



Tribal Compliance & Operations Work Group

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Agenda

- TCOW Slides Updated to Indicate if Slide Affects I or T or U
- State Plan Amendment Update of All-Inclusive Rate
- Medication Assisted Treatment Overview
- Electronic Authorization Submissions testing
- MTM and TCOW Schedule for 2018
- P1 Payment Snapshot and Top 5 Rejections
- FAQ and Open Discussion
- Attachments – State Plan Amendment (17-0042), list of EPSDT codes, CY2018 MTM and TCOW registration links

TCOW Slides Updated to Indicate if Slide Affects I or T or U

- Claims billed by IHS and 638 clinics have different billing/policy than claims billed by Urban Indian Organizations
- At the bottom of all TCOW slides, next to the page number there will now be indication of who is impacted by the slides

I/T/U or I/T or U



State Plan Amendment Update of All-Inclusive Rate

- SPA 17-0042 submitted to CMS on 09/28/2017
 - HCA hopes for approval by CMS by 12/27/2017
 - CMS guidance indicates that the earliest effective date is 09/29/2017
- Highlight of changes
 - The list of providers who are “included” in the encounter rate is removed
 - Telemedicine is added as encounter eligible
 - The number of encounters changes from one-of-each-categorical-encounter-per-day to up to 5 encounters per day



State Plan Amendment Update of All-Inclusive Rate

Questions received during October TCOW

Q. Was the list of eligible providers who are eligible to bill the encounter rate increased?

A. The current State Plan is not clear on who is eligible for the encounter rate. This has led to the issues that we are currently having in regards to who is eligible to bill the encounter rate.

Q. A *Medicaid eligible provider*, does that mean a provider that can bill under their own credential? I mean the nurse visits that are supervised by a doctor, we bill under the doctor per incident to rules

A. HCA used the Nevada State Plan as a model, and HCA will research how Nevada implemented similar language and how CMS interprets this language. Stay tuned

Q. Is there any idea when RN's may be able to get the encounter rate? an RN can be an encounter eligible as of 10/01/17?

A. If the state plan is approved, as submitted, then HCA believes that RNs rendering Medicaid covered services would qualify for the encounter rate (claims will still be billed under their supervisor's NPI/credential). Stay tuned



State Plan Amendment Update of All-Inclusive Rate

Questions received during October TCOW

Q. Are dental Hygienists eligible for encounter rate or no?

A. If the state plan is approved, as submitted, then HCA believes that Hygienists rendering Medicaid covered services would qualify for the encounter rate (claims may still be billed under their supervisor's NPI/credential). Stay tuned

Q. Will there be clarification on expected documentation expected for the new providers being accepted and covered CPT / DX under these providers for Tribal encounters?

A. Documentation requirements are based on standards of care, scopes of practice, and program requirements. Please refer to the parent program and your providers' standards of care

Q. Will there be clarification on expected documentation needed for the face to face visit. currently the documentation isn't the same as the list of high level providers. Will there be increased expectation for changes in documentation for the face to face visit?

A. See above for documentation requirements, in addition evidence of face to face services needs to be reflected in the medical records



State Plan Amendment Update of All-Inclusive Rate

Questions received during October TCOW

Q. Does the 5 payable visits apply to urbans?

A. The 5 visits per day applies to IHS and 638 facilities. FQHCs still follow FQHC guidelines

Q. Once the changes are communicated will we be able to bill retro active to 10-1-2017?

A. If the State Plan is approved by CMS, as submitted, the earliest effective date is 09/29/2017



Medication Assisted Treatment

- The [SUD Billing Guide](#) lists Methadone administration (HCPCS H0020) as a payable service and is payable up to once per day
- The [Physician Billing Guide](#) lists the following as payable services
- Office visits related to (*for prescribing*) acamprosate (Campral®), naltrexone (ReVia®), naltrexone (Vivitrol®) or buprenorphine/Naloxone (Suboxone) are payable services
- NOTE: if the client is enrolled in Managed Care the services are billed to the client's Managed Care Plan
- NOTE: the product/drug is reimbursed through the pharmacy/Point of Sale system



Electronic Authorization Submissions

- The ProviderOne screens have always had “On-Line Prior Authorization Submission” on the home page but ProviderOne has not been ready to accept on-line authorization submissions
- The On-Line Prior Authorization Submission will be available soon, HCA is currently testing
- If you would like to help with testing the on-line Prior Authorization process please contact mike (testing will be with real authorization requests)

MTM and TCOW Schedule for 2018

- Attached to today's webinar is a list of the regularly scheduled meetings for HCA and the webinar Registration links if you would like to get them all on your calendar all at once
 - Monthly Tribal Meeting (first Wednesdays)
 - Tribal Compliance and Operations Workgroup (second Wednesdays)

ITU Payment Snapshot

Payment percentages for I/T/U claims processed in the last quarter.

