Washington State Health Care Authority

Tribal Compliance & Operations Work Group

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Washington State Health Care Authority

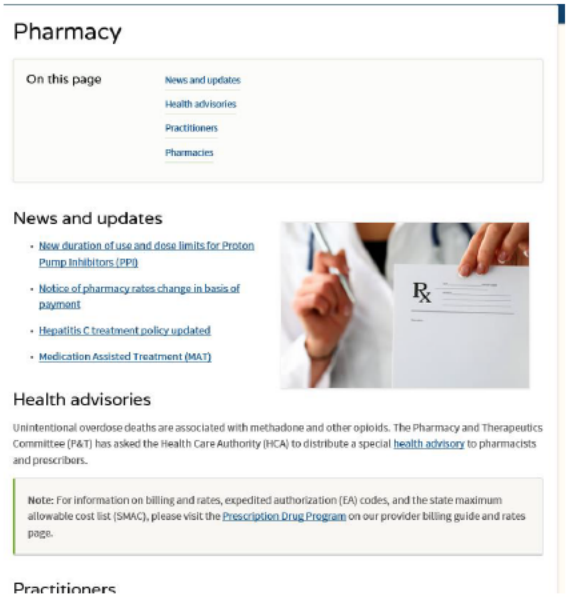
Agenda

- HCA Pharmacy/Point of Sale – common billing issues
- *Incident To* guidelines
- Dental Managed Care
- Claims Billed or Paid without a T1015
- Coding for *Behavioral Health* Services
- Immunization Billing
- Top 10 rejections
- FAQ and Open Discussion

- Attachments – Immunization cheat sheet and *Does xxxxx qualify for the IHS encounter rate*

Pharmacy/Point of Sale

- The HCA Pharmacy team will be available to answer questions regarding Pharmacy/Point of Sale
- We will be working out of the Pharmacy website
- Please let us know if you are having any issues with Pharmacy claims and how we can help



I/T/U

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Incident To Guidelines

The Tribal Health Billing Guide and the FQHC billing guide both indicate that an encounter is not payable if the service or supply is *incident to/incidental to* the services of a health care professional.

Refer to the Medicare Benefit Policy Manual - *Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness*

During the course of a professional visit – a client may see more than one healthcare professional – if the services of the auxiliary personnel are incident to the physician's primary visit (and on the same calendar day as the physician's primary visit) – the services of the auxiliary personnel are included in the physician's encounter payment.

If, however, the services of the auxiliary personnel are on a different calendar day from the physician's primary visit then the services of the auxiliary personnel may be reported and billed at the encounter rate. The difference is due to the fact that the encounter reimbursement only covers services within the calendar day of the visit

Examples on next page

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Incident To Guidelines

Examples of Incident To services

Client is receiving a primary care visit and the MD sends the client down the hall to see the Nurse for a flu shot. The Nurse visit is incident to the MD visit and is not encounter eligible

Client is receiving a primary care visit and LPN takes the client's vitals, RN does a brief history before the client sees the MD. The services of the nurses are not reported separately

Client received a primary care visit and MD instructs client to return daily for injections to be administered by the nurse. The subsequent nurse injections are incident to the MD visit, however, since the subsequent nurse injections are outside of the calendar day of the MD visit they may be reported separately and billed at the encounter rate (if the service otherwise meets the definition of an encounter)

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Dental Managed Care

- HCA is moving towards dental managed care in 2019
  - Tribal Roundtable #2 is on 08/14/2018 from 10:30-12:30
    webinar registration link https://attendee.gotowebinar.com/register/8107266967435452931
  - Tribal Consultation is on 09/05/2018 from 1:00-4:00
    webinar registration link https://attendee.gotowebinar.com/register/4382594362530386179
- We had concerns during the previous TCOW regarding the loss of the encounter rate for non-AI/AN clients

I/T/U

Claims Billed or Paid without a T1015

SPA 17-0042 was approved last December (retroactive to 09/29/2017)

