Washington State Health Care Authority

Tribal Compliance & Operations Work Group

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Washington State Health Care Authority

Agenda

- 2019 IHS Encounter Rate (placeholder)
- Well Child Visits and Foster Care clients
- CY2018 payment summary
- Medicare Crossovers in P1
- Intergovernmental Transfer (IGT) For Non-AI/AN SUD Encounters
  - 2019 FMAP rate change
- Top 10 rejections for CY2018
- FAQ and Open Discussion

- Attachments – EPSDT codes, generally not payable diagnoses, NPI IMC Fact Sheet, SUD FMAPs

2019 IHS Rate (Placeholder)

- 2019 IHS Encounter rate? (placeholder)
- Not on the federal register yet

Well Child Visits and Foster Care Clients

EPSDT (Early and Periodic Screening, Diagnosis and Treatment, *Well Child*) visits have the following frequency schedule for HCA

- 5 checkups between birth and one year
- 3 checkups between one and three years
- One checkup each year between three and six years
- One checkup every other year for ages seven through 20 years

What if the client is in Foster Care?

EPSDT well-child checkups are not limited for children in foster care. EPSDT well-child checkups are allowed after every change of placement and as often as considered necessary. Refer to the EPSDT billing guide, page 28 for more information on EPSDT visits for foster care clients

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Calendar Year 2018 Payment Summary

All claims were sorted by NPI & the payment percentage for CY2018 was measured. Here are the payment percentages, sorted by category

- Medical 100 100 97 97 96 96 95 95 95 94 94 94 94 93 91 91 91 90 89 **88** 88 87 87 87 86 86 85 84 82 81 80 78 78 77 77 75 73 73 72 72 69 68 67 60 60 59 49 46 0
- Dental 93 92 91 91 91 90 88 88 87 87 87 87 **86** 84 84 84 83 83 82 82 81 81 80 79 77 73 71 70 63
- Mental Health 99 99 98 98 98 98 97 97 97 97 96 96 96 95 95 95 95 95 95 94 94 94 94 93 **92** 90 90 86 83 83 81 79 77 75 72 69 58
- SUD 99 99 99 99 99 99 99 98 98 98 97 97 97 96 96 **96** 96 96 95 95 94 93 93 92 89 86 86 86 85 84 84 79 79 78 76 68 49
- Medicare cross-overs 100 99 93 93 93 92 90 83 82 78 71 65 64 **52** 50 48 47 44 44 41 40 33 33 33 30 29 27 23 14 11 6 4 2 0 0 0

Bold-fonted - arithmetic average

Red font – mike will prioritize assistance

Medicare *Cross-Overs* in P1

Medicare usually forwards claims to the state Medicaid agencies as part of the *cross-over* agreement

The *Cross-over* claims for IHS/638 clinics generally have a 100% rejection rate in P1 because Medicare will reject claims with a T1015 or a UA modifier. The easiest way to correct these claims is directly in the P1 portal.

1. If you bill Medicare on a HCFA (professional/837P) format, the claim should be forwarded to P1 in HCFA format, which is the required format for IHS Encounter claims. If the service qualifies for the encounter rate (face to face, etc) – follow these 3 steps

The claim will be a *Resubmit Denied/Voided claim* in P1

1. The billing/group taxonomy needs to be an encounter eligible taxonomy (usually 208D00000x, if this taxonomy was billed to Medicare then Medicare should be forwarding it)
2. Add the appropriate AI/AN (UA if Medical, HE if Mental Health) or nonAI/AN (SE) modifiers to <u>every line</u> on the claim
3. If the service is eligible for the balance of the encounter rate, add a T1015+UA (or T1015+SE) line

Q. What if the client is a Medicare-only client and not eligible for the encounter rate?

A. The claim will not pay the balance of the encounter rate. You could look up the client's benefit but it may be faster in the long run to just bill the claims rather than spend the extra time looking up eligibility

Want help? Just ask mike, we can walk thru some of the claims – the first few will be the hardest but it should take less than about 2 minutes per claim to reprocess these in P1 after you have reprocessed a few

