Washington State Health Care Authority

Integrated Managed Care SERI, National Provider ID (NPI) & Taxonomies

FAQs

07/09/2019

Question	Answer
1. Do non-billing providers have to answer the attestation questions?	The enrollment application checklist questions (step 16 for the online application) are required to be completed for all provider (billing and non-billing) applications submitted to HCA, no exceptions. The Mental Health Professionals Attestation Form is sent out by HCA when applications are received for licensed mental health (MH) professionals. However, it is not applicable to those providers who work for an agency that is licensed under the Department of Health (DOH), even if the provider is not licensed.
2. To clarify, if a MH therapist is an employee under a facility, they are not required to fill out an attestation form?	If the facility is licensed then yes the MH therapist is not required to fill out the attestation form.
3. Will all American Indian/Alaska Natives (AI/AN) individuals have a managed care organization (MCO)? If not, will we be required to complete the attestation form to serve this population?	AI/AN clients have the option to enroll with an MCO, or to be served in the fee-for-service (FFS) system. If you would like to enroll to be a provider in the AI/AN FFS service system so that you can directly bill P1 for services delivered to AI/AN FFS clients, please review the fact sheets about enrolling in the AI/AN FFS program. If a facility/agency is only participating in the AI/AN FFS program, and not participating in Integrated Managed Care (IMC) or with a behavioral health organization (BHO), then clinicians, and servicing providers are not required to enroll with HCA, and are not required to be used on claims for the AI/AN FFS BH program. Since these practitioners are not required to be enrolled, they are not required to complete the application checklist questions.

	However, if the facility/Agency is also participating with Integrated Managed Care or with a Behavioral Health Organization, then the clinicians and servicing providers are required to enroll with HCA, and required to complete the application checklist questions. See also question 64.
4. Where can we find the 18 types of taxonomies?	See the taxonomy crosswalk HCA provided in the NPI IMC Fact Sheet. The fact sheet is posted on the HCA website at https://www.hca.wa.gov/about-hca/healthier-washington/regional-resources, under the "General" tab. HCA has received a notification from clearinghouses that they cannot accept the local taxonomy codes created by HCA. Clearinghouses can only accept federal taxonomies provided by the National Plan & Provider Enumeration System (NPPES). This impacts the following local HCA taxonomy codes: 101Y99993L, 101Y99994L, 101Y99995L, 101Y99996L. To resolve this issue for providers that bill an MCO or clearinghouse, HCA recommends the following: • Clinicians with the above noted taxonomies should enroll your NPI with HCA under the local (SERI) taxonomy *as well as* your NPPES taxonomy. • When submitting claims/encounters to an MCO or clearinghouse, these clinicians should always use the NPPES taxonomy. If you have already registered the clinician's NPI under one of these local taxonomies, please *also register* the clinician's NPI with HCA under the NPPES taxonomy. If you have not yet registered, please be sure to register the clinician's NPI with HCA under both our local taxonomy as well as the clinician's selected NPPES taxonomy.

	Note: If the clinician bills directly and not through an MCO or clearinghouse, please enroll using the local (SERI) taxonomy only.
5. Is there a way to get an electronic extract from P1 to see which taxonomies have been registered?	HCA will not be supplying a list of clinicians and their taxonomies registered in ProviderOne to the agencies. Dianne Baum will be connecting with the BHOs to facilitate the provision of this information. However, agencies (i.e., providers) with access to the ProviderOne portal have the ability to add, remove and update the mental health professional's associated with the facility or agency NPI. This functionality also allows agencies to create and export a list of professionals associated with the agency NPI at any time, and allows the agencies to review and update the taxonomy (s) registered with HCA for those professionals.
6. Is a clinician required to enter in a license number in P1 when registering their NPI?	There are instructions for dealing with registering a non-licensed provider and you can enter "NA" into that field; if the provider is licensed then HCA would like them to include their number. Do not use a slash – please just put the letters NA.
7. Isn't the claim & encounter one and the same?	They are very similar in that they report the same information about services rendered, they both have to be submitted in 837 formats, and they both have to follow HIPAA compliance rules, but they are not quite the same. A claim is a bill submitted by the provider to the payer in order to receive a FFS for service payment for the service(s) rendered and reported on the claim. An encounter is what the MCO submits to HCA to represent claims they have paid to their enrolled providers. Providers who are paid on a capitated basis or cost reimbursement are also required to submit encounter data to the MCO, representing the services rendered.
8. Can providers code bill for ADIS (Alcohol Drug Information School)?	This is a non-Medicaid service, so providers need to work with payers to see if you can obtain a contract for this particular service. You may also want to talk with your regional Behavioral Health – Administrative Service Organization (BH-ASO) about a contract for this service. If you have a contract for this service, then yes you should submit encounter data.

9. Why can't providers continue to run exclusion checks monthly on our board members instead of submitting their SSNs for the feds to check this?	HCA encourages them to do that, but HCA is also required by CFR to perform this activity.
10. Where and when can we get the new SERI guide?	HCA will share the updated SERI Guide with the Webinar email list, the MCOs, the BHOs, and Beacon Health Options and will also distribute it via the Greater Columbia, Spokane and Pierce provider workgroups. When HCA identify the appropriate place to publish it on our Website we will also do this and share the link.
11. For BH-ASOs who will be using the Prior Authorization (PA) field for an actual PA number, where should they put the EBP code?	HCA will not be requiring EBP reporting by the BH-ASO for non-Medicaid clients.
12. How will secure detox and free-standing E&T be reported? Will it continue to use an 837i claim?	Yes, it will be an 837i claim submitted to the MCO. For free standing E&Ts, use revenue code 1002 and HCPC code H0017. For hospital-based E&Ts, use revenue code 0126 with HCPC code H0017.
13. When will we be able to start testing out new systems for the encounter reporting?	The MCOs are able to do testing already. Please reach out to the MCOs to begin testing.
14. Do interns seeking a Master's degree need an NPI?	Yes. See questions 15 and 16 about interns getting an NPI.
15. When enrolling interns, what provider type should they be categorized as?	Nationally, an intern can get an NPI with a student taxonomy (390200000X) with the NPPES, so that should be the first step. The provider type would just be based on education level, intern or not. For the purposes of enrolling with HCA and selecting a taxonomy from the crosswalk, if they are an MA or PhD level intern, then use MA/PhD with the designation non-licensed. If their education level is below an MA (for example, if they are at the BA level), then the intern would use the "below MA" option. See question 16.
16. What taxonomy should be used for those who are interns?	Use the taxonomy code 390200000X- Student in an Organized Health Care Education/Training Program for the purposes of registering with NPPES and acquiring an NPI that would be as close as any

	available in the federal code set for mental health professionals in training. This taxonomy code should also be used for claims/encounter submittal to an MCO or clearinghouse. However, for purposes of enrolling with HCA, select the HCA local taxonomy that is the best fit for the educational preparation of the intern, as indicated in the crosswalk on the NPI IMC Fact Sheet. Note: When enrolling with HCA, if the clinician will be submitting claims/encounters to an MCO or clearinghouse then you should register the clinician's NPI under both the HCA local taxonomy as well as the NPPES taxonomy. If the clinician bills directly and not through an MCO or clearinghouse, please enroll using the local (SERI) taxonomy only. See questions 4 and 15.
17. We have several students that have a Bachelor's degree who are matriculated in and doing an internship to complete their Master's degree. Do we use taxonomy 09 - bachelor degree?	See question 15.
18. Does a master's level intern therapist, who has an NPI and is an agency-affiliated counselor, need to complete this HCA registration?	Yes.
19. Does billing for MH/substance use disorder (SUD) interns differ based on whether the interns are practicing by themselves vs. being supervised by a licensed professional? (For example, an agency has interns working independently but do not have onsite supervision. Currently this provider bills an H0004 code through the BHO).	Billing and payment is between the provider and the MCO – the SERI guide is about how to report the encounter data properly. For individual treatment services reporting H0004 select the taxonomy option390200000X- Student in an Organized Health Care Education/Training Program. However, in the outpatient treatment section for substance use modalities the H004 requires the provider be either a CDP or a CDPT. You would select that applicable to the intern. These are the only two services for which H004 is an option.
20. If an unlicensed intern is directly supervised by a licensed clinician and is not working independently, can an agency bill under the supervising provider rather than the intern?	You can report the encounter using the taxonomy code 390200000X- Student in an Organized Health Care Education/Training Program when submitting the claim/encounter to an MCO or clearinghouse. Ideally, this approach would mean there is no

