

Washington Apple Medicare Connect

**Medicare
Advantage Dual
Special Needs
Plans (DSNP) Tribal
Health Billing
Reference**

January 1, 2026

Disclaimer

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

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

About this guide*

This guidance is developed to support our Tribal partners in billing Dual Special Needs Plans for services provided to Washington State Dually eligible clients. This guidance is not meant to change how Commercial Medicare plans, Original Medicare, or Medicaid processes or pays for claims. This guidance only supports Tribes in working with Washington State Contracted Dual Special Needs plans.

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

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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 HCA.

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

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's [provider alerts webpage](#).

To access provider documents, go to HCA's [provider billing guides and fee schedules webpage](#).

Confidentiality toolkit for providers

The [Washington State Confidentiality Toolkit for Providers](#) is a resource for providers required to comply with health care privacy laws.

Where can I download HCA forms?

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

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What has changed?

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

Subject	Change	Reason for Change
Initial Version		Support billing for Tribal partners to DSNP

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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.

All Inclusive Rate (AIR) - 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 All Inclusive Rate (AIR) is published by the federal Office of Management and Budget in the Federal Register on an annual basis.

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

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

Bureau of Indian Affairs (BIA) – Federal agency under the Department of the Interior responsible for the administration and management of land held in trust by the United States for AI/ANs and Indian Tribes. Developing forestlands, leasing assets on these CPT® codes and descriptions only are copyright 2024 American Medical Association.

lands, directing agricultural programs, protecting water and land rights, developing and maintaining infrastructure, providing for health and human services, and economic development are all part of this responsibility taken in cooperation with the AI/ANs.

CMS – Centers for Medicare and Medicaid Services.

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

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

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

DSHS – Washington State Department of Social and Health Services.

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

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relationships that serve people more effectively and efficiently than before.

Encounter – An encounter is a documented direct face-face contact between a patient and a provider, or other person who is authorized by State licensure law to order or furnish services for diagnosis or treatment of the patient and is allowed to bill for services to Medicare.

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

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

Health Care Professional - See 45 CFR 60.3

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 CPT® codes and descriptions only are copyright 2024 American Medical Association.

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.

Part C Medicare Advantage – Medicare Part C, also known as Medicare Advantage, is a health plan option that must cover everything that original Medicare covers, and extra benefits not covered by original Medicare.

- Medicare Advantage (MA) health plans, or Part C, are private insurance companies who contract with Medicare to provide Managed Medicare. They contract with the Centers for Medicare and Medicaid services (CMS) and combine Part A and Part B benefits. A client must already have Medicare Part A and Part B to be eligible for an MA plan.
- Part C plans provide all Part A and Part B coverage and follow the same Federal rules regarding benefit design and cost sharing but may offer additional supplemental benefits as approved by CMS. Some MA plans may also offer Part D coverage as well.
- Dual Eligible Special Needs Plans (D-SNP) are a type of MA Part C plan for people who are eligible for both Medicare and Apple Health. Under a D-SNP, Medicare and Apple Health partner together to provide healthcare and services. D-SNPs are known as Apple Health Medicare Connect in the state of Washington.

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- A client with a D-SNP will appear under the Managed Care Information field when verifying information. Any other Medicare Part C and Part D plan will be found in the Coordination of Benefits segments.

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

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

Taxonomy - A hierarchical code set designed to categorize the type, classification, and/or specialization of health care providers.
[Find Your Taxonomy Code | CMS.](#)

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).

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

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

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

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

Washington Apple Health – See [WAC 182-500-0120](#).

Program Overview

Washington Apple Health (Medicaid) and Federally Recognized Tribes

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

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

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

- **Direct IHS Clinic:** IHS may directly operate one or more clinics to provide outpatient health care services without affiliation with an inpatient hospital. These facilities are called Direct IHS Clinics in this guide. Under the MOA, Direct IHS Clinics may receive the IHS encounter rate as published annually in the Federal Register.

HCA automatically processes a retroactive claims adjustment each year to ensure payment of the updated rate.

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

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

What are the basic provider eligibility requirements for Medicaid payment?

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

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

What are the basic provider eligibility requirements for Medicare payment?

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

- Meet Medicare requirements including getting an NPI;
- Complete a Medicare Enrollment Application; and
- Respond to requests for more information timely.

