Washington State Health Care Authority

Washington Apple Health (Medicaid)

Substance Use Disorder Billing Guide

(Fee-for-Service)

October 1, 2024

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If the broken link is in the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **October 1, 2024,** and supersedes earlier billing guides to this program.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> 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 HCA.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Confidentiality toolkit for providers

The Washington State Confidentiality Toolkit for Providers is a resource for providers required to comply with health care privacy laws.

Where can I download HCA forms?

To download an HCA form, see HCA's Forms & Publications webpage. Type only the form number into the Search box (Example: 13-835).

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* This publication is a billing instruction.

Copyright disclosure

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Who May Provide Substance Use Disorder Treatment Services?	Added link for certified peer counselor information Revised note box for SUD claim billing	Billing clarification
Opioid Treatment Programs (Opiate Substitution Therapy)	• Revised bullets for dose preparation and administration of treatment medication • Removed note box referencing the Physician-Related Services/Health Care Professional Services Billing Guide for reimbursement information	• To align with current policy • Reimbursement for treatment medication has been relocated to this guide; see **Buprenorphine-containing products reimbursement** below.
Buprenorphine-containing products reimbursement	New section with reimbursement information	This section has been relocated from the Physician-Related Services/Health Care Professional Services Billing Guide

Subject	Change	Reason for Change
How to bill for combination therapy	New section that includes a table of reimbursable HCPCS codes	This section has been relocated from the Physician-Related Services/Health Care Professional Services Billing Guide

Washington State Health Care Authority

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Resources Available

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See HCA's Billers and Providers webpage
Finding out about payments, denials, claims processing, or HCA managed care organizations	See HCA's Billers and Providers webpage
Electronic billing	See HCA's Billers and Providers webpage
Finding HCA documents (e.g., Washington Apple Health billing guides and fee schedules)	See HCA's Billers and Providers webpage
Transfer board or devices	See HCA's Billers and Providers webpage
Private insurance or third-party liability, other than HCA managed care	See HCA's Billers and Providers webpage
Questions regarding policy or payment rates	The Division of Behavioral Health and Recovery PO Box 45330 Olympia, WA 98504-5330 360-725-1500 **or** Washington State Health Care Authority Medical Assistance Customer Service Center (MACSC) Contact MACSC 1-800-562-3022

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

HCA-designee – Any entity expressly designated by HCA to act on its behalf.

American Indian/Alaska Native (AI/AN) – A person having origins in any of the original peoples of North America, or people who self-identify as AI/AN when they:

- Apply or re-certify for Medicaid
- Submit a change in Healthplanfinder or through HCA Medicaid Customer Service Center.

Apple Health client without a managed care plan - A person who is not assigned to a managed care plan, but who is still eligible for the Medicaid fee-for-service benefit administered by HCA.

Approved treatment facility - A treatment facility, either public or private, for profit or nonprofit, approved by HCA according to Chapter 246-341 WAC* and RCW 71.05.

American Society of Addiction Medicine (ASAM) - A professional medical society dedicated to increasing access and improving the quality of addiction treatment.

ASAM Criteria - A clinical tool used to systematically evaluate the severity and diagnosis of a person's need for treatment along six dimensions, and then use a fixed combination rule to determine which level of care a substance-using person will respond to with the greatest success. ASAM also includes recommendations regarding substance use disorder (SUD) treatment services.

Assessment - The set of activities conducted on behalf of a new patient, for the purpose of determining eligibility, evaluating treatment needs, and making necessary referrals and completing forms. The assessment includes all practices listed in applicable sections of Chapter 246-341 WAC or its successor. For the purpose of determining eligibility for Chemical Dependency Disposition Alternative (CDDA), the set of activities will include completion of all of the following:

- The Adolescent Drug Abuse Diagnosis (ADAD)
- The *Kiddie* version of the Schedule of Affective Disorders and Schizophrenia (K-SADS)
- American Society of Addiction Medicine (ASAM) questionnaire forms

Case management services – Services provided by a certified substance use disorder professional (SUDP), a substance use disorder trainee (SUDPT), under the clinical supervision of a SUDP to assist people in gaining access to needed medical, social, educational, and other services.

Certified Peer Counselor- (CPC)- A person who: has self-identified as a consumer of behavioral health services; has received specialized training

approved by the Division of Behavioral Health and Recovery (DBHR); has passed the Washington State test, which includes both written and oral components of the training; has been certified by DBHR; has passed a Washington State background check; and is registered as an agency-affiliated counselor with the Department of Health (DOH).

Client - A person receiving substance use disorder treatment services from a DOH-certified agency.

Core provider agreement – An agreement between HCA and eligible providers. HCA reimburses enrolled eligible providers for covered medical services, equipment, and supplies they provide to eligible clients.

