



Tribal Compliance & Operations Work Group

Mike Longnecker
HCA Tribal Affairs Office
April 12, 2017



Agenda

- 2017 IHS rate is in P1
- ProviderOne updates: NonNative claims paying incorrect rate, Multiple units on T1015
- FAQ and Open Discussion
- Attachments
 - Generally not payable diagnosis codes
 - Obstetrics and encounter billing reference sheet
 - Vision care and Washington Apple Health



2017 IHS rate

- The 2017 All Inclusive Rate (AIR) is \$391.00
- ProviderOne has been updated and claims are paying at the 2017 rate
- Mike will reprocess claims that previously paid at the 2016 rate
- Note: There is an issue with non-Native Medical and mental health claims paying at the non-Native SUD rates (95%), this issue is scheduled for correction on 05/05/2017

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
- P1 correction is scheduled for 05/05/2017. Mike will reprocess incorrectly paid claims after 05/05/2017

ProviderOne update – Multiple Encounters

- Refer to 09/14/2016 TCOW slides for more information
- Some services, like maternity visits and orthodontics qualify for multiple units on the T1015 line.
- P1 was rejecting the encounter lines on these claims and paying FFS only
- P1 was updated in late March, 2017 - claims are being reprocessed



FAQ and Open Discussion

Q. Secondary claims billed to P1 recently started rejecting (EOB 16 N48). Was there a P1 update?

A. P1 has been updated in regards to secondary claims.

If a claim for secondary payment is billed to P1 and the client has commercial insurance (not Medicare B or C):

- If P1 “knows” that the client has commercial insurance the claim should be routed to the coordination of Benefits section for adjudication
 - There is currently a P1 defect for this scenario. Correctly billed claims are being rejected. P1 update scheduled for 05/08/2017
- If P1 does not “know” that the client has commercial insurance the claim may be rejected in P1 until P1 is updated to reflect the client’s commercial insurance coverage. HCA recommends using the [Contact Us](#) link to report the insurance coverage before billing the claims to P1. I have heard that the turnaround time for client/insurance updates is 3-5 days. Please let mike know if you experience any delays in the process
- How to tell if P1 “knows” if a client has private insurance can be determined by a Client Benefit Inquiry in P1 – if there is commercial insurance in the client’s “Coordination of Benefits Information” screen then P1 “knows”



FAQ and Open Discussion

Q. I have a claim for SUD crisis services (H2011) that is rejected in P1 as not covered

A. Crisis Services, is a payable mental health service. However, if the claim is billed as SUD the service *might* be covered. Stay tuned, pending guidance from DSHS

FAQ and Open Discussion

Q. Vivitrol (Naltrexone for Opioid dependence) used to require Prior Authorization. Does Vivitrol still require prior authorization?

A. No, effective 01/09/2017 Vivitrol (HCPCS J2315) does not require prior authorization for ProviderOne claims. In addition, the Managed Care Organizations (MCOs) also removed the Prior Authorization requirements effective March 6, 2017



FAQ and Open Discussion

Q. Can we start sending the IGT amounts based on the 2017 rate even though P1 has not started paying at the 2017 rate?

A. Start using the 2017 rate. P1 was updated on March 23rd



FAQ and Open Discussion

Q. Why did my claim deny with EOB 109? *Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.*

A. This is a “Crime Victims” claim (based on diagnosis). Crime Victim claims will pay in P1 and then HCA will try to recover from the Crime Victims fund (*pay and chase*). There is one exception to the *pay and chase* rule for Crime Victims - claims for child rape (Z0441, Z0442) **must** be billed to Crime Victims. P1 will only pay if there is a Crime Victims denial attached to the claim. Crime Victims mailing address is

State of WA, Dept of Labor & Industries
Crime Victims Compensation Program
PO Box 44520
Olympia, WA 98504-4520



FAQ and Open Discussion

Q. Why did my claim for Pancreatitis (K8590, *Acute pancreatitis without necrosis or infection, unspecified*) reject in P1 as nonpayable? (EOB 167 - *This (these) diagnosis(es) is (are) not covered.*

A. Refer to the list of Generally not payable ICD9 and ICD10 codes attached to this webinar. K8590 is in the list.

HCA clinical staff added K8590 to the list of nonpayable codes due to the word “unspecified” in the diagnosis description



FAQ and Open Discussion

Q. Why did P1 reject the encounter payment for a CNP client with EOB N30 (*Patient ineligible for this service*)?

A. CNP clients with RAC 1211 are *State funded*, **non-citizen** clients. Non-citizen clients are not eligible for an encounter payment.

