Washington State Health Care Authority

Washington Apple Health (Medicaid)

Ambulatory Surgery Centers Billing Guide

July 1, 2022

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an HCA rule arises, the HCA rule applies.

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

About this guide[1]

This publication takes effect **July 1, 2022**, and supersedes earlier billing guides to this program.

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

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

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

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Where can I download HCA forms?

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

[1] This publication is a billing instruction.

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Copyright disclosure

What has changed?

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

Subject	Change	Reason for Change
Client eligibility – Clients who are not enrolled in an HCA-contracted managed care plan for physical health services	Clarified who pays if a client received Medicaid-covered services before being automatically enrolled in a BHSO	Program enrollment clarification
Client eligibility – Integrated managed care	Revised paragraph to reflect enrollment in an integrated managed care plan	Clarification
Client eligibility – American Indian/Alaska Native (AI/AN) Clients	Created new subsection and moved this information out of the *Integrated managed care* section	Create a stand-alone section for just AI/AN clients

Subject	Change	Reason for Change
What are the general billing requirements?	Added to the note box that when prior authorization (PA) is required or when using an expedited prior authorization (EPA) number, providers must enter the PA or EPA number on the claim submitted to the MCO	Billing clarification

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Resources Available

Topic	Resources Information
Request for prior authorization	See HCA's ProviderOne Resources webpage.
Additional information regarding this program	Contact the Customer Service Center.
Additional HCA resources	See HCA's ProviderOne Resources webpage.

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

Ambulatory Surgery Center (ASC) - Any distinct entity certified by Medicare as an ASC that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

Coinsurance-Medicare – The portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not pay. Under Part A, coinsurance is a per day dollar amount. Under Part B, coinsurance is 20 percent of reasonable charges.

Health Care Financing Administration Common Procedure Coding System (HCPCS) – Coding system established by the Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services [CMS]) to define services and procedures.

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Ambulatory Surgery Centers

(Refer to WAC 246-330-105 and chapter 70.230 RCW)

What is the purpose of this program?

The purpose of the ambulatory surgery centers (ASC) program is to reimburse providers for the facility costs of surgical procedures that can be performed safely on an ambulatory basis in an ASC.

What is covered?

HCA covers the procedure codes listed in the fee schedule when the surgical services are medically necessary and not solely used for cosmetic treatment or surgery.

The following may be found in the appropriate program publications:

- Authorization requirements
- Centers of Excellence (COE) provider lists
- Coverage criteria (such as age, diagnostic, Medical Care Services client eligibility)
- Expedited prior authorization (EPA) lists
- Sterilization requirements and forms
- Unit limitations

For example:

- Dental-Related Services Billing Guide
- Family Planning Billing Guide
- Physician-Related Services/Health Care Professional Services Billing Guide
- Sterilization Billing Guide

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Client Eligibility

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's services card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service HCA will not pay for.

Verifying eligibility is a two-step process:

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

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

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

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

1. By visiting the Washington Healthplanfinder's website.
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to: Washington Healthplanfinder, PO Box 946, Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit the Washington Healthplanfinder's website or call the Customer Support Center.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Medicaid-eligible clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

For clients enrolled in an HCA-contracted managed care organization (MCO), the client's MCO covers services provided at ambulatory surgery centers (ASCs) when the client's primary care provider (PCP) determines that the services are appropriate for the client's health care needs. Providers must bill the MCO directly.

All medical services covered under an HCA-contracted MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider
- Facility fees associated with dental CDT® and CPT® procedures as designated by modifier SG

Note: Site of service prior authorization (PA) for eligible managed care clients will continue to be determined by HCA for facilities associated with dental procedure codes.

HCA continues to pay for the following through fee-for-service (FFS):

- Professional fees for dental procedures using CDT codes
- Professional fees using CPT codes only when the provider's taxonomy starts with 12

See the Dental-Related Services Billing Guide or the Physician-Related Services/Health Care Professional Services Billing Guide for how to bill professional fees.

A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

Managed care enrollment

Apple Health (Medicaid) places clients into an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for. However, some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's **Get Help Enrolling** page.
- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:

  Go to **Washington HealthPlanFinder website**.

- **Available to all Apple Health clients:**
  - Visit the **ProviderOne Client Portal website**:
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.
  - Request a change online at **ProviderOne Contact Us** (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

For online information, direct clients to HCA's **Apple Health Managed Care** webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS Medicaid program will reimburse providers for the covered services. Some examples of populations that

may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan-receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

For full details on integrated managed care, see HCA's **Apple Health managed care webpage** and scroll down to "Changes to Apple Health managed care."

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as "**Coordinated Care Healthy Options Foster Care**."

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care Medical Team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's **Mental Health Services Billing Guide**, under *How do providers identify the correct payer*?

American Indian/Alaska Native (AI/AN) Clients

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

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

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

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Authorization

What are the general guidelines for authorization?

Authorization requirements are not a denial of service.

When a service requires authorization, the provider must properly request written authorization under HCA's rules and this Medicaid billing guide.

When the provider does not properly request authorization, HCA returns the request to the provider for proper completion and resubmission. HCA does not consider the returned request to be a denial of service.

Prior authorization

When prior authorization is required for services performed in an ambulatory surgery center (ASC), a provider must send or fax a request for authorization along with medical justification to HCA. (See Resources Available).

> Note: Please see HCA's ProviderOne Billing and Resource Guide for more information on requesting authorization.

What are the specific authorization requirements for surgical procedures?

(See WAC 182-531-1700)

Surgical procedures requiring a medical necessity review by HCA

To implement the prior authorization requirement for selected surgical procedures (including hysterectomies and other surgeries of the uterus), HCA will conduct medical necessity reviews. For details about the prior authorization (PA) requirements for these procedures, refer to either:

- Physician-Related Services/Health Care Professional Services Billing Guide
- Physician-Related/Professional Services Fee Schedule (Select a procedure code and refer to the comments field for the accompanying authorization submittal requirement.)