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/provider-enrolment/Med-Prov-Enroll-MLN9658742.html>

Minimum Requirements to bill a DSNP

1. Be known to Medicare
2. If contracted, they have been credentialed with the plan.
3. Meet all minimum requirements to bill Medicare

How does a Direct IHS Clinic, a Tribal 638 Clinic, or a Tribal FQHC become an enrolled Medicaid provider? Providers, including Direct IHS Clinics, Tribal 638 Clinics, and Tribal FQHCs, must submit a Core Provider Agreement (CPA), HCA 09-015, for each Billing National Provider Identifier (NPI) number registered.

See [Where can I download HCA forms?](#)

For more information regarding CPAs, see HCA's [provider enrollment website](#).

Submit applications for Medicaid provider enrollment to:

Provider Enrollment

Attn: Tribal Enrollment Coordinator

PO Box 45562

Olympia, WA 98504-5562

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

To become a Medicare provider and file Medicare claims, a provider must first enroll in the Medicare program. To enroll, they must have an NPI. And to get an NPI, the application will need to include the taxonomy code that reflects the classification and specialization.

Complete the Medicare Enrollment Application. Enroll using PECOS, the online Medicare enrollment system. PECOS has video and print tutorials and to walk a provider through the enrollment to ensure the information is accurate. [PECOS Fact Sheet](#)

Keep information current. To avoid having Medicare privileges revoked, a Provider must be sure to report changes timely. [Become a Medicare Provider or Supplier | CMS](#)

Which providers are eligible for the All-Inclusive Rate (AIR)?

See the [Definitions](#) section for the definition of **Encounter**.

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

- Be an Indian Health Care Provider, 638 Facility, or Tribal FQHC
- Be enrolled as a provider with Medicare in accordance with the requirements CFR 42 CFR 424.510
- Perform services within the scope of their practice Client Eligibility

Many Dually-Eligible Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for Behavioral Health Services.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services. *Client's must follow Medicare rules for enrollment and disenrollment from DSNPs.*



How do I verify a client's Medicare eligibility?

Check the client's Plan ID Cards or follow the process below to verify that a client has DSNP coverage for the date of service and that the client's benefit package covers the applicable service.

Apple Health Medicare Connect clients are enrolled in a contracted Medicare Advantage Health Plan (DSNP). This means that they have signed up for a Medicare Part C Medicare Advantage Dual Special Needs Plans. Each plan is contracted with the Centers for Medicare and Medicaid services and has a State Medicaid Agency Contract.

Check patient eligibility through these online tools and services:

- Medicare Administrative Contractor (MAC) online provider portal
- Billing agencies, clearinghouses, or software vendors
- Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) You may see different Medicare eligibility responses based on the tool you use.

To check eligibility, you'll need your patient's:

- MBI
- First and last name
- Date of birth (MM/DD/YYYY)

MLN Fact Sheet MLN 8816413 Checking Medicare Eligibility
[mln8816413-checking-medicare-eligibility.pdf](#)

You can also find Eligibility information on HCA's ProviderOne (Find Medicaid Link) [verifying-apple-health-medicare-connect-enrollment.pdf](#)

Verifying Medicaid eligibility is a two-step process:

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

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

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

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

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

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

Yes. Apple Health Medicare Connect clients have chosen to enroll in one of HCA's contracted DSNPs. For these clients, DSNP enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

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

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

For full Dually Eligible clients, Dental care not covered by the DSNP may be billed directly to HCA (regardless of the client's enrollment in an MCO).

Send claims to the client's Medicare Advantage plan for payment. If the client is AI/AN, DSNPs are required to pay for covered services regardless of whether the Tribe is contracted with the DSNP. However, if the client is non-AI/AN, call the client's DSNP to discuss payment prior to providing the service. The DSNP is required to pay for qualifying services at the IHS Medicare Out-Patient All-Inclusive Rate (AIR) if the client is an IHS-eligible AI/AN. The DSNP is required to pay for qualifying services at the Medicare rate if the client is non-AI/AN. Providers may bill clients only in very limited circumstances as described in [WAC 182-502-0160](#).

