

Washington Apple Health (Medicaid)

Tribal Health Billing Guide

July 1, 2019

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This billing guide is designed to assist Tribal health care facilities and providers to deliver health care services to eligible clients, and to bill the Medicaid agency for delivering those services. This publication takes effect July 1, 2019, and supersedes earlier guides to this program.

This Tribal Health Program Billing guide applies to providers in the Indian Health Service (IHS) and in Tribal 638 Facilities. Providers who are not in IHS or in Tribal 638 Facilities should refer to the appropriate program-specific provider billing guide.

This guide is intended to be used in conjunction with all of the following:

- [Medicaid Washington Administrative Code \(WAC\)](#)
- [ProviderOne Billing and Resource Guide](#)
- [Program-specific billing guides](#)

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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.

What has changed?

Subject	Change	Reason for Change
Entire Guide	General housekeeping and formatting corrections	To improve usability of document
	Terminology changes (e.g., Replacing “facilities” with “clinics” when referring to Direct IHS Clinics and Tribal 638 Clinics, and replacing references to “native” with “American Indian/Alaska Native (AI/AN)” where applicable)	To implement new tribal FQHC Alternative Payment Methodology (APM) and align with State Health Official Letter #16-002
Definitions	Replaced “Chemical Dependency Professional (CDP)” and “Chemical Dependency Professional Trainee (CDPT)” with “Substance Use Disorder Professional (SUDP)” and Substance Use Disorder Trainee (SUDT)”	To comply with ESHB 1768, 2019 Regular Session and align Tribal Health program with Substance Use Disorder (SUD) program
Behavioral Health Organization (BHO)	Removed the North Sound region	Effective July 1, 2019, behavioral health services in the North Sound region will be provided under integrated managed care
Integrated managed care regions	Effective July 1, 2019, a new integrated managed care region, called North Sound , will be implemented. North Sound region includes Island, San Juan, Skagit, Snohomish, and Whatcom counties.	New integrated managed care region
What additional requirements must Tribal health clinics follow when billing?	Removed sections regarding requirement to have multiple encounters on the same claim.	To reflect current policy
How do I bill for a medical service encounter?	Removed incorrect billing taxonomy 208D0000X and added billing taxonomy code 171M00000X	To align with Maternity Support Services program billing instructions

Subject	Change	Reason for Change
Dental Health Aide Therapists (DHATs)	Effective July 1, 2019, the agency will pay Direct IHS Clinics, Tribal 638 Clinics and Tribal FQHCs for medically necessary services provided to American Indian/Alaska Native (AI/AN) clients enrolled in the Washington Apple Health program by DHATs.	To implement budget proviso (ESHB 1109 Sec. 211(49), 2019 Regular Session)
Expedited Prior Authorization (EPA) guidelines	Added new EPA code 870001349 for Wraparound with Intensive Services (WISe) procedure code T1041 with U8 modifier.	To align Tribal Health Program billing instructions with WISe program billing instructions
Certified public expenditures	Added instructions and information regarding certified public expenditures (CPE) and removed instructions for intergovernmental transfer (IGT)	To implement certified public expenditures in lieu of intergovernmental transfers

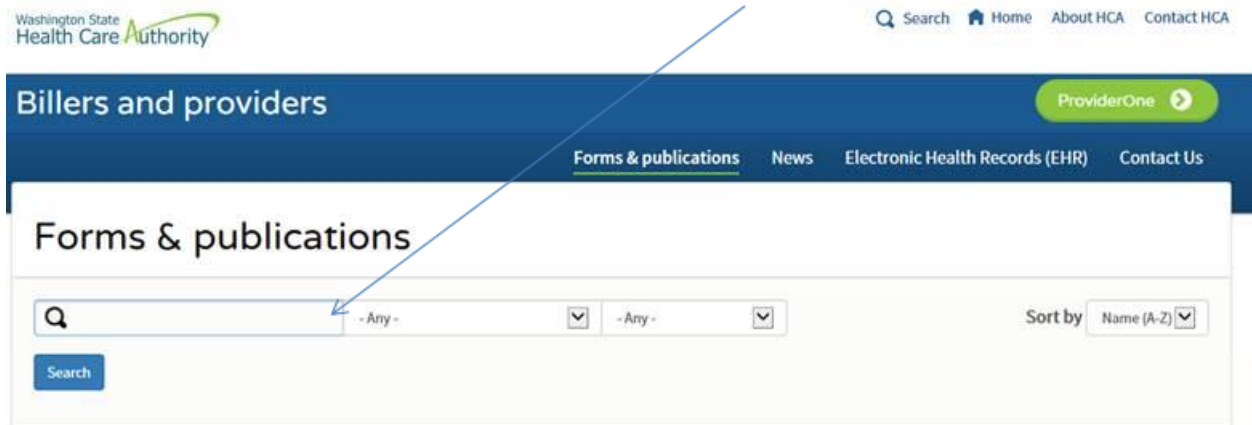
How can I get agency provider documents?