- Changed from one-of-each-category of encounter to *up to five (5) outpatient visits per day*
- Changed the list of providers who are *included in the encounter rate* to *any health care professional authorized…under the State Plan*

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 – claim will need to be reprocessed to add a T1015 (*mike* can't change claims)

Q. Can HCA pull data on claims that were billed or paid without a T1015?

A. Yes, data has been analyzed and mike reached out to everybody that had claims billed or paid without a T1015. There were 2 common scenarios on the claims

1. Claim contained a T1015 but the T1015 was rejected (EOB 18). These claims are retroactively payable due to the retroactive approval of the SPA. The claims just need to be reprocessed

2. Claim did not contain a T1015 but the code appears to meet the definition of an encounter

Continued on the next slide

Claims Billed or Paid without a T1015

2,300 claims were billed or paid without a T1015 (DOS 09/29/2017 – 03/09/2018)

Mike has reached out on the claims, following are the top 4 issues

- 1544 claims – *missing T1015* – claim appears to meet the definition of an encounter but there was no T1015 line on the claim
- 144 claims – *Billed before P1 was ready for the SPA* – claim is encounter eligible due to the retroactive approval of the SPA
- 43 claims – *99211 qualifies* - 99211 is commonly called a "nurse visit". All levels of E&M qualify for the encounter rate (if the E&M is a medicaid covered service and the E&M is not incident to the supervising professional's services that occurred on the same day)
- 40 claims – *96372 qualifies but claim has an expensive drug code.* Therapeutic injections (CPT 96372) are encounter eligible.
  - *Pharmaceuticals/drugs are outside the all-inclusive rate and are reimbursed under the fee-for-service system at the applicable fee-for-service rates*. (State Plan)
  - The claims had CPT 96372 but also had a drug code (e.g. Depo-shot or Vivitrol).
  - If the drug code is on the same claim as the encounter visit then the drug code will get included in the encounter payment (mike was not able to update P1) – avoid this issue by billing the pharmaceutical/drug on a separate claim from the encounter-eligible (T1015) service

I/T

Claims Billed or Paid without a T1015

2,300 claims were billed or paid without a T1015 (DOS 09/29/2017 – 03/09/2018)

Mike has reached out on the claims, following are the top 10 CPT/HCPCS/ADA codes that were billed or paid without a T1015

- 99211 (810 claims)
- 96372 (308 claims)
- 99212 (143 claims)
- D1206 (133 claims)
- 96153 (88 claims)
- 99213 (66 claims)
- D1120 (47 claims)
- H0004 (40 claims)
- 96154 (39 claims)
- D1110 (37 claims

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Coding for *Behavioral Health* Services

- *Behavioral Health*, as a HealthCare category, does not exist in P1 at this time. What may be a *Behavioral Health* claim is usually either a Mental Health Claim or an SUD claim
- This is important to keep in mind because most clients have co-occurring issues but when the claim is billed to HCA - the *Behavioral Health* claim must be either a Mental Health claim or an SUD claim (e.g., there is no co-occurring category for *Behavioral Health* at this time)

Continued on next slide

I/T/U

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Coding for *Behavioral Health* Services

Mental Health claims follow the Mental Health Services Billing Guide, the only payable mental health codes are on pages 37-42*

- Billing taxonomy is either 261QF0400x (FQHC) or 2083P0901x (IHS/638)
- Claims require an individual servicing NPI and their corresponding taxonomy

SUD claims follow the SUD Billing Guide, the only payable SUD codes are on pages 19-21

- Billing taxonomy is either 261QF0400x (FQHC) or 261QR0405x (IHS/638)
  - NOTE: FQHCs have special taxonomy requirements and need to add the 261QR0405x as the "servicing taxonomy" for SUD claims
  - NOTE: Methadone Administration and Case Management have special taxonomy requirements, refer to the SUD billing guide for details
- SUD claims always require certain procedure/modifier/taxonomy combinations, refer to the tables on page 19-21. Ask mike for a cheat sheet for either Outpatient SUD or Residential SUD

* IHS/638 clinics rendering mental health services that are above the Access to Care Standard – refer to the Tribal Health Billing Guide for more information

