

TCOW

Tribal Compliance and Operations Workgroup and Quarterly Tribe+MCO meeting

March 13, 2019

Agenda

- ▶ MCO issues from Tribes
- ▶ 2019 IHS Rate
- ▶ 100% FMAP for services received through a tribal facility
- ▶ 638-FQHC
- ▶ Peer Support (Mental Health)
- ▶ NCCI Overview
- ▶ Outpatient SUD and the 5-encounter-per-day-SPA
- ▶ Top 10 claim rejections
- ▶ FAQ and Open Discussion

MCO Issues From Tribes

Q. For claims/billing issues – what is the turnaround time that we can expect when questions are sent?

Amerigroup

Provider Services Program

The Amerigroup Provider Services call center offers prior Authorization, automated member eligibility, case and disease management, claims assistance such as simple adjustments, health education materials, outreach services, and more. Call 1-800-454-3730 Monday-Friday From 8 a.m. – 5 p.m. Pacific time.

Community Health Plan of Washington
Coordinated Care
Molina
United Healthcare

Q. Do the managed care plans have folks to assist with EDI issues?

Amerigroup

Electronic data interchange (EDI)

Call our EDI hotline at 1-800-590-5745 to get started.

We accept claims through Availity (payer 26375) as our preferred clearinghouse for EDI transactions. Contact Availity at 1-877-334-8446.

Community Health Plan of Washington
Coordinated Care
Molina
United Healthcare

2019 IHS Rate

- ▶ The 2019 IHS Outpatient Visit Rate is \$455.00
- ▶ P1 was updated and claims are paying at the new rate
- ▶ The annual mass adjustment is pending and should be wrapped up in a couple of months

100% FMAP for Services Received Through a Tribal Facility

[SHO 16-002](#) (02/26/2016) – 100% FMAP (Federal Medical Assistance Percentages) is available for services *received through* a 638/IHS facility

Refer to the SHO (State Health Official) letter and the [FAQ for SHO 16-002](#) for more information. Summary:
IHS/Tribal facilities¹ may enter into care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements would be eligible for the enhanced federal matching authorized under section 1905(b) of the Social Security Act at a rate of 100 percent. Upon execution of a written care coordination agreement, this will be effective immediately for states for the expenditures for services furnished by non-IHS/Tribal providers to AI/AN Medicaid beneficiaries who are patients of an IHS/Tribal facility acting under such agreement, as described below

There are specific requirements listed in the SHO 16-002 notice, refer to the notice for complete information on the care coordination requirements

Q. How does HCA/P1 know to claim 100% FMAP for the service?

A. The non-tribal provider will need to add a data element to the claim (possibly an EPA, Expedited Prior Authorization)

Q. Now that HCA is claiming 100% FMAP, what happens with the money that HCA is saving?

A. Stay tuned, there is a bill in the legislature that would reinvest any new Medicaid savings from the 100% FMAP savings back into the ITU system of care

638-FQHC

As per the CMS suggestion as outlined in the [FAQ for SHO#16-002](#), HCA is submitting a State Plan Amendment (#19-0009; 638-FQHC). The Draft SPA is attached to today's webinar

If the SPA is approved **as written**, these are the only changes to expect

1. 638-FQHC encounter payments will not be restricted to services rendered *inside the 4-walls*
 - Medicaid covered services in elder homes, schools, alternative living facilities and other locations are payable at the encounter rate (sites of service must continue to be clinically appropriate)
 - 638-FQHC can enter into a contract with an outside specialist/provider and thereby make the outside specialist/provider part of the 638-FQHC group. Services rendered by the outside specialist/provider may be billed to P1 at the 638-FQHC encounter rate
2. FQHCs have a *one-facility - one-rate* rule
 - Services for nonAI/AN clients who are enrolled in managed care are eligible for the 638-FQHC rate. Medical/Dental/Mental Health services are eligible for the full encounter rate, SUD services will continue to pay at the federal share with the Tribe responsible for local matching funds

Q. What is the 638-FQHC rate?

A. The CMS FAQ indicates that there will be an APM (Alternative Payment Model) for the 638-FQHCs which will be at least equal to the IHS rate

There is one more 638-FQHC webinar scheduled on 03/29 9:00-10:30 <https://attendee.gotowebinar.com/register/3399911351166813187>

NOTE: the 03/15 638-FQHC webinar is cancelled

Peer Support (Mental Health)

