

Social Services ProviderOne Billing Supplement for Providers of Medical Nutrition Therapy

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](#).

The purpose of this billing supplement is to assist ProviderOne social services providers to properly bill the Health Care Authority (agency) for services provided to eligible clients.

What procedure codes may I bill the agency?

Bill the agency using the following procedure codes when authorized for a blanket code¹:

Blanket Code	CPT Procedure Code	Short Description
SA890	97802	Medical nutrition, indiv, initial
SA890	97803	Medical nutrition, indiv, subsequent

How do I bill for services?

- 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
- Also, see the agency's [ProviderOne Billing and Resource Guide](#) for general billing information.

¹ A blanket code is a service code the DSHS worker authorizes that is connected to one or more procedure codes (i.e., CPT® or HCPCS). Social service providers may bill the agency using any procedure code connected to the blanket code, up to the maximum amount authorized. Both the blanket code and the maximum amount appear on the authorization letter DSHS sends to the social service provider.

Note: To prevent billing denials, check the client's eligibility for other coverage **before** scheduling services and at the **time of the service**. See the agency's [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility and how to request a limitation extension or exception to rule. Providers must exhaust other coverage before submitting a request for payment to the agency under a social services authorization.

National correct coding initiative

The agency continues to follow the National Correct Coding Initiative (NCCI) policy. The Centers for Medicare and Medicaid Services (CMS) created this policy to promote national correct coding methods. NCCI assists the agency to control improper coding that may lead to inappropriate payment. The agency bases coding policies on the following:

- The American Medical Association's (AMA) CPT® manual
- National and local policies and edits
- Coding guidelines developed by national professional societies
- The analysis and review of standard medical and surgical practices
- Review of current coding practices

Procedure code selection must be consistent with the current CPT guidelines, introduction, and instructions on how to use the CPT coding book. Providers must comply with the coding guidelines that are within each section (e.g., E/M services, radiology, etc.) of the current CPT book.

The agency may perform a post-pay review on any claim to ensure compliance with NCCI. NCCI rules are enforced by the ProviderOne payment system. Visit the [NCCI](#) on the web.

Who do I contact if I have questions?

Visit the Washington Apple Health [Contact Us](#) page for further information about program coverage, how to bill, or who to contact with questions.