Fee-for-service (FFS) – The general payment method HCA or HCA's designee uses to pay for covered medical services provided to clients, except those services covered under HCA's prepaid managed care programs. See WAC 182-500-0035.

Group therapy - Planned therapeutic or counseling activity for a group of two to 16 people. Acupuncture may be included as a group therapy activity if both of the following are met:

- The provision of these services is written into the master treatment plan for the client
- The services are documented in the client case file in the progress notes

Individual therapy - A planned therapeutic or counseling activity provided to an eligible client. Individual therapy includes treatment provided to a family group consisting of a primary client and one or more significant others, or treatment provided to a couple who are partnered. Individual therapy may be provided to a family group without the primary client present or to a client without the family present.

Institution for mental diseases (IMD) - A hospital, nursing facility, or other institution of more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases, including medical attention, nursing care, and related services. An IMD may include inpatient chemical dependency facilities of more than sixteen beds which provide residential treatment for alcohol and substance abuse. See WAC 182-500-0050.

Interim maintenance treatment – Services provided in an opioid treatment program, in conjunction with appropriate medical services, while a patient is awaiting transfer to an opioid treatment program that provides comprehensive maintenance treatment, as defined in 42 C.F.R. 8.12(j).

Maximum allowable - The maximum dollar amount a provider may be reimbursed by HCA for specific services, supplies, or equipment.

Mental health care provider (MHCP): A person working in a behavioral health agency, under the supervision of a mental health professional, who has primary responsibility for implementing an individualized plan for mental health rehabilitation services. A person working as a mental health care provider must be a registered agency affiliated counselor and have a minimum of one year of education or experience in mental health or a related field.

Mental health professional (MHP) – A person who has one of the following credentials:

- Licensed advanced registered nurse practitioner working as a psychiatric advanced registered nurse practitioner
- Certified agency affiliated counselor
- Licensed agency affiliated counselor
- Licensed marriage and family therapist
- Licensed marriage and family therapist associate
- Licensed mental health counselor
- Licensed mental health counselor associate
- Licensed osteopathic physician, working as a psychiatrist
- Licensed physician, working as a psychiatrist
- Licensed physician assistant working under the supervision of a psychiatrist
- Licensed physician, working as a child psychiatrist
- Licensed psychologist
- Licensed registered nurse, working as a psychiatric nurse
- Licensed social worker (advanced, independent clinical, or associate)

Opioid treatment programs (OTP) - Opioid treatment program services include dispensing opioid treatment medication, along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to an individual to alleviate the adverse medical, psychological, or physical effects incident to opioid use disorder as described in **Chapter 246-341 WAC**. See HCA's **Physician-Related Services Billing Guide** for more information about OTP, which includes, but is not limited to how HCA reimburses for buprenorphine/naloxone when administered or dispensed in an OTP.

Residential services - A complete range of services and supports performed in a live-in setting as authorized by HCA.

Pregnant and postpartum women (PPW) assessment - Assessment provided to an eligible woman who is pregnant or postpartum. The postpartum period covers the 60 days after delivery and any remainder of the month in which the 60th day falls.

Provider Entry Portal (PEP) – A web-based portal that allows registration and data submission, as defined by the **Behavioral Health Data System Data Guide**, by non-tribal providers for American Indian/Alaska Native (AI/AN) Medicaid clients not enrolled in managed care.

ProviderOne - HCA's primary provider payment processing system.

ProviderOne Client ID - A system-assigned number that uniquely identifies a single client within the ProviderOne system; the number consists of nine numeric characters followed by "WA."

Secure withdrawal management and stabilization - Care and treatment of a person while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs. The designated crisis responder (DCR) will determine if a person is "gravely disabled or presenting a likelihood of serious harm to self or others due to a substance use disorder." Treatment provided is for people who meet Involuntary Treatment Act (ITA) criteria due to a substance use disorder (**Chapter 71.05 RCW**).

Substance use disorder (SUD) – A cluster of cognitive, behavioral, and physiological symptoms indicating that a person continues using a substance despite significant substance-related problems. The diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substance.

Substance Use Disorder Professional (SUDP) – A person who has met the requirements of **WAC 246-811-030** and is certified to provide SUD services according to **RCW 18.205.030**.

Substance Use Disorder Professional Trainee (SUDPT) – A person working toward the education and experience requirements for certification as a substance use disorder professional, and who has been credentialed as a SUDPT.

Substance use disorder treatment – Behavioral health services provided to an eligible client designed to mitigate or reverse the effects of substance use disorder and restore normal physical and psychological functioning. Substance use disorder treatment is characterized by a combination of drug and alcohol education sessions, individual therapy, group therapy, and related activities provided to clients and their families.

Urinalysis – Analysis of a client's urine sample for the presence of alcohol or controlled substances by a licensed laboratory or a provider who is exempted from licensure by the Department of Health.

