for which they are eligible.

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.

Checking eligibility

- 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 policies.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health services (mental health and substance use disorder) for eight of the Regional Service Areas (RSAs) in the state. The remaining regions have [fully integrated managed care \(FIMC\)](#).

See the agency's [Mental Health Services Billing Guide](#) for details.

Fully Integrated Managed Care (FIMC)

For clients who live in an FIMC region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted MCO. The BHO will not provide behavioral health services in these counties.

Clients living in an FIMC region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

Effective July 1, 2017, American Indian/Alaska Native (AI/AN) clients living in an FIMC region of Washington may choose to enroll in one of the agency-contracted MCOs available in that region or they may choose to receive all these services through Apple Health FFS. If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's [American Indian/Alaska Native webpage](#).

For more information about the services available under the FFS program, see the agency's [Mental Health Services Billing Guide](#) and the [Substance Use Disorder Billing Guide](#).

For full details on FIMC, see the agency's [Changes to Apple Health managed care webpage](#).

FIMC Regions

Clients who reside in either of the following two FIMC regions and who are eligible for managed care enrollment must choose an available MCO in their region. Specific details, including information about mental health crisis services, can be found on the agency's [Apple Health managed care webpage](#).

North Central Region – Douglas, Chelan and Grant Counties

Effective January 1, 2018, the agency will implement the second FIMC region known as the North Central Region, which includes Douglas, Chelan, and Grant Counties.

Southwest Washington Region – Clark and Skamania Counties

Effective April 1, 2016, the agency implemented the first FIMC region known as the Southwest Washington Region, which includes Clark and Skamania Counties. Clients eligible for managed care enrollment choose to enroll in one of two available MCOs in this region.

Apple Health Foster Care (AHFC)

Coordinated Care of Washington (CCW) provides all physical health care (medical) benefits, lower-intensity outpatient mental health benefits and care coordination for all Washington State foster care enrollees through a single, statewide managed care plan known as Apple Health Core Connections (AHCC).

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as
“Coordinated Care Healthy Options Foster Care.”

See the agency’s [Apple Health managed care page](#), Apple Health Foster Care for further details.

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 clients 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.

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 be:

- Medically necessary;
- Conducted face-to-face or via real-time telemedicine;
- Identified in the Medicaid State Plan as a service that is both of the following:
 - ✓ Covered by the agency, and
 - ✓ Performed by a health care professional within their scope of practice;
- 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;
- Not “incident to” the services of a health care professional; and
- Compliant with Medicaid National Correct Coding Initiative (NCCI) guidelines.

How many encounters does the agency cover?

The agency pays for up to five (5) encounters per day, per client, regardless of the type of service, provided that the facility does not:

- Unbundle services that are normally rendered during a single visit for the purpose of generating multiple encounters;
- Develop facility procedures or otherwise ask clients 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 client’s record.

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 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 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).

What services and supplies are incident to professional services?

Services and supplies that are “incident to” the services delivered by a health care professional do not qualify for the encounter rate, but are included in the encounter rate paid for those services. Services and supplies are “incident to” the services of a health care professional when they 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 payment;
- Of a type commonly furnished in an outpatient clinic setting (for example, tongue depressors, bandages, etc.); or

- Furnished by health care center employees under the direct, supervision of a health care professional. Direct supervision means that the supervising professional is immediately available to provide assistance and direction throughout the time the supervised employee is furnishing services and does not require the supervising professional to be present in the same room.

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 is a health care professional authorized to provide services to an Apple Health client.
- 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 claim line used to bill HCPCS code T1015. If the claim that is correctly billed has only one or more of the following services and HCPCS code T1015, the claim will not be eligible for the encounter payment:
 - ✓ 36400-36425
 - ✓ 36511-36515
 - ✓ 38204-38215
 - ✓ 70000-79999

- ✓ 80000-89999
- ✓ 90281-90749
- ✓ 99441-99443
- ✓ 99492-99494
- ✓ D0210, D0220, D0230, D0240, D0270, D0272, D0273, D0274, D0321, D0330, D0340, D0350, D0460, D0501
- ✓ G0512
- ✓ 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.

Fee Schedule Information

Maximum allowable fees for all codes that are not included in the specific-program billing guides, including CPT® codes and selected HCPCS codes, are listed in the fee schedule.

