Washington State Health Care Authority

Washington Apple Health (Medicaid)

Tribal Health Billing Guide

June 8, 2024

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or HCA rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **June 8, 2024,** and supersedes earlier billing guides to this program.

The Health Care Authority is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

Refer also to HCA's **ProviderOne billing and resource guide** for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's **provider alerts webpage**.

To access provider documents, go to HCA's **provider billing guides and fee schedules webpage.**

Confidentiality toolkit for providers

The **Washington State Confidentiality Toolkit for Providers** is a resource for providers required to comply with health care privacy laws. To learn more about the toolkit, **visit the HCA website**.

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* This publication is a billing instruction.

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Where can I download HCA forms?

To download an HCA form, see HCA's Forms & Publications webpage. Type only the form number into the Search box (Example: 13-835).

Copyright disclosure

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Definitions	Added definitions for "pharmacy" and "point-of-sale"	To add definitions related to the new pharmacy claim billing instructions
Definitions	Added definition for "Tribal FQHC Affiliate"	To add a definition related to new billing instructions specific to Tribal FQHC Affiliates
Which providers are eligible for the IHS encounter rate?	Added language to specify that health care professionals include Tribal FQHC Affiliates	To specify that Tribal FQHC Affiliates are health care professionals eligible for the encounter rate
Are managed care clients eligible for services provided by a Direct Indian Health Service Clinic, a Tribal 638 Clinic, or a Tribal FQHC?	Added language related to managed care organizations and pharmacy claims billed through point-of-sale	To specify that, for pharmacy claims billed through point-of-sale, the MCO is responsible for payment of the prescription, not the encounter rate
How many encounters does HCA cover?	Added a new paragraph for pharmacy claims	To specify how the encounter rate applies to pharmacy claims

Subject	Change	Reason for Change
How does HCA determine if a claim is eligible for an encounter payment?	Added language applicable to pharmacy claims	To specify the conditions that must be met for a pharmacy claim to be eligible for an encounter payment
How does HCA determine if a claim is eligible for an encounter payment?	Added CPT codes 91318-91322 to the list of codes that, if billed with HCPCS code T1015, are not eligible for the encounter payment	To specify that drugs or pharmaceuticals provided during a clinic visit do not qualify for the encounter payment
What additional requirements must Tribal health clinics follow when billing?	Added the underlined language: "Except for pharmacy/POS claims, an encounter-eligible service must be billed with HCPCS T1015."	The point-of-sale system does not require HCPCS T1015 to capture the encounter rate
How do I bill for a medical service encounter? How do I bill for a dental encounter? How do I bill for a mental health encounter? How do I bill for an SUD encounter?	Added a billing instruction for services provided by a Tribal FQHC Affiliate	To provide specific billing instructions for services provided by a Tribal FQHC Affiliate
Pharmacy Services	Added new section regarding pharmacy claims and expedited authorization	To provide billing instructions specific to the point-of-sale system

Subject	Change	Reason for Change
Enrolling/Disenrolling American Indian/Alaska Native Clients from Managed Care or Primary Care Case Management	Added a new paragraph: "When contacting HCA by telephone, the client must be present and give permission for any enrollment change."	To clarify that only the client may authorize enrollment changes

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Table of Contents

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to **chapter 182-500 WAC** for a complete list of definitions for Washington Apple Health.

"638" Compact – Compact (or Annual Funding Agreement) to carry out self-governance as authorized by Title II, P.L. 103-413, III, P.L. 100-472, which built upon the Self-Governance Demonstration Project and transfers control to Tribal governments, upon Tribal request, over funding and decision-making of federal programs, activities, functions, and services as an effective way to implement the federal policy of government-to-government relations with Indian Tribes.

"638" Contract – A contract between Tribes and the Indian Health Service (IHS) that provides for Tribes to assume responsibility for providing social and health care services to AI/ANs. Authorized by Public Law 93-638, Indian Self Determination Act.

Alternative Payment Methodology (APM) – See **WAC 182-548-1400**.

American Indian/Alaska Native (AI/AN) - A person having origins in any of the original peoples of North America.

Attestation – Clients self-attest their AI/AN status.

Bureau of Indian Affairs (BIA) – Federal agency under the Department of the Interior responsible for the administration and management of land held in trust by the United States for AI/ANs and Indian Tribes. Developing forestlands, leasing assets on these lands, directing agricultural programs, protecting water and land rights, developing and maintaining infrastructure, providing for health and human services, and economic development are all part of this responsibility taken in cooperation with the AI/ANs.

CMS – Centers for Medicare and Medicaid Services.

Canadian First Nation/Jay Treaty Person - A person born in Canada, having at least 50% aboriginal blood.

Client - (for the purposes of this billing guide only) – A person receiving substance use disorder services from a DBHR-certified agency.

Direct IHS Clinic – A clinic that is operated directly by the Indian Health Service (IHS).

DSHS – Washington State Department of Social and Health Services.

Division of Behavioral Health and Recovery (DBHR) – Moved to the Health Care Authority July 1, 2018. DBHR provides support for mental health, substance use disorder, and problem gambling services. The public mental health programs promote recovery and resiliency and reduce the stigma associated with mental illness. The substance abuse prevention and substance use disorder treatment programs promote strategies that support healthy lifestyles by preventing the misuse of alcohol, tobacco, and other drugs, and support recovery from the disease of substance use disorder. The problem gambling program mitigates the effects of problem gambling on the family and helps families remain economically self-sufficient without requiring assistance from other state

programs. DBHR brings operational elements like medical assistance, substance use disorder and mental health into closer working relationships that serve people more effectively and efficiently than before.

Encounter – An encounter is a face-to-face contact between a health care professional and a Medicaid beneficiary for the provision of medically necessary, Medicaid-defined services from a Direct IHS Clinic, Tribal 638 Clinic, or Tribal FQHC within a calendar day, as documented in the patient's record.

Encounter Payment – HCA's payment of the IHS Encounter Rate to Direct IHS Clinics, Tribal 638 Clinics, or Tribal FQHCs in accordance with the Memorandum of Agreement.

Federally recognized Tribe – Tribal entities acknowledged by the U.S. Government and eligible for funding and services from BIA by virtue of their status as Indian Tribes. Tribes are acknowledged to have the immunities and privileges available to other federally acknowledged Indian Tribes by virtue of their government-to-government relationship with the United States as well as the responsibilities, powers, limitations, and obligations of such Tribes.

HCA – The Washington State Health Care Authority, which has been designated by the Washington State legislature as the single state Medicaid agency.

Health Care Professional - See WAC 182-500-0045.

