Washington Apple Health

TRIBAL HEALTH PROGRAM

Provider Guide

April 1, 2015

Washington State Health Care Authority

About this guide[1]

This provider 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, 2015, and supersedes earlier guides to this program.

> This Tribal Health Program Provider 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 guide.

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

- Medicaid State Plan
- Medicaid Washington Administrative Code (WAC)
- ProviderOne Billing and Resource Guide
- Program-specific provider guides (PGs)

All requirements of the Medicaid State Plan apply to Tribal health care facilities, programs, providers, and clients. This includes, but is not limited to, coverage benefit limitations, prior authorization, and reimbursement requirements and limitations. Refer to program-specific Provider Guides (PGs) for covered services, prior authorization (PA) requirements, expedited prior authorization (EPA) criteria, and limitations.

> 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.

What has changed?

Subject	Change	Reason for Change
All	Revised and reorganized entire provider guide	Aligns with change in billing model implemented in 2012

---

[1] This publication is a billing instruction.

How can I get agency provider documents?

To download and print agency provider notices and provider guides, go to the agency's [Provider Publications](#) website.

Table of Contents

Alert! The page numbers in this table of contents are now "clickable"—simply hover over on a page number and click to go directly to the page. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks on the left side of the document. (If you don't immediately see the bookmarks, right click on the document and select Navigation Pane Buttons. Click on the bookmark icon on the left of the document.)

Alert! The page numbers in this table of contents are now "clickable"—simply hover over on a page number and click to go directly to the page. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks on the left side of the document. (If you don't immediately see the bookmarks, right click on the document and select Navigation Pane Buttons. Click on the bookmark icon on the left of the document.)

Resources Available

> **Note:** This section contains important contact information relevant to the Tribal Health Program. For more contact information, see the agency's Resources Available web page.

Topic	Contact Information
Tribal health program mental health and chemical dependency treatment services	Division of Behavioral Health and Recovery **Tribal Liaison** (360) 725-1457
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 guide. Refer to the agency's online [Washington Apple Health Glossary](#) for a more complete list of definitions.

"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) - Persons having origins in any of the original peoples of North America.

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

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 - Person born in Canada, having at least 50% aboriginal blood.

Chemical Dependency – An alcohol or drug addiction, or dependence on alcohol and one or more other psychoactive chemicals.

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

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

- A spouse or partner of an eligible AI/AN.

- An individual who has not attained 19 years of age, or is an

incacitated 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, Chemical Dependency, 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 chemical dependency 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 chemical dependency. 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, chemical dependency 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.

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 individuals on and after July 11, 1996, through Direct IHS Facilities or 638 Tribal Facilities.

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 Chemical Dependency Treatment Services Program – A qualified Tribal chemical dependency 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 – The brand name for all Washington State medical assistance programs, including Medicaid. The brand name may be shortened to "Apple Health".

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 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 MOA, 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 is permitted to receive the IHS encounter rate for eligible services provided to Medicaid enrollees. 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 enrollees. For more information regarding FQHCs, see the agency's Federally-Qualified Health Centers Provider 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 enrollees and do not receive an encounter rate. Refer to the appropriate program-specific billing instructions 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 (http://www.ihs.gov/locations/), 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 all of the following:
- 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
- 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.

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:

- Be an approved Tribal health program on the Indian Health Service (IHS) list

- 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 on a signed CPA with the agency

- Perform services within the scope of their practice

- Provide only medically necessary services in accordance with the agency's program-specific billing instructions

- 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

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 Scope of Categories of Service Table.

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.

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 individuals 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 (CD 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
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.

Non-native clients are not eligible for mental health encounters unless the client meets the definition of a clinical family member.

Are managed care enrollees eligible for services provided by a Direct 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 AI/AN clients.

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

- Chemical dependency treatment
- Dental care
- Mental health services

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:** 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): 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 a PCCM provider. 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.

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; or
- The client was not referred to you by the PCCM/PCP; or
- You are not providing emergency care or women's health services

Contact the PCCM/PCP to get a referral.

Encounter vs. Fee-for-Service

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

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

- Medically necessary.
- 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 clinic staff.

What are the categories of encounters the agency recognizes?

The agency recognizes four categories of Tribal encounters:

- Medical
- Dental
- Mental health
- Chemical dependency

> **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 Chemical Dependency sections in this provider guide.

Can services qualify in two different encounter categories?

Yes. The IHS encounter category for a billed service is based on the provider guide that describes the service. Some providers are licensed to provide services described in multiple provider guides that translate to multiple permitted encounter categories. For example, psychiatrists are licensed to provide services found in both the [Mental Health Services Provider Guide](#) and the [Physician-Related Services/Health Care Professional Services Provider 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.

