Washington State Health Care Authority

Tribal Compliance & Operations Work Group

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January 11, 2017

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Agenda

- Tribal Oversight for Program Integrity and Compliance
- CMS issues new guidance on services provided outside of the clinic facility
- Non-Native SUD FMAP rate update
- ProviderOne updates: Payment issue for non-Native clients, multiple encounters
- CY 2014 - 2016 payment percentages
- CY 2016 Top 5 rejections
- FAQ and Open Discussion
- Attachments – 100% FMAP expansion guidance from CMS, Generally not payable ICD9/10 diagnosis list, Draft IHS encounter payment table, Draft Vision Care and Washington Apple Health

Tribal Oversight for Program Integrity and Compliance

- The Tribal Affairs Office has received requests for assistance with ensuring compliance with issues such as charting, documentation, billing, personnel (licensing), etc
- HCAs Tribal Oversight for Program Integrity and Compliance (TOPIC) team will work with the Tribes to conduct mock audits to identify and correct any possible issues that may be audit findings if an audit was being conducted
- Tools and Resources will be provided to help Tribes self-audit to ensure compliance
- Let us know what areas you feel you would want the most help with

CMS Issues New Guidance on Services Provided Outside of the Clinic Facility

- On December 15th, CMS had an ALL TRIBES' CALL regarding reimbursement for services provided outside of an IHS/Tribal facility

  If the Tribal facility is enrolled in the state Medicaid program as a provider of "clinic services" under 42 CFR 440.90, the Tribal facility may not bill … at the facility rate for services that are provided outside of the facility.

- On December 22nd, CMS had a Targeted State Call regarding reimbursement for services provided outside of an IHS/638 facility

  CMS could support payment of the outpatient IHS/AIR for FQHC services under an APM. To effectuate this change, CMS is encouraging Tribal Health programs to work with state Medicaid agencies to have their provider designation changed from clinic to FQHC. No other steps need be taken by the Tribal Health program. The state Medicaid agency will be required to submit a state plan amendment to designate payment for Tribal FQHC services at the IHS AIR as an APM. States will be given a grace period to consult with Tribes and to modify the state plan.

STAY TUNED, more information will be presented on future webinar

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Non-Native SUD FMAP Rate Update

- Substance Use Disorder claims at IHS/638 facilities for non-Native clients pay the federal portion of the Federal Medical Assistance Percentages (FMAP) rate with the intergovernmental transfer (IGT) process for the local matching funds
- The following FMAP changes are in effect beginning 01/01/2017

  NOTE: FMAP rate is based on the date the claim is paid, not the date of service
- The next anticipated FMAP change is scheduled for January, 2018
- The following slide lists the actual IGT amounts

Benefit Package/RAC	FMAP prior to 01/01/2017	FMAP as of 01/01/2017
ABP / 1201	100%	95%
Presumptive SSI / 1217	85%	86%
Classic, MAGI / all others	50%	50%

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Non-Native SUD FMAP Rate Update

Continued from previous slide

Date of Service	IHS rate	Client RAC	FMAP	P1 payment	IGT match to be sent to DSHS
CY 2015	$350	1201 (ABP)	95%	$332.50	$17.50
		1217 (SSI)	86%	$301.00	$49.00
		All others	50%	$175.00	$175.00
CY 2016	$368	1201 (ABP)	95%	$349.60	$18.40
		1217 (SSI)	86%	$316.48	$51.52
		All others	50%	$184.00	$184.00
CY 2017	TBD	1201 (ABP)	95%	See CY 2016 until rate is announced	
		1217 (SSI)	86%		
		All others	50%		

FMAP and IGT rates are current as of 01/01/2017 with no planned changes until 01/01/2018

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ProviderOne Updates – Non-Native Claims Paying Incorrect Rate

- Medical, Dental, and Mental Health claims for non-Native Medicaid FFS clients are eligible for the full IHS encounter rate
- Medical and Mental Health claims for non-Native clients are incorrectly paying at the non-Native SUD FMAP rates
- Issue noticed 01/06/2017
- No ETA on correction yet

ProviderOne Updates – 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

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CY 2014 – 2016 Payment Percentages

P1 claims payment percentages for 2014-2016

	Payment Percentages in P1		
	CY 2014	CY 2015	CY 2016
Medical	76%	81%	85%
Dental	83%	85%	86%
Mental Health	86%	89%	93%
SUD	84%	91%	94%

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CY 2016 Medical - Top 5 Rejections

EOB	Description	Comments	Reject %
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Claim was missing the AI/AN (UA) or non-AI/AN (SE) modifier	15%
24	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in MCO	11%
18	Exact duplicate claim/service	Duplicate billing	10%
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	4%
22	This care may be covered by another payer per coordination of benefits.	Client has Medicare	3%

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CY 2016 Dental - Top 5 Rejections