Intergovernmental Transfer (IGT) For Non-AI/AN SUD Encounters

- SUD claims for nonAI/AN clients require the local matching funds be sent to HCA
- The local matching fund rate, FMAP (Federal Medical Assistance Percentage) changed on 01/01/2019, the new FMAP rates for the IGT are attached to today's webinar
- The FMAP rates for CY2019 will be updated when the CY2019 IHS rate is announced
- CPE (Certified Public Expenditure) should be replacing IGT during 2019

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Medical - Top 20 EOB Translations for CY2018

EOB	Description	Comments
204 ITU 02190	*This service/equipment/drug is not covered under the patient's current benefit plan*	• Claims were Medicare cross-overs and the client is a medicare-only client • Client is not full-scope coverage (e.g. family planning only) • Rendering taxonomy on claim was not adopted by P1 (eg 390200000x, 101YA0400x)
18 ITU 98325 98328	*Exact duplicate claim/service*	Dupe
167 ITU 03755	*This (these) diagnosis(es) is (are) not covered.*	Some ICD-10 diagnosis codes are *generally not payable if billed as the primary diagnosis on a medical claim.* An updated list is attached to today's webinar
24 ITU 02035	*Charges are covered under a capitation agreement/managed care plan.*	Client is enrolled in one of the Apple Health Managed Care Plans (e.g., Amerigroup, CHPW, Coordinated Care, Molina or United Healthcare)
181 ITU 16030	*Procedure code was invalid on the date of service*	The Procedure code was probably valid but P1 was not able to determine how much to pay on the service. Double check the fee schedule to see if the code is listed. CPT 80101 was ended in 2014

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Medical - Top 20 EOB Translations for CY2018

EOB	Description	Comments
236 ITU 25000	*This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements*	Code pair is not payable in combination per NCCI rules.
96 / N130 ITU 03005	*Non-covered charge(s). Consult plan benefit documents/guidelines for information about restrictions for this service*	The Physician fee schedule helps point to the noncovered codes
96 /N30 ITU 02370	*Non-covered charge(s) Patient ineligible for this service*	Client is a Medicare only client (SLMB, QDWI, or QI1) and does not have P1 coverage
16 / M119 ITU 03640	*Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).*	Most drug codes need an NDC & the NDC needs to be associated to the drug code (Medispan reports the code/NDC pairs)
16 N290 ITU 01245	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier*	• Claim was missing the rendering NPI

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Medical - Top 20 EOB Translations for CY2018

EOB	Description	Comments
16 N290 ITU 01010	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier*	The rendering NPI on the claim has not been enrolled in P1 yet This is one of the rare times that mike suggests holding claims (only because P1 will remove the NPI from the claim, making it virtually impossible to find on mike's side)
97 / N20 ITU 03920	*The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. + Service not payable with other service rendered on the same date.*	Vaccine Administrative fee billing has certain requirements, if you do not have mike's immunization cheat sheet – just ask
22 ITU 02205	*This care may be covered by another payer per coordination of benefits*	Client has Medicare Part B or C. If Medicare has already been billed – refer to EOB 16/N48 (the Medicare payment was not reported correctly per P1)
29 ITU 00750	*The time limit for filing has expired*	Medicare "Cross-over" is outside the timely filing window. HCA has the following timely rule for Medicare "cross-overs" • 6 months from the Medicare EOB date to get the claim billed to P1 • If a claim met the initial 6 month requirement but needs correcting we get up to 2 years from the date of service for corrections
29 ITU 00190	*The time limit for filing has expired*	Claim is outside the timely filing window. HCA has the following timely rule: • 365 days from the date of service to get the claim billed to P1 • If a claim met the initial 365 day requirement but needs correcting we get up to 2 years from the date of service for corrections

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Medical - Top 20 EOB Translations for CY2018

EOB	Description	Comments
16 N288 ITU 01485	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider taxonomy*	• Rendering taxonomy on claim is not one that the provider is enrolled with • Licensed has expired (when licenses expire, P1 automatically expires the taxonomy too)
11 ITU 03335	*The diagnosis is inconsistent with the procedure*	CPT 82306 (Vit D) is only covered for certain conditions. See page 159 of the Physician billing guide.
97 / N20 ITU 14095	*The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. + Service not payable with other service rendered on the same date*	If this EOB is on an E&M (99201-99215) it is due to an HCA-policy regarding E&Ms not payable on same day as an immunization. This is similar to the NCCI edit with a similar resolution - modifier 25 may be added to the E&M (if appropriate) to waive the rule
A1 / N59 ITU 03785	*Please refer to your provider manual for additional program and provider information*	Well child (EPSDT) visits can only contain the codes that HCA chose for EPSDT claims. This information is not shared in the billing guides. Codes that can be paid on an EPSDT claim are attached to today's webinar.