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

Medicare Part C Enrollment

Most Medicare Eligible clients may be enrolled in a DSNP the first of the following month they become Medicare eligible and they choose to join a DSNP. To join a DSNP a client must:

- Have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance)
- Live in the service area of the plan you want to join.
- Be a U.S. citizen or lawfully present in the U.S.
- Have your Medicare Number and your Part A and/or Part B coverage start dates. Find this information on your Medicare card.

The coverage start date will depend on a client's enrollment period. Visit [Medicare.gov](https://www.medicare.gov) for further information.

<https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan>

Clients who are not enrolled in a DSNP for physical health services

Some Medicare clients choose not to enroll with a DSNP for their Part A and Part B services. These clients are eligible for services under Original Medicare, a fee-for-service (FFS) program. Original Medicare covers most medically necessary services and supplies in hospitals, doctors' offices, and other health care facilities. Original Medicare doesn't cover some services, like routine physical exams, eye exams, and most dental care. Tribes must follow all rules for payment from Medicare. This guidance does not alter how Original Medicare will pay for services.

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The BHSO is available for Full Dually-Eligible clients and covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO, except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into an integrated managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care Alumni.

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American Indian/Alaska Native (AI/AN) Clients

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

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

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

Determining Whether a Service is an Encounter

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

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

- The client's recipient aid category (RAC) code is encounter-eligible.
- The claim is billed by a Direct IHS Clinic, Tribal 638 Clinic, or Tribal FQHC
- The claim is billed on a professional form or in an accepted format either UB04 Professional Claim or CMS 1500. The Tribe will use whatever format they most commonly use to bill Medicare directly.
- The billing taxonomy is not required on the claim but they should include it to ensure proper payment from Medicaid.
- The servicing provider is a health care professional authorized to provide services to a Medicare client.
- For professional and dental claims, the relevant G Code is billed on a service line on the claim.
- The client is identified as an AI/AN Client in the 834 file generated by HCA or confirmed by ProviderOne.

Express permission to use ASC X12 copyrighted materials has been granted. How many encounters does HCA cover?

Professional and Dental claims

A DSNP will pay for up to one encounter per day, per type, encounters per day, per client. They are:

- One (1) Medical Claim
- One (1) Dental Claim
- One (1) Mental Health Claim

This applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, or whether the first visit is related or unrelated to the subsequent visit.

This would include situations where the patient has a medically necessary face-to-face visit with a practitioner, and is then seen by another practitioner, including a specialist, for further evaluation of the same condition on the same day, or is then seen by another practitioner, including a specialist, for evaluation of a different condition on the same day.

Exceptions for multiple visits:

- If the Client suffers an illness or injury that requires treatment on the same day, such as running a high fever later in the day from the morning visit
- The Client has a medical and mental health visit on the same day

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

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

- The client's is a DSNP enrolled member.
- 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), Institutional (UB-04/CMS-1450) or dental (837D/ADA) claim. The Tribe will use whatever format they most commonly use to bill Medicare directly.
- The servicing provider, or prescribing provider on a pharmacy claim, is a health care professional authorized to provide within their scope of practice.
- The billing taxonomy is not required on the claim but a tribe should include it to ensure proper payment.
- For professional and dental claims, the relevant G Code is billed on a service line on the claim.
- The claim has at least one line for a service that is correctly billed and eligible for payment for the same date of service. How are services not eligible for an encounter paid?

Allowable G Code	Definition
G0466	A medically necessary, face-to-face encounter (one-on-one) between a new patient and a IHCP practitioner during which time one or more

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	encounter eligible services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a visit.
G0467	A medically necessary, face-to-face encounter (one-on-one) between an established patient and a IHCP practitioner during which time one or more encounter eligible services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a visit
G0468	A IHCP visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV.
G0469	A medically necessary, face-to-face mental health encounter (one-on-one) between a new patient and a IHCP practitioner during which time one or more encounter eligible services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.
G0470	A medically necessary, face-to-face mental health encounter (one-on-one) between an established patient and a IHCP practitioner during which time one or more encounter eligible services are rendered and includes a typical bundle of Medicare-covered services that would be

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

Fee Schedule Information

A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.

[Fee Schedules - General Information | CMS](#)

Billing

What are the general billing requirements?

Providers must follow the DSNP and Medicare Billing Rules

These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments
- What fee to bill for eligible clients
- When providers may bill a client
- Billing for clients eligible for Patient Responsibility as allowed
- 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.

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?

FOR DSNPs to complete