Washington State Health Care Authority

Tribal Compliance & Operations Work Group

+

Quarterly Tribe & MCO Meeting

Mike Longnecker
HCA Tribal Affairs Office
December 12, 2018

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Agenda

- Diabetic Education
- Intergovernmental Transfer (IGT) For Non-AI/AN SUD Encounters – 2019 rate change
- Tribe and MCO Meeting
- Disclosure of Ownership
- De-Activated Providers
- Calendar Year 2019 schedule
- Top 10 rejections
- FAQ and Open Discussion

- Attachments – MCO contact list, Tribal contact list for the MCOs, EPSDT codes, CY2019 meeting schedule

THE IMPACT OF DIABETES IN WASHINGTON STATE

Heart, Disease, Stroke, and Diabetes Prevention Program,
Community Based Prevention Section

Objectives

- Diabetes & Prediabetes Impact in Washington State
- Strategies to support at-risk populations
- Billing Best Practices for Diabetes Self-Management Education and Support (DSMES) for Medicaid Population
- Medicare Diabetes Prevention Program

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Brief Information about Diabetes

- Chronic condition where the body is unable to regulate blood *glucose* levels

- Three different types of diabetes:
  - Type 1: Body produces little to no *insulin*
  - Type 2: Body does not make enough *insulin* or does not use it properly
  - Gestational Diabetes: Women may develop it during pregnancy

GLUCOSE:
Sugar converted into energy by the cells

INSULIN:
Hormone that helps glucose into the cell

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What is Prediabetes?

- Glucose levels are elevated, but not high enough to diagnose diabetes
- Actions can help prevent prediabetes from becoming type 2 diabetes, and reduce the risk of heart attack and stroke associated with prediabetes
- Many people with prediabetes who do not change their lifestyle—by losing weight (if needed) and being more physically active—will develop type 2 diabetes within 5 years.

PREVENTION:

More than half of the cases of type 2 diabetes may be prevented if prediabetes is identified and treated.

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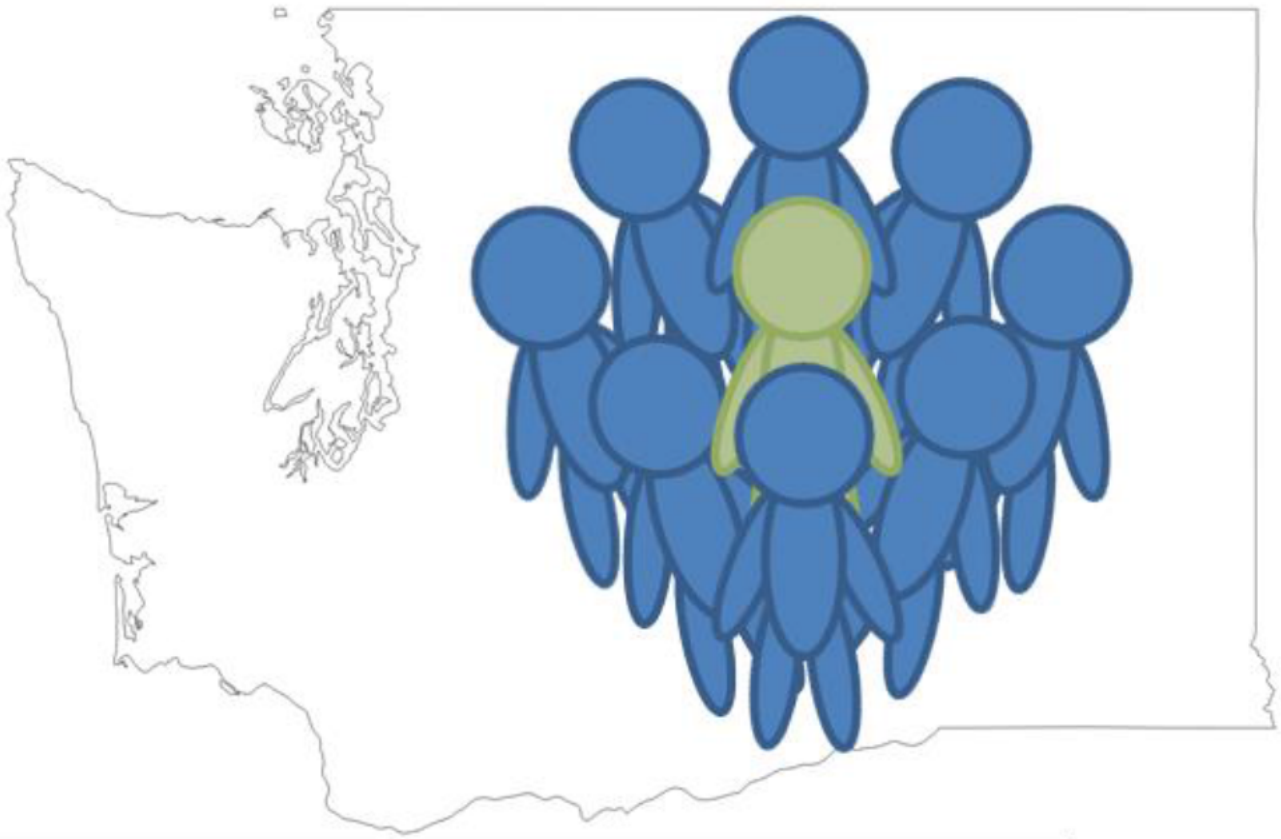
Diabetes in Washington



685,573

People in Washington have **diabetes**

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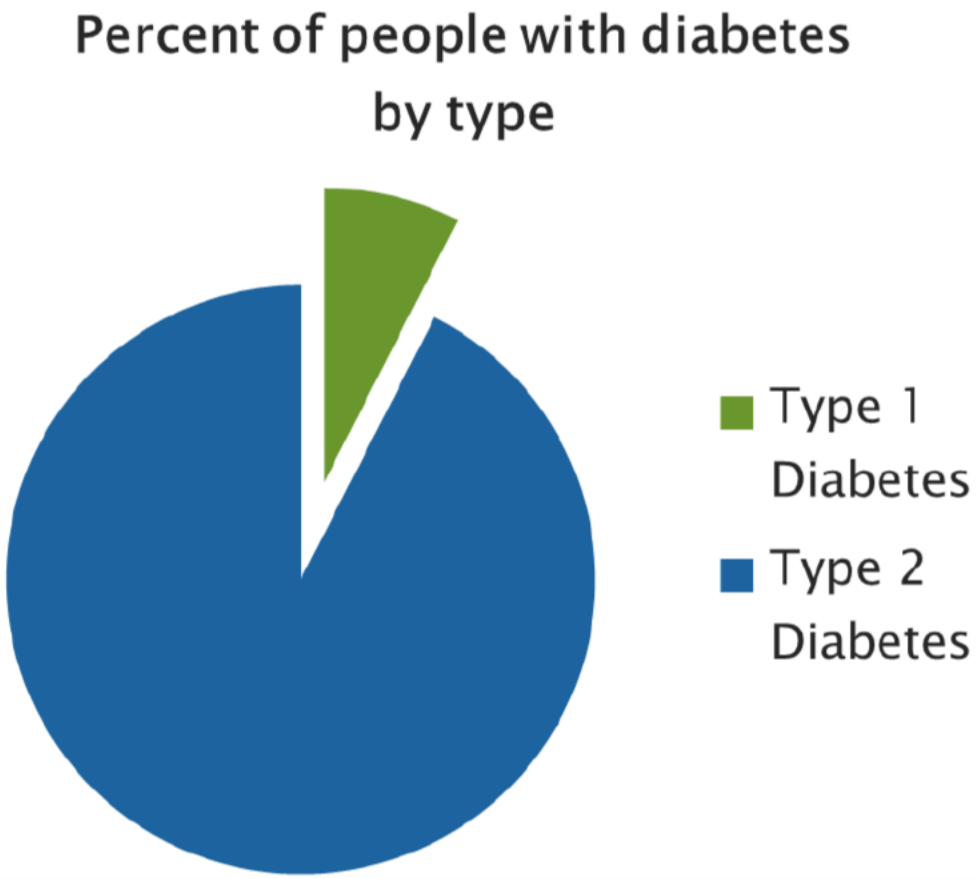
Percentage of people with Diabetes