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Immunization Billing

- Attached to today's webinar is a cheat sheet for billing for immunizations for kids and adults and how to determine if the immunization is free from the Department of Health
- Jean (HCA's immunization manager) will be at the webinar and is also following the *we can't fix it if we don't know it's broke* approach – please let us know what we can do better or let us know what is working in regards to immunizations

I/T/U

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Medical - Top 10 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	16
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 or 225700000x)	11
18 ITU	Exact duplicate claim/service	Duplicate billing	9
24 ITU 02035	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in MCO	6
16 + N288 ITU 01485	Missing/incomplete/invalid rendering provider taxonomy	Performing (*rendering, servicing*) taxonomy on claim is not a taxonomy that the performing provider is enrolled with	4

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Medical - Top 10 Rejections

EOB	Description	Comments	Reject %
96+ N30 ITU 02370	Patient ineligible for this service	Client was a Medicare-only client (SLMB, QDWI)	4
29 ITU 00190	The time limit for filing has expired	Claim was received outside the 365 timely filing window	4
167 ITU 03755	This (these) diagnosis(es) is (are) not covered.	Some ICD-10 diagnosis codes are *generally not payable if billed as the primary diagnosis on a medical claim.* The list of codes is attached to today's webinar	3
22 ITU 02205	This care may be covered by another payer per coordination of benefits	Client has Medicare (B or C)	3
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	2

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Dental - Top 10 Rejections

EOB	Description	Comments	Reject %
16 + N255 T 01475	Missing/incomplete/invalid billing provider taxonomy	Claims appear to just have software issues Urbans – billing taxonomy is 261QF0400x IHS/Tribal – billing taxonomy is 122300000x	18
197 I/T 01220	Precertification/authorization/ notification absent	IHS/638 dental claims need an EPA number added to indicate if the client is AI/AN or non-AI/AN AI/AN – 870001305 Non-AI/AN – 870001306	11
29 ITU 00190	The time limit for filing has expired	Claim was received outside the 365 timely filing window	6
6 ITU 03145	The procedure/revenue code is inconsistent with the patient's age	Oral Hygiene instructions is for age 0-8 Prophy age is divided as follows D1110, adult – age 14 and over D1120, child – age 0 – 13	5
96 / N428 ITU 03175	Not covered when performed in this place of service	Limited Visual Oral Assessment (D0190 D0191) and Oral Hygiene Instructions (D1330) are not covered in office settings	5

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Dental - Top 10 Rejections

EOB	Description	Comments	Reject %
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	5
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	3
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")	3
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	3
18 ITU	Exact duplicate claim/service	Duplicate billing	3

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Mental Health - Top 10 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)	15
18 ITU	Exact duplicate claim/service	Duplicate billing	12
16 + N290 ITU 01010	Missing/incomplete/ invalid rendering provider primary identifier	Performing (*rendering, servicing*) provider not in P1	8
4 I/T 01220	The procedure code is inconsistent with the modifier used or a required modifier is missing	The AI/AN modifier (HE) or the non-AI/AN modifier (SE) was missing. Some of the claims were medicare cross-overs, which are generally fixable in P1	6
16/ N288 ITU	Missing/incomplete/invalid rendering provider taxonomy	Performing (*rendering, servicing*) taxonomy on claim is not a taxonomy that the performing provider is enrolled with	6

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Mental Health - Top 10 Rejections

EOB	Description	Comments	Reject %
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
16 + N290 ITU 01245	Missing/incomplete/ invalid rendering provider primary identifier	Performing (*rendering, servicing*) provider not in P1	4
236 I/T 25000	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.	HCA is mandated to follow NCCI guidelines, see February, 2018 TCOW for more information	2
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)	2
181 ITU 16030	Procedure code was invalid on the date of service	The code was probably valid. EOB 181 happens when P1 cannot figure how much to price the line, usually a servicing taxonomy issue	2

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SUD - Top 10 Rejections

EOB	Description	Comments	Reject %
18 ITU	Exact duplicate claim/service	Duplicate billing	13
204 ITU 02190	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)	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	8
24 U 01365	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in a BHO (or FIMC)	6
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	6