To access provider alerts, go to the agency’s [Provider Alerts](#) webpage.

To access provider documents, go to the agency’s [Provider billing guides and fee schedules](#) webpage.

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and provider's webpage, select [Forms & publications](#). Type the HCA form number into the **Search box** as shown below (Example: 13-835).



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Resources Available

Note: This section contains important contact information relevant to the Tribal Health Program. For more contact information, see the agency's [Billers and Providers](#) webpage.

Topic	Contact Information
Tribal health program mental health and substance use disorder treatment services	Behavioral Health Administration Tribal Liaison (360) 725-3475
Tribal health program medical or dental services	Washington Apple Health (Medicaid) Tribal Health Program Manager (360) 725-1649 tribalaffairs@hca.wa.gov

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.

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

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.

Behavioral Health Organization (BHO) – See WAC [182-500-0015](#)

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.

Substance Use Disorder Professional (SUDP) – A person certified as a substance use disorder professional by the Washington State Department of Health under Chapter 18.205 RCW.

Substance Use Disorder Trainee (SUDT) – A person certified as a substance use disorder trainee by the Washington State Department of Health under Chapter 18.205 RCW.

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

Clinical Family Member (for mental health services only) – A person who maintains a familial relationship with a Tribal member, including:

- A spouse or partner of an eligible AI/AN.
- A person under age 19, or is an incapacitated adult; *and* is the natural or adopted child, step-child, foster-child, legal ward, or orphan of an eligible AI/AN.
- A child in common, a foster or custodial child, or an adopted child placed within a family unit in which any member is an eligible AI/AN.
- A non-AI/AN woman pregnant with an eligible AI/AN's child. If unmarried, the woman may be a Clinical Family Member if an eligible AI/AN male attests in writing that he is the father of the unborn child, or AI/AN paternity is determined by order of a court of competent jurisdiction.
- A non-AI/AN adult who has guardianship, custodial responsibility, or is acting *in loco parentis* (to assume the duties and responsibilities of a parent or acting as temporary guardian) for an eligible AI/AN minor.

Courtesy Dosing – Temporary dosing from another approved Opiate Substitution Treatment facility provided to a patient when they are away from their home clinic.

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 24-hour period ending at midnight, as documented in the patient's record.

Encounter Payment – The agency'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 US 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.

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.

Substance use disorder — A problematic pattern of substance abuse leading to clinically significant impairment or distress, ranging in severity from mild, moderate, or severe.

Substance use disorder treatment - Medical and rehabilitative social services provided to an eligible client designed to mitigate or reverse the effects of substance use disorder and restore normal physical and psychological functioning. Drug addiction or drug abuse treatment is characterized by a combination of drug and alcohol education sessions, individual therapy, group therapy and related activities provided to detoxified 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 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 the agency 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](https://www.wa.gov/govpub/0000/00000/000000120.htm).

Program Overview

Washington Apple Health (Medicaid) and Federally Recognized Tribes

The State of Washington 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, the agency supports a government-to-government relationship between Tribes and the State of Washington. The agency 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 a number of ways.

- **Direct IHS Clinic:** IHS may directly operate one or more clinic 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. The agency 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. The agency 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. The agency automatically processes a retroactive claims adjustment each year to ensure payment of the updated rate.

The agency 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 the agency.

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 Clinic, and Tribal FQHCs must submit a *Core Provider Agreement (CPA)*, HCA 09-015, for each National Provider Identifier (NPI) number registered. See [Where can I download agency forms?](#)

Satellite locations must be identified on the main clinic CPA or on a separate CPA. For more information regarding CPAs, see the agency's [ProviderOne Billing and Resource Guide](#).

Submit applications for Medicaid provider enrollment to:

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

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 must meet all of the following:

- Meet the requirements of WAC 182-502-0010
- Be enrolled as a provider with the agency 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 the agency
- Perform services within the scope of their practice

Client Eligibility

Most Apple Health clients are enrolled in an agency-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 the agency's [Apple Health managed care webpage](#) 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 the agency will not pay for.

Is the client enrolled in an agency-contracted managed care organization (MCO), in a behavioral health organization (BHO), or is the client receiving services through fee-for-service (FFS) Apple Health?