Peer Support for Mental Health (not SUD) has been an Apple Health managed care covered service for years, previously covered under the RSNs and now covered under the *BHO* and *Integrated Managed Care* plans. There is a SPA pending for SUD Peer Support, which will be discussed during a future meeting

HCA billing overview:

- All services billed to HCA/P1 follow one of the [HCA billing guides](#)
- Mental Health Services follow the [HCA Mental Health Billing Guide](#). Part 1 of the Mental Health Billing Guide contains all the billable services for HCA's mental health program. NOTE: Part 2 of the billing guide is for [SERI](#) billers who see FFS clients; do not go to part 2.
- Peer Support and Crisis Services are not listed as covered services in (Part 1 of the) Mental Health billing guide and are not a P1-covered service

Q. Are we required to refer our clients to the BHO/MCO for Peer Support and Crisis Services?

A. NO. Refer to page 35 of the [Tribal Health Billing guide](#). AI/AN clients who wish to practice their elective exemption rights under [42 U.S.C. 1396u-2](#) may elect to receive those services at a tribal facility if the tribal facility is able to render the service. The client does not need to disenroll from managed care in order to receive these services. In other words, *AI/AN clients have the right to culturally competent care*

NOTE: This is only for AI/AN clients, nonAI/AN clients do not have the elective exemption right

Peer Support (Mental Health)

Peer counseling is provided by certified peer counselors who have met state requirements, taken the approved class, and passed the state test

The Health Care Authority's (HCA) Peer Support Program trains and qualifies mental health consumers as certified peer counselors (CPCs)

- For more information on becoming a peer counselor contact Mary Chambers, mary.chambers@hca.wa.gov
- For more information about the Peer Counselor Program contact: Pattie Marshall, pattie.marshall@hca.wa.gov

Certified Peer counselor services are currently billable by IHS/638 clinics but we have not seen any claims yet

Billing for the services of a Peer Support Counselor:

- The CPT/HCPCS code is H0038 (*Self-help/peer svc per 15 minutes*) (page 36-37 of the [Tribal Health Billing Guide](#))
- The servicing provider on the claim will be the certified peer counselor **supervisor's** NPI and taxonomy. (similar to Registered Nurses, HCA does not enroll certified peer counselors and their services are reported under their supervisor's credential)
- Add the AI/AN modifier (HE) to the claim and EPA (870001349) to indicate that the client is exercising their elective exemption rights
- The services of a certified peer counselor are eligible for the IHS encounter rate

NCCI Overview

HCA follows the [Medicaid National Correct Coding Initiative](#) (NCCI) Policy. HCA does not, however, follow the [CMS NCCI](#) policy. *NCCI assists the agency to control improper coding that may lead to inappropriate payment*

NCCI may be split into two separate sets of rules

1. NCCI procedure-to-procedure (PTP) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported
2. Medically Unlikely Edits (MUEs) define for each HCPCS/CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service

The following slides will look at each rule separately

NCCI Overview – PTP Edits

Here is a sample of the [PTP codeset](#)

Quarter Begin Date	Category	Column 1	Column 2	Effective Date	Deletion Date	Modifier Indi...	PTP Edit Rationale
04/01/2019	Practitioner Services	0001 M	36591	10/01/2015	10/01/2015	9	CPT Manual or CMS manual coding instructions

A - The quarter that the rule started (skip)

B - Category (choices are Practitioner, Outpatient Hospital, and DME)

C - Column 1 code. If there is a code-pair conflict the rule is that the column 1 code is the payable code

D - Column 2 code. This is the code that is not payable if the code in Column 1 is paying

E - This is the date that the rule started

F - This is the date that the rule ended (if blank then rule still applies)

G – Modifier indicator – sometimes a modifier can override the NCCI rule and make both services payable when appropriate

- Modifier indicator 0 -- the PTP edit is not overridable by use of a modifier
- modifier indicator 1 -- the PTP edit may be overridden sometimes by use of a modifier However, if both codes in the edit pair have the same anatomic modifier and neither code has modifier 58, 59, 78, 79, XE, XP, XS, or XU, the PTP edit is not bypassed.
- Modifier indicator 9 – the edit has been deleted and the modifier indicator is no longer relevant

Which modifiers may be used under appropriate clinical circumstances to bypass an NCCI PTP edit?