Category	ITU Payment percentage	Global payment percentage
Medical	78%	81%
Dental	82%	93%
Mental Health	82%	81%
SUD	92%	88%

Medical – Top 5 Rejections

EOB	Description	Comments
204 ITU	This service/equipment/ drug is not covered under the patient's current benefit plan	Client does not have full-scope coverage, either family planning only or Medicare-only. Sometimes we will also get this rejection if the rendering taxonomy on the claim is not one that is used by P1 (eg 390200000x or 101YA0400x)
18 ITU	Exact duplicate claim/service	Duplicate billing
16/ ITU	Missing/incomplete/invalid rendering provider taxonomy	Performing (<i>rendering, servicing</i>) taxonomy on claim is not a taxonomy that the performing provider is enrolled with
16/ N290 ITU	Missing/incomplete/ invalid rendering provider primary identifier	Performing (<i>rendering, servicing</i>) provider not in P1 or is a provider that is enrolled in P1 due to Social Services or Dept of Corrections claims but is not payable on HCA claims
24 ITU	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in MCO

Dental – Top 5 Rejections

EOB	Description	Comments
18 ITU	Exact duplicate claim/service	Duplicate billing
204 ITU	This service/equipment/ drug is not covered under the patient's current benefit plan	Client does not have full scope coverage. Most claims were Medicare-only clients
26 ITU	Expenses incurred prior to coverage.	Client is not eligible on this date (could be before or after coverage ends)
16/ N290 ITU	Missing/incomplete/ invalid rendering provider primary identifier	Performing (<i>rendering, servicing</i>) provider not in P1
119 ITU	Benefit maximum for this time period or occurrence has been reached	Fluoride limitations, see Dental Billing Guide for complete policy. At a high level Age 0–6 – once every 4 months Age 7–18 – once every 6 months Age 19+ – once every 12 months

Mental Health – Top 5 Rejections

EOB	Description	Comments
204 ITU	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) we will also get this rejection if the rendering taxonomy on the claim is not one that is used by P1 (eg 101YA0400x)
16/ N290 ITU	Missing/incomplete/ invalid rendering provider primary identifier	Performing (<i>rendering, servicing</i>) provider not in P1
16/ N288 ITU	Missing/incomplete/invalid rendering provider taxonomy	Performing (<i>rendering, servicing</i>) taxonomy on claim is not a taxonomy that the performing provider is enrolled with
4 I/T	The procedure code is inconsistent with the modifier used or a required modifier is missing	Claim was missing the AI/AN (HE) or non-AI/AN (SE) modifier
24 U	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in MCO or BHO (only affected Urban Org claims)

Substance Use Disorder – Top 5 Rejections

EOB	Description	Comments
204 ITU	This service/equipment/ drug is not covered under the patient's current benefit plan	Client does not have full-scope coverage there were a few large batches of claims that had servicing taxonomy 101YA0400x (SUD is basically always 261QR0405x (except methadone and case management)
16/ N290 ITU	Missing/incomplete/ invalid rendering provider primary identifier	Related to the 204 EOB. Reminder – SUD claims cannot contain individual servicing NPIs, SUD claims are billed with clinic NPIs only
16 / N288 ITU	Missing/incomplete/invalid rendering provider taxonomy	Related to 204 EOB
4 ITU	The procedure code is inconsistent with the modifier used or a required modifier is missing	Refer to SUD billing guide for modifier requirements – modifier on the billing code is almost always HF
181 ITU	Procedure code was invalid on the date of service	EOB on 181 is almost always because the code did not have the HF modifier or the code isn't in the SUD fee schedule

FAQ and Open Discussion

Q. Is acupuncture covered and payable at the encounter rate?

A. Acupuncturists are not Medicaid Enrollable providers (WAC 182 502 0003)

Q. Is acupuncture, when rendered by a Medicaid Enrollable provider, such as a physician, covered and payable at the encounter rate?

