



# Tribal Compliance & Operations Work Group

Mike Longnecker  
HCA Tribal Affairs Office  
February 14, 2018

# Agenda

- SPA 17-0042 was implemented on 01/01/2018
  - Previously, there was a list of providers who are *included in the encounter rate*. Currently *any health care professional authorized to provide services under the State Plan* is eligible for the encounter rate
  - Previously, a client was allowed one-of-each-categorical-encounter-per-day. Currently a client is allowed *up to five (5) outpatient visits per Medicaid beneficiary per calendar day for professional services*
  - Previously an encounter must be rendered face-to-face. Currently an encounter may be rendered via *face-to-face or telemedicine contact*
- Intergovernmental Transfer (IGT) requirements for Non-AI/AN SUD
- Tribal FQHC and the 4-walls issue
- *Claims payment snapshot and Top 5 rejections*
- *FAQ and Open Discussion*
- *Handouts – Does xxxxx qualify for the IHS encounter rate, NCCI and Mental Health, NCCI and SUD, ESPDT codes*



## SPA 17-0042 – Which Providers are Eligible for the Encounter Rate?

- Prior to 01/01/2018 there was a list of providers who are *included in the encounter rate* (page 15 of [previous Tribal Health Billing Guide](#))
- Beginning 01/01/2018 (and retroactive to 09/29/2018) an encounter is payable *for any health care professional authorized to provide services under the State Plan* ([State Plan](#) and page 18 of [current Tribal Health Billing Guide](#))



## SPA 17-0042 – Which Providers are Eligible for the Encounter Rate?

Q. Did P1 change the billing requirements for servicing NPI/taxonomy with the SPA?

A. No, there have been no changes in regards to servicing NPI/Taxonomy codes on claims. For Example, the services of a Registered Nurse (RN) are still billed under the RN's supervisor (stay tuned for reference). The only billing change that happened in regards to the SPA and servicing NPI/taxonomy is whether or not a T1015 is added to the claim



# SPA 17-0042 – Which Providers are Eligible for the Encounter Rate?

Q. Which providers were not in the list of providers who are *included in the encounter rate* but are now encounter eligible because they are *Health Care professionals authorized to provide services under the State Plan*?

A. Following is a brief list of Health Care Professionals authorized to provide services under the State Plan but were not in the previous list of providers who were *included in the encounter rate*

- Medical – Licensed or certified RNs, LPNs, MAs, CNAs, Chiropractors and Dietitians
- Dental – Licensed or Certified Dental Hygienists and Dental Assistants
- Mental Health - No changes, all licensed MHPs were previously eligible
- SUD – No changes, SUD must be rendered by a CDP/CDPT, exception – Methadone dispensing cannot be rendered by a CDP/CDPT and must be rendered by a person licensed/certified to dispense methadone

## SPA 17-0042 – How Many Encounters are Allowed per Day?

- Prior to 01/01/2018 – a client is eligible for one-of-each-categorical-encounter in a 24 hour period
- Beginning 01/01/2018 (and retroactive to 09/29/2017) a client is eligible for *up to five (5) outpatient visits per Medicaid beneficiary per calendar day for professional services.*

# SPA 17-0042 – How Many Encounters are Allowed per Day?

- A client is eligible for up to 5 encounters in a calendar day for medicaid-covered services
- Do not unbundle services that are normally rendered during a single visit for the purpose of generating multiple encounters
- Do not ask clients to make repeat or multiple visits in order to complete what is accomplished in a single visit
- Medicaid is mandated to follow [NCCI](#) (National Correct Coding Initiative) guidelines.
- Attached to today's webinar is an analysis of NCCI requirements and how they impact Mental Health and SUD services



# SPA 17-0042 – How Many Encounters are Allowed per Day?

- If a client will have more than one encounter **on a day** – the separate encounters must be billed on separate claim forms
  - For example, if a client has 2 or more mental health visits on 02/14/2018 – the separately payable encounters must be on separate claim forms
  - If a client has a single visit on many different dates – the visits may be on one claim or on separate claim forms
- When billing for separate encounters, modifiers (e.g., 59 25, XE, XP, XU etc) may be required in order to indicate that the separate encounter was actually a separate encounter
- Separate encounters must be medically necessary, documentation (in the chart notes) must support the billing for separate encounters
- It is now more important than ever to not bill duplicate claims



