Washington State Health Care Authority

Tribal Compliance & Operations Work Group

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December 14, 2016

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Agenda

- ProviderOne Updates: MCO wraparounds, duplicates, multiple encounters, claim notes, timeliness, NCCI for SUDs and browser support
- Disclosure Requirements for ITUs
- Top 5 denials
- FAQ and Open Discussion
- Attachments
  - MCO single Point of Contact – updated list
  - Does xxxx qualify for the IHS encounter rate

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ProviderOne Claims Update – MCO Wraparounds

- On November 20th, P1 was updated to start automatically processing correctly billed MCO wraparound claims
  - P1 update was retroactive and claims have been reprocessed
- Prior to the P1 changes:
  - MCO wraparounds were processed manually by two HCA offices, which often took 60-90+ days to process
  - Staffing changes in early 2016 caused most of the MCO wraparounds to begin denying in error
- Refer to 09/14/2016 TCOW slides for background information

ProviderOne claims Issue – Duplicate Rejections

- On November 20th, P1 was updated to automatically process correctly billed claims for different encounter categories for the same client on the same date of service, even if the client gets care on the same day from different tribal providers
  - Previously, the denials would have EOB B20 on the T1015 line
- Claims denied in error have been reprocessed
- Limited dental evaluations (D0140) are still being rejected with B20 if client received an evaluation at a different clinic. System techs working on a permanent resolution (ETA early 2017). In the interim, Mike will continue to reprocess claims that have B20 on the D0140 line
- Refer to 09/14/2016 TCOW slides for background information

ProviderOne Claims Issue – Multiple Encounters

- Claims that have multiple units on the T1015 line are currently paying as FFS only (rejecting the T1015 line with EOB N362)
- Please contact Mike if you have any claims for multiple encounters that are not paying correctly
- Mike will continue to reprocess claims that are incorrectly paid in P1
- System techs are working on a permanent resolution (no ETA yet)

- Refer to 09/14/2016 TCOW slides for background information

ProviderOne Update – Most Claim Notes No Longer Supported

- ProviderOne is being automated and claim notes are no longer being used in P1. Exceptions are
  - *SCI=NN* or *SCI=NA* on SUD claims
  - *SCI=B* for baby on mom's ID
  - *Electronic TPL* (preferred) or *sending insurance EOB*
- All other claim notes are being disregarded due to P1 automation
- Please update software if possible so that it doesn't automatically add claim notes

ProviderOne Claims Issue – Timeliness Rejections

- Non-Medicare secondary claims must be received within 365 days from the date of service and, if needed, corrections may be made up to 24 months after the date of service if the original claim was received within 365 days
- Medicare secondary claims must be received within 6 months of the Medicare EOMB date and, if needed, corrections may be made up to 24 months after the date of service if the original claim was received within 6 months of the EOMB date

ProviderOne Claims Issue – Timeliness Rejections - continued

Claims received outside of the initial timely filing window will reject as non-timely unless there is proof of timely filing on the claim

- Claims that are *reprocessed* maintain the "claim trail" and retain the original claim submission date (timely TCN)
- Two ways to reprocess claims:
  - HIPAA frequency 7 (replacement) of a previously paid or denied claim
  - P1 uses a *claim adjustment/void* or *resubmit denied/voided claim* as the equivalent of HIPAA frequency 7
- Reprocess claims and avoid claim notes whenever possible
- Contact Mike if you are unable to reprocess claims

ProviderOne Claims Update – NCCI and SUD

- DSHS/HCA has received CMS approval to waive the NCCI Medically Unlikely Event (MUE) restrictions for 96153 and 96154
- HCA will reprocess claims that previously rejected for over-limit (EOB A1/N362)
- HCA cannot reprocess claims that were previously billed for less than the MUE value; you will need to resubmit these claims (e.g., client was seen for 3 hours but claim was billed for 2 hours)
- Refer to 09/14/2016 TCOW slides for background information

ProviderOne Updates – Browser Support

Beginning sometime in January 2017, HCA will only support the following 4 web browsers:

- Google Chrome
- Internet Explorer
- Mozilla Firefox
- Safari

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Medicaid Provider Ownership and Disclosure Requirements

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Disclosure: History

During the second quarter of 2015, HCA received queries from multiple Indian health care providers about being required to provide SSNs and dates of birth for managing employees, board members, and officers.