In the fee schedule, the agency identifies procedure codes that may require prior authorization. However, this list may not be all-inclusive. Prior authorization, limitations, or requirements detailed in agency billing guides and Washington Administrative Code (WAC) remain applicable. The agency's fee schedules are available on the agency's [Provider billing guides and fee schedules webpage](#).

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?

Bill all services related to the encounter visit 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.

For multiple encounters on the same day for the same client, bill all services related to a single encounter visit followed immediately by HCPCS T1015. This matches each encounter visit to each T1015 line.

- **Multiple encounters (other than outpatient substance use disorder (SUD)) on the same day by a single provider.** If a provider rendered separate and distinct services (other than outpatient SUD services) in more than one encounter on a single date of service, bill on the same claim all services related to the multiple encounter visits rendered by that provider for that client on that date of service. Include modifiers as appropriate to indicate that the encounters on the claim are for separate and distinct services performed on the same date (for example modifiers 59, XE, XP, etc.). **Exception:** Early and periodic screening and treatment (EPSDT) services must all be billed together on a separate claim form.

- **Multiple encounters (other than outpatient SUD) on the same day by different providers.** If different providers rendered services (other than outpatient SUD services) in more than one encounter on a single date of service, those services may be billed on different claim forms for the different servicing National Provider Identifiers (NPIs), even if the services are for the same client and date of service.
- **Multiple outpatient SUD encounters on the same day.** Bill on the same claim all outpatient SUD services related to multiple encounter visits for the same client on the same date of service, even if the services are rendered by different providers. However, no more than one outpatient SUD group therapy service may be billed in a calendar day. ProviderOne does not accept individual servicing NPIs on SUD claims.

Resubmitting claims. If a previously submitted claim needs to be corrected and resubmitted, the previously submitted claim must be replaced/reprocessed. Otherwise, the correction/resubmission may be denied.

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](#) webpage, 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 \(EDI\)](#) webpage.

Note: As provided in 25.U.S. Code §1621e(h), Tribes and Tribal organizations may submit paper claims to:

Health Care Authority
P.O. Box 42727
Olympia, WA 98504-2727

Medical Services

What is a medical encounter?

A medical encounter is an Encounter (see [Definitions](#)) 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 agency’s program-specific billing guides for a list of Medicaid-covered services

- [Chiropractic Services for Children](#)
- [Diabetes Education Program](#)
- [Early and Periodic Screening, Diagnosis & Treatment \(EPSDT\) Program](#)
- [Family Planning](#)
- [Habilitative Services](#)
- [Maternity Support Services/Infant Case Management](#)
- [Medical Nutrition Therapy](#)
- [Outpatient Rehabilitation](#) (physical therapy, occupational therapy, speech therapy)
- [Planned Home Births and Births in Birthing Centers](#)
- [Physician–Related Services/Health Care Professional Services](#)
- [Physician–Related Services/Health Care Professional Services](#) (see Foot Care Services)
- [Physician–Related Services/Health Care Professional Services](#) (see Ophthalmology – vision care services)
- [Sterilization Supplement](#)

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 (the amount billed for HCPCS code T1015 is not relevant as it does not affect payment).
- 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

Note: Maternity Support Services claims must also be billed with servicing taxonomy 171M00000X; see the [Maternity Support Services - Infant Case Management Billing Guide](#).

Note: All claims must comply with the requirements in the [Billing](#) section of this guide.

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

Global services are services that cover a span of time but the CPT/HCPCS code is billed only once, usually at the end of treatment. When billing for a global service, the units billed on the claim line for HCPCS code T1015 must equal the number of face-to-face visits that occurred with the health care professional in order to complete the service. When the client is seen on multiple days for a maternity service package (e.g., CPT 59400), add modifier TH to the HCPCS code T1015. The date of service on the line for HCPCS code T1015 must be the same date as on the line billing the maternity service CPT code. The following services are global services that often require multiple visits in order to complete the service.