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 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 Pharmaceuticals and Drugs Separate from Professional Services.

- Courtesy dosing (see Definitions).

- Case management services (maternity support services/infant case management, 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 (e.g., pharmaceuticals/ 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 (e.g., 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 (e.g., tongue depressors, bandages, etc.).

- 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 (e.g., nurse, therapist, technician, or other aide).

Are pharmaceuticals/drugs included in the encounter payment?

No. Prescriptions for pharmaceuticals/drugs that are filled outside of the clinical visit are not included in the encounter rate and are reimbursed on a fee-for-service basis. Intrauterine devices (IUDs) are also not included in the encounter rate and are reimbursed on a fee-for-service basis separate from the professional service to implant them.

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 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

- ✓ D0210, D0220, D0230, D0240, D0270, D0272, D0273, D0274, D0321, D0330, D0460, D0501
- ✓ H0030
- ✓ All J codes
- ✓ P3000-P3001
- ✓ All Q codes
- ✓ All S codes (except S9436 and S9445-S9470)

How are services not eligible for an encounter paid?

Services that are not eligible for the IHS Encounter Rate are payable on a fee-for-service basis using the agency's published fee schedules. For information on fee-for-service reimbursement, 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.

Billing and Claim Forms

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, **the appropriate AI/AN or non-native modifiers, EPA, or claim note are required on all claims**.

How do I complete the CMS-1500 claim form?

The agency's online webinars are available to providers with instructions on how to bill professional claims and crossover claims electronically:

- Direct Data Entry: Professional Claim
- Direct Data Entry: Professional with Primary Insurance
- Direct Data Entry: Medicare Crossover (Fee-For-Service) Claim

Also, see Appendix I of the agency's ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 claim form.

How do I complete the Dental ADA claim form?

The agency's online webinars are available to providers with instructions on how to bill dental claims electronically:

- Direct Data Entry: Dental Claim
- Direct Data Entry: Dental Claim with Primary Insurance (Secondary Dental Claim)

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 provider guides (billing instructions) 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

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 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 provider 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 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

> **Note:** All claims must comply with the requirements in the **Billing and Claims Forms** 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 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.

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 guides (billing instructions) 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 expedited prior authorization 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 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 program-specific provider 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 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

> **Note:** All claims must comply with the requirements in the **Billing and Claims Forms** 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 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.

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 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.

AI/AN clients may receive outpatient mental health services as follows:

- If the client is enrolled in an MCO and the client's mental health needs do not meet the regional support network (RSN) Access-to-Care Standard (see below), the client's MCO covers the services.

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

In addition, AI/AN clients have the choice to receive services through a Direct IHS Facility or a Tribal 638 Facility without regard to the RSN 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 RSN-level services from a Direct IHS Facility or Tribal 638 Facility require an 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 RSN-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?

Providers eligible for a mental health encounter	Refer to the agency's program-specific provider guide (billing instruction) for a list of Medicaid covered services
Mental Health Professionals	Mental Health Services Tribal Health, page 27 (*EPA Guidelines*).
Psychiatrists	Mental Health Services Tribal Health, page 27 (*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 RSN Access-to-Care standard, refer to the Mental Health Services Provider Guide. For mental health services that are at or above the RSN Access-to-Care standard, refer to the expedited prior authorization (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 expedited prior authorization 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 RSN 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.

Mental Health Services above the RSN Access-to-Care Standard						
Modality	HCPCS code and modifier (*HE for AI/AN or SE for non-AI/AN*)	Description	Provider types (*see table below for explana-tions*)	EPA (*see EPA Code and Criteria Table below*)	Rate	Place of service
Crisis Services	H0030 HE or SE	Behavioral health hotline service (not encounter eligible)	01, 02, 03, 04, 05, 09, 10, 12	EPA 870001349	$10.00	05, 06, 07, 08
	H2011 HE or SE	Crisis intervention services, per 15 minutes		EPA 870001349	$11.35	05, 06, 07, 08
Day Support	H2012 HE or SE	Behavioral health day treat, per hour	04, 05, 06, 09, 10, 12	EPA 870001349	$31.05	05, 06, 07, 08
Medication Monitoring	H0033 HE or SE	Oral medication administra-tion, direct observation	01, 02, 03, 04, 05, 06, 09, 10, 12	EPA 870001349	$8.60	05, 06, 07, 08
	H0034 HE or SE	Medication training and support, per 15 minutes		EPA 870001349	$22.47	05, 06, 07, 08
Peer Support	H0038 HE or SE	Self-help/peer services, per 15 minutes	06, 14	EPA 870001349	$15.00	05, 06, 07, 08
Stabilization Services	S9484 HE or SE	Crisis Intervention	01, 02, 03, 04, 05, 09,	EPA 870001349	$11.60	05, 06, 07, 08