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SUD - Top 10 Rejections

EOB	Description	Comments	Reject %
16 / N288 ITU 01485	Missing/incomplete/invalid rendering provider taxonomy	Related to 204 EOB	6
16/ N290 ITU 01010	Missing/incomplete/ invalid rendering provider primary identifier	SUD claims should not be billed with individual servicing provider information	4
170/ N95 ITU 03740	This provider type/provider specialty may not bill this service	Acupuncture and labs are not payable on SUD claims. Some claims were missing the HF modifier on the SUD code	3
258 I/T 02224	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service	Contact mike, if EOB 258 but client presented for services then either The client escaped, or P1 does not know that the client is not incarcerated	2
96 + N130 ITU 03005	Consult plan benefit documents/guidelines for information about restrictions for this service	Service is not covered (acupuncture	2

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Prior TCOW Questions

- Attached to today's webinar is a list of the TCOW questions received during the TCOWs beginning with the March, 2018 TCOW
- An ongoing TCOW questions file is being developed and will eventually be on the Tribal Affairs website

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FAQ and Open Discussion

Q. If a service is rendered by an MA/LPN/RN per their supervisor's order – are these encounter eligible?

A. Outpatient visits that are a face to face or telemedicine contact between any health care professional authorized to provide services under the State Plan and a Medicaid beneficiary for the provision of title xix defined services are eligible for the encounter rate

If a physician signs off on the service (is the servicing NPI on the claim) then the service becomes a physician service and physicians are covered under the Medicaid program

If the MA/LPN/RN visit is incident to the physician's visit and occurred on the same day as the physician's visit – the MA/LPN/RN visit is included in the physician's encounter payment

Note: telemedicine is encounter eligible for IHS/638 providers but not encounter eligible for FQHCs

FAQ and Open Discussion

Q. We looked up a client and their managed care information in P1 says "Health Home Only" – what does that mean?

A. Refer to the ProviderOne Billing And Resource Guide, page 26 -- *A health home is not a managed care plan and clients enrolled in a health home will remain fee for service* (bill P1, clients are encounter-eligible)

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name
HM: Health Maintenance Organization	MC: Capitated	UHC - Health Home Only

I/T/U

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FAQ and Open Discussion

Q. During the June TCOW you mentioned that CPT 96372 *(therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular)* qualifies for the encounter rate. Often these are done for pain relief or birth control and can also be done by a nurse, in these case are they also encounter eligible?

A. CPT 96372 is a medicaid-covered professional service that is rendered face to face and meets the definition of an (IHS) encounter when rendered by a Health Care Professional authorized under the state plan for the provision of Medicaid-covered services

Q. What if the injection was given by a Nurse (RN)?

A. RNs are not part of the Medicaid program, 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

I/T/U

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FAQ and Open Discussion

Q. When will P1 be ready for Direct Data Entry (DDE) of prior authorization requests?

A. Now (beginning 08/06/2018). We have a few folks from the Prior Authorization team scheduled to present information during the September TCOW

The Prior Authorization website has been updated

FAQ and Open Discussion

Q. Does the provider that places the order for the RN services need to be in the office at time of the RN service? Can it be another provider that is in the office, not the ordering provider?

A. No, there is no requirement that the prescriber be on the premises when a RN or LPN carry out standing orders or provide nursing services

Q. Does a provider have to be in the office at all when RN services are being done since the order was already placed?

A. No-see above

Q. For standing orders…what are the rules and/or guidelines from HCA on standing orders? I know that CMS strongly advises against standing orders but they don't forbid them

A. HCA does not have any guidelines or policies regarding standing orders

Q. If standing orders are allowed, are there timeframes on them? Is there a limit on what can be done as a standing order?

A. HCA does not have any guidelines or policies regarding standing orders

FAQ and Open Discussion

Q. Mike, can you double-check your June, TCOW slides (page 16)? Is Diabetic Counseling billable when rendered by a Pharmacist?