Indian Health Service (IHS) – A federal agency under the Department of Health and Human Services, including contracted Tribal health programs, entrusted with the responsibility to assist eligible AI/ANs with health care services.

IHS Beneficiary – An AI/AN who provides proof of being a member in or a descendent of a federally recognized Indian Tribe and who is eligible for services funded by the IHS.

IHS Encounter Rate – The all-inclusive rate for an Encounter at a Direct IHS Clinic, Tribal 638 Clinic, or Tribal FQHC set forth in the Memorandum of Agreement. The IHS Encounter Rate is published by the federal Office of Management and Budget in the Federal Register on an annual basis.

Memorandum of Agreement (MOA) – The December 19, 1996, memorandum of agreement between the federal Health Care Financing Administration (now CMS) and IHS. The MOA established the IHS encounter rate for payment of Medicaid services provided to AI/AN people on and after July 11, 1996, through Direct IHS Clinics, Tribal 638 Clinics, or Tribal FQHCs.

Pharmacy – Every location licensed by the State Board of Pharmacy in the state where the practice of pharmacy is conducted.

Point-of-sale (POS) – A pharmacy claims processing system capable of receiving and adjudicating claims online.

Substance use disorder — A cluster of cognitive, behavioral, and physiological symptoms indicating that a person continues using a substance despite significant substance-related problems. The diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substance.

Substance Use Disorder Professional (SUDP) – A person who has met the requirements of WAC 246-811-030 and is certified to provide SUD services under RCW 18.205.030.

Substance Use Disorder Professional Trainee (SUDPT) – A person working toward the education and experience requirements for certification as a substance use disorder professional, and who has been credentialed as a SUDPT.

Substance use disorder treatment - Behavioral health services provided to an eligible client designed to mitigate or reverse the effects of substance use disorder and restore normal physical and psychological functioning. Substance use disorder treatment is characterized by a combination of drug and alcohol education sessions, individual therapy, group therapy, and related activities provided to clients and their families.

Telemedicine - See WAC 182-531-1730(1).

Tribal 638 Clinic – A clinic operated by a Tribe or Tribal organization, funded by Title I or V of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, amended), and enrolled in the state Medicaid program as a clinic.

Tribal FQHC – A Tribal 638 Clinic enrolled in the state Medicaid program both as a Federally Qualified Health Center, covered by the Social Security Act § 1902(bb), and to receive payment under the Tribal FQHC Alternative Payment Methodology (AMP).

Tribal FQHC Affiliate – An offsite/non-Tribal provider contracted to furnish services on behalf of the Tribal FQHC. Its services are services of the contracting Tribal facility for purposes of this guide.

Tribal FQHC APM – Payment based on an Alternative Payment Methodology (APM) that is the published outpatient IHS encounter rate. The Tribal FQHC APM pays for the same outpatient services and the same number of encounters per day that other Tribal 638 Clinics provide.

Tribal Substance Use Disorder Treatment Services Program – A qualified Tribal substance use disorder treatment program that contracts with HCA under the provisions of the MOA.

Tribal organization – Any legally established organization of Indians which is controlled, sanctioned, or chartered by one or more federally recognized Tribes or whose governing body is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; see Section 4(26) of the Indian Health Care Improvement Act, 25 U.S.C. §1603(26).

Washington Apple Health – See WAC 182-500-0120.

Program Overview

Washington Apple Health (Medicaid) and Federally Recognized Tribes

Washington State recognizes Congress's intent to provide Medicaid funds to Indian Health Service (IHS) and Tribal governments for the delivery of Medicaid services to eligible members of federally recognized Tribes. Under the Centennial Accord and Section 1902(a)(73) of the Social Security Act, HCA supports a government-to-government relationship between Tribes and Washington State. HCA partners with federally recognized Tribes to use all possible Medicaid and state health funding to assist Tribes in addressing the health needs of American Indian/Alaska Natives (AI/ANs) and to raise their health status to the highest possible level. This billing guide applies to Direct IHS Clinics, Tribal 638 Clinics, and Tribal FQHCs.

What is a Direct IHS Clinic, a Tribal 638 Clinic, or a Tribal FQHC?

Under the rules of Indian Health Service (IHS) and CMS, including the 1996 Memorandum of Agreement (MOA) between IHS and the Health Care Financing Administration (now known as CMS), and CMS State Health Official Letter 16-002 (dated February 26, 2016), IHS health programs may operate in several ways.

- Direct IHS Clinic: IHS may directly operate one or more clinics to provide outpatient health care services without affiliation with an inpatient hospital. These facilities are called Direct IHS Clinics in this guide. Under the MOA, Direct IHS Clinics may receive the IHS encounter rate as published annually in the Federal Register. HCA automatically processes a retroactive claims adjustment each year to ensure payment of the updated rate.
- Tribal 638 Clinic. A federally recognized Tribe may choose to operate a health care facility and receive funds under Title I or Title V of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended) to provide outpatient health care services without affiliation with an inpatient hospital. These facilities are called Tribal 638 Clinics in this guide. Under the MOA, Tribal 638 Clinics may receive the IHS encounter rate as published annually in the Federal Register. HCA automatically processes a retroactive claims adjustment each year to ensure payment of the updated rate.
- Tribal Federally Qualified Health Center (FQHC): A Tribe may choose to designate their Tribal 638 Clinic as an FQHC to receive payment at the IHS encounter rate under the Alternative Payment Methodology applicable to Tribal FQHCs in the Medicaid State Plan (the Tribal FQHC APM). These facilities are called Tribal FQHCs. Under the APM, Tribal FQHCs may receive the IHS encounter rate as published annually in the Federal Register. HCA automatically processes a retroactive claims adjustment each year to ensure payment of the updated rate.

HCA allows only Direct IHS Clinics and Tribal 638 Clinics that are included in the IHS Facilities List provided by IHS to CMS, and Tribal FQHCs that receive payment under the Tribal FQHC APM, to participate in the Medicaid Tribal Health Program and receive the IHS encounter rate.

What are the basic provider eligibility requirements for Medicaid payment under this billing guide?

To be eligible for Medicaid payments, a Direct IHS Clinic, Tribal 638 Clinic, and Tribal FQHC must:

- Meet state and federal requirements for Medicaid (including Section 1911 of the Social Security Act);
- Meet all Washington State standards for licensure except that servicing providers may be licensed by any state; and
- Be approved by HCA.

How does a Direct IHS Clinic, a Tribal 638 Clinic, or a Tribal FQHC become an enrolled Medicaid provider?

Providers, including Direct IHS Clinics, Tribal 638 Clinics, and Tribal FQHCs, must submit a Core Provider Agreement (CPA), HCA 09-015, for each Billing National Provider Identifier (NPI) number registered. See Where can I download HCA forms?

