Washington State Health Care Authority

Tribal Billing Workgroup (TBWG)

February 11, 2015
Mike Longnecker
HCA Tribal Affairs Office

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Agenda

- Monthly data and analysis
- Billing workgroup schedule for 2015
- Primary Care Incentive Payments (PCIP) – resolved
- Billing guide update – one step closer
- Mental health (RSN) modalities – tied to Billing guide
- Psychiatrist billing – Medical or Mental health? – request comments
- Managed care denials - ongoing
- Encounter billing secondary to other insurance – cheat sheet
- Back-dating newly enrolled providers - workaround
- Tribal Affairs website – request comments
- Electronic Health Records - update
- FAQ and Open Discussion

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December 2014 Claims Data (I/T/U)

	dollars	clients*	% of claims paid
Totals	$5,382,587	10,474	See categories
Medical	$1,277,720	3,710	85%
Dental	$563,531	1,672	89%
Mental Health	$860,064	1,331	84%
Chemical Dep	$2,100,101	794	97%
POS	$458,561	5,370	60%
Other FFS	$122,608	207	28%**

* Client count will not be the sum from the categories due to 'overlap' (clients can be in more than 1 category)
** most of the claims are Medicare crossovers that come directly from Medicare

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Medical Claims – Top Denials

EOB	Description	Comments
24	Charges are covered under a capitation agreement managed care plan	Client is Enrolled in one of the Managed Care Plans
167	This (these) diagnosis(es) is (are) not covered	Medicaid does not consider some diagnosis codes eligible for **medical** treatment. Most claims had CD diagnoses (303-305) NOTE: 1. Office visit for Campral, ReVia, Vivitrol, Buprenorphine, Suboxone is covered – refer to physician guide, P. 257 for criteria. P. 257 is at end of this presentation 2. Office visit for Suboxone and Buprenorphine are carved out of Managed Care (bill P1 directly for clients enrolled in Managed Care)
16 N288	Missing /incomplete /invalid rendering provider taxonomy	Claims had a servicing taxonomy that the provider is not enrolled with. Two possible resolutions: 1.Change the claims so that they are submitted with the taxonomy that the provider is enrolled with 2.Update the provider's file to include the taxonomy that is being billed (if appropriate, a *brain surgeon* taxonomy would not be for a GP Dr) Not sure what the provider is enrolled with? Contact Mike If you choose option 2 contact Mike so he can reprocess claims so you do not have to rebill

Medical Claims – Top Denials

EOB	Description	Comments
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage
170 N95	Payment is denied when performed/billed by this type of provider	Eyeglasses/Frames/Lenses are only available through the agency's contracted provider (Correctional Industries (C.I.) Optical)
31	Patient cannot be identified as our insured	Client ID usually invalid but sometimes there is a space after the "WA" – P1 treats the space as a value and it makes the ID invalid If rebilling in the P1 screens the space issue gets automatically fixed (P1 screens ignore the space and if client ID is invalid you will get an error popup before submitting the claim)
16 N290	Missing/incomplete/invalid rendering provider primary identifier	See slide Backdating Newly Enrolled Rendering Provider
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	AI/AN or non-native modifier was missing

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Medical Claims – Top Denials

EOB	Description	Comments
Various		Medicare Crossovers that Cross-over directly from the Medicare intermediary are usually missing three items: 1. Billing taxonomy is not an encounter eligible taxonomy 2. AI/AN or non-Native modifier is missing 3. T1015 is missing
22	This care may be covered by another payer per coordination of benefits	Client has Medicare
18	Exact duplicate claim/service	Duplicate billing
16 MA39	Missing/incomplete /invalid gender	Usually incorrect gender submitted on claim but we have seen some female *Mike* and Male *Sally* clients in P1. Contact Mike if you have what appears to be a gender mismatch in P1
16 N329	Missing /incomplete /invalid patient birth date	Usually incorrect birthday on claim. If you think you have the right birthday on the claim or are unsure, contact Mike

