Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

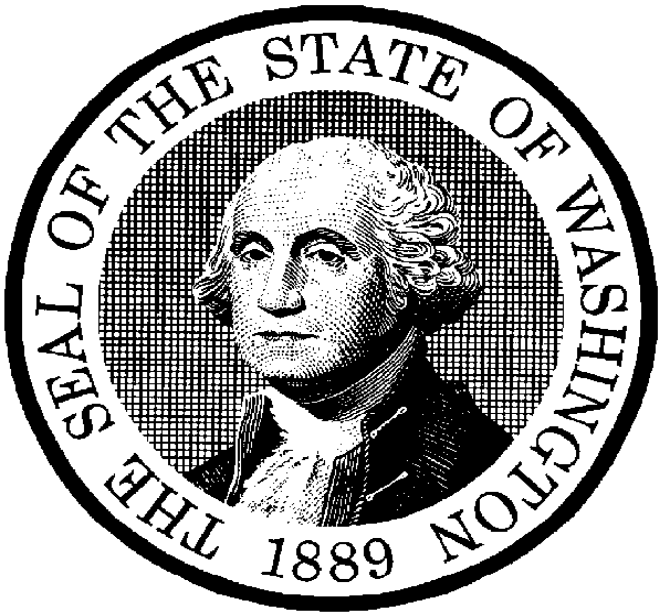
Department of Health

Community & Family Health

and

Department of Social Health Services

Health and Recovery Services Administration



Prenatal Diagnosis Genetic Counseling

Billing Instructions

Copyright Disclosure

About this publication

This publication supersedes all previous HRSA Prenatal Genetic Counseling Billing Instructions and Numbered Memoranda 99-24 and 00-30.

Published by the Health and Recovery Services Administration
Washington State Department of Social and Health Services

Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

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Important Contacts

A provider may use HRSA's toll-free lines for questions regarding its program. However, HRSA's response is based solely on the information provided to HRSA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern HRSA's programs. (WAC 388-502-0020(2)).

How can I use the Internet to…

Find information on becoming a DSHS provider?

Visit Provider Enrollment at
http://maa.dshs.wa.gov/provrel/
Click ***Sign up to be a DSHS WA state Medicaid provider*** and follow the on-screen instructions to find information on becoming a DSHS provider; or

Ask questions about the status of my provider application?

Visit Provider Enrollment at
http://maa.dshs.wa.gov/provrel/

- Click ***Sign up to be a DSHS WA state Medicaid provider***.
- Click ***I want to sign up as a DSHS Washington State Medicaid provider***.
- Click ***What happens once I return my application?*** (on the left side of the screen).

Submit a change of address or ownership?

Visit Provider Enrollment at
http://maa.dshs.wa.gov/provrel/
Click ***I'm already a current Provider*** to submit a change of address or ownership.

If I don't have access to the Internet, how do I find information on becoming a DSHS provider, ask questions about the status of my provider application, or submit a change of address or ownership?

Call Provider Enrollment at:
800.562.3022 (toll free)

or write to:
HRSA Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

Where do I send my claims?

Hard Copy Claims:
Division of Medical Benefits and Care Management
PO Box 9248
Olympia, WA 98507-9248

How do I obtain copies of billing instructions or numbered memoranda?

To view an electronic copy, visit HRSA on the web at http://hrsa.dshs.wa.gov
(click ***Billing Instructions/Numbered Memoranda***)

Who do I contact for information regarding Regional Genetic Counseling clinics in my area?

Call:
Debra Lochner Doyle, MS, CGC
Department of Health
Genetic Counseling Section
253.395.6742

Who do I contact if I have questions regarding…

Payments, denials, general questions regarding claims processing, HRSA managed care organizations?

Visit the Customer Service Center for Providers on the web at:
http://maa.dshs.wa.gov/provrel/ (click ***I'm already a current provider***)

or call/fax:
800.562.3022 (toll free)
360.725.2144 (fax)

or write to:
HRSA Customer Service Center
PO Box 45562
Olympia, WA 98504-5562

Private insurance or third party liability, other than HRSA managed care organizations?