A. Yes if the pharmacist is billing out of a clinic that has been approved for Diabetic Education (refer to the Diabetic Education Billing Guide)

The professional services that are payable for a pharmacist's professional services include

- Tobacco cessation for pregnant clients (physician billing guide)
- Clozaril case management (physician billing guide)
- Emergency contraception counseling (prescription drug billing guide)
- Vaccine Administration fee (prescription drug billing guide)
- Diabetic Education (if the clinic has been approved for the Diabetic Education Program) (Diabetic Education billing guide)

If you are not sure if you are an approved Diabetic Education Provider, ask mike

I/T/U

FAQ and Open Discussion

Q. Does HCA cover paramedicine?

A. Not yet. House Bill 1358 has not been implemented yet.

Paramedicine is an emerging profession, it allows EMTs/Paramedics to provide some healthcare services to underserved populations.

A scenario explains why the question was asked

Over the years, paramedics have routinely been called out to various sites and, when they get there, they find that the client is not "sick" enough to need to go to the hospital.

For example – client calls because he has chest pain. The EMT's get there and determine that there is no need to go to the hospital, they see he has elevated BP and suggest a primary care visit. The EMTs do not have a billable service, even after driving to the site

Stay tuned

I/T/U

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FAQ and Open Discussion

Q. How do I determine if a client is AI/AN and eligible for federal funds?

A. A client must meet the provisions of 25 U.S.C. 1603(c) (d) for federally recognized Tribal members and their descendants

Q. How do folks at the clinics verify that the client is eligible?

The question to the left was asked during the June TCOW. Here are the responses to the question that were received during the webinar

- *Our registration checks tribal enrollment cards*
- *Depends on the system being utilized - if Real Time Eligibility is offered then that would be the preferred method*
- *IHS has specific guidelines that we require the client to meet. They have to have an enrollment document as well as a descendant can have birth certificates linking them to the eligible AI/AN*
- *Our front desk staff verifies their Tribal status by a tribal ID, letter of enrollment and for descendants, parents' Tribal Id and child birth certificates*

FAQ and Open Discussion

Q. We have a dual-credentialed provider (MHP and CDP) who would like to bring clients in for group therapy but split the sessions

The first half of the session is Mental Heatlh

The second half of the session is SUD

Are these separately billable?

A. Yes, the services are separately billable if all of the following are true

- The services did not occur concurrently
- The services each have separate and distinct chart notes
- The services each have separate and distinct treatment plans
- The services comply with NCCI requirements

- IT (AND U? pending guidance for Urbans/FQHCs)

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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. Yes, Shingrix was added as a payable service beginning on May 1, 2018.

- Clients must be age 50 or greater
- Follow CDC guidelines (2 dose schedule, HCA rate is currently $140.00 per dose)
- Follow immunization cheat sheet that is attached to today's webinar

I/T/U

FAQ and Open Discussion

Q. During June TCOW you mentioned 2 different types of authorizations

- **The code** needs prior authorization
- The code does not need authorization but **the service** needs authorization (often because it exceeds HCA's frequency schedule)

What if the client needs more than the allowed number of fluorides? What can we do?

A. A Limitation Extension (LE) is an authorization of services beyond the designated benefit limit allowed in WAC (182 501 0169) and HCA billing guides. Stay tuned for more information on Authorization requests during the September TCOW. Direct Data Entry of Authorizations was recently adopted in P1

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FAQ and Open Discussion

Q. Does HCA enroll Optometrists? What services can an optometrist render?

A. Optometrists are eligible to enroll with HCA (WAC 182 501 0002)

Services billable by Optometrists may be found in the following billing guides

Vision Hardware for Clients Age 20 and Younger, and the Physician-Related Services/Health Care Professional Services Billing Guide (page 198)

Q. Are the professional services of an Optometrist eligible for the encounter rate?

A. IHS/638 encounters – Yes, an Optometrist is a Health Care Professional authorized to provide services under the state plan

FQHC – yes (42 CFR 405.241)