Mike has noticed that some clients who are RAC 1211 later get assigned a different CNP RAC that **is** eligible for the encounter rate. When this happens I can tell that the RAC 1211 was assigned due to failure to verify social security number when the client signed up for benefits. If the client corrects the social security number they are assigned a different CNP RAC that is eligible for encounter payments. The prior RAC 1211 dates can be corrected in P1 to reflect citizenship but only if the claim is forwarded to mike



FAQ and Open Discussion

Exemption Certificate Number (ECN)

A number the Marketplace provides when you qualify for a health insurance exemption. When you fill out an exemption application, the Marketplace will review it and determine if you qualify. The Marketplace will mail you a notice of the exemption eligibility result. If you qualify for an exemption, the notice will include your unique identifier, called the exemption certificate number (ECN). You'll need your ECN when you file your federal taxes for the year you don't have coverage. Each member of your household who qualifies for the exemption will get their own ECN. You'll use the numbers to complete [IRS Form 8965—Health Coverage Exemptions \(PDF\)](#).

Q. Where can a client find their Exemption Certificate Number (ECN)?

A. The Health Benefit Exchange is the agency that issues ECS. If a HealthPlanFinder call center employee says otherwise, please ask for a supervisor



FAQ and Open Discussion

Q. Do Satellite or branch locations need to be added to our Core Provider Agreement or files in P1?

A. No, there is no such requirement (in WAC, CFR or HCA policy) that requires a billing provider to add satellite/branch locations to their domain in P1. The only exception would be Durable Medical Equipment (DME). DME providers must enroll with Medicare and Medicare requires each DME location to be separately enrolled.



FAQ and Open Discussion

Q. Can we bill a Medicare secondary claim to P1 if we have the Medicare EOB but not the actual payment yet?

A. yes, the EOB is sufficient. There is no need to wait for the actual payment



FAQ and Open Discussion

Q. How do we bill for global OB care at the encounter rate?

A. This is an example of when it is acceptable to bill multiple units on the T1015 line due to the fundamental difference between the concept of global fee-for-service billing (which may cover services that occur days, weeks, even months after the date of service on the claim) and encounter billing (which only covers services rendered within a 24 hour period).

OB billing cheat sheet attached to today's webinar



FAQ and Open Discussion

Q. How long do we have to retain the billing information in our office?

A. 6 years.

Refer to WAC [182 502 0020](#) for record retention requirements. Partial excerpt from WAC below

Providers must:

(1) Maintain documentation in the client's medical or health care records to verify the level, type and extent of services provided to each client to fully justify the service and billing, including, but not limited to:

- (a) Client's name and date of birth;
- (b) Dates of services;
- (c) Name and title of person performing the service;
- (d) Chief complaint or reason for each visit;
- (q) Specific claims and payments received for services;

(5) Make charts and records available to the medicaid agency, its contractors or designees, and the United States Department of Health and Human Services (DHHS) upon request, for six years from the date of service or longer if required specifically by federal or state law or regulation;



FAQ and Open Discussion

Q. CMS requires that the physical address for the site of service be indicated on the claim. Does HCA require that the physical address for the site of service be on the claim?

A. The CMS requirement may be found here

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf>

Refer to “item 32” guidance.

This information is relevant if the services are provided off-site. According to HCA audit staff, the address should be on the claim (paper claim equivalent is box 32, this is also part of a HIPAA transaction)

FAQ and Open Discussion

Q. Can you remind us of the guidelines for telemedicine? Does it qualify for an encounter?

A. Telemedicine is currently not eligible for an IHS/FQHC encounter because it does not appear to meet the definition of face-to-face.

What services may be rendered under telemedicine in fee for service?

From the Physician billing guide - *The agency reimburses medically necessary covered services through telemedicine when the service is provided by a Washington Apple Health provider and is within their scope of practice*

- Originating site (where client sits) – bills a facility fee (Q3014)
- Distant site (where provider sits) – bills the actual service with modifier GT or 95
 - The Physician billing guide indicates to use Place of Service code 02 for telehealth (distant site) but P1 is not ready for POS 2 yet

Mike will try to get an HCA approved code-set for the services payable at the distant site



FAQ and Open Discussion

Q. Why did P1 reject my claim for timely, there is a timely TCN in the claim notes

A. Try to avoid claim notes as much as possible, especially for proving timely. Try to use the “claim trail” instead of claim notes (e.g., always reprocess a claim that needs corrections rather than submitting a brand new claim). There are situations where a claim note may have to be used to prove timely and yet P1 is auto-rejecting the claims (due to automation), when this happens the only way to resolve the issue is to send mike the TCN(s) for special handling



FAQ and Open Discussion

Q. Why doesn't Medicare pay the All Inclusive Rate on Medicare claims?

A. Stay tuned. Here is the 2017 rate announcement -

<https://www.gpo.gov/fdsys/pkg/FR-2017-01-18/pdf/2017-01075.pdf>

The *Medicare Rate* for 2017 is \$349.00 does that mean that the states need to pay the encounters at \$349.00 for Medicare dual eligible or does it mean that Medicare should pay \$349.00 for Part B service or does it mean something else?



