Indian Health Services (IHS) and Tribal Clinics

Program Overview

Indian Health Programs may be operated by the Indian Health Service (IHS), Tribal Organization or an Urban Indian Organization - (I/T/U). Medically necessary services are reimbursable when the services are provided by an Indian Health Program to an eligible American Indian or Alaskan Native (AI/AN) Medicaid or Nevada Check Up recipient.

Policy

The Medicaid Services Manual (MSM) is on the Division of Health Care Financing and Policy (DHCFP) website at http://dhcfp.nv.gov (select "Manuals" from the "Resources" webpage).

- MSM Chapter 3000 covers policy for Indian Health Programs.
- MSM Chapter 100 contains important information applicable to all provider types.

Tribal FQHC

The Tribal Federally Qualified Health Centers (FQHCs) must separately identify the services provided by a non IHS/Tribal provider under a written agreement that can be claimed as services of the tribal clinic.

Reimbursements

Indian Health Services (IHS), tribal clinics, and Tribal FQHCs are reimbursed at the all-inclusive encounter rate.

In order to be reimbursed:

1. The service must have been medically necessary as defined in MSM Chapter 100 (Medicaid Program), and
2. The recipient must have been eligible for Nevada Medicaid/Nevada Check Up and IHS or tribal clinic services when the service was provided.

Prior Authorization Requirements

Covered services provided at an IHS, tribal clinic, or Tribal FQHC to eligible Medicaid or Nevada Check Up AI/AN recipients do not require prior authorization.

Telehealth

1. Providers must follow guidelines set forth in MSM Chapter 3400 (Telehealth Services).
2. Originating site: Use procedure code Q3014. Originating site Telehealth services are not reimbursable as encounters.
3. Distant site: Use encounter code T1015. Distant site Telehealth services may be reimbursable as encounters (see Encounters below).

Encounter Service Limits

IHS, tribal clinics, and Tribal FQHCs may receive up to five (5) outpatient encounters per recipient, per day, by any health care professional as approved in the Nevada Medicaid State Plan.

Encounter Billing

T1015 (Clinic visit/encounter, all-inclusive)

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Providers should bill using the clinic's National Provider Identifier (NPI) in both the servicing and billing provider fields.

Providers must submit claims to Nevada Medicaid. Claims must comply with the instructions in the 837P Companion Guide for electronic transactions located on the Electronic Claims/EDI webpage.

Tribal FQHCs should utilize the encounter code, T1015, with the modifier U1 to differentiate services being provided by a contracted non IHS/Tribal provider.

Encounters

Clinics may only request reimbursement for one (1) professional group, per recipient, per day, by any health care professional as approved in the Nevada Medicaid State Plan. However, in emergency situations (as defined in the Addendum to the Medicaid Services Manual) clinics may request up to two (2) encounters for the same professional group, per recipient, per day, by any health care professional as approved in the Nevada Medicaid State Plan.

Encounter examples

Scenario one: The following three encounters with different professional groups are allowed on the same day:

Encounter 1: Recipient visits physician who writes a prescription.
Encounter 2: Recipient visits the pharmacy to fill the prescription.
Encounter 3: Recipient visits a psychologist.

Scenario two: Only one of the following encounters is allowed, because the profession is the same.

Encounter 1: Recipient visits physician for a sore throat in the morning.
Encounter 2: Recipient visits physician for dermatitis in the afternoon.

Scenario three: The following exception to the service limitation allows for emergency situations. In this situation, two encounters with the same profession are allowed:

Encounter 1: Recipient visits physician for a sore throat in the morning.
Encounter 2: Recipient visits physician for a broken arm in the afternoon.

Preventative services

1. Family Planning: When family planning services are provided, include the most appropriate current diagnosis code(s). Providers are encouraged to provide family planning services as outlined in MSM Chapter 600 (Physician Services).
2. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: When EPSDT services are provided, include the most appropriate current diagnosis code(s). Providers are encouraged to follow the periodicity schedule listed in MSM Chapter 1500 (Healthy Kids Program).