Mental Health Services above the RSN Access-to-Care Standard						
Modality	**HCPCS code and modifier** (*HE for AI/AN or SE for non-AI/AN*)	**Description**	**Provider types** (*see table below for explanations*)	**EPA** (*see EPA Code and Criteria Table below*)	**Rate**	**Place of service**
		mental health services, per hour	10, 12			
Therapeutic psycho-education	H0025 HE or SE	Behavioral health prevention education service	01, 02, 03, 04, 05, 06, 09, 10, 12	EPA 870001349	$6.58	05, 06, 07, 08
	H2027 HE or SE	Psycho-educational service, per 15 minutes		EPA 870001349	$12.01	05, 06, 07, 08

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.

How do I bill for a mental health encounter?

Facilities must follow the agency's program-specific provider 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)

* Non-native Mental Health encounters are eligible for Clinical Family Members only.

Type of encounter	Billing taxonomy	AI/AN modifier	Non-native modifier (for clinical family member)
Mental Health	2083P0901X	HE	SE

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

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 99211 due to 99213
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.

Chemical Dependency and Treatment Services

What is a chemical dependency encounter?

A chemical dependency (CD) 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 eligible for a chemical dependency encounter	Refer to the agency's program-specific provider guide (billing instruction) for a list of Medicaid covered services
Chemical Dependency Counselors and Chemical Dependency Counselor Trainees	Chemical Dependency (Outpatient) Provider Guide

How many chemical dependency encounters does the agency pay for?

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

How do I bill for a chemical dependency encounter?

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

- Bill a professional (837P/CMS1500) claim
- Bill with billing taxonomy 261QR0405X
- Add HCPCS T1015
- Bill with an 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 1201)	SE	SCI=NN
Non-native ABP SSI (RAC 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 and Claims Forms** section of this guide.

What is the payment for a chemical dependency encounter?

The agency pays Tribal health care facilities the full encounter rate for CD 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 CD treatment services under 42 C.F.R. 433.51. The agency pays Tribal health care facilities the federal portion of the IHS encounter rate (i.e., the Federal Medical Assistance Percentage (FMAP)) for CD 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 CD treatment services to non-native clients, the Tribal health care facility must deposit the State Match funds with the Office of the State Treasurer. DBHR draws upon the account to provide the local matching funds. DBHR 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?	How much does claim pay (federal portion)?
Classic Medicaid	49.97%	Any encounter eligible RAC except 1201 or 1217	50.03% of encounter rate
ABP	0%	RAC 1201	100% of encounter rate
ABP Presumptive SSI (MAGI Adult)	19.99%	RAC 1217	80.01% of encounter rate

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 2015. The claims processing date determines which FMAP and State Match is applicable.

Sample chemical dependency 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 CD claims with an individual servicing/rendering NPI/taxonomy.

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

Tribes submitting CD 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 three options:

1. **Electronic Funds Transfer (EFT) or Wire 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: **105000000617**.
    The EFT or Wire routing number is: **026009593**.

2. **Automated Clearing House (ACH) transfer**
    Before sending the ACH, email DSHS with the transfer amount and date. (See the DSHS contact information below.)

    The account number for the agency is: **105000000617**.
    The ACH routing number is: **123308825**.

    DSHS EFT and ACH contacts:
    Melissa Walker   Melissa.Walker@dshs.wa.gov
    Adriann Jordan   Adriann.Jordan@dshs.wa.gov
    Debra Minton   Debra.Minton@dshs.wa.gov

3. **Physical check**

> **Note:** The process takes longer for payment by check.

    Please 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 388-877 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 AI/AN or non-native modifiers
  - ✓ An encounter (T1015) line

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 (MCOs)

- 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."

Enrolling/Disenrolling AI/AN Clients from Managed Care or PCCM

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 medical care per WAC 182-538-130:

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

The agency processes requests from Direct IHS Facilities or 638 Tribal Facilities to enroll or disenroll Medicaid clients from managed care pursuant to their federal exemption under 42 U.S.C.1396u-2. Requests are processed electronically using the WEBFORM online at: https://fortress.wa.gov/hca/p1contactus/

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.
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.

Administrative Contract Programs

Medicaid Administrative Claiming (MAC)

The Medicaid Administrative Claiming (MAC) program reimburses Tribes for administrative-related activities for Medicaid eligible people.

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

For more information, contact:

Medicaid Outreach Unit Supervisor
(360) 725-1647

You may also visit the MAC website.