Washington State
Health Care Authority
Tribal Compliance & Operations
Work Group
+
Quarterly Tribe & MCO Meeting

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September 12, 2018

Agenda

- Dental Managed Care
- Prior Authorization Submission Update
- MCO payment at the IHS encounter rate
- Tribe and MCO Discussion
- Top 10 rejections
- FAQ and Open Discussion

- Attachments – EPSDT codes, NPI list for MCOs, Molina Brochure, Molina top denials

Washington State Health Care Authority

Dental Managed Care

The projected costs of the Managed Care Dental Program requires that the Legislature be given the opportunity to enact a budget that provides the funding necessary to implement the program. In order to ensure the Legislature has time to complete its important work, the Health Care Authority's (HCA) Managed Care Dental Program will not be implemented until July 1, 2019.

The HCA will continue to administer the current Apple Health fee-for-service (FFS) dental program until the Managed Care Dental Program is implemented.

I/T/U

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Prior Authorization Submission Update

- Prior Authorizations may now be submitted directly into the P1 portal (direct data entry/DDE) instead of on paper forms
- Refer to the HCA Prior Authorization website for more information, there are self-service trainings on the HCA Prior Authorization website and we will walk through one of them

I/T/U

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MCO Payment at the IHS encounter Rate

- P1 reconfiguration to support MCO payment of the IHS encounter rate by reimbursing the MCOs for the encounter differential should be completed in early 2019
- HCA is ready to work with MCOs on beginning MCO-system reconfiguration and testing with P1

I/T

Tribe and MCO Discussion

Q. We were told that we could bill with the "WA" client ID numbers – is that still true?

Q. MCO rejected a claim indicating that the client has commercial insurance but P1 does not indicate that the client has commercial insurance. How do we correct this?

Q. Can the managed care plans present a top-5 list of denials?

Q. A client has one of our doctors as their PCP, if we refer the client out of the clinic will the MCO cover the referral?

I/T/U

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Medical - 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, 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%
24 ITU 02035	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in MCO	6%
18 ITU	Exact duplicate claim/service	Duplicate billing	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	5%
16 + N290 ITU 01010	Missing/incomplete/ invalid rendering provider primary identifier	Performing (*rendering, servicing*) provider not in P1. contact mike as soon as possible because P1 is removing the NPI from the claims, which makes it harder/impossible for mike to find the claims	4%

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Medical - Top 10 Rejections

EOB	Description	Comments	Reject %
16 + N290 ITU 01245	Missing/incomplete/ invalid rendering provider primary identifier	Either claim was billed without a performing NPI or the performing NPI that was submitted on the claim is provider not in P1	4%
96+ N30 ITU 02370	Patient ineligible for this service	Client was a Medicare-only client (SLMB, QDWI)	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.*	3%
22 ITU 02205	This care may be covered by another payer per coordination of benefits	Client has Medicare (B or C)	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 physical therapy by FQHC (PT is not covered under FQHC program)	2%

Washington State Health Care Authority

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	16%
18 ITU	Exact duplicate claim/service	Duplicate billing	7%
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	7%
29 ITU 00190	The time limit for filing has expired	Claim was received outside the 365 timely filing window	5%
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 Crowns and (posterior) endo not covered for adults	5%

Washington State Health Care Authority

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	4%
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	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	3%
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	3%
119 / M86 ITU 12180	Service denied because payment already made for same/similar procedure within set time frame	Child prophy (cleaning) was too soon age 0-18 - covered once every 6 months Age 19+ - covered once per year	3%

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Mental Health - Top 10 Rejections

EOB	Description	Comments	Reject %
18 ITU	Exact duplicate claim/service	Duplicate billing	12%
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	10%
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)	9%
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	7%
16 + N290 ITU 01245	Missing/incomplete/ invalid rendering provider primary identifier	Performing (*rendering, servicing*) provider not in P1	3%

Washington State Health Care Authority

Mental Health - Top 10 Rejections

EOB	Description	Comments	Reject %
16 + N290 ITU 01010	Missing/incomplete/ invalid rendering provider primary identifier	Performing (*rendering, servicing*) provider not in P1. contact mike as soon as possible because P1 is removing the NPI from the claims, which makes it harder/impossible for mike to find the claims	3%
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 2083P0901x	3%
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%
96 + N130 ITU 03005	Consult plan benefit documents/ guidelines for information about restrictions for this service	Service is not covered. There were some CPT 90839 claims – IHS/638 clinics can bill for Crisis but HCA did not adopt 90839/90840 – see Tribal guide, p 35	1%

