
Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics

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This section contains information for billing services rendered by Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics. For IHS/MOA billing code information, refer to the *Indian Health Services (IHS), Memorandum Of Agreement (MOA) 638, Clinics: Billing Codes* section in this manual.

Notice: Welfare and Institutions Code Section 14131.10 excludes chiropractic services under the Medi-Cal program. See *Chiropractic Services* section in this manual for policy details, including information regarding exemptions to the excluded benefits.

Program History

On April 21, 1998, the Department of Health Care Services (DHCS) implemented the IHS/MOA between the federal IHS and the Centers for Medicare & Medicaid Services. The IHS/MOA changed the reimbursement policy for services provided to Medi-Cal recipients within American Indian or Alaskan native health care facilities identified as 638 facilities.

DHCS compiled a list of IHS clinics and mailed a letter to each provider informing them of the option to participate as a 638 clinic under the MOA. Providers electing to participate were asked to complete and return an “*Elect to Participate*” *Indian Health Services Memorandum of Agreement (IHS/MOA) Application* (form DHCS 7108) to DHCS.

Enrollment

Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs) and certain Primary Care Clinics (PCCs) designated by the federal IHS as eligible to participate in the IHS Memorandum of Agreement (MOA) may enroll as IHS clinic providers. Clinics cannot be designated as both an IHS and an RHC/FQHC/PCC provider. Other current provider numbers are inactivated at the time of enrollment.

Providers may enroll as an IHS clinic by completing an “*Elect to Participate*” *Indian Health Services Memorandum of Agreement (IHS/MOA) Application* (form DHCS 7108). The application is available on the Provider Enrollment page and Forms page of the Medi-Cal website (www.medi-cal.ca.gov). The application may be mailed to:

Department of Health Care Services
Provider Enrollment Division
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413

Faxed applications will not be considered.

Services Available

This program provides the following:

- Physician services
- Physician assistant services
- Nurse practitioner services
- Nurse midwife services
- Clinical psychologist services†
- Clinical social worker services†
- Marriage and Family Therapist Services†
- «Licensed Professional Clinical Counselor†»
- Acupuncture
- Visiting nurse if services are provided in the Tribal facilities
- Services and supplies incidental to physician services
- Comprehensive Perinatal Services Program (CPSP) services as defined in *Welfare and Institutions Code (W&I Code)*, Section 14134.5, and *California Code of Regulations (CCR)*, Title 22, Section 51179.7
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services
- Medi-Cal ambulatory services
- Optometry services
- Dental services

Note: «IHS-MOA clinic providers may render any dental service in a face-to-face encounter between a billable treating provider and an eligible patient that is within the scope of the treating provider's practice, complies with the Medi-Cal Dental *Manual of Criteria and Schedule of Maximum Allowances* (available on the [Provider Handbook](#) web page of the DHCS Medi-Cal Dental website, and determined to be medically necessary pursuant to California *Welfare and Institutions Code (W&I Code)*, Section 14059.5.» Each provider shall develop a treatment plan that optimizes preventative and therapeutic care and that is in the patient's best interest, taking into consideration their overall health status. All phases of the treatment plan shall be rendered in a safe, effective, equitable, patient-centered, timely, and efficient manner.

For dental services, documentation should be consistent with the standards set forth in the *Manual of Criteria* of the Medi-Cal Dental Provider Handbook and all state laws.

- End of life services

Note: Refer to the *End of Life Option Act Services* section of the appropriate Part 2 manual for additional information.

Medi-Services

Medi-Service limitations apply for services provided in an IHS clinic, unless the recipient is under age 21.

Prescriptions

IHS-MOA clinics may be reimbursed for prescriptions or refills if they are a licensed pharmacy and approved by Medi-Cal to render pharmacy services. If the pharmacy does not qualify, prescriptions or refills are not separately reimbursable with Medical, per visit billing code sets.