When would billing the encounter under the supervisor NPI be appropriate?	situation where the supervisor would be reporting the encounter as their own.
21. What taxonomy should be used for those who are volunteers? What do we put in the rendering provider field? Can we put the supervising clinician's taxonomy? This specifically pertains to a crisis hotline call where a volunteer might be the person answering the phone, under the supervision of an MHP.	In this instance, the IMC SERI will instruct that you put the billing provider NPI (agency NPI) into the rendering provider field.
22. Can we have another one of these webinars? This has been very helpful.	It will be considered.
23. Can I get a copy of the slide show?	Yes. The PowerPoint is also attached to the webinar for your convenience. If you need the PowerPoint, email Venus.Sanders@hca.wa.gov.
24. What happens after January 1 when a clinician registers their NPI but is waiting for the registration to go through? How long will it take to be processed?	HCA is committed to working on processing enrollments as quickly as possible on an ongoing basis. If an enrollment needs to be backdated, you need to contact HCA directly at providerenrollment@hca.wa.gov with a request. See questions 71, 75 and 76.
25. If the date of service is prior to the date that the NPI enrollment has been processed by HCA, will the encounter reject?	The encounter will be rejected. However, there is a P1 process providers can use to request that their date of enrollment be backdated as noted in question 24. See questions 71, 75 and 76.
26. Are the MCOs verifying the servicing providers against the billing providers (i.e. are encounters rejected if the servicing provider isn't associated with the billing provider in the MCO's system)?	HCA does not validate servicing providers against billing providers. The MCOs generally do not either, although you should confirm that independently with each payer. See question 81.
27. For residential treatment, should we provider the facility NPI rather than the NPI of the specific clinician?	Yes.
28. What is the normal timeframe to process NPI's in ProviderOne?	About 1 month although currently HCA is processing them in a week.
29. If a clinician has an NPI umbrella of "billing facility" number and then they leave to work	An individual clinician can be enrolled under a number of different organizations, provider stays

somewhere else, will they need to enroll their NPI number under a new facility?	enrolled with the Medicaid program when they move to another clinic. Just need to add association to the new clinic and remove the association to the old clinic. See question 5.
30. What does "bachelor level with exception" mean?	(Per WAC 388-865-0150) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986; A person who had an approved waiver to perform the duties of a mental health professional that was requested by the Regional Support Network and granted by the mental health division prior to July 1,2001; or A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the Mental Health Division consistent with WAC 388-865-02.
31. There are some taxonomy codes on the HCA crosswalk that we do not see in the NPPES system. Are these specific to HCA?	Yes, HCA created some local taxonomy codes that you will see in the P1 system and not in the NPPES system. In particular, the codes with "9999" in the middle and end with an "L" are local codes. Providers will use these HCA local taxonomy codes for the purpose of enrolling with HCA. Providers should use their NPPES taxonomies when submitting claims/encounters to an MCO or clearinghouse. See question 4.
32. If billing providers have different locations and their clinicians work in different locations, do they need to register their NPI with each of the 5 billing providers?	Yes, that would be ideal and this is not a difficult process. If you need help with this please email providerenrollment@hca.wa.gov See question 61.
33. Will prescribers still need to have a "unique Medicaid provider number" or is the NPI sufficient?	The NPI is sufficient as long as it is enrolled with P1, it will not reject.
34. Where do the taxonomies go on the 837?	There is a companion guide that tells you where you would enter that- on the HIPAA page. The link for the HIPAA page is here: https://www.hca.wa.gov/billers-providers-

	partners/prior-authorization-claims-and-billing/hipaa-electronic-data-interchange-edi. Scroll down to the heading called ProviderOne 5010 companion guides and then click on the link called '837 Encounters'.
35. Will Behavioral Health Organizations (BHOs) be getting 835s back for data submitted for services before 1/1/19 (BHOs will be submitting data for services prior to 1/1/19 through Feb or March of 2019).	Response files are generated for organizations that *submit encounters directly* to HCA. The type of response file (i.e., ETRR versus 835) that transitioning BHOs receive will depend on the line of business under which the encounters are submitted: • BHO encounters submitted under the BHO ProviderOne ID for dates of service through 12/31/2018 will have responses returned on an ETRR. This includes encounters submitted under the BHO ProviderOne ID both before and after 1/1/2019. • BHO encounter adjustments or voids submitted under the BHO ProviderOne ID for dates of service prior to 12/31/2018 will receive ETRRs. • BH-ASO encounters submitted under the BH-ASO ProviderOne ID for dates of service on and after 1/1/2019 will receive an 835 response file. • For questions related to response files for encounters submitted by MCOs to HCA for services provided to Medicaid enrollees, please contact the MCOs directly.
36. Will the MCOs be updating their contracts with the new modifiers and removal of HF modifier?	Yes, for those that explicitly include codes and modifiers in the contract, they will.
37. We have previously been able to report and EBP code of 185 for promising practices. Will this continue to be an option, or is the interpretation of EBPs intended to mean only those specifically identified on the WSIPP report(s)?	EBPs will continue to be reported. Please review the EBP FAQ document for further information about how EBPs will be reported in the future.
38. In the Taxonomy crosswalk, there is no mapping for Provider Type 08 (N/A). This Provider Type is used most frequently with	You will report the billing provider NPI in the rendering provider field for this service.

CPT code H0046 UB (request for service). How will we submit this service?	
39. In SUD, no case management services were billable unless you were a Chemical Dependency Professional (CDP) or a Chemical Dependency Professional Trainee (CDPT) at a minimum. Will this be changing?	No, this cannot be changed because it is a state plan requirement.
40. Why do we have to submit SSNs for board members?	This is a federal requirement that cannot be changed.
41. In the federal NPPES system there is no taxonomy for CDPT. Is it OK to use the taxonomy for CDP in the NPPES system and then use the 101Y99995L when registered with P1?	Yes, that is what you should do in that scenario. However, when submitting claims/encounters to an MCO or clearinghouse you should use your NPPES taxonomy, not 101Y99995L.
42. If our program is a subcontractor of a larger agency, do the staff go under the larger agency or us as a subcontractor in ProviderOne?	In ProviderOne, clinician and other professional staff will need to go under (i.e., be associated with) the agency NPI identified on a claim (encounter). If the larger agency NPI is being used on the claim, then clinician and other professionals used on the claim of an agency subcontractor will need to go under the larger agencies NPI. However, if a smaller agency subcontractor's NPI is to be used on claims, then the staff will need to go under the subcontractor NPI (and the subcontractor NPI would be required to be enrolled with HCA).
43. If someone has a type 1 NPI, for a private practice, how will that impact this process?	If a provider is contracting directly with the MCO as private practice, then the private practice provider's NPI would be required to be enrolled with HCA. If an agency or facility contracts with a private practice provider, and uses the individuals NPI on a claim as a servicing provider, then the private practice NPI would need to be enrolled with HCA.
44. Some of the answer during the Webinar are referencing mental health, SUD and behavioral health. Are mental health and behavioral health not the same?	When HCA refers to "behavioral health" it is referring to mental health and substance use disorder. When HCA refers to "mental health" it means it is specific to mental health only. When HCA refers to SUD, it means it is specific to SUD only. So, behavioral health is a term that is used to

	refer to something that applies to both mental health and SUD.
45. Comment for providers to be aware of: Be cautious that your staff do not inadvertently request a new NPI # for your agency - it is possible. The contact information for your agency should be up-to-date because NPPES will let you know	Thank you for this suggestion.
46. How does the "units" capture services lasting more than 1 hour and doesn't fit in to the "1 unit" description? Specifically, could you clarify the unit reporting for 90853- MH group? How does this capture more intensive groups that are 2 or more hours long?	HCA are open to discussing "rules" or "guidelines" about units and how many can be billed. Please make these suggestions when you review the SERI document if it isn't addressed in the document draft adequately.
47. How can we find out about a batch process so that we can enroll 200+ NPI's with P1?	Please email providerenrollment@hca.wa.gov if you have a request to use a batch process for 200+ NPI enrollments.
48. If your agency is currently servicing only--do we complete the application for servicing only? Or do we complete the application as a billing agency as we negotiate with the MCOs?	HCA is not aware of a situation in which the agency would be servicing only. There must be a billing NPI that can be used in order to be billing for services. The agency is required to have either a Nonbilling Agreement or Core Provider Agreement on file with HCA. Please reach out directly to HCA with more information on this case. You can email providerenrollment@hca.wa.gov.
49. My question is related to the taxonomy codes for Applied Behavioral Analysis (ABA) providers. Do Certified Behavior technicians use the 103K taxonomy and the 999999 taxonomy? Majority of the behavior technicians have a bachelor's degree.	ABA services are not billed as a BH service. These services are billed as a physical health service and not delivered through a BHO, so these services will not be reported as an encounter in SERI.
50. I noticed 261QR0405X is not part of the taxonomy crosswalk. Will I continue to use this code for SUD at the billing level?	The taxonomy crosswalk was designed to assist with identifying the appropriate taxonomy to be used for individuals enrolling with HCA. 261QR0405X is a non-individual taxonomy, to be used for agencies and other types of organizations and facilities, not for use by individuals.