Tribal-FQHC – stay tuned (*probably.* But until TFQHC is fully vetted I cannot commit to a yes/no answer)

I/T/U

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FAQ and Open Discussion

Q. Dental Managed Care is coming in 2019. Do AI/AN patients have to enroll in a dental managed care plan?

A. No.

Clients will not be automatically enrolled in a managed care plan but may request enrollment in a managed care plan, if available in their area (use the HCA Contact Us portal)

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FAQ and Open Discussion

Q. How do we bill separately for IUDs and contraceptives?

A. Background information is in the State Plan - *Pharmaceuticals/drugs are outside the all-inclusive rate and are reimbursed under the fee-for-service system at the applicable fee-for-service rates*.

Due to P1 limitations, if a pharmaceutical/drug is on the same claim as an encounter-eligible service (and T1015) then the pharmaceutical/drug payment will become part of the encounter payment on the claim. This may be avoided by billing two separate claims to P1 -- one claim for the professional services at the encounter rate and a separate claim for just the pharmaceutical/drug

I/T – not U

FAQ and Open Discussion

Q. What is considered a gap in services for SUD?

A. Stay tuned

This is in regards to the following Q&A during the June TCOW

Q. How often should an SUD assessment be conducted?

A. An assessment should be done as soon as a person begins to seek out services, we used to follow a 6 month process for new assessments if the patient left services and/or relapsed. It would now depend on the agency, the contract requirements, RCW and WAC

Q. If a client's last assessment was 2 or more years ago and there has not been a change in the client's condition is there a need for a re-assessment?

A. If the client is still in services, a new assessment is not needed as long as there has been constant contact. If the client has had a gap in service and wants to re-enter services the assessment would need to be redone or updated

I/T/U

FAQ and Open Discussion

Q. Is Telepsychiatry going to be encounter eligible?

A. Yes, SPA 17-0042 was adopted last winter (retroactive to 09/29/2017). Telemedicine was added as an encounter-eligible service

Telemedicine is not listed as a payable service in the Mental Health Billing guide but follow the prior TCOW guidance in regards to the services that can be rendered via telemedicine (if it can normally be done face to face then it can be done via telemedicine, HCA does not follow CPT/HCPCS designations of services that can be rendered via telemedicine). Remember to add modifier GT or 95 to the telemedicine claim and the place of service code is 02 (following the Physician Related Services/Health Care Professionals billing guide

NOTE: for the 4-walls rule, 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. Refer to the April, 2018 TCOW for more information

I/T

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FAQ and Open Discussion

Q. Where can we find the I.H.S. facility list?

A. The I.H.S. facilities are on the I.H.S. website

The 638 facilities are provided to the states by CMS

Q. Is there a list of the addresses for the facilities so that we can comply with the CMS requirement?

A. Stay tuned

Q. How do we get a facility added to the facilities list?

A. Stay tuned, I will try to find someone in the IHS Portland Area Office to help with this question. This is in regards to the 4-walls limitation.

I/T

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FAQ and Open Discussion

Q. During the June TCOW you mentioned that Locum Tenens are billed under their own NPI, can you verify because CMS indicates that Locum Tenens are billed under the provider that they are covering

A. Follow HCA's Physician-Related Services/Health Care Professional Services billing guide, page 29 - *Enter the provider NPI and taxonomy of the locum tenens physician who performed the substitute services in the Rendering (Performing) Provider section of the electronic claim.* (and add modifier Q6, ideally after the UA/HE (AI/AN) or SE (nonAI/AN) modifier)

HCA is aware that CMS does indicate that the services of a Locum Tenens are billed using the standing doctor's NPI. HCA does not follow CMS guidelines in regards to Locum Tenens

NOTE: 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

I/T/U

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FAQ and Open Discussion

Q. My Intergovernmental Transfer (IGT) matching funds for SUD was 'rejected' – what do we do?

A. Stay tuned, IGT will eventually be replaced by a Certified Public Expenditure (CPE) process. The reason for the rejection was unrelated to the CPE change and was due to HCA/DBHR integration

I/T

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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

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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.