Washington State Health Care Authority

Tribal Compliance & Operations Work Group

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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

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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

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

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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

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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
02190		
01245		
01010		
01485		
02255		

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Medical - Top 20 EOB Translations for CY2018

EOB	Description	Comments
01390		
02035		
02207		
01475		
02204		

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Medical - Top 20 EOB Translations for CY2018

EOB	Description	Comments
01220		
00580		
02370		
03755		
16030		

Medical - Top 20 EOB Translations for CY2018

EOB	De98325scription	Comments
02035		
25000		
03640		
03005 98325 03920 00305		

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Dental - Top 20 EOB Translations for CY2018

EOB	Description	Comments
98328		
02190		
02255		
01390		
01445		

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Dental - Top 20 EOB Translations for CY2018

EOB	Description	Comments
00190		
02125		
01485		
01245		
00500		

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Dental - Top 20 EOB Translations for CY2018

EOB	Description	Comments
03005		
03145		
03175		
16030		
11120		

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Dental - Top 20 EOB Translations for CY2018

EOB	Description	Comments
12190		
12195		
12180		
03720		
12215		

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Mental Health - Top 20 EOB Translations for CY2018

EOB	Description	Comments
02190		
01010		
01245		
01475		
01485		

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Mental Health - Top 20 EOB Translations for CY2018

EOB	Description	Comments
01390		
00190		
00265		
01445		
02035		

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Mental Health - Top 20 EOB Translations for CY2018

EOB	Description	Comments
98325		
01220		
25000		
03005		
03740		

Mental Health - Top 20 EOB Translations for CY2018

EOB	Description	Comments
16030		
12270		
03005		
14363		

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SUD - Top 20 EOB Translations for CY2018

EOB	Description	Comments
02190		
00190		
01485		
14368		
01010		

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SUD - Top 20 EOB Translations for CY2018

EOB	Description	Comments
02125		
02120		
02255		
14369		
01475		

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SUD - Top 20 EOB Translations for CY2018

EOB	Description	Comments
01365		
98325		
16030		
25010		
03740		

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SUD - Top 20 EOB Translations for CY2018

EOB	Description	Comments
00800		
02224		
03005		
00305		
03955		

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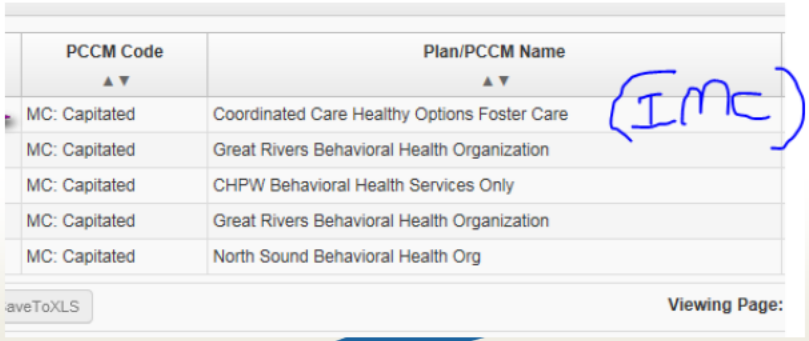
Prior TCOW Questions

- 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

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
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

IMC

aveToXLS

Viewing Page:

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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

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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

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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

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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

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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

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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

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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

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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

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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!)

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

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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

FAQ and Open Discussion

Q. Any update on the SUD Match going quarterly?

A. Stay tuned. (summer, 2019?)

I/T

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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

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

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Questions?

Send comments and questions to:

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- The bottom-left corner of each slide will contain either I/T (impacts IHS and Tribal) or I/T/U (impacts IHS, Tribal and Urbans) or U (only impacts Urban)
- 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.