FAQ and Open Discussion

Q. If we provide a service that should not be paid should we send a claim? Scenario I have is for SUD services and client received a group therapy in the morning and an individual therapy in the afternoon

A. I have a mantra “bill for what you did” but in this instance if you bill for what you did you would risk overpayment due to the overpayment loophole that exists in ProviderOne.

Stay tuned for more information

04/12 – UA's (80307) are paying in P1 (shouldn't be payable)



FAQ and Open Discussion

Q. Does HCA cover dental “Scoop and fill”/Interim restorations?

A. Interim therapeutic restoration (“Scoop and fill”), ADA code D2941 was added to the ABCD dental program as a covered service beginning April 1, 2016.

The ABCD dental program is a specialized program for ABCD-trained dentists who serve younger clients (age 0-5). Most services in the ABCD program are the same as the regular dental program with two exceptions. ABCD-trained dentists may also render these services for young clients and receive the encounter rate

- Family Oral Health Education (D9999) – helps parents (and kids) learn how to take care of little kids’ teeth
- Scoop and Fill (interim restoration) (D2941) – less invasive restoration on primary teeth

For more information and EPA criteria please refer to the ABCD dental billing guide at <http://www.hca.wa.gov/assets/billers-and-providers/abcd-dental-bi-20170101.pdf>



FAQ and Open Discussion

Q. A few months ago mike shared a cheat sheet with Medicare denial codes and the resulting disposition in P1. I had a claim that medicare rejected with EOB #49, which was in the list of EOBs that would allow P1 to pay primary.

A. The P1 techs tried to code P1 to pay primary for the dual eligible clients if the service is **never** covered by Medicare (e.g., dental and SUD). Some services are **sometimes** covered by Medicare and P1 needs the denial EOB but, due to P1 automation, the claims are being auto-rejected. The only way to get these claims to pay in P1 is to contact mike



FAQ and Open Discussion

Q. Can you update the SUD match rate slide for the 2017 rate?

Date of Service	IHS rate	Client RAC	FMAP	PI 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	\$391	1201 (ABP)	95%	\$371.45	\$19.55
		1217 (SSI)	86%	\$336.26	\$54.74
		All others	50%	\$195.50	\$195.50

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

FAQ and Open Discussion

Q. Dental claims for 'dry socket' are being rejected in P1

A. Dry Socket (a painful condition that occurs after a tooth is extracted and the blood clot gets dislodged) is medically necessary and payable. Claims were billed under palliative care (D9110)

Refer to the [Dental Billing Guide](#) (p.76) for more information on billing for post-surgical complications

Postsurgical complications

The agency covers treatment of post-surgical complications (e.g., dry socket). Documentation supporting the medical necessity of the service must be in the client's record.

CDT® Code	Description	PA?	Requirement	Maximum Allowable Fee
D9930	treatment of complications (post-surgical) – unusual circumstances	N	Tooth designation required	Fee Schedule



FAQ and Open Discussion

Q. Our clinicians are required to actively observe clients taking TB and STD medications due to outbreaks. Is this reimbursable?

A. Directly Observed Treatment (DOT) information can be found at DOH's TB site - <http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/Tuberculosis>

DOT is not covered under HCA's programs, stay tuned for guidance from DOH

Note: *Medication Monitoring*, as a mental health service for clients who meet the DSHS Access to Care standard is a covered service

Pended Questions

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

Pended Questions

Q. During the June 2016 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. 04/12/2017 update - P1 will be updated soon to waive the limit for diabetics. Stay tuned for the final OK/all done



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

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

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?

04/12/2017 – if Tribes convert to TFQHC status (after HCA is ready) then the Tribes may contract with individual providers (and pay the individual providers) and the Tribes may be able to bill for services at the encounter rate.

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



Pended Questions

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

- Refer to TCOW slides from 01/11/2017 for background information
- On 01/18/2017 CMS shared an FAQ regarding the 100% FMAP expansion and indicates that “CMS has no present intention to review claims by Tribal “clinic services” providers for services furnished outside of the “four walls” before January 30, 2021 (Q 13)
- HCA needs time to create an Alternative Payment Methodology, update the state plan and make the necessary P1 changes before any Tribes are able to convert to this new type of FQHC that is required by CMS.
- This new type of FQHC is being labeled Tribal-FQHC (TFQHC)
- Please wait for HCA to provide analysis and make the necessary research before requesting to be a TFQHC
- In the meantime, keep doing what you have been doing before the CMS 4-walls discussion started

Questions?

Send comments and questions to:

Mike Longnecker

michael.longnecker@hca.wa.gov

360-725-1315

Jessie Dean

jessie.dean@hca.wa.gov

360-725-1649

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.