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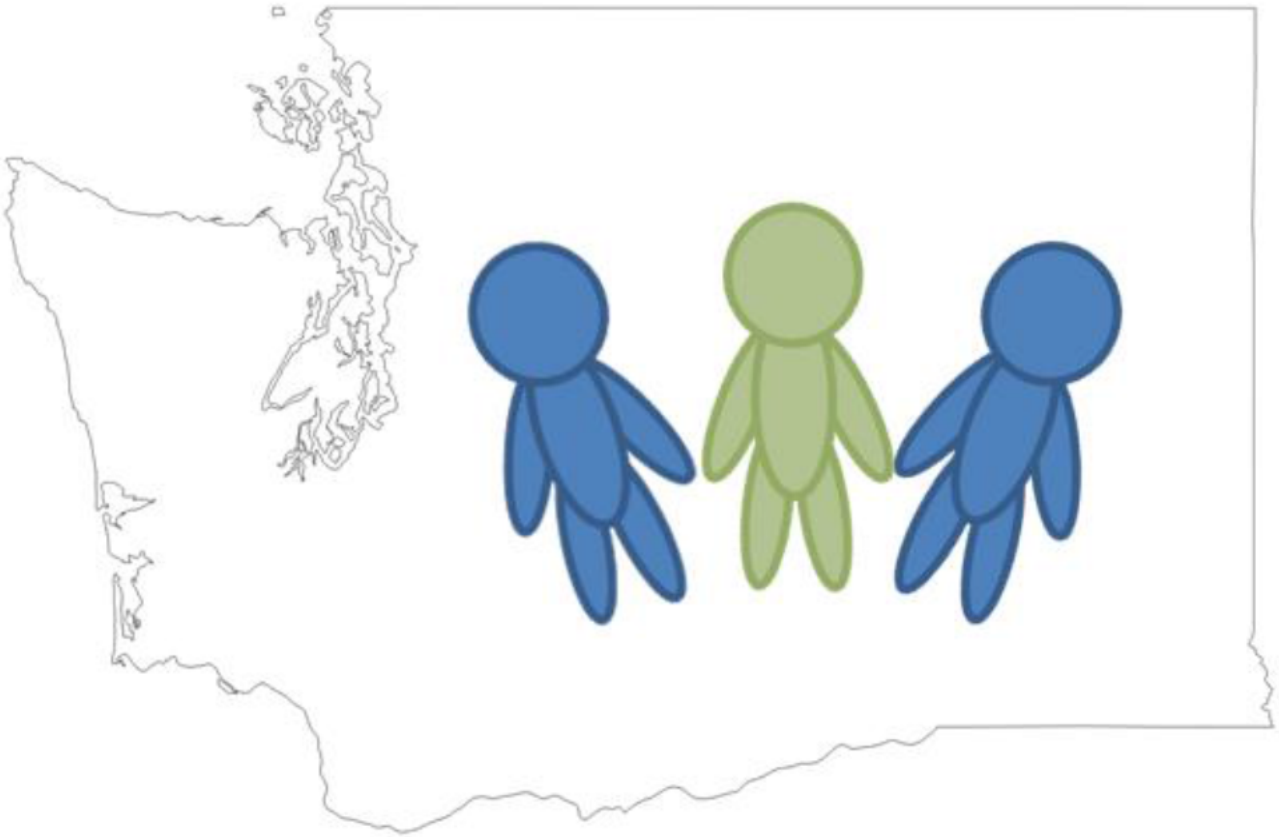
Prediabetes in Washington



1.9 million

Adults in Washington have **prediabetes**

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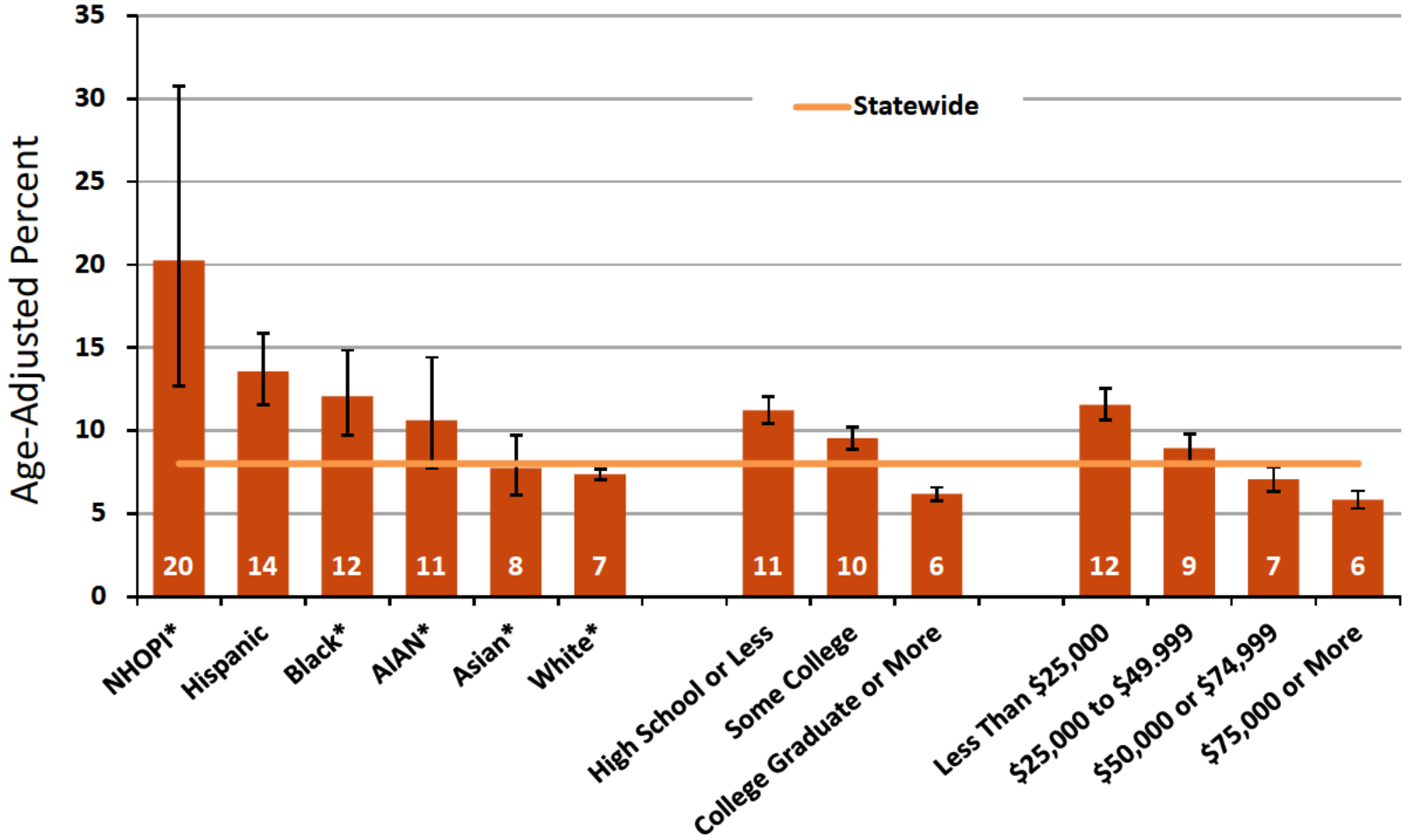
Differences in Diabetes Burden



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Cost of Diagnosed Diabetes

8 billion

Dollars are spent on **diabetes** each year

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Financial Impact of Diabetes in Washington

Washington State Forecasts	2020	2025	2030
Total annual cost (2015 dollars)	$9.8 Billion	$11.6 Billion	$13.4 Billion
Annual medical costs	$7.4 Billion	$8.8 Billion	$10.1 Billion
Annual nonmedical costs	$2.4 Billion	$2.8 Billion	$3.3 Billion

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10 Leading Causes of Death Washington State

Cardiovascular Diseases and Diabetes combined are the #1 cause of death in Washington State

1	Cancer	23.2%
2	Heart Disease	20.2%
3	Alzheimer's	6.4%
4	Unintentional Injury	5.8%
5	COPD	5.8%
6	Stroke	4.9%
7	Diabetes Mellitus	3.3%
8	Suicide	2.1%
9	Liver Disease	1.9%
10	Flu & Pneumonia	1.6%

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Strategies to Support

- Screening at risk population
- Diabetes Education/ Medical Nutrition Therapy
- Psychosocial Assessment
- Immunizations
- Blood Pressure
- Lipids
- Smoking Cessation
- Kidney testing
- Eye exams
- Foot checks

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What Organizations Can Do for Prevention

