Washington State Health Care Authority

Tribal Compliance & Operations Work Group

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Washington State Health Care Authority

Agenda

- Multiple encounters on the same date
- Billing instructions updates
- Tribal-FQHC
- CMS 4-walls and place of service
- Encounter billing for global services
- Clinic contact information for the MCOs
- CY2017 P1 payment snapshot
- Top 5 rejections
- Prior TCOW questions
- FAQ and Open Discussion

Multiple Encounters on the Same Date

- The March TCOW indicated that if a client is receiving more than one encounter one a date of service (e.g. 2 medical visits **or** 2 mental health visits **or** 2 dental visits **or** 2 SUD visits) all services may need to be on one claim
- Some billing software packages will not allow more than one encounter on a claim
- Stay tuned – the intent was not to make billing more difficult, the intent was to ensure accurate payments

Billing Instructions Updates

- The HCA Tribal Health Billing Guide has recently undergone a few changes
- The Tribal Health Billing Guide changes were made without *consulting* with the Tribes
- Future Tribal Health Billing Guide updates will be shared with the Tribes for consideration and approval before publishing

Tribal-FQHC

1. CMS indicates that Tribes are not permitted to render services (at the encounter rate) if the services are rendered outside of the 4-walls

2. There are no federal provisions that permit the encounter rate for managed care enrolled non-AI/AN clients (dental managed care is scheduled for 2019)

- These two issues may be avoided if the Tribe becomes a TribalFQHC (with Medicaid)
- FQHC scope of services that are payable are different than the scope of services that are payable under the IHS/638 model
- A comprehensive comparison of the scope of services for FQHC and IHS/638 is being developed

I/T

CMS 4-Walls and Place of Service

- December, 2016 - During CMS targeted state call, CMS advised the states of the 4-walls rule *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. This is referred to as the 'four walls' limitation.* The TribalFQHC option is being explored at this time
- January, 2017 - CMS shared an FAQ - *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 unless there is clear evidence of bad faith efforts to engage in improper claiming procedures in violation of this guidance*.
- Q. How can Medicaid know if a service was rendered inside the four walls or not?
- A. The place of service on the claim indicates where the service was rendered

05 = *A facility or Location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization*

07 = *A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization*

What if a service is done in a school?

- If the Tribe leases a location in the school, this would make the location at the school meet the definition of 05 or 07
- If the Tribe does not lease a location in the school, this would make the location at the school meet the regular definition of 03 and outside of the 4-walls

Encounter Billing for Global Services

Multiple Encounters means two different things

- *Multiple Encounters* on a single date of service are separately billable if the services are separate and distinct and each visit is Medicaid covered. (SPA #17-0042)
  - Units billed on the T1015 line is 1
- *Multiple Encounters* reported on a T1015 line due to the global payment rules (e.g. Maternity). Refer to Medical and Dental sections of the Tribal Billing Guide for more information.
  - Units billed on the T1015 line are greater than 1 (e.g. T1015 x 2 or T1015 x 10)
  - Refer to 09/14/2016 TCOW for more information

- Related to the Global Billing/Multiple Encounter – reminder that Encounter billers are not subject to post-operative coverage timelines in regards to billing for post-op care. E&M services/encounters (without mod 24) during a surgical follow-up period are payable for encounter billers (refer to 11/12/2015 TCOW for more information)

I/T/U

Clinic Contact Information for the MCOs

- Attached to today's webinar is an ITU contact list that we share with the managed care plans
- Contact list is intended for the MCOs if they need to reach out for assistance
- Let mike know if your contact information needs to be updated

CY2017 P1 Payment Summary

ProviderOne claims data for Calendar Year 2017

Category	ITU payment percentage	Non-ITU payment percentage
Medical	85%	74%
Dental	86%	91%
Mental Health	93%	83%
SUD	94%	87%
TOTALS	89%	78%

I/T/U

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Medical - Top 5 Rejections

EOB	Description	Comments	Reject %
18 ITU	Exact duplicate claim/service	Duplicate billing	14%
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. Most of the claims were medicare cross-overs, which are generally fixable in P1	10%
204 ITU 02190	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)	5%
24 ITU 02035	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in MCO	5%
22 ITU 02205	This care may be covered by another payer per coordination of benefits	Client has Medicare (B or C)	4%

