Washington State Health Care Authority

Tribal Compliance & Operations Work Group

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Quarterly Tribe/MCO Meeting

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HCA Tribal Affairs Office
March 14, 2018

Agenda

- 9:00-10:00 - Tribal Compliance & Operations Workgroup
  - Multiple Encounters on the Same Date
  - *Health Care Professionals* and ProviderOne
- 10:00-12:00 - Tribe and MCO Meeting
  - Open Discussion
  - NPI list and MCO/Tribal Point of Contact lists
  - Paying for Services at the IHS Encounter Rate

  Time permitting:
- SPA FAQ
- FAQ and Open Discussion

Tribal Compliance & Operations Workgroup

Multiple Encounters on the Same Date

- A client is eligible for up to 5 encounters in a calendar day for Medicaid-covered services

- To avoid payment and billing issues, *sometimes* the services must all be on the same claim, the next few slides will outline the billing

NOTE: Due to the nature of the service, SUD group therapy is eligible for a single encounter payment per day, regardless of the number of group therapy sessions the client attends or the number of CDPs involved.

I/T

Multiple Encounters on the Same Date

- Multiple **Medical**, **Dental**, and **Mental Health** encounters that are rendered on the same date of service by the same billing NPI and the **same** rendering provider must be billed on the same claim form

- Include claim modifiers as appropriate to indicate that the encounters are separate and distinct from other encounters on the same date

- Bill all services related to each single encounter visit followed immediately by a T1015 line

- Exception, HCA requires Early and Periodic Screening, Diagnosis and Referral for Treatment (EPSDT) services to be billed on separate claim forms from non-EPSDT services

- Sample claim is for a mental health individual visit and a mental health group+family visit on the same date (assuming that the individual visit was separate and distinct from the group and family visits)

CORRECTLY billed claim for 2 separate and distinct encounters (one individual and then a family + group)

03/14/2018-	90832+HE
03/14/2018-	T1015+HE
03/14/2018-	90853+HE
03/14/2018-	90846+HE
03/14/2018-	T1015+HE

DO NOT BILL LIKE THIS, ProviderOne has no way to know which T1015 goes with which CPT/HCPCS codes

03/14/2018-	90832+HE
03/14/2018-	90853+HE
03/14/2018-	90846+HE
03/14/2018-	T1015+HE
03/14/2018-	T1015+HE

I/T

Multiple Encounters on the Same Date

- Multiple **Medical**, **Dental**, and **Mental Health** encounters that are rendered on the same date of service by the **different** providers may continue to be billed on different claim forms.

- Include claim modifiers as appropriate to indicate that the encounters are separate and distinct from other encounters on the same date

I/T

Multiple Encounters on the Same Date

- Multiple **SUD** encounters that are rendered on the same date of service by the same billing NPI must be billed on the same claim, even if the services are rendered by different servicing providers.

- Bill all services related to each single encounter visit followed immediately by a T1015 line

- NOTE: SUD Group therapy allows one encounter per day, regardless of the number of Group therapy sessions or providers that the client sees.

CORRECTLY billed claim for 2 separate and distinct encounters (one individual and then a group + group)

03/14/2018-	H0004+HF
03/14/2018-	T1015+HF
03/14/2018-	96153+HF
03/14/2018-	96153+HF
03/14/2018-	T1015+HF

DO NOT BILL LIKE THIS, ProviderOne has no way to know which T1015 goes with which CPT/HCPCS codes

03/14/2018-	H0004+HF
03/14/2018-	96153+HF
03/14/2018-	96153+HF
03/14/2018-	T1015+HF
03/14/2018-	T1015+HF

I/T

Multiple Encounters on the Same Date

Billing Guide

update for April

What additional requirements must Tribal health clinics follow when billing?

Bill all services related to the encounter visit on the same claim. This includes any services performed during an encounter-eligible visit that are not encounter eligible. **Example:** Lab services performed during the same visit as an office visit.

