Washington State Health Care Authority

Washington Apple Health (Medicaid)

Diabetes Education Program Billing Guide

January 1, 2020

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

About this guide*

This publication takes effect January 1, 2020, and supersedes earlier guides to this program.

HCA 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.

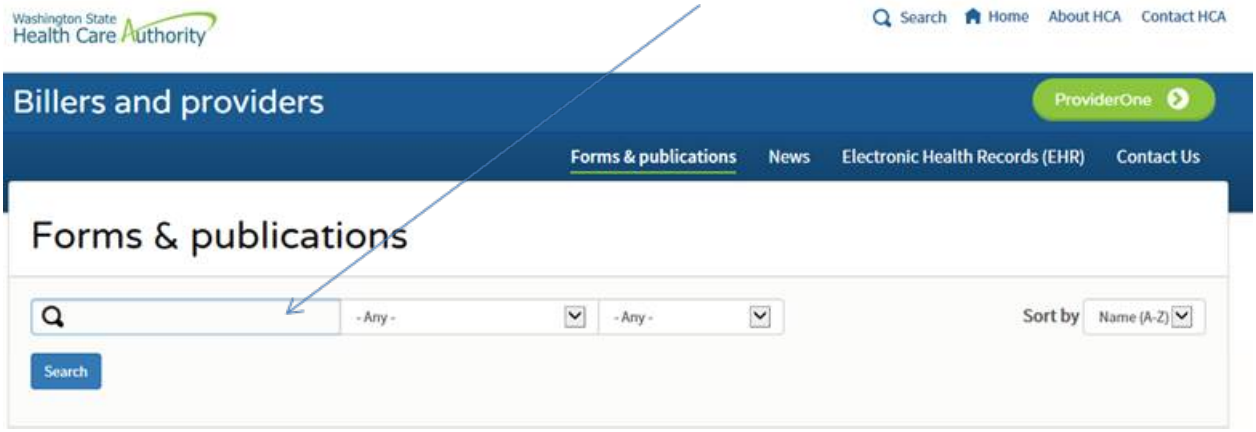
What has changed?

Subject	Change	Reason for Change
Behavioral Health Organization (BHO)	Removed this section	Effective January 1, 2020, behavioral health services in all regions will be provided under integrated managed care.
Integrated Managed Care Regions	Effective January 1, 2020, integrated managed care is being implemented in the last three regions of the state: • **Great Rivers** (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties) • **Salish** (Clallam, Jefferson, and Kitsap counties) • **Thurston-Mason** (Mason and Thurston counties)	Effective January 1, 2020, HCA completed the move to whole person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (IMC).

* This publication is a billing instruction.

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and provider's webpage, select Forms & publications. Type the HCA form number into the **Search box** as shown below (Example: 13-835).



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Resources Available

Topic	Contact Information
Information on becoming a provider or submitting a change of address or ownership	See the agency ProviderOne Resources webpage
Information about payments, denials, claims processing, or agency-contracted managed care organizations	
Electronic billing	
Finding agency documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than agency-contracted managed care	
Information on becoming a diabetes education provider and obtaining an application	Department of Health Heart Disease, Stroke, and Diabetes Prevention Unit PO Box 47855 Olympia, WA 98504 360- 236-3750 Download and complete the reimbursement application from the Department of Health's Diabetes Prevention and Management webpage

Definitions

This list 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.

Authorization – Washington State Health Care Authority's (the agency's) official approval for action taken for, or on behalf of, an eligible Washington Apple Health client. This approval is only valid if the client is eligible on the date of service.

Fee-for-service – The general payment method the agency uses to reimburse providers for covered medical services provided to medical assistance clients when those services are not covered under agency-contracted managed care plans or the Children's Health Insurance Program (CHIP).

FIMC "Fully Integrated Managed Care" – A term used to refer to those designated regions where all Apple Health physical behavioral health benefits are administered by managed care organization.

Health Care Common Procedure Coding System (HCPCS) – A standardized coding system used primarily to identify products, supplies, and services not included in the Current Procedural Terminology (CPT) codes. This includes ambulance services, durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician's office.