HCA submitted requests to CMS Program Integrity in 2015 and to CMS Tribal Affairs in 2016

CMS Tribal Affairs helped give HCA definitive guidance on September 28, 2016.

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Disclosure: Requirements

42 C.F.R. § 455.104 requires HCA to obtain from every Medicaid provider (except individuals or groups) (including through Managed Care Entities) the name, address, date of birth, and SSN of:

- Any managing employee of the provider; and
- Any person with an ownership or control interest in the provider.
  - Additional disclosure requirements apply to persons with an ownership or control interest in the provider.

Disclosure: Definitions

42 C.F.R. § 455.101 defines:

- "Managing employee"
  - A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the provider.
- "Person with an ownership or control interest"
  - A person or corporation that:
    - Has total direct and indirect ownership interest ≥ 5%,
    - Owns 5% or more of any loan secured by the provider,
    - Is an officer or director of the provider organized as a corporation, or
    - Is a partner of the provider organized as a partnership.

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Disclosure: Scenarios for Indian Health Care Providers

- IHS and Tribal 638 facilities typically disclose for:
  - Managing employee - Tribal health director or tribal clinic administrator.
  - No requirement to disclose information about any person with an ownership or control interest because IHS and Tribal 638 programs are not corporations or partnerships.
- Urban Indian Health Programs typically disclose for:
  - Managing employee - Executive director or chief executive officer.
  - Members of Board of Directors.
  - Officers.

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Disclosure: Timing Requirements

42 C.F.R. § 455.104 requires these disclosures from providers to be made at any of the following times:

- When the provider submits the provider application.
- When provider signs the provider agreement.
- When HCA asks the provider during the revalidation of enrollment process under 42 C.F.R. § 455.414.
  - HCA must revalidate the enrollment of every provider at least every 5 years.
- Within 35 days after any change in ownership of the provider.

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Medical - Top 5 Rejections

EOB	Description	Comments	Denial %
24	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in MCO	9%
167	This (these) diagnosis(es) is (are) not covered.	Some diagnosis codes are not payable if billed as the primary diagnosis on a medical claim. Ask mike for the list of codes if you don't have it	5%
181	Procedure code was invalid on the date of service	Code may be an expired or invalid code or it could be that P1 could not figure out how to price the service	4%
22	This care may be covered by another payer per coordination of benefits.	Client has Medicare	4%
18	Exact duplicate claim/service	Duplicate billing	4%

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Dental - Top 5 Rejections

EOB	Description	Comments	Denial %
204	This service/equipment/ drug is not covered under the patient's current benefit plan	Client is not full-scope (e.g. QMB only or Family Planning)	13%
15	The authorization number is missing, invalid, or does not apply to the billed services or provide	Some dental services require prior authorization, refer to dental billing guide	6%
6	The procedure/revenue code is inconsistent with the patient's age.	Crowns and (posterior) root canals not payable for adults	6%
18	Exact duplicate claim/service	Duplicate billing	5%
119	Benefit maximum for this time period or occurrence has been reached	Fluoride limitations, see Dental Billing Guide for complete policy. Fluoride limits are also listed in today's FAQ	4%

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Mental Health - Top 5 Rejections

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing	35%
204	This service/equipment/drug is not covered under the patient's current benefit plan	Servicing taxonomy issues, see EOB 204 in the September TCOW	26%
16 / N288	Missing/incomplete/invalid rendering provider taxonomy	Performing (*rendering, servicing*) taxonomy on claim is not a taxonomy that the performing provider is enrolled with	15%
16/ N290	Missing/incomplete/ invalid rendering provider primary identifier	Performing (*rendering, servicing*) provider not in P1	10%
96 / N30	Patient ineligible for this service	Client is Medicare Only	4%