- *Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI*
- *Global surgery modifiers: 24, 25, 57, 58, 78, 79*
- *Other modifiers: 27, 59, 91, XE, XP, XS, XU*

H – Rationale. Generally the code pair is not payable per CPT/CMS coding or per the NCCI’s “misuse of column 1 with column 2” rule

- [Adjustment Reason 236](#) is the EOB used when a claim is rejected per NCCI PTP rules
- Attached to today’s webinar is a review of NCCI PTP coding for the common Mental Health and SUD codes

NCCI Overview - MUE

Here is a sample of the [MUE file](#)

Quarter Begin Date A	Category B	HCPCS/CPT Code C	MUE Value D	MUE Rationale E
01/01/2019	Practitioner Services	0001U	1	Code Descriptor / CPT Instruction
04/01/2019	Practitioner Services	0001U	4	Number of Units

A – The quarter that the rule started (skip)

B – Category (choices are Practitioner, Outpatient Hospital, and DME)

C – The CPT or HCPCS code

D – The maximum reportable number of units

E – Rationale

[Adjustment Reason 273](#) + [Remark code N362](#) are the EOBs used when a claim is rejected per the MUE rules

NCCI Overview – PTP-Like Edits

HCA has other policies that seem similar to the NCCI PTP rules, here are two of them

Physician-Related billing guide

HCA policy summarized – E&Ms are not payable on the same day as immunizations

Do not bill an E/M code unless a significant and separately identifiable condition exists and is reflected by the diagnosis. When a significant and separately identifiable condition exists, bill the appropriate E/M code with modifier 25. If the E/M code is billed without modifier 25 on the same date of service as a vaccine administration, the agency will deny the E/M code Exception: The E/M code 99211 may not be billed with a vaccine or the vaccine administration code (page 210)

NOTE: This rule applies if the servicing provider is the same on both claims but P1 sometimes erroneously rejects the E&M when rendered by a different provider from the immunization – when this happens, call mike before reprocessing to add modifier 25 to the E&M

Adjustment Reason 97 and Remark N20 are EOBs used when a claim is rejected per the HCA E&M vs immunization rule

Mental Health billing guide (page 38) *Eligible providers who are approved to provide mental health services may bill one psychiatric or psychological service per day, per client, which includes the evaluation and management service*

Adjustment Reason 119 is the EOB used when a claim is rejected per the HCA one Mental health visit per day rule.

NOTE: this HCA rule should be ending on July 1, 2019

Outpatient SUD

HCA has received new guidance for SUD encounters

During the [March, 2018 TCOW](#) it was noted that SUD **group therapy** was covered once per day, regardless of the number of group therapy sessions or providers that the client sees

The HCA Tribal Affairs Office has received further clarification regarding Outpatient SUD - Encounters are payable for up to **1 of each** type of visit/encounter per day. No more than 1 of each of these may be billed per day.

- One-on-one (H0004)
- Group therapy (96153)
- Family (client present) (96154)
- Family (client not present) (96155)
- Assessment (H0001)
- Methadone Administration (only for Methadone approved clinics) (H0020)

Per the [State Plan](#), the encounter rate is *paid for up to five (5) outpatient visits per Medicaid beneficiary per calendar day for professional services*

Top 10 Rejections - Medical

EOB	Description	Comments
204 ITU 02190	<i>This service/equipment/drug is not covered under the patient's current benefit plan</i>	<ul style="list-style-type: none"> • Claims were Medicare cross-overs and the client is a medicare-only client • Client is not full-scope coverage (e.g. family planning only) • Rendering taxonomy on claim was not adopted by P1 (eg 390200000x, 101YA0400x)
16 N290 ITU 01245	<i>Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier</i>	<ul style="list-style-type: none"> • Claim was missing the rendering NPI • The rendering NPI on the claim has not been enrolled in P1 yet
16 N288 ITU 01485	<i>Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider taxonomy</i>	<ul style="list-style-type: none"> • Rendering taxonomy on claim is not one that the provider is enrolled with • Licensed has expired (when licenses expire, P1 automatically expires the taxonomy too)
26 ITU 02255	<i>Expenses incurred prior to coverage</i>	<p>Client was not eligible on this date of service.</p> <p>NOTE: we have recently found that some clients are determined to be retroactively eligible after the claim(s) have been rejected, it is OK to reprocess claims if they are still timely</p>
16 N329 ITU 02125	<i>Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid patient birth date</i>	Client birthday on claim does not match client birthday in P1 – contact mike to get P1 updated