Division of Eligibility and Service Delivery
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
800.562.6136 (toll free)

Assistance with Electronic Billing?

HRSA/HIPAA E-Help Desk
Toll free: 800.562.3022 (Choose option #2, then option #4) or e-mail: hipaae-help@dshs.wa.gov

ACS EDI Gateway, Inc.
Toll free : 800.833.2051 or
http://www.acs-gcro.com/

How do I find out about Internet Billing (Electronic Claims Submission)?

WinASAP and WAMedWeb
http://www.acs-gcro.com/
Select *Medicaid*, then *Washington State*

All other HIPAA transactions
https://wamedweb.acs-inc.com/

To use HIPAA Transactions and/or WinASAP 2003 enroll with ACS EDI Gateway by visiting ACS on the web at: http://www.acs-gcro.com/Medicaid_Accounts/Washington_State_Medicaid/washington_state_medicaid.htm (click on "Enrollment")

Or by calling: 800.833.2051.

Once the provider completes the EDI Provider Enrollment form and faxes or mails it to ACS, ACS will send the provider the web link and the information needed to access the web site. If the provider is already enrolled, but for some reason cannot access the WAMedWeb, then the provider should call ACS at 800. 833.2051.

Where can I view and download rates?

Visit
http://maa.dshs.wa.gov/RBRVS/Index.htm

How do I use the WAMedWeb to check on a client's eligibility status?

If you would like to check client eligibility for free, call ACS at 800.833.2051 or HRSA at 800.562.3022 (option #2)

You may also access the WAMedWeb tutorial at http://fortress.wa.gov/dshs/maa/WaMedWebTutor/

Definitions & Abbreviations

The section defines terms and abbreviations (includes acronyms) used in this booklet.

Agency - A prenatal diagnosis genetic counseling service provider with at least one board certified or board eligible genetic counselor on staff who is supervised by a practicing licensed physician.

American Board of Genetic Counseling (ABGC) - A national organization that certifies genetic counselors. Prior to 1993, the certification of genetic counselors was conducted by the American Board of Medical Genetics (ABMG).

Authorization Number - A nine-digit number, assigned by HRSA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pending, or denied.

Authorization Requirement - In order to obtain authorization for some services and equipment, you must provide proof of medical necessity. Each request must include a complete, detailed description of the diagnosis and/or any disabling conditions, justifying the need for the equipment or the level of service being requested.

Client – An applicant approved for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office(s) (CSO) - An office of the department [of Social and Health Services] which administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement - The basic contract that HRSA holds with providers serving HRSA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Emergency Medical Condition – The sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part. [WAC 388-500-0005]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Genetic Counselor - An individual who:

- Holds a post-baccalaureate degree; and
- Is qualified as a counselor and coordinator of services and resources in the care of persons with genetically caused and predisposed disorders.

Genetic Counselor, Board-certified /Board-eligible - A genetic counselor who has successfully passed the American Board of Medical Genetics (ABMG) general genetic examination as well as the subspecialty examination of genetic counseling (if prior to 1993) OR the American Board of Genetic Counseling examination. A ***board eligible genetic counselor*** has successfully completed an ABGC accredited training program and has been admitted to the next available ABGC certification examination. (held once every 3 years).

Health and Recovery Services Administration (HRSA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Health care providers - Persons licensed or certified by the state of Washington under Title 18 RCW to provide prenatal care or to practice medicine. [WAC 246-680-010]

Health maintenance organization (HMO) – See Managed Care.

Laboratory - A private or public person, agency, or organization performing prenatal tests for congenital and heritable disorders.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by HRSA for specific services, supplies, or equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Identification (ID) card – Medical ID cards are the forms DSHS uses to identify clients of medical programs. Medical ID cards are good only for the dates printed on them. Clients will receive a Medical Identification (ID) card in the mail each month they are eligible.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each HRSA client consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Primary Care Case Management (PCCM) The health care management activities of a provider that contracts with the department to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services [WAC 388-538-050]

Primary Care Provider (PCP) – A person licensed or certified under Title 18 RCW including, but not limited to, a physician and advanced registered nurse practitioner (ARNP), or a physician assistant who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialist and ancillary care, and maintains the client's or enrollee's continuity of care. [WAC 388-538-050]

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Remittance And Status Report (RA) - A report produced by HRSA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a program client.
[WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
[WAC 388-500-0005]

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge that you bill the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

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About the Program

What is the purpose of the Prenatal Diagnosis Genetic Counseling program?