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Dental Claims – Top Denials

EOB	Description	Comments
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage
6	The procedure/revenue code is inconsistent with the patient's age	Some dental services are only allowed for children (sealants, hygiene instructions, crowns, posterior root canals)
31	Patient cannot be identified as our insured	Client ID usually invalid but sometimes there is a space after the "WA" – P1 treats the space as a value and it makes the ID invalid If rebilling in the P1 screens the space issue gets automatically fixed (P1 screens ignore the space and if client ID is invalid you will get an error popup before submitting the claim)

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Dental Claims – Top Denials

EOB	Description	Comments
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Dental claims need EPA (funding source) AI/AN client 870001305 Non-Native 870001306
16 N288	Missing/incomplete /invalid rendering provider taxonomy	Claims had a servicing taxonomy that the provider is not enrolled with. Two possible resolutions: 1. Change the claims so that they are submitted with the taxonomy that the provider is enrolled with 2. Update the provider's file to include the taxonomy that is being billed (if appropriate, an *Oral Surgeon* taxonomy would not be for a general dentist) Not sure what the provider is enrolled with? Contact Mike. If you choose option 2 contact Mike so he can reprocess claims so you do not have to rebill
16 N37	Missing/incomplete /invalid tooth number/letter	Some services need either a tooth, or an arch, or a quadrant number. Most common - scaling/planing (D4341 D4342) needs a quadrant. Refer to Dental Tooth, Arch, Quad Numbering sheet at the end of this presentation

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Dental Claims – Top Denials

EOB	Description	Comments
16 N329	Missing/incomplete/invalid patient birth date	Usually incorrect birthday on claim. If you think you have the right birthday on the claim or are unsure, contact Mike
A1 N192	Patient is a Medicaid/Qualified Medicare Beneficiary	QMB-only clients are only eligible for fee for service secondary to Medicare
119	Benefit maximum for this time period or occurrence has been reached	Various frequency limits in the dental program for office visits, cleanings, fluorides, etc. Refer to Dental Limit Table at the end of this presentation

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Mental Health Claims - Top Denials

EOB	Description	Comments
18	Exact duplicate claim/service	Duplicate claims
16 N288	Missing /incomplete /invalid rendering provider taxonomy	Claims had a valid servicing taxonomy but the taxonomy on the claim wasn't one that the MHP was enrolled with. Not sure what the MHP is enrolled with? Contact Mike. Two resolutions: 1. Change the claims so that they are submitted with the taxonomy that the MHP is enrolled with. Update the provider's file to include the taxonomy that is being billed (if appropriate, wouldn't give a *brain surgeon* taxonomy to an MHP). If you choose option 2 contact Mike so he can reprocess claims so you do not have to rebill
26	Expenses incurred prior to coverage	Client not eligible on this date. Could be before or after coverage

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Mental Health Claims - Top Denials

EOB	Description	Comments
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	Children's Mental Health claims are manually reviewed. Usually when I see B7 it is denied in error. Sometimes the MHP needs to get the children's Mental Health OK in the system. Get a B7? Contact Mike. If you get new counselor, M&F therapist, Social Worker or psych nurse it might save time if the Attestation form was filled out & sent to Mike during enrollment
24	Charges are covered under a capitation agreement/managed care plan.	Client is enrolled in Managed Care (FQHC/Urban claims)
A1 N362 or 96 N20	The number of Days or Units of Service exceeds our acceptable maximum. Or Service not payable with other service rendered on the same date.	CPT code for MH visit had more than 1 unit on the line Resolution – most CPT's that are not 'per x minutes' must be billed at 1 unit. CPT 90853 was observed most often

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Mental Health Claims - Top Denials

EOB	Description	Comments
31	Patient cannot be identified as our insured	Client ID usually invalid but sometimes there is a space after the "WA" – P1 treats the space as a value and it makes the ID invalid. Resolution – rebill. If rebilling in the P1 screens the space issue gets automatically fixed (P1 screens will not accept invalid data)
16 M53	Missing/incomplete/invalid days or units of service	Submitted units must be whole numbers and usually a '1'. Some claims received with 1.5 units
96 N59 or 181	Please refer to your provider manual for additional program and provider information or Procedure modifier was invalid on the date of service	Most claims were Crisis Services. Please continue to bill for the Crisis Services and other RSN modalities, this will establish timeliness and allow me to help find all the claims when P1 is updated
16 N286	Missing/incomplete/invalid referring provider primary identifier	Mental health claims do not require a referring NPI, HOWEVER, if a referring NPI is on the claim then it must be an NPI that is in P1