Withdrawal management – Care and treatment of a person while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

- Acute – Inpatient program that is medically monitored by nurses with on-call physicians available 24/7 for consultation. They have "standing orders" and available medications to help with withdrawal symptoms.
- Sub-Acute – Residential program that is clinically managed with limited medical coverage by staff and counselors who monitor patients. Generally, any treatment medications are self-administered.

Substance Use Disorder Treatment

Who should use this billing guide?

Providers who deliver Medicaid substance use disorder services to Apple Health clients who are not enrolled in a managed care plan or a behavioral health services only (BHSO) program for:

- Department of Health (DOH)-certified substance use disorder (SUD) providers registered in the Provider Entry Portal (PEP). See the **Contractor and provider resources webpage** for information about registering through PEP.
- Providers who have registered through the PEP for those Apple Health clients not enrolled in a managed care plan.
- Indian health care providers who are certified or approved by the Department of Health (DOH) to treat SUD.
- Federally qualified health centers (FQHCs) rendering services for eligible Apple Health clients.

To correctly bill, providers must use this billing guide, the appropriate fee schedule(s), and their Core Provider Agreement with HCA.

See the **Coverage Table** for appropriate CPT® codes, modifiers, and taxonomies. Room and board charges must also be billed through ProviderOne.

Institution for Mental Diseases (IMD)

Effective for dates of service on and after August 1, 2018, institutions for mental diseases (IMDs) with approval from the Centers for Medicare and Medicaid Services (CMS) for a Section 1115 SUD IMD waiver must bill for services provided to American Indian/Alaska Native (AI/AN) Medicaid clients not enrolled in an integrated managed care plan directly through ProviderOne.

Who should NOT use this billing guide?

Providers billing for a client who has coverage through one of the managed care organizations (MCOs). See **Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?**

> Note: A person who is not eligible for or covered by Medicaid may receive some services through the **Behavioral Health Administrative Services Organization (BH-ASO)**, within its available funding.

Client Eligibility

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO) or behavioral health service organization (BHSO). This means that Apple Health pays a monthly premium to an MCO or BHSO 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 or BHSO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA's **Apple Health managed care web 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.

Who can receive substance use disorder (SUD) treatment services under fee-for-service?

To receive fee-for-service (FFS) substance use disorder (SUD) treatment services, a client must meet all of the following:

- Must not be enrolled in an MCO or BHSO when the services begin.
  - SUD-eligible clients may receive FFS outpatient SUD clinic services when not enrolled in an MCO or BHSO program for claim date of service.
  - SUD-eligible clients may receive FFS SUD overnight treatment services when not enrolled in an MCO or BHSO program on the date of admittance.
- Have Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) diagnosis of substance use disorder, mild, moderate, or severe
- Meet medical necessity criteria as stated in the American Society of Addiction Medicine (ASAM)
- Be age 10 or older (treatment for clients under age 10 must be authorized)

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 HCA will not pay for.

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 HCA'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 deter-mine if the requested service is a covered benefit under the Apple Health client's bene-fit package, see HCA's **Program Benefit Packages and Scope of Services webpage.**

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to **Washington Healthplanfinder** - select the "Apply Now" button. For patients age 65 and older or on Medicare, go to **Washington Connections** – select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Supports (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

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

Yes. Most Apple Health clients are enrolled in one of HCA's contracted managed care organizations (MCO). For these clients, managed care enrollment is displayed on the client benefit inquiry screen in ProviderOne. (Screen Shot)

All medical services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. The MCO is responsible for:

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

> **Note**: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

Managed care enrollment

Most Apple Health clients are enrolled in an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may start their first month of eligibility in the fee-for-service (FFS) program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination. **Exception:** Apple Health Expansion clients are enrolled in managed care and will not start their first month of eligibility in the FFS program. For more information, visit Apple Health Expansion. Providers must check eligibility to determine enrollment for the month of service.

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 HCA's Apply for or renew coverage webpage.

Clients' options to change plans

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account:** Go to Washington healthplanfinder website.
- **Available to all Apple Health clients:**
  - Visit the ProviderOne Client Portal website:
  - Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

For online information, direct clients to HCA's Apple Health Managed Care webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Apple Health clients do not meet the qualifications for managed care enrollment. These clients are eligible for physical health services under the fee-for-service (FFS) program.

In this situation, each managed care organization (MCO) will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in integrated managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO program, with the exception of American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO program, the FFS Medicaid program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care Alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care enrollment plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care's (CC) Apple Health Core Connection Foster Care program receive both medical and behavioral health services from CC.

Clients under this program are:

- Under the age of 18 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**."

The Apple Health Customer Services team can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAS) team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's **Mental Health Services Billing Guide**, under *How do providers identify the correct payer*?

Apple Health Expansion

Individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs and who receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contract health plan. For more information, visit **Apple Health Expansion**.