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Dental - Top 20 EOB Translations for CY2018

EOB	Description	Comments
96 N130 ITU 03005	*Non-covered charge(s). Consult plan benefit documents/guidelines for information about restrictions for this service*	Service not covered. The dental fee schedule does a nice job of outlining covered codes for kids and adults
96 N428 ITU 03175	*Non-covered charge(s) Not covered when performed in this place of service*	Oral Hygiene Instructions (D1330) and Limited Visual Oral Assessment (D0190/D0191) are not covered in a dental office or clinic setting
6 ITU 03145	*The procedure/revenue code is inconsistent with the patient's age.*	Oral Hygiene Instructions (D1330) are covered for clients age 0-8 Crowns are not covered for adults Root canals (molars/bicuspids) not covered for adults
119 ITU 12195	*Benefit maximum for this time period or occurrence has been reached*	Fluoride limits exceeded. If you don't have mike's dental cheat sheet with the tooth numbering and common dental limits, just ask
18 ITU 98325 98328	*Exact duplicate claim/service*	Dupe

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Dental - Top 20 EOB Translations for CY2018

EOB	Description	Comments
181 ITU 16030	*Procedure code was invalid on the date of service*	The Procedure code was probably valid but P1 was not able to determine how much to pay on the service (e.g., a crown for an adult has no rate and may be rejected with this EOB along with the "not covered" EOB)
119 M86 ITU 12180	*Benefit maximum for this time period or occurrence has been reached Service denied because payment already made for same/similar procedure within set time frame.*	Cleaning (Prophy) too soon Kids (0–18) – once per 6 months Adults (19+) – once per year (extra allowed for DDA and ALF clients)
197 ITU 11120	*Precertification/authorization/ notification/pre-treatment absent*	Some dental services require prior authorization (e.g., dentures) – easiest to refer to the dental billing guide to see which services need prior authorization
16 N255 ITU 01475	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid billing provider taxonomy*	Billing/group taxonomy not valid • FQHCs use 261QF0400x • IHS/638 use 122300000x
A1 / N81 ITU 03720	*Procedure billed is not compatible with tooth surface code.*	Sealants (D1351) are covered for clients age 20 and younger for the O–Occlusal surface on the following teeth: 2, 3, 14, 15, 18, 19, 30, 31, A, B, I, J, K, L, S, & T (see billing guide if client is DDA)

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Dental - Top 20 EOB Translations for CY2018

EOB	Description	Comments
119 ITU 12190	*Benefit maximum for this time period or occurrence has been reached*	Complete panoramic xrays (D0330 D0210) are covered once in a three-year period (age 14+)
197 IT 01220	*Precertification/authorization/ notification/pre-treatment absent*	Missing the EPA (IHS/638 only) AI/AN client - EPA 870001305 nonAI/AN client - EPA 870001306
204 ITU 02190	*This service/equipment/drug is not covered under the patient's current benefit plan*	Most clients were either Medicare-only (either QMBonly or SLMB, QDWI or QI-1)
119 ITU 12215	*Benefit maximum for this time period or occurrence has been reached*	Sealants are allowed once (per tooth) in a 3 year period (DDA clients are once in a 2 year period)
29 ITU 00190	*The time limit for filing has expired*	Claim is outside the timely filing window. HCA has the following timely rule: • 365 days from the date of service to get the claim billed to P1 • If a claim met the initial 365 day requirement but needs correcting we get up to 2 years from the date of service for corrections

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Dental - Top 20 EOB Translations for CY2018