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 the agency'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 the agency's [Program Benefit Packages and Scope of Services](#) webpage.

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

1. By visiting the Washington Healthplanfinder's website at:
www.wahealthplanfinder.org
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to:
Washington Healthplanfinder
PO Box 946
Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

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. When verifying eligibility using ProviderOne, if the client is enrolled in an agency-contracted managed care organization (MCO) or behavioral health organization (BHO), managed care enrollment will be displayed on the *benefit inquiry* screen in ProviderOne. The MCO or BHO is the primary payer for most Medicaid-covered services for Washington Apple Health clients.

- Direct IHS Clinic or Tribal 638 Clinic – With certain exceptions, the remaining balance of the IHS encounter rate may be billed to ProviderOne for American Indian/Alaska Native (AI/AN) clients only. For these exceptions, see [Substance Use Disorder and Treatment Services](#).
- Tribal FQHC – With certain exceptions, the remaining balance of the IHS encounter rate may be billed to ProviderOne for both AI/AN clients and non-AI/AN clients. For these exceptions, see [Substance Use Disorder and Treatment Services](#).

The following services provided by Direct IHS Clinics, Tribal 638 Clinics, or Tribal FQHCs may be billed directly to the agency (regardless of the client’s enrollment in an MCO or BHO):

- Substance use disorder treatment (for both AI/AN and non-AI/AN clients)
- Dental care (for both AI/AN and non-AI/AN clients)
- Mental health services (for AI/AN clients and for non-AI/AN clients who meet the definition of Clinical Family Member)

Send claims to the client's MCO or BHO, as applicable, for payment. If the client is AI/AN, MCOs are required to pay for covered services regardless of whether or not 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. Providers may bill clients only in very limited circumstances as described in [WAC 182-502-0160](#).

Note: Clients enrolled in an MCO or BHO are eligible for fee-for-service substance use disorder (SUD) treatment services that are provided through a Direct IHS Clinic, Tribal 638 Clinic, or Tribal FQHC. These clients are also eligible for SUD treatment services:

- Through their regional BHO, except in the fully integrated managed care regions. To access these services through the BHO, use the [BHO Contacts](#) for Medicaid Services Information found on [HCA's Behavioral health and recovery webpage](#).
- Through their MCO for clients who reside in a fully integrated managed care region.

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 the agency'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 agency-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 for which they are eligible.

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 the Washington Healthplanfinder's [Get Help Enrolling](#) webpage.
- 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.

Behavioral Health Organization (BHO)

The Health Care Authority manages the contracts for behavioral health services (mental health and substance use disorder) for the following three Regional Service Areas (RSAs):

- **Great Rivers:** Includes Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties
- **Salish:** Includes Clallam, Jefferson, and Kitsap counties
- **Thurston-Mason:** Includes Thurston and Mason counties

To view a map and table of the integrated managed care plans available within each region, please see [Changes coming to Washington Apple Health](#). You may also refer to the agency's [Apple Health managed care webpage](#).

See the agency's [Mental Health Services Billing Guide](#) for details.

Apple Health – Changes for July 1, 2019

Effective July 1, 2019, HCA is continuing to shift to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and drug or alcohol treatment, together known as “behavioral health”). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

Agency-contracted managed care organizations (MCOs) in certain Region Service Areas (RSAs) have expanded their coverage of behavioral health services (mental health and substance use disorder treatment), along with continuing to cover physical health services. The RSAs are outlined in the [Integrated Managed Care Regions](#) section.

Apple Health clients who are not enrolled in an agency-contracted MCO for their physical health services (e.g., dual-eligible Medicare-Medicaid clients) will still receive their behavioral health services through one of the agency-contracted MCOs. The MCO will provide only behavioral health services for the client.

Most clients will remain with the same health plan, except in regions where client's plan will no longer be available. HCA will auto-enroll these clients to one of the offered plans.

Clients can change their plan at any time by:

- Visiting the [ProviderOne Client Portal](#).
- Calling Apple Health Customer Service toll-free at 1-800-562-3022. This automated system is available 24 hours a day, 7 days a week.

- Requesting a change online through our secure [Contact us – Apple Health \(Medicaid\) client web form](#). Select the topic “Enroll/Change Health Plans.”

Visiting the [Washington Healthplanfinder](#) (only for clients with a Washington Healthplanfinder account).

Integrated managed care

For clients who live in an integrated managed care region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client’s agency-contracted MCO. The BHO will not provide behavioral health services in these regions.