For multiple encounters on the same day for the same client, bill all services related to a single encounter visit followed immediately by a T1015 line. This matches each encounter visit to each T1015 line.

- **Multiple encounters (other than outpatient SUD) on the same day by a single provider**. If a provider rendered separate and distinct services (other than outpatient substance use disorder (SUD) services) in more than one encounter on a single date of service, bill on the same claim all services related to the multiple encounter visits rendered by that provider for that client on that date of service. Include claim modifiers as appropriate to indicate that the encounters on the claim are for separate and distinct services performed on the same date (for example, 59, XE, XP, etc.). Exception, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are always billed on separate claim forms from non-EPSDT services

- **Multiple encounters (other than outpatient SUD) on the same day by different providers**. If different providers rendered services (other than outpatient SUD services) in more than one encounter on a single date of service, those services may be billed on different claim forms for the different servicing National Provider identifiers (NPIs), even if the services are for the same client and date of service.

- **Multiple outpatient SUD encounters on the same day**. Bill on the same claim all outpatient SUD services related to multiple encounter visits for the same client on the same date of service, even if the services are rendered by different providers, provided that no more than one outpatient SUD group therapy service may be billed in a calendar day. ProviderOne does not accept individual servicing NPIs on SUD claims.

Resubmitting claims. If a previously submitted claim needs to be corrected and resubmitted, the previously submitted claim must be replaced/reprocessed. Otherwise, the correction/resubmission may be denied.

I/T

Health Care Professionals and ProviderOne

Q. Are the services of a Registered Nurse (RN) payable at the encounter rate?

A. Medicaid does not cover RN services except under limited situations (MSS, FQHC visiting nurse, Health Homes).

However, if an RN provides services to a patient, consults with a supervising physician or ARNP, and the visit is a Medicaid covered service, then the Physician or ARNP may bill ProviderOne

Language in the State Plan:

An Encounter is a face to face or telemedicine contact between any health care professional authorized to provide services under the state plan and a Medicaid beneficiary…

The HCA-covered services did not change on 01/01/2019. The only change was to remove the list of providers who were *included in the encounter rate* so that the encounter rate is paid for *any health care professional authorized to provide services under the state plan.*

To determine if HCA covers the services of a xxxxx (substitute xxxxx with the type of *health care professional*), follow the HCA billing guide that authorizes the service. Mike is more than happy to help with navigating the billing guides.

I/T

Tribe and MCO Meeting

Tribe/MCO Meeting – Open Discussion

Open Discussion

P1 is denying claims as untimely:

- MCO processes the claim and denies it for no prior auth due to provider not being contracted.

- Follow up calls are made to MCO to explain we are a tribal clinic and do not have to be contracted.

- The claim denies for a second time with the initial denial being upheld, and the cycle repeats.

- It is not so much a timing issue as MCOs not complying with federal law.

I/T/U

Tribe/MCO Meeting- NPI list and Points of Contact

- Managed Care plans have asked for a list of providers (billing and servicing) to assist with claims issues – NPI list from P1 claims for CY2015-CY2017 attached to today's webinar

- MCO Contact information and Tribal Contact information lists attached, please let mike know if the lists need to be updated

I/T/U

Tribe/MCO Meeting – Paying for Services at the IHS Encounter Rate

- For MCO-enrolled AI/AN clients, the IHS encounter rate is payable for Medicaid-covered services at a IHS or tribal 638 facility.

  - MCO added benefits are not eligible for the IHS encounter rate.

