Washington Apple Health (Medicaid)

Ambulatory Surgery Centers Billing Guide

April 1, 2018

About this guide*

This publication takes effect April 1, 2018, and supersedes earlier guides to this program.

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> 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
How do providers get paid for implantable devices?	Added information about necessary supplies being included in the CPT code for the procedure and not being billed as a separate CPT code. Items over and above those included with the procedure must be billed with specific CPT/HCPCS code. If a specific appropriate code is not available, use HCPCS code L8699 with prior authorization.	Clarification

How can I get agency provider documents?

To access provider alerts, go to the agency's provider alerts web page.

To access provider documents, go to the agency's provider billing guides and fee schedules web page.

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* This publication is a billing instruction.

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Resources Available

Topic	Resources Information
Request for prior authorization	See the agency's [ProviderOne Resources](#) web page.
Additional information regarding this program	Contact the [Customer Service Center.](#)
Additional Medicaid agency resources	See the agency's [ProviderOne Resources](#) web page.

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 Center for Medicare and Medicaid Services [CMS]) to define services and procedures.

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?

The agency 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.

Authorization requirements, expedited prior authorization (EPA) lists, Centers of Excellence (COE) provider lists, coverage criteria (such as age, diagnostic, Medical Care Services client eligibility), sterilization requirements and forms, and unit limitations may be found in the appropriate program publications.

For example:

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

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.**

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 the agency will not pay for.

Is the client enrolled in an agency-contracted managed care organization (MCO), in a behavioral health organization (BHO), or is the client receiving services through fee-for-service (FFS) Apple Health?

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 web page.

> **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.

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

Yes. For clients enrolled in an agency-contracted managed care organization (MCO), the client's MCO covers services provided at ambulatory surgery centers 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.

> **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.

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.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health services (mental health and substance use disorder) for eight of the Regional Service Areas (RSAs) in the state. The remaining regions have fully integrated managed care (FIMC).

See the agency's Mental Health Services Billing Guide for details.

Fully Integrated Managed Care (FIMC)

For clients who live in an FIMC region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted MCO. The BHO will not provide behavioral health services in these counties.

Clients living in an FIMC region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

> **Effective July 1, 2017, American Indian/Alaska Native (AI/AN)** clients living in an FIMC region of Washington may choose to enroll in one of the agency-contracted MCOs available in that region or they may choose to receive all these services through Apple Health FFS. If they do 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 FIMC, see the agency's [Changes to Apple Health managed care webpage](#).

FIMC Regions

Clients who reside in either of the following two FIMC regions and who are eligible for managed care enrollment must choose an available MCO in their region. Specific details, including information about mental health crisis services, can be found on the agency's [Apple Health managed care webpage](#).

> **North Central Region – Douglas, Chelan and Grant Counties**
> **Effective January 1, 2018,** the agency will implement the second FIMC region known as the North Central Region, which includes Douglas, Chelan, and Grant Counties.
>
> **Southwest Washington Region – Clark and Skamania Counties**
> **Effective April 1, 2016,** the agency implemented the first FIMC region known as the Southwest Washington Region, which includes Clark and Skamania Counties. Clients eligible for managed care enrollment choose to enroll in one of two available MCOs in this region.

Apple Health Foster Care (AHFC)

Coordinated Care of Washington (CCW) provides all physical health care (medical) benefits, lower-intensity outpatient mental health benefits and care coordination for all Washington State foster care enrollees through a single, statewide managed care plan known as Apple Health Core Connections (AHCC).

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.**"

See the agency's [Apple Health managed care page](#), Apple Health Foster Care for further details.

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 the agency's rules and this Medicaid billing guide.

- When the provider does not properly request authorization, the agency returns the request to the provider for proper completion and resubmission. The agency 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 the agency. (See Resources Available).

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

What are the specific authorization requirements for surgical procedures?
[Refer to WAC 182-531-1700]

Surgical procedures requiring a medical necessity review by the agency

To implement the prior authorization requirement for selected surgical procedures (including hysterectomies and other surgeries of the uterus), the agency 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 Qualis Health

The agency and Qualis 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

Qualis Health conducts the review of the request to establish medical necessity for surgeries, but does not issue authorizations. Qualis Health forwards its recommendations to the agency. The agency 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 [Qualis Health](#).

For more information about the requirements for submitting medical necessity reviews for authorization please refer to the agency'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 the agency'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, the agency reimburses either:

- The lesser of the billed amount

  -or-

- Up to 100 percent of the agency'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 the agency's maximum allowable

The agency 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?

To receive payment for implantable devices, providers must:

- Use HCPCS procedure code C1713 or L8699 when billing for an implantable device.

- 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 the agency's ASC fee schedule. Claims may be denied without a primary procedure code appearing on the claim.

- Use a HCPCS procedure code (C1713 or L8699) only once per claim. Bill multiple units if appropriate.

- Bill the agency the acquisition cost (AC). AC means the cost of an item excluding shipping, handling, and any applicable taxes as indicated by a manufacturer's invoice (See WAC 182-550-1050.)

If the implantable device is a necessary supply, not an "over and above" supply, CPT considers it inclusive to the procedure code billed, and the agency will not reimburse separately. For example, in order 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. If a specific appropriate code is not available, you may bill using HCPCS code L8699 with prior authorization.

How do providers get paid for corneal tissue?

Effective for claims with dates of service on and after January 1, 2016, the agency 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.

The agency 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 the agency'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).

Billing

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Effective for claims billed on and after October 1, 2016
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.

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What are the general billing requirements?

Providers must follow the Medicaid agency'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

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 web page, 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) web page.

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 agency-designated taxonomy and the ASC modifier.