- Make sure health-promoting foods are available
- Support physical activity at all levels
- Be aware of gaps in services and resources, and who is impacted by these gaps – such as screening & treatment
- Know what resources are available, and connect/support
- Provide opportunities for social connection and partnership
- Advocate for better health for all

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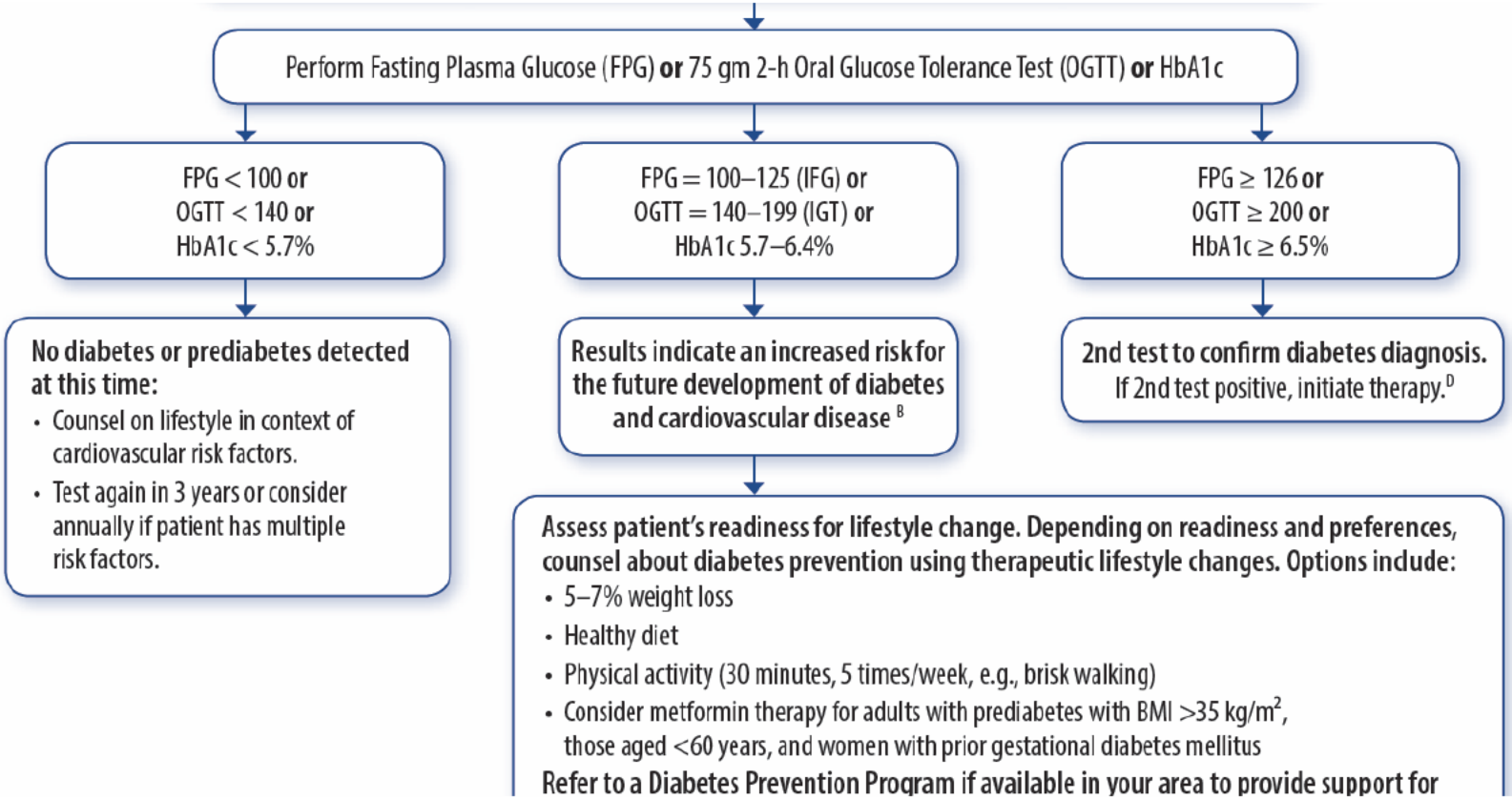
Diabetes Screening Algorithm



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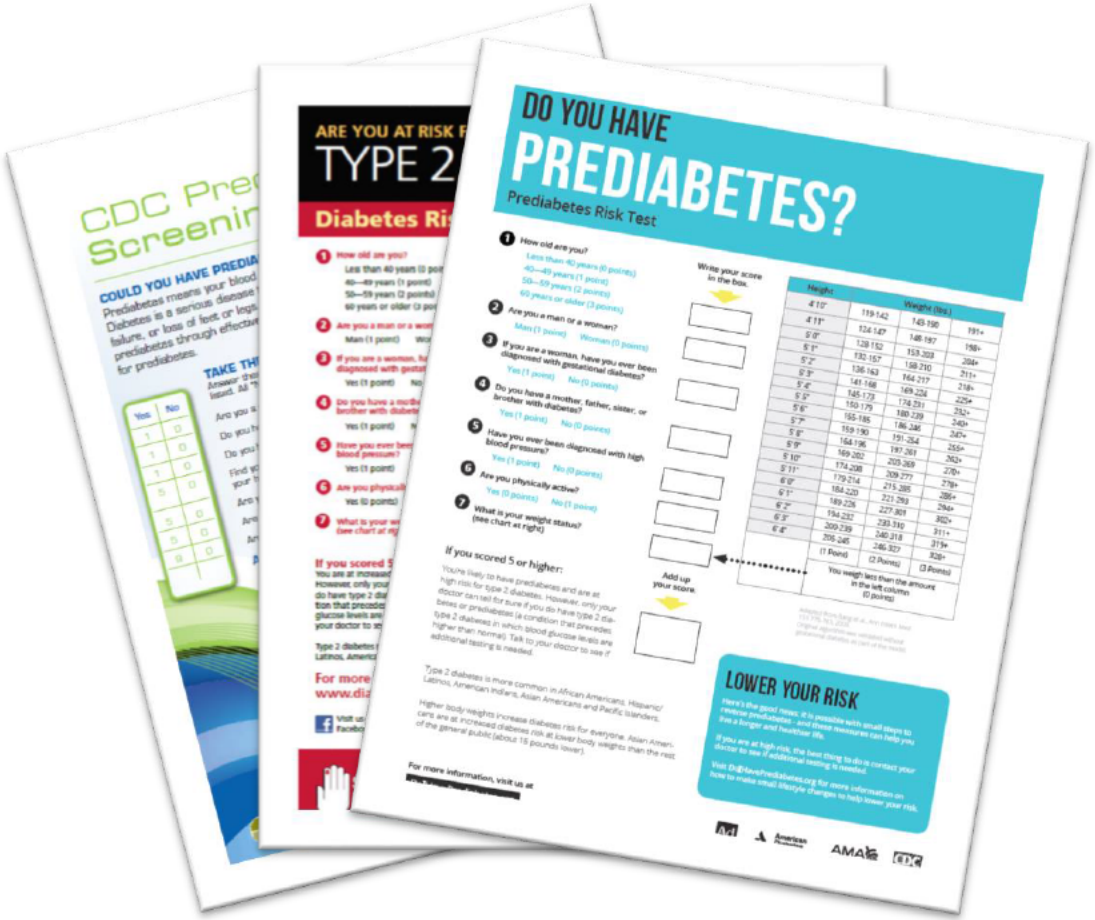
Supporting Prevention

- Encourage prediabetes screening by sharing these questionnaires with your community and encouraging people with prediabetes to participate in DPP