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SUD - Top 5 Rejections

EOB	Description	Comments	Denial %
204	This service/ equipment/drug is not covered under the patient's current benefit plan	SUD claims were billed with individual servicing NPIs. SUD claims are only billed with facility NPI/taxonomy	21%
16/ N290	Missing/incomplete/ invalid rendering provider primary identifier	SUD claims were billed with individual servicing NPIs. SUD claims are only billed with facility NPI/taxonomy	20%
96 N130	Consult plan benefit documents/guidelines for information about restrictions for this service	Lab codes (CPT 80000 series) are not payable on SUD claims	9%
170/ N95	This provider type/provider specialty may not bill this service	Most of the claims were UAs/lab codes or acupuncture. The only payable codes for SUD are in the SUD guide	9%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	SUD claims have modifier requirements for the SUD codes. I/T/U claims will almost always have HF modifier on the SUD code (refer to SUD billing guide)	4%

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FAQ and Open Discussion

Q. Can a claim be billed without a T1015 line in order to receive the FFS rate if the FFS rate is greater than the IHS encounter rate?

A. No, if an IHS or Tribal 638 facility elects to receive the IHS encounter rate, they are paid according to the IHS encounter methodology.

- See 1996 IHS-HCFA MOU: "If the facility chooses to be designated as an IHS provider for purposes of the payment policy and this MOA, it will receive the IHS payment rate for services to AI/ANs; however, at state option, the IHS payment rate may not be available for services to non-Indian Medicaid beneficiaries as the state will not receive 100-percent FMAP for services to non-Indians."
- See Medicaid State Plan http://www.hca.wa.gov/assets/program/SP-Att-4-Payment-for-Services.pdf (p. 217) "Services provided by facilities of the Indian Health Service (IHS) which includes…638 [clinics], are paid at the [IHS] rate……"

Note: IHS/638 clinics – pharmaceuticals/drugs are outside the encounter rate and may be reimbursed as FFS (if the drug is on the same claim as the encounter it will get bundled into the encounter)

FAQ and Open Discussion

Q. Face-to-face services are encounter eligible; lab services are not face-to-face. Can we bill the lab codes on a separate claim from the encounter?

A. No, per the State Plan "Included in the outpatient per visit rate are laboratory and x-ray services provided on-site."

If a face-to-face claim is billed and a FFS lab claim is billed – P1 will currently allow payment on both claims. I have been referring to this as the Overpayment Loophole and hope that P1 is corrected in the future so that we can avoid audit risk

FAQ and Open Discussion

Q. Are we required to use Place of Service (POS) 07 (638 facility) or 05 (IHS facility) on all our claims for the encounter rate?

A. No, follow regular coding guidelines - the POS on a claim should be the POS where the service was rendered.

- Office Visits are payable in office setting (POS 11) – note that these could also be coded 07 or 05
- Home Visits (e.g. Home E&Ms) are payable in a home setting (POS 12)
- School visits (e.g. dental screenings) are payable in a school setting (POS 03)

The State Plan for the IHS encounter rate does not restrict the POS for services payable at the IHS encounter rate

FAQ and Open Discussion

Q. What do I do if I have a paid claim that will not come up in the P1 screens to reprocess (*resubmit denied/voided claim* or *adjustment/void*)?

A. Contact Mike at the Tribal Affairs Office.

There are a few reasons why you would not be able to reprocess a claim in P1:

1. The claim may have already been reprocessed, which would result in a new final TCN. If a TCN needs to be re-reprocessed, you need to use the final TCN in the claim trail.

   For example, TCN1 was replaced by TCN2, and TCN2 was replaced by TCN3. The final TCN is TCN3 and is the only reprocessable TCN.

   TCN1 → TCN2 → TCN3

2. There may have been a third party insurance recovery on the claim. HCA sometimes receives money from client's insurance after the claim has paid. HCA will apply the funds to the claim and then "lock" it up so that it can't be double-recouped.

FAQ and Open Discussion

Q. When submitting a secondary claim to P1, the insurance carrier code is entered in the claim (Regence is KC01). There are no carrier codes for the MCOs; we enter in the name of the MCO. Would it be more consistent if a carrier code was used instead of billers using any name that they decide? (e.g., *Molina, Molina Healthcare, MHC, Molina MCO*, etc.)