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Chemical Dependency Claims – Top Denials

EOB	Description	Comments
181	Procedure code was invalid on the date of service	Usually noticed with Mental Health type codes. The only covered codes on CD claims are: H0001, H0002, H0003, H0020, H2033, 96153, 96154, 96155, T1017 (page 18 of CD billing guide)
B5	Coverage/program guidelines were not met or exceeded	Usually noticed with Group Therapy (96153, H2033). Group Therapy must be at least 45 minutes (3 units) and not more than 3 hours (12 units)
16 N286	Missing/incomplete/invalid referring provider primary identifier	CD claims do not need referral, however – if a referring NPI is on the claim then the NPI must be valid in P1

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Chemical Dependency Claims – Top Denials

EOB	Description	Comments
11	The diagnosis is inconsistent with the procedure	CD billing guide (p. 23) indicates that the diagnosis must be 30390, 30490, 30500 or 30590 Previous communication with DSHS/programmers indicated that the primary diagnosis must be 303.90-303.93, 304.90-304.93 For youth (age 10-20) or pregnant clients the above diagnoses OR 305.00, 305.90

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2015 IHS encounter rate

- Not announced yet
- Stay tuned

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2015 Meeting Schedule

Tribal Billing Workgroup (TBWG) Second Wednesday (* unless noted) 9:00-10:00 AM	**Medicaid Monthly Meeting (M3)** Fourth Wednesday 9:00-10:00 AM
February 11	**February 25**
March 11	**March 25**
April 8	**April 22**
May 13	**May 27**
June 10	**June 24**
July 8	**July 22**
August 12	**August 26**
September 9	**September 23**
October 14	**October 28**
November 12 (* Thursday)	**November 25**
December 9	**December 23**

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Primary Care Incentive Payment

- Update: the quarterly incentive payment from Medicare/MCO is an **'incentive'** and not considered part of the claim payment
- **DO NOT** adjust the P1 claims to add the PCP incentive
- The Encounter payment remains unchanged
- All information accessible here

  http://www.hca.wa.gov/medicaid/Documents/aca_faq.pdf

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Billing Guide Update

Drafts are in final stages

Drafts represent what has been in place since October, 2012

Tentative changes to billing guide:

- No changes to billing model at this time

  no funds available for a change request.
- All updates will be to reflect what we have been doing since October, 2012

Drafts are available for review/comments – just ask Mike

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Mental Health

- HCA is moving forward with a fee schedule for the RSN modalities that have not been paying
- The RSN modalities will be defined and coded in the Tribal Health Billing Guide
- Bill claims 'now' even though system is not ready – this will establish timeliness.

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Mental Health

- Service Modalities that have been coded
- Brief Intervention – refer to Individual, Family, and Group
- Family Treatment – 90846, 90847
- Group Treatment – 90849, 90853
- Individual Treatment Services – 90785, 90832, 90833*, 90834, 90836*, 90837, 90838*
- Intake Evaluation – 90791, 90792*, E&M*
- Medication Management – M0064*, E&M*
- Psychological Assessment** – 96101, 96110, 96111, 96116, 96118, 96119

* services rendered by Psych MD, Psych ARNP or Psych Mental Health Nurse Practitioner-board certified

** Assessment/testing has limits/PA/EPA criteria , refer to Mental health billing guide

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Mental Health

- Service Modalities pending P1 updates, RSN codes most likely to be adopted
- Medication Monitoring (Medication training and support)
  RSN code H0033, H0034
  NOTE: this is not *Medication Management*
- Crisis Services RSN code H0030, H2011
- Day Support RSN code H2012
- Peer Support RSN code H0038
- Stabilization services RSN code S9484
- Therapeutic Psycho-Education RSN code H0025, H2027

NOTE: These Modalities will be payable retroactive once P1 update is made.