For more information regarding CPAs, see HCA's provider enrollment website.

Submit applications for Medicaid provider enrollment to:

Provider Enrollment
Attn: Tribal Enrollment Coordinator
PO Box 45562
Olympia, WA 98504-5562

Which providers are eligible for the IHS encounter rate?

See the Definitions section for the definition of **Encounter.**

To be eligible for the IHS encounter payment, health care professionals, including Tribal FQHC Affiliates, must meet all the following:

- Meet the requirements of WAC 182-502-0010
- Be enrolled as a provider with HCA in accordance with the requirements of WAC 182-502-0010 and affiliated with a Direct IHS Clinic, Tribal 638 Clinic, or a Tribal FQHC that is enrolled with HCA
- Perform services within the scope of their practice

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Client Eligibility

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA's **Apple Health managed care page** for further details.

> It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service HCA will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health.** For detailed instructions on verifying a patient's eligibility for Apple Health, see the Client Eligibility, Benefit Packages, and Coverage Limits section in HCA's **ProviderOne Billing and Resource Guide**.

If the patient is eligible for Apple Health, proceed to Step 2. If the patient is not eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's **Program Benefit Packages and Scope of Services webpage**.

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to Washington Healthplanfinder - select the "Apply Now" button. For patients age 65 and older or on Medicare, go to Washington Connections select the "Apply Now" button.
- **Mobile app:** Download the WAPlanfinder app – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, Forms & Publications webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Support (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the Health Benefit Exchange Navigator.

Are managed care clients eligible for services provided by a Direct Indian Health Service (IHS) Clinic, a Tribal 638 Clinic, or a Tribal FQHC?

[Refer to WAC 182-538-060 and -095 and WAC 284-43-200]

Yes. Most Medicaid-eligible clients are enrolled in one of HCA's contracted-MCOs. For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical and pharmacy services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

Dental care (professional services) may be billed directly to HCA (regardless of the client's enrollment in an MCO). Dental prescriptions are billed to the client's MCO.

Except for pharmacy claims billed through point-of-sale (POS) (see next paragraph), send claims to the client's MCO for payment. If the client is AI/AN, MCOs are required to pay for covered services regardless of whether the Tribe is contracted with the MCO. However, if the client is non-AI/AN, call the

client's MCO to discuss payment prior to providing the service. The MCO is required to pay for qualifying services at the IHS encounter rate if the client is an IHS-eligible AI/AN. The MCO is required to pay for qualifying services at the IHS encounter rate if the client is non-AI/AN only if the Tribe is designated a Tribal FQHC with Apple Health. Providers may bill clients only in very limited circumstances as described in **WAC 182-502-0160**.

For pharmacy claims billed through POS, the MCO is responsible for paying the prescription, not the encounter rate. HCA will generate a payment for the balance of the encounter rate.

> **Note**: To prevent billing denials, check the client's eligibility before scheduling services and at the time of the service; also, verify proper plan authorization or referral. See HCA's **ProviderOne Billing and Resource Guide** for instructions on how to verify a client's eligibility.

Primary Care Case Management (PCCM). PCCM is a case management program, not an insurance plan. If a client has chosen services with a PCCM, this information will be displayed on the benefit inquiry screen in ProviderOne. These clients must obtain or be referred for services via one of the health care professionals in the client's PCCM clinic. The PCCM provider is responsible for coordination of care, just as the Primary Care Provider (PCP) would be in a managed care plan. Clients do not need a referral from a PCCM to be able to receive emergency or women's health care services.

The PCCM contract was developed as an alternate resource for federally recognized Tribal members who are eligible for Medicaid Managed Care and for care at Direct IHS Clinics, Tribal 638 Clinics, or Tribal FQHCs. This contract is available to Tribes interested in providing case management services to federally-recognized Tribal members eligible for managed care. The contract allows one clinic to bill the encounter rate for treatment services to a Medicaid-eligible client and be paid for case management services for that same client.

Tribes may participate in PCCM or Medicaid Administrative Claiming (MAC). To avoid duplication of services and payment, tribes must participate in only one of these two programs.

For more information, call (360) 725-1649.

> **Note:** You may not receive payment if the client is enrolled with a PCCM/PCP and any of the following apply:
>
> - You are not the client's designated PCCM/PCP
> - The client was not referred to you by one of the health care providers at the PCCM clinic/PCP

- You are not providing emergency care or women's health services

Contact the PCCM/PCP to get a referral

Managed care enrollment

Apple Health (Medicaid) places clients into an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for. However, some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care.

Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to HCA's **Apply for or renew coverage webpage**, under *How to apply for or renew Apple Health (Medicaid) coverage*.
- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:

  Go to **Washington Healthplanfinder website**.
- **Available to all Apple Health clients:**
  - Visit the **ProviderOne Client Portal website**:
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.
  - Request a change online at **ProviderOne Contact Us** (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

For online information, direct clients to HCA's **Apple Health Managed Care webpage**.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an HCA-contracted managed care plan are automatically enrolled in a BHSO, except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS Medicaid program will reimburse providers for the covered services. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care (IMC)

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

For full details on integrated managed care, see HCA's **Apple Health managed care webpage** and scroll down to "Changes to Apple Health managed care."

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 18 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

> These clients are identified in ProviderOne as "**Coordinated Care Healthy Options Foster Care**."

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support Team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's Mental Health Services Billing Guide, under How do providers identify the correct payer?

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) **American Indian/Alaska Native webpage**.

Which clients do not qualify for the encounter payment?

Clients identified in ProviderOne with the following recipient aid category (RAC) codes do not qualify for the encounter payment:

RAC Code: 1034, 1040, 1056, 1057, 1060, 1062, 1077, 1078, 1081, 1082, 1085, 1087, 1090, 1092, 1097, 1098, 1099, 1100, 1112, 1113, 1119, 1120, 1123, 1125, 1127, 1133, 1155, 1157, 1158, 1159, 1160, 1161, 1176, 1177, 1179, 1180, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1190, 1191, 1192, 1193, 1194, 1195, 1208, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1270, 1272, 1273, 1276, 1277, 1278

1206 and 1207 are not eligible for SUD encounters but are eligible for medical, dental, and mental health encounters

HCA pays for services to clients with these RAC codes at the standard rates without an encounter payment.