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SUD - 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 there were a few large batches of claims that had servicing taxonomy 101YA0400x (SUD is basically always 261QR0405x (except methadone and case management)	15%
16 / N288 ITU 01485	Missing/incomplete/invalid rendering provider taxonomy	Related to 204 EOB	14%
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	8%
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%
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%

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SUD - Top 10 Rejections

EOB	Description	Comments	Reject %
4 IT 00800	The procedure code is inconsistent with the modifier used or a required modifier is missing	T1015 still requires a modifier AI/AN = T1015+HF nonAI/AN RAC 1201 = T1015+SE RAC 1217 = T1015+HB All others = T1015+HX	5%
24 U 01365	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in a BHO (or FIMC)	4%
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/U 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	3%

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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. Are Sports Physicals covered?

A. Sports Physicals are not listed as a covered benefit for HCA. However, Well Child (EPSDT) visits are covered under the following frequency schedule

Age 0-0 - 5 screenings/visits during 1st year

Age 1-2 -3 screenings/visits (this is a 2 year span, a total of 3 visits allowed in the 2 year span)

Age 3-6 - 1 screening/visit per year

Age 7-20 - 1 screening per 24 months

Note: foster kids are allowed extra visits, refer to the EPSDT billing guide for more information

E&Ms are also covered when **medically necessary** and do not have a frequency schedule.

Refer to the list of diagnosis codes that are generally not payable on a medical claim.

- ICD Z025 (*Encounter for examination for participation in sport*) is in the non-payable list
  - a sports physical may not be *medically necessary,* but regardless, this diagnosis is not payable in P1 if billed as the primary diagnosis
- ICD J4520 (*Mild intermittent asthma, uncomplicated*) is not in the non-payable list
  - J4520 appears to be a *medically necessary* diagnosis

I/T/U

FAQ and Open Discussion

Q. Vitamin D screening (CPT 82306, 82652) is listed as covered but only for certain diagnoses (Physician-Related billing guide, p 158). Hypervitaminosis is listed as covered but not hypovitaminosis. Can Vitamin D testing be paid for hypovitaminosis?

A. HCA's clinical staff indicates that 'hypo' is not listed as covered and suggests looking at the disease or condition that caused the issue. For example, does the person have intestinal mal-absorption, etc?

I/T/U

FAQ and Open Discussion

Q. During August TCOW (pp. 7-9) we discussed how a Therapeutic injection (CPT 96372) may qualify for the IHS (and FQHC) encounter rate.

- During August TCOW, HCA was asked why vaccine administration (CPT 90471) does not qualify for the encounter rate, it is face to face and seems to meet the definition of an encounter
- After the August TCOW, HCA was also asked why blood draw codes (36415, 36416) are not paid at the encounter rate

Refer to attachment "Does xxxxx qualify for the encounter rate?" step # 4 lists the codes that do not qualify for the encounter rate

The codes that are listed on page 23-24 of the Tribal Health Billing Guide will be reviewed in the future.

I/T Only
NOT Urban

Washington State Health Care Authority

FAQ and Open Discussion

Q. We did not know that the client had to sign a form before getting dentures, is this a new policy?

A. Refer to the current dental billing guide (p. 56)

The client will need to sign the Denture Agreement of Acceptance (form # 13-809) during the final denture try-in if the client is satisfied with the denture. HCA may request a copy of the Denture Agreement of Acceptance form and services may be recouped if the form is not available

I/T/U

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FAQ and Open Discussion

Q. Is it true that we can bill an encounter rate for pharmacy prescriptions?

A. no

We are not yet set up to pay for pharmacy prescriptions at the IHS encounter rate. To do so will require a State Plan Amendment and, more significantly, a way for HCA to pay at the encounter rate. Our pharmacy point-of-sale system will not allow us to receive the necessary information to pay at the encounter rate.

We will try to address the payment issue next year. As soon as we find a way forward, we will then issue a tribal notice with the State Plan Amendment for paying at the IHS encounter rate for pharmacy prescriptions. Until then, we cannot pay for pharmacy prescriptions at the IHS encounter rate.

I/T

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FAQ and Open Discussion

Q. If an assessment or evaluation does not lead to a definitive diagnosis will HCA pay for the assessment or evaluation?

A. Refer to the September, 2016 TCOW slides (pp 27-31). The policy for SUD services will be changing beginning on October 1, 2018 – an SUD assessment will not require that the client meet the SUD diagnosis criteria in order for the SUD assessment to be payable

I/T/U

Washington State Health Care Authority

FAQ and Open Discussion

Q. Are there any suggestions for how to deal with increased costs for vaccinations e.g. Shingrix and Gardasil 9 for adults as they are not directly billable for clinics billing under the encounter rate

Tribal Health Clinics (IHS/638) – *Pharmaceuticals/drugs are outside the all-inclusive rate and are reimbursed under the FFS system at … FFS rates* (state plan).

