Washington Apple Health (Medicaid)

Ambulatory Surgery Centers Billing Guide

October 1, 2016

About this guide

This publication takes effect October 1, 2016, 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
Billing	Effective October 1, 2016, all claims must be filed electronically. See blue box notification.	Policy change to improve efficiency in processing claims

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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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Important Changes to Apple Health Effective April 1, 2016

These changes are important to all providers because they may affect who will pay for services.

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client's Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. See the Southwest Washington Provider Fact Sheet on the agency's [Early Adopter Region Resources](#) web page.

New MCO enrollment policy – earlier enrollment

Beginning April 1, 2016, Washington Apple Health (Medicaid) implemented a new managed care enrollment policy placing clients into an agency-contracted MCO **the same month** they are determined eligible for managed care as a new or renewing client. This policy eliminates a person being placed temporarily in fee-for-service while they are waiting to be enrolled in an MCO or reconnected with a prior MCO.

- **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.

Clients currently in fee-for-service or currently enrolled in an MCO are not affected by this change. Clients in fee-for-service who have a change in the program they are eligible for may be enrolled into Apple Health Managed Care depending on the program. In those cases, this enrollment policy will apply.

How does this policy affect providers?

- 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 new policies.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs will replace the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the Mental Health Services Billing Guide. BHOs use the Access to Care Standards (ACS) for mental health conditions and American Society of Addiction Medicine (ASAM) criteria for SUD conditions to determine client's appropriateness for this level of care.

Fully Integrated Managed Care (FIMC)

Clark and Skamania Counties, also known as SW WA region, is the first region in Washington State to implement the FIMC system. This means that physical health services, all levels of mental health services, and drug and alcohol treatment are coordinated through one managed care plan. Neither the RSN nor the BHO will provide behavioral health services in these counties.

Clients must choose to enroll in either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW). If they do not choose, they are auto-enrolled into one of the two plans. Each plan is responsible for providing integrated services that include inpatient and outpatient behavioral health services, including all SUD services, inpatient mental health and all levels of outpatient mental health services, as well as providing its own provider credentialing, prior authorization requirements and billing requirements.

Beacon Health Options provides mental health crisis services to the entire population in Southwest Washington. This includes inpatient mental health services that fall under the Involuntary Treatment Act for individuals who are not eligible for or enrolled in Medicaid, and short-term substance use disorder (SUD) crisis services in the SW WA region. Within their available funding, Beacon has the discretion to provide outpatient or voluntary inpatient mental health services for individuals who are not eligible for Medicaid. Beacon Health Options is also

responsible for managing voluntary psychiatric inpatient hospital admissions for non-Medicaid clients.

In the SW WA region some clients are not enrolled in CHPW or Molina for FIMC, but will remain in Apple Health fee-for-service managed by the agency. These clients include:

- Dual eligible – Medicare/Medicaid
- American Indian/Alaska Native (AI/AN)
- Medically needy
- Clients who have met their spenddown
- Noncitizen pregnant women
- Individuals in Institutions for Mental Diseases (IMD)
- Long-term care residents who are currently in fee-for-service
- Clients who have coverage with another carrier

Since there is no BHO (RSN) in these counties, Medicaid fee-for-service clients receive complex behavioral health services through the Behavioral Health Services Only (BHSO) program managed by MHW and CHPW in SW WA region. These clients choose from CHPW or MHW for behavioral health services offered with the BHSO or will be auto-enrolled into one of the two plans. A BHSO fact sheet is available online.

Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18th birthday

American Indian/Alaska Native (AI/AN) children will **not** be auto-enrolled, but may opt into CCW. All other eligible clients will be auto-enrolled.

AHCC complex mental health and substance use disorder services

AHCC clients who **live in** Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will use the BHO Access to Care Standards

to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.

AHCC clients who **live outside** Skamania or Clark County will receive complex mental health and substance use disorder services from the BHO and managed by DSHS.

Contact Information for Southwest Washington

Beginning on April 1, 2016, there will not be an RSN/BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to an individual who is not eligible for or enrolled in Medicaid.

If a provider does not know which MCO a client is enrolled in, this information can located by looking up the patient assignment in ProviderOne.

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

MOLINA HEALTHCARE	Molina Healthcare of Washington, Inc. 1-800-869-7165
COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009
Beacon Health Options	Beacon Health Options 1-855-228-6502

Resources Available

Topic	Resources Information
Request for prior authorization	See the agency's <u>ProviderOne Resources</u> web page.
Additional information regarding this program	Contact the <u>Customer Service Center.</u>
Additional Medicaid agency resources	See the agency's <u>ProviderOne Resources</u> web page.

Definitions

This section defines terms and abbreviations, including acronyms, used in these billing instructions.

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/Healthcare Professional Services Billing Guide

Client Eligibility

Who is eligible?

Please see the agency ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

> **Note:** Refer to the agency's Program Benefit Packages and Scope of Services web page for a current listing of Benefit Packages.

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

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.

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.

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/Healthcare 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
- Upper and lower extremities
- Carpal tunnel release
- 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.

For more information about the requirements for submitting medical necessity reviews for authorization please refer to the agency's current Physician-Related Services/Healthcare 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.)

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/Healthcare 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.
This billing guide still contains information about billing paper claims.
This information will be updated effective January 1, 2017.

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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 is the CMS-1500 Claim form completed?

Instructions on how to bill professional claims and crossover claims electronically can be found on the agency's Billers and Providers web page, under Webinars. See Medical provider workshop. Also, see Appendix I of the agency's ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 claim form (version 02/12).

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

The following CMS-1500 claim form instructions relate to ambulatory surgery centers:

Field No.	Name	Entry
23.	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.
24B.	Place of Service:	Enter 24 (ambulatory surgery center).
24D.	ASC Modifier	Enter SG

Field No.	Name	Entry
33B.	Taxonomy Code	Enter 261QA1903X

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

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