Top 10 Rejections - Medical

EOB	Description	Comments
16 N290 ITU 01390	<i>Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier</i>	Rendering NPI on the claim was either the billing group's NPI or the rendering NPI is not in P1 for the date of service or the rendering NPI was <i>De-Activated</i> in October
24 ITU 02035	<i>Charges are covered under a capitation agreement/managed care plan.</i>	Client is enrolled in one of the Apple Health Managed Care Plans (e.g., Amerigroup, CHPW, Coordinated Care, Molina or United Healthcare)
16 N48 ITU 02207	<i>Claim/service lacks information or has submission/billing error(s). Claim information does not agree with information received from other insurance carrier</i>	Client has Medicare (B or C) and it appears that Medicare made a payment but the claim was not billed as a "medicare cross-over"
16 N255 ITU 01475	<i>Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid billing provider taxonomy</i>	Billing/group taxonomy not valid <ul style="list-style-type: none"> FQHCs use 261QF0400x IHS/638 use 208D00000x (general medical), 225100000x (phys therapy), 152W00000x (optometrist), 235z00000x (speech therapy), or 225x00000x (occupational therapy)
16 N34 ITU 02204	<i>Incorrect claim form/format for this service.</i>	Claim was billed as a Medicare cross-over but there was money in what HCA calls the "insurance field" on the claim. If client does not have commercial insurance along with medicare – most likely the Medicare payment was in the "insurance field" on the claim & needs to be deleted If client does have commercial insurance along with medicare and we get an N34 – most likely P1 does not know that the client has commercial insurance (see page 29 of the P1 billing and resource guide)

Top 10 Rejections - Dental

EOB	Description	Comments
18 ITU	<i>Exact duplicate claim/service</i>	Duplicate billing
204 ITU 02190	<i>This service/equipment/drug is not covered under the patient's current benefit plan</i>	Most clients were either Medicare-only (either QMBonly or SLMB, QDWI or QI-1)
26 ITU 02255	<i>Expenses incurred prior to coverage</i>	Client was not eligible on this date of service. NOTE: we have recently found that some clients are determined to be retroactively eligible after the claim(s) have been rejected, it is OK to reprocess claims if they are still timely
16 N290 ITU 01390	<i>Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier</i>	Rendering NPI on the claim was either the billing group's NPI or the rendering NPI is not in P1 for the date of service or the rendering NPI was <i>De-Activated</i> in October
16 N290 ITU 01445	<i>Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier</i>	Rendering provider is not current in P1. Could be due to licensure or the <i>De-Activation</i> issue, contact mike

Top 10 Rejections - Dental

EOB	Description	Comments
29 ITU 00190	<i>The time limit for filing has expired</i>	<p>Claim is outside the timely filing window. HCA has the following timely rule:</p> <ul style="list-style-type: none"> • 365 days from the date of service to get the claim billed to P1 • If a claim met the initial 365 day requirement but needs correcting we get up to 2 years from the date of service for corrections <p>NOTE: due to HCA automation, corrected claims must be billed as replacements rather than use a claim note to prove timeliness</p>
16 N329 ITU 02125	<p><i>Claim/service lacks information or has submission/billing error(s).</i></p> <p><i>Missing/incomplete/invalid patient birth date</i></p>	Client birthday on claim does not match client birthday in P1 – contact mike to get P1 updated
16 N288 ITU 01485	<p><i>Claim/service lacks information or has submission/billing error(s).</i></p> <p><i>Missing/incomplete/invalid rendering provider taxonomy</i></p>	<ul style="list-style-type: none"> • Rendering taxonomy on claim is not one that the provider is enrolled with • Licensed has expired (when licenses expire, P1 automatically expires the taxonomy too)
16 N290 ITU 01245	<p><i>Claim/service lacks information or has submission/billing error(s).</i></p> <p><i>Missing/incomplete/invalid rendering provider primary identifier</i></p>	<ul style="list-style-type: none"> • Claim was missing the rendering NPI • The rendering NPI on the claim has not been enrolled in P1 yet
181 ITU 16030	<i>Procedure code was invalid on the date of service</i>	The Procedure code was probably valid but P1 was not able to determine how much to pay on the service (e.g., a crown for an adult has no rate and may be rejected with this EOB along with the “not covered” EOB)