See page 8 of the August TCOW for tips on avoiding bundling issues with drugs and encounter claims

FQHCs - *The agency performs monthly recoupments for pharmacy services delivered by FQHCs in order to avoid duplicate payments for pharmacy services already included in their encounter rate* (FQHC billing guide). Pending guidance from FQHC team

If the HCA FFS rate is lower than your cost for a drug/pharmaceutical, please let HCA know at professionalrates@hca.wa.gov

I/T and U

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FAQ and Open Discussion

Q. Would a pharmacist be eligible for incident to billing

A. Stay tuned, this is a CMS policy that mike will need to research further

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FAQ and Open Discussion

Q. For FQHCs billing dental (for example D2740 crown), are the Lab Fees included in the allowable fee amount. One of our dentists was told in Tribal or Urban clinics the lab fee was not included. can we confirm?

A. The lab fee is included in the payment for the dental service. The only time that dental lab fees may be reported and billed separately is in the case of dentures when the client is not able to complete the denture process (e.g., the client is not eligible at the final seat date or client moves from the state, more examples on page 61 of the dental billing guide

I/T and U

FAQ and Open Discussion

Q. Our Providers are not always here when the pt comes in for follow up incident to visits. Per the basic requirements "Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services." We have other providers here but not the ordering. Would these visits be billable?

A. Stay tuned

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FAQ and Open Discussion

Q. Are there guidelines to documentation needed for 96372 services to qualify for encounter billing?

A. I need to split the question up

Q1 – are there guidelines to documentation needed for CPT 96372?

Q2 – are there guidelines to documentation needed claims billed at the IHS encounter rate

Stay tuned

FAQ and Open Discussion

Q. When will P1 be ready for the Match for SUD?

A. Stay tuned, HCA needs to complete analysis on the CPE process

I/T

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FAQ and Open Discussion

Q. Is Telemedicine eligible for Urbans

A. Telemedicine is not listed as an encounter eligible service for FQHCs

For Tribal (IHS/638) clinics – telemedicine was added to the State Plan as an encounter eligible service January, 2019 (retro to 09/29/2017)

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FAQ and Open Discussion

Q. Our region is currently not an integrated region, we will be going to FIMC at the beginning of 2019. What role will the BHOs play in the care of patients? Will they have to authorized care for outpatient settings or will it be run much like the Southwest region?

A. In the non-integrated regions, AI/AN clients have two independent types of Apple Health Managed Care that they may elect to enroll in

- Managed care for Physical Health and lower acuity mental health
- Managed care for Substance Use Disorder and higher acuity mental health

In the integrated regions, AI/AN clients have one type of Apple Health Managed Care that they may elect to enroll in

- Managed care for physical and behavioral health

Q. Will the managed care plans need to authorize care for outpatient settings?

A. CMS recently gave guidance that managed care plans must be given the ability to apply their standard prior authorization and utilization management procedures to all services except primary care.

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FAQ and Open Discussion

Q. We billed D2394 (*restoration, 4 or more surfaces*) for 5 surfaces but P1 rejected the claim indicating incorrect number of surfaces – was this an error?

A. P1 rejected claim in error. P1 update is scheduled for September 22, mike will reprocess claims after the P1 fix

D2161, D2335, D2394 are for *4 or more surface* codes that are currently being rejected in error if there are 5 surfaces. Do not rebill, mike will reprocess claims

I/T/U

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FAQ and Open Discussion

Q. Dental assistants are not licensed, however some are certified. If a dental service was performed by a non-certified dental assistant would that qualify for an encounter?

A. Certified Dental Assistants and Licensed Dental Hygienist are consider a 'Health Care Professional' Per current SPA and Tribal Billing guides. if the service was rendered by a non-certified dental assistant – HCA has not completed the analysis on this question yet, stay tuned

I/T

FAQ and Open Discussion

Q. During the February 2018 TCOW, you shared a list of codes that are payable on a Well Child (EPSDT) claim. E&M codes (99201-99215) not in the list, can these be billed separately?