Treatment Authorization Requests (TARs)

IHS-MOA services do not require a *Treatment Authorization Request* (TAR), but providers are required to meet the same documentation requirements that are necessary in a TAR for the same service under Medi-Cal. IHS facilities are subject to the same limitation of scope and duration of services as other Medi-Cal providers.

Claims for Comprehensive Perinatal Services Program (CPSP) support services in excess of the basic allowances will not be denied for the absence of a TAR. However, the provider must maintain the same level of documentation required for authorization. Justification includes:

- Clinical finding and high-risk factors involved in the pregnancy
- Explanation of why basic CPSP services are not sufficient
- Services that would have been requested
- Description and amount of services and time
- Anticipated benefit or result and outcome or additional services

The recipient's medical records should be available for review by DHCS staff.

Medical Visit

«IHS-MOA clinics may be reimbursed for up to three visits a day for one recipient if one is a medical visit, a mental health visit, and an ambulatory/dental visit. An IHS-MOA clinic encounter is defined as:

A face-to-face encounter provided in the Tribal facility between a patient and the health professional of the clinic or the center;

A synchronous audio-only or asynchronous modality encounter which takes place between a patient and the health professional of the clinic or center.»

Mental Health Visits

A mental health visit may also be utilized for an Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit face-to-face encounter between an IHS-MOA recipient and a clinical psychologist, clinical social worker, or other health professional for therapeutic mental health services.

Ambulatory Visit

An ambulatory visit is a face-to-face encounter between an IHS-MOA recipient and a health care professional other than a physician or mid-level practitioner which is included in California's Medi-Cal State Plan. This encounter must occur in the tribal health facility.

Medi-Cal ambulatory visit services are reimbursed at the IHS-MOA all-inclusive rate:

Physical therapy (subject to CCR, Title 22, Section 51309)

Occupational therapy (subject to CCR, Title 22, Section 51309)

Speech pathology (subject to CCR, Title 22, Section 51309)

Audiology (subject to CCR, Title 22, Section 51309)

Podiatry (subject to CCR, Title 22, Section 51309)

Drug and alcohol visits (subject to Medi-Cal participation requirements)

Chiropractic (subject to CCR, Title 22, Section 51309 as well as W&I Code Section 14131.10. Refer to the *Chiropractic Services* section in this manual for information regarding exemptions to the excluded benefits.)

Acupuncture (subject to CCR, Title 22, Section 51309)

Telemedicine

Dental

Note: IHS-MOA clinic providers may render any dental service in a face-to-face encounter between a billable treating provider and an eligible patient that is within the scope of the treating provider's practice, complies with the Medi-Cal Dental *Manual of Criteria* <<(https://dental.dhcs.ca.gov/Dental_Providers/Denti-Cal/Provider_Handbook)>>, and determined to be medically necessary pursuant to California *Welfare and Institutions* Code (W&I Code) 14059.5. Each provider shall develop a treatment plan that optimizes preventative and therapeutic care and that is in the patient's best interest, taking into consideration their overall health status. All phases of the treatment plan shall be rendered in a safe, effective, equitable, patient-centered, timely and efficient manner.

<<For dental services, documentation should be consistent with the standards set forth in the *Manual of Criteria* of the Medi-Cal Dental Provider Handbook and all state laws.>>

Non-medical transportation is not included in the IHS-MOA visit rate and is reimbursed separately.

Radiology and laboratory services are included in the IHS-MOA visit rate and are not reimbursed separately.

Services for Recipients In Managed Care Plans

When billing for services rendered to Medi-Cal managed care members, and the services are covered by the Managed Care Plan (MCP), IHS-MOA providers must bill the MCP. No differential billing is required.

Billing for Straight Medi-Cal with Medicare Advantage HMO Plans

Facilities submitting claims for fee-for-service Medi-Cal recipients in a fee-for-service Medicare Advantage Plan should bill with Crossover Claims billing code sets. Also, the phrase "For a fee-for-service Medi-Cal recipient in a fee-for-service Medicare Advantage Plan" must be included in the *Remarks* (Box 80) field of the claim or in an attachment to the claim.