# SPA 17-0042 - Telemedicine

- Telemedicine is encounter eligible beginning 01/01/2018 (and retroactive to 09/29/2017)
- Telemedicine is outlined in the [Physician Billing Guide](#)
- The *Professional* (telemedicine) service may now be billed with a T1015
- The *facility fee* for telemedicine is not encounter-eligible
- More information on telemedicine is on the following slide



# SPA 17-0042 - Telemedicine

- Telemedicine is HIPAA-compliant, interactive, real-time audio and video telecommunications to deliver covered services that are within a practitioner's scope of practice to a client at a site other than the site where the provider is located
  - The originating site (where the client sits) may bill a facility fee, facility fees are not encounter eligible
  - The distant site (where the provider sits) – bills for the actual service with modifier GT or 95. The place of service code is 02. A T1015 line is added to the telemedicine claim in order to pay at the encounter rate
- HCA does not follow CMS guidelines in regards to the code-set for telemedicine-qualified services. Services that are normally performed face to face but can be rendered without being actually in the same room may be billed as telemedicine for HCA

# SPA Q&A

Q. The IHS Encounter rate has always been referred to as an “outpatient”. Does that mean that only “outpatient” services are payable at the IHS encounter rate?

A. Stay tuned



# SPA Q&A

Q. Can HCA reprocess the claims that were previously billed due to the retroactive approval of the SPA?

A. If the claim was billed without a T1015 – Mike doesn't have a way to change the data on a claim, they will need to be resubmitted and the T1015 added

Q. Can mike pull data on claims that were billed without a T1015

A. Stay tuned

Q. Can mike reprocess the claims that had the T1015 rejected but the rest of the claim paid?

A. Stay tuned, I started to pull data but found that many of the claims really were just dupes anyway



# SPA Q&A

Refer to “SPA Q&A” attached to today’s webinar.

Feedback is appreciated. I would like to convert this into an FAQ that would be readable

# Intergovernmental Transfer (IGT) For Non-AI/AN SUD Encounters

- IGT (InterGovernmental Transfer) is required when SUD services for non-AI/AN clients are billed at IHS/638 clinics
- Page 45-47 of the [current billing guide](#) has the complete information
- Tribe is required to submit the local matching funds to DSHS. DSHS will confirm that the funds were received and issue the local matching funds back to the Tribe within 5-7 days
- The next 2 slides may be useful for adding up the local matching fund requirement before sending to DSHS



# Intergovernmental Transfer (IGT) For Non-AI/AN SUD Encounters

## 2018 SUD FMAP RATES

Tribal IHS/638 Encounter billing for Substance Use Disorders and the Federal Medical Assistance Percentages (FMAP)  
Cheat sheet is for date of service during Calendar Year 2018 and for claims billed during Calendar Year 2018

	AI/AN client		NonNative classic and non-Alternative Benefit Plan (ABP)	nonNative ABP	NonNative SSI
Client RAC	Any CD encounter eligible RAC		Any CD encounter eligible RAC except 1201 or 1217	1201	1217
CD billing code modifier	Refer to the Tribal billing guide (DBHR CD outpatient general fund is <i>usually</i> HF and only HF)				
T1015 modifier	HF		HX	SE	HB

### EXAMPLES

Claim note	SCI=NA		SCI=NN	SCI=NN	SCI=NN
CD group therapy	96153 HF T1015 HF		96153 HF T1015 HX	96153 HF T1015 SE	96153 HF T1015 HB
CD individual therapy	H0004 HF T1015 HF		H0004 HF T1015 HX	H0004 HF T1015 SE	H0004 HF T1015 HB
Federal/State Match percentage (FMAP)	100/0		50/50	94/6	89.60/10.4
How much does the claim pay?	\$427.00		\$213.50	\$401.38	\$382.59
How much IGT is required to be sent to DSHS?	\$0		\$213.50	\$25.62	\$44.41