A. Codes from the February TCOW are re-attached to today's webinar. If a Well Child code is billed (CPT 99381-99395) and the client is age 0-20 then the **entire claim** becomes a Well Child visit and only the codes from the list can be paid on a Well Child claim. Below are two common scenarios and solutions

- Client receives a Well Child visit and client diagnosed with warts to be removed (e.g., CPT 17000)
  - CPT 17000 is not payable on the same claim as the Well Child visit.
  - CPT 17000 may be reported on a separate claim and if the services are distinctly separate from the Well Child visit it may also qualify for the encounter rate
- Client receives a Well Child visit and clinician would also like to conduct an evaluation (e.g., CPT 99213) to address a medical issue
  - CPT 99213 is not payable on the same claim as the Well Child visit.
  - CPT 99213 may be reported on a separate claim and if the services are distinctly separate from the Well child visit it may also qualify for the encounter rate

NOTE: Medicaid is mandated to follow NCCI guidelines. Modifiers may be required under certain circumstance and, depending on the actual CPT/HCPCS codes, the services may not be payable together regardless of modifier (per NCCI)

I/T and Urban? Pending approval for Urbans

FAQ and Open Discussion

Q. SUD group therapy used to have a minimum of 45 minutes. We are not seeing the minimum time listed in the SUD billing guide, is there a minimum?

A. The 45 minute minimum for SUD group therapy was removed on April 1, 2016. follow coding guidelines for the timed codes. CPT 96153 is a timed code (*per 15 minutes*). Timed codes follow a 50% rule per coding guidelines – "A unit of Time is attained when the mid-point is passed" (CPT professional, 2017, page xv)

I/T/U

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FAQ and Open Discussion

Q. Can P1 be updated so that it will show the client's managed care account number when we do a Client Benefit Inquiry?

A. Stay tuned, P1 currently does not show the client's managed care account number. It would require a P1 change in order to show the managed care account number

I/T/U

Washington State Health Care Authority

FAQ and Open Discussion

Q. Is SBIRT (Screening, Brief Intervention & Referral to Treatment) an encounter eligible service?

A. YES

SBIRT is one of the services that may help with Healthcare Integration, refer to the Physician-Related billing guide (pp 237-241) for background information on SBIRT

An SBIRT-certified provider may work in the primary care setting (medical, dental or mental health) and render SBIRT services in the primary care setting.

SBIRT is comprised of 3 parts

- **Screening** – not separately billable and occurs during a primary care visit
- **Brief Intervention** – if the screening indicates at risk behavior the client may receive a Brief Intervention. Clients are eligible for up to 4 brief interventions per calendar year (the first intervention may even occur on the same day as the primary care visit)
- **Referral to Treatment** – if the screening indicates a severe problem or dependence the client should be referred to an SUD provider for full assessment and SUD treatment

NOTES: SBIRT is currently restricted to certain settings (p 238) – there will be no site of service restrictions for SBIRT beginning on 01/02/2019

If a CDP is SBIRT-trained – please contact mike, their Brief Interventions can be reported under their own NPI but CDPs are usually not enrolled in P1 – mike will help

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. 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

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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)

I/T/U

Washington State Health Care Authority

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

Washington State Health Care Authority

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 and how long a person has been away from services

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

Washington State Health Care Authority

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

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

Washington State Health Care Authority

FAQ and Open Discussion

Q. What if we have a Mental Health Associate but their supervising psychologist is licensed in another state? For the Associate's clinical hours – is there a rule that says that the supervisor has to be a Washington-licensed provider in order for the hours to count?

A. Start at the DOH RCWs - http://app.leg.wa.gov/WAC/default.aspx?cite=246-809

Thanks to our DOH partners for assisting with this answer

The supervisor does not have to have a Washington license but they do have to meet all the requirements to be a supervisor. Usually this is not an issue, as the supervisor has to have the license to work in the state and be able to oversee the associate's caseload. The associate could submit the supervisors credentials and get a determination if the supervisor meets the RCW requirements for her/his professional certification

I/T

Washington State Health Care Authority

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 – the bank account information for DSHS/HCA was updated recently. The Tribal Health Billing Guide will be updated for October 1st. The information is on the Tribal Affairs website under Resources-Quick Reference sheets

I/T

Washington State Health Care Authority

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

Washington State Health Care Authority

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.

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Appendix

Does [*insert topic*] Qualify for the IHS Encounter Rate?

Revised 02/09/2018
Mike Longnecker
HCA Tribal Affairs Office

Does Methadone qualify for the IHS encounter rate?

Does Methadone Qualify for the IHS Encounter Rate?

Washington State Health Care Authority

Q. When a patient goes into a facility solely for methadone dosage intake, does that qualify for an encounter rate?

A. The following slides identify the criteria that determine if a service qualifies for the IHS encounter rate.

Washington State Health Care Authority

What Services Qualify for the IHS Encounter Rate?