Top 10 Rejections – Mental Health

EOB	Description	Comments
204 ITU 02190	<i>This service/equipment/drug is not covered under the patient's current benefit plan</i>	Clients were either Medicare-only clients or the performing taxonomy was a taxonomy that has not been implemented in P1 (e.g. 1041c0700x and 101YA0400x are not used in P1)
16 N290 ITU 01245 01010	<i>Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier</i>	<ul style="list-style-type: none"> • Claim was missing the rendering NPI • The rendering NPI on the claim has not been enrolled in P1 yet
16 N255 ITU 01475	<i>Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid billing provider taxonomy</i>	Billing/group taxonomy not valid <ul style="list-style-type: none"> • FQHCs use 261QF0400x • IHS/638 use 2083P0901x
16 N288 ITU 01485	<i>Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider taxonomy</i>	<ul style="list-style-type: none"> • Rendering taxonomy on claim is not one that the provider is enrolled with • Licensed has expired (when licenses expire, P1 automatically expires the taxonomy too) • Some providers were <i>De-Activated</i> in P1 on 10/01 (contact mike)
16 N290 ITU 01390	<i>Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier</i>	Rendering NPI on the claim was either the billing group's NPI or the rendering NPI is not in P1 for the date of service or the rendering NPI was <i>De-Activated</i> in October

Top 10 Rejections – Mental Health

EOB	Description	Comments
29 ITU 00190	<i>The time limit for filing has expired</i>	Claim is outside the timely filing window. HCA has the following timely rule: <ul style="list-style-type: none"> • 365 days from the date of service to get the claim billed to P1 • If a claim met the initial 365 day requirement but needs correcting we get up to 2 years from the date of service for corrections
16 M47 ITU 00265	<i>Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN)</i>	The TCN that is being reprocessed is either an invalid TCN or a TCN that has already been reprocessed. Reminder: A “claim” can be reprocessed as many times as necessary (with the 2 year timely window) A “TCN” can only be reprocessed one time, if the newest TCN still needs fixing then only the newest TCN is the fixable one Mike suggests always skipping over EOB M47 because it is almost always just a dead-end and the other TCN is the one to look at
16 N290 ITU 01445	<i>Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier</i>	Rendering provider is not current in P1. Could be due to licensure or the <i>De-Activation</i> issue, contact mike
24 U 02035	<i>Charges are covered under a capitation agreement/managed care plan</i>	Client is enrolled in an Apple Health Managed Care Plan that covers the service (currently only affected Urban Org claims)
107 ITU 00570	<i>The related or qualifying claim/service was not identified on this claim.</i>	Prolonged Care (99354-99357) is an add-on code that can only be billed with certain other codes. HCA did not follow CPT - HCA did not add 90837 as a base code for the add-on codes

Top 10 Rejections – Substance Use Disorder

EOB	Description	Comments
204 ITU 02190	<i>This service/equipment/drug is not covered under the patient's current benefit plan</i>	Clients were Medicare-only clients (QMB-only, SLMB, QDWI, QI-1)
29 ITU 00190	<i>The time limit for filing has expired</i>	Claim is outside the timely filing window. Non-Medicare-crossovers have the following timely rule <ul style="list-style-type: none"> • 365 days from the date of service to get the claim billed to P1 • If a claim met the initial 365 day requirement but needs correcting we get up to 2 years from the date of service for corrections
16 /N288 ITU 01485	<i>Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider taxonomy</i>	Claims were billed with a rendering NPI and taxonomy – SUD claims are billed at the clinic level only
4 I/T 14368 14369	<i>The procedure code is inconsistent with the modifier used or a required modifier is missing.</i>	Non AI/AN SUD claims at Tribal IHS and 638 facilities have certain modifier requirements due to the FMAP. Refer to SUD FMAP 2018 attachment
16 /N290 ITU 01010	<i>Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider primary identifier</i>	Claims were billed with a rendering NPI and taxonomy – SUD claims are billed at the clinic level only

Top 10 Rejections – Substance Use Disorder

EOB	Description	Comments
16 /N329 ITU 02125	<i>Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid patient birth date</i>	Client birthday on claim does not match client birthday in P1 – contact mike to get P1 updated
16 MA39 ITU 02120	<i>Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid gender</i>	Two different types of P1 gender issues: <ul style="list-style-type: none"> • “mike” is in P1 as a girl or “Sally” is in P1 as a boy – contact mike to get P1 updated • Client has identified as transgender – gender on claim must match the gender that the client indicated in P1
26 ITU 02255	<i>Expenses incurred prior to coverage</i>	Client was not eligible on this date of service. NOTE: we have recently found that some clients are determined to be retroactively eligible after the claim(s) have been rejected, it is OK to reprocess claims if they are still timely
16 N255 ITU 01475	<i>Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid billing provider taxonomy</i>	Billing/group taxonomy not valid <ul style="list-style-type: none"> • FQHCs use 261QF0400x • IHS/638 use 261QR0405x
107 I/T 14366	<i>The related or qualifying claim/service was not identified on this claim</i>	There was no paying service on the claim for the T1015 to support. The T1015 is only payable if there is a qualifying code on the claim that is also paying