Service	CPT/HCPCS codes	Maximum number of encounters allowed to complete the service
Antepartum care only, 4-6 visits	59425	6
Antepartum care only, 7 or more visits	59426	11
Vaginal/cesarean delivery, antepartum and postpartum care	59400, 59510, 59610, 59618	15
Vaginal/cesarean delivery without the antepartum and postpartum care	59410, 59515, 59614, 59622	4
Postpartum care only	59430	3

Post-operative coverage

Some services (excluding the maternity codes listed above) have a global post-operative care period that is bundled into the service (usually a 10-, 45- or 90-day post-operative period). Office visits related to the surgery are normally considered bundled into the surgical payment; however, the post-operative bundling requirements do not apply to Medicaid encounter rate billers. Office visits that are related to surgeries that have post-operative global periods should be coded and billed with the appropriate Evaluation and Management code; do not add modifier 24 and do not bill with post-operative visit CPT code 99024.

Dental Services

What is a dental encounter?

A dental encounter is an Encounter (see [Definitions](#)) 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?

Refer to the agency's program-specific provider billing guides for a list of Medicaid covered services

- [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 Services](#) website.

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.

EPA Criteria Coding List

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

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 (the amount billed for HCPCS code T1015 is not relevant as it does not affect payment); and
- 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 for the service that requires further authorization).

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

Note: All claims must comply with the requirements in the [Billing](#) section of this guide.

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

Global services are services that cover a span of time, but the American Dental Association (ADA) code is billed only once, usually at the end of the treatment period. When billing for a global service, the units billed on the claim line for HCPCS code T1015 must equal the number of face-to-face visits that occurred with the health care professional in order to complete the service. The following services are global services that often require multiple visits in order to complete the service.

Service	CPT/HCPCS codes	Maximum number of encounters allowed to complete the service
Crowns	D2710-D2799	2
Endodontics (root canals)	D3310-D3330	2
Prosthodontics (dentures)	D5110-D5226	5 per arch or set
Limited Orthodontic Treatment, banding	D8010-D8030	4
Limited Orthodontic Treatment, each follow up visit	D8010-D8030	2
Interceptive Orthodontic treatment	D8050-D8060	2
Comprehensive Orthodontic Treatment, banding	D8070-D8080	5
Comprehensive Orthodontic Treatment, each followup	D8070-D8080	2

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

Orthodontic codes must be billed according to the [Orthodontic Services Billing Guide](#); each follow-up visit is billed at the end of the global period. 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.

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Months from appliance placement date	Orthodontic Billing and Encounter Reporting											Total Encounters Allowed
	0	3	6	9	12	15	18	21	24	27	30	
Number of encounters allowed – Comprehensive Treatment (D8070-D8080)	0	0	5*	2	2	2	2	2	2	2	2	21
Number of encounters allowed – Limited Treatment (D8010-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 HCPCS code T1015. If the claim is not adjusted, the claim will be denied as a duplicate billing.

Mental Health Services

What is a mental health encounter?

A mental health encounter is an Encounter (see [Definitions](#)) 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 a Mental Health Professional (MHP) or psychiatrist. Subject to other Medicaid rules (such as clinic services provided outside of the facility not being eligible for Medicaid reimbursement), services are provided at locations convenient to the client, by or under the supervision of an MHP or psychiatrist. HIPAA compliance must be maintained for all services.

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

- For clients who do not live in a fully integrated managed care region (FIMC):
 - ✓ 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 is enrolled in a BHO and 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 clients whose needs meet or exceed the Access-to-Care Standard. (See [Mental Health Services Billing Guide](#).)
- For clients who live in an FIMC region:
 - ✓ If the client is enrolled in an MCO, the client's MCO covers all Medicaid-covered mental health services

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.

Where do I find program-specific policy?

Refer to the agency’s program-specific provider billing guide for a list of Medicaid covered services

[Mental Health Services](#) or Tribal Health (*EPA Guidelines*)

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. In addition, Clinical Family Members are encouraged to receive treatment at Tribal clinics to promote better health outcomes in AI/AN households.