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Psychiatrists

- Current Tribal Billing Guide indicates that the services of a psychiatrist are included in the Medical category of encounter
- Claims review indicates that 85% of psychiatrist claims are being billed under Mental Health
- Billing Guide is being updated, should Psychiatrist services be included in Mental Health in the future?

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Managed Care Denials

- Meeting/Webinar February 13, 1:00-3:00 PM with the Managed Care Plans and Tribal Health Programs.
- Claims denied by the Managed Care Plans can still be sent to the HCA Managed Care help-desk at hcamcprograms@hca.wa.gov or to Mike.

  Update – when forwarding EOBs – please batch the EOBs per MCO – this helps avoid HIPAA privacy issues so that (eg) Molina does not get a CHPW claim
- MCO will only pay noncontracted providers if the client is AI/AN in ProviderOne – you do not have a way to tell if a client is coded as AI/AN in P1
- Claims denied by HCA/P1 can be sent to mike, as always – a claim number (TCN) is all I need

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Encounter Billing Secondary to Other Insurance - Native client

Private Insurance	Medicaid Managed Care (MCO, eg "Molina")	Medicare Part B or C
Medical, Dental, Mental Health and Chemical Dependency encounters: Private insurance is primary P1 is secondary Claims pay up to the encounter rate after private insurance Bill a Secondary claim	**Medical encounter**: MCO is primary P1 is secondary Claims pay up to the encounter rate after MCO Bill an MCO wraparound **Mental Health Encounter**: If MCO pays – bill an MCO wraparound If MCO denies – bill P1 primary (do not indicate other insurance on claim) **Dental and Chemical Dependency encounters** P1 is primary	**Medical encounter** Medicare is primary P1 is secondary Claims pay up to the encounter rate after Medicare Bill a Medicare "crossover" **Mental Health encounter** Medicare is primary if the servicing provider is not a Counselor (101YM0800x) Social Worker (104100000x) Marriage and Family Therapist (106H00000x) P1 is secondary Claims pay up to the encounter rate after Medicare Bill a Medicare "crossover" *Note*: counselor, social worker, Marriage and family therapist claims are billed directly to P1 **Dental and Chemical Dependency encounters** P1 is primary

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Encounter Billing Secondary to Other Insurance - Non-Native client

Private Insurance	Medicaid Managed Care (MCO, eg "Molina")	Medicare Part B or C
Medical, Dental, Mental Health and Chemical Dependency encounters: Private insurance is primary P1 is secondary Claims pay up to the encounter rate after private insurance Bill a Secondary claim	**Medical and Mental Health ~~encounter~~ claims**: MCO is primary if group has contract with the MCO No Secondary payment after MCO **Dental and Chemical Dependency encounters** P1 is primary	**Medical encounter** Medicare is primary. P1 is secondary Claims pay up to the encounter rate after Medicare Bill a Medicare "crossover" **Mental Health encounter** Medicare is primary if the servicing provider is not a Counselor (101YM0800x), Social Worker (104100000x) or Marriage and Family Therapist (106H00000x) P1 is secondary Claims pay up to the encounter rate after Medicare Bill a Medicare "crossover" *Note*: counselor, social worker, Marriage and family therapist claims are billed directly to P1 **Dental and Chemical Dependency encounters** P1 is primary

Note: Mental Health encounters for non-native clients are only for clients who meet the definition of clinical family member (refer to billing guide - definition added to end of this presentation)

NOTE: Chemical Dependency encounters require the intergovernmental Transfer (IGT) process with DSHS
ABP clients (RAC 1201) are 100% Federal dollars and therefore have 0% State dollars and no IGT process at this time, all other non-native clients require the State match submission and claims pay at the Federal Share

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Back-Dating Newly Enrolled Rendering Providers

- The Effective/start date of a rendering provider is the date that the rendering provider is approved by HCA (WAC 182-502-0005 (6))
- Provider Enrollment allows back-dating of newly enrolled providers (form # 12-333)
- Claims for Providers who were back-dated are erroring out internally in P1 (EOB N290)
- P1 correction might be ready by June, 2015
- In the interim, the servicing providers are manually being corrected and claims fixed
- Get an EOB 290? Send to mike

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Tribal Affairs Website

- Ideas, comments suggestions?