Determining Whether a Service is an Encounter

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

HCA pays Direct IHS Clinics, Tribal 638 Clinics, and Tribal FQHCs participating in the Medicaid Tribal Health Program the IHS encounter rate for services that meet all the requirements for the encounter rate in this billing guide. For a health care service to qualify as an encounter, it must be:

- Medically necessary;
- Conducted face-to-face or via real-time telemedicine;
- Identified in the Medicaid State Plan as a service that is both of the following:
  - Covered by HCA, and
  - Performed by a health care professional within their scope of practice;
- Documented in the client's file in the provider's office (client records must be maintained by the primary health care facility to ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA));
- Performed in the health care facility identified on the IHS facility list as a Direct IHS Clinic or a Tribal 638 Clinic;
- Performed in a setting that is appropriate for a service provided by a Tribal FQHC;
- Not "incident to" the services of a health care professional that were rendered on the calendar day of the encounter (see **What services and supplies are incident to professional services?**); and
- Compliant with Medicaid National Correct Coding Initiative (NCCI) guidelines.

How many encounters does HCA cover?

Professional and Dental claims

HCA pays for up to five (5) encounters per day, per client, regardless of the type of service, provided the facility does not:

- Split services that are normally rendered during a single visit for the purpose of generating multiple encounters;
- Develop facility procedures or otherwise ask clients to make repeated or multiple visits to complete what is considered a reasonable and typical office visit unless it is medically necessary. Medical necessity must be clearly documented in the client's record.

Pharmacy claims

HCA pays for one encounter per day, per client, regardless of the number of prescriptions filled. The first claim processed for payment for each date is eligible for the encounter rate plus a professional dispensing fee; subsequent claims for each date are reimbursed at the regular pharmacy rate plus a professional dispensing fee. If the fee schedule amount of the first processed claim is greater than the encounter rate, the claim pays at the fee schedule amount, not the encounter rate.

Which types of services do NOT qualify for an encounter payment?

The following services do not qualify for an encounter payment:

- Drugs or pharmaceuticals provided during a clinic visit. See also, **Are pharmaceuticals and drugs included in the encounter payment?**
- Case management services (for example, HIV/AIDS case management).
- Telemedicine facility fee. See also, **Is the telemedicine facility fee included in the encounter payment?**

What services and supplies are incident to professional services?

Services and supplies that are "incident to" the services delivered by a health care professional do not qualify for the encounter rate but are included in the encounter rate paid for those services. Services and supplies are "incident to" the services of a health care professional when they are rendered on the same calendar day as the health care professional services and are:

- Administered as part of the practitioner's professional services (for example, pharmaceuticals and drugs given by injection, oral, or topical delivery as part of a clinical visit);
- Furnished as an incidental, although integral, part of the practitioner's professional services (for example, professional component of an x-ray or lab);
- Of a type commonly furnished either without charge or included in the encounter payment;
- Of a type commonly furnished in an outpatient clinic setting (for example, tongue depressors, bandages, etc.); or
- Furnished by health care center employees under the direct supervision of a health care professional. Direct supervision means that the supervising professional is immediately available to provide assistance and direction throughout the time the supervised employee is furnishing services and does not require the supervising professional to be present in the same room.

Are pharmaceuticals and drugs included in the encounter payment?

No. Pharmaceuticals and drugs are not included in the encounter rate, but they are payable separately from the encounter rate at the applicable rate in the fee schedule. Pharmaceuticals, drugs, IUDs, and contraceptive implants must be billed on a separate claim from the encounter claim to avoid including the items in the encounter payment.

Is the telemedicine facility fee included in the encounter payment?

No. The telemedicine facility fee (HCPCS code Q3014) is not included in the encounter rate, but it is payable separately from the encounter rate at the applicable rate in the fee schedule. The telemedicine facility fee must be billed on a separate claim from the encounter claim to avoid including the item in the encounter payment. Refer to HCA's Provider Billing Guides and Fee Schedules webpage, under *Telehealth*.

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

HCA determines a claim to be encounter-eligible (i.e., a claim meets the requirements for IHS encounter rate eligibility) when all the following conditions are true:

- The client's recipient aid category (RAC) code is encounter-eligible.
- The claim is billed by a Direct IHS Clinic, Tribal 638 Clinic, or Tribal FQHC
- The claim is billed on a professional (837P/CMS-1500) or dental (837D/ADA) claim or is a NCPDP transaction through the pharmacy POS.
- Except for pharmacy claims, the billing taxonomy on the claim is one of the taxonomy codes listed in this guide.
- The servicing provider, or prescribing provider on a pharmacy claim, is a health care professional authorized to provide services to an Apple Health client.
- For professional and dental claims, HCPCS code T1015 is billed on a service line on the claim (a claim may contain more than one T1015, depending on services rendered). Pharmacy claims do not require HCPCS T1015.
- The appropriate IHS beneficiary American Indian/Alaska Native (AI/AN) or client is not an IHS beneficiary AI/AN modifier, expedited prior authorization, expediated authorization, or claim note is billed on the claim (see instructions below for each category of encounter).
- The claim has at least one line for a service that is correctly billed and eligible for payment for the same date of service as indicated for the claim line used to bill HCPCS code T1015. If the claim that is correctly billed has only one or

more of the following services and HCPCS code T1015, the claim will not be eligible for the encounter payment:

- CPT® codes 70000-79999 with modifier 26
- CPT® codes 80000-89999 with modifier 26
- CPT® codes 90281-90399 unless modifier SL is present
- CPT® codes 90476-90479 and 90481-90759 unless modifier SL is present
- CPT® codes 91300, 91301, 91303-91309, 91311-91322 unless modifier SL is present
- CPT® codes 99091, 99454, 99457, 99458
- CPT® codes 99492-99494
- HCPCS code D9996
- HCPCS code G0512
- HCPCS codes H0030, H2036
- All HCPCS J codes
- All HCPCS Q codes
- All HCPCS S codes (except S9436, S9445, S9446, S9470, S9482, and S9484)
- HCPCS codes T1016, T1017, T1041
- HCPCS codes T2022

How are services not eligible for an encounter paid?

Services that are not eligible for the IHS Encounter Rate are payable using HCA's fee schedules. For information on Apple Health covered services, refer to the appropriate Fee Schedule.

> **Note**: Tribal providers are required to include the appropriate IHS beneficiary American Indian/Alaska Native (AI/AN) or client is not an IHS beneficiary AI/AN designators (i.e., modifiers, EPA/EA numbers, or claim notes as described in the instructions on the following pages for each category of encounter) on all claims.

Fee Schedule Information

Maximum allowable fees for all codes that are not included in the specific program billing guides, including CPT® codes and selected HCPCS codes, are listed in the fee schedule.