A.HCA did not create carrier codes for the MCOs due to the relative rareness of their use. The carrier codes are also linked to the private commercial insurances that are built into P1. Since the MCOs are not considered private commercial insurance, they did not receive carrier codes.

Q. Are the codes different for MCO insurance and commercial insurance? Can this cause issues?

A. No, it shouldn't cause issues. HCA's Coordination of Benefits staff are aware of the 5 MCOs and how they may be identified on their claims. The HBE health plans offered by the MCO plans do have carrier codes.

FAQ and Open Discussion

Q. How often are dental evaluations reimbursed?

A.

Comprehensive Oral Evaluations (D0150) are covered

- Once every 5 years, or
- As needed for established patients who have a documented significant change in health conditions (see EPA criteria in the Dental Billing Guide)

Periodic Oral Evaluations (D0120) are covered

- Once every 6 months (if after a comprehensive Evaluation 6 months must elapse before the Periodic Oral Evaluation)
- Once every 4 months for clients of the Developmental Disabilities Administration (DDA)

Limited Oral Evaluations (D0140) are covered

- As necessary, only when the provider rendering the Limited Oral Evaluation is not providing routine scheduled dental services on the same day

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FAQ and Open Discussion

Q. The National Plan & Provider Enumerations System (NPPES) website lists taxonomy codes when a provider is looked up. Is the taxonomy that is listed on NPPES the taxonomy that we should bill when billing claims to P1?

A. Not always.

- The NPPES was not intended to capture taxonomy information; the taxonomy information may not be accurate
- The NPPES website's primary purpose is to validate a NPI with a provider entity; NPPES is a valid primary source for this purpose
- What we have heard from CMS is that the rest of the information on this site supplied by the provider is not validated by NPPES (demographics, taxonomy, licensure, etc). We use other sites as primary source for validation (such as DOH to validate license numbers)

FAQ and Open Discussion

Q. During previous webinar Mike outlined criteria to determine if a service qualifies for the IHS encounter rate (*Does xxxxx qualify for the IHS encounter rate* is attached to today's webinar). Webinar slides mentioned that services may be rendered off-site except for SUD services. WAC 388 877B 0300 indicates that services may be rendered off-site. Is SUD allowed outside of the approved facility at satellite locations?

A. Stay tuned, pending guidance from DSHS partners

FAQ and Open Discussion

Frequency allowance for Fluoride application (D1206 D1208) had minor changes on November 1, 2016.

Previously fluoride was allowed three times per year for clients age 0-6. Sometimes the data would show fluoride on 01/01/20xx, 01/02/20xx and 01/03/20xx - all fluorides for the year were used up within days.

Update on November 11th helps to avoid this issue and is best illustrated in the following table

Age	Fluoride frequency	Special notes for billing?
0 thru 6	One per 4 months	No
7 thru 18	One per 6 months	No
19 and older	One per 12 months	No
Ortho client (age 0 thru 20)	One per 4 months	Add claim note "client in ortho treatment" & contact mike if claim rejects with EOB 119
DDA client (all ages)	One per 4 months	No, P1 *knows* if the client is a DDA client
Client living in Alternative Living Facility (all ages)	One per 4 months	Place of service should be ALF (13 or 14). Contact mike if claim rejects with EOB 119

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FAQ and Open Discussion

Q. We have an outside vision company coming into the health clinic to provide services to our AI/AN community. Can we use Place of Service (POS) 07? Do these outside providers have to contract with the MCOs?

A. POS – follow regular coding guidelines. The IHS rate is not dependent upon the POS code on the claim

05 – facility or location owned and operated by IHS for AI/AN clients who do not require hospitalization

07 – facility or location owned and operated by a Tribe or Tribal organization under a 638 agreement for AI/AN clients who do not require hospitalization

Is a contract with the MCOs required if the client is enrolled with an MCO? It depends on who the **pay-to** provider is on the claim.

- Vision company – contract with MCO is required (payment is the MCO rate, not the IHS encounter rate
- Tribe – contract with the MCO is not required. The vision care providers will be subcontracted with the Tribe to provide services on behalf of the Tribe (payment is at the IHS encounter rate)
  - The Tribe should check with IHS provider rules as well.