How do I determine if a service qualifies as an encounter? The service must be

1. Medically necessary
2. Conducted face-to-face or by telemedicine
3. A covered service according to the Medicaid State Plan
4. Not listed in the Tribal Health Billing Guide as a code that does not qualify for the encounter rate
5. Performed by a health care professional authorized to provide services under the state plan and within their scope of practice –6. Documented in the client's file in the provider's office
7. Performed in the facility identified on the IHS facility list or at satellite or branch locations (SUD must be **in** the approved facility).

IHS/638 services need to be within the 4 walls of the facility per CMS guidance, however - the 4 walls issue will not be audited until 2021, until that time please keep doing what you have been doing & services outside of the facility are payable at the encounter rate (except for SUD)

8. For an Apple Health Client who is eligible for the IHS encounter rate

The following slides will address each item individually

Washington State Health Care Authority

What Services Qualify for the IHS Encounter Rate?

1. What is *Medically Necessary?*

WAC 182-500-0070 defines Medically necessary as

A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purposes of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all.

What Services Qualify for the IHS Encounter Rate?

2. What is *Face to Face or by telemedicine?*

- Face to face is self explanatory
- Telemedicine is *HIPAA compliant, interactive, real-time audio and video telecommunication* (see WAC 182 531 1730)

Washington State Health Care Authority

What Services Qualify for the IHS Encounter Rate?

3. What is *A Covered Service According to the State Plan?*

The service is described in the Medicaid State Plan. In general, if the service is listed in an HCA Provider Guide, the service is probably covered.

What Services Qualify for the IHS Encounter Rate?

4. What are the codes in the Tribal Guide that **do not** qualify for the encounter rate?

Generally the codes that do not qualify for the IHS encounter rate are labs/xrays/drugs. The following codes are listed in the Tribal Health Guide as not encounter eligible

36400-36425, 36511-36515, 38204-38215, 70000-79999, 80000-89999, 90281-90749, 99441-99443, D0210, D0220, D0230, D0240, D0270, D0272, D0273, D0274, D0321, D0330, D0340, D0350, D0460, D0501, H0030, J/Q/S-codes, P3000-P3001, T1017

NOTE: it was easier to go with a not-eligible list rather than an eligible list because the eligible list is too large

What Services Qualify for the IHS Encounter Rate?

5. What is *Performed by a health care professional authorized to provide services under the state plan and within their scope of practice?*

"Health care professional" *means a provider of health care services licensed or certified by the state in which they practice (WAC 182 500 0045)* ; for Indian health care providers, federal rules require Medicaid to accept providers licensed in any state.

"Within their scope of practice" means services that the health care professional is authorized to perform by virtue of their license. In general, HCA relies on DOH for guidance on scope of practice matters.

NOTE: if the service is incident to another service on the same day then the incident to service is not encounter eligible and is included in the payment for the primary visit (all services should be on one claim for incident to billing in regards to encounters)

What Services Qualify for the IHS Encounter Rate?

6. What is *Documented in the client's file in the provider's office*?

The standards for documentation by a provider are generally provided in WAC – DOH or DSHS. In general, the client's file should reflect the diagnoses and services provided by the provider.

What Services Qualify for the IHS Encounter Rate?

7. What is *Performed in the facility identified on the IHS facility list or at satellite or branch locations (SUD must be in the approved facility)?*

IHS maintains a list of IHS and 638 facilities, which IHS delivers to CMS as needed; HCA works with IHS PAO to maintain its list of IHS/638 facilities.

"Performed in the facility…" usually means rendered on-site, but certain places of service are also acceptable depending on medical necessity or client benefit (making sure all other criteria and HIPAA privacy are met).

The 4-walls issue is on hold until 2021. HCA needs to research the new T-FQHC criteria. Until 2021 CMS will not be auditing on the 4-walls issue

What Services Qualify for the IHS Encounter Rate?

8. What is *an Apple Health Client who is eligible for the IHS encounter rate?*

Refer to the current Tribal Health Program billing guide, page 24 – which clients do not qualify for the encounter rate – Recipient Aid Categories (RACs) that do not qualify for the IHS encounter rate are listed

Does Methadone Qualify for the IHS Encounter Rate?

Does Methadone dosing or administration qualify for the IHS encounter rate?

If the Methadone administration

(1) Is medically necessary,

(2) Is rendered face to face,

(3) Is a covered service,

(4) Not in the list of not encounter eligible codes (Methadone admin is H0020)

(5) Is performed by a health care professional authorized to provide services under the state plan and working within his/her scope of practice,

(6) Must be documented in the client’s file,

(7) Is performed in the approved facility, and

(8) Is for an Apple Health Client who is eligible for the IHS encounter rate,

Then it meets the criteria and qualifies for the IHS encounter rate.