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)	Place of Service
Crisis Services	H0030	Alcohol and/or drug hotline	01, 02, 03, 04, 05, 09, 10, 12	EPA 870001349	05, 06, 07, 08
	H2011	Crisis interven svc, 15 min		EPA 870001349	05, 06, 07, 08
Day Support	H2012	Behav hlth day treat, per hr	04, 05, 06, 09, 10, 12	EPA 870001349	05, 06, 07, 08

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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)	Place of Service
Medication Monitoring	H0033	Oral med adm direct observe	01, 02, 03, 04, 05, 06, 09, 10, 12	EPA 870001349	05, 06, 07, 08
	H0034	Med trng & support per 15min		EPA 870001349	
Peer Support	H0038	Self-help/peer svc per 15min	06, 14	EPA 870001349	05, 06, 07, 08
Stabilization Services	S9484	Crisis intervention per hour	01, 02, 03, 04, 05, 09, 10, 12	EPA 870001349	05, 06, 07, 08
Therapeutic psycho-education	H0025	Alcohol and/or drug preventi	01, 02, 03, 04, 05, 06, 09, 10, 12	EPA 870001349	05, 06, 07, 08
	H2027	Psychoed svc, per 15 min		EPA 870001349	

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 (the amount billed for code T1015 is not relevant as it does not affect payment); and
- 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.

Substance Use Disorder and Treatment Services

What is a substance use disorder (SUD) encounter?

An SUD encounter is an Encounter (see [Definitions](#)) 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?

Refer to the agency's program-specific billing guide found on the agency's [Provider billing guides and fee schedules webpage](#) for a list of Medicaid-covered services.

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).

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;
- Do not add individual servicing provider NPIs or taxonomy codes;
- Use only the modifiers listed in the [Substance Use Disorder](#) billing guide as primary;
- Add HCPCS code T1015 (the amount billed for HCPCS code T1015 is not relevant as it does not affect payment); and
- Bill with claim note. Claim note must be entered exactly as listed in the table below.

Note: Be sure to bill with an American Indian/Alaska Native (AI/AN) or non-native modifier **ONLY on the line for code T1015**

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 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.

Tribal Health Program

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	6%	RAC code 1201	94% of encounter rate
ABP Presumptive SSI (MAGI Adult)	10.40%	RAC code 1217	89.60% 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.

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 FSA OAS EFT Return-Reversals Desk dshsfsaoaseftretrev@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](#).

Billing for the Encounter Rate After Other Payers

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

Billing for the encounter rate after private insurance

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

Billing for the encounter rate secondary to Medicare

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

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.
- Such wraparound payments are only permitted for AI/AN clients.

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 primary care case management (PCCM) provider, if available in their area, that is a Direct Indian Health Service (IHS) Facility, 638 Tribal Facility, or Urban Indian Health Program (which is a Federally Qualified Health Center)
- The agency's fee-for-service (FFS) system

In addition, an 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 behavioral health care:

- For clients who do not live in a fully integrated managed care region (FIMC):
 - ✓ Enrollment with a behavioral health organization (BHO) available in their area
 - ✓ The agency's FFS system
- For clients who live in an FIMC region:
 - ✓ Enrollment with an agency-contracted managed care organization (MCO) available in their area for FIMC
 - ✓ Enrollment with an agency-contracted MCO available in their area for behavioral health services only (BHSO) if the client is not eligible to enroll in MCO for FIMC
 - ✓ The agency's 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 on the [HCA Contact Us page](#):

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 Web Form**” button.
2. The “**Client Web Form**” will appear.
3. Enter in the following information, per the form
 - ✓ Your email address
 - ✓ Client's services card number
 - ✓ Client’s name, birthdate and zip code
 - ✓ Under “Select topic” choose “Enroll/Change Health Plans”
 - ✓ Under “Other Comments:” enter the following:
 - Client is American Indian/Alaska Native), enrolled in [name of Tribe]; and
 - If the client requests to enroll in or disenroll from an MCO:
 - ✓ *“I have consulted with the client regarding their options for managed care, and the client would like to opt in to [or out of] the MCO.”*

or

 - If the client requests to enroll in or disenroll from a BHO:
 - ✓ *“I have consulted with the client regarding their options for managed care, and the client would like to opt in to [or out of] the BHO.”*

or

 - If the client is not eligible to enroll in MCO for FIMC and the client requests to enroll in or disenroll from an MCO for BHSO:
 - ✓ *“I have consulted with the client regarding their options for managed care, and the client would like to opt in to [or out of] the MCO for BHSO.”*

or

 - If the client requests to enroll in the PCCM program:
 - ✓ *“Please enroll in the [Name of Tribe]’s PCCM program.”*
4. 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.

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 Health.
- 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](#).