Diabetes Education Program

Provider Guide

July 1, 2014

Washington State Health Care Authority

About this guide*

This publication takes effect July 1, 2014, and supersedes earlier guides to this program.

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
No change at this time		

How can I get agency provider documents?

To download and print agency provider notices and provider guides, go to the agency's Provider Publications website.

* This publication is a billing instruction.

Table of Contents

Important Contacts

Note: This section contains important contact information relevant to the Diabetes Education program. For more contact information, see the *Resources Available* web page.

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the agency *Resources Available* web page
Finding out about payments, denials, claims processing, or Agency managed care organizations	
Electronic or paper billing	
Finding Agency documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Agency managed care	
Who do I contact for more information on becoming a diabetes education provider and obtaining an application?	Diabetes Prevention and Control Program Department of Health PO Box 47855 111 Israel Rd SE Tumwater, WA 98501 1-253- 395-6758

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the agency *ProviderOne Billing and Resource Guide* for a more complete list of definitions.

Authorization – MPA official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

Fee-for-service – The general payment method MPA uses to reimburse providers for covered medical services provided to medical assistance clients when those services are not covered under MPA's Managed Care plans or State Children's Health Insurance Program (SCHIP).

HCPCS- See **Healthcare Common Procedure Coding System**.

Healthcare Common Procedure Coding System (HCPCS) - Standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

Maximum Allowable Fee – The maximum dollar amount that MPA reimburses a provider for specific services, supplies, and equipment.

Medical Identification Card(s) – See *Services Card*.

Medically Necessary – See WAC 182-500-0005.

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

ProviderOne – the Health Care Authority's (the agency's) primary provider payment processing system.

ProviderOne Client ID- A system-assigned number that uniquely identifies a single client within the ProviderOne system; the number consists of nine numeric characters followed by WA.
For example: 123456789WA.

Services Card – A plastic "swipe" card that the agency issues to each client on a "one-time basis." Providers have the option to acquire and use swipe card technology as one method to access up-to-date client eligibility information.

- The Services Card replaces the paper Medical Assistance ID Card that was mailed to clients on a monthly basis.
- The Services Card will be issued when ProviderOne becomes operational.
- The Services Card displays only the client's name and ProviderOne Client ID number.
- The Services Card does not display the eligibility type, coverage dates, or managed care plans.
- The Services Card does not guarantee eligibility. Providers are responsible to verify client identification and complete an eligibility inquiry.

Transaction Control Number (TCN) - A unique field value that identifies a claim transaction assigned by ProviderOne.

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

- The usual and customary charge billed to the general public for the same services; or

- 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 Health Care Authority's (Agency's) Education Program is to provide medically necessary diabetes education to eligible clients**.**

Provider Qualifications

All physicians, advanced registered nurse practitioners (ARNPs), clinics, hospitals, and Federally Qualified Health Centers (FQHCs) are eligible to apply to be a diabetes education provider. The Diabetes Prevention and Control Program (DPCP) at the Department of Health (DOH) developed the application criteria and will evaluate all applications for this program.

For more information on becoming a diabetes education provider contact:

Diabetes Prevention and Control Program
Department of Health
PO Box 47855
111 Israel Rd SE
Tumwater, WA 98501
1-253-395-6758

Once DOH gives its approval, your NPI provider will be given an identifier that adds you as an approved Diabetic Education provider. When billing the agency, use your NPI.

Here is the link to the lists of hospitals and clinics approved to provide services for Agency clients:
http://www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PatientCareResources/DiabetesManagementResources/DiabetesSelfManagementEducationMedicaid.aspx

Authorization

Note: Please see the agency *ProviderOne Billing and Resource Guide* for more information on requesting authorization.

Client Eligibility

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington 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 Washington Apple Health.** For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's current ProviderOne Billing and Resource Guide.

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

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's Health Care Coverage—Program Benefit Packages and Scope of Service Categories web page.

Note: Patients who are not Washington 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 Managed Care Plan Eligible? [Refer to WAC 182-538-060 and 095 or WAC 182-538-063 for GAU clients]

YES! When verifying eligibility using ProviderOne, if the client is enrolled in an Agency managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their managed care plan by calling the telephone number provided to them.

All medical services covered under a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

- Payment of covered services; and
- Payment of services referred by a provider participating with the plan to an outside provider.

Note: To prevent billing denials, please 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 plan. See the agency *ProviderOne Billing and Resource Guide* for instructions on how to verify a client's eligibility.

Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM provider, this information will be displayed on the Client Benefit Inquiry screen in ProviderOne. These clients must obtain or be referred for services via a PCCM provider. The PCCM provider is responsible for coordination of care just like the PCP would be in a plan setting.

Note: To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper referral is obtained from the PCCM provider. Please see the agency *ProviderOne Billing and Resource Guide* for instructions on how to verify a client's eligibility.

Coverage

What Is Covered?

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

Procedure Code	Brief Description	Maximum Allowable Fee
G0108	Diab manage trn per indiv, per session One unit = 30 minutes	Rates Development Fee Schedules
G0109	Diab manage trn ind/group One unit = 30 minutes	

- 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, and/or in combinations for a maximum of six (6) 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.

Payment

What Does the agency Pay for?

The agency pays for a maximum of six (6) hours of education/diabetes management per client, per calendar year.

What Does the agency NOT Pay for?

The agency does not pay for diabetes education:

- Provided by individual instructors using their NPI alone.
- If those services 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?

To receive payment for diabetes education, the provider must:

- Bill either HCPCS code G0108 or G0109 using the CMS-1500 claim form;
- Bill using the main clinic NPI in box 33 along with the individual practitioner's NPI in box 24J on the CMS-1500 claim form. The agency will only pay for diabetes education that is billed by a clinic.

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the agency *ProviderOne Billing and Resource Guide*. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the agency for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Billing for clients eligible for both Medicare and Medicaid;
- Third-party liability; and
- Record keeping requirements.

Completing the CMS-1500 Claim Form

> **Note:** Refer to the agency *ProviderOne Billing and Resource Guide* for general instructions on completing the CMS-1500 Claim Form.

The following CMS-1500 Claim Form instructions relate to the Diabetes Education Program:

Field No.	Name	Entry
24b.	**Place of Service**	Enter the appropriate **two digit** code as follows: **Code Number** — **To Be Used For** 11 — Office 22 — Outpatient Hospital
24J.	**Rendering Provider ID#**	Enter the individual practitioner's NPI here.
33.	**Physician's, Supplier's Billing Name, Address, Zip Code And Phone #**	Enter the provider's *Name* and *Address* on all claim forms. Enter the main clinic's NPI here.