# Intergovernmental Transfer (IGT) For Non-AI/AN SUD Encounters

Date of service	IHS rate	Client RAC	FMAP	P1 payment	IGT Match to be sent to DSHS
CY2016	\$368	1201 (ABP)	94%	\$345.92	\$22.08
		1217 (SSI)	89.60%	\$329.73	\$38.27
		All others	50%	\$184.00	\$184.00
CY2017	\$391	1201 (ABP)	94%	\$367.54	\$23.46
		1217 (SSI)	89.60%	\$350.34	\$40.66
		All others	50%	\$195.50	\$195.50
CY2018	\$427	1201 (ABP)	94%	\$401.38	\$25.62
		1217 (SSI)	89.60%	\$382.59	\$44.41
		All others	50%	\$213.50	\$213.50

FMAP and IGT rates are current as of 01/01/2018 with no planned changes until 01/01/2019





# Tribal FQHC and the 4-walls issue

Refer to the [01/11/2017](#) and [03/08/2017](#) TCOW slides for background information

Please allow time for HCA to complete the TFQHC analysis.



# ITU Payment Snapshot

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

Category	Payment percentage
Medical	77%
Dental	75%
Mental Health	87%
SUD	87%



# Medical – Top 5 Rejections

EOB	Description	Comments	Reject %
4 I/T 01220	The procedure code is inconsistent with the modifier used or a required modifier is missing	The AI/AN modifier (UA) or the non-AI/AN modifier (SE) was missing. Some of the claims were medicare cross-overs, which are generally fixable in P1	9%
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)	6%
18 ITU	Exact duplicate claim/service	Duplicate billing	6%
24 ITU 02035	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in MCO	6%
16 / N34 02207	Incorrect claim form/format for this service	Claims were billed to P1 secondary to Medicare B or C but were not billed as “crossovers” or the claim is a tertiary claim and P1 does not “know” that the client has commercial insurance	5%

# Dental – Top 5 Rejections

EOB	Description	Comments	Reject %
18 ITU	Exact duplicate claim/service	Duplicate billing	26%
A1 / N149 U 14363	Rebill all applicable services on a single claim	The P1 overpayment/Unbundling issue was closed for the Urban Indian Orgs. All services (per category/visit) need to be on one claim	14%
119 ITU 13425	Benefit maximum for this time period or occurrence has been reached	Adult Prophylaxis (cleaning) limit (once per 12 months)	3%
119 / n640 ITU 14000	Exceeds number/frequency approved/allowed within time period.	Bitewing X-ray limit (4 bitewings per 12 months)	3%
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	3%



# Mental Health – Top 5 Rejections

EOB	Description	Comments	Reject %
4 I/T 01220	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	20
204 ITU 02190	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)	15
16/ N290 ITU 01010	Missing/incomplete/ invalid rendering provider primary identifier	Performing ( <i>rendering, servicing</i> ) provider not in P1	6
18 ITU	Exact duplicate claim/service	Duplicate billing	5
24 U 02035	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in MCO or BHO (only affected Urban Org claims)	4

# Substance Use Disorder – Top 5 Rejections

EOB	Description	Comments	Reject %
18 ITU	Exact duplicate claim/service	Duplicate billing	35%
24 U 01365	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in a BHO (or FIMC)	8%
181 ITU 16030	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	7%
4 ITU 00800	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	6%
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)	5%

# FAQ and Open Discussion

Q. The November billing webinar included a list of codes that are payable on a well child (EPSDT, Early and Periodic Screening, Diagnosis and Treatment) claim. Can you include the code descriptions?

A. Yes, the codes/descriptions that are payable on an EPSDT claim are attached to today's webinar



# FAQ and Open Discussion

Q. Is there a list of tribal employees who are allowed to be exempt for income purposes? Such as Natural Resource employees, Seafood Company employees (processors, marketing, admin). I know fishermen are exempt but I am not sure the ruling for the rest of these types of employees. The fishermen are contractors and not actual employees

A. The eligibility rules can be found at WAC 182-509-0340 for MAGI-based Medicaid and at WAC 182-512-0770 for Classic Medicaid. There is no list of tribal employees, because job descriptions can vary. In general, if the tribal employee is a tribal member whose job is related to the tribe's exercise of its treaty rights, that employee's income from the job is exempt. Likewise, if the tribal member is a fisherman who receives a 1099 from the tribe, the income from that contract work is exempt because it is related to the tribe's exercise of its treaty fishing rights.