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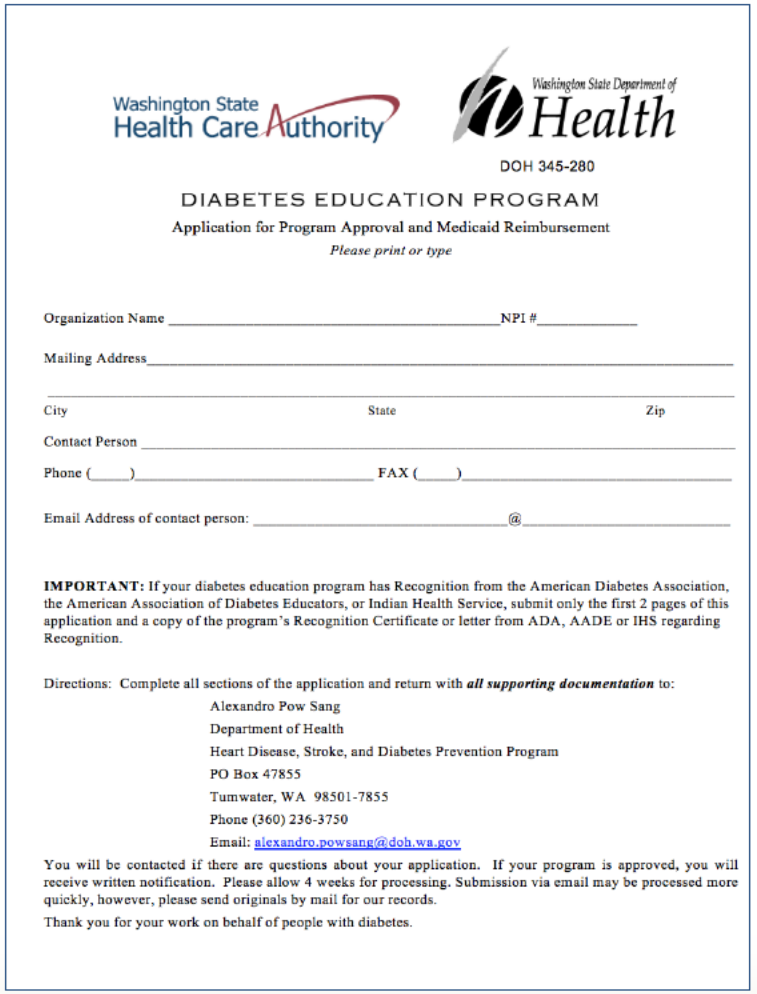
Medicaid Reimbursement for DSMES Programs

- Medicaid Coverage for DSMES in Washington State became effective in January1998
- Known as Apple Health
- Implemented to support preventive health services and to reduce the impact of diabetes in our state
- Provides medically necessary diabetes education to eligible clients.

Diabetes Education Program

- Clinics and hospitals statewide may apply for reimbursement from Medicaid for diabetes education programs.
- This is a joint project between the Washington State Department of Health and Medicaid.



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Washington State Department of Health

DOH 345-280

DIABETES EDUCATION PROGRAM

Application for Program Approval and Medicaid Reimbursement

Please print or type

Organization Name _____ NPI #_____

Mailing Address_____

_____

City State Zip

Contact Person _____

Phone (____)_____ FAX (____)_____

Email Address of contact person: _____@_____

IMPORTANT: If your diabetes education program has Recognition from the American Diabetes Association, the American Association of Diabetes Educators, or Indian Health Service, submit only the first 2 pages of this application and a copy of the program's Recognition Certificate or letter from ADA, AADE or IHS regarding Recognition.

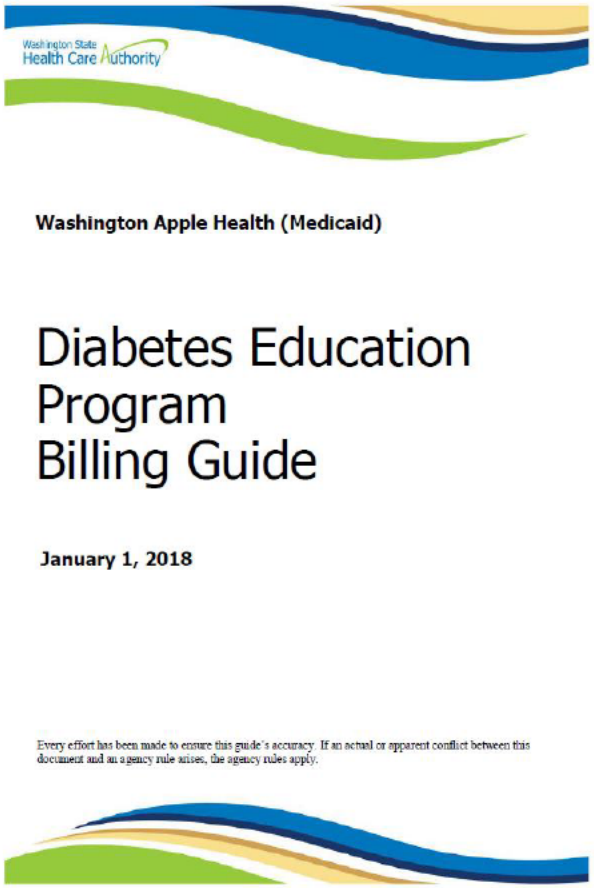
Directions: Complete all sections of the application and return with ***all supporting documentation*** to:

Alexandro Pow Sang
Department of Health
Heart Disease, Stroke, and Diabetes Prevention Program
PO Box 47855
Tumwater, WA 98501-7855
Phone (360) 236-3750
Email: alexandro.powsang@doh.wa.gov

You will be contacted if there are questions about your application. If your program is approved, you will receive written notification. Please allow 4 weeks for processing. Submission via email may be processed more quickly, however, please send originals by mail for our records.

Thank you for your work on behalf of people with diabetes.

What is Included



- It covers 6 hours of diabetes education and diabetes management per year. Provider may request more per individual case.
- Minimum of 30 minutes per billed unit.
  - Each unit is equal to 30 minutes of education
  - For services provided in a:
    - professional (non-hospital) setting use HCPCS Codes = G0108 and G0109.
    - hospital outpatient setting, use revenue code 0942.
- If benefit limit for diabetes education is reached, a provider may request prior authorization for a limitation extension from Health Care Authority.

Diabetes Education Program Billing Guide

Washington State Health Care Authority

Fee Schedule

Health Care Authority (HCA)

Diabetes Education Program Fee Schedule

July 1, 2017

Code Status Indicator	Code	Mod	Maximum Allowable NFS	Maximum Allowable FS	PA Required	Comments
R	G0108		$31.85	$31.74		
R	G0109		$8.49	$8.71		

Status Indictors

D = Discontinued / Deleted Code

N = New Code

P = Policy Change

R = Rate Update

Legend

PA= Written/ Fax Prior Authorization

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Medicare Diabetes Prevention Program

- Covered by Medicare as of April 1st 2018.
- Benefit will be covered through Part B Medical Insurance.
- Medicare Advantage subscribers are eligible for MDPP if their plan has contracted with an MDPP enrolled supplier.
- Covers up to 2 years of in-person sessions.
  - Months 0 to 6 – Core Sessions
  - Months 7 to 12 – Core Maintenance Sessions
  - Months 13 to 24 – Ongoing Maintenance Sessions
- To bill Medicare provider must meet MDPP Preliminary Recognition, or full CDC DPRP Recognition.

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For More Information

- Diabetes Epidemic & Action Report
  - http://doh.wa.gov/DEAR
- Washington State Diabetes Connection
  - http://diabetes.doh.wa.gov/
- Living Well with Chronic Conditions
  - http://livingwell.doh.wa.gov/
- CDC List of Diabetes Prevention Programs
  - https://nccd.cdc.gov/DDT_DPRP/CitiesList.aspx?STATE=WA

Resources

American Association of Diabetes Educators
- https://www.diabeteseducator.org/docs/default-source/legacy-docs/_resources/pdf/research/scopestandards_final2_1_11.pdf?sfvrsn=2
- https://www.diabeteseducator.org/patient-resources/tip-sheets-and-handouts

American Diabetes Association – Professional resources
- http://care.diabetesjournals.org/content/40/10/1409
- http://care.diabetesjournals.org/content/41/Supplement_1/S1

American Diabetes Association- Diabetes Standards of Care
- http://professional.diabetes.org/admin/UserFiles/0%20-%20Sean/Documents/January%20Supplement%20Combined_Final.pdf

Center for disease Control - Diabetes Medication Use Among Adults with Diabetes
- http://www.cdc.gov/diabetes/statistics/treating_national.htm

Healthy People
- http://www.healthypeople.gov/2020/topics-objectives/topic/diabetes?topicid=8

Indian Health Services
- http://www.ihs.gov/forpatients/healthtopics/Diabetes/

Infographic: A Snapshot of Diabetes in America
- http://www.diabetes.org/diabetes-basics/statistics/cdc-infographic.html

Living Well with Chronic Conditions
- http://livingwell.doh.wa.gov/resources/living-well-marketing-resources-fact-sheets-evidence-based-studies-gis-maps

MDPP Fee Schedule
- https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2017-08-16-MDPP-Call-Presentation.pdf

National Diabetes Surveillance System
- http://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html

Stanford Medicine – Patient Education
- http://patienteducation.stanford.edu/programs/diabeteseng.html

Washington Information Network
- http://win211.org/

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Contact information – Department of Health