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Dental - Top 5 Rejections

EOB	Description	Comments	Reject %
18 ITU	Exact duplicate claim/service	Duplicate billing	8%
119 ITU 12195	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	8%
204 ITU 02190	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	6%
181 ITU 16030	Procedure code was invalid on the date of service	EOB 181 really means "P1 could not figure out how to price the line" – most claims were crowns/root canals or core buildup for adults (there is no adult rate in P1 so "P1 could not figure out how to price the line")	4%
15 ITU 11120	The authorization number is missing, invalid, or does not apply to the billed services or provider.	Most services were technically not payable (crowns/root canals or core buildup) for adults. I/T providers may see this EOB if the AI/AN (870001305) or nonAI/AN (870001306) authorization is missing	4%

Mental Health - Top 5 Rejections

EOB	Description	Comments	Reject %
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)	12%
18 ITU	Exact duplicate claim/service	Duplicate billing	9%
16/ N290 ITU 01010	Missing/incomplete/ invalid rendering provider primary identifier	Performing (*rendering, servicing*) provider not in P1. contact mike, let's get the provider onboarded (if applicable)	7%
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	6%
16 / N255 01475	Missing/incomplete/invalid billing provider taxonomy	Claims appear to just have software issues Urbans – Billing taxonomy is 261QF0400x IHS/Tribal – Billing taxonomy is 2083P0901x (for mental health)	5%

SUD - Top 5 Rejections

EOB	Description	Comments	Reject %
18 ITU	Exact duplicate claim/service	Duplicate billing	11%
204 ITU 02190	This service/equipment/ drug is not covered under the patient's current benefit plan	there were a few large batches of claims that had servicing taxonomy 101YA0400x (SUD is basically always 261QR0405x (except methadone and case management)	10%
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	9%
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%
16 / N290 ITU 01010	Missing/incomplete/ invalid rendering provider primary identifier	SUD claims are not billed using individual servicing provider IDs. Mike actively working with provider/RPMS on this issue	6%

Prior TCOW Questions

- Attached to today's webinar is a list of the TCOW questions received last month
- An ongoing TCOW questions file is being developed

FAQ and Open Discussion

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 is on the IHS facility list)

FAQ and Open Discussion

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

FAQ and Open Discussion

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. It is OK if the consultant is outside the 4-walls. In order to qualify for the IHS rate, **the client** is required to be in the 4-walls of the clinic setting.

I/T NOTE: telemedicine does not qualify for an FQHC encounter

FAQ and Open Discussion

Q. Is silver Diamine (fluoride) payable?

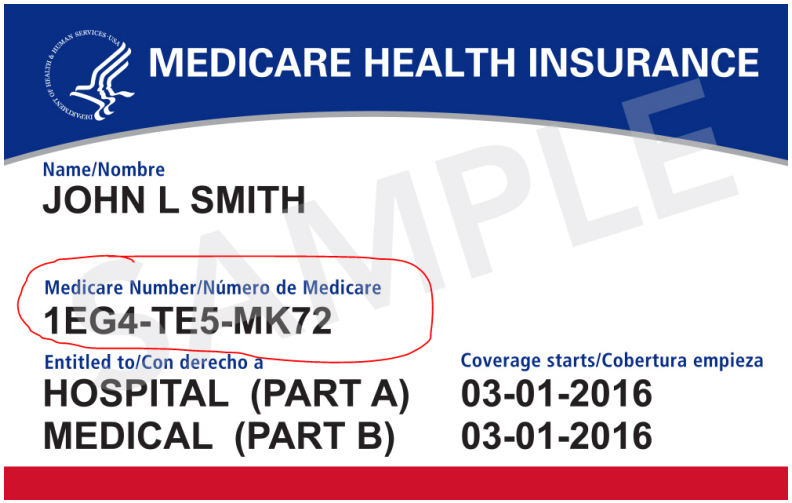
A. yes, beginning with the 11/03/2017 dental billing guide, Silver Diamine fluoride (D1354) is a payable service – up to two times per client per tooth in a 2 year period (see dental billing guide for current policy)

Is D1354 encounter eligible? Yes, at this time D1354 is not listed as a service that does not qualify for the encounter rate (FQHC and IHS/638)

FAQ and Open Discussion

Q. Medicare is rolling out the new medicare cards now, the client's social security number will be replaced with a non-identifying number. Will the P1 client benefit inquiries be updated to include the new Medicare ID numbers?

A. yes, the new medicare numbers will be added to the P1 benefit inquiry screen soon. let mike know if you see any mismatches



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

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

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.