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Electronic Health Records

Christine Chumley, Health Record Technology (HIT) Program Manager

February 28 is the attestation deadline for calendar year 2014

CMS UPDATE:

Intent to engage in rulemaking activity for the 2015 reporting year

- Shortening the reporting period to 90 days
- Aligning both hospital and provider reporting periods to a calendar year
- Modifying other aspects of the program to reduce complexity and less the reporting burden

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Electronic Health Records

Need EHR help?

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

- Security or log in issues with ProviderOne? Please contact: ProviderOneSecurity@hca.wa.gov for assistance with your P1 password or when you have a change in staff resulting in a new System Administrator for your office.
- Please remember that if you do not have your own security credentials granting you access to the EHR domain in ProviderOne, our staff is not able to discuss any information with you.
- CMS EHR Help Desk: 1-888-734-6433 Option #1
- CMS Account Security and to update your accounts contact person: 1-866-484-8049 Option #3
- Website for Health IT: HealthIT.wa.gov

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Open Questions and Open Discussion

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

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Questions Log

Spend-down

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

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

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

Interim update:

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

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

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Questions Log

Medicare crossovers

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

Contractors are rejecting the claim rather than deny the line.

Stay tuned

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Questions Log

Pharmacists

What about PharmD's? encounter or FFS? Are we lobbying for pharmacists to be able to get encounter rate for med therapy management?

PharmD's are not encounter eligible at this time. What services can a pharmacist render on a professional/HCFA claim? Stay tuned

Interim update:

PharmD's are currently not encounter eligible but they are eligible to perform the following services:

Tobacco cessation for pregnant clients (physician billing guide)

Clozaril case management (physician billing guide)

Emergency contraception counseling (Pharmacy guide)

Vaccine administration fee (Pharmacy guide)

Questions Log

Managed Care

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

Stay tuned, pilot project might be starting with the FQHCs

Can you please email out contact info for the 5 HCA staff that are in charge of MCO's? Thanks!

Waiting for direct contact information.

Questions Log

Managed Care Timeliness

- Why can managed care plans set timely billing to 90 days when HCA is 365?
- CHPW allows a year for billing.
- We have been told that all Managed Medicaid plans must follow the 1 year timely filing rules. We must first appeal with the plan and if not resolved, then the state will cut a check
- Amerigroup has 90 day limit
- Amerigroup allows billing up to 6 months
- I believe the timely issues for managed care are because the contract each provider has signed has stated the time frames and I do believe you can negotiate with each insurance regarding these time billing frames. I know this to be true in private practices
- I have been told that the timely standard for all 5 MCOs is 1 year

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Questions Log

Can we can only bill for services done in this facility? Meaning not done at school, berry picking, etc.. There seems to be some question regarding the place of service. Private pay (regence, hma, etc only allows services done at the facility only)

Billing guide below, I *italicized*

- **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.
- • Face-to-face.
- • Identified in the Medicaid State Plan as a service that is:
  - 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 HIPAA compliance.
- • Performed in the health care facility identified on the IHS facility list *or at other locations where tribal facility-supported activities are performed by qualified clinic staff.* Services provided in any other location must comply with HIPAA provisions regarding confidentiality.

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Dental Limit Table

Fluoride D1206/D1208				
Age 0-6	Age 7-18	Age 19+	Age 0-18 in ortho	All ages, DDD
3 per year	2 per year	1 per year	3 per year	3 per year

Prophylaxis/cleaning D1110 and D1120			
Age 0-18	Age 19+	All ages, DDD	All ages, Nursing home client
1 per 6 months	1 per year	3 per year	4 per year

Exams D0120/D0150*		
All ages	All ages, DDD	* D0150 is a new patient, allowed once per 3 years if the client has not been seen in the clinic
1 per 6 months	3 per year	

Sealants D1351	
Age 0-20	All ages, DDD
1 per 3 years (per tooth)	1 per 2 years (per tooth)
Tooth # A,B,I,J,K,L,S,T, 2, 3, 14, 15, 18, 19, 30, 31 – surface O	Tooth # A,B,I,J,K,L,S,T, 2, 3, 4, 5, 12, 13, 14, 15, 18, 19, 20, 21, 28, 29, 30, 31 – surface O