Clients living in an integrated managed care region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

American Indian/Alaska Native (AI/AN) clients living in an integrated managed care region of Washington may choose to enroll in one of the agency-contracted MCOs available in that region or they may choose to receive all these services through Apple Health FFS. If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency’s [American Indian/Alaska Native webpage](#).

For more information about the services available under the FFS program, see the agency’s [Mental Health Services Billing Guide](#) and the [Substance Use Disorder Billing Guide](#).

For full details on integrated managed care, see the agency’s [Changes to Apple Health managed care webpage](#).

Integrated managed care regions

Clients who reside in the following integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency’s [Apple Health managed care webpage](#).

Region	Counties	Effective Date
North Sound	Island, San Juan, Skagit, Snohomish, and Whatcom	July 1, 2019 (new)
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman	January 1, 2019
King	King	January 1, 2019
Pierce	Pierce	January 1, 2019
Spokane	Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties	January 1, 2019
North Central	Grant, Chelan, Douglas, and Okanogan	January 1, 2018 January 1, 2019 (Okanogan)
Southwest	Clark, Skamania, and Klickitat	April 2016 January 1, 2019 (Klickitat)

Integrated Apple Health Foster Care (AHFC)

Effective January 1, 2019, 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 will receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 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.”

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 Administrative Services Organization (BH-ASO). For details, see the agency's [Mental Health Services Billing Guide](#), under *How do providers identify the correct payer?*

Which clients do not qualify for the encounter payment?

Clients identified in ProviderOne with the following recipient aid category (RAC) codes are enrolled in a state-only program and services provided to these clients do not qualify for the encounter payment:

RAC Code	Medical Coverage Group Codes
1040	F99
1056, 1057, 1176, 1177 only	K03
1060, 1062, 1179, 1180 only	K95
1060, 1062, 1179, 1180 only	K99
1077, 1078, 1081, 1082, 1158-1161, 1182-1185 only	L04
1190-1195 only	L24
1085, 1087, 1155, 1157, 1186, 1187 only	L95
1085, 1087, 1090, 1092, 1155, 1157, 1186, 1187, 1188, 1189	L99
1206, 1207 (SUD encounters only)	N13
1208	N21
1210	N25
1211	N31
1212, 1213	N33
1097, 1098 only	P05
1099, 1100	P06
1112, 1113	S03
1119, 1120	S07
1034, 1123	S30
1125, 1127	S95
1125, 1127	S99
1214	A01
1215	A01
1216	A05

The agency pays for services to clients with these RAC codes at the standard fee-for-service rates without an encounter payment.

Encounter vs. Fee-for-Service

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

The agency 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 of 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 the agency, 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 the agency cover?

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

- Unbundle 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.

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

The following services do not qualify for an encounter payment:

- Blood draws, laboratory tests, and/or x-rays – these services are bundled into the encounter rate if they are provided within the same 24-hour period as the encounter-eligible service. If these services are provided outside of that 24-hour period, they are reimbursable at the standard fee-for-service (FFS) rate.

For example: A dental x-ray is bundled into the encounter rate if the patient receives an encounter-eligible dental service within the same 24-hour period. A dental x-ray is never bundled into a medical encounter rate. A dental x-ray that is provided without an encounter-eligible dental service is reimbursed through FFS.

- Drugs or medication treatments provided during a clinic visit. See also [Are pharmaceuticals and drugs included in the encounter payment?](#)
- Courtesy dosing (see Definitions).
- Case management services (for example, HIV/AIDS case management).

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 reimbursable through fee-for-service. Pharmaceuticals, drugs, IUDs, and contraceptive implants must be billed on a separate claim from the encounter claim to avoid bundling the items into the encounter payment.

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

The agency determines a claim to be encounter eligible (i.e., a claim meets the requirements for IHS encounter rate eligibility) when all of 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.
- The billing taxonomy on the claim is one of the taxonomy codes listed in this guide.
- The servicing provider is a health care professional authorized to provide services to an Apple Health client.
- HCPCS code T1015 must be billed on a service line on the claim.
- The appropriate American Indian/Alaska Native (AI/AN) or non-AI/AN modifier, EPA 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:

- ✓ 36400-36425
- ✓ 36511-36515
- ✓ 38204-38215
- ✓ 70000-79999
- ✓ 80000-89999
- ✓ 90281-90749
- ✓ 99441-99443
- ✓ 99492-99494
- ✓ D0210, D0220, D0230, D0240, D0270, D0272, D0273, D0274, D0321, D0330, D0340, D0350, D0460, D0501
- ✓ G0512
- ✓ H0030
- ✓ All J codes
- ✓ P3000-P3001
- ✓ All Q codes
- ✓ All S codes (except S9436 and S9445, S9446, S9470)
- ✓ T1002, T1017, T1027, T1041
- ✓ T2022

How are services not eligible for an encounter paid?