- Refer to attachment *Does XXXXX qualify for the IHS encounter rate 2018?*

I/T

Tribe/MCO Meeting – Paying for Services at the IHS Encounter Rate

Washington State
Health Care Authority

Payable at the Encounter Rate, regular office visit	
CPT/HCPCS code	Amount paid
99213	42.55
T1015	384.45
TOTAL	**$427.00**

Payable at the Encounter Rate, regular office visit and lab service	
CPT/HCPCS code	Amount paid
99213	42.55
36415	2.14
T1015	382.31
TOTAL	**$427.00**

Payable at the Encounter Rate, regular office visit and surgery	
CPT/HCPCS code	Amount paid
99213	42.55
37200	131.93
T1015	252.52
TOTAL	**$427.00**

Payable at the Encounter Rate, regular office visit and lab but the lab was rejected because *the sky is blue*	
CPT/HCPCS code	Amount paid
99213	42.55
36415	0
T1015	382.21
TOTAL	**$427.00**

Payable at the Encounter Rate, regular office visit and brain surgery	
CPT/HCPCS code	Amount paid
99213	42.55
64610	441.83
T1015	<-57.38>
TOTAL	**$427.00**

Payable at the Encounter Rate, regular office visit and immunization	
CPT/HCPCS code	Amount paid
99213+25	42.55
90471	15.56
T1015	368.89
TOTAL	**$427.00**

I/T

Tribe/MCO Meeting – Paying for Services at the IHS Encounter Rate

Not Payable at the encounter rate, the only paying code is in the list on page 29 of the Tribal billing guide

CPT/HCPCS	Amount paid
99396	0 – (adult preventive visits are not Medicaid covered)
36415	2.14
T1015	0
TOTAL	$2.14

Not Payable at the encounter rate, the only paying code is in the list on page 29 of the Tribal billing guide

CPT/HCPCS code	Amount paid
99213	0 – (NCCI rejected due to the 90471)
90471	$15.56
T1015	0
TOTAL	15.56

Not Payable at the encounter rate, the only paying code is in the list on page 29 of the Tribal billing guide – the original claim should have been replaced

CPT/HCPCS	Amount paid
99213	0 – rejected as a duplicate
71010	22.50
T1015	0
TOTAL	22.50

Not Payable at the encounter rate, the only paying code is in the list on page 29 of the Tribal billing guide

CPT/HCPCS code	Amount paid
71010	22.50
T1015	0
TOTAL	$22.50

Not Payable at the encounter rate, the only paying code is in the list on page 29 of the Tribal billing guide

CPT/HCPCS	Amount paid
99213 on 01/01/2019	42.55
T1015 on 01/02/2019	0 – (there was no paying CPT code on this date of service that is not on the not–encounter eligible list)
TOTAL	42.55

Not Payable at the encounter rate, the only paying code is in the list on page 29 of the Tribal billing guide

CPT/HCPCS	Amount paid
99213+SE	42.55
T1015+SE	0 – (the SE modifier indicates that the client is non–AI/AN)
TOTAL	42.55

I/T

Tribe/MCO Meeting – Paying for Services at the IHS Encounter Rate

Q. Which clients are eligible for the encounter rate?

A. For MCO-enrolled clients – the client must be AI/AN

Q. How does the MCO know if a client is AI/AN?

A. The IHS or Tribal 638 Provider will add a data element (modifier) to the claim to indicate that the client is eligible for federal funding

Category	Variable to indicate that client is AI/AN	Value of variable
Medical	Modifier	UA (SE is non–AI/AN)
Mental Health	Modifier	HE (SE is non–AI/AN
SUD	Claim note	Sci=na (or SCI=NA)

Modifiers could not be used on SUD claims because the modifiers have multiple meanings

I/T

Tribe/MCO Meeting – Paying for Services at the IHS Encounter Rate

Q. Can the encounter rate be paid for non-Medicaid covered services?

A. No, services like preventive visits for adults (CPT 99385-99396) and traditional healing are not a Medicaid-covered benefit even though they may be reimbursed by the Managed Care Organizations

Q. How does HCA determine if a claim is eligible for an encounter?

A. Page 29 of the current Tribal Health Billing Guide – a claim is eligible for the IHS encounter rate if

- The claim is billed by an IHS or Tribal 638 facility;

- The claim is on HCFA (837P) format (or dental in fee-for-service);

- A T1015 line is added for each eligible encounter;