Heart Disease, Stroke, & Diabetes Prevention Unit

Alexandro Pow Sang
Alexandro.powsang@doh.wa.gov
Diabetes Prevention Lead

handle: WADeptHealth


Washington State Department of
Health

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

- IGT (InterGovernmental Transfer) is required when SUD services for non-AI/AN clients are billed at IHS/638 clinics
- Page 40 of the current billing guide has the complete information
- Tribe is required to submit the local matching funds to HCA. HCA will confirm that the funds were received and should issue the local matching funds back to the Tribe within 5-7 days
- The next 2 slides may be useful for adding up the local matching fund requirement before sending to HCA
- The switch to CPE is anticipated to occur in mid 2019

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

2019 SUD FMAP RATES					
Tribal IHS/638 Encounter billing for Substance Use Disorders and the Federal Medical Assistance Percentages (FMAP) Cheat sheet is for date of service during Calendar Year 2018 and for claims billed during Calendar Year 2019					
	AI/AN client		NonNative classic and non-Alternative Benefit Plan (ABP)	nonNative ABP	NonNative SSI
Client RAC	Any CD encounter eligible RAC		Any CD encounter eligible RAC except 1201 or 1217	1201	1217
CD billing code modifier	Refer to the Tribal billing guide (DBHR CD outpatient general fund is *usually* HF and only HF)				
T1015 modifier	HF		HX	SE	HB
EXAMPLES					
Claim note	SCI=NA		SCI=NN	SCI=NN	SCI=NN
CD group therapy	96153 HF T1015 HF		96153 HF T1015 HX	96153 HF T1015 SE	96153 HF T1015 HB
CD individual therapy	H0004 HF T1015 HF		H0004 HF T1015 HX	H0004 HF T1015 SE	H0004 HF T1015 HB
Federal/State Match percentage (FMAP)	100% / 0%		50% / 50%	93% / 7%	93% / 7%
How much does the claim pay?	$427.00 **		$213.50 **	$397.11 **	397.11 **
How much IGT is required to be sent to DSHS?	$0		$213.50 **	$29.89 **	$29.89 **

** Note: this is the 2018 rate. We have to continue to use the 2018 rate until the 2019 rate is announced

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

Date of service	IHS rate	Client RAC	FMAP (begins 1/1/2019)	P1 payment	IGT Match to be sent to DSHS
CY2017	$391	1201 (ABP)	93%	$363.63	$27.37
		1217 (SSI)	93%	$363.63	$27.37
		All others	50%	$195.50	$195.50
CY2018	$427	1201 (ABP)	93%	$397.11	$29.89
		1217 (SSI)	93%	$397.11	$29.89
		All others	50%	$213.50	$213.50
CY2019	TBD	Use 2018 rates until CY 2019 rate is announced			

FMAP and IGT rates are current for 01/01/2019 with no planned changes until 01/01/2020

I/T

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Tribe and MCO Meeting

Q. How do we credential a new Doctor with the MCOs?

- **Amerigroup** Amerigroup does not credential individual docs – Amerigroup credentials the Indian health facility.
- **Community Health Plan of Washington** - Send a request to credential a provider to the Provider.Credentialing@chpw.org inbox.
- **Coordinated Care**
- **Molina Healthcare**
- **United Healthcare Community Plan**

Tribe and MCO Meeting

Q. In preparation for MCO payment of the IHS encounter rate - can Tribes submit claims now with the coding that will be needed later?

- **Amerigroup**
- **Community Health Plan of Washington** - YES
- **Coordinated Care**
- **Molina Healthcare**
- **United Healthcare Community Plan**

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Tribe and MCO Meeting

- Questions? Issues?

We hope to be able to announce that the Managed Care Plans are paying at the (IHS) encounter rate during 2019. P1 updates need to happen on HCA's side first

Disclosure of Ownership

Refer to the December, 2016 TCOW for background information.

CMS Tribal Affairs helped give HCA definitive guidance on September 28, 2016

P1 was updated on November 18th to require the Disclosure of Ownership from the Tribes (the Urban Organizations were already in compliance

42 C.F.R. § 455.104 requires HCA to obtain from every Medicaid provider (except individuals or groups) (including through Managed Care Entities) the name, address, date of birth, and SSN of:

- Any managing employee of the provider; and
- Any person with an ownership or control interest in the provider.
  - Additional disclosure requirements apply to persons with an ownership or control interest in the provider.

I/T -- Urbans were already in compliance

Disclosure of Ownership

42 C.F.R. § 455.101 defines:

- "Managing employee"
  - A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the provider.
- "Person with an ownership or control interest"
  - A person or corporation that:
    - Has total direct and indirect ownership interest ≥ 5%,
    - Owns 5% or more of any loan secured by the provider,
    - Is an officer or director of the provider organized as a corporation, or
    - Is a partner of the provider organized as a partnership

I/T -- Urbans were already in compliance

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Disclosure of Ownership

- IHS and Tribal 638 facilities typically disclose for:
  - Managing employee - Tribal health director or tribal clinic administrator.
  - No requirement to disclose information about any person with an ownership or control interest because IHS and Tribal 638 programs are not corporations or partnerships.
- Urban Indian Health Programs typically disclose for:
  - Managing employee - Executive director or chief executive officer.
  - Members of Board of Directors.
  - Officers.

I/T -- Urbans were already in compliance

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Disclosure of Ownership

42 C.F.R. § 455.104 requires these disclosures from providers to be made at any of the following times:

- When the provider submits the provider application.
- When provider signs the provider agreement.
- When HCA asks the provider during the revalidation of enrollment process under 42 C.F.R. § 455.414.
  - HCA must revalidate the enrollment of every provider at least every 5 years.
- Within 35 days after any change in ownership of the provider.

I/T -- Urbans were already in compliance

Disclosure of Ownership

- If you have not entered in the Disclosure of Ownership information, please contact HCA's Provider Enrollment help desk for help in how to make the update in P1 (mike is not able to "see" how the update is made)
- The Enrollment help desk may be reached at providerenrollment@hca.wa.gov or at 800-562-3022 ext 16137 (M-F except Wednesdays)

I/T -- Urbans were already in compliance

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De-Activated Servicing Providers

- Some servicing providers were De-Activated in P1 on October 1st
- HCA's Provider Enrollment team reached out to the providers during the summer of 2018. If the provider did not answer before October 1st they were De-Activated in P1
- mike still says *Everything is Fixable*
  - If prescriptions are not involved, reach out to mike for help
  - If prescriptions are involved, reach out to mike and remind him that prescriptions are not being filled so that I can request an expedite
- Most of the providers were individual providers who are also able to be the pay-to provider in P1. The provider may want to continue to be a "billing" (pay to) provider or they may want to be a "servicing only" (never gets a check from P1) provider but they will need to choose which to be before re-enrolling in P1
- Mike suggest if you get EOB N288 or N290 to just send him the TCN

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Calendar Year 2019 Schedule

Attached to the webinar is the Calendar Year 2019 MTM (Monthly Tribal Meeting) and TCOW (Tribal Compliance and Operations Workgroup schedule along with the Webinar registration links and Outlook invites

- MTM – 1st Wednesdays from 9:00-1:00
- TCOW – 2nd Wednesdays from 9:00-11:00 (MCO meetings are 9-12)

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Medical - Top 20 EOB Translations

EOB	Description	Comments
204 ITU 02190	*This service/equipment/drug is not covered under the patient's current benefit plan*	• Claims were Medicare cross-overs and the client is a medicare-only client • Client is not full-scope coverage (e.g. family planning only) • Rendering taxonomy on claim was not adopted by P1 (eg 390200000x, 101YA0400x)
18 ITU 98328	*Exact duplicate claim/service*	Dupe
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.* Ask mike for the list if you don't already have it
24 ITU 02035	*Charges are covered under a capitation agreement/managed care plan.*	Client is enrolled in one of the Apple Health Managed Care Plans (e.g., Amerigroup, CHPW, Coordinated Care, Molina or United Healthcare)
181 ITU 16030	*Procedure code was invalid on the date of service*	The Procedure code was probably valid but P1 was not able to determine how much to pay on the service. Double check the fee schedule to see if the code is listed. CPT 80101 was ended in 2014

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Medical - Top 20 EOB Translations