FAQ and Open Discussion

Q. I just received a notice to revalidate our enrollment as an Apple Health (Medicaid) provider, the first I've received in over 15 years.

A. Federal regulations require the Washington State Health Care Authority (HCA) to revalidate the enrollment of all Medicaid providers at least every five years. If you receive a revalidation letter, follow the guidance in the letter. If you get stuck or need help, contact the Enrollment team at 800 562 3022 ext 16137 (M-F except Wednesdays) or HCAPR@hca.wa.gov

Do not start the Revalidation process unless you receive the notice from HCA
If you do not think that you will be able to complete the revalidation prior to the due date – contact mike as soon as possible

FAQ and Open Discussion

Q. If a child is covered by Medicaid and is between ages 12 and 24 months and are seen in a tribal clinic – are they subject to federally mandated lead testing?

A. Lead toxicity screening is mandatory at age 12 months and 24 months for all children, including children enrolled in an agency-contracted managed care organization, regardless of lead exposure risk.

Additionally, all children between age 36 months and 72 months must receive a lead toxicity screening if they have not been tested previously ([Physician-Related Billing Guide](#), page 157)

FAQ and Open Discussion

During the [January 2019 TCOW](#) issues regarding Medicare cross-overs were discussed

Q. What if we have to convert the UB to HCFA in P1? Is the timely rule still 6 months?

A. Yes. Other than Pharmacy claims there are two timely rules ([WAC 182 502 0150](#))

1. If Medicare (B or C) did not make a payment or apply the payment to the deductible
 - a. Claim must be received in P1 within 365 days from the date of service
 - b. If a claim met the initial 365 day rule but needs corrections then we get a total of 2 years from the date of service
2. If Medicare (B or C) did make a payment or apply the payment to the deductible
 - a. Claim must be received within 6 months from the date that Medicare processed the claim
 - b. If a claim met the initial 6 month rule but still needs corrections then we get a total of 2 years from the date of service

Notice that the Medicare timely anchor shifts from *'6 months from the date that Medicare processed the claim'* to *'date of service'*

Due to P1 automation claim notes are no longer respected, this is why it is important to always **replace** claims and never just **rebill** them. If a claim note is used to prove timely but the claim still gets rejected for timely, contact mike

Once the claim is outside the 2 year window see #8 WAC 182 502 0150 - *After twenty-four months from the date the service was provided to the client, the agency does not accept any claim for resubmission, modification, or adjustment. This twenty-four-month period does not apply to overpayments that a provider must refund to the agency by a negotiable financial instrument, such as a bank check*

FAQ and Open Discussion

During January TCOW we mentioned dental exam D0150 and the 'once-per-5-year-rule' for that code. HCA Audit team reminded mike that the D0150 is not just a 5 year limit, the client cannot have been treated within the past 5 years at all in order for a D0150 to be billable

Dental Exams are covered as follows

D0120 - *Periodic Oral Evaluations, once every 6 months*

D0150 - *Comprehensive Oral Evaluations as an initial examination.* Refer to dental billing guide and ADA coding book for criteria

D0140 - *Limited oral evaluations, only when the provider performing the limited evaluation is not providing routine scheduled dental services for the client on the same day* (Limited oral evaluations do not have a periodicity schedule)

FAQ and Open Discussion

January TCOW follow up

Q. We heard that Coordinated Care Healthy Options is an IMC (Integrated Managed Care) plan beginning on 01/01/2019. Why doesn't P1 say that is an IMC?

A. HCA staff did not see a need to update P1 at this time because the foster care population is only enrolled in one managed Care Plan (CCW)

The Apple Health Core Connections (AHCC) is under the statewide MCO (Coordinated Care) for youth in out-of-home care, adoption support, and alumni of foster care.