In the fee schedule, HCA identifies procedure codes that may require prior authorization. However, this list may not be all-inclusive. Prior authorization, limitations, or requirements detailed in HCA billing guides and Washington Administrative Code (WAC) remain applicable. HCA's fee schedules are available on HCA's Provider billing guides and fee schedules webpage.

Washington State Health Care Authority

Billing

What are the general billing requirements?

Providers must follow HCA's ProviderOne Billing and Resource Guide.

These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments
- What fee to bill HCA for eligible clients
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
- Billing for clients eligible for both Medicare and Medicaid
- Third-party liability
- Record keeping requirements

What additional requirements must Tribal health clinics follow when billing?

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

Except for pharmacy/POS claims, an encounter-eligible service must be billed with HCPCS T1015.

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

How do I submit claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's Billers and Providers webpage, under Webinars.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA Electronic Data Interchange (EDI) webpage.

Note: As provided in 25.U.S. Code §1621e(h), Tribes and Tribal organizations may submit paper claims to:

Health Care Authority
P.O. Box 42727
Olympia, WA 98504-2727

Washington State Health Care Authority

Medical Services

What is a medical encounter?

A medical encounter is a face-to-face contact between a health care professional and a Medicaid beneficiary for the provision of services described in the program-specific policies listed below (see "encounter" in Definitions). Service limitations and prior authorization requirements (program-specific policies) apply to all Medicaid clients for applicable Medicaid-covered services.

Refer to HCA's program-specific billing guides for a list of Medicaid-covered services, such as:

- Childbirth Education
- Chiropractic Services for Children
- Diabetes Education Program
- Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Program
- Family Planning
- Habilitative Services
- Maternity Support Services/Infant Case Management
- Medical Nutrition Therapy
- Outpatient Rehabilitation (physical therapy, occupational therapy, speech therapy)
- Planned Home Births and Births in Birthing Centers
- Physician–Related Services/Health Care Professional Services
- Physician–Related Services/Health Care Professional Services (see Foot Care Services)
- Physician–Related Services/Health Care Professional Services (see ophthalmology – vision care services)
- Sterilization Supplement

How do I bill for a medical service encounter?

Facilities must follow HCA's program-specific billing guide and do all the following:

- Bill a professional (837P/CMS1500) claim.
- Bill with an appropriate billing taxonomy (listed below).
- Add HCPCS code T1015 (the amount billed for HCPCS code T1015 is not relevant as it does not affect payment).
- For services provided by a Tribal FQHC Affiliate, add HCPCS code T2025. On the T2025 line, both the billed and paid amount are $0. Modifiers UA and SE are accepted but not required on the T2025 line.

- Bill with an IHS beneficiary American Indian/Alaska Native (AI/AN) or a client is not an IHS beneficiary AI/AN modifier on every line on the claim (after adding all modifiers that may be required by the source program).

Type of encounter	Billing taxonomy	IHS beneficiary AI/AN modifier	Client is not an IHS beneficiary AI/AN modifier
Medical, general	208D00000X	UA	SE
Medical, physical therapy rendered by physical therapist	225100000X	UA	SE
Medical, occupational therapy rendered by occupational therapist	225X00000X	UA	SE
Medical, speech therapy rendered by speech therapist	235Z00000X	UA	SE
Medical, physical therapy, speech therapy, occupational therapy rendered by a physician, podiatrist, ARNP, PAC or specialty physician	208D00000X	UA	SE
Medical, optometrist	152W00000X	UA	SE
Medical, Maternity Support Services	171M00000X	UA	SE
Childbirth Education	174400000X	UA	SE

Note: Maternity Support Services claims must also be billed with servicing taxonomy 171M00000X; see the Maternity Support Services - Infant Case Management Billing Guide.

Note: All claims must comply with the requirements in the Billing section of this guide.

How do I bill for global services performed in a Direct IHS Clinic, Tribal 638 Clinic, or Tribal FQHC?

Global services are services that cover a span of time but the CPT/HCPCS code is billed only once, usually at the end of treatment. When billing for a global service, the units billed on the claim line for HCPCS code T1015 must equal the number of face-to-face visits that occurred with the health care professional to complete the service. When the client is seen on multiple days for a maternity service package (e.g., CPT® code 59400), add modifier TH to the HCPCS code T1015. The date of service on the line for HCPCS code T1015 must be the same date as on the line billing the maternity service CPT code. The following services are global services that often require multiple visits to complete the service.

Service	CPT® codes	Maximum number of encounters allowed to complete the service
Antepartum care only, 4-6 visits	59425	6
Antepartum care only, 7 or more visits	59426	11
Vaginal/cesarean delivery, antepartum and postpartum care	59400, 59510, 59610, 59618	15
Vaginal/cesarean delivery only, including postpartum care	59410, 59515, 59614, 59622	4
Postpartum care only	59430	3

Post-operative coverage

Some services (excluding the maternity codes listed above) have a global post-operative care period that is included in the service (usually a 10-, 45- or 90-day post-operative period). Office visits related to the surgery are normally

considered included in the surgical payment; however, the post-operative inclusion requirements do not apply to Medicaid encounter rate billers. Office visits that are related to surgeries that have post-operative global periods should be coded and billed with the appropriate Evaluation and Management code; do not add modifier 24 and do not bill with post-operative visit CPT® code 99024.

Washington State Health Care Authority

Dental Services

What is a dental encounter?

A dental encounter is a face-to-face contact between a health care professional and a Medicaid beneficiary for the provision of services described in the program-specific policies listed below (see "encounter" in Definitions). Service limitations and prior authorization requirements (program-specific policies) apply to all Medicaid clients for applicable Medicaid-covered services.

Where do I find program specific policies?

Refer to HCA's program-specific provider billing guides for a list of Medicaid-covered services

- Access to Baby and Child Dentistry (ABCD)
- Dental Related Services
- Orthodontic Services

Dental providers can find more detailed information regarding dental programs, prior authorization, and patient release forms at HCA's Dental Services webpage.

Expedited prior authorization (EPA)

EPA is designed to eliminate the need for written authorization. HCA establishes authorization criteria and identifies EPA with specific codes.

To bill HCA for diagnostic conditions, procedures, and services that meet the EPA criteria on the following pages, the provider must bill with a 9-digit EPA number (see EPA Criteria Coding List) and enter the EPA in the authorization number field.

EPA Guidelines

The provider must verify that the requirements for use of the EPA number are met. If the EPA number requires medical necessity, then the client's medical record documentation must support the medical necessity and be available upon HCA's request. If HCA determines the documentation does not support the EPA criteria requirements, the claim will be denied and any amounts paid will be recouped.