The Prenatal Diagnosis Genetic Counseling program was established to ensure that all Health and Recovery Services Administration (HRSA) clients have access to high quality, comprehensive prenatal genetic health care services. Rapid advances in the field of genetics may outpace many obstetrical providers' abilities to stay current in standards of genetics practice and/or understand the complex ramifications oftentimes associated with genetic testing. In 1993, the Department of Health (DOH) and the Department of Social & Health Services (DSHS) established the Prenatal Diagnosis Genetic Counseling program to promote the use of genetic counselors. These health care professionals are nationally certified in the field of genetics and can ensure clients receive informed consent, particularly regarding reproductive issues. Funds in the DOH Division of Community & Family Health Genetic Services Section budget are used as the required state match for this reimbursement program for prenatal diagnosis genetic counseling services.

Referrals

Prenatal genetic counseling services are covered fee-for-service. No prior authorization is required. Clients in Medical Assistance fee-for-service and those enrolled in Healthy Options may self-refer or be referred by any provider. Clients in the Primary Care Case Management program must be referred by their Primary Care Case Manager. These services are available to all women/couples during their pregnancy and up to 90 days post-partum.

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Client Eligibility

Who is eligible?

Pregnant clients presenting Medical Identification (ID) Cards with the following identifiers are eligible for prenatal diagnosis genetic counseling during pregnancy and through the end of the month containing the 60th day after the pregnancy ends:

Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP-Children's Health	Children's Health
CNP-SCHIP	Children's Health Insurance Program
CNP-Emergency Medical Only	Categorically Needy Program-Emergency Only
General Assistance-No Out of State Care	ADATSA, ADATSA Medical Only
LCP-MNP	Limited Casualty Program-Medically Needy Program

Who is not eligible?

Pregnant clients presenting Medical ID cards with the following identifiers are not eligible for prenatal diagnosis genetic counseling*****:

Program Identifier	Medical Program
Detox Only	DETOX
MIP-EMER Hospital - No Out of State Care	Medically Indigent Program
Family Planning Only	Family Planning Only
GA-U No Out of State Care	General Assistance - Unemployable
QMB-Medicare Only	Qualified Medicare Beneficiary-Medicare Only

***** These clients, if pregnant, may be eligible for other medical assistance programs that may cover prenatal diagnosis genetic counseling. Please refer pregnant clients to their local Community Services Office to be evaluated for a possible change in their medical assistance eligibility.

Clients enrolled in a Healthy Options managed care plan

Who is eligible for Prenatal Genetic Counseling?

- Fee-for-service (FFS) and Healthy Options (HO) clients may self-refer or be referred by any provider.

- Primary Care Case Management (PCCM) clients must be referred by their Primary Care Case Manager.

- The above clients are eligible for prenatal diagnosis genetic counseling during pregnancy and through the end of the month containing the 60th day after the pregnancy ends. These services may be provided in an office, outpatient, or inpatient hospital setting.

Note: HRSA does not require prior authorization for prenatal genetic counseling services and pays providers through the FFS system.

Prenatal procedures beyond genetic counseling must be requested directly through the client's Primary Care Provider (PCP) or PCCM. For PCCM clients, the referral number is required in field 17A on the 1500 Claim Form. (See *General Billing* for further information.)

On-line Update 11/7/2007: This page was updated on-line only. Providers were given these changes in Numbered Memorandum 06-106. However, due to a publication error, this page was not updated at that time.

Coverage

What is covered?

HRSA pays for:

- One initial prenatal genetic counseling service; **and**
- Two follow-up prenatal genetic counseling services per pregnancy (within an 11-month period).