	261QR0405X could be used for agencies, organizations and facilities enrolling with HCA as long as they are certified by DOH as a SUD clinic.
51. Are old taxonomies automatically deleted?	No, they stay in the system. The provider would just need to log on and add the new taxonomy to the profile or end date a taxonomy no longer applicable to an individual.
52. Do facilities have a taxonomy to use?	Yes, MH, SUD or co-occurring based on their type of service.
53. We have a staff member who is a Master's level and is agency affiliated, what taxonomy do we use?	For clinicians with the local HCA taxonomy codes 101Y99993L, 101Y99994L, 101Y99995L, and 101Y99996L who bill an MCO or clearinghouse, their NPIs should be registered under both the clinician's local taxonomy code as well as their NPPES taxonomy code. For purposes of submitting claims/encounters to an MCO or clearinghouse, these providers should use the taxonomy which is registered with NPPES. If a clinician bills HCA directly and not through an MCO or clearinghouse, they should enroll using the local (SERI) taxonomy only. See question 4.
54. If a provider works for an agency and is enrolling their NPI, and they want to ask for a retro-active effective date, does the provider need to ask or can the agency ask?	HCA will accept a request from either one.
55. Does the taxonomy code in the NPPES site have to match to taxonomy code that will be put into the ProviderOne system?	No. Please register the NPI with the most appropriate taxonomy available in NPPES, and also register the NPI with P1 using the most appropriate HCA local taxonomy. In some cases, because there are local codes in P1, these may not be the same as what you see in NPPES. See question 4.
56. For Master's level mental health counselors (MA and MSW) who are not licensed but are credentialed, can they register for either one of these Taxonomy Codes: 101YM0800X (Mental Health Counselor) 101Y99996L (Ma/PhD non licensed)?	When these clinicians enroll their NPIs with HCA they must use taxonomy code 101Y99996L. They should also enroll their NPIs under their NPPES taxonomy code if they will be billing an MCO or clearinghouse. For purposes of submitting claims/encounters to an MCO or clearinghouse, these providers should use the taxonomy which is

	registered with NPPES (see questions 4 and 53 above).
57. Should the FQHC change theirs to a different provider type? (An FQHC's EHR defaults to the FQHC Type II taxonomy, should they change that to a mental health type II instead?)	Continue to use the taxonomies FQHCS use now for reporting services that meet the requirements of a SERI encounter: When billing for services eligible for an encounter payment, the agency requires FQHCs to use billing taxonomy 261QF0400X at the claim level. The servicing taxonomy is also required as follows: Community mental health centers must bill servicing taxonomy 261QM0801X or 251S00000X.
58. How do you answer Step 16 on the ProviderOne application (the enrollment application checklist questions) when setting up a nonbilling provider? HCA's handout it states these must be answered Yes or No.	Step 16 in the enrollment application checklist questions are required to be completed for all provider (billing and non-billing) applications submitted to HCA, no exceptions. Each question must be answered with a yes or no. The online application has an optional field for comments, and providers can submit additional attachments if needed.
59. When enrolling an individual servicing provider, what state agency does the health care agency pick (Department of Corrections (DOC), Department of Social and Health Services (DSHS), or HCA)? Should the health care agency choose both DSHS & HCA?	HCA.
60. If a provider is already in the ProviderOne system as a Clinical Social Worker and has that taxonomy, but also has CDP license, does the provider have to add that taxonomy? (An organization may have multiple taxonomies for their organization but not for their providers). Are these older taxonomies you have deleted transferring to the new taxonomy automatically?	Yes, you should register the NPI under all appropriate taxonomies so in this case you would also register your NPI as a CDP in addition to a licensed clinical social worker. In HCA, taxonomy 1041C0700X was recently removed from use in ProviderOne, and has been replaced by 104100000X. Yes, for those providers who had 1041C0700X, taxonomy 104100000X was automatically added to their profile.
61. If staff work for two or more separate agencies, do they complete this process with all of the agencies?	Yes please do. Only one enrollment application with HCA is required for each individual, regardless of the number of agencies they work at.

	Clinicians enrolled with HCA working in different agencies can register (i.e. associate) their NPI with each billing Agency location, this is not a difficult process. See question 32.
62. The agency number format has changed for licensure under DOH. Under DBHR the number was six digits. Now, the DOH agency license has a credential number alpha numeric 12 digits. Agencies will renew at different times over the course of the year. Is the new and old format addressed in the SERI for reporting?	HCA has determined that this topic (reporting of the site specific agency ID) is not appropriate for the SERI guide and is reviewing this issue, and HCA will be addressing it in the MCO Encounter Data Reporting Guide.
63. Will the Z code continue to be rejected?	As long as the code is valid and coded to the number of digits specified by ICD10, no DX code should be rejected.
64. For an agency that is participating with the MCOs and looking at doing fee for service, what would HCA recommend that they do now as they enter NPI information?	Please review the fact sheets regarding enrolling as an AI/AN fee for service provider. See also question 3.
65. Will the BHOs in the 2020 regions use the new SERI on January 1, 2019?	The BHOs in the 2020 regions will begin using the IMC SERI on July 1, 2019. All providers/MCOs/BH-ASOs/BHOs in the State must begin using the IMC SERI no later than July 1, 2019.
66. Are all MCOs set up to accept codes that comply with the 7/31/2018 SERI guide?	Yes, all MCOs are set up to accept codes from the latest SERI guide.
67. What is the difference between Specialized Mental Health and Mental Health Fee Schedules?	The Mental Health Fee Schedule is for those services rendered as part of the physical benefits. These services are covered by all the MCOs and HCA's fee-for-service program. An eligible provider must be licensed by DOH. It is a limited set of services that does not include: inpatient, residential SUD, wrap around services or all the other services covered by the BHO. In the past HCA would have said these services are for people who do not meet the BHO access to care standards. The Specialized Mental Health fee schedule is applicable to those individuals **who are not assigned to a BHO, BHSO or BH-ASO for their BH services**. However, these clients do receive the

	more comprehensive BH services (comparable to the services a BHO used to provide when the access to care standards were meet) through a new HCA FFS program with very specific rules as to who it services and who can provide services under it. Eligible providers bill ProviderOne directly for payment. A provider must be eligible meet the criteria as described on page 99 of the MH PG at this link: https://www.hca.wa.gov/assets/billers-and-providers/mental-health-svc-bi-20190101.pdf. An Federally Qualified Health Center (FQHC) does not meet the criteria on this page and therefore, cannot provide or be paid for services as described in this specific section of the guide. Neither of these fee schedules is going to be a reliable place for an IMC BHA provider, who renders higher acuity services, to look for assistance in what is covered or how or how much will be paid. The BH code set used for IMC is in the SERI, each MCO should work with their providers to assist them in knowing how to bill for the SERI services AND not reference the MH guides or fee schedules.
68. CPT codes in the current SERI are not on the 2019 Specialized MH Fee Schedule. Are we supposed to use the Fee Schedule or the SERI? We opted to continue with the SERI until 7/1/19. Some of the codes we use that are not on the Specialty Mental Health Fee Schedule are 90785, H2021 and H0032 (the last two are used by WISe).	Use the SERI to bill services you are delivering as a licensed BHA. There is no application of the Specialized MH Fee schedule to any service rendered under the BHA umbrella, including WISe services, rendered in the IMC regions. Please use the SERI and follow the instructions about which codes are considered a WISE service with the U8 modifier. Bill this to the MCO in the IMC regions.
69. A provider that is an FQHC has to take into consideration the FQHC, MH and SUD billing claims submission. Since we have been instructed to follow HCA billing guides when submitting claims to the MCOs, do we submit claims using the TG modifier and specified taxonomies?	An FQHC may be providing both level of BH services: lower acuity as a physical benefit and higher acuity as a comprehensive BH benefit. As stated previously, use the SERI guide for coding assistance when you are licensed as a BHA and rendering what is generally considered a higher level acuity service. If you are rendering a lower level of service, the basic MH fee schedule may be helpful to you. For both level of service, use the FQHC provider taxonomy of 261QF0400X for the billing provider level taxonomy. The FQHC program manager is determining if any further specific data is required and when that decision is made HCA will share it with the providers and the plans.