Services that are not eligible for the IHS Encounter Rate are payable as FFS using the agency's fee schedules. For information on FFS, refer to the appropriate [Fee Schedule](#).

Note: Tribal providers are required to include the appropriate AI/AN or non-AI/AN designators (i.e., modifiers, EPA 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, the agency identifies procedure codes that may require prior authorization. However, this list may not be all-inclusive. Prior authorization, limitations, or requirements detailed in agency billing guides and Washington Administrative Code (WAC) remain applicable. The agency's fee schedules are available on the agency's [Provider billing guides and fee schedules webpage](#).

Billing

What are the general billing requirements?

Providers must follow the agency'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 the agency 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.

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 the agency'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

Medical Services

What is a medical encounter?

A medical encounter is an Encounter (see [Definitions](#)) for services described in the program-specific policies listed below. Service limitations and prior authorization requirements (program-specific policies) apply to all Medicaid clients for applicable Medicaid covered services.

Refer to the agency’s program-specific billing guides for a list of Medicaid-covered services

- [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 the agency’s [program-specific billing guide](#) and do all of 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).
- Bill with an American Indian/Alaska Native (AI/AN) or non-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	AI/AN modifier	Non-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

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 in order to complete the service. When the client is seen on multiple days for a maternity service package (e.g., CPT 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 in order to complete the service.

Service	CPT/HCPCS 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 bundled into the service (usually a 10-, 45- or 90-day post-operative period). Office visits related to the surgery are normally considered bundled into the surgical payment; however, the post-operative bundling 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.

Dental Services

What is a dental encounter?

A dental encounter is an Encounter (see [Definitions](#)) for services described in the program-specific policies listed below. 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 the agency'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 the agency's [Dental Services](#) webpage.

Expedited prior authorization (EPA)

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

To bill the agency 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 the agency's request. If the agency 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 AI/AN
870001306	Dental services	Client is non-AI/AN

How do I bill for a dental encounter?

Facilities must follow the agency’s Washington Apple Health [program-specific billing guide](#) and do all of 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
- Bill with an American Indian/Alaska Native (AI/AN) or non-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	AI/AN EPA	Non-AI/AN EPA
Dental	122300000x	870001305	870001306

Note: All claims must comply with the requirements in the [Billing](#) section of this guide.

Dental Health Aid Therapists (DHATs)

As authorized under chapter 70.350 RCW, the agency pays Direct IHS Clinics, Tribal 638 Clinics, and Tribal FQHCs for medically necessary services provided by dental health aid therapists (DHATs) to American Indian/Alaska Native (AI/AN) clients enrolled in the Washington Apple Health program as follows:

- Until the state general funds appropriated for DHAT services are exhausted for the state fiscal years ending June 30, 2020, and June 30, 2021, or until DHATs are covered by the Medicaid dental program, whichever is sooner.
- The person providing services is certified as a dental health aide therapist by:
 - ✓ A federal Community Health Aide Program Certification Board (CHAP); or
 - ✓ A federally recognized Indian tribe that has adopted certification standards that meet or exceed the requirements of a federal Community Health Aide Program Certification Board.
- All services must be performed:
 - ✓ In a practice setting within the exterior boundaries of a tribal reservation and operated by an Indian health program;
 - ✓ In accordance with the standards adopted by the certifying body, including scope of practice, training, supervision, and continuing education;
 - ✓ According to any applicable written standing orders by a supervising dentist; and
 - ✓ On people who are members of a federally recognized tribe or otherwise eligible for services under Indian health service criteria, pursuant to the Indian Health Care Improvement Act, 25 [U.S.C. Sec. 1601].

Note: DHATs must obtain a National Provider Identifier (NPI) and be enrolled with taxonomy 125J00000X.

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 in order to complete the service. The following services are global services that often require multiple visits in order to complete the Medicaid-covered service.

Service	CPT/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	D8010-D8030	4
Limited Orthodontic Treatment, each follow up visit	D8010-D8030	2
Interceptive Orthodontic treatment	D8050-D8060	2
Comprehensive Orthodontic Treatment, banding	D8070-D8080	5
Comprehensive Orthodontic Treatment, each followup	D8070-D8080	2

When billing for orthodontic services, Direct IHS Clinics, Tribal 638 Clinics, and Tribal FQHCs must follow the same guidelines as non-Tribal providers. Orthodontic codes must be billed according to the [Orthodontic Services Billing Guide](#).