EOB	Description	Comments
16 / N39 ITU 00145	*Procedure code is not compatible with tooth number/letter.*	Follow this outline If the billing guide says an arch (01 02) or quad (10 20 30 40) is required – add the arch or quad If the billing guide says a tooth number is required – add the tooth number. Some restoration codes are for anterior or posterior teeth only
119 ITU 12005	*Benefit maximum for this time period or occurrence has been reached*	Periodic Oral Evaluations (D0120) are covered once every 6 months (The Comprehensive code, D0150 is usually referred to as a "new patient" code) NOTE: Limited Oral Evaluations (D0140) do not have a frequency schedule like the comp/periodic evals See the dental billing guide, page 27–28 for information on the Limited Eval service
119 / N640 ITU 14000	*Exceeds number/frequency approved/allowed within time period.*	Bitewings (D0270 D0272 D0273 D0274) are allowed up to (a total of) 4 bitewings per year
26 ITU 02255	*Expenses incurred prior to coverage*	Client was not eligible on this date of service. NOTE: we have recently found that some clients are determined to be retroactively eligible after the claim(s) have been rejected, it is OK to reprocess claims if they are still timely
119 ITU 12045	*Benefit maximum for this time period or occurrence has been reached*	The comprehensive Eval (D0150) is covered once in a 5 year period unless the client has a documented significant change in health conditions. If it has been 6 months or more since the last Evaluation a Periodic (D0120) may be billed

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Mental Health - Top 20 EOB Translations for CY2018

EOB	Description	Comments
18 ITU 98325	*Exact duplicate claim/service*	Dupe
204 ITU 02190	*This service/equipment/drug is not covered under the patient's current benefit plan*	Clients were either Medicare-only clients or the performing taxonomy was a taxonomy that has not been implemented in P1 (e.g. 1041c0700x and 101YA0400x are not used in P1)
16 N290 ITU 01245	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier*	Claim was missing the rendering NPI
16 N290 ITU 01010	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier*	The rendering NPI on the claim has not been enrolled in P1 yet This is one of the rare times that mike suggests holding claims (only because P1 will remove the NPI from the claim, making it virtually impossible to find on mike's side)
236 ITU 25000	*This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements*	Not payable in combination per NCCI guidelines. During February, 2018 mike did an NCCI review for mental health codes - need a copy? Just ask

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Mental Health - Top 20 EOB Translations for CY2018

EOB	Description	Comments
16 N255 ITU 01475	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid billing provider taxonomy*	Billing/group taxonomy not valid • FQHCs use 261QF0400x • IHS/638 use 2083P0901x
96 / N130 ITU 03005	*Non-covered charge(s). Consult plan benefit documents/guidelines for information about restrictions for this service*	Service not covered. Refer to the code-table beginning on page 38 of the Mental Health Billing Guide for the list of HCA-covered mental health codes
24 U 02035	*Charges are covered under a capitation agreement/managed care plan*	Client is enrolled in MCO or BHO (only affected Urban Org claims)
181 ITU 16030	*Procedure code was invalid on the date of service*	The Procedure code was probably valid but P1 was not able to determine how much to pay on the service

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Mental Health - Top 20 EOB Translations for CY2018

EOB	Description	Comments
22 ITU 02205	*This care may be covered by another payer per coordination of benefits*	Client has Medicare Part B or C. If Medicare has already been billed – refer to EOB 16/N48 (the Medicare payment was not reported correctly per P1)
11 ITU 03335	*The diagnosis is inconsistent with the procedure*	SBIRT (CPT 99408/99409) requires the primary diagnosis be either Z7141 (alcohol) or Z7151(drug) CPT 82306 (Vit D) is only covered for certain conditions. See page 159 of the Physician billing guide.
107 ITU 00570	*The related or qualifying claim/service was not identified on this claim.*	Prolonged Care (99354–99357) is an add-on code that can only be billed with certain other codes. HCA did not follow CPT – HCA did not add 90837 as a base code for the add-on codes
16 N288 ITU 01485	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider taxonomy*	• Rendering taxonomy on claim is not one that the provider is enrolled with • Licensed has expired (when licenses expire, P1 automatically expires the taxonomy too)

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Mental Health - Top 20 EOB Translations for CY2018

EOB	Description	Comments
16 N290 ITU 01390	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier*	Rendering NPI on the claim was either the billing group's NPI or the rendering NPI is not in P1 for the date of service or the rendering NPI was *De-Activated* in October (if provider is still De-Activated, contact HCA's Provider Enrollment help desk (providerenrollment@hca.wa.gov) and cc mike
16 / N255 I/T 00305	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid billing provider taxonomy	Billing/group taxonomy not valid • FQHCs use 261QF0400x • IHS/638 use 2083P0901x
96 N30 IT 03841	*Non-covered charge(s)* *Patient ineligible for this service*	The IHS encounter rate is not payable if a client is on state-funds only. Refer to page 20 of the Tribal Health Billing Guide for the list of RAC codes that do not qualify for the encounter rate
29 ITU 00190	*The time limit for filing has expired*	Claim is outside the timely filing window. HCA has the following timely rule: • 365 days from the date of service to get the claim billed to P1 • If a claim met the initial 365 day requirement but needs correcting we get up to 2 years from the date of service for corrections