70. The H0038 CPT code is not on the HCA MH Fee Schedule but it is on the Specialized MH Fee Schedule. The SERI shows a number of possible modifiers but the Specialized Fee Schedule shows only a TG modifier. • Can this code be billed WITHOUT the TG modifier? • Would the rate from the Specialized Fee Schedule still apply, or is there a different rate?	The Specialized MH fee schedule and Provider guide and the SERI support two different BH programs administered by different entities for two different types of clients. If you are a qualified provider and enrolled with ProviderOne to provide services to a person that is covered under the FFS Specialized BH program follow the instructions in that guide and Fee schedule; if you are providing services to a person covered by the BHO or the MCO BHSO or a BH-ASO use the SERI. How to determine who is covered by what program is in the HCA MH guide. Note that we are trying to focus on questions from the integrated managed care perspective; the Specialized Fee Schedule was developed for specific providers who treat a group of clients who receive BH services through a benefit administered by HCA FFS program. Questions about which codes to use for the FFS population can be directed as below: For questions about billing guides, contact the Medical Assistance Customer Service Center (MACSC) online or at 1-800-562-3022. For questions about rates or fee schedules, email ProfessionalRates@hca.wa.gov.
71. Do providers have to wait until their National Provider Identifier (NPI) registration is completed in order to begin submitting claims?	No, providers can bill an MCO before they get a ProviderOne number/Medicaid ID. HCA has instructed the MCOs that they should accept claims from providers without waiting for the providers to be enrolled by HCA.
72. How long does it take for an NPI application to go through at the federal level?	In general, the NPI process takes minutes.
73. One of the requirements to get the organization NPI is to get the EIN which we are not able to provide (became an issue during the federal government shutdown). Also some of our new staff don't have ProviderOne access and we need the NPI organization number in order to get them Provider one access.	The last we heard from CMS, the NPI applications are continuing to be processed and enumerated as normal. If providers are having problems with this process, please forward the tracking numbers for NPI applications that are delayed to George Wagner at george.wagner@hca.wa.gov, cc'ing Provider Enrollment at ProviderEnrollment@hca.wa.gov, and HCA will forward on to CMS so they can look into it more closely.

74. When new providers come in, whether they're new to our system, we have them fill out a DOH application for agency affiliated or other applicable. • Can these providers provide direct services 60 days from the date of hire, or is it 60 days from pending status with DOH? • To even get the ProviderOne application started, we have to have a DOH credential. Can individuals provide services while this process is pending, either under a supervisory oversite with someone who is already fully credentialed with all of the systems, or do we need to wait? • Or, can we provide services with the assumption that there will be credentialing approval and then upload those with the MCOs once the individual is credentialed?	HCA believes this question is more appropriately answered by the MCOs; see their responses below: Amerigroup: It appears the question being asked is whether a provider can bill for services when their DOH credential or license is pending. AMG will not credential anyone who is not licensed with the WA DOH. If the provider is billing under a supervising licensed behavioral health provider and that individual is contracted and PAR in our system, then claims should pay to the rendering licensed behavioral health provider. If there are additional question on this please contact Kathleen Boyle. Molina: Specific to the second question, Molina allows our IMC behavioral health providers to be loaded into our system and render services prior to confirmation that their NPI has been registered with HCA. Please see additional detail below: • Provider must have an NPI to be loaded into our system. • Provider can be loaded into our system and render services prior to obtaining a ProviderOne number (which would signify that the provider has registered their NPI with HCA). • BH Agencies have been credentialed via HDO, so for Molina, credentialing does not come into play in this scenario. Coordinated Care (CCW): For the first question, we believe this may be a question for DOH rather than MCOs. DOH has an FAQ on this topic on their website under "Licenses, Permits and Certificates" → "Professions- New, Renew, or Update" → "Agency Affiliated Counselor" → "Frequently Asked Questions". If we're misunderstanding something, please let us know. In regards to the second question, we believe the question of whether an individual can provide services before credentialing is complete is a question for DOH based on our understanding that MCOs credential on the agency level and that agencies credential agency affiliated counselors. Regarding payment, CCW requires a roster of individual agency counselors, which includes individual NPI for rendering providers. NPI is

	required for claims systems configuration to ensure timely claims payment. Community Health Plan of Washington: For the first question: CHPW will not credential without DOH license. For the second question: CHPW will credential providers with current DOH license if they have a Core Provider Agreement or application in process. United HealthCare (UHC): For behavioral providers, new providers joining a contracted and credentialed agency must be an enrolled Medicaid provider with the state prior to us adding to the agency roster for claims payment, but can otherwise be added. We are able to credential at an agency level on the BH site because individual credentialing is not available for providers who are not independently licensed. We know that non independently licensed staff provide direct services to our Medicaid beneficiaries. The agency credentialing allows us to use a provider roster that is then loaded into our claim databases to allow claims payment and encounters. For medical providers, we require each individual provider complete credentialing with UHC before they can see members and bill for services. This is because all medical providers do have required licensure, and we must verify that they are in good standing with all regulatory entities for all lines of business. The only exceptions are for true hospitalist providers, including anesthesia and emergency medicine working out of a hospital. HCA recommends reaching out directly to MCOs if needed on this question.
75. HCA informed providers that they are working through a backlog of ProviderOne applications due to the large volume of applications submitted to HCA during the month of December. Will this backlog affect any of our MCO billings? I generally try to submit claims when an individual discharges, which means that it is conceivable I will be submitting prior to the applications being finalized. I would rather hold off on	HCA is diligently working through the backlog to catch up the pending enrollments. Any BH provider applications received before Dec. 31, 2018 will be backdated to January 1, 2019. Newer BH provider applications will be back-dated to the date of application until March 30, 2019. The MCOs are aware of the issue and should be able to handle these claims. Let HCA know if you run into problems, or reach out directly to the MCOs.

submitting if the claims will not be considered "clean" due to this process.	
76. Will the backdating of provider enrollment applications to 1/1/19 be done for all applications received in December, or just those applications that are processed after 1/1/19?	See 75 above. The MCOs should check with their WISe providers and make sure they got their applications in by Dec. 31. If not please alert HCA.
77. How do we correct an erroneous ProviderOne provider taxonomy?	Pioneer can reach out to Provider Enrollment directly for assistance with correcting an erroneous provider taxonomy; call Provider Enrollment at 1-800-562-3022 Ext 16137.
78. One of the first tasks I completed was registering our NPI's. I registered using the separate taxonomy codes for my CDP's and CDPT's. Then in the Provider Readiness group we were told that these NPI numbers wouldn't work and both CDP's and CDPT's need to be registered under the same federal tax ID. I attempted to update the NPI registration for my CDPT's and we got this response back from HCA: "We are unable to add this taxonomy to the NPI's listed below since they only have a trainee certification."	The confusion seems to be with the Taxonomy 101YA0400X that is being requested for some of the CDPT providers not their NPI's. That taxonomy is reserved for fully licensed CDP providers. HCA has provided a list of acceptable taxonomies for these professionals that are not fully licensed: **Mental Health & CDPT in Training 101Y99995L**. There are 2 other NUCC taxonomies that are acceptable, they are: **Mental Health Counselor 101Y00000X** or **Student/Trainee 390200000X.**
79. I attempted to register a contracted employee's NPI with HCA and got an error message stating we could not do so as her NPI is already in the production area. She is a full-time employee of another agency for her mental health taxonomy code. However, she is contracted to provide SUD services with our agency. It is my understanding that any encounters and claims we submit must be linked to a provider, their NPI, and their taxonomy. How do I get her registered under our agency for her SUD taxonomy code? Will our claims/encounters go through if I do not enroll her under the CDPT code, since she is	Please update your list of Servicing Only providers by adding her NPI and Start Date and because she is already enrolled her name will auto fill.