EOB	Description	Comments
96 /N30 ITU 02370	*Non-covered charge(s)* *Patient ineligible for this service*	Client is a Medicare only client (SLMB, QDWI, or QI1) and does not have P1 coverage
96 / N130 ITU 03005	*Non-covered charge(s).* *Consult plan benefit documents/guidelines for information about restrictions for this service*	The Physician fee schedule helps point to the noncovered codes
236 ITU 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*	Code pair is not payable in combination per NCCI rules.
16 / M119 ITU 03640	*Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).*	Most drug codes need an NDC & the NDC needs to be associated to the drug code (Medispan reports the code/NDC pairs)
97 / N20 ITU 03920	*The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. + Service not payable with other service rendered on the same date.*	Vaccine Administrative fee billing has certain requirements, if you do not have mike's immunization cheat sheet – just ask

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Medical - Top 20 EOB Translations

EOB	Description	Comments
97 / N20 ITU 14095	*The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. + Service not payable with other service rendered on the same date*	If this EOB is on an E&M (99201-99215) it is due to an HCA-policy regarding E&Ms not payable on same day as an immunization. This is similar to the NCCI edit with a similar resolution - modifier 25 may be added to the E&M (if appropriate) to waive the rule
16 N290 ITU 01245 01010	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier*	• Claim was missing the rendering NPI • The rendering NPI on the claim has not been enrolled in P1 yet
16 N288 ITU 01485	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider taxonomy*	• Rendering taxonomy on claim is not one that the provider is enrolled with • Licensed has expired (when licenses expire, P1 automatically expires the taxonomy too)
4 ITU 03715	*The procedure code is inconsistent with the modifier used or a required modifier is missing.*	EOB 4 on immunizations often means that the immunization is "free from DOH". Ask mike for the immunization cheat sheet if you don't have it

Medical - Top 20 EOB Translations

EOB	Description	Comments
A1 / N59 ITU 03785	*Please refer to your provider manual for additional program and provider information*	Well child (EPSDT) visits can only contain the codes that HCA chose for EPSDT claims. This information is not shared in the billing guides. Codes that can be paid on an EPSDT claim are attached to today's webinar.
6 ITU 03145	*The procedure/revenue code is inconsistent with the patient's age.*	Medical Nutrition is only covered for kids (age 0-20)
22 ITU 02205	*This care may be covered by another payer per coordination of benefits*	Client has Medicare Part B or C. If Medicare has already been billed - refer to EOB 16/N48 (the Medicare payment was not reported correctly per P1)
29 ITU 00190	*The time limit for filing has expired*	Claim is outside the timely filing window. HCA has the following timely rule: • 365 days from the date of service to get the claim billed to P1 • If a claim met the initial 365 day requirement but needs correcting we get up to 2 years from the date of service for corrections
A1 / N362 ITU 03993	*The number of Days or Units of Service exceeds our acceptable maximum*	Most services on medical claims are billed at a single unit per line (including CPT 90472)

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Dental - Top 20 EOB Translations

EOB	Description	Comments
18 ITU 98328	*Exact duplicate claim/service*	Dupe
96 N130 ITU 03005	*Non-covered charge(s). Consult plan benefit documents/guidelines for information about restrictions for this service*	Service not covered. The dental fee schedule does a nice job of outlining covered codes for kids and adults
6 ITU 03145	*The procedure/revenue code is inconsistent with the patient's age.*	Oral Hygiene Instructions (D1330) are covered for clients age 0-8 Crowns are not covered for adults Root canals (molars/bicuspids) not covered for adults
96 N428 ITU 03175	*Non-covered charge(s) Not covered when performed in this place of service*	Oral Hygiene Instructions (D1330) and Limited Visual Oral Assessment (D0190/D0191) are not covered in a dental office or clinic setting
119 ITU 12195	*Benefit maximum for this time period or occurrence has been reached*	Fluoride limits exceeded. If you don't have mike's dental cheat sheet with the tooth numbering and common dental limits, just ask

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Dental - Top 20 EOB Translations

EOB	Description	Comments
119 M86 ITU 12180	*Benefit maximum for this time period or occurrence has been reached* *Service denied because payment already made for same/similar procedure within set time frame.*	Cleaning (Prophy) too soon Kids (0–18) – once per 6 months Adults (19+) – once per year (extra allowed for DDA and ALF clients)
181 ITU 16030	*Procedure code was invalid on the date of service*	The Procedure code was probably valid but P1 was not able to determine how much to pay on the service (e.g., a crown for an adult has no rate and may be rejected with this EOB along with the "not covered" EOB)
197 ITU 11120	*Precertification/authorization/ notification/pre-treatment absent*	Some dental services require prior authorization (e.g., dentures) – easiest to refer to the dental billing guide to see which services need prior authorization
29 ITU 00190	*The time limit for filing has expired*	Claim is outside the timely filing window. HCA has the following timely rule: • 365 days from the date of service to get the claim billed to P1 • If a claim met the initial 365 day requirement but needs correcting we get up to 2 years from the date of service for corrections
119 ITU 12190	*Benefit maximum for this time period or occurrence has been reached*	Complete panoramic xrays (D0330 D0210) are covered once in a three-year period (age 14+)

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Dental - Top 20 EOB Translations

EOB	Description	Comments
A1 / N81 ITU 03720	*Procedure billed is not compatible with tooth surface code.*	Sealants (D1351) are covered for clients age 20 and younger for the O–Occlusal surface on the following teeth: 2, 3, 14, 15, 18, 19, 30, 31, A, B, I, J, K, L, S, & T (see billing guide if client is DDA)
204 ITU 02190	*This service/equipment/drug is not covered under the patient's current benefit plan*	Most clients were either Medicare–only (either QMBonly or SLMB, QDWI or QI–1)
119 ITU 12005	*Benefit maximum for this time period or occurrence has been reached*	Periodic Oral Evaluations (D0120) are covered once every 6 months (The Comprehensive code, D0150 is usually referred to as a "new patient" code) NOTE: Limited Oral Evaluations (D0140) do not have a frequency schedule like the comp/periodic evals See the dental billing guide, page 27–28 for information on the Limited Eval service
26 ITU 02255	*Expenses incurred prior to coverage*	Client was not eligible on this date of service. NOTE: we have recently found that some clients are determined to be retroactively eligible after the claim(s) have been rejected, it is OK to reprocess claims if they are still timely
119 / N640 ITU 14000	*Exceeds number/frequency approved/allowed within time period.*	Bitewings (D0270 D0272 D0273 D0274) are allowed up to (a total of) 4 bitewings per year

Washington State Health Care Authority

Dental - Top 20 EOB Translations

EOB	Description	Comments
119 ITU 12215	*Benefit maximum for this time period or occurrence has been reached*	Sealants are allowed once (per tooth) in a 3 year period (DDA clients are once in a 2 year period)
119 ITU 12045	*Benefit maximum for this time period or occurrence has been reached*	The comprehensive Eval (D0150) is covered once in a 5 year period unless the client has a documented significant change in health conditions. If it has been 6 months or more since the last Evaluation a Periodic (D0120) may be billed
16 / N39 ITU 00145	*Procedure code is not compatible with tooth number/letter.*	Follow this outline If the billing guide says an arch (01 02) or quad (10 20 30 40) is required – add the arch or quad If the billing guide says a tooth number is required – add the tooth number. Some restoration codes are for anterior or posterior teeth only
119 ITU 13425	*Benefit maximum for this time period or occurrence has been reached*	Cleaning (prophy) was too soon. Cleaning is covered once every • Six months for a client age 18 and younger. • Twelve months for a client age 19 and older.
119 ITU 13075	*Benefit maximum for this time period or occurrence has been reached*	Claim was for a "filling" (restoration) but the tooth surface was "filled" within the past 2 years

Washington State Health Care Authority

Mental Health - Top 20 EOB Translations

EOB	Description	Comments
204 ITU 02190	*This service/equipment/drug is not covered under the patient's current benefit plan*	Clients were either Medicare-only clients or the performing taxonomy was a taxonomy that has not been implemented in P1 (e.g. 1041c0700x and 101YA0400x are not used in P1)
18 ITU 98325	*Exact duplicate claim/service*	Dupe
16 N290 ITU 01245 01010	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier*	• Claim was missing the rendering NPI • The rendering NPI on the claim has not been enrolled in P1 yet
16 N290 ITU 01390	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier*	Rendering NPI on the claim was either the billing group's NPI or the rendering NPI is not in P1 for the date of service or the rendering NPI was *De-Activated* in October