Note: CPT code 96040 must be billed for **both** the initial visit and the two follow-up visits. When billing HRSA, providers must use ICD-9-CM diagnosis code V26.33 (genetic counseling) to receive payment for prenatal genetic counseling services.

A follow-up visit involves the consultant's re-evaluation of a client for whom he/she previously rendered an opinion or advice.

What is not covered?

HRSA does not cover telephone or email consultations for prenatal diagnosis genetic counseling.

On-line Update 11/7/2007: This page was updated on-line only. Providers were given these changes in Numbered Memorandum 06-106. However, due to a publication error, this page was not updated at that time.

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Provider Requirements

Who is eligible for reimbursement from HRSA to provide prenatal diagnosis genetic counseling?

Only a prenatal diagnosis genetic counseling service provider (referred to as an "agency" in these billing instructions) is eligible for reimbursement from HRSA to provide prenatal diagnosis genetic counseling. The agency must have at least one board-certified/board-eligible genetic counselor on staff who works with, and is supervised by, a practicing physician. The American Board of Genetic Counseling determines board certification/eligibility as of 1993.

What is my responsibility as a prenatal diagnosis genetic counseling provider?

- Agencies must provide prenatal diagnosis genetic counseling services according to policies and guidelines provided in these billing instructions and in the HRSA Core Provider Agreement.

- HRSA requires prenatal genetic counselors to:

  - ✓ Be able to elicit and interpret individual and family histories;
  - ✓ Know medical aspects of problems encountered in genetic service programs;
  - ✓ Know genetic and mathematic principles well enough to understand the limitations, significance, and interpretations of specialized laboratory and clinical procedures and to transmit and interpret genetic information to patients and families;
  - ✓ Be skilled in the interviewing and counseling techniques required to:

    - ➢ Elicit necessary information from the patient or family to reach appropriate conclusions about treatment and needs;
    - ➢ Anticipate areas of difficulty and conflict;
    - ➢ Help the families and individuals recognize and cope with their emotional and psychological needs;
    - ➢ Transmit pertinent information effectively;
    - ➢ Recognize situations that require referral;
    - ✓ Be knowledgeable enough about available health care resources to make appropriate referrals; and
    - ➢ Facilitate community referrals as indicated.

How do I become registered as a service provider?

1. Obtain a Core Provider Agreement from HRSA or DOH Genetic Services Section.

2. Send:

   (a) The completed Core Provider Agreement
   (b) An ABMG/ABGC certification or a letter verifying genetic counselor's eligibility to sit for the upcoming examination; and
   (c) A photocopy of the supervising physician's license to:

   Debra Lochner Doyle, MS, CGC
   Department of Health
   Genetic Services Section
   Creekside 3 at Center Point
   20435 72nd Ave. S. Suite 200
   Kent, WA 98032
   253.395.6742
   email: debra.lochnerdoyle@doh.wa.gov

3. The Genetic Services Section staff will send a copy of approved Provider Agreement forms to HRSA. This will serve as a written request to HRSA for issuing an **HRSA provider number**.

4. Agencies with existing HRSA provider numbers for physician services will be issued a *separate* provider number **specific to prenatal diagnosis genetic counseling services** as provided by a board certified/board eligible genetic counselor.

5. After receiving the genetic counseling provider number, you may bill *retroactively* for services provided in accordance with HRSA policies for clients (up to one year from the date of service). (See page 16 “What is the time limit for billing?”)

Patient Authorization to Disclose Health Care Information

- Agencies must adhere to the Uniform Health Care Information Act (UHCIA), which prohibits agencies from releasing client information without the client's consent. **A valid authorization for disclosure must**:

  - ✓ Identify the nature of the information to be disclosed;
  - ✓ Identify the name, address, and institutional affiliation of the person to whom the information is to be disclosed;
  - ✓ Identify the physician or other health care provider who is to make the disclosure; and
  - ✓ Be in writing and be dated and signed by the patient.

