

Washington Apple Health (Medicaid)

Ambulatory Surgery Centers Billing Guide

October 1, 2017

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

About this guide*

This publication takes effect October 1, 2017, 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
<u>Fully Integrated Managed Care (FIMC)</u>	<p>Effective January 1, 2018, the agency is implementing a second FIMC region, the North Central (NC) region, which includes Douglas, Chelan, and Grant Counties.</p> <p>The agency has updated and consolidated the FIMC information in this guide and provided several hyperlinks to the agency's <u>Managed Care webpage</u>, the agency's <u>Integrated physical and behavioral health care webpage</u>, and the agency's <u>Regional resource web page</u>.</p>	<p>Notification of new region moving to fully integrated managed care (FIMC)</p>

* This publication is a billing instruction.

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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Table of Contents

About this guide2
 What has changed?2
 How can I get agency provider documents?3

Resources Available6

Definitions7

Ambulatory Surgery Centers8
 What is the purpose of this program?8
 What is covered?8

Client Eligibility9
 Who is eligible?9
 Are clients enrolled in an agency-contracted managed care organization (MCO) eligible?9
 Effective July 1, 2017, not all Apple Health clients were enrolled in a BHO/FIMC/BHSO10
 Effective January 1, 2017, some fee-for-service clients who have other primary health insurance will be enrolled into managed care10
 Effective April 1, 2016, important changes to Apple Health10
 New MCO enrollment policy – earlier enrollment 11
 How does this policy affect providers? 11
 Behavioral Health Organization (BHO) 11
 Fully Integrated Managed Care (FIMC) 12
 FIMC Regions 12
 Apple Health Core Connections (AHCC) 13
 AHCC complex mental health and substance use disorder services 13
 Contact Information for Southwest Washington 14

Authorization15
 What are the general guidelines for authorization?15
 Prior authorization 15
 What are the specific authorization requirements for surgical procedures?15
 Surgical procedures requiring a medical necessity review by the agency 15
 Surgical procedures requiring a medical necessity review by Qualis Health 16

Payment17
 What is included in the facility payment?17

Alert! This Table of Contents is automated. Click on a page number to go directly to the page.



Ambulatory Surgery Centers

Payment for multiple surgical procedures	17
What is not included in the facility payment?	18
How do providers get paid for implantable devices?.....	18
How do providers get paid for corneal tissue?.....	19
Where is the fee schedule located?	19
Billing	20
What are the general billing requirements?	20
How do I bill claims electronically?	20



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

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.

Effective July 1, 2017, not all Apple Health clients were enrolled in a BHO/FIMC/BHSO

On July 1, 2017, some Apple Health clients were not enrolled in a behavioral health organization (BHO), fully integrated managed care (FIMC), or behavioral health services only (BHSO) program. For these clients, substance use disorder (SUD) services are covered under the fee-for-service (FFS) program.

Effective January 1, 2017, some fee-for-service clients who have other primary health insurance will be enrolled into managed care

On January 1, 2017, the agency enrolled some fee-for-service Apple Health clients who have other primary health insurance into an agency-contracted managed care organization (MCO).

This change did not affect all fee-for-service Apple Health clients who have other primary health insurance. The agency continues to cover some clients under the fee-for-service Apple Health program, such as dual-eligible clients whose primary insurance is Medicare.

For additional information, see the agency's [Managed Care web page](#), under Providers and Billers.

Effective April 1, 2016, important changes to Apple Health

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 agency's [Regional 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 replaced 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)

For clients who live in a fully integrated managed care (FIMC) region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted managed care organization (MCO). The Behavioral Health Organization (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 must 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 fee-for-service (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 behavior health services. 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, including which clients residing in an FIMC region are not enrolled with an MCO and information on complex behavioral health services for foster children in an FIMC region, see the agency's [Managed Care web page](#), the agency's [Integrated physical and behavioral health care web page](#), and the agency's [Regional resource web page](#).

FIMC Regions

North Central Region (NC) – Douglas, Chelan and Grant Counties

Effective January 1, 2018, the agency will implement the second FIMC region known as the NC region which includes Douglas, Chelan, and Grant Counties. Clients eligible for managed care enrollment will choose to enroll in an available MCO in their region. Specific details, including information about mental health crisis services can be found on the agency's [Managed Care web page](#), the agency's [Integrated physical and behavioral health care web page](#), and the agency's [Regional resource web page](#).

Southwest Washington Region (SW WA) – Clark and Skamania Counties

Effective April 1, 2016, the agency implemented the first FIMC region known as the SW WA 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: Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW).

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 automatically 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 is not a 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 be 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
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 COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009
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Beacon Health Options	Beacon Health Options 1-855-228-6502
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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](#).)

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

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](#).

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.

Ambulatory Surgery Centers

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.