already enrolled with Catholic Charities under her mental health taxonomy?	
80. Is the billing provider taxonomy required in box 33B on the CMS 1500 HCFA form?	Yes.
81. Are the MCOs validating taxonomies against services? There isn't a CDPT federal taxonomy code so we would have to bill with the counselor taxonomy. Would that make it past billing edits? Also, our EHR only allows us to enroll practitioners with one taxonomy.	There are no edits validating that a taxonomy used on an encounter is on the provider's file, and HCA does not plan on adding taxonomy edits to P1. As long as the taxonomy is recognized by P1, the encounter will not be rejected. So from HCA, the validation shouldn't be an issue. However, encounters need to be submitted as instructed to support accurate data analysis. Note: assume provider is referring to a CD counselor code. If they bill a clearinghouse they will need to enroll with HCA with two taxonomies: the one they registered their NPI with and the one assigned in SERI. When they bill they will bill with the one that they used to get their NPI. If they bill directly, when they enroll use the SERI taxonomy only.
82. When new guidance indicated encounters should not be submitted with local (HCA) taxonomy codes, but rather with NPPES taxonomy, providers have been struggling to determine which federal taxonomy to use for unlicensed staff. Guidance was to use their best judgement. King County initially set validation rules in place against the crosswalk provided by HCA, which doesn't include a cross walk for the local taxonomy codes. So potentially, providers could potentially submit taxonomies that are not on the crosswalk. We don't have an official SERI guide, and the draft SERI only has the local taxonomy codes for under masters level staff. • Will HCA accept a taxonomy in an encounter that is not listed in the draft SERI? I'm not certain what level of validation will be done for taxonomy. Can you confirm?	See the response in question 81.

83. Does P1 recognize the full set of taxonomy codes published by NUCC? Or this there a specific set of recognized codes for behavioral health, and if so, is there a list of recognized codes?	ProviderOne does not use all of the taxonomy codes published by NUCC; however, all of the codes listed on the crosswalk table in the NPI Fact Sheet are recognized by P1 (see question 4 for a link to the page on the HCA website where the NPI Fact Sheet is posted). When submitting applications using the online ProviderOne portal, the available taxonomies in P1 are listed given the taxonomy provider type and provider specialty chosen. Outside of the ProviderOne functionality described above, there is not a list of HCA-recognized taxonomy codes which has been published by HCA.
84. I am using/referencing the BHT/HCA Taxonomy codes published November 2018 and have identified other taxonomy codes as we registered our clinicians for their NPI's (identified the codes on their website). Examples: • Masters level students, I used 'Below Master's Degree' 101Y99995L and she has used 'Student in an Organized Health Care Education/Training Program 390200000X; • LICSW I used 104100000X and she used 'Social Worker; Clinical' 1041C0700X; • And for Masters level whom are not licensed I used 'MA/PHD (non-licensed)' 101Y99996L and she used 'Social Worker' 104100000X. Would the taxonomy code for interns fall under 390200000X? When we're linked to the taxonomy code list from the NPI website it shows the title being, "Student in an Organized Health Care Education Training Program". The definition of "Organized Health Care Education Training Program" is listed as 'pending'. Would we be able to apply for NPIs for the interns through this? Are interns required to have a license or certification in order to apply for an NPI?	Typically, HCA has been recommending enrolling at the highest applicable level, but I recommend you contact Provider Enrollment (info below) to get specific answers on these. Please let us know if you're still having issues after contacting Provider Enrollment. **Provider Enrollment** Phone: 1-800-562-3022 ext. 16137 Email: providerenrollment@hca.wa.gov See questions 15 and 16.

85. Historically, an MCO had viewed 0124 and 0126 as specifically billable by psych hospitals and hospitals with secure detox units, whereas the other codes would be appropriate for residential treatment centers to bill. I'm okay if we are allowing RTC's to bill the 0124's and 0126's, I just want to ensure that we are all on the same page so that reporting and encounters are consistent.	H2035 with 1002 or 0126 rev code- alcohol and/or drug treatment program, per hour & using the POS code "55". This would be used for acute and subacute admissions and reported by the hour. HCA discussed an option for MH too when this occurs on a per diem code. HCA proposes H0046 with a rev code for 1001 or 0124. Again HCA will make it billable by hour. It has to have the rev code and POS so HCA knows when H0046 is reported it will be recognized.
86. MH & SUD Outpatient (OP) & SUD Inpatient (IP) uses one type of transaction (837P), and MH IP & E&T & Secure Detox uses a second type of transaction (837I). Therefore, a transaction with a CPT/HCPCS code via 837P, or a transaction with a revenue code via 837I can be sent, but we cannot send a transaction with both types of codes (CPT/HCPCS and Revenue Codes).	An 837i is the encounter type you would be submitting with the Rev code and CPT/HCPC code combo. HCA checked with our encounter staff and the 837i is configured to report this data. An 837P is not, but the situations where this combo is requested is not applicable to professional services, it is for those identified by HCA to be reported at the facility level.
87. What codes do we use during this interim period while waiting for the IMC SERI guide to be released? Should we use the updated codes from the draft IMC SERI and NPI/SERI guidance last October or stick with the 7/1/18 SERI until the new one is finalized?	The providers were instructed to inform the MCOs whether they preferred to use the old SERI guide or the draft IMC SERI, and each provider was configured to send encounters based on their preference. Please reach out to your MCO if you have any questions about which codes they will accept during this interim period.
88. Why we are credentialed and contracted as "facilities" but the HCA wants claims reported at the "rendering provider" level?	Rendering/servicing provider is a required field under Federal requirements for what HCA as a Medicaid health care provider must require reported. PER CFR HCA must enroll rendering providers and know who is rendering services on any given claim to assure they are enrolled because an individual that receives federal funds cannot be a person that has been found guilty of fraud or had action taken against their license and been reported to the OIG's national provider data base as a person who cannot practice in Medicare or Medicaid. In the SERI framework this correlates to the two digit provider specialty # you used to use, but it now requires a NPI and taxonomy for this field.

	The managed care provider network enrollment requirement was included in the CMS managed care Final Rule changes in May of 2016.
89. There are a number of encounters we rejected internally due to taxonomy codes that either weren't specifically called out in the cross-walk or draft SERI guide, or were reserved by HCA for other purposes. For example, 171M00000X Case Manager might be a possible code to use but it is reserved by HCA for FFS Maternity Support. • If providers use the 171M00000X code, is that going to be a problem during the initial transition period? Or, do we need to have providers correct those encounters and resend them?	Case management is an SUD service allowed in the SERI. The provider should use one of the listed taxonomy codes for the provider type based on education level or specialty and report the service as case management.
90. I need to address a policy for when HCA FFS is paying primary for an approved BH inpatient stay. HCA is paying for the inpatient E&M visits but denying the prolonged service – CPT 99356. Recent instruction was to send this CPT to the MCO. This particular CPT is an add-on code and must be billed in conjunction with the inpatient E&M visit. It is not logical to separate this from the parent code and bill the MCO. I'm sure an MCO would have editing to deny an add-on CPT if not billed with an appropriate parent code. In the case of an authorized admission covered by HCA, is it our expectation that you will only address and pay for the services listed below? Can you please review and address the possible addition of prolonged services to this guidance? Billing the MCO will not work unless you've instructed MCOs to allow this service even if the parent code is not billed. CPT identifies 99356 as an add-on code; • Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour	It appears there are two issues here: The issue of billing the MCO and HCA, and then the coding issue. Gail Kreiger is looking in to this and HCA will follow up.