# FAQ and Open Discussion

Q. Will Medicaid pay for services that are covered by Medicaid but not Medicare for the duals?

A. I would need more information (codes) in order to answer the question correctly

Generally, if a client is a dual eligible then P1 will reject the claim to bill Medicare

If HCA knows that a service is never covered by Medicare then P1 was setup to allow those claims to be billed directly to P1, below are common scenarios that have been setup in P1 to allow primary payment

- Dental (ADA format), Substance Use Disorder (taxonomy 261QR0405x)
- CPT/HCPCS codes that are coded as not payable by Medicare (e.g., all HCPCS H-codes)
- Some providers are not able to enroll with Medicare (Marriage and Family Therapists, Licensed Counselors, Naturopaths)

If Medicare does not cover the service and the service is not listed above, contact mike for more guidance

## 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)

**CHIP is encounter eligible for SUD beginning 01/01/2018, P1 is being updated soon.**

Stay tuned (not final until claims are reprocessed)



# FAQ and Open Discussion

Q. We have a new employee that we want to have access to P1, do you have a cheat sheet?

A. Check out this webinar <https://www.hca.wa.gov/assets/billers-and-providers/medicaid101medicalworkshop.pdf>

- The first step is finding your System Administrator(s). If you need help, contact mike
- Start on page 14 -- if you can log in as a System Administrator you'll be able to add the new employee
- When you get to page 22 – you get to decide what profile to assign the new employee. Remember to only give them access to what they need to have access to
- Keep following the steps to page 26



# FAQ and Open Discussion

Q. There are 2 SUD scenarios that I'm having difficulty billing

1. A youth is caught with a substance at school. The Youth is not diagnosed with abuse or dependence
2. A person gets a DUI after a one-time lapse in judgement and is court-ordered to have an assessment and is not diagnosed with abuse or dependence

[The SUD billing guide](#) has an approved list of diagnosis codes but they are all abuse or dependence related. If the client is not diagnosed with abuse or dependence can the SUD claim/assessment be billed?

A. Regrettably, if there is no abuse or dependence diagnosis we have no way to bill for it. This also includes clients who are *in remission*

SUD services require that the primary diagnosis code be in the list of approved codes beginning on page 25

# FAQ and Open Discussion

Q. How can I tell when a claim was sent to P1 and whether it was in a batch or not?

A. There is a lot of information that is part of the claim number itself. Example

301834600045292000 = 3 0 18346 0 0045292 000

- First digit (3) – how the claim was billed
  - 1 = paper, 2 = the P1 portal, 3 = HIPAA batch, 4 = P1 did it (usually a mass adjustment)
- Second digit (0) – is claim a medicare cross-over?
  - 0 = no, 2 = probably (not always, “probably”)
- Third-seventh digits (18346)– the *Julian Date* that P1 received the claim
  - 18 = 2018, 346 = day # 346, December 12<sup>th</sup>, December 12, 2018
- 8<sup>th</sup> digit (0) – is the claim an adjustment or void?
  - 0 = no, 1 = yes (take back side/credit side), 2 = yes (payback side/final claim)
- Ninth-fifteenth digits (0045292) – this is just claim number 45,292 that P1 received on that date
- Sixteenth-eighteenth digits (000) – the claim line number (we generally do not look at claim lines, that is why our TCNs always end with 000)



# FAQ and Open Discussion

What Taxonomy code should I put on a claim?

Follow these 3 general guidelines for taxonomy submissions on P1 claims

1. Billing taxonomy – make sure that the billing NPI is enrolled with the taxonomy submitted on the claim, IHS/638 Encounter claims follow this guideline

- Medical – 208D00000x (or 225100000x PT, 225x00000x OT, 235Z00000x ST, 152W00000x vision)
- Dental – 122300000x
- Mental Health – 2083P0901x
- SUD - 261QR405X

2. Servicing taxonomy – make sure that the servicing NPI is enrolled with the taxonomy submitted on the claim.

3. Billing and/or servicing – choose the taxonomy most appropriate for the service, do not think too much on this, just consider that a brain surgeon taxonomy would not be appropriate for a broken toe repair



# 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

## FAQ and Open Discussion

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

A. 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



# Questions?

Send comments and questions to:

Mike Longnecker

[michael.longnecker@hca.wa.gov](mailto:michael.longnecker@hca.wa.gov)

360-725-1315

Jessie Dean

[jessie.dean@hca.wa.gov](mailto: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.

