


Washington Apple Health (Medicaid)

Hospital-Based Inpatient Detoxification Billing Guide

July 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 July 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>Client Eligibility</u>	Effective July 1, 2017, not all Apple Health clients will be enrolled in a BHO/FIMC/BHSO	Policy Update
	Effective July 1, 2017, AI/AN clients living in the FIMC regions have a change to services available	

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* This publication is a billing instruction.

Table of Contents

About this guide	2
What has changed?	2
Resources Available	5
Definitions.....	6
About the Program	7
What is the purpose of the Hospital-Based Inpatient Detoxification program?	7
Client Eligibility	8
How can I verify a client’s eligibility?	8
Are clients enrolled in an agency managed care plan eligible?	9
Effective July 1, 2017, not all Apple Health clients will be enrolled in a BHO/FIMC/BHSO	9
Effective July 1, 2017, changes to services available to AI/AN clients living in the FIMC regions	9
Effective January 1, 2017, some fee-for-service clients who have other primary health insurance were enrolled into managed care	10
Effective April 1, 2016, important changes to Apple Health	10
New MCO enrollment policy – earlier enrollment	10
How does this policy affect providers?.....	11
Behavioral Health Organization (BHO)	11
Fully Integrated Managed Care (FIMC).....	11
Apple Health Core Connections (AHCC).....	12
AHCC complex mental health and substance use disorder services	12
Contact Information for Southwest Washington	13
Coverage	14
What services does the agency cover?.....	14
Alcohol and drug detoxification	14
Alcohol and drug detoxification for clients detained or involuntarily committed.....	15
Authorization.....	16
Payment	17
For which services does the agency pay?	17
Billing	18
What are the general billing requirements?	18
How do hospitals bill?	18
How do physicians bill?.....	19

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

Hospital-Based Inpatient Detoxification

How do I bill for services provided to clients with an involuntary commitment for chemical dependency (ITA)?.....	19
How do I bill claims electronically?	19

Resources Available

Note: This section contains important contact information relevant to the Hospital-Based Inpatient Detoxification program. For more contact information, see the agency's [Billers and Providers](#) web page.

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the agency's ProviderOne Resources web page.
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic billing	
Finding agency documents (e.g., billing instructions, fee schedules)	
Private insurance or third-party liability, other than agency managed care	
Contacting DBHR or submitting claims for Involuntary Treatment Act (ITA) extended detoxification	Division of Behavioral Health and Recovery PO Box 45330 Olympia, WA 98504 1-877-301-4557

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.

Chemical Dependency - An alcohol or drug addiction, or dependence on alcohol and one or more other psychoactive chemicals.

Detoxification - Care and treatment in a residential or hospital setting of persons intoxicated or incapacitated by alcohol or other drugs during the period in which the person is recovering from the transitory effects of intoxication or withdrawal. Acute detoxification provides medical care and physician supervision; subacute detoxification is non-medical.

Free-Standing Detox Center - A facility that is not attached to a hospital and in which care and treatment is provided to persons who are recovering from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

Intensive Inpatient Treatment-
Nonhospital, DBHR-certified facilities for sub-acute, or detoxified clients, or both, focused on primary chemical dependency services in residential or outpatient settings.

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

Rehabilitation Services - Hospital-based intensive inpatient substance abuse treatment, medical care, and assessment and linkages.

Usual and Customary Fee - The rate that may be billed to the agency for certain services or equipment. This rate may not exceed the following:

- The usual and customary charge that a provider bills the general public for the same services
- If the general public is not served, the rate normally offered to other contractors for the same services

About the Program

What is the purpose of the Hospital-Based Inpatient Detoxification program?

The Hospital-Based Inpatient Detoxification program provides services to clients receiving hospital-based alcohol, or drug detoxification services, or both, in counties where no free-standing detoxification centers are available.

Note: If a provider's facility is certified to treat pregnant women under a chemically using pregnant (CUP) women agreement, the provider must use the agency's [Chemically Using Pregnant \(CUP\) Women](#) billing guide.

Client Eligibility

How can I verify a client's eligibility?

WAC [182-508-0005](#)

Providers must verify that a client has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. Verify the client's eligibility for Washington Apple Health. For detailed instructions on verifying a client's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's current [ProviderOne Billing and Resource Guide](#).

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

Step 2. Verify service coverage under the Washington Apple Health client's benefit package. To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's [Program Benefit Packages and Scope of Services](#) web page.

Note: A person who wishes to apply for Washington Apple Health can do so 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, a person may visit www.wahealthplanfinder.org or call the Customer Support Center.

Are clients enrolled in an agency managed care plan eligible?

WAC [182-538-060](#) and [095](#), or WAC [182-538-063](#) for MCS clients

Yes. Providers can use ProviderOne to easily check if the client is enrolled in a managed care plan. Managed care enrollment will be displayed on the Client Benefit Inquiry Screen. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their managed care plan by calling the telephone number provided to them.

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

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

Note: To prevent billing denials, please check the client's eligibility **before** scheduling services and at the **time of the service** to make sure proper authorization or referral is obtained from the plan. 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 will be enrolled in a BHO/FIMC/BHSO

On July 1, 2017, some Apple Health clients will not be enrolled in a BHO/FIMC/BHSO program. For these clients, SUD services are covered under the fee-for-service (FFS) program.