(list separately in addition to code for inpatient E&M service) • Use 99356 in conjunction with 90837, 99218-99220, 99221-99223, 99224-99226, 99231-99233, 99234-99236, 99251-99255, 99304-99310	
91. As part of a partnership, we are opening a new IP Psych Hospital. As part of this DOH licensed facility, we will have a Crisis Stabilization Unit (CSU). We are looking to understand how to appropriately bill for these services. Some payers have indicated the S codes out of the SERI guidelines. As I look at a draft updated SERI (not a final published version), I see the following: S9484 Crisis intervention, per hour — Specifies not to use in a facility licensed by the DOH S9485 Crisis intrvntn mh, per diem — Specifies it can be used in a licensed DOH facility This seems to indicate that for Medicaid, we would look to bill a per diem for services in the CSU, as opposed to an hourly charge like a standard 'observation' charge for IP hospital units. If this is correct, would the facility have to have other specific certification to bill Medicaid for this code (DBHR for example)?	Yes, for a stabilization facility they would report using the per diem code under the existing SERI (S9485). The facility must be licensed by DOH and certified by DOH to provide stabilization services. This per diem approach for stabilization will be the same in the new SERI.
92. The SERI states that the EBP scoring is for Medicaid services provided to Medicaid clients. Does this mean the non-Medicaid funded clients do not require EBP scores to be submitted on encounters?	Yes, your understanding is correct.
93. Billing for case management: We operate an outpatient SUD facility. We have 1 case manager and 2 peer support that provide	Providers will be able to begin billing for SUD peer services delivered by a DBHR certified SUD peer support provider on July 1, 2019. SUD Peer Support

services to MCO covered clients. These three employees are not CDPTs or CDPs. Those 3 individuals have been coding their services to case management (T1016) on our trackers but the SERI calls out that SUD case management must be provided by a CDP or CDPT. My question is this: What code can we use and submit to an MCO for services provided by these individuals? They are providing services such as assisting clients with housing, clothing, food, work, workforce redevelopment and peer support. I am sending this question to you in hopes that you can help me determine the correct code to use.	will be added to the SUD modalities in SERI. There won't be a new code for it, rather you will use the same MH peer code but with a SUD diagnosis- using the diagnosis code to differentiate between MH and SUD peer services. Does this other person qualify for the " Other" code under the case management code? If not, HCA recommends you seek consultation from Department of Health to ensure staff are practicing within their scope of practice and within your agency's DOH license.
94. The taxonomies in the new SERI are limited, are these going to be strict with claims and cause denials if using taxonomies outside of those listed? So far, we have been using NPPES taxonomies and those are not listed so just want to make sure. Example: the general counselor one 101Y00000X we use since it is NPPES approved.	HCA expects the taxonomy to be consistent with the SERI Provider Type chart. But an exception is: Clinicians with the taxonomy codes 101Y99993L, 101Y99994L, 101Y99995L, 101Y99996L should use the NPPES taxonomy when submitting claims through a clearinghouse. However, If the clinician is billing directly and not through an MCO/clearinghouse then they must use the SERI taxonomies. See question 4.
95. On the SUD assessment Code H0001 in the new SERI, it is listed as UN (units) but 1=1 min. So my understanding is you want it to say UN but then list the minutes the service took - is that a typo? We would have to manually edit that before submitting the claim so not sure if other providers would have the same issue.	This code can be reported in minutes or units. HCA was asked to allow this code to be reported in minutes and we found that we were able to allow that flexibility. 1 unit = 1 minute was added just to clarify how to bill in units if the provider decides to report in units rather than minutes. Providers should work with their MCO/BHO as to what is required.
96. For all system partners, at a recent WISe provider meeting, we realized that there was continuing unclarity around the coding for Crisis calls. Crisis response is a required part of the WISe program. Different providers have been given differing directions on how to code these. Has there been a decision about the appropriate SERI code for WISe providers to use in order to not have these claims/encounters denied or rejected?	Please use the SERI and follow the instructions about which codes are considered a WISE service with the U8 modifier. Report H2011 for these services. HCA will discuss with the plans removing the "ASO ONLY" from this modality.

97. H2011: I would like to confirm that we can continue to use H2011 for crisis services that are NOT provided by the BH-ASO crisis line. We have used that code with the U8 modifier for WISe, for mental health professional crisis response to our families. It looks like we can still use it, as it has the U8 modifier as a possibility but the service itself is described under the 'BHASO only' section.	Report H2011 for these services. HCA will discuss with the plans removing the "ASO ONLY" from this modality.
98. H2027: In the description, it states Provider Type 12- Other (Clinical Staff) but there is no definition as to who qualifies. Would a CDP or CDPT be able to use this code?	No, if that provider type were allowed for this modality it would be specifically added as a Provider Type
99. H0023: It mentions "targeted population". Are there some examples that we could get for the Engagement and Outreach H0023 on page 126 of SERI 2019? Would AI/AN be a "targeted population"?	Examples of "targeted populations" on the SUD side would be Pregnant or Parenting Women (PPW), youth, or IUID (IV drug users). Examples on the mental health side would be adults with Serious Mental Illness (SMI) or children who meet the Serious Emotionally Disturbed (SED) criteria. Homeless would also be another targeted population.
100. H0023 is a state funded code, does that mean if for SUD, we would be able to use the SABG to pay for these?	Refer to the BHO or BH-ASO. MCO's don't have SABG funds.
101. Engagement and Outreach H0023 - looks like this CANNOT be used for MCO Medicaid clients as it is State funded - is this true? Is there another code to use or do we stop providing this service to MCO clients? The code also used for Rehab Case management -state funded service. Engagement & Outreach has been available for both Medicaid & State funded services.	Yes, this is state funded only. Not available for federal funds match. Need to look into further to clarify. If the provider is contracted, providers can bill for it depending on contract.
102. Care Coordination – H2021- can only be used for people 21 and under. Is there a code for Adults for Care Coordination with medical providers, or do we use H2015 Comp. Comm. Support Services?	This age limitation on H2021 is not new to SERI. HCA will work with the MCOs to determine if a code should be added for adults or this age restriction removed for the next release.

Wonder if the limit is applicable only to the child & family team meetings, not to all H2021… Modifiers there are more than youth age. If it is only for 21 and under, is there flexibility to have expansion?	
103. Page 94 of the IMC SERI under "SUD Assessment" – states "H0001 or 0124"- what is "0124"? It's not listed anywhere that we can find.	0124 is a revenue code used for inpatient (overnight) facility-based care. Offering the opportunity to use one or the other based on how the systems were programmed. But for this code it was removed as that was an error on that modality.
104. HH Modifier- Under the BHO we did not use this code for COD services, we used mental health services codes. Our COD groups are run by CDP's and it appears now that they will not "count" as COD services because the CDP's are not mental health certified? This will under report COD services significantly.	Provision of COD services should be reported as described under the modality called "Co-Occurring Treatment" currently on page 124 of the SERI. This is not a new addition to the SERI. HCA is continuing to work on this issue and we will provide additional updates soon.
105. COD Treatment (pg. 124 of the IMC SERI) – It appears from the Notes section that if a CDP/CDPT is also an Agency Affiliated Counselor – they are able to bill for these services using the HH modifier. Is that correct?	Yes, COD treatment should be reported as described under the modality called "Co-Occurring Treatment" currently on page 124 AND can be provided by a CDP/CDP, who is an agency affiliated counselor with the HH modifier. The agency must also be dual licensed for MH and SUD services. HCA is continuing to work on this issue and we will provide additional updates soon.
106. Can HCA advise if they intend to or will add a code to SERI to accurately capture non-Medicaid UAs being billed across the system?	The code is H0003 for non-Medicaid UAs. HCA is adding this new code to the SERI to report non-Medicaid UAs. See "Interim Guidance" released 6/21/2019. In addition, this code as well as the other UA codes in SERI, can be used for these other modalities besides the OTP modality: • Outpatient and Intensive Outpatient Treatment • Withdrawal Management • Secure Detox • Intensive Residential Treatment • Long-Term Care Residential Services