Maximum allowable fee – The maximum dollar amount that the agency reimburses a provider for specific services, supplies, and equipment.

Usual and customary fee – The rate that may be billed to the agency for certain services, supplies, or equipment. This rate may not exceed either of the following:

- The usual and customary charge billed to the general public for the same services
- If the general public is not served, the rate normally offered to other contractors for the same services

About the Program

What is the purpose of the Diabetes Education Program?

The purpose of the Diabetes Education Program is to provide medically necessary diabetes education to eligible clients**.** For additional information or more details, contact diabetes@doh.wa.gov or call 360-236-3750.

What providers and settings are eligible for this program?

Physicians, advanced registered nurse practitioners, physician assistants, registered nurses, registered dietitians, pharmacists, clinics, hospitals, and federally qualified health centers (FQHCs) can apply to the Washington State Department of Health (DOH) to become an approved diabetes education provider under this program. Other health professionals who are certified diabetes educators (CDEs) can also apply.

For more information on becoming a diabetes education provider, contact:

Department of Health
Heart Disease, Stroke, and Diabetes Prevention Unit
PO Box 47855
Olympia, WA 98504
360-236-3750

The reimbursement application can be downloaded and completed from the Department of Health's Diabetes Prevention and Management webpage.

Once DOH gives its approval, your National Provider Identifier (NPI) will acknowledge you as an approved diabetes education provider. When billing the agency (HCA) for diabetes education services, use your NPI.

Client Eligibility

Most Apple Health clients are enrolled in an agency-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 the agency'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.

Verifying 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 the agency 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 the agency'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 the agency's Program Benefit Packages and Scope of Services webpage.

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

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org

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 www.wahealthplanfinder.org or call the Customer Support Center.

Clients who want to participate in the Diabetes Education Program must be referred by a licensed primary health care provider.

Are clients enrolled in an agency-contracted managed care organization eligible?

(WAC 182-538-060 , 063 , and 095)

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

All medical services covered under an agency-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

Note: 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.

Note: To prevent billing denials, check the client's eligibility **prior** to scheduling services and at the **time of the service**, and make sure proper authorization or referral is obtained from the agency-contracted MCO, if appropriate. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-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. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

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.

Apple Health – Changes for January 1, 2020

Effective January 1, 2020, the Health Care Authority (HCA) completed the move to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

IMC is implemented in the last three regions of the state:

- **Great Rivers** (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties)
- **Salish** (Clallam, Jefferson, and Kitsap counties)
- **Thurston-Mason** (Mason and Thurston counties)

These last three regions have plan changes, with only Amerigroup, Molina, and United Healthcare remaining. There are changes to the plans available in these last three regions. The only plans that will be in these regions are Amerigroup, Molina and United. If a client is currently enrolled in one of these three health plans, their health plan will not change.

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 agency-contracted managed care plan for physical health services

Some Medicaid clients do not meet he 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. Clients who are not enrolled in an agency-contracted managed care plan are automatically enrolled in a BHSO, with exception of American Indian/Alaskan Native clients. 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 (IMC)

Clients qualified for managed care enrollment and living in integrated managed care (IMC) regions will receive all physical health services, mental health services, and substance use disorder treatment through their agency-contracted managed care organization (MCO).

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

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

If a client does not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's American Indian/Alaska Native webpage.

For more information about the services available under the FFS program, see the agency's Mental Health Services Billing Guide and the Substance Use Disorder Billing Guide.

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

Integrated managed care regions

Clients residing in integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency's Apple Health managed care webpage.

Region	Counties	Effective Date
Great Rivers	Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum	January 1, 2020
Salish	Clallam, Jefferson, Kitsap	January 1, 2020
Thurston-Mason	Thurston, Mason	January 1, 2020
North Sound	Island, San Juan, Skagit, Snohomish, and Whatcom	July 1, 2019
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman	January 1, 2019
King	King	January 1, 2019

Region	Counties	Effective Date
Pierce	Pierce	January 1, 2019
Spokane	Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties	January 1, 2019
North Central	Grant, Chelan, Douglas, and Okanogan	January 1, 2018 January 1, 2019 (Okanogan)
Southwest	Clark, Skamania, and Klickitat	April 2016 January 1, 2019 (Klickitat)

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 the agency'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 the agency's Mental Health Services Billing Guide, under *How do providers identify the correct payer*?