Effective July 1, 2017, changes to services available to AI/AN clients living in the FIMC regions

Effective July 1, 2017, American Indian/Alaska Native (AI/AN) clients must choose to enroll in one of the managed care plans, either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW) under the FIMC model receiving all physical health services, all levels of mental health services and drug and alcohol treatment coordinated by one managed care plan; or they may choose to receive all these services through Apple Health fee-for-service (FFS). If they do not choose, they will be auto-enrolled into Apple Health FFS for all their health care services.

Effective January 1, 2017, some fee-for-service clients who have other primary health insurance were 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 site, 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 Southwest Washington Provider Fact Sheet on 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 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 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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Coverage

What services does the agency cover?

The agency covers the following hospital-based inpatient detoxification services only when performed in participating, agency-enrolled hospitals:

- Alcohol detoxification
- Drug detoxification
- Alcohol and drug detoxification for clients detained or involuntarily committed

Alcohol and drug detoxification

When billing, providers must use one or more of the diagnosis codes that most closely describes the diagnosis. Providers are required to use the code of *highest specificity* (five digit codes) from ICD *whenever possible and applicable*.

Service	ICD Diagnosis Codes	Policy
Alcohol detoxification	See the agency's Approved Diagnosis Codes by Program web page for Hospital-Based Inpatient Detoxification	Covered for up to three days
Drug detoxification		Covered for up to five days

Note: Submit claims for alcohol or drug detoxification to the agency (see [Resources Available](#)). When submitting claims, follow the billing instructions found in the [Billing](#) section.

Alcohol and drug detoxification for clients detained or involuntarily committed

Service	ICD Diagnosis Codes	Policy
Protective custody, or detention, or both, of persons incapacitated by alcohol or other drugs	Same codes found in Alcohol and Drug Detoxification	<p>RCW 70.96A.120 provides for the protective custody and emergency detention of persons who are found to be incapacitated or gravely disabled by alcohol or other drugs in a public place.</p> <p>Follow the guidelines in Alcohol and Drug Detoxification when providing services to clients who are both of the following:</p> <ul style="list-style-type: none"> • Detained under the protective custody provisions of RCW 70.96A.120; and • Not being judicially committed to further care.
Involuntary commitment for chemical dependency	Same codes found in Alcohol and Drug Detoxification	<p>RCW 70.96A.140 provides for the involuntary commitment (ITA) of persons incapacitated by chemical dependency.</p> <p>When a Petition for Commitment to Chemical Dependency Treatment is filed or a Temporary Order for Treatment is invoked on a client under care in a hospital, there may be a need to hold the client beyond the three- to five-day limitations described in Alcohol and Drug Detoxification.</p> <p>In these situations, the three-day and five-day limitations may be extended up to an additional six days. In this event, DBHR will pay for the following:</p> <ul style="list-style-type: none"> • Up to a maximum of nine days for Alcohol ITA Extended Detoxification • Eleven days for Drug ITA Extended Detoxification

Note: Submit claims for alcohol or drug detoxification to the agency (see [Resources Available](#)). When submitting claims, follow the billing instructions found in the [Billing](#) section.

Authorization

See the agency's [ProviderOne Billing and Resource Guide](#) for more information about requesting authorization.

Payment

For which services does the agency pay?

WAC [182-550-2650](#) (5)

The agency pays for services only when they meet all of the following conditions. The services must be:

- Provided to eligible persons (see [Client Eligibility](#)).
- Directly related to detoxification.
- Performed by a certified detoxification center or by a general hospital that has a contract with the agency to provide detoxification services.

The agency limits payment for detoxification services to one of the following:

- Three days for an acute alcoholic condition
- Five days for acute drug addiction

The agency pays for detoxification services only when notified *within ten days of the date* detoxification began and all eligibility factors are met.

Payment for hospital-based inpatient detoxification services is based on the following:

Hospitals	Per diem. View current per diem rates at Inpatient Hospital Rates
Physicians	Physician-Related/Health Care Professional Services Fee Schedule

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 agency [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 hospitals bill?

When billing for detoxification services, use the following revenue codes **only**:

Revenue Code	Description
126	Room & Board – Semi-Private (Two Beds) Detoxification
136	Room & Board – Semi-Private (Three and Four Beds) Detoxification
156	Room & Board – Ward Detoxification
250	Pharmacy
260	IV Therapy
270	Medical/Surgical Supplies & Devices
300	Laboratory
320	Radiology – Diagnostic
450	Emergency Room
730	EKG/ECG (Electrocardiogram)
740	EEG (Electroencephalogram)

How do physicians bill?

Physicians wishing to bill for detoxification services provided to the agency clients must follow the instructions found in the agency's [Physician-Related/Health Care Professional Services Provider Guide](#).

How do I bill for services provided to clients with an involuntary commitment for chemical dependency (ITA)?

To receive payment, submit both of the following forms in addition to the completed institutional claim:

- A DSHS [13-628](#) billing form with a statement on the form that the services are “ITA Extended Detoxification”
- A copy of the **cover page** from the client's Temporary Order for Treatment or Petition for Commitment to Chemical Dependency Treatment

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.

The following claim instructions relate to hospital-based inpatient detoxification:

Name	Entry
Place of Service	Enter “21”.