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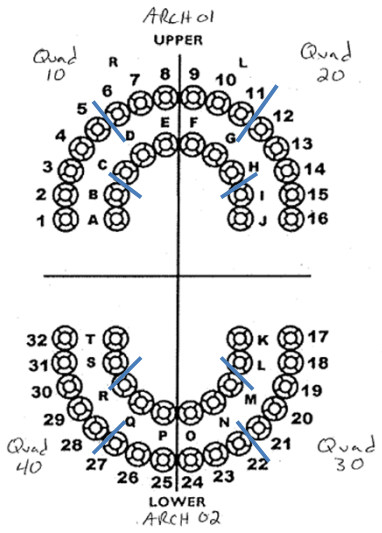
Dental Tooth, Arch, Quad numbering



Supernumerary (extra) teeth

- Only services covered are extractions
- Coding:
- Permanent dentition – add '50'
  8 becomes 58 … 21 becomes 71
- Primary dentition – add an 'S'
  A becomes AS … Q becomes QS

Tooth Surfaces (used for restorations)

- Mesial – side that comes in contact with adjacent tooth. Mesial faces the front of the mount
- Distal – side that comes in contact with adjacent tooth. Distal faces the back of the mouth
- Incisal (anterior) or Occlusal (posterior) – biting surface
- Lingual – side that is facing the tongue
- Facial (anterior) or Buccal (posterior) – side that is facing the cheek/lips

Anterior vs Posterior (blue lines)

Anterior - 6,7,8,9,10,11,22,23,24,25,26,27, C,D,E,F,G,H,M,N,O,P,Q,R

Posterior – 1,2,3,4,5,12,13,14,15,16,17,18,19,20,21,28,29,30,31,32,A,B,I,J,K,L,S,T

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Coding Criteria for Campral, ReVia, Vivitrol, Buprenorphine and Suboxone

Expedited Prior Authorization Criteria Coding List

The first five digits of the EPA number must be **87000**. The last 3 or 4 digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria

EPA Code	Service Name	CPT/HCPCS/ Dx Code	Criteria
047	Office visit related to prescribing Acomprosate (Campral®) for alcohol dependency.	**CPT codes:** 99201-99215 **Dx codes:** 303.90 to 303.93	Clients must be enrolled in DBHR-certified treatment
048	Office visit related to prescribing naltrexone (ReVia®) for alcohol or opiate dependency.	**CPT codes:** 99201-99215 **Dx codes:** 303.90 to 303.93; 304.00-304.03	Clients must be enrolled in DBHR-certified treatment
049	Office visit related to administering naltrexone (VIVITROL®) for alcohol or opiate dependency.	**CPT codes:** 99201-99215 **Dx codes:** 303.90 to 303.93; 304.00-304.03	Clients must be enrolled in DBHR-certified treatment
050	Office visit related to prescribing buprenorphine and naloxone (SUBOXONE®) opiate dependency. Drug Screening related to prescribing buprenorphine and naloxone (SUBOXONE®) opiate dependency.	**CPT codes:** 99201-99215 **Dx codes:** 304.00-304.03 Drug Screening: **HCPCS code** G0431 QW – limited to one per day and **CPT code:** 80102. **Dx codes:** 304.00-304.03	The provider must be certified and approved to prescribe Buprenorphine-Suboxone. The provider must have a CLIA waiver Urine drug screens for benzodiazepines, amphetamine/methamphetamine, cocaine, methadone, opiates, and barbiturates must be done before each prescription is dispensed during the first month of therapy. Clients must be enrolled in DBHR-certified treatment

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Clinical Family Member

Mental Health encounters for non-native clients are only for clients who meet the definition of a clinical family member

- A Clinical Family Member is a 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 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 AI/AN woman pregnant with an eligible AI/AN's child. If unmarried, the woman is eligible if the 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 AI/AN 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.

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Thank you

Send TBWG comments and questions to:

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360-725-1315

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360-725-1649

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