Tribal Health Program

Direct IHS Clinics, Tribal 638 Clinics, and Tribal FQHCs are reimbursed by an encounter payment and may bill up to the maximum number of encounters shown in the chart below. The chart below illustrates comprehensive treatment timeframes and maximum units allowed during those periods.-

Months from appliance placement date	Orthodontic Billing and Encounter Reporting											Total Encounters Allowed
	0	3	6	9	12	15	18	21	24	27	30	
Number of encounters allowed – Comprehensive Treatment (D8070-D8080)	0	0	5*	2	2	2	2	2	2	2	2	21
Number of encounters allowed – Limited Treatment (D8010-D8030)	0	4*	2	2	2	-	-	-	-	-	-	10

* The date of service on the claim must be the same as the appliance placement date and clinical records must document the number of separate visits

During the first six months (comprehensive treatment) or three months (limited treatment), a Direct IHS Clinic, Tribal 638 Clinic, or Tribal FQHC may bill on the date of the appliance placement for up to one unit and up to a total of five (comprehensive treatment) or four (limited treatment) units. To bill for more than one unit during the first six months (comprehensive treatment) or four months (limited treatment), the provider must see the client and document the encounter in the client’s file.

If a Direct IHS Clinic, Tribal 638 Clinic, or Tribal FQHC chooses to bill in this manner instead of waiting the full six months (comprehensive treatment) or four months (limited treatment), the latest paid claim must be adjusted each time and another unit added to the line containing the HCPCS code T1015. If the claim is not adjusted, the claim will be denied as a duplicate billing.

Mental Health Services

What is a mental health encounter?

A mental health encounter is an Encounter (see [Definitions](#)) for services described in the program-specific policies listed below. 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.

These services are provided to reach the goals of an Individualized Service Plan. Medical necessity is determined by a Mental Health Professional (MHP) or psychiatrist. Subject to other Medicaid rules (such as clinic services provided outside of the clinic not being eligible for Medicaid reimbursement), services are provided at locations convenient to the client, by or under the supervision of an MHP or psychiatrist. HIPAA compliance must be maintained for all services.

American Indian/Alaska Native (AI/AN) clients may receive outpatient mental health services as follows:

- For clients who do not live in a fully integrated managed care region (FIMC):
 - ✓ If the client is enrolled in a managed care organization (MCO) and the client's mental health needs do not meet the Behavioral Health Organization (BHO) Access-to-Care Standard (see below), the client's MCO covers the services.
 - ✓ If the client is enrolled in a BHO and the client's mental health needs meet or exceed the BHO Access-to-Care Standard (regardless of whether the client is enrolled in an MCO), the client's BHO covers the services. BHOs are Washington State's system of mental health managed care for Medicaid clients. BHOs contract with local community mental health clinics to provide both emergency mental health services and ongoing mental health services for clients whose needs meet or exceed the Access-to-Care Standard. (See [Mental Health Services Billing Guide](#).)
- For clients who live in an FIMC region:
 - ✓ If the client is enrolled in an MCO, the client's MCO covers all Medicaid-covered mental health services

In addition, AI/AN clients have the choice to receive services through a Direct IHS Clinic, a Tribal 638 Clinic, or a Tribal FQHC without regard to the BHO Access-to-Care Standard, because AI/ANs have an elective exemption from Medicaid Managed Care under [42 U.S.C.1396u-2](#). Claims for AI/AN clients who receive BHO-level services from a Direct IHS Clinic, Tribal 638 Clinic, or Tribal FQHC require expedited prior authorization (EPA). AI/AN clients do not need to disenroll from Medicaid Managed Care to receive care at a Direct IHS Facility, Tribal Clinic, or Tribal FQHC and no referral is necessary.

Non-AI/AN clients may receive BHO-level outpatient mental health services at a Direct IHS Clinic or Tribal 638 Clinic only if the client meets the definition of a Clinical Family Member.

Non-AI/AN clients may receive BHO-level outpatient mental health services at a Tribal FQHC regardless of whether the client meets the definition of a Clinical Family Member.

Where do I find program-specific policy?

Refer to the agency's program-specific provider billing guide for a list of Medicaid-covered services

[Mental Health Services](#) or Tribal Health (see *EPA Guidelines* below)

For mental health services that are below the BHO Access-to-Care standard, refer to the [Mental Health Services Billing Guide](#). For mental health services that are at or above the BHO Access-to-Care standard, refer to the EPA guidelines below for more information.