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SUD - Top 20 EOB Translations for CY2018

EOB	Description	Comments
18 ITU 98328	*Exact duplicate claim/service*	Dupe
24 Urbans 01365	*Charges are covered under a capitation agreement/managed care plan*	FQHCs only – client is enrolled in a BHO, BHSO or IMC
204 ITU 02190	This service/equipment/drug is not covered under the patient's current benefit plan	Most claims had a taxonomy issue. SUD claims are billed at the clinic level only with 261QR0405x (FQHCs use 261QF0400x + 261QR0405x)
181 ITU 16030	*Procedure code was invalid on the date of service*	The Procedure code was probably valid but P1 was not able to determine how much to pay on the service. Labs and acupuncture are not payable
4 I/T/U 00800	*The procedure code is inconsistent with the modifier used or a required modifier is missing.*	EOB 4 has a few different meanings, in this instance it was regarding the modifier on the SUD code (almost always HF)

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SUD - Top 20 EOB Translations for CY2018

EOB	Description	Comments
170 N95 ITU 03740	*Payment is denied when performed/billed by this type of provider* *This provider type/provider specialty may not bill this service*	• Labs and acupuncture are not payable • If the SUD code is missing a modifier (e.g. HF) we also see this EOB
4 I/T 01220	The procedure code is inconsistent with the modifier used or a required modifier is missing.	EOB 4 has a few different meanings, in this instance it was regarding the modifier on the T1015 code AI/AN client: T1015+HF nonAI/AN client RAC 1201 = T1015+SE RAC 1217 = T1015+HB All others = T1015+HX
96 / N130 ITU 03005	*Non-covered charge(s). Consult plan benefit documents/guidelines for information about restrictions for this service*	Service not covered. Refer to the code-tables on page 19 of the SUD billing guide for the list of HCA-covered SUD codes
29 ITU 00190	*The time limit for filing has expired*	Claim is outside the timely filing window. Non-Medicare-crossovers have the following timely rule • 365 days from the date of service to get the claim billed to P1 • If a claim met the initial 365 day requirement but needs correcting we get up to 2 years from the date of service for corrections

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SUD - Top 20 EOB Translations for CY2018

EOB	Description	Comments
273 / N362 ITU 25010	*Coverage/program guidelines were exceeded + The number of Days or Units of Service exceeds our acceptable maximum.*	Assessment (H0001) is always '1' unit
16 /N288 ITU 01485	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider taxonomy	Claims were billed with a rendering NPI and taxonomy – SUD claims billed to P1 are billed at the clinic level only
A1 N61 I/T 01515	*Claim/Service denied* *Rebill services on separate claims*	**DO NOT rebill on separate claims.** Tribal IHS and 638 SUD claims need a claim note. EOB N61 happens when the claim note is not correct AI/AN clients – SCI=NA (or sci=na) nonAI/AN clients – SCI=NN (or sci=nn)
258 ITU 02224	*Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.*	Clients are not eligible for (outpatient) P1 coverage while incarcerated. If the client was at the clinic but the claim rejected with EOB 258 – contact mike to get the client's eligibility corrected in P1 (sometimes the jails are taking clients for services, when this happens, the jail is still responsible)
11 ITU 03955	*The diagnosis is inconsistent with the procedure*	SUD claims (other than the Assessment service) require that the primary diagnosis be in the approved list of diagnoses

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SUD - Top 20 EOB Translations for CY2018