The Coordinated Care foster care team can be reached at 844-354-9876 or contact Jennifer Estroff directly at 206-492-9019

As of early March, 594 AI/AN youth had been opted-in to AHCC by tribal or state social workers, adoptive parents, or by alumni members themselves. Coordinated Care is happy to visit any tribe or IHCP to learn how we can support the work tribes are doing for their youth in out-of-home care, and how we can include traditional healing practices and connect youth back to their tribes and culture as part of their healing

PCCM Code ▲▼	Plan/PCCM Name ▲▼
MC: Capitated	Coordinated Care Healthy Options Foster Care (IMC)
MC: Capitated	Great Rivers Behavioral Health Organization
MC: Capitated	CHPW Behavioral Health Services Only
MC: Capitated	Great Rivers Behavioral Health Organization
MC: Capitated	North Sound Behavioral Health Org

FAQ and Open Discussion

Q. The [SUD billing guide](#) indicates that a Substance Use Disorder Assessment is '*Covered once per treatment episode for each new and returning client*' (page 24). What is a "treatment episode"?

A. In a clinical sense any services rendered between a client's intake and a client's discharge would be considered a treatment episode

In the WAC describing clinical practices in a state licensed behavioral health agency (WAC 246-341) there is no formal definition of how long a clinical episode can or cannot be; as clinically a treatment episode would be individualized depending on each client and their respective course of treatment

FAQ and Open Discussion

Q. Can you share the contact information for the Provider Enrollment teams?

- HCA - contact the Provider Enrollment team at 800 562 3022 ext 16137 (M-F, except Wednesdays) or providerenrollment@hca.wa.gov
- Amerigroup -
- Community Health Plan of WA -
- Coordinated Care - To get IHCP providers credentialed with Coordinated Care, please email us at CONTRACTING@coordinatedcarehealth.com
- Molina -
- United HealthCare –

FAQ and Open Discussion

Q. There are new taxonomy codes listed for April 1, 2019. should we start using them on April 1?

A. No, do not use the new taxonomy codes in P1

The new [taxonomy codes](#) are in the MLN Matters article [MM11121](#)

2083A0300x “Addiction medicine” is new – this taxonomy has not been adopted by P1, do not use this taxonomy on any FFS claims at this time

NOTE: There are many taxonomy codes that have not been adopted by HCA (e.g., 2084A0401x). If a taxonomy has not been adopted by P1 and is used on a claim – we will most likely get rejection EOB 204 (*not covered under the client’s benefit plan*). HCA does not publish or announce which taxonomy codes are adopted. Follow these guidelines for taxonomy

- Billing taxonomy – FQHCs are always 261QF0400x, IHS/638 Tribes are 208D00000x (medical), 122300000x (dental), 2083P0901x (Mental Health), or 261QR0405x (SUD)
- Servicing (also called rendering or performing) taxonomy – other than SUD, which is billed at the clinic level only – follow this guidance
 - Whatever servicing taxonomy you add to a claim must be a servicing taxonomy that the provider is enrolled with in P1
 - Whatever servicing taxonomy you add to a claim should be appropriate for the service (don’t think too much about this, just consider that a brain surgeon taxonomy is not appropriate for a broken toe)

Note: [description changes](#) of taxonomy codes are effective on the date that the description changed

FAQ and Open Discussion

Q. For SUD group services – how many people can be in the group?

A. The [SUD billing guide](#) indicates that Group Therapy is *Planned therapeutic or counseling activity conducted by one or more certified CDPs or CDPTs to a group of two or more unrelated individuals.*

Q. What is the **maximum** size of the group?

A. This is not in the SUD billing guide & the DOH WAC has not been posted yet, here is the [interim WAC](#)

WAC 246-341-0738 *Outpatient services—Level one outpatient substance use disorder services.*

(1) ASAM level one outpatient substance use disorder services provide a program of individual and group counseling, education, and activities, in accordance with ASAM criteria.

(2) An agency certified to provide level one outpatient substance use disorder services must meet the behavioral health agency licensure, certification, administration, personnel, and clinical requirements in WAC 246-341-0300 through 246-341-0650.