	Please see the Interim Guidance memo distributed 6/21/2019.
107. We needed to use Taxonomy Codes that were not identified in the Behavioral Health SERI for a number of our clinicians. We are wanting to understand if ProviderOne will produce error reports (response files) due to the use of Taxonomy Codes that were not identified in the Behavioral Health SERI but are relevant to the service provided.	See question 4 above. Answer also provided below: 1) First register with the federal NPI program: • If able, use the most appropriate taxonomy we have in SERI • If not, use a taxonomy that is acceptable for the federal level registration 2) Then register with P1 using: • The SERI taxonomy, if you were able to use this with the federal NPI registration process • The federal taxonomy you had to use for the federal NPI process **AND** the closest SERI taxonomy. You need to register in P1 with both 3) Then report encounters using: • The SERI taxonomy, if you report your encounters directly • The federal taxonomy you chose to register your NPI at the federal level, if you use to submit your encounters through a TPA. We learned TPAs can only use taxonomies that are recognized at the federal level.
108. SERI definition of "interactive complexity" for play therapy- hoping to get more clarification on situations where you can use it. Can providers who regularly use a modality of play therapy for very young children use an interactive complexity code? (Versus when it's an investigative process with multi-system involvement (e.g. CPS)	This is not new to SERI. Can use as it is defined. Discuss with the BHO or MCO if you need further clarification. We will work with MCOs for more instruction for next release.
109. Billing for multiple services/encounters on the same day: Many times we have problems getting paid for providing multiple services, with the same CPT code, for a client in a day. They often are denied as duplicate billings. We use the 59 modifier to let the Insurer know that these are separate	The XE modifier is being added for the purpose of reporting the same provider, on the same day, same non E&M codes used multiple times. See memo distributed 6/21

encounters and not duplicates. The 59 modifier is not in the SERI. 1) Can we continue to use 59 / will it be added to the SERI? 2) Can we use the 25 Modifier even though it is not with an E&M code and our therapists are not physicians?	Use the 25 modifier for reporting the same provider, on the same day, same E&M codes used multiple times.
110. Rule change regarding S0109: Could you confirm that we do not have to bill the Methadone medication by the milligram? Has this requirement officially been removed?	Yes, this code and the requirement will be removed in the next release. You are not obligated to use this now. See "Interim Guidance" document released 6/21/2019.
111. How can providers bill for a UA collected by a non-credentialed staff? The SERI only seems to allow credentialed staff to bill for this, but several providers are currently using non-credentialed staff. Follow-up Question: We're trying to determine how to report the urinalysis testing and if there should be an additional provider type allowed since not all agencies use the provider types listed (page 99 of SERI). Some agencies use technicians or support staff positions for this service and these don't fit into any of the provider types listed. What is the best way for agencies to report the urinalysis service? Are they required to use the licensed professional staff to do the urinalysis?	The SERI guide is not a billing document it is the tool for standardizing the collecting of encounter data. At this time, there is no urine collection code. We will discuss this with the MCOs. The urinalysis codes provided is for the testing done on site.
112. In the previous SERI, T1001 was available to ARNPs, but it is not listed in the IMC SERI. Is this current? Should ARNP not be included for T1001 or is this no longer available for ARNPs?	An ARNP would report an E&M code for an evaluation. The T1001 code is intended for reporting a nursing assessment conducted by an RN or LPN who is doing an assessment to document and report to a higher licensed practitioner (e.g., ARNP).
113. Regarding roll ups, is the below scenario the correct way to handle roll up services? Here is my scenario: The same provider provides 3 discontinuous Case Management services, (3 different service encounters w/ the same CPT code),	In the example you provide, you should then report the three CPT codes separately, of course. We added modifier XE for reporting for the same non-E&M code, for the same day, by the same

on the same day for the same patient. All of these services meet the minimum time defined by the CPT code. The exception states that a provider can roll-up the minutes to a single service and report total number of units if the same service was provided discontinuously to a consumer on a single day by the same provider, AND the service was provided for less than the minimum time…" As none of the services in the scenario above were provided for less than the minimum time, according to the current SERI language, they do not fit the exception and I would not bundle/roll-up the service encounters.	provider situation when the minimum time allowed for the code was met.
114. RTF Room and Board for MH and SUD: Currently, we are using H2036 HH to report our MH Room and Board and H2036 CG to report a bed hold. I think that Amerigroup had mentioned that we would begin using HE, but that is a modifier that is not on the 2019 SERI. I noticed that the HH is still being used in the 2019 SERI, so there is still a little bit of confusion on this.	HE was the code in the previous SERI to delineate between MH and SUD. This IMC SERI uses the diagnosis code for that delineation. HH was retained to report a co-occurring treatment service. In this situation, the provider would report both MH and SUD diagnosis codes.
115. There is some confusion among behavioral health providers about which codes to use when provider contracts include certain "hard coded" codes. Some providers have codes in their MCO contracts (specifically, a case management code) that is different than the code in the IMC SERI. Which code should the providers use? Do the MCOs have to comply with the SERI, or do they have a choice in which codes they use?	Most providers do not have hard-coded codes in their contracts, these codes are only in a few provider contracts and they are specific codes for specific services. The MCOs need to work directly with their providers to figure out how to pay them for these hard-coded codes. The MCOs will review their contracts to figure out which providers have the hard-coded contracts and reach out to those providers to let them know by Monday, 6/17, then they will work with those providers to figure this issue out individually. Amerigroup: In regards to confusion around the care management code T1016 & T1017, we reviewed all of our provider contracts in the region and none of them actually have this code specifically included in their contract. We are currently reaching out to providers to let them know they should be following the 7/1/19 IMC SERI code (T1016) so that we can ensure they don't have any issues come 7/1.

116. If you look at the language of the SERI below regarding MH RTFs, people interpret the definitions very differently:

- Some say that this means that the first 30 days are coded at H0018 and the days beyond that at H0019.
- Others say that we need to determine from the get-go whether a facility is a short or long-term facility. So, an acute SUD residential facility (ASAM 3.5) that keeps people for about 30 days would use a H0018 code, whereas a Recovery House (ASAM 3.1) that is considered to offer long-term services would only use the H0019 code. **But what about MH RTFs? They invariably serve people beyond 30 days. Do they only use H0019 as well?**

The main problem behind this issue is a financial one: the rates for H0019 are significantly lower than those for H0018 (by about $100). MH RTFs are very worried that they will be faced with significantly less revenue if we consider them to be long term facilities.

Code	CPT/HCPCS Definition	UN / MJ	Mod	Provider Type
REVENUE CODE: 1001 or 01x4 HCPC CODE: H0018	BH srvcs; short-term residential (nonhospital residential tx program), w/o R&B, per diem	UN (1= a day; 1 or more)	UD	Billing Provider NPI and Taxonomy
REVENUE CODE: 1001 or 01x4 HCPC CODE: H0019	BH srvcs; long-term residential (nonmedical, non-acute care in a residential tx program where stay is typically longer than 30 days), w/o R&B, per diem	UN (1= a day; 1 or more)	UD	Billing Provider NPI and Taxonomy

This coding scheme was in the original SERI.

H0018 short term

H0019 long term and more than 30 days.

No, HCA does not read the definition in HCPC to mean first and then beyond

We can discuss this with the MCOs for the next release.

If an RTF would use this modality to report the encounter, then they would use the H0019.

It isn't about the type of facility they are considered, it is about the service they are rendering.

117. We want to confirm that these codes should all be termed effective 7/1/19 based on the SERI guide. The codes in red are under the inpatient professional services section:

On grid/ not in guide					
0100	0203	H0008	H2035	99217	99231
0113	0204	H0009	H2035 HD	99218	99232

These codes are not in the SERI and are not applicable for reporting encounters to HCA.

0123	0118	1004	H2035 HZ	99219	99233
0133	0128	H2034	H2035 H9	99220	99238
0143	0138	907	90889	99221	99251
0153	0148	912	H0006	99222	99252
0119	0158	913	T1017	99223	99239
0129	H2013	H0035	T2003	99234	99253
0139	0190	0900	86580	99235	99358
0149	0191	0906	90870	99236	99359
0159	0192	H0015	0901	99254	99315
	0193	0905		99255	99316

118. We want to clarify the coverage for psych vs. substance abuse services. 1) Are all of the services listed on page 2 of the SERI guide only covered for MH diagnoses? 2) Do we need to re-evaluate if these should only be covered for MH diagnosis codes and/or Substance Use diagnosis codes? In 2016 when the SWWA plan was implemented, these services were set up to allow both psych and substance diagnosis codes based on Beacon Clinical direction. This allowed the funds to do the "talking" as far as what is covered and what is not, some funds cover Substance or Mental Health diagnosis codes only.	One would expect a MH service to be reported using a MH diagnosis and an SUD services to be reported with a SU diagnosis. However, the provider is responsible for selecting the code that best represents the context of the encounter and selecting the most appropriate diagnosis code.
119. We are looking for some guidance over which fund sources should be available for the following services:	The old SERI provided this guidance: ORCSP - GF- State