A. Acupuncture is not a Medicaid covered service (WAC 182 531 0150)



FAQ and Open Discussion

Q. Are orthotic inserts covered?

A. Stay tuned



FAQ and Open Discussion

Q. If a client has commercial insurance and their insurance denies stating not authorized – is this billable to P1?

A. If the commercial insurance denial EOB is 1, 2, 3, 6, 9, 11, 35, 39, 40, 45, 49, 50, 51, 54, 55, 56, 59, 94, 96, 97, 119, 149, 151, 167, 168, 170, 198, 202, 204, 222, 234, 248, A1, B1 – refer to the October 11, 2017 TCOW slides for guidance on how to bill to P1.

Rest of answer is pending COB section approval: (stay tuned)

For any other denial – submit the claim and the insurance denial EOB along with the claim for review by HCA's Coordination of Benefits section



FAQ and Open Discussion

Q. For SBIRT billing – can a CDP do the full SBIRT counseling and billing?

A. Yes, this is one of the rare instances where the CDP will need to be enrolled in P1. Claims are billed under the clinic NPI with the CDP's NPI and taxonomy. The Claim may be in the Medical, Dental, or Mental Health Category but **never** in the SUD category



FAQ and Open Discussion

Q. We billed a Well Child visit but CPT [00000] was rejected on the claim – is there a list of codes/services that are payable on Well Child visits?

A. Well Child Visits are part of the EPSDT (Early and Periodic Screening, Diagnosis and Treatment) program. The following information is from the EPSDT billing guide

Bill for services such as laboratory work, hearing tests, x-rays, or immunization administration using the appropriate procedure code(s), along with the EPSDT screening (CPT® codes 99381 - 99395) on the same claim.

Note: When physicians and ARNPs identify ... problems ... during an EPSDT screening examination, the provider may treat the client or refer the client to another provider. Physicians and ARNPs are not limited to the procedure codes listed within this billing guide. They may also use the agency's Physician-Related Services/Health Care Professional Services Billing Guide as necessary. Any office, laboratory, radiology, immunization, or other procedure rendered as part of follow-up treatment must be billed on a separate professional claim from the EPSDT screening

Attached to today's webinar are the list of codes that may be billed on the same claim as the Well Child visit



FAQ and Open Discussion

Q. How do we bill for Locum Tenens?

A. Claims for Locums are billed using the Locum's servicing NPI and taxonomy (and modifier Q6) (page 27 of the [Physician Billing Guide](#))

Locums, Temps and permanent physicians are all enrolled the same in P1 as servicing providers

- A Locum is a person who is temporarily filling the place of another (allowed up to 90 contiguous days) (42 USC Chapter 7, subchapter XIX sec 1396a 32(c))
- Temps and permanent physicians do not have the same 90-contiguous-day rule



FAQ and Open Discussion

Q. If we can't receive reimbursement for those in the poky, and county/city jails bring their inmates to IHS so they don't have to pay for the medical/dental care, how do we recoup costs from the city/county jail. If they go to private entities or the hospitals they are allowed to bill the jail entity so shouldn't I/T/U's be able to be reimbursed somehow?

A. The Jail is responsible for the healthcare of their enrollees while the enrollee is in custody and IHS would bill the city/county jail as any other private entity would bill the city/county jail



FAQ and Open Discussion

Q. If a provider sees a patient in Federal jail (BIA) can they bill Medicaid? Or is that considered outside the tribes 4-walls?

A. While the client is incarcerated they do not have Medicaid coverage and the jail is responsible for the health care of their enrollees during the incarceration.

I want to separate the 4-walls question – the jail would be outside the 4-walls unless the Health Clinic has a jail within the facility – if the Health Clinic has a jail within the facility then that would be inside the 4 walls but clients lose coverage during their incarceration anyway



FAQ and Open Discussion

Q. Why did my SUD claim deny the T1015 line with EOB 204? The billing codes paid but not the T1015

A. Currently clients in the Children's Health Insurance Program (CHIP, RAC 1206 1207) are listed in the billing guide as not eligible for an SUD encounter (eligible for other categories, just not SUD)

Stay tuned for more information



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.