EPA Criteria Coding List

EPA code	Service Modality	Criteria
870001305	Dental services	Client is an IHS beneficiary AI/AN

EPA code	Service Modality	Criteria
870001306	Dental services	Client is not an IHS beneficiary AI/AN

How do I bill for a dental encounter?

Facilities must follow HCA's Washington Apple Health program-specific billing guide and do all the following:

- Bill a dental (837D/ADA) claim;
- Bill with the appropriate billing taxonomy - 122300000X;
- Add HCPCS code T1015 (the amount billed for HCPCS code T1015 is not relevant as it does not affect payment); and
- For services provided by a Tribal FQHC Affiliate, add HCPCS code T2025. On the T2025 line, both the billed and paid amount are $0. EPA 870001305 and 870001306 are accepted but not required on the T2025 line.
- Bill with an IHS beneficiary American Indian/Alaska Native (AI/AN) or client is not an IHS beneficiary AI/AN EPA number at document level (if the dental service requires further authorization, use the dental authorization number on the claim line for the service that requires further authorization).

Type of encounter	Billing taxonomy	IHS beneficiary AI/AN EPA	Client is not an IHS beneficiary AI/AN EPA
Dental	122300000x	870001305	870001306

Note: All claims must comply with the requirements in the Billing section of this guide.

How do I bill for global services performed in a Direct IHS Clinic, a Tribal 638 Clinic, or a Tribal FQHC?

Global services are services that cover a span of time, but the American Dental Association (ADA) code is billed only once, usually at the end of the treatment period. When billing for a global service, the units billed on the claim line for HCPCS code T1015 must equal the number of face-to-face visits that occurred with the health care professional to complete the service. The following services are global services that often require multiple visits to complete the Medicaid-covered service.

Service	HCPCS codes	Maximum number of encounters allowed to complete the service
Crowns	D2710-D2799	2
Endodontics (root canals)	D3310-D3330	2
Prosthodontics (dentures)	D5110-D5226	5 per arch or set
Limited Orthodontic Treatment, banding	D8020-D8030	4
Limited Orthodontic Treatment, each follow up visit	D8670	2
Interceptive Orthodontic treatment	D8060	2
Comprehensive Orthodontic Treatment, banding	D8080	4
Comprehensive Orthodontic Treatment, each follow up	D8670	2

Note: HCA does not cover the HCPCS codes listed in the global services table in all circumstances. For coverage and billing information for these services, refer to the dental and orthodontic program billing guides. See Where do I find program specific policies?

Washington State Health Care Authority

Mental Health Services

What is a mental health encounter?

A mental health encounter is a face-to-face contact between a health care professional and a Medicaid beneficiary for the provision of services described in the program-specific policies listed below (see "encounter" in **Definitions**). Service limitations and prior authorization requirements (program-specific policies) apply to all Medicaid clients for applicable Medicaid-covered services. Refer to the **Mental Health Services Billing Guide** for more information.

Where do I find program-specific policy?

Refer to HCA's program-specific provider billing guide for a list of Medicaid-covered services. See the **Mental Health Services Billing Guide**.

How do I bill for a mental health encounter?

Facilities must follow HCA's Washington Apple Health **program-specific billing guide** and do all the following:

- Bill a professional (837P/CMS1500) claim;
- Bill with the appropriate billing taxonomy
  - Part 1 mental health services – 2083P0901X
  - Part 2 mental health services (Community Mental Health Centers) – 261QM0801X
- Add HCPCS code T1015 (the amount billed for code T1015 is not relevant as it does not affect payment); and
- For services provided by a Tribal FQHC Affiliate, add HCPCS code T2025. On the T2025 line, both the billed and paid amount are $0. Modifiers HE and SE are accepted but not required on the T2025 line.
- Bill with an IHS beneficiary American Indian/Alaska Native (AI/AN) or client is not an IHS beneficiary AI/AN modifier on every line on the claim (**after** adding on billing code lines all modifiers that may be required by the source program).

Type of encounter	Billing taxonomy	IHS beneficiary AI/AN modifier	Client is not an IHS beneficiary AI/AN modifier
Mental Health, Part 1 of the Mental Health Services Billing Guide	2083P0901X	HE	SE
Mental Health, Part 2 of the Mental Health Services Billing Guide	261QM0801X	HE	SE

Note: All claims must comply with the requirements in the Billing section of this guide.

Washington State Health Care Authority

Substance Use Disorder and Treatment Services

What is a substance use disorder (SUD) encounter?

An SUD encounter is a face-to-face contact between a health care professional and a Medicaid beneficiary for the provision of services described in the program-specific policies listed below (see "encounter" in **Definitions**). Outpatient alcohol and/or drug treatment services are defined in **chapter 246-341 WAC**.

Where do I find program-specific policy?

Refer to HCA's program-specific billing guide found on HCA's **Provider billing guides and fee schedules** webpage for a list of Medicaid-covered services.

How do I bill for an SUD encounter?

Facilities must follow HCA's Washington Apple Health **program-specific billing guide** and do all the following:

- Bill a professional (837P/CMS1500) claim;
- Bill with billing taxonomy 261QR0405X;
- On SUD billing codes, use only the modifiers listed in the **Substance Use Disorder Billing Guide** as primary;
- Add HCPCS code T1015 (the amount billed for HCPCS code T1015 is not relevant as it does not affect payment); and
- For services provided by a Tribal FQHC Affiliate, add HCPCS code T2025. On the T2025 line, both the billed and paid amount are $0. Modifiers HB, HF, HX, and SE are accepted but not required on the T2025 line.
- Bill with claim note. Claim note must be entered exactly as listed in the table below.

> **Note**: Be sure to bill with an IHS beneficiary American Indian/Alaska Native (AI/AN) or client is not an IHS beneficiary AI/AN modifier ONLY on the line for code T1015

Client	Modifier on the T1015 line (use only one modifier on T1015 lines, from the list below)	Claim Note (must be written exactly as this)
IHS beneficiary AI/AN client	HF	SCI=NA
Client is not an IHS beneficiary AI/AN ABP (RAC code 1201 or 1274)	SE	SCI=NN
Client is not an IHS beneficiary AI/AN ABP Supplemental Security Income (SSI) (RAC code 1217)	HB	SCI=NN
Client is not an IHS beneficiary AI/AN classic Medicaid **(All RAC codes except 1201, 1274, or 1217)**	HX	SCI=NN

Note: All claims must comply with the requirements in the Billing section of this guide.

Note: If a client who is not an IHS beneficiary has RAC codes 1201 or 1274 and 1217 for the date of service, the client is deemed retroactively eligible for Supplemental Security Income (SSI) and claims are billed according to RAC code 1217.