Providers submitting claims for fee-for-service Medi-Cal recipients in a Capitated Medicare Advantage Plan should bill with Capitated Medicare Billing Code Sets.

Billing for Managed Care and Medicare

IHS-MOA facilities bill using the same process as described in the previous heading "Services for Recipients in Managed Care Plans" when rendering services to a recipient enrolled in Medi-Cal managed care and Medicare.

Billing for Capitated Medicare Advantage Plans

Generally, claims submitted to Medi-Cal for Crossover Claims and Capitated Medicare Advantage Plan billing code sets must include documentation of Medicare denial in one of the following ways:

- Enter three key facts in the Remarks field (Box 80) of the claim:
 - Whether the facility is IHS-MOA
 - That the recipient is a managed care patient
 - One of the following: No EOMB/No MRN/No RA

Or

- On an 8 1/2" x 11" attachment to the claim, specify the following: MOA Medi-Cal patient enrolled in a capitated Medicare Advantage HMO and no EOMB (or MRN) (or RA) received from the capitated Medicare Advantage HMO.

Crossover Claim Completion Instructions

For crossover claims, providers do not complete the *Payer Name* field (Box 50) or *Prior Payments* field (Box 54) with prior payment amounts from Medicare or the Medicare carrier. Additional information is available in the *Medicare/Medi-Cal Crossover Claims: Outpatient Services* section.

Annual Reconciliations

An annual reconciliation request is filed with the Audits and Investigations (A&I) Division. A&I will review the filed reconciliation request to ensure every IHS-MOA facility is receiving its full federal MOA per-visit reimbursement rates.

DHCS A&I forms are available on the "Forms" page of the DHCS website at <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/AuditsInvestigationsForms.aspx>.

Rate Determination for Non Medi-Cal Managed Care Recipients

Rates for Capitated Medicare Advantage Plans are adjusted upon request by the IHS-MOA facilities. A&I has posted forms on the "Forms" page of DHCS website. The IHS-MOA facility can request to change rates for Capitated Medicare Advantage Plans at any time in which their Medicare Advantage Plan contract has changes.

Alternatively, the MOA can include the Capitated Medicare Advantage Plans rate-change form with their annually-filed reconciliation request. Forms are available on the "Forms" page of the DHCS website.

EPSDT/CHDP Reporting Requirements and Billing

IHS-MOA Clinics bill Early and Periodic Screening, Diagnostic and Treatment/Child Health and Disability Prevention (EPSDT/CHDP) services using the *UB-04* claim. Effective September 1, 2019, IHS-MOA Clinics no longer submit the *Confidential Screening/Billing Report Information Only* (PM 160 Information Only) with claims to fulfill reporting purposes. Instead, providers fulfill reporting requirements by including informational lines on their claims. Required reporting data will be extrapolated from the informational lines.

Providers submitting paper claims can refer to a sample *UB-04* claim populated with an informational line in the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Billing Examples* provider manual section. Instructions for submitting informational lines on electronic claims is available in the *Medi-Cal Computer Media Claims (CMC) Billing and Technical Manual*, “Special Billing Instructions: Federally Qualified Health Centers, Rural Health Clinics, and Indian Health Services-Memorandum of Agreement” section.

Telehealth

Overview

Policy related to telehealth is established pursuant to Assembly Bill 415 (Logue, Chapter 547, Statutes of 2011), known as the Telehealth Advancement Act of 2011. Providers may refer to the *Medicine: Telehealth* section of the appropriate Part 2 manual for additional information.

Definitions

For purposes of this policy, the following definitions shall apply:

Telehealth and Other Terms

For definitions of “telehealth,” “asynchronous store and forward,” “synchronous interaction,” “distant site” and “originating site,” providers may refer to the *Medicine: Telehealth* section in the appropriate Part 2 manual.