EOB	Description	Comments
16 / M51 ITU 03130	*Missing/incomplete/invalid procedure code(s).*	Old (noncovered) CPT (80101) on claims
16 N255 ITU 01475	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid billing provider taxonomy*	Billing/group taxonomy not valid • FQHCs use 261QF0400x • IHS/638 use 261QR0405X
16 /N290 ITU 01010	Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier	Claims were billed with a rendering NPI and taxonomy – SUD claims billed to P1 are billed at the clinic level only
26 ITU 02255	Expenses incurred prior to coverage	Client was not eligible on this date of service. NOTE: we have recently found that some clients are determined to be retroactively eligible after the claim(s) have been rejected, it is OK to reprocess claims if they are still timely
96 N30 IT 03841	Non-covered charge(s) Patient ineligible for this service	The IHS encounter rate is not payable if a client is on state-funds only. Refer to page 20 of the Tribal Health Billing Guide for the list of RAC codes that do not qualify for the encounter rate

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Prior TCOW Questions

- Attached to today's webinar is a list of the TCOW questions received during the TCOWs beginning with the March, 2018 TCOW
- An ongoing TCOW questions file is being developed and will eventually be on the Tribal Affairs website

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FAQ and Open Discussion

Q. We heard that Coordinated Care Healthy Options Foster Care is an IMC (integrated managed care) plan beginning on 01/01/2019. why doesn't P1 say that it is an integrated plan?

A. *Because the Foster Care population is only enrolled in one Managed Care Plan (CCW), HCA did not see a need at this time to make the change in P1*

PCCM Code	Plan/PCCM Name
MC: Capitated	Coordinated Care Healthy Options Foster Care (IMC)
MC: Capitated	Great Rivers Behavioral Health Organization
MC: Capitated	CHPW Behavioral Health Services Only
MC: Capitated	Great Rivers Behavioral Health Organization
MC: Capitated	North Sound Behavioral Health Org

aveToXLS Viewing Page:

FAQ and Open Discussion

Q. We heard that we need to enroll our LPNs, RNs, Peer Support Specialists and CDPs in P1 beginning on 01/01/2019, is this true?

A. See the attached NPI IMC Fact sheet, this is for services that will be billed to the IMCs. Claims that are billed to P1 are not changing

- Substance Use Disorder claims billed to P1 will continue to be billed at the facility level only, without servicing NPIs/Taxonomies
- Mental Health claims (along with medical) rendered by LPN, RN, Peer Support Specialists, etc will continue to be billed following HCAs (*unwritten*) policy regarding reporting for the services of those folks under their supervisor's credentials

Services that are billed to the IMCs will follow the new guidance and the providers referenced will need to be enrolled in P1

Q. can P1 be updated for consistency?

A. No, due to P1 limitations, P1 will not be updated

FAQ and Open Discussion

Q. We noticed that Medicare is no longer forwarding claims for some clients. We used to see MA07 (*The claim information has also been forwarded to Medicaid for review*) but we noticed that it stopped on a couple of clients

A. Reach out to mike. HCA does send a client roster to Medicare. Sometimes the roster needs to be corrected

FAQ and Open Discussion

Q. Is there a list of part D plans that HCA enrolls clients into? We need to help a client switch plans.

A. When a client is on Medicaid, HCA sends an annual file that reports who is on Medicaid (and has Medicare). This list

goes out around July each year. At that point clients are "deemed" low income and are able to get part D subsidy.

However, in order take part of that subsidy clients MUST choose a "benchmark" part D plan. These subsidy plans change

each year. To enroll in these plans clients can either call SHIBA for help picking a plan or they can call the plan directly (HCA's Medicare folks suggest calling SHIBA (Senior Health Insurance Benefits Advisors)).

If a client is in a Part D plan and wishes to switch, HCA cannot assist but SHIBA can help (HCA's Medicare folks suggest getting a benchmark or Low Income Subsidy) plan.

Here is a link to the Medicare & You booklets - https://www.medicare.gov/medicare-and-you

The SHIBA contact number for WA is 800 562 6900

The Medicare & You electronic booklet does not contain the list of part C/D plans like the paper booklets that are mailed

FAQ and Open Discussion

Q. The list of diagnosis codes that are generally not payable includes Z0131, *Encounter for examination of blood pressure with abnormal findings.* Why isn't this payable?

A. Stay tuned, forwarded to HCA clinical staff

Also asking about some noncovered TMJ diagnoses

M26601 RIGHT TEMPOROMANDIBULAR JOINT DISORDER UNSPEC
M26602 same thing but for LEFT
M26603 same thing but for bilateral

Peanut Allergy (Z91010) had a similar issue but was fixed recently

FAQ and Open Discussion

Q. When we go to January one is Medicaid going to have all of our non billable providers and providers that are not listed in medicaid are they going to have them all listed now?

