IHS CARE COORDINATION AGREEMENTS AND REFERRALS

OVERVIEW

Services referred by Great Plains Area IHS facility to a provider that has a fully executed care coordination agreement with Great Plains Area IHS facility are eligible for 100 percent Federal Medical Assistance Percentage (FMAP).

To qualify for the enhanced FMAP a referral must be made by a Great Plains Area IHS facility. A referral is required for the enhanced FMAP even if the services are exempt from requiring a referral under the care management program (Primary Care Provider Program and Health Home Program). The specialty provider/provider receiving the referral from Great Plains Area IHS facility must also comply with the Referral Records Requirement section of the Referral Provider Manual and the provisions of the signed care coordination agreement.

Great Plains Area IHS facility are located in the following cities:

- Rosebud
- Sisseton
- Pine Ridge
- Eagle Butte
- Rapid City
- Ft Thompson
- Lower Brule
- Wagner

Community based providers such as hospital and long-term care facilities who have a signed Care Coordination Agreement with Great Plains Area IHS are able to participate. Providers interested in getting a Care Coordination Agreement in place can contact Medical Services at DSS.Medicaid@state.sd.us

In order to receive services under a Care Coordination Agreement the recipient must be eligible for both Medicaid and IHS. The recipient must be enrolled in a federally recognized Tribe to be eligible for IHS services and have an established relationship with IHS.

ELIGIBLE SERVICES

Services subject to Care Coordination Agreements are services that are not available from the referring site including but are not limited to:

- Long term care facility services
- PRTF/SUD/CSP agency services
- Renal services
- Necessary emergent and acute care
- NICU stays
CMS State Health Official (SHO) Letter
To be eligible for care coordination the service must meet federal requirements described in CMS SHO Letter #16-002. At a minimum care coordination must involve:

1. The IHS/Tribal facility practitioner providing a request for specific services (by electronic or other verifiable means) and relevant information about his or her patient to the non-IHS/Tribal provider;
2. The non-IHS/Tribal provider sending information about the care it provides to the patient, including the results of any screening, diagnostic or treatment procedures, to the IHS/Tribal facility practitioner;
3. The IHS/Tribal facility practitioner continuing to assume responsibility for the patient’s care by assessing the information and taking appropriate action, including, when necessary, furnishing or requesting additional services; and
4. The IHS/Tribal facility incorporating the patient's information in the medical record through the Health Information Exchange or other agreed-upon means.

INELIGIBLE SERVICES

Services are considered to have not met the care coordination requirements in the following circumstances:

- A referral was not provided or no Care Coordination Agreement was in place; and
- Retroactive referrals, excluding retroactive referrals for care management (Primary Care Provider and Health Home) recipients.

Services that do not meet care coordination requirements are still reimbursable if they otherwise meet Medicaid coverage requirements.

DOCUMENTATION REQUIREMENTS

General referral documentation requirements are available in the South Dakota Medicaid Referral Provider Manual.

IHS referrals must be renewed annually if applicable. Referrals must be documented in the medical record. The referring provider may specify the length of time a referral is valid. Referrals should document the IHS provider making the referral. Documentation of the referral must be contained in the PRTF/SNF/CSP medical records.

Referrals for in-patient services can be included on the loop/segment of the claim or in the provider claims work que in the Medicaid Portal.

Providers are required to share medical record updates back to the referring IHS provider within 30 days of providing services.
CLAIM INSTRUCTIONS

Claim instructions are available on our provider manual webpage. Examples of listing the referring provider on a claim are provided below.

CMS 1500 Example

- Dr. Smith (Example Servicing NPI: 111111111) works at Pine Ridge IHS Hospital (Example Billing NPI: 222222222) and makes a referral for John Doe to receive PRTF services.
- The PRTF documents the referral from Dr. Smith in John Doe’s medical record and provides medical records and updates to Dr. Smith as required under the Care Coordination Agreement.
- The PRTF bills for services provided to John Doe to Medicaid. The PRTF lists the billing NPI for Dr. Smith in box 17 and 17b on the claim form.

UB-04 Example

- Dr. Smith (Example Servicing NPI: 111111111) works at Pine Ridge IHS Hospital (Example Billing NPI: 222222222) and makes a referral for Jane Doe to receive nursing facility care.
- The Nursing Facility documents the referral from Dr. Smith in Jane’s medical record and provides medical records and updates to Dr. Smith as required under the Care Coordination Agreement.
- The Nursing Facility bills for services provided to Jane to Medicaid. The nursing facility lists the billing NPI for Dr. Smith in box 78 on the claim form.

DEFINITIONS

1. “Care Coordination Agreement (CCA)” - Agreement between Great Plains Indian Health Service and non-IHS provider allowing for 100% federal reimbursement for services provided to American Indian recipients at non-IHS providers.

2. “Federal Medical Assistance Percentage (FMAP)” - A calculation updated annually to determine the state vs federal payment for social services programs such as Medicaid.

3. “Psychiatric Residential Treatment Facility (PRTF)” - A non-hospital psychiatric facility with a provider agreement with a State Medicaid Agency to provide the inpatient services benefit to Medicaid-eligible individuals under the age of 21.

4. “Intergovernmental Personnel Act (IPA)” – An exchange of skilled personnel between government and non-government institutions allowing State staff to work within IHS facilities.
5. “Community Support Provider (CSP)”- A community-based provider who provides services to individuals with developmental disabilities though a Home and Community Based Services waiver program.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. How is a referral initiated?

IHS may refer or transfer a recipient to another provider or facility for services. Medicaid IPA nurses can also assist providers in obtaining an IHS referral for individuals admitted to a hospital, nursing facility, or psychiatric residential treatment facility. It is important to notify the IPA nurses as soon as possible for individuals that may be eligible. IPA nurses will review eligibility and follow up with the appropriate IHS service unit to get a referral.

The billing provider needs to make sure the NPI number for the IHS service unit the patient is referred from is included as the referring provider on the claim.

2. How often does a referral need to be renewed?

Referrals must be renewed at least annually or sooner if the referral included an end date that is less than a year.

3. Can a referral be retroactive?

Referrals must meet the requirements of this manual. Generally, this requires obtaining a referral prior to rendering a medical service or prior to discharge from an inpatient hospital facility. For care management program (Primary Care Provider Program and Health Home Program) recipients, a referral for a medical service or an inpatient hospital admission may be retroactive at the provider’s discretion in accordance with the Referral Provider Manual. Referrals for nursing facility services or psychiatric residential treatment facility services cannot be retroactive.

4. How do I list the referring provider on a claim?

Providers should list the referring provider’s NPI number on the claim. The NPI number can be found on the referral sent to the facility from the IPA nurse. Refer to the Claim Instructions section of this manual for more information.
5. If a person discharges and readmits to the same facility within the one-year time frame of the original referral, is a new referral needed?

Yes, a new referral is required if the services are considered a new admission or required to be billed as a separate admission.