Visit

Providers may refer to “Medical Visit,” “Mental Health Visits” and “Ambulatory Visit” in this manual section.

Billable Provider

Providers may refer to “Services Available” in this manual section.

Established Patient

A Medi-Cal eligible recipient who meets one or more of the following conditions:

- The patient has a health record with the IHS-MOA clinic that was created or updated during a visit that occurred in the clinic. The patient's health record must have been created or updated within the previous three years.
- The patient is homeless and has an established health record that was created from a visit occurring within the last three years that was provided within or outside of the IHS-MOA clinic. All consent for telehealth services for these patients must be documented.
- The patient is assigned to the IHS-MOA clinic by their Managed Care Plan (MCP) pursuant to a written agreement between the plan and the IHS-MOA clinic.

Documentation Requirements

Providers may refer to the *Medicine: Telehealth* section in the appropriate Part 2 manual.

Covered Services

Services rendered via telehealth must be IHS-MOA covered services.

Non-Covered Services

An e-consult is not a reimbursable telehealth service for IHS-MOA clinics.

Synchronous Telehealth Reimbursement Requirements

Services provided through synchronous telehealth for an established patient are subject to the same program restrictions, limitations and coverage that exist when the service is provided in-person.

- «IHS-MOA clinics must submit claims for telehealth services using the appropriate per visit IHS-MOA billing codes, modifiers and related claims submission requirements. Providers may refer to the *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics: Billing Codes* section in the appropriate Part 2 manual.»
- IHS-MOA clinics are not eligible to bill an originating site fee or transmission charges. The costs of these services should be included in the IHS-MOA rate.

Synchronous Audio-Only Requirements

An audio-only visit is eligible for reimbursement if provided by a billable provider, regardless of the location of the patient or provider.

Asynchronous Store and Forward Reimbursement Requirements

A patient may not be “established” on an asynchronous store and forward service with the exception of a homeless patient. Reimbursement is permitted for an established patient by a billable provider at the distant site.

Note: Providers should note “Non-Covered Services” in this manual section.

«Synchronous Telehealth Table»

Originating Site Location of Patient	Distant Site Location of Telehealth Provider	Billing and Reimbursement Policy
IHS-MOA Corporation (Corp) A – Site 1 <i>Established patient with non-billable provider</i>	IHS-MOA Corp A – Site 2 <i>Billable provider</i>	IHS-MOA Corp A – Site 2 can bill one visit at the IHS-MOA rate.
IHS-MOA Corp A – Site 1 <i>Established patient with billable provider</i>	IHS-MOA Corp A – Site 2 <i>Billable provider</i>	Only one site can bill one visit at the IHS-MOA rate.
IHS-MOA Corp A <i>Established patient with non-billable provider</i>	IHS-MOA Corp B <i>Billable provider</i>	IHS-MOA Corp B can bill one visit at the IHS-MOA rate. No IHS-MOA rate reimbursement is permitted for IHS-MOA Corp A.
IHS-MOA Corp A <i>Established patient with billable provider</i>	IHS-MOA Corp B <i>Billable provider</i>	IHS-MOA Corp A can bill one visit at the IHS-MOA rate if it is medically necessary for a billable provider to be present. IHS-MOA Corp B can bill one visit at the IHS-MOA rate.
IHS-MOA Corp A <i>Established patient with non-billable provider</i>	Non IHS-MOA <i>Billable provider (no service payment contract)</i>	The provider at the non IHS-MOA can bill the MCP or fee-for-service directly if no service payment contract exists between IHS-MOA Corp A and the non IHS-MOA billable provider. No IHS-MOA rate reimbursement is permitted for IHS-MOA Corp A.