- The appropriate AI/AN modifier (UA for medical services) is added to the claim; and

- The claim has at least one line for a service that is correctly billed and eligible for payment, if the claim that is correctly billed must contain at least one paying code that is not in the list on page 29 of the Tribal Health Billing Guide

I/T

Tribal Compliance & Operations Workgroup
(time permitting)

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, in the interim

- FQHCs are not paid at the FQHC rate for inpatient services
- The 4-walls limitation would also prohibit Tribes from rendering services in an inpatient setting (unless the facility was on the IHS facility list)

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

I/T

SPA Q&A

Q. During the February TCOW we were discussing the nurse visits for clients who have Medicare. Would it be possible in P1 to set a taxonomy code to not need Medicare information when the servicing taxonomy is _____? This currently works for SUDs and Mental Health.

A. Mental health services rendered by a Social Worker, Marriage & Family Therapist and Counselor do not need to be billed to Medicare before billing P1 because those providers are not enrollable with Medicare; those providers are covered in the Medicaid program.

SUD services do not need to be billed to Medicare before billing P1 because SUD services are not covered by Medicare but are covered by Medicaid.

RNs are not part of the Medicaid fee-for-service program. If an RN is working under the supervision of a physician/ARNP and the visit is a medicaid covered service, then the physician or ARNP may bill P1.

NOTE: Medicare may pay for RN services as part of the Medicare benefit but RNs are not part of the Medicaid FFS program, Medicare cross-overs that are billed to P1 are billed according to HCA policy.

I/T

SPA Q&A

Q. Now that telemedicine is encounter eligible, how are telemedicine claims billed?

A. Telemedicine is covered in the Physician-Related Services/Health Care Professional Services Billing Guide (p.88-91)

Originating Site (location of client) – eligible to bill a facility fee (HCPCS Q3014, current rate is $24.63)

Distant Site (location of provider) – eligible to bill for the actual service that was rendered via telemedicine. Add modifier GT or 95 and use place of service code 02 (Telehealth). Telemedicine is payable at the encounter rate for Medicaid-covered services.

Telemedicine is not mentioned in other HCA billing guides at this time.

Q. If the consultant is outside of the 4-walls of the facility are the services considered outside of the 4-walls and not billable per the CMS 4-walls rule?

A. Stay tuned, pending CMS guidance

I/T

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

I/T

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 the February 14, 2018 TCOW

I/T/U

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 (processers, 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.

I/T/U

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

I/T/U

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. 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). This is because CHIP is not a title XIX program

I/T

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

I/T/U

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 diagnoses 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

I/T/U

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 12th,   December 12, 2018
- 8th 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

I/T/U

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

I/T

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

I/T/U

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

I/T

FAQ and Open Discussion

Q. if client is in an MVA and there are medical visits as a result of the MVA – should P1 be billed or the car-insurance?

A. Bill Medicaid unless you are aware of Personal Injury Protection (PIP) insurance and can collect from that. There is no rule that says that the service MUST be billed to Medicaid. If the claim is billed to Medicaid, Medicaid will not reject to bill the car insurance – Medicaid will pay (Medicaid will then try to recover from any liable third parties…. Pay & chase). Keep in mind that Medicaid has a 1-year timeliness rule for claims submissions

I/T/U

FAQ and Open Discussion

Q. Is Medicaid going to cover the new Shingles vaccine? The new vaccine is more effective than the current vaccine.   Shingrix (CPT 90750)

A. Stay tuned

I/T/U

FAQ and Open Discussion

Q. In a previous webinar you indicated that some commercial insurance EOB codes can be added to the claim so that the denial EOB doesn't need to be sent. Can you share the EOBs?

A. Stay tuned

I/T/U

Questions?

Send comments and questions to:

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- The bottom-left corner of each slide will contain either I/T (impacts IHS and Tribal) or I/T/U (impacts IHS, Tribal and Urbans) or U (only impacts Urban)
- 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.