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) **American Indian/Alaska Native webpage.**

Who May Provide Substance Use Disorder Treatment Services?

Substance use disorder treatment services may be provided by the following practitioners within their scope of practice:

- Certified substance use disorder professionals (SUDP)
- Certified substance use disorder professional trainee (SUDPT) under the supervision of an SUDP
- Licensed advanced registered nurse practitioner
- Licensed marriage and family therapist
- Licensed marriage and family therapist associate
- Licensed mental health counselor
- Licensed mental health counselor associate
- Licensed osteopathic physician
- Licensed osteopathic physician assistant
- Licensed physician
- Licensed physician assistant
- Licensed psychologists
- Licensed social worker (advanced, independent clinical, or associate)

For certified peer support scope of practice and information, see the **Peer Support Services** section.

> **Note:** Do not add individual servicing NPIs to SUD claims. Bill at the clinic level only on an 837P/professional claim.

Who is Eligible for Substance Use Disorder Treatment Services?

Substance use disorder treatment services are available for eligible Apple Health clients who are not enrolled in an integrated managed care plan or a BHSO program and have one of the following recipient aid categories (RACs):

Recipient aid categories (RACs)			
1014-1023	1039*	1046-1049*	1052-1055
1059*	1061*	1065-1074	1083-1084*
1086*	1088-1089*	1091*	1101-1111
1121-1122	1124 & 1126*	1134	1146-1153
1162-1169	1174-1175	1194	1196-1207
1209	1211-1225	1236 & 1269	1274-1281

- RAC codes with * indicate those people who may have a spenddown.
- See HCA's **Provider spenddown step-by-step resource** and HCA's **ProviderOne billing and resource guide** for more information about spenddown.

> **Note:** For authorization requirements and information regarding secure withdrawal management and stabilization for clients enrolled in an integrated managed care plan or behavioral health services only (BHSO), contact the corresponding entity.

Coverage Table

HCA covers the following substance use disorder (SUD) services with the coverage limitations listed in this guide.

When a specific diagnosis cannot be made or is unknown at the time of assessment, the following diagnoses are reimbursable:

- Z71.41- Alcohol abuse counseling and surveillance
- Z71.51- Drug abuse counseling and surveillance

The following combinations of HCPCS or CPT® code, modifier*, and taxonomy may be reimbursed for the SUD program. Claims must be billed in 837P/Professional claim format.

Outpatient SUD Services

HCPCS or CPT® Code	Modifier	Short Description	Service	Taxonomy
H0001	HD	Alcohol and/or drug assess	Substance use disorder assessment, Pregnant and Parenting Women (PPW)	261QR0405X
H0001	HF	Alcohol and/or drug assess	Substance use disorder assessment	261QR0405X

* Modifier	Description
HA	Child/Adolescent Program
HB	Adult Program, non-geriatric
HD	Pregnant and Parenting Women (PPW) Program
HF	Substance Abuse Program
HV	Funded State Addiction Agency
TG	Complex/High tech level of care

HCPCS or CPT® Code	Modifier	Short Description	Service	Taxonomy
H0004	HF	Alcohol and/or drug services	Individual therapy, without family present, per 15 minutes	261QR0405X
H0038	HF	Self-help/peer svc	SUD Peer Services	261QR0405X
H0020	HF	Alcohol and/or drug services	Opiate Substitution Treatment, methadone administration See the **Opioid Treatment Programs (OTP) section** of this guide for more information about Opioid Substitution Treatment.	261QM2800X
T1017	HF	Targeted case management	Case management, each 15 minutes	251B00000X
96164	HF	Health behavior intervention, group, face-to-face; initial 30 minutes	Group/ Face to face	261QR0405X
96165	HF	Health behavior intervention, group, face-to-face; each additional 15 minutes	Group/ Face to face	261QR0405X

HCPCS or CPT® Code	Modifier	Short Description	Service	Taxonomy
96167	HF	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	Family w/ patient present/ face to face	261QR0405X
96168	HF	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes	Family w patient present/ face to face	261QR0405X
96170	HF	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes	Family without patient present, face to face	261QR0405X
96171	HF	Health behavior intervention, family (without the patient present), face-to-face; additional 15 minutes	Family without patient present, face to face	261QR0405X

HCPCS or CPT® Code	Modifier	Short Description	Service	Taxonomy
Residential SUD Services				
H0010	HA	Alcohol and/or drug services	Youth sub-acute withdrawal management	3245S0500X
H0010	HF	Alcohol and/or drug services	Adult sub-acute withdrawal management	324500000X
H0011	HA	Alcohol and/or drug services	Youth acute withdrawal management	3245S0500X
H0011	HF	Alcohol and/or drug services	Adult acute withdrawal management	324500000X
H0018	HA	Alcohol and/or drug services	Youth recovery house	3245S0500X
H0018	HF	Alcohol and/or drug services	Adult recovery house	324500000X
H0018	HV	Alcohol and/or drug services	Adult intensive inpatient residential, w/o room and board, per diem	324500000X
H0019	HA	Alcohol and/or drug services	Youth intensive inpatient residential, w/o room and board, per diem	3245S0500X