Synchronous Telehealth Table (continued)

Originating Site Location of Patient	Distant Site Location of Telehealth Provider	Billing and Reimbursement Policy
IHS-MOA Corp A <i>Established patient with billable provider</i>	Non IHS-MOA <i>Billable provider (no service payment contract)</i>	IHS-MOA Corp A can bill one visit at the IHS-MOA rate. The provider at the non IHS-MOA can bill the MCP or fee-for-service directly if no service payment contract exists between IHS-MOA Corp A and the non IHS-MOA billable provider.
Non IHS-MOA <i>Established patient with non-billable provider</i>	IHS-MOA Corp A <i>Billable provider</i>	IHS-MOA Corp A can bill one visit at the IHS-MOA rate. No IHS -MOA rate reimbursement is permitted for the non IHS-MOA.
Non IHS-MOA <i>Established patient with billable provider (no service payment contract)</i>	IHS-MOA Corp A <i>Billable provider</i>	The non IHS-MOA can bill the MCP or fee-for-service directly if no service payment contract exists between IHS-MOA Corp A and the non IHS-MOA billable provider. IHS-MOA Corp A can bill one visit at the IHS-MOA rate.

«Synchronous Telehealth Table (continued)»

Originating Site Location of Patient	Distant Site Location of Telehealth Provider	Billing and Reimbursement Policy
IHS-MOA Corp A <i>Homeless patient</i>	IHS-MOA Corp A <i>Billable provider</i>	IHS-MOA Corp A can bill one visit at the IHS-MOA rate.
IHS-MOA Corp A <i>Homeless patient with billable provider</i>	IHS-MOA Corp B <i>Billable provider</i>	IHS-MOA Corp A can bill one visit at the IHS-MOA rate if it is medically necessary for a billable provider to be present. IHS-MOA Corp B can bill one visit at the IHS-MOA rate.

«Asynchronous Store and Forward Telehealth Table»

Originating Site Location of Patient	Distant Site Location of Telehealth Provider	Billing and Reimbursement Policy
IHS-MOA Corp A – Site 1 <i>Established patient with non-billable provider</i>	IHS-MOA Corp A – Site 2 <i>Billable provider</i>	IHS-MOA Corp A – Site 2 can bill one visit at the IHS-MOA rate.
IHS-MOA Corp A – Site 1 <i>Established patient with billable provider</i>	IHS-MOA Corp A – Site 2 <i>Billable provider</i>	Only one site can bill one visit at the IHS-MOA rate.
IHS-MOA Corp A – Site 1 <i>Established patient with non-billable provider</i>	IHS-MOA Corp B <i>Billable provider</i>	IHS-MOA Corp B can bill one visit at the IHS-MOA rate. No IHS-MOA rate reimbursement is permitted for IHS-MOA Corp A.
IHS-MOA Corp A <i>Established patient with billable provider</i>	IHS-MOA Corp B <i>Billable provider</i>	Only one site can bill one visit at the IHS-MOA rate.
IHS-MOA Corp A <i>Established patient with non-billable provider</i>	Non IHS-MOA <i>Billable provider (no service payment contract)</i>	The provider at non IHS-MOA can bill the MCP or fee-for-service directly if no service payment contract exists between IHS-MOA Corp A and the non IHS-MOA billable provider. No IHS-MOA rate reimbursement is permitted for IHS-MOA Corp A.

«Asynchronous Store and Forward Telehealth Table (continued)»