Surgical procedures requiring a medical necessity review by Comagine Health

HCA and Comagine Health have contracted to provide web-based submittal for utilization review services to establish the medical necessity of selected surgical procedures in the following categories:

- Spinal, including facet injections
- Major joints
- Thoracic outlet release

Comagine Health conducts the review of the request to establish medical necessity for surgeries but does not issue authorizations. Comagine Health forwards its recommendations to HCA. HCA must authorize any surgical procedures.

Requests initiated electronically require supporting documentation to be included with the electronic submission or faxed per the instructions found at **Comagine Health**.

For more information about the requirements for submitting medical necessity reviews for authorization please refer to HCA's current **Physician-Related Services/Health Care Professional Services Billing Guide**.

> **Note**: To prevent billing denials, check the client's eligibility **before** scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained. Providers must receive authorization from the client's primary care provider before providing services, **except for emergency services**. See HCA's **ProviderOne Billing and Resource Guide** for instructions on how to verify a client's eligibility.

Payment

What is included in the facility payment?

The facility payment (maximum allowable fee) includes all the following:

- The client's use of the facility, including the operating room and recovery room
- Nursing services, technician services, and other related services
- Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment related to the care provided
- Diagnostic or therapeutic items and services directly related to the surgical procedure
- Administrative, recordkeeping, and housekeeping items and services
- Materials and supplies for anesthesia

Payment for multiple surgical procedures

For providers performing multiple surgical procedures in a single operative session, HCA reimburses either:

- The lesser of the billed amount

-or-

- Up to 100 percent of HCA's maximum allowable for the procedure with the highest group number

For the *second* procedure, reimbursement is either:

- The lesser of the billed amount

-or-

- Up to 50 percent of HCA's maximum allowable

HCA does not make additional reimbursement for more than two surgical procedures.

To expedite payment of claims, bill all surgeries performed during the same operative session on the same claim. This includes secondary claims with payment by a primary commercial insurance and Medicare crossover claims.

What is not included in the facility payment?

The following services are not included in the facility payment:

- Physicians' professional services
- The sale, lease, or rental of durable medical equipment to clients for use in their homes
- Prosthetic devices (for example, intraocular lens)
- Ambulance or other transportation services

- Leg, arm, back, and neck braces
- Artificial legs, arms, and eyes
- Implantable devices

How do providers get paid for implantable devices?

If the implantable device is a necessary supply, not an "over and above" supply, CPT considers it inclusive to the procedure code billed, and HCA will not reimburse separately. For example, to place the tympanostomy tube, the tube is a necessary supply, not an "over and above" supply. Under CPT, this supply is included in the procedure code billed. In cases where items are over and above those usually included with the procedure, bill using a specific CPT/HCPCS code.

To receive payment for implantable devices, providers must:

- Use an appropriate HCPCS procedure code (must be covered on the HCA ASC fee schedule) when billing for an implantable device.
- If a specific appropriate code is not available, you may bill using HCPCS code L8699 with prior authorization.
- Bill for implantable devices on the same claim as the primary procedure code associated with the device. The primary procedure code must be covered on HCA's ASC fee schedule. Claims may be denied without a primary procedure code appearing on the claim.
- Use a HCPCS procedure code only once per claim. Bill multiple units if appropriate.
- Bill HCA the acquisition cost (AC) by attaching to the claim the manufacturer's invoice for the implantable device that includes the client's name and date of purchase. AC means the cost of an item excluding shipping, handling, and any applicable taxes as indicated by a manufacturer's invoice (See WAC 182-531-0050).

How do providers get paid for corneal tissue?

Effective for claims with dates of service on and after January 1, 2016, HCA will pay for corneal tissue processing (HCPCS procedure code V2785) by acquisition cost (AC). To receive payment, providers must:

- Bill the amount paid to the eye bank for the processed eye tissue.
- Attach invoice to claim.

HCA will update the Ambulatory Surgery Centers Fee Schedule to reflect this change.

Where is the fee schedule located?

To view or download a fee schedule, see HCA's **online fee schedule**.

The notations in the code status column of the fee schedule are intended to alert providers that there is specific policy, regulation, or criteria related to the use of the code noted. Providers should review the program-specific publications for details (such as, **Dental – Related Services Billing Guide**, **Physician-Related Services/Health Care Professional Services Billing Guide**, and **Family Planning Billing Guide**).

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Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this policy change, see Paperless Billing at HCA. For providers approved to bill paper claims, see HCA's Paper Claim Billing Resource.

What are the general billing requirements?

Providers must follow HCA's ProviderOne Billing and Resource Guide. These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
-
- How to bill for clients eligible for both Medicare and Medicaid
- How to handle third-party liability claims
- What standards to use for record keeping

Note: **Effective on or after January 1, 2020**, hospital and ASC facility fees for eligible clients enrolled in an HCA-contracted managed care organization must be billed directly through the client's MCO. When PA is required or when using an expedited prior authorization (EPA) number, providers must enter the PA or EPA number on the claim submitted to the MCO.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's Billers and Providers webpage, under Webinars.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA Electronic Data Interchange (EDI) webpage.

When billing for the facilities, ensure that all procedures are billed on the claim. Please make all adjustments on the original claim.

The following claim instructions relate to ambulatory surgery centers:

Name	Entry
Prior Authorization Number	When applicable. If the service you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.
Place of Service	Enter 24 (ambulatory surgery center).
ASC Modifier	Enter SG
Taxonomy Code	Enter 261QA1903X

To prevent claim denials, you must submit claims with HCA-designated taxonomy and the ASC modifier.