- The expiration date of a valid disclosure authorization may not be more than 90 days in the future. If no date is specified, the authorization expires 90 days after it is signed. Furthermore, a patient may revoke a disclosure authorization at any time, unless it is required for payments to health care providers or other substantial action has been taken in reliance on the authorization.

- The UHCIA also contains provisions regarding patient representatives' access to records, retention and safeguarding patient records by providers, and remedies against providers who do not comply with the UHCIA.

Disclosing Patient Information *without* the Patient's Consent
[RCW 70.02.050]

- A health care provider may disclose health care information about a patient without the patient's authorization to the extent a recipient needs to know the information, if the disclosure is:

  - ✓ To a person who the provider reasonably believes is providing health care to the patient;

  - ✓ To any other person who requires health care information for health care education, or to provide planning, quality assurance, peer review, or administrative, legal, financial, or actuarial services to the health care provider; or for assisting the health care provider in the delivery of health care and the health care provider reasonably believes that the person:

    - ➢ Will not use or disclose the health care information for any other purpose; and
    - ➢ Will take appropriate steps to protect the health care information;

- ✓ To any other health care provider reasonably believed to have previously provided health care to the patient, to the extent necessary to provide health care to the patient, unless the patient has instructed the health care provider in writing not to make the disclosure;

- ✓ To any person if the health care provider reasonably believes that disclosure will avoid or minimize an imminent danger to the health or safety of the patient or any other individual, however there is no obligation under this chapter on the part of the provider to so disclose;

- ✓ Oral, and made to immediate family members of the patient, or any other individual with whom the patient is known to have a close personal relationship, if made in accordance with good medical or other professional practice, unless the patient has instructed the health care provider in writing not to make the disclosure;

- ✓ To a health care provider who is the successor in interest to the health care provider maintaining the health care information;

- ✓ For use in a research project that an institutional review board has determined:

    - ➢ Is of sufficient importance to outweigh the intrusion into the privacy of the patient that would result from the disclosure;
    - ➢ Is impracticable without the use or disclosure of the health care information in individually identifiable form;
    - ➢ Contains reasonable safeguards to protect the information from redisclosure;
    - ➢ Contains reasonable safeguards to protect against identifying, directly or indirectly, any patient in any report of the research project; and
    - ➢ Contains procedures to remove or destroy at the earliest opportunity, consistent with the purposes of the project, information that would enable the patient to be identified, unless an institutional review board authorizes retention of identifying information for purposes of another research project;

- ✓ To a person who obtains information for purposes of an audit, if that person agrees in writing to:

    - ➢ Remove or destroy, at the earliest opportunity consistent with the purpose of the audit, information that would enable the patient to be identified; and
    - ➢ Not to disclose the information further, except to accomplish the audit or report unlawful or improper conduct involving fraud in payment for health care by a health care provider or patient, or other unlawful conduct by the health care provider;

- ✓ To an official of a penal or other custodial institution in which the patient is detained;

- ✓ To provide directory information, unless the patient has instructed the health care provider not to make the disclosure;

- ✓ In the case of a hospital or health care provider to provide, in cases reported by fire, police, sheriff, or other public authority, name, residence, sex, age, occupation, condition, diagnosis, or extent and location of injuries as determined by a physician, and whether the patient was conscious when admitted.

- A health care provider [must] disclose health care information about a patient without the patient's authorization if the disclosure is:

  - ✓ To federal, state, or local public health authorities, to the extent the health care provider is required by law to report health care information; when needed to determine compliance with state or federal licensure, certification or registration rules or laws; or when needed to protect the public health;

  - ✓ To federal, state, or local law enforcement authorities to the extent the health care provider is required by law;

  - ✓ To county coroners and medical examiners for the investigations of deaths;

  - ✓ Pursuant to compulsory process in accordance with RCW 70.02.060.

Notifying Clients of Their Right to Make Their Own Health Care Decisions

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give all adult clients written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

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General Billing

Fee Schedule

You may view HRSA's Prenatal Diagnosis Genetic Counseling Fee Schedule on-line at

http://maa.dshs.wa.gov/RBRVS/Index.html

For a paper copy of the fee schedule:

- **Go to:** http://www.prt.wa.gov/ (Orders filled daily.) Click on General Store. Follow prompts to Store Lobby → Search by Agency → Department of Social and Health Services → Health and Recovery Services Administration → desired issuance; **or**

- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX 360.586.6361/ telephone 360.586.6360. (Orders may take up to 2 weeks to fill.)