Originating Site Location of Patient	Distant Site Location of Telehealth Provider	Billing and Reimbursement Policy
IHS-MOA Corp A <i>Established patient with billable provider</i>	Non IHS-MOA <i>Billable provider (no service payment contract)</i>	IHS-MOA Corp A can bill one visit at the IHS-MOA rate. The provider at the non IHS-MOA can bill the MCP or fee-for-service directly if no service payment contract exists between IHS-MOA Corp A and the non IHS-MOA billable provider.
Non IHS-MOA <i>Established patient with non-billable provider</i>	IHS-MOA Corp A <i>Billable provider</i>	IHS-MOA Corp A can bill one visit at the IHS-MOA rate. No IHS-MOA rate reimbursement is permitted for the non IHS-MOA.
Non IHS-MOA <i>Established patient with billable provider (no service payment contract)</i>	IHS-MOA Corp A <i>Billable provider</i>	The non IHS-MOA can bill the MCP or fee-for-service directly if no service payment contract exists between IHS-MOA Corp A and the non IHS-MOA billable provider. IHS-MOA Corp A can bill one visit at the IHS-MOA rate.
IHS-MOA Corp A <i>Homeless patient</i>	IHS-MOA Corp A <i>Billable provider</i>	IHS-MOA Corp A can bill one visit at the IHS-MOA rate.
IHS-MOA Corp A <i>Homeless patient with billable provider</i>	IHS-MOA Corp B <i>Billable provider</i>	Only one site can bill one visit at the IHS-MOA rate.

«Community Health Worker (CHW) Preventive Services

IHS-MOA providers may be reimbursed for CHW preventive services. CHW services are preventive health services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health. CHW services that are provided based on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law are reimbursable at the fee-for-service rate.

IHS-MOAs may bill the fee-for-service rate for CHW services using the following CPT® codes:

Code	Description	Modifier
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	U2
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	U2
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	U2

For additional information on covered services, documentation requirements, eligibility criteria, and claim submission, refer to the [Community Health Worker \(CHW\) Preventive Services](#) manual section. For managed care beneficiaries, refer to the most recent Managed Care All Plan Letter for CHW services on the DHCS website and contact the Managed Care Plan for the appropriate billing codes.

CHW Treatment Authorization Request (TAR) Requirements

CPT codes 98960, 98961, and 98962 require a TAR when the maximum frequency is exceeded. For information on submitting TARs online, refer to the electronic TAR (eTAR) workbooks on the [Medi-Cal Provider Training Workbooks](#) page. For more information on submitting paper TARs, refer to the [TAR Overview](#) section of the Part 1 manual and the [TAR Completion](#) section of the appropriate Part 2 manual.>>

«Asthma Preventive Services (APS)

IHS-MOA providers may be reimbursed for APS. APS comprise clinic-based asthma self-management education, home-based asthma self-management education and in-home environmental trigger assessments for eligible beneficiaries of any age, as medically necessary, subject to applicable utilization controls. APS that are provided based on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law are reimbursable at the fee-for-service rate.

IHS-MOA providers may bill the fee-for-service rate for APS using the following CPT and HCPCS codes and modifiers:

Code	Description	Modifier
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	U3
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	U3
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	U3
T1028	Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs	U3

For additional information on covered services, documentation requirements, eligibility criteria, and claim submission, refer to the [Asthma Preventive Services \(APS\)](#) manual section. For managed care beneficiaries, contact the Managed Care Plan for the appropriate billing codes.

APS TAR Requirements

CPT codes 98960, 98961, 98962, and HCPCS code T1028 require a TAR when the maximum frequency is exceeded. For information on submitting TARs online, refer to the electronic TAR (eTAR) workbooks on the [Medi-Cal Provider Training Workbooks](#) page. For more information on submitting paper TARs, refer to the [TAR Overview](#) section of the Part 1 manual and the [TAR Completion](#) section of the appropriate Part 2 manual.>>

«Doula Services

IHS-MOA providers may be reimbursed for doula services at the fee-for-service (FFS) rate. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants. The IHS-MOA provider must bill for doula services under the billing clinic National Provider Identifier (NPI). The doula provider must be enrolled in Medi-Cal as an individual doula provider and listed on the claim as a rendering provider. Doula providers must not bill Medi-Cal as an individual practitioner for services provided to a patient of an IHS-MOA. For a full list of definitions, billing codes, documentation requirements and more, providers may refer to the [Doula Services](#) section in the appropriate Part 2 manual.>>

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
†	Interns must be under the supervision of a licensed mental health professional, in accordance with the requirements of applicable state laws.