Expedited prior authorization (EPA) guidelines

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

To bill the agency 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.

For the following mental health services that are above the BHO Access-to-Care Standard, the Tribal provider must verify that the requirements for use of the EPA number 87001349 are met. This EPA number is applicable only to clients who have an elective exemption from Medicaid Managed Care under [42 U.S.C.1396u-2](#) or who are Clinical Family Members. For Direct IHS Clinics, Tribal 638 Clinics, and Tribal FQHCs, the typical basis for the elective exemption under 42 U.S.C. 1396u-2 is that the client is AI/AN. In addition, Clinical Family Members are encouraged to receive treatment at Tribal 638 Clinics to promote better health outcomes in AI/AN households.

Tribal Health Program

Modality	HCPCS Code	Short Description	Provider Type (See legend)	EPA (See EPA Code and Criteria Table)
Crisis Services	H0030	Alcohol and/or drug hotline	01, 02, 03, 04, 05, 09, 10, 12	EPA 870001349
	H2011	Crisis interven svc, 15 min		EPA 870001349
Day Support	H2012	Behav hlth day treat, per hr	04, 05, 06, 09, 10, 12	EPA 870001349
Medication Monitoring	H0033 Administration and observation	Oral med adm direct observe	01, 02, 03, 04, 05, 06, 09, 10, 12	EPA 870001349
	H0034 Training and support	Med trng & support per 15min		EPA 870001349
Peer Support	H0038	Self-help/peer svc per 15min	06, 14	EPA 870001349
Stabilization Services	S9484	Crisis intervention per hour	01, 02, 03, 04, 05, 09, 10, 12	EPA 870001349
Therapeutic psycho-education	H0025	Alcohol and/or drug preventi	01, 02, 03, 04, 05, 06, 09, 10, 12	EPA 870001349
	H2027	Psychoed svc, per 15 min		EPA 870001349
Wraparound with Intensive Services (WISe)	T1041 with U8 modifier	Comm bh clinic svc per month	Concept does not apply. Approved WISe providers may bill for the service	EPA 870001349

Note: For more information on Wraparound with Intensive Services (WISe), see the agency's [WISe Program, Policy, and Procedure manual](#).

Explanation of Provider Type Codes	
Code	Definition
01	RN/LPN
02	ARNP/PA
03	Psychiatrist/MD
04	MA/PhD
05	Below Master's Degree
06	DOH Credentialed Certified Peer Counselor
09	Bachelor Level with Exception/Waiver
10	Master Level with Exception/Waiver
12	Other (Clinical Staff)
14	Non-DOH Credentialed Certified Peer Counselor

EPA Code and Criteria

EPA code	Service Modality	Criteria
870001349	Crisis Services, Day Support, Medication Monitoring, Peer Support, Stabilization services, Therapeutic psych-education	Either: (1) client has elective exemption from Medicaid Managed Care under 42 U.S.C.1396u-2 (e.g., client is AI/AN); or (2) client is a Clinical Family Member.

Note: Modalities listed above are only for clients who have an elective exemption from Medicaid Managed Care under [42 U.S.C.1396u-2](#).

How do I bill for a mental health encounter?

Facilities must follow the agency's Washington Apple Health [program-specific billing guide](#) and do all of the following:

- Bill a professional (837P/CMS1500) claim;
- Bill with the appropriate billing taxonomy - 2083P0901X;
- Add HCPCS code T1015 (the amount billed for code T1015 is not relevant as it does not affect payment); and
- Bill with an AI/AN or non-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	AI/AN modifier	Non-AI/AN modifier
Mental Health	2083P0901X	HE	SE

Note: All claims must comply with the requirements in the [Billing](#) section of this guide.

Substance Use Disorder and Treatment Services

What is a substance use disorder (SUD) encounter?

An SUD encounter is an Encounter (see [Definitions](#)) for services described in the program-specific policies listed below. Outpatient alcohol and/or drug treatment services are defined in [Chapter 388-877 WAC](#).

Where do I find program-specific policy?

Refer to the agency's program-specific billing guide found on the agency's [Provider billing guides and fee schedules webpage](#) for a list of Medicaid-covered services.

Who can receive substance use disorder treatment services?

Clients must have a Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) diagnosis of substance use disorder, mild, moderate, or severe in order to receive services.

Clients must meet medical necessity criteria as stated in the American Society of Addiction Medicine (ASAM).

How do I bill for an SUD encounter?

Facilities must follow the agency's Washington Apple Health [program-specific billing guide](#) and do all of the following:

- Bill a professional (837P/CMS1500) claim;
- Bill with billing taxonomy 261QR0405X;
- Do not add individual servicing provider NPIs or taxonomy 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
- Bill with claim note. Claim note must be entered exactly as listed in the table below.