(3) An agency certified to provide level one outpatient substance use disorder services must ensure both of the following:

(a) Group therapy services are provided with a staff ratio of one staff member for every sixteen individuals; and

(b) A group counseling session with twelve to sixteen youths includes a second staff member

Q. What if I have 4 CDPs? Can I have a group of 64? (4 CDPs x *ratio of one staff member for every for every sixteen* = 64)

A. Mike received answer directly back from our DOH partners – *The maximum group size is 16*

FAQ and Open Discussion

Q. Does HCA (under FFS) cover treatment for problem gambling under the mental health benefit?

A. Yes, if the MHP is certified through the ECPG ([Evergreen Council on Problem Gambling](#)) or has a national or international certification. All other Medicaid criteria, such as eligibility and medical necessity apply)

- ICD10 F630 (*Pathological Gambling*) is a covered diagnosis
- ICD10 Z726 (*Gambling and Betting*) is not payable if billed as the primary diagnosis (e.g., treatment for Z726 is not covered). HCA does not publish a list of the diagnosis codes that are generally not payable if billed as the primary diagnosis on a medical claim, contact mike if you need the list

Under [WAC 182 100 0100](#) the problem gambling program is available to anyone who is not covered by private insurance, Medicaid, etc (or whose coverage doesn't include problem gambling treatment).

Q. Doesn't HCA cover foot care (nail debridement) in a client's home?
A. Yes. This is a great example of why it is OK to question P1 rejections

The nail debridement code (CPT 11720) has been updated and is now payable in a home setting (POS 12)

Q. Is there a connection between Tribal FQHC and FMAP?

A. Yes, but there are three different FMAP issues that we are concerned with

1. 100% FMAP for *services received through* an IHS/638 facility ([SHO 16-002](#)) -- including Tribal clinic and 638-FQHC
2. 638-FQHC services for AI/AN clients will continue to pay at 100% FMAP, even if the servicing doctor/specialist is outside the 4 walls -- IHS/638 clinics are subject to the 4-walls rule whereas 638-FQHC is not
3. SUD services for nonAI/AN clients will continue to pay at the federal share with the tribe responsible for local matching funds -- including Tribal clinic and 638-FQHC

FAQ and Open Discussion

Q. Can we have more information on CGM (Continuous Glucose Monitor) training?

A. Stay tuned

FAQ and Open Discussion

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

A. Another great example of why it is OK to question the policy – Z0131 has been updated and is now a payable diagnosis. Mike will reprocess rejected claims soon

Also asking about some noncovered TMJ diagnoses (stay tuned)

M26601 RIGHT TEMPOROMANDIBULAR JOINT DISORDER UNSPEC

M26602 same thing but for LEFT

M26603 same thing but for bilateral

FAQ and Open Discussion

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

A. FQHCs – yes, must be on separate claims (P1 will not allow a well child code to pay on the same claim as an “unwell” code). See page 21 of the [FQHC guide](#)

IHS/638 clinics refer to page 44 of [October TCOW](#)

FAQ and Open Discussion

Q. Would a pharmacist be eligible for **incident** to billing

- FQHC answer - Generally pharmacy costs/salaries are included in the clinic's encounter rates. Clinics should not be able to bill incidental (outside of the encounter rate). These costs are considered bundled with the encounter rate
- IHS/638 answer –
 - If the service is on the same calendar day as the primary service – no.
 - If the service is on a different calendar day as the primary service – yes, here are the professional services that HCA recognizes for Pharmacists
 - Tobacco cessation for pregnant clients ([physician billing guide](#))
 - Clozaril case management ([physician billing guide](#))
 - Emergency contraception counseling ([prescription drug billing guide](#))
 - Vaccine Administration fee ([prescription drug billing guide](#))
 - Diabetic Education (if the clinic has been approved for the Diabetic Education Program) ([Diabetic Education billing guide](#))

FAQ and Open Discussion – Open Questions

Q. Any update on the SUD Match going quarterly?

A. Stay tuned, this is in reference to the switch to the CPE process (Spring/Summer, 2019?)

FAQ and Open Discussion – Open Questions

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

I need to split the question up

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

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

A1 – refer to January, 2019 TCOW slides

A2 – no guidelines, follow mike’s ‘does xxxxx qualify for the encounter rate?’ cheat sheet

FAQ and Open Discussion – Open Questions

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

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

FAQ and Open Discussion

Q. Does HCA cover paramedicine?

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

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

A scenario explains why the question was asked

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

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

Stay tuned

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- The bottom-left corner of each slide will contain either I/T (impacts IHS and Tribal) or I/T/U (impacts IHS, Tribal and Urbans) or U (only impacts Urban)
- If there is a difference between any information in this webinar and current agency documents (e.g. provider guides, WAC, RCW, etc), the agency documents will apply.

Thank you!