EOB	Description	Comments	Reject %
18	Exact duplicate claim/service	Duplicate billing	11%
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)	8%
6	The procedure/revenue code is inconsistent with the patient's age.	Crowns and (posterior) root canals not payable for adults. Oral Hygiene instructions (D1330) only for age 0-8	6%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	This is a best-fit EOB. Claim was missing the EPA AI/AN client 870001305 Non-AI/AN client 870001306	4%
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	4%

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CY 2016 Mental Health - Top 5 Rejections

EOB	Description	Comments	Reject %
18	Exact duplicate claim/service	Duplicate billing	34%
204	This service/equipment/drug is not covered under the patient's current benefit plan	Servicing taxonomy issues, see EOB 204 in the September, 2016 TCOW	10%
16 / N255	Missing/ incomplete/ invalid billing provider taxonomy	Mental health claims require 2083P0901x (I/T) or 261QF0400x(FQHC) group taxonomy	9%
119 / M80	Not covered when performed during the same session/date as a previously processed service for the patient	Similar to duplicate, usually involves different levels of mental health services on same day	7%
16/ N290	Missing/incomplete/ invalid rendering provider primary identifier	Performing (*rendering, servicing*) provider not in P1	3%

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CY 2016 SUD - Top 5 Rejections

EOB	Description	Comments	Denial %
18	Exact duplicate claim/service	Duplicate billing	46%
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	7%
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	6%
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%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	I/T claims were missing the AI/AN (HF) or non-AI/AN (HX, HB, SE) modifiers	2%

FAQ and Open Discussion

Q. Can you provide a cheat sheet for HCA's Vision Care Program?

A. Please see draft cheat sheet attached to today's webinar. Feedback is welcome

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FAQ and Open Discussion

Q. Beginning in January, 2017 clients with private insurance may be enrolled with MCO coverage. Can you update the IHS encounter payment reference sheet?

A. Please see draft cheat sheet attached to today's webinar. Feedback is welcome

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FAQ and Open Discussion

Q. Can you help with provider license updates? I get lost in the P1 screens trying to make corrections

A. P1 has an automatic update for licenses for providers who are licensed in Washington. If provider is licensed out of state there is no automatic update. I have a reference sheet for how to correct expired licenses.

Any other requests for reference sheets?

FAQ and Open Discussion

Q. Are injectables included in an office visit? Is it OK to separate claims and bill for the office visit at the encounter rate and the injectable on a separate claim as FFS

Urban Orgs (FQHC) – No, pharmacy services are included in the encounter rate. The agency performs monthly recoupments for pharmacy services delivered by FQHCs in order to avoid duplicate payments for pharmacy services already included in their encounter rate.

IHS/638 facilities – Yes/no, per the state plan "Pharmaceuticals/drugs are outside the encounter rate and are reimbursed under the fee-for-service system", per the Tribal Billing Instructions – if the drug is administered as part of the practitioner's professional services then it is included in the encounter payment

If the drug is incident to the visit (e.g., lidocaine) then it would be bundled

If the drug is filled at the pharmacy or is not incident to the visit it is not bundled and may be billed on a separate claim at the FFS rate in addition to the encounter

Stay tuned

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 and coded to the highest level of specificity

- Office Visits are payable in an office (POS 11).
- Office visits are payable at a Tribal facility (07) or IHS facility (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

The red font above is from the December, 2016 billing webinar which was prior to the new CMS guidance concerning the 4-walls limitation. Per CMS guidance, Tribal and IHS *clinic services* must be rendered in the facility

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FAQ and Open Discussion

Q. Are SUD services allowed off-site?

A. Stay tuned

Background information – Previous information indicated that SUD services must be rendered within the approved facility per DSHS contracting.

WAC 388 877B 0300(#9) - Services may be rendered off site if criteria apply

The SUD billing guide (p. 25) indicates that the following are the only appropriate places of service for SUD claims

05 – IHS facility

07 – 638 facility

50 – FQHC

55 – Residential Substance Use Disorder Treatment Facility

57 – Non-Residential Substance Use Disorder Treatment Facility

FAQ and Open Discussion

Q. If the client sees a doctor/nurse and then also sees a MHP on the same day are they both encounter eligible?

Urban Orgs (FQHC) – HCA covers up to one of each type of encounter per day

- Medical/maternity/mental health other than services meeting the access to care standards for Behavioral Health Organizations (BHOs)
- Maternity support services/infant case management
- Dental
- Mental health – BHO services
- Substance use disorder
- Mental health – Psychiatrist/psychologist other than access to care standards for BHO

IHS/638 facilities – HCA covers up to one of each type of encounter per day

- Medical
- Dental
- Mental Health
- SUD

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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 diagnosis reference sheet has been updated to include the type of claim. Reference sheet attached to today's webinar. Family Planning (Z300 series) are in the list but the restriction only applies to well-child (EPSDT) visits and the Z300 codes are payable on regular medical claims

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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.

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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.