HCPCS or CPT® Code	Modifier	Short Description	Service	Taxonomy
H0019	HB	Alcohol and/or drug services	Residential treatment, Pregnant and Parenting Women (PPW) w/Children, w/o room and board, per diem	324500000X
H0019	HD	Alcohol and/or drug services	Residential treatment, Pregnant and Parenting Women (PPW) w/o Children, w/o room and board, per diem	324500000X
H0019	TG	Alcohol and/or drug services	Residential treatment, long term recovery	324500000X
H2036	HA	A/D Tx program, per diem	Youth room and board*	3245S0500X
H2036	HF	A/D Tx program, per diem	Adult Room & Board*	324500000X
H2036	HD	A/D Tx program, per diem	PPW room and board*	324500000X

HCPCS or CPT® Code	Modifier	Short Description	Service	Taxonomy
80305	HF	Drug test prsmv dir opt obs	Drug testing	261QR0405X 324500000X 3245S0500X 261QM2800X Use the corresponding taxonomy with the service being provided
80306	HF	Drug test prsmv instrmnt	Drug testing	261QR0405X 324500000X 3245S0500X 261QM2800X Use the corresponding taxonomy with the service being provided
80307	HF	Drug test prsmv chem anlyzr	Drug testing	261QR0405X 324500000X 3245S0500X 261QM2800X Use the corresponding taxonomy with the service being provided

*Room and board is paid with state-only funds.

Telemedicine

Telemedicine is covered under HCA's Substance Use Disorder program. Refer to HCA's **Provider Billing Guides and Fee Schedules webpage**, under *Telehealth*, for more information on the following:

- Telemedicine policy, under *Telemedicine policy and billing*
- Audio-only procedure code lists, under *Behavioral health audio-only procedure codes*

For COVID PHE telemedicine policies, refer to HCA's **Provider Billing Guides and Fee Schedules webpage**, under *Telehealth* and scroll down to *Clinical policy and billing for COVID-19*.

Problem gambling

Outpatient problem gambling services must be provided by a certified problem gambling counselor. The counselor must work for a Department of Health-certified problem gambling agency that provides outpatient treatment services and meets the criteria and provisions in **WAC 246-341-1200**.

Outpatient treatment services related to gambling disorders must be performed by:

- A licensed practitioner who holds a gambling counselor certification, as defined in state law; or
- A licensed practitioner under the supervision of a certified gambling counselor (WAC 246-341-1200).

Guidance for problem gambling billing:

- The U7 modifier must be used as the primary modifier with the codes when billing for problem gambling services. Problem gambling does not require the HF modifier.
- An assessment must be completed prior to service delivery.
- Services are payable by HCA with the use of appropriate ICD-10 codes (e.g. F63.0, problem gambling and Z72.6, gambling and betting.)

Problem gambling treatment codes

Problem Gambling Code	Modifier*	Taxonomy
H0001	U7	261QR0405X
H0004		
96164		
+ 96165		
96167		
+ 96168		
96170		
+ 96171		

+ Indicates add-on code

* Modifier U7 – M/caid care lev 7 state def

See the Coverage Limitations Table for limitations on these codes.

> **Note:** For newly licensed and certified problem gambling agencies, contact FFSquestions@hca.wa.gov to confirm all information is complete prior to billing.

Coverage Limitations

Covered substance use disorder (SUD) treatment services are subject to the following limitations.

Service	Limitation
Acute Withdrawal Management	Covered once per day, per client
Case Management **T1017**	One unit equals 15 minutes Must be provided by a licensed provider within their scope of practice. See Who May Provide Substance Use Disorder Treatment Services? Providers cannot bill for the following activities: • Outreach • Time spent reviewing file notes • Internal staffing • Writing treatment compliance notes and progress reports to the court • Interactions with probation officers • Court reporting
Individual Therapy **H0004 - Individual therapy, without family present, per 15 minutes**	Individual therapy sessions are payable up to 3 hours per day. Must be provided by a licensed provider within their scope of practice. See Who May Provide Substance Use Disorder Treatment Services?
Group Therapy	Health behavior intervention, Group, face-to-face • 96164 HF – first 30 minutes • 96165 HF – each additional 15 minutes, must be on the same claim as 96164 A Group Therapy session is payable up to 11 units per client, per day (1 unit of 'first 30 minutes' and 10 units of 'each additional 15 minutes')