A. There are no changes in regards to the types of providers who are enrolled in P1 for ITU claims that are billed to P1. Refer to HCA's NPI IMC Fact sheet, attached to today's webinar

FAQ and Open Discussion

Q. Last month you told urbans we could not bill for Well Child visits and other services separately. If I understand correctly you are now recommending that if a separate service done we bill on separate claim? (question from an Urban Org)

A. **FQHCs** – stay tuned. Mike thought that he read somewhere that FQHCs get **ONE** medical encounter but I need to verify with HCA's FQHC experts.

IHS/638 clinics refer to page 44 of October TCOW

I/T/U

FAQ and Open Discussion

Q. If you have to split out the well child and cpt 17000. would you need to split out the well woman check and insertion of iud or nexplanon on the same visit?

A. Refer to October, 2018 TCOW for background information.

Recap – if, during a well child visit the client is determined to be *unwell* and medically necessary services are rendered – both visits may be payable as long as the visits are separate and distinct visits.

HCA doesn't really have a "well adult" visit, we are most likely referring to either

- The E&M and if the E&M is separate and distinct from the IUD services then the visits are separately billable
- A cancer screen, cancer screens **are covered**, see page 156 of the Physician-related billing guide

IT & U

Drugs (including IUDs and Nexplanon) are outside the all-inclusive rate and reimbursed under FFS (NOTE: if on the same claim as an encounter the drug payment will be absorbed into the encounter payment due to P1 design)

I/T only

FAQ and Open Discussion

Q. During the October TCOW (page 22) you shared how to look in P1 to see if a client is a DDA (Developmental Disabilities Administration) client. I have a disabled client but P1 does not indicate that the client is disabled, how do we correct this?

A. Client will need to contact DDA. DSHS/DDA website seems straightforward

I/T/U

FAQ and Open Discussion

Q. Our Providers are not always here when the pt comes in for follow up incident to visits. Per the basic requirements "Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services." We have other providers here but not the ordering. Would these visits be billable?

A. Per CMS the ordering provider does not have to be present but another qualified (Dr.) supervising must be present (thank you Lydia!)

Washington State Health Care Authority

FAQ and Open Discussion

Q. During the February 2018 TCOW, you shared a list of codes that are payable on a Well Child (EPSDT) claim. E&M codes (99201-99215) not in the list, can these be billed separately?

A. Codes from the February TCOW are re-attached to today's webinar. If a Well Child code is billed (CPT 99381-99395) and the client is age 0-20 then the **entire claim** becomes a Well Child visit and only the codes from the list can be paid on a Well Child claim. Below are two common scenarios and solutions

- Client receives a Well Child visit and client diagnosed with warts to be removed (e.g., CPT 17000)
  - CPT 17000 is not payable on the same claim as the Well Child visit.
  - CPT 17000 may be reported on a separate claim and if the services are distinctly separate from the Well Child visit it may also qualify for the encounter rate
- Client receives a Well Child visit and clinician would also like to conduct an evaluation (e.g., CPT 99213) to address a medical issue
  - CPT 99213 is not payable on the same claim as the Well Child visit.
  - CPT 99213 may be reported on a separate claim and if the services are distinctly separate from the Well child visit it may also qualify for the encounter rate

NOTE: Medicaid is mandated to follow NCCI guidelines. Modifiers may be required under certain circumstance and, depending on the actual CPT/HCPCS codes, the services may not be payable together regardless of modifier (per NCCI)

FQHC GUIDANCE received 12/13/2018 from HCA's FQHC team

If a client needs to be seen by different practitioners with different specialties or the client needs to be seen multiple times due to unrelated diagnoses then each encounter must be billed on a separate claim form.

FAQ and Open Discussion

Q. Where can we find the I.H.S. facility list?

A. The I.H.S. facilities are on the I.H.S. website

The 638 facilities are provided to the states by CMS

Q. Is there a list of the addresses for the facilities so that we can comply with the CMS requirement?

A. No. CMS has indicated that the State Medicaid agency should be able to get the list from the Tribal facility

Q. How do we get a facility added to the facilities list?

A. Contact Peggy Ollgaard, Director, Division of Business Operations. Portland Area Indian Health Service for more information

Peggy.Ollgaard@ihs.gov

503.414.5598 Office

I/T

FAQ and Open Discussion

Q. My Intergovernmental Transfer (IGT) matching funds for SUD was 'rejected' – what do we do?

A. Contact Mike.

The IGT Process will eventually be replaced by a CPE (Certified Public Expenditure) process.