Note: RAC codes 1201, 1274, and 1217 are not specific to non-AI/AN clients. IHS-eligible AI/AN clients may also have RAC codes 1201, 1274, and 1217.

What is a residential treatment facility cost-based rate?

The Medicaid State Plan authorizes tribal facility-specific cost-based rates for residential substance use disorder treatment services. The cost-based rates are stated in the Indian health care provider's approvals and are not published in HCA fee schedules.

Where do I find program-specific policy?

Refer to HCA's program-specific billing guide found on HCA's **Provider billing guides and fee schedules** webpage for a list of Medicaid-covered services.

How do I bill for a residential treatment facility – cost-based rate?

Follow HCA's program-specific billing guide and do all the following:

- Bill a professional (837P/CMS1500) claim
- Bill with billing taxonomy 324500000x or 3245S0500x
- Use one primary modifier and one additional modifier. Use only the modifiers listed in the **Substance Use Disorder Billing Guide** as primary, with one of the additional modifiers listed below:
    - Add modifier HF to the SUD code if the client is an IHS-eligible American Indian/Alaska Native (AI/AN)
    - Add one of the following modifiers to the SUD code if the client is a non-AI/AN, depending on the client's RAC indicated in the ProviderOne system:
        - RACs 1201 and 1274– add modifier SE
        - RAC 1217 – add modifier HB
        - All other RACs – add modifier HX
- Add HCPCS code T1015 (the amount billed for HCPCS code T1015 is not relevant as it does not affect payment)
- Do not use date spans on the billing lines. Each line must be for a single date of service.
- Bill SUD room and board charges (HCPCS code H2036) on a separate claim form from the residential treatment services

Client	Modifier on T1015 line (use only one modifier on T1015 lines, from the list below)
IHS beneficiary AI/AN client	HF
Client is not an IHS beneficiary AI/AN ABP (RAC codes 1201 and 1274)	SE
Client is not an IHS beneficiary AI/AN ABP Supplemental Security Income (SSI) (RAC code 1217)	HB
Client is not an IHS beneficiary AI/AN classic Medicaid **(All RAC codes except 1201, 1274, or 1217)**	HX

Note: RAC codes 1201, 1274, and 1217 are not specific to non-AI/AN clients. IHS-eligible AI/AN clients may also have RAC codes 1201, 1274, and 1217.

What is the payment for an SUD encounter?

HCA pays Direct IHS Clinics, Tribal 638 Clinics, and Tribal FQHCs the full encounter rate or cost-based rate for SUD treatment services provided to Medicaid-eligible IHS beneficiary AI/AN clients.

For Medicaid-eligible clients who are not IHS beneficiaries, the state requires local matching funds equal to the state's portion of Medicaid expenses for SUD treatment services under 42 C.F.R. 433.51. HCA pays Tribal health care facilities the federal portion of the Indian Health Services (IHS) encounter rate or cost-based rate (i.e., the Federal Medical Assistance Percentage (FMAP)) for SUD treatment services for non-AI/AN Medicaid clients when a Tribe certified to the state that it has spent the tribal match amount for the services reimbursed. This method does not require any transferring of funds back and forth.

Certified Public Expenditures (CPE)

With CPE, the local or tribal government that is responsible for the non-federal match sends the state agency a document certifying that they have incurred qualified expenditures in an amount equal to the applicable non-federal match. Once the state agency receives the CPE certification from the local or tribal government, the state agency sends an amount equal to the federal portion to the local or tribal government. The state agency then uses the certified public

expenditures and the expenditure for the federal portion as the basis to draw down the appropriate federal portion from the federal government.

Certification frequency

To comply with the Centers for Medicare and Medicaid Services (CMS) requirements, HCA must receive tribal government CPE certifications every quarter. Payment of the federal portion will not be contingent on HCA's receipt of the CPE certification because ProviderOne is programmed to pay the federal portion as claims are processed.

To help participating tribes provide the CPE certification for the appropriate amounts, HCA will provide a report during the month after each calendar quarter end for all outpatient SUD claims submitted during the previous calendar quarter, with adjustments for any claim adjustments processed during the previous calendar quarter. HCA must receive the tribe's CPE certification before the end of the next calendar quarter. For example:

- **HCA sends the report.** HCA will provide each participating tribe a report for claims processed during the prior calendar quarter with:
  - Every outpatient or cost-based rate SUD claim submitted and/or adjusted in ProviderOne during the prior calendar quarter along with the applicable non-federal match amount for that claim; and
  - The total amount of the non-federal match for the calendar quarter.
- **Tribe sends CPE certification.** On or before the end of the following calendar quarter, the tribe will send its CPE certification to HCA.

If HCA does not receive the tribe's CPE certification by the end of the next calendar quarter, HCA may suspend ProviderOne payments for outpatient or cost-based rate SUD services provided to clients who are not IHS beneficiaries until HCA receives the tribe's CPE certification.

Non-AI/AN Medicaid Category	State Match Required	Which Medicaid category applies to which RAC code?	How much does claim pay (federal portion)?
Classic Medicaid	50%	Any encounter eligible RAC code except 1201, 1274, or 1217	50% of encounter or cost-based rate
ABP	10%	RAC code 1201 or 1274	90% of encounter or cost-based rate
ABP Presumptive SSI (MAGI Adult)	10%	RAC code 1217	90% of encounter or cost-based rate

Note: If a client who is not an IHS beneficiary has RAC codes 1201 or 1274 and 1217 for the date of service, the client is deemed retroactively eligible for Supplemental Security Income (SSI) and claims are billed according to RAC code 1217.

Note: The Federal Medical Assistance Percentages (FMAP) rate and the State Match (equal to 100% less the FMAP rate) vary quarterly. FMAP examples are from January 2020. The claims processing date determines which FMAP and State Match is applicable.

Washington State Health Care Authority

Pharmacy Services

What is a pharmacy encounter?

A pharmacy/POS encounter is a face-to-face contact between a health care professional and a Medicaid beneficiary for services provided under the Prescription Drug Program (see "encounter" in **Definitions**). Refer to HCA's **Prescription Drug Program Billing Guide** for these services. Service limitations and prior authorization requirements apply to all Medicaid clients for applicable Medicaid-covered services.

Expedited authorization (EA)

EA is designed to eliminate the need for written authorization. HCA establishes authorization criteria and identifies EA with specific codes. To bill HCA for diagnostic conditions, procedures, and services that meet the EA criteria, the provider must bill with a 9-digit EA number (see EPA Criteria Coding List) and enter the EA in the authorization number field.