Washington State Health Care Authority

Mental Health - Top 20 EOB Translations

EOB	Description	Comments
96 / N130 ITU 03005	*Non-covered charge(s). Consult plan benefit documents/guidelines for information about restrictions for this service*	Service not covered. Refer to the code-tables on page 35-40 of the Mental Health Billing Guide for the list of HCA-covered mental health codes
236 ITU 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*	Not payable in combination per NCCI guidelines. During February, 2018 mike did an NCCI review for mental health codes - need a copy? Just ask
16 N288 ITU 01485	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider taxonomy*	• Rendering taxonomy on claim is not one that the provider is enrolled with • Licensed has expired (when licenses expire, P1 automatically expires the taxonomy too) • Some providers were *De-Activated* in P1 on 10/01 (contact mike)
181 ITU 16030	*Procedure code was invalid on the date of service*	The Procedure code was probably valid but P1 was not able to determine how much to pay on the service
22 ITU 02205	*This care may be covered by another payer per coordination of benefits*	Client has Medicare Part B or C. If Medicare has already been billed - refer to EOB 16/N48 (the Medicare payment was not reported correctly per P1)

Washington State Health Care Authority

Mental Health - Top 20 EOB Translations

EOB	Description	Comments
16 N255 ITU 01475	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid billing provider taxonomy*	Billing/group taxonomy not valid • FQHCs use 261QF0400x • IHS/638 use 2083P0901x
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)
29 ITU 00190	*The time limit for filing has expired*	Claim is outside the timely filing window. HCA has the following timely rule: • 365 days from the date of service to get the claim billed to P1 • If a claim met the initial 365 day requirement but needs correcting we get up to 2 years from the date of service for corrections
16 N290 ITU 01445	*Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier*	Rendering provider is not current in P1. Could be due to licensure or the *De-Activation* issue, contact mike
107 ITU 00570	*The related or qualifying claim/service was not identified on this claim.*	Prolonged Care (99354-99357) is an add-on code that can only be billed with certain other codes. HCA did not follow CPT - HCA did not add 90837 as a base code for the add-on codes

Washington State Health Care Authority

Mental Health - Top 20 EOB Translations

EOB	Description	Comments
16 N48 ITU 02207	*Claim/service lacks information or has submission/billing error(s).* *Claim information does not agree with information received from other insurance carrier*	Client has Medicare (B or C) and it appears that Medicare made a payment but the claim was not billed as a "medicare cross-over"
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*.
18 I/T 12120	*Duplicate*	Duplicate T1015 submissions (claims were prior to 09/29/2017. If duplicates are billed after 09/29/2017 there is a chance of overpayment
258 ITU 02224	*Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.*	Clients are not eligible for (outpatient) P1 coverage while incarcerated. If the client was at the clinic but the claim rejected with EOB 258 – contact mike to get the client's eligibility corrected in P1
03740	*This provider type/provider specialty may not bill this service*	Refer to the code table on page 35 of the mental health billing guide

Washington State Health Care Authority

SUD - Top 20 EOB Translations

EOB	Description	Comments
18 ITU	*Exact duplicate claim/service*	Duplicate billing
24 Urbans 01365	*Charges are covered under a capitation agreement/managed care plan*	FQHCs only – client is enrolled in a BHO, BHSO or IMC
181 ITU 16030	*Procedure code was invalid on the date of service*	The Procedure code was probably valid but P1 was not able to determine how much to pay on the service. Labs and acupuncture are not payable
4 I/T/U 00800	*The procedure code is inconsistent with the modifier used or a required modifier is missing.*	EOB 4 has a few different meanings, in this instance it was regarding the modifier on the SUD code (almost always HF, refer to SUD codes attachment)

Washington State Health Care Authority

SUD - Top 20 EOB Translations

EOB	Description	Comments
170 N95 ITU 03740	*Payment is denied when performed/billed by this type of provider This provider type/provider specialty may not bill this service*	• Labs and acupuncture are not payable • If the SUD code is missing a modifier (e.g. HF) we also see this EOB
273 / N362 ITU 25010	*Coverage/program guidelines were exceeded + The number of Days or Units of Service exceeds our acceptable maximum.*	Assessment (H0001) is always '1' unit
29 ITU 00190	*The time limit for filing has expired*	Claim is outside the timely filing window. Non-Medicare-crossovers have the following timely rule • 365 days from the date of service to get the claim billed to P1 • If a claim met the initial 365 day requirement but needs correcting we get up to 2 years from the date of service for corrections
96 / N130 ITU 03005	*Non-covered charge(s). Consult plan benefit documents/guidelines for information about restrictions for this service*	Service not covered. Refer to the code-tables on page 19 of the SUD billing guide for the list of HCA-covered SUD codes
26 ITU 02255	*Expenses incurred prior to coverage*	Client was not eligible on this date of service. NOTE: we have recently found that some clients are determined to be retroactively eligible after the claim(s) have been rejected, it is OK to reprocess claims if they are still timely

Washington State Health Care Authority

SUD - Top 20 EOB Translations

EOB	Description	Comments
A1 N61 I/T 01515	*Claim/Service denied* *Rebill services on separate claims*	**DO NOT rebill on separate claims.** Tribal IHS and 638 SUD claims need a claim note. EOB N61 happens when the claim note is not correct AI/AN clients – SCI=NA (or sci=na) nonAI/AN clients – SCI=NN (or sci=nn)
16 / M51 ITU 03130	*Missing/incomplete/invalid procedure code(s).*	Old (noncovered) CPT (80101) on claims
4 I/T 03610	*The procedure code is inconsistent with the modifier used or a required modifier is missing.*	SUD billing codes always need a modifier (refer to billing guide, outpatient SUD almost always needs HF on the billing code)
11 ITU 03955	*The diagnosis is inconsistent with the procedure*	SUD claims (other than the Assessment service) require that the primary diagnosis be in the approved list of diagnoses
16 MA39 ITU 02120	*Claim/service lacks information or has submission/billing error(s).* *Missing/incomplete/invalid gender*	Two different types of P1 gender issues: • "mike" is in P1 as a girl or "Sally" is in P1 as a boy – contact mike to get P1 updated • Client has identified as transgender – gender on claim must match the gender that is indicated in P1

Washington State Health Care Authority

SUD - Top 20 EOB Translations

EOB	Description	Comments
258 ITU 02224	*Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.*	Clients are not eligible for (outpatient) P1 coverage while incarcerated. If the client was at the clinic but the claim rejected with EOB 258 – contact mike to get the client's eligibility corrected in P1
A1 / N 362 ITU 03993	*The number of Days or Units of Service exceeds our acceptable maximum.*	Residential billers – the units need to equal the span of dates
A1 / N192 ITU 02200	*Patient is a Medicaid/Qualified Medicare Beneficiary*	Client is in the QMB-only program. (RAC 1112 or1113) If client was QMB-dual (eg CNP/QMB or LCP/QMB) the claim would pay in P1 (SUD is currently not covered by Medicare)
96 N30 IT 03841	*Non-covered charge(s)* *Patient ineligible for this service*	The IHS encounter rate is not payable if a client is on state-funds only. Refer to page 20 of the Tribal Health Billing Guide for the list of RAC codes that do not qualify for the encounter rate
16 N329 ITU 02125	*Claim/service lacks information or has submission/billing error(s).* *Missing/incomplete/invalid patient birth date*	Client birthday on claim does not match client birthday in P1 – contact mike to get P1 updated

Washington State Health Care Authority

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

Washington State Health Care Authority

FAQ and Open Discussion

Q What are the requirements to be a Diabetic Education Provider?

A. Hopefully Alexandro's presentation answered all our questions

Refer to page 7 of the Diabetic Education Billing Guide for background information

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 paper EOB doesn't need to be sent. Can you share the EOBs?

A. Refer to the Adjustment Reason and Remark code lists on the WPC website

If Adjustment Reason is any of the following, P1 will reject the claim to bill the primary payer - 4, 15, 16, 17, 18, 22, 23, 24, 29, 38, 42, 46, 47, 72, 95, 100, 107, 109, 116, 125, 129, 133, 136, 165, 192, 209, 226, 227, 228, 242, 243, 252, B11

If Adjustment Reason is any of the following, P1 will waive the Coordination of Benefits editing and allow P1 to pay primary - 1, 2, 3, 6, 9, 11, 35, 39, 40, 45, 49, 50, 51, 54, 55, 56, 59, 94, 96, 97, 119, 149, 151, 167, 168, 170, 198, 202, 204, 222, 234, 248, A1, B1

Page 71 of the P1 Billing & Resource Guide points to where the EOBs get entered in P1.