In the meantime, if you are having issues with checks not being returned, contact mike

I/T

FAQ and Open Discussion

Q. Any update on the SUD Match going quarterly?

A. Stay tuned. (summer, 2019?)

I/T

FAQ and Open Discussion

Q. Are there guidelines to documentation needed for 96372 services to qualify for encounter billing?

A. I need to split the question up

Q1 – are there guidelines to documentation needed for CPT 96372?

Q2 – are there guidelines to documentation needed claims billed at the IHS encounter rate

A1 – HCA's clinical team feels it should follow the same as E&Ms

Evaluation and management documentation and billing

The evaluation and management (E/M) service is based on key components listed in the CPT® manual. Providers must use either the 1995 or 1997 Documentation guidelines for evaluation and management services to determine the appropriate level of service.

Once the licensed practitioner chooses either the 1995 or 1997 guidelines, the licensed practitioner must use the same guidelines for the entire visit. Chart notes must contain documentation that justifies the level of service billed.

Documentation must:

- Be legible to be considered valid.
- Support the level of service billed.
- Support medical necessity for the diagnosis and service billed.
- Be authenticated by provider performing service with date and time.

Keys to documenting medical necessity to support E/M service:

- Document all diagnoses managed during the visit.
- For each established diagnosis, specify if the patient's condition is stable, improved, worsening, etc.
- Document rationale for ordering diagnostic tests and procedures.
- Clearly describe management of the patient (e.g., prescription drugs, over the counter medication, surgery).

A provider must follow the CPT coding guidelines and their documentation must support the E&M level billed. While some of the text of CPT has been repeated in this billing guide, providers should refer to the CPT book for the complete descriptors for E/M services and instructions for selecting a level of service.

A2 - Stay tuned

FAQ and Open Discussion

Q. Would a pharmacist be eligible for incident to billing

A. Stay tuned, this is a CMS policy that mike will need to research further

FAQ and Open Discussion

Q. Dental assistants are not licensed, however some are certified. If a dental service was performed by a non-certified dental assistant would that qualify for an encounter?

A. Certified Dental Assistants and Licensed Dental Hygienist are consider a 'Health Care Professional' Per current SPA and Tribal Billing guides. if the service was rendered by a non-certified dental assistant – HCA has not completed the analysis on this question yet, stay tuned

I/T

Washington State Health Care Authority

FAQ and Open Discussion

Q. Does HCA cover paramedicine?

A. Not yet. House Bill 1358 has not been implemented yet.

Paramedicine is an emerging profession, it allows EMTs/Paramedics to provide some healthcare services to underserved populations.

A scenario explains why the question was asked

Over the years, paramedics have routinely been called out to various sites and, when they get there, they find that the client is not "sick" enough to need to go to the hospital.

For example – client calls because he has chest pain. The EMT's get there and determine that there is no need to go to the hospital, they see he has elevated BP and suggest a primary care visit. The EMTs do not have a billable service, even after driving to the site

Stay tuned

I/T/U

FAQ and Open Discussion

Q. What is considered a gap in services for SUD?

A. Stay tuned, this answer will be reworked because the original answer was a subjective answer and "gap in services" is not defined.

This is in regards to the following Q&A during the June TCOW

Q. How often should an SUD assessment be conducted?

A. An assessment should be done as soon as a person begins to seek out services, we used to follow a 6 month process for new assessments if the patient left services and/or relapsed. It would now depend on the agency, the contract requirements, RCW and WAC and how long a person has been away from services

Q. If a client's last assessment was 2 or more years ago and there has not been a change in the client's condition is there a need for a re-assessment?

A. If the client is still in services, a new assessment is not needed as long as there has been constant contact. If the client has had a gap in service and wants to re-enter services the assessment would need to be redone or updated

I/T/U

Washington State Health Care Authority

Questions?

Send comments and questions to:

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- If there is a difference between any information in this webinar and current agency documents (e.g. provider guides, WAC, RCW, etc), the agency documents will apply.