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FAQ and Open Discussion

Q. An incarcerated community member was admitted to the hospital recently. The client is Medicaid eligible but since she is in jail her coverage terminated in P1. Can the client's Medicaid be reinstated? Previous billing webinar used the "where does the client rest their head at night?" question to determine if the client is currently incarcerated or released. Does this still apply while client is at an inpatient hospital and there is a guard on duty?

A. The "where you lay your head" rule still applies. The fact that there is a guard on duty while the client is in a hospital does not impact our ability to claim federal match. An In-Person Assister or Navigator should be able to re-active the client's coverage.

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FAQ and Open Discussion

Q. Does P1 pay for annual preventive cancer screens? G0101 with diagnosis Z00.00 was rejected?

A. Refer to page 133 of the Physician-Related Services/Health Care Professional Services Billing Guide at http://www.hca.wa.gov/assets/billers-and-providers/physician-related-services-bi-20161001.pdf

There are no diagnosis requirements established for these services; however, Z00.00 is in the list of generally not payable diagnoses

HCPCS Code	Short Description	Limitations
G0101	CA screen; pelvic/breast exam	Females only; As indicated by nationally recognized clinical guidelines. [Use for Pap smear professional services]
G0103	PSA screening	Once every 12 months when ordered for clients age 50 and older
G0104	CA screen; flexi sigmoidscope	Clients age 50 and older who are not at high risk Once every 48 months
G0105*	Colorectal scrn; hi risk ind	Clients at high risk for colorectal cancer One every 24 months
82270	Occult blood, feces	N/A
81519	Genomic testing (breast)	Requires EPA (see EPA #87001386).
G0121*	Colon CA scrn; not high risk ind	Clients age 50 and older Once every 10 years
G0122	Colon CA scrn; barium enema	Clients age 50 and older Once every 5 years
S8032	Low-dose computed tomography for lung cancer screening	Requires EPA (see EPA #870001362). If the client does not meet EPA criteria, PA is required (see Prior Authorization)

*Note: Per Medicare guidelines, the agency's payment is reduced when billed with modifier 53 (discontinued procedure).

FAQ and Open Discussion

Q. How can I tell if HCA has a diagnosis requirement for a medical service?

A. Refer to the Physician Related Services/Health Care Professional Services Billing Guide at http://www.hca.wa.gov/assets/billers-and-providers/physician-related-services-bi-20161001.pdf

Find the subsection that addresses the service. If there is a diagnosis requirement, it will either be listed in the section or there will be a pointer to the *Approved Diagnosis Codes by Program* web page at http://www.hca.wa.gov/assets/billers-and-providers/physician_related_professional.pdf

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FAQ and Open Discussion

Q. There are birth control diagnoses (e.g., Z300.11) listed in the Generally Not Payable list of diagnoses. What code should we use instead?

A. The list of Generally Not Payable diagnosis codes does include some birth control diagnoses, and these are not payable on EPSDT (well child) claims. They are payable on regular Medical claims.

- Mike will try to recreate the list of generally not payable diagnoses for Medical only and omit EPSDT, stay tuned for a final **Medical** list

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FAQ and Open Discussion

Q. Did the CPT code for SUD individual therapy change? We were told to bill with 96154

A. The codes in SUD did change on 07/01/2015

SUD prior to 06/30/2015

96154-HF	[redacted]	Health and behavior intervention, family with patient present	Individual Therapy with Client Present
96155-HF	[redacted]	Health and behavior intervention, family without patient present	Individual Therapy Without Client Present
96153-HF	[redacted]	Health and behavior intervention, family without patient present	Group Therapy

SUD after 07/01/2015

H0004-HF	[redacted]	Behavioral health counseling and therapy, per 15 minutes	Individual Therapy Without Family Present
96153-HF	[redacted]	Health and behavior intervention, group (2 or more patients)	Group Therapy
96154-HF	[redacted]	Health and behavior intervention, family with patient present	Individual Family Therapy With Enrollee Present
96155-HF	[redacted]	Health and behavior intervention, family without the patient present	Individual Family Therapy Without Enrollee Present