Coverage

What is covered?

The agency covers up to six hours of diabetes education and diabetes management per client, per calendar year.

- You must provide a minimum of 30 minutes of diabetes education/management per billed unit.
- You may:
  - ✓ Bill procedure codes as a single unit, in multiple units, or in combinations for a maximum of six hours (12 units). You may use any combination of the codes to meet the individual needs of the client.
  - ✓ Provide diabetes education in a group or individual setting, or a combination of both, depending on the client's needs.

Note: Additional units of diabetes education beyond these limits may be approved upon request based on medical necessity. For more information, see How can I request a limitation extension (LE)?

What is not covered?

The agency does not cover:

- Services provided by an individual instructor or facility that has not been approved by DOH.
- Services performed by providers that have not been approved to bill Medicaid for diabetes education.
- Services that are an expected part of another program provided to the client (e.g., school-based healthcare services or adult day health services).

How do I receive payment?

For diabetes education services provided in a **professional (non-hospital) setting**, you must:

- Bill either HCPCS code G0108 or G0109 using an electronic professional claim.
- Bill using the main clinic NPI in the Billing Provider NPI field along with the individual practitioner's NPI in the Rendering (Performing) Provider NPI field on an electronic professional claim. The agency will only pay for diabetes education that is billed by an approved diabetes education provider.
- Provide a minimum of 30 minutes of education/management per session.

For services provided in a **hospital outpatient setting,** you must:

- Bill using revenue code 0942.
- Provide a minimum of 30 minutes of education/management per session.

Note: Services provided in the outpatient clinic must be submitted on a professional claim to receive payment. Services provided in the outpatient setting, but not in the clinic, must be submitted on an institutional claim to receive payment.

Note: The agency requires authorized hospital outpatient diabetes education programs to bill with revenue code 0942. Use of HCPCS codes G0108 and G0109 will cause a denial of the claim.

How can I request a limitation extension (LE)?

When clients reach their benefit limit of diabetes education, a provider may request prior authorization for an LE from the agency.

The agency evaluates requests for prior authorization of covered diabetes education that exceed limitations in this billing guide on a case-by-case basis in accordance with WAC 182-501-0169. The provider must justify that the request is medically necessary (as defined in WAC 182-500-0070) for that client.

> **Note:** Requests for an LE must be appropriate according to the client's eligibility or program limitations. Not all eligibility programs cover all services.

The following documentation is required for all LE requests:

- A completed *General Information for Authorization* form (HCA 13-835, see Where can I download agency forms?)
    - ✓ This request form MUST be the first page when you submit your request.
- A completed *Fax/Written Request Basic Information* form (HCA 13-756, see Where can I download agency forms?)**,** all of the documentation listed on this form, and any other medical justification

Fax LE requests to: (866) 668-1214

Coverage Table

Procedure/ Revenue Codes	Short Description	Maximum Allowable Fee
Procedure code G0108*	Diab manage trn per indiv, per session One unit = 30 minutes	Rates Development Fee Schedules
Procedure code G0109*	Diab manage trn ind/group One unit = 30 minutes	
Revenue code 0942*	Diab manage trn per indiv per session or diab manage trn ind/group	

**Procedure codes G0108 and G0109 are for professional (non-hospital) billing, and revenue code 0942 is for outpatient hospital billing.*

Billing

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

What are the general billing requirements?

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

- 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

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency'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.

The following claim instructions relate to the Diabetes Education Program:

Name	Entry
Place of Service	Enter the appropriate **two digit** code as follows: **Code Number** — **To Be Used For** 11 — Office 22 — Outpatient Hospital
Billing Provider	Enter the provider's *Provider NPI* and *Taxonomy Code*.
Rendering (Performing) Provider	Enter the individual practitioner's *Provider NPI* and *Taxonomy Code*.