Billing Procedures Specific to this Program

- Agencies must bill HRSA on the 1500 Claim Form for services, using a separate prenatal diagnosis genetic counseling provider number assigned by HRSA (See *Important Contacts*).

- Although providers have up to one year to bill to facilitate reconciliation of our account and reimbursement for unused funds, Regional Genetic Clinics with approved Core Provider Agreements ("agencies") are asked to submit billings within 120 days of the date of service.

What is the time limit for billing? [(Refer to WAC 388-502-0150]

HRSA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. HRSA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- ## Initial Claims

  ✓ HRSA requires providers to submit an **initial claim** to HRSA and obtain an ICN within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders HRSA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

Note: If HRSA has recouped a plan's premium, causing the provider to bill HRSA, the time limit is 365 days from the date the plan recouped the payment from the provider.

✓ HRSA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

- DSHS certification of a client for a retroactive[2] period; or
- The provider proves to HRSA's satisfaction that there are other extenuating circumstances.

✓ HRSA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to HRSA's billing limits.

[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) for a covered service received from the client for the period he/she is determined to be medical assistance-eligible, and then bill HRSA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to HRSA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill HRSA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill HRSA.

- **Resubmitted Claims**

  ✓ Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  Note: HRSA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ HRSA does not pay the claim.

What fee should I bill HRSA for eligible clients?

Bill HRSA your usual and customary fee**.**

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

For the client who has chosen to obtain care with a Primary Care Case Manager (PCCM), the identifier in the HMO column will be "PCCM." These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the PCP is in a plan setting. ***Please refer to the client's Medical ID Card for the PCCM***.

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM name in field 17 on the 1500 Claim Form; and
- Enter the seven-digit, HRSA-assigned identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill HRSA, the claim will be denied.

Newborns of Healthy Options clients who are connected with a PCCM are fee-for-service until a PCCM has been chosen. These services must be billed to HRSA.

Note: If you treat a Healthy Options client who has chosen to obtain care with a PCCM and you are not the PCP, or the client was not referred to you by the PCCM/PCP, ***you may not receive payment***. You will need to contact the PCCM/PCP to get a referral.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different from HRSA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as HRSA's, prior to any payment by HRSA.

You must meet HRSA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding HRSA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by HRSA, or if you have reason to believe that HRSA may make an additional payment:

- Submit a completed claim form to HRSA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the HRSA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the Comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on HRSA's website at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 800.562.6136.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- **Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, *for at least six years from the date of service* or more if required by federal or state law or regulation.**

Completing the 1500 Claim Form

Attention! HRSA now accepts the new 1500 Claim Form.

- **On November 1, 2006,** the HRSA began accepting the new 1500 Claim Form (version 08/05).
- **As of April 1, 2007**, HRSA will no longer accept the old HCFA-1500 Claim Form.

Note: HRSA encourages providers to make use of electronic billing options. For information about electronic billing, refer to the *Important Contacts* section.

Refer to HRSA's current *General Information Booklet* for instructions on completing the 1500 Claim Form. You may download this booklet from HRSA's web site at: http://maa.dshs.wa.gov (click ***Billing Instructions/Numbered Memoranda***, ***Accept*** the agreement, and then click ***Billing Instructions***). You may also request a paper copy from the Department of Printing (see Important Contacts section).

Instructions Specific to Prenatal Diagnosis Genetic Counseling Providers

The following 1500 Claim Form instructions relate to Prenatal Diagnosis Genetic Counseling:

Field No.	Name	Field Required	Entry
24B	**Place of Service**	Yes	These are the only appropriate code(s) for Washington State Medical Assistance. **Code** — **To Be Used For** 1 — Inpatient hospital 2 — Enter one of the following 3 — Office

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