EA Guidelines

The provider must verify that the requirements for use of the EA number are met. If the EA number requires medical necessity, then the client medical record documentation must support the medical necessity determination and be available upon HCA's request. If HCA determines the documentation does not support the EA criteria requirements, HCA denies the claim and recoups any amounts paid.

EA Criteria Coding List

EA code	Service modality	Criteria
870001305	POS	Client is an IHS beneficiary AI/AN
870001306	POS	Client is not an IHS beneficiary AI/AN

How do I bill for a pharmacy/POS encounter?

Pharmacies must follow HCA's Prescription Drug Program Billing Guide and do all the following:

Bill a NCPDP transaction through the pharmacy POS claim.

Bill with an IHS beneficiary American Indian/Alaska Native (AI/AN) or client is not an IHS beneficiary AI/AN EA number.

Encounter type	IHS beneficiary AI/AN EA number	Client is not an IHS beneficiary AI/AN EA number
POS	870001305	870001306

Billing for the Encounter Rate after Other Payers

HCA pays Tribal health programs the IHS Encounter Rate differential after other primary payers have paid, such as private insurance, Medicare, and Apple Health managed care plans.

Billing for the encounter rate after private insurance

Claims must meet all applicable billing and encounter criteria as outlined in this guide.

For instructions on billing after private insurance, refer to the **ProviderOne Billing and Resource Guide**, which instructs billers to submit third party liability amounts at header only to correctly receive encounter payments.

Billing for the encounter rate secondary to Medicare

- Per the **ProviderOne Billing and Resource Guide**, bill HCA the same services and billed amounts that were billed to Medicare.
- Claims must meet all applicable billing and encounter criteria as outlined in this guide. Typically, this involves adding both of the following to a Medicare crossover claim:
  - Appropriate IHS beneficiary American Indian/Alaska Native (AI/AN) or client is not an IHS beneficiary AI/AN modifiers.
  - An encounter HCPCS code T1015.
- Encounter claims must be in a professional or dental claim format, even if Medicare requires providers to bill in the institutional claim format.

Note: Do not include any Medicare allowed amount, paid amount, coinsurance amount, or deductible amount on the HCPCS code T1015.

Note: Medicare may cover opioid treatment programs (OTP) under a bundled service that is not in alignment with Apple Health's OTP. If Medicare covers OTP under a bundled service, then it is acceptable to report multiple units on the T1015 line according to the number of Apple Health-covered SUD services rendered.

Enrolling/Disenrolling American Indian/Alaska Native Clients from Managed Care or Primary Care Case Management

An American Indian/Alaska Native (AI/AN) client who meets the provisions of 25 U.S.C. 1603 for federally recognized Tribal members and their descendants may choose one of the following for their medical care per WAC 182-538-130:

- Enrollment with an HCA-contracted managed care organization (MCO) available in their area
- Enrollment with a primary care case management (PCCM) provider, if available in their area, that is a Direct Indian Health Service (IHS) Clinic, Tribal 638 Clinic, or Urban Indian Health Program (which is a Federally Qualified Health Center)
- HCA's fee-for-service (FFS) system

In addition, an AI/AN client who meets the provisions of 25 U.S.C. 1603 for federally recognized Tribal members and their descendants may choose one of the following for their behavioral health care:

- Enrollment with an HCA-contracted managed care organization (MCO) available in their area for FIMC
- Enrollment with an HCA-contracted MCO available in their area for behavioral health services only (BHSO) if the client is not eligible to enroll in MCO for FIMC
- HCA's FFS system

HCA may process requests from Direct IHS Clinics, Tribal 638 Clinics, or Tribal FQHCs submitted on behalf of an AI/AN Medicaid client to enroll or disenroll from managed care according to their federal exemption under 42 U.S.C.1396u-2. Managed care enrollment changes take effect the first day of the month after the request is received. If the request indicates an urgent or access to care issue, the managed care change may be made retroactive to the first day of the current month.

When contacting HCA by telephone, the client must be present and give permission for any enrollment change.

Providers assisting clients through the ProviderOne (P1) client portal must have a signed document on file that includes:

- Client name
- Requested plan change and effective date
- Date requested
- Client's signature

Requests are processed electronically using the Webform on the **HCA Contact Us page**:

To enroll or disenroll an AI/AN Medicaid client from an HCA-contracted MCO or PCCM click **the Contact Us** hyperlink.

- The "Contact us – Medical provider" page will appear.
- Enter in the following information, per the form
  - Your email address
  - Your billing NPI
  - Your first and last name (not the client's name) and title
  - Under "Select topic" choose "AI/AN Client Update"
  - Under "Other Comments:" enter the following:
- Client is American Indian/Alaska Native, enrolled in [name of Tribe]; and
- If the client requests to enroll in or disenroll from an MCO:
  - *"I have consulted with the client regarding their options for managed care, and the client would like to opt in to [or out of] the MCO."*

    or
- If the client is not eligible to enroll in an MCO for integrated managed care and the client requests to enroll in or disenroll from an MCO for BHSO:
  - "I have consulted with the client regarding their options for managed care, and the client would like to opt in to [or out of] the MCO for BHSO."

    or
- If the client requests to enroll in the PCCM program:
  - "Please enroll in the [Name of Tribe]'s PCCM program."
- A "Thank you for contacting us" screen will appear with a service request number appearing in red. Record the service request number as proof of having submitted the request.

Washington State Health Care Authority

Medicaid Administrative Claiming

Medicaid Administrative Claiming (MAC)

Some of Washington's most vulnerable residents have trouble accessing needed health care. Government agencies provide many services to Washington residents daily, ensuring their overall well-being. Federal funds are available through HCA's MAC program to reimburse government agencies for some of the costs of their allowable Medicaid administrative activities when those activities support provision of services, as outlined in the Medicaid State Plan.

Note: Tribes may participate in PCCM or Medicaid Administrative Claiming (MAC). To avoid duplication of services and payment, tribes must participate in only one of these two programs.

Note: The Community Health Representative (CHR) or other allied staff within the Health Home Lead entity organization has the option of participating in the MAC Program or the Health Home Program. To avoid duplication of services and payment, staff may participate in only one of the two programs, not both.

Purpose of the Washington State MAC Program

- Provide outreach to residents with no or inadequate medical coverage.
- Explain benefits of Apple Health.
- Assist Washington residents in applying for Apple Health.
- Link residents to appropriate Medicaid covered services.

Examples of Reimbursable MAC Activities

- Informing Washington State Tribal residents about Medicaid.
- Assisting Tribal residents in applying for Apple Heath.
- Arranging transportation in support of Medicaid covered services.
- Linking Medicaid clients or potential Medicaid clients in need of health care services to Medicaid providers.

For more information, see the MAC webpage.