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FAQ and Open Discussion

Q. How are we supposed to bill P1 for clients who have Medicare Advantage (Part C)?

A. Bill like a medicare cross-over. Don't bill Part C payments as if they are private insurance, the claims will reject to bill Medicare (EOB 22). Contact Mike for cheat sheets on billing medicare cross-over claims directly in P1

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Pended Questions

Q. During the June webinar, you listed out diagnosis codes that would waive the once-per-two-year vision exam limit. Why are only some of the diabetes diagnoses listed? Type II (E11.xx) is the most common category of diabetes within the AI/AN population, and I believe that the standard of care is that diabetic patients, regardless of the cause of the DM have an annual eye exam. This shouldn't be determined if the symptoms are in control or not because retinopathy can be found during an annual eye exam even with a patient that has very good control over their glucose. If it wasn't necessary the requirement would not have been included on so many quality measure requirements for DM patients. I also routinely see chart notes of patients who were non-compliant until the beginning of retinopathy.

A. Medical consultants are reviewing the codes & policy. Stay tuned.

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Pended Questions

Q. Can nurse only visits (e.g., vaccinations) be billed? How are these billed if the nurses do not get enrolled in P1?

A. Claims are billed under their supervisor's NPI.

Q. Are the services of an RN/LPN eligible for the encounter rate?

A. **IHS/638 clinics** - Nurses (RN/LPN) are not included in the list of IHS-encounter-eligible providers. Services of an RN (and any other provider who is not in the list of encounter-eligible providers) are not encounter eligible, even if under the supervision of an encounter-eligible provider (e.g. the performing NPI on the claim isn't what truly matters).

FQHC – Nurses (RN/LPN) are included in the list of providers who may provide services at an FQHC. (claims are not billed with the RN/LPN's performing NPI).

Q. What if the RN/LPN does not have a supervising provider? Nurse only visits do occur and are generally not signed off on by a provider for things such as immunizations or pregnancy tests, etc.

A. Pending research, stay tuned. All nurses have a supervising provider – the physician or the clinic. Nurses are not licensed independently (and have no NPI).

Pended Questions

Questions/comments during prior billing webinar regarding 100% FMAP

- Has the state thought about how to identify FMAP claims? What would be the incentive of having agreements with outside referring providers and the outside providers
- You can require the referring provider NPI to identify IHS facility referrals
- Will the HCA work with AIHC on developing a boilerplate care coordination agreement?
- We have issues with referrals and outside specialty providers accepting Medicaid or at their limit. It would be nice if FMAP would help with opening doors to specialty clinics. Especially with the tribes in rural areas. Can we look into increasing payment amounts for certain areas?
- Hopefully the 1115 waiver will provide a way to work this out, so outside providers can access the 100% FMAP
- When will Tribes be able to meet with the state to work on FMAP coordination? Tribes received clear instructions to work with the state to implement FMAP
- Is there a template for the FMAP Coordination of Care agreement that we can access?

Stay tuned, feel free to share comments/suggestions/ideas.

Pended Questions

Q. For next work group meeting, can we discuss the face to face requirement for encounters and how it relates to telemedicine.

A. Refer to May 16, 2015 TBWG/TCOW for more background on FFS (code) billing. Does telemedicine meet the HCA definition of *face to face?* Stay tuned.

Pended Questions

Q. Two MCO's have optical claims going to a different entity. The two subcontractors will not accept our claims or provide required subcontractor info to be able to bill. Therefore, optical claims to those two MCOs are useless.

A. Refer to slides on this attachment - *CMS Disclosure Rule 42 C.F.R. §455.104*

Pended Questions

Q: Can ARNP (not psych) providing 'mindfulness' session bill encounter rate? See UW webpage on mindfulness-based stress reduction:

http://www.uwhealth.org/alternative-medicine/mindfulness-based-stress-reduction/11454

A. We are working on a full response. Below is a draft response:

No. The ARNP would need to be a Psych ARNP (enrolled in P1) and the client would need to be diagnosed by a licensed Mental Health Professional who indicated this treatment modality in the client's MH treatment plan.

Stay tuned

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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.