• Offender Re-entry Community Safety Program (ORCSP) • Pregnant, Post Partum, or Parenting Women's (PPW) Housing Support Services • Request for Services	PPW -GF- State & SABG Request for services- GF-State
120. As you know in WA, there are many times that providers are providing services in the community. In the past, we have tried to be as specific as possible when deciding with POS a provider can bill. When it comes to Place of Service (POS) for the services listed in the SERI, is there a recommended approach? Do you want us to be more inclusive of POS, or is using POS 99 acceptable? Can you use the codes in question 118 above as examples of what you would like us to include in POS?	HCA strongly recommends reporting POS using national POS codes that best reflects the setting for services rendered.
121. Can code H0038 be billed without modifiers?	See question 70 above.
122. Under Care Coordination Services, for code H2021, is this for adults only?	This was from the old SERI. Given the description and reference to child and family, it seems to infer the services are only for a client under 21 years of age. We will adjust this on the next release and reword this so it is clearer.
123. What is the difference between pricing and payment eligibility modifiers? (Can you provide examples of pricing before payment- so in the following grouping, is this order correct: HH, UD, UK, U6, U8, GT?)	Pricing modality is when that modality drives how the fee is derived. One is either adding money or reducing money paid depending on the reimbursement policy. Examples are: 25; maybe 52, 53, GT, HH, HK, HT, U6, U8, XE *depending* on the MCO contract. Payment eligibility modifiers is one that is reporting program information. Examples are: H9, HD, HV, HW, HZ, U5, U9, UB, UD. Examples are provided as guidance from HCA. Providers should work with MCOs/BHOs for clarity as indicated.
124. In your previous instruction to us, you mentioned no modifiers with Revenue codes,	This probably requires more conversation with the MCOs. When reporting the service using a HCPC

which is how our system is configured today. But then in the SERI guide, you have sections like Intensive Inpatient Residential Services and list both Revenue Code 1002 or 01x6/ HCPC code H0018 with modifiers HD, HZ, and U5. How should this be configured?	(H0018) one would use a modifier, but an inpatient revenue code (e.g Room and Board) does not commonly use a modifier. However, we need to investigate the ability for systems to take data in this field when a revenue code is being used.
125. Are the taxonomies listed in SERI intended to be an exhaustive list? That is, if a provider's taxonomy is no in SERI, does that mean they are not allowed to render services listed in SERI? Or should they use a different taxonomy? Or should the taxonomies listed in IMC SERI not be considered exhaustive (and left to MCO discretion as to whether a given non-SERI taxonomy can render the service)? The context is that we are now seeing taxonomies on provider rosters that are not in the IMC SERI. Some examples are below: • 247200000X - Technician, Other • 101YP2500X - Counselor Professional • 106S00000X - Behavior Technician • 163WA0400X - Registered Nurse Addiction (Substance Use Disorder) • 90200000X - Student in an Organized Health Care Education/Training Program • 2470A2800X - Technician, Health Information: Assistant Record Technician • 225400000X - Rehabilitation Practitioner	Yes the taxonomies listed in SERI are intended to be an exhaustive list. The intent was to try to follow the original SERI on this issue as much as possible so that the trend data is not disrupted too much. SERI taxonomies are not driven by licensure, only. If a person providing services is not licensed, then it is about their education prep. If one of the options provided in SERI is not applicable then one should use " Other clinical". As SERI states, if the provider is unable to register with the taxonomy assigned in SERI because it was not a Federally recognized taxonomy, the provider should enroll with the MCO or BHASO and with P1 using both the federal taxonomy and the SERI assigned one. Unless the provider is billing and reporting encounters through a TPA, report encounters using the taxonomy assigned in SERI. SERI provides instructions on page 135 about this. For the Registered Nurse Addiction (Substance Use Disorder), use 163W00000X RN. HCA does not distinguish between RN specialties.
126. We suggest that HCA include additional multiple service modifiers in the SERI guide. Right now the only modifier included is 25 and that modifier is only appropriate for E&M codes. We have created a reference document that explains correct usage of the modifiers including 25, 59 and the X's. We realize an official SERI revision might take some time, but if HCA is able to advise shortly whether it will include additional modifiers in SERI and exactly which ones it will include, it would be helpful so we can provide some "interim" direction to providers and BH-ASOs who are looking for guidance.	We are adding a XE for multiple services by the same provider, using the same non E&M code, for the same client in the same day. This was conveyed in the Memo distributed 6/21/2019.

127. <u>Minutes for 90791 and 90792:</u> 1) We request that HCA consider allowing minutes for 90791 and 90792 to ensure parity and fairness with mental health evaluations, which can also vary greatly depending on the complexity/acuity of the member. 2) If it would be helpful to other MCOs (if they are unable to implement minutes), we could also consider moving H0001, 90791 and 90792 to units where 1 unit = 15 minutes (with more than one unit allowed per encounter). Then providers could bill the closest number of units based on the actual time spent.	HCA will ask the other MCOs about both of this.
128. Does the state have a preference in how we order our modifiers? As we configure out system, we are concerned that all providers have the same information on how to order the modifiers when they submit claims, as the order the modifiers are submitted in will impact whether the claim will be accepted or rejected.	While there is currently no edit to check the order here is the general rule per our certified coder: pricing mods go before payment-eligible mods, and location mods are always last.
129. Our system does not allow us to pay rates based on taxonomy. In order to distinguish a different fee schedule for different licensure levels, we would like to use modifiers. This is for Beacon use only, and would not be sent to the State in our outbound encounter files.	You should not remove anything from a claim that is submitted to you and then submitted to HCA as an encounter. While HCA doesn't currently edit on taxonomy, providers must report encounter using the taxonomies on the provider type chart OR as directed in the SERI when encounters are submitted through a TPA. The taxonomy edit will be something considered in the future.
130. What does the Revenue Code 01X4 mean?	That is the coding sequence for the revenue codes used on an inpatient claim to report the use of an inpatient psych bed. The series is: 0114, 0124, 0134, 0144.
131. Can a modifier be used with a revenue code?	Modifiers are not commonly used with a revenue code for R&B. But in this case, the modifier is used to identify the program being served. So if you can accept the modifier that is probably best until we investigate this further.

132. What is the HE modifier for? It is not listed in the SERI guide, but it is referenced.	HE was removed on all modality pages. HCA must have missed this one, so we are fixing that in the next release. See "Interim Guidance" document distributed 6/21/2019. We also replaced all the UCs with HK that were missed.
133. Is the TN modifier term'd?	TN wasn't on the original SERI. What is your experience using that? What was it used to ID? FYI a data review HCA did also didn't ID the use of a TN modifier.
134. So for clarity of the responses provided in questions 128 – 133 above: a) It is okay if we use modifiers to indicate licensure levels (we would be using): HM LESS THAN BACHELOR DEGREE LEVEL HN BACHELORS DEGREE LEVEL TD RN TE (LPN/LVN) b) We would not remove the modifiers from claims, and c) We would reinforce with providers that correct taxonomies should be used in case taxonomy edits are considered in the future?	The agency isn't going to say it is "okay" under our policy. If you need to use a mechanism to distinguish types of providers to support reimbursement, that is your business decision. (a) However, if you decide to use a modifier in addition to the taxonomy number then do not remove the modifier. (b) Correct taxonomies **must be** used; not **should be** used. And all encounters must be reported with the taxonomy a instructed in the SERI guide. (c) See Q & A 107
135. Is a below master's level provider type acceptable for code 90837 in IMC SERI?	No, this is an error. Any provider type less than a Master's degree should not be reported with this modality. We will amend in the next release.
136. Now that we are in the new SERI world we have discovered that there doesn't appear to be a code for SUD services 1-9 minutes. We used to use H0047 which was under Case Management in the old SERI. That code is now under Recovery Support Services- which we don't provide. Is this the code we would use for any SUD service 1-9 minutes? It's not really clear to us given that it's under a category that doesn't really apply to Alcohol/Drug abuse svc. NOS.	There may not be a code for less than 10 minutes. T1016 is what you would use for at least 10 minutes of interaction. It is not clear to what service is actually being provided for less than 10 minutes, what is actually occurring?

137. What is the final determination on the use of the ET modifier to indicate crisis?	HCA will revisit this with the MCOs and BHOs to resolve.
138. The SGIA fund is mentioned in the SERI guide under sobering services (pg. 114). What is this fund?	This stands for State Grant-in-Aid. We believe this is a former funding source that used to fund sobering services, but is not a current fund source. That said, we've carried it through in the SERI guide and will remove it in future release.