Tribal Health Program

Note: Be sure to bill with an American Indian/Alaska Native (AI/AN) or non-AI/AN modifier **ONLY on the line for code T1015**

Client	Modifier on T1015 line	Claim Note (must be written exactly as this)
AI/AN client	HF	SCI=NA
Non-AI/AN ABP (RAC code 1201)	SE	SCI=NN
Non-AI/AN ABP Supplemental Security Income (SSI) (RAC code 1217)	HB	SCI=NN
Non-AI/AN classic Medicaid (All RAC codes except 1201 and 1217)	HX	SCI=NN

Note: All claims must comply with the requirements in the [Billing](#) section of this guide.

What is the payment for an SUD encounter?

The agency pays Direct IHS Clinics, Tribal 638 Clinics, and Tribal FQHCs the full encounter rate for SUD treatment services provided to Medicaid-eligible AI/AN clients.

For Medicaid-eligible non-AI/AN clients, 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. The agency pays Tribal health care facilities the federal portion of the Indian Health Services (IHS) encounter 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, the agency must receive tribal government CPE certifications every quarter. Payment of the federal portion will not be contingent on the agency'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, the agency 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. The agency must receive the tribe's CPE certification before the end of the next calendar quarter. For example:

- **The agency sends the report.** On or before April 30, the agency will provide each participating tribe a report with:
 - ✓ Every outpatient SUD claim submitted and/or adjusted in ProviderOne from January 1 through March 31 along with the applicable non-federal match amount for that claim, and
 - ✓ The total amount of the non-federal match for the January 1 through March 31 period.

- **Tribe sends CPE certification.** On or before June 30, the tribe will send its CPE certification to the agency.

If the agency does not receive the tribe’s CPE certification by the end of the next calendar quarter, the agency may suspend ProviderOne payments for outpatient SUD services provided to non-AI/AN clients until the agency 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 or 1217	50% of encounter rate
ABP	7%	RAC code 1201	93% of encounter rate
ABP Presumptive SSI (MAGI Adult)	7%	RAC code 1217	93% of encounter rate

Note: If a non-AI/AN client has RAC codes 1201 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 2019. The claims processing date determines which FMAP and State Match is applicable.

Billing for the Encounter Rate after Other Payers

The agency 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](#).

Billing for the encounter rate secondary to Medicare

- Medicare crossovers require all the same code lines 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 American Indian/Alaska Native (AI/AN) or non-AI/AN modifiers.
 - ✓ An encounter HCPCS code T1015.
- Encounter claims must be in a professional 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.

Billing for the encounter rate after Medicaid Managed Care Organization (MCO) payment

- Claims must meet all applicable billing and encounter criteria as outlined in this guide.
- Indicate the amount paid by the MCO in the insurance field on the claim.
- Such wraparound payments are only permitted for AI/AN clients.
- Providers may bill the MCO with the appropriate AI/AN modifiers and HCPCS T1015.

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

An American Indian/Alaska Native (AI/AN) client who meets the provisions of [25 U.S.C. 1603\(c\) \(d\)](#) 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 agency-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)
- The agency's fee-for-service (FFS) system

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

- For clients who do not live in a fully integrated managed care region (FIMC):
 - ✓ Enrollment with a behavioral health organization (BHO) available in their area
 - ✓ The agency's FFS system
- For clients who live in an FIMC region:
 - ✓ Enrollment with an agency-contracted managed care organization (MCO) available in their area for FIMC
 - ✓ Enrollment with an agency-contracted MCO available in their area for behavioral health services only (BHSO) if the client is not eligible to enroll in MCO for FIMC
 - ✓ The agency's FFS system

The agency 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](#).

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 agency contracted MCO or PCCM click the [Contact Us](#) hyperlink.

1. The “**Contact us – Medical provider**” page will appear.
2. Enter in the following information, per the form
 - ✓ Your email address
 - ✓ Your billing NPI
 - ✓ Your first and last name (not the client’s name)
 - ✓ 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 requests to enroll in or disenroll from a BHO:
 - ✓ *“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 BHO.”*
 - *or*
 - If the client is not eligible to enroll in MCO for FIMC 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.”*
3. 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.

Medicaid Administrative Claiming

Medicaid Administrative Claiming (MAC)

Some of Washington’s most vulnerable residents experience difficulty accessing needed health care. Government agencies provide many services to Washington residents on a daily basis, 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 Health.
- 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](#).