Service	Limitation
Family Therapy	Health behavior interventions (with the patient present), face-to-face • 96167 HF-First 30 minutes • 96168-HF- each additional 15 minutes, must be on the same claim as 96167 Family therapy sessions are payable up to a maximum of 11 units per client, per day. Health behavior interventions (without the patient present) • 96170- HF first 30 minutes • 96171- HF each additional 15 minutes be on the same claim as 96170 HCA must follow NCCI policy unless a waiver is granted to HCA on certain codes. **Note:** When family members attend an individual session whether in lieu of or along with, the primary client, the session may be claimed only once regardless of the number of family members present.
Peer Support **H0038 HF- Self-help/ peer svc per individual**	One unit equals 15 minutes
Opiate Substitution Treatment	Covered once per day while a client is in treatment See the Opioid Treatment Programs (OTP) section of this guide for more information about Opiate Substitution Treatment.

Service	Limitation
Substance Use Disorder Assessment	Covered once per day, per client, for each new and returning client **Note:** Providers must not bill updates to assessments or treatment plans as separate assessments. This billing guide follows NCCI requirements on codes unless stated in the policy. Service Encounter Reporting Instructions (SERI) are set up with different reporting requirements.
Sub-Acute Withdrawal Management	Covered once per day, per client

When may a behavioral health agency bill for take-home naloxone?

A behavioral health agency may bill separately when an individual receives take-home naloxone from an:

- Inpatient setting upon discharge
- Outpatient clinic

See the Prescription Drug Program Billing Guide for more information.

Opioid Treatment Programs (Opiate Substitution Therapy)

Opioid Treatment Programs (OTP) provide bundled services. Services are consistent with all state and federal requirements and appropriate treatment practices. Bundled services must include, as a minimum, all of the following services:

- Physical evaluation upon admission
- Medical examination within 14 days of admission and annually thereafter
- Initial treatment plan and treatment plan review quarterly, and semi-annually after the first two years of continuous treatment
- Vocational rehabilitation services as needed (may be by referral)
- Dose preparation
- Dose administration and dispensing of methadone medication
    - One dose per day while a client is in treatment. See Coverage Limitations.

  - See the Coverage Table for appropriate CPT® and HCPCS codes
- Withdrawal management if and when needed
- Patient case management
- Individual and/or group counseling
- One session of family planning; 30 minutes of counseling and education per month for pregnant enrollees
- HIV screening, counseling, and testing referral
- Courtesy dosing

Note: Courtesy dosing is a covered service and is billable to HCA. (Charging the client for a covered service may be a violation of your Core Provider Agreement under WAC 182-502-0160).

Note: For interim maintenance treatment of methadone administration (HCPCS code H0020), add secondary modifier TF. If an opioid program service is delivered in an opioid treatment program mobile medication unit, use place of service code 15.

Buprenorphine-containing products reimbursement

HCA reimburses for buprenorphine-containing products in an opioid treatment program (OTP). The OTP must be certified by the Department of Health (DOH)- and the State Opioid Treatment Authority (SOTA). Before billing for this service, the OTP must submit a copy of its DOH certification and NPI number to HCA. Mail or fax documentation to:

Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562
Fax: 360-725-2144

Clients enrolled in an HCA-contracted managed care organization (MCO) must contact their MCO for information regarding their coverage.

How to bill for combination therapy

Providers must bill according to the actual tablet strength dispensed and not the dose given.

Examples:

- If dispensing a 10mg dose as a 1-2mg tablet and a 1-8mg tablet, bill one unit of J0572 and 1 unit of J0574. Do not use HCPCS code J0575.