If Adjustment Reason is not listed above then the claim will most likely be reviewed by somebody in HCA's Coordination of Benefits section

I/T/U

Washington State Health Care Authority

FAQ and Open Discussion

Q. The list of diagnosis codes that are generally not payable includes Z0131, *Encounter for examination of blood pressure with abnormal findings.* Why isn't this payable?

A. Stay tuned, forwarded to HCA clinical staff

Also asking about some noncovered TMJ diagnoses

M26601 RIGHT TEMPOROMANDIBULAR JOINT DISORDER UNSPEC
M26602 same thing but for LEFT
M26603 same thing but for bilateral

Peanut Allergy (Z91010) had a similar issue but was fixed recently

Washington State Health Care Authority

FAQ and Open Discussion

Q. We are following your immunization cheat sheet and added the SL modifier. We were paid $16.27 instead of $5.96, is that an error?

A. For October 1, 2018 thru June 30, 2019 the rate is increased to $16.27

Normally we look at the Professional Administered Drug fee schedule but for the *Vaccines for Children* program we will look at the Enhanced Pediatric Fee Schedule

Note: P1 will not pay more than the billed amount

FAQ and Open Discussion

Q. What do we do if a client's Managed Care Plan recouped claims because the client is retroactively dis-enrolled from Managed Care? The date of service is more than a year old and P1 will reject for timely

A. Refer to the P1 Billing & Resource Guide, page 55 for billing tips when there are retroactive changes that may impact timeliness

HCA may grant exceptions to the timely filing limit when either of the following cause billing delays:

- The client receives retroactive Apple Health coverage, which displays in the eligibility results. The agency allows one year from the date of retroactive eligibility award.
- For various reasons, ProviderOne may recoup premiums to a client's managed care plan, causing the plan to recover payments. Those bills would then need to be submitted fee for service. ProviderOne will allow one year from the date the plan recouped the payment for a given claim if you enter "Managed care recoupment [date]" in the remarks or comments field.
- The commercial payer recouped their payment as primary. You have one year from the date of the takeback to submit the claim to ProviderOne. Enter the "primary payer" and "recoupment [date]" in the remarks or comments field.
- Providers can prove to the agency that there are extenuating circumstances. To appeal a decision made by HCA, send a written appeal using the Contact Us secure mail server. Include any information relevant to why the claim could not be submitted within the timely filing guidelines.

Washington State Health Care Authority

FAQ and Open Discussion

Q. If a client is on QMB and spenddown, can the client be billed or can the services be applied to the spenddown?

A. The Bill a Client Webinar does not address this

The Bill a Client FAQ does not address this

HCA's call center staff suggests calling the Spenddown unit directly at 877 501 2233

Washington State Health Care Authority

FAQ and Open Discussion

Q. We had an office visit rejected for no referral in P1, do office visits require a referral?

A. A Referring NPI is not required for office visits (CPT 99201-99215) in P1. A referring NPI is *rarely* required on P1 claims. Even if a referring NPI is not required – if a claim is billed with a referring NPI and the referring NPI is not valid in P1 then the claim will be rejected.

The following services require a referring NPI on the claim

- Physical Therapy (billing taxonomy 225100000x)
- Occupational Therapy (billing taxonomy 225x00000x)
- Speech Therapy (billing taxonomy 235z00000x)
- Consultations (CPT 99241-99275)
- Taking an xray (CPT 7xxxxx series without modifier 26)
- There are a few other services that require a referring NPI on the claim but they are out of scope for our ITU professional/dental claims

Claims that require a referring NPI but the referring NPI is missing are rejected with the same EOB (16+N286) as claims that do not require a referring NPI but the claim was billed with an "invalid" referring NPI

Washington State Health Care Authority

FAQ and Open Discussion

Q. We have Physical therapist with taxonomy 208100000X. Do we still bill with the GP modifier?

A. **Servicing** taxonomy for Physical Therapists is usually 225100000x (needs modifier GP).

Specialty Physicians may be 208100000x and they do not require modifier GP but there are other taxonomy requirements because this is no longer part of the "physical therapy" program

Who is provider?	Which billing guide	Billing Taxonomy	Servicing taxonomy	Modifiers?
Physical Therapist	Outpatient Rehab	FQHC – not billable for encounters IHS/638 – 225100000x	Always use the taxonomy that the servicing provider is enrolled with in PI	FQHC – not billable for encounters IHS/638 – GP
Specialty physician	Physician	FQHC – 261QF0400x IHS/638 – 208D00000x		AF (page 210 of the Physician billing guide)

Washington State Health Care Authority

FAQ and Open Discussion

Q. When we go to January one is Medicaid going to have all of our non billable providers and providers that are not listed in medicaid are they going to have them all listed now?

A. There are no changes in regards to the types of providers who are enrolled in P1 for ITU claims that are billed to P1.

Also pending FQHC guidance, stay tuned

Washington State Health Care Authority

FAQ and Open Discussion

Q. How is the provider notified when they are deactivated in P1 for recertification? We recently had this occur for our provider who hasn't used his NPI for quite some years and it is affecting pt care as he can't write for prescriptions

A. A letter was sent to the provider address that is on file in P1. some of these addresses may be outdated

Contact mike if you get an EOB N288 or N290 or if you have prescriptions being rejected. Most of the De-Activated providers have been fixed.

If prescriptions are not involved – no hurry

If prescriptions are involved – remind mike

I will help with the information to be relayed to HCA's Provider Enrollment team

I/T/U

Washington State Health Care Authority

FAQ and Open Discussion

Q. Will P1 also pay encounter rate for non AI/AN wrap around with MCO?

A. At this time – no.

The encounter rate is payable for AI/AN clients enrolled in managed care because there are federal protections.

The encounter rate is not payable to nonAI/AN clients enrolled in managed care because there are no federal protections for nonAI/AN clients

NOTE: the TribalFQHC option is being developed & TribalFQHCs will be able to receive the encounter rate for nonAI/AN clients in managed care (SUD may continue to pay at the federal share)

I/T

Washington State Health Care Authority

FAQ and Open Discussion

Q. Last month you told urbans we could not bill for Well Child visits and other services separately. If I understand correctly you are now recommending that if a separate service done we bill on separate claim? (question from an Urban Org)

A. **FQHCs** – stay tuned. Mike thought that he read somewhere that FQHCs get **ONE** medical encounter but I need to verify with HCA's FQHC experts.

IHS/638 clinics refer to page 44 of October TCOW

FAQ and Open Discussion

Q. Any update on the SUD Match going quarterly?

A. Stay tuned. (summer, 2019?)

I/T

FAQ and Open Discussion

Q. if you have to split out the well child and cpt 17000. would you need to split out the well woman check and insertion of iud or nexplanon on the same visit?

A. Refer to October, 2018 TCOW for background information.

Recap – if, during a well child visit the client is determined to be *unwell* and medically necessary services are rendered – both visits may be payable as long as the visits are separate and distinct visits.

HCA doesn't really have a "well adult" visit, we are most likely referring to the E&M and if the E&M is separate and distinct from the IUD services then the visits are separately billable

Drugs (including IUDs and Nexplanon) are outside the all-inclusive rate and reimbursed under FFS (NOTE: if on the same claim as an encounter the drug payment will be absorbed into the encounter payment due to P1 design)

I/T and U? pending guidance from FQHC

Washington State Health Care Authority

FAQ and Open Discussion

Q. Splitting out drugs is only for I/T correct?

A. Correct. If a drug is on the same claim as the T1015 line then the drug payment will just get absorbed into the encounter rate. Resolution is to split the claims.

Washington State Health Care Authority

FAQ and Open Discussion

Q. Can we use a Q6 modifer for Locum providers? Do we follow the same billing guidelines as Medicare for Locum providers?

A. HCA does not follow medicare guidelines in regards to Locums. Refer to the physician billing guide, page 26

1. The locum needs to be enrolled in P1. the Locum will be the servicing NPI on the claim.

2. Add modifier Q6

Washington State Health Care Authority

FAQ and Open Discussion

Q. During the October TCOW (page 22) you shared how to look in P1 to see if a client is a DDA (Developmental Disabilities Administration) client. I have a disabled client but P1 does not indicate that the client is disabled, how do we correct this?

A. Contact DDA, stay tuned.. mike can't just say "contact DDA"…

I/T/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

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

Washington State Health Care Authority

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

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

Washington State Health Care Authority

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

Washington State Health Care Authority

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

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. 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. No. CMS has indicated that the State Medicaid agency should be able to get the list from the Tribal facility

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. 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

Questions?

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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.