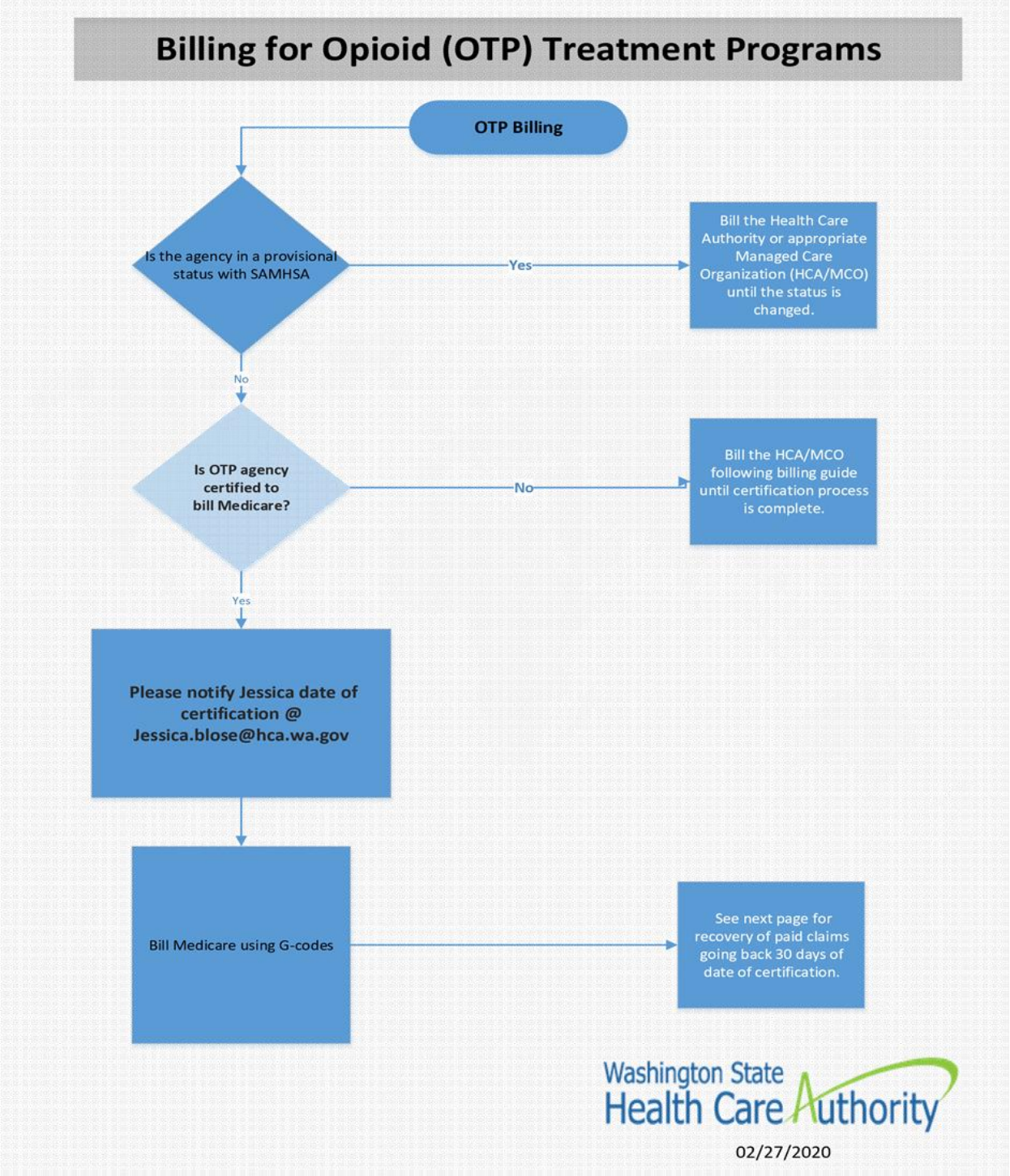
- For a 16mg dose, bill two units of HCPCS code J0574. Use HCPCS code J0575 only when dispensing a tablet strength greater than 10mg.

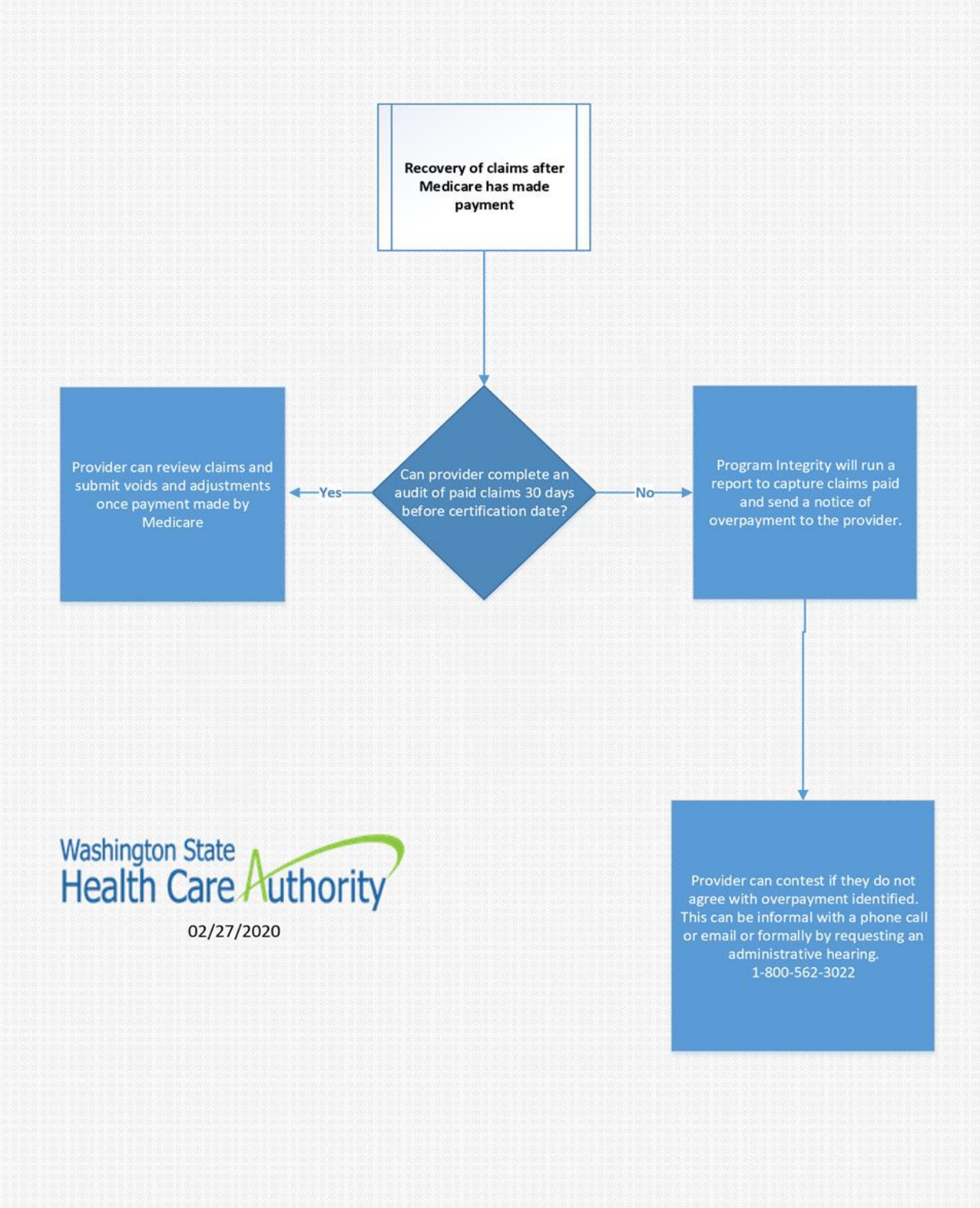
HCA reimburses the following codes:

HCPCS Code	Short Description	Limitation Restricted to ICD Dx and/or Dosing
J0572	Buprenorphine/naloxone	Oral, less than or equal to 3mg buprenorphine
J0573	Buprenorphine/naloxone	Oral, greater than 3mg but less than or equal to 6 mg buprenorphine
J0574	Buprenorphine/naloxone	Oral, greater than 6mg but less than or equal to 10 mg buprenorphine
J0575	Buprenorphine/naloxone	Oral, greater than 10mg buprenorphine

For rates, see the **Professional administered drugs fee schedule.**

Note: HCA considers film to be included as orally administered buprenorphine/naloxone.





Note: OTP Providers who have claims for dually eligible Medicaid/Medicare patients where Medicare paid as primary should utilize the CMS approved and published G-codes when submitting crossover claims to the Managed Care Organization for Medicaid reimbursement."

Drug testing for substance use disorder

For Apple Health clients not enrolled in a managed care plan who are receiving medications for substance use disorder under the fee-for-service medical benefit, medical necessity is outlined in WAC 182-500-0070. For a person receiving treatment from a Department of Health licensed and certified substance use disorder treatment agency, HCA limits reimbursement to medically necessary drug/screens/urinalysis testing. Drug screens must meet medical necessity and be ordered by a physician as part of a medical evaluation.

This guidance does not apply to urinalysis drug screening for people participating in a court ordered or diversion program. Monitoring for the use of drugs for the single purpose of assessing compliance with a court order is not considered part of the medical or behavioral health Medicaid benefit. This guidance is also not applicable to workplace drug testing. For more information, see Apple Health Covered Drug Screen/Urinalysis Testing.

Behavioral health treatment agencies prescribing medication for opioid and other substance use disorders and opioid treatment programs (OTP)*: Immunoassay codes 80305, 80306, and 80307

Test Type	Non-pregnant	Pregnant	Billing
Presumptive, point of care, urine drug tests for drugs of abuse	Up to 24 per 12 months	Up to 18 during pregnancy	Bill the corresponding taxonomy from the coverage table in this guide

Substance use Disorder treatment agencies that do not prescribe medications for SUD* Immunoassay codes 80305, 80306, and 80307

Setting	Frequency	Limitation Extension Request
Withdrawal management (detoxification) programs	One at admission	A confirmatory or more frequent immunoassay testing, (presumptive) may be requested with a limitation extension. Approval will be based on medical necessity and clinical documentation. Bill the corresponding taxonomy from the coverage table in this guide.
Residential (inpatient)	One per month	
Intensive outpatient treatment programs	Four the first month, then two per month	
Outpatient treatment programs	Two per month	

* Drug screens ordered in a credentialed treatment agency must be ordered by a prescribing provider or be necessary to assess suitability for medical tests or treatment. Clinical documentation must meet and support medical necessity criteria.

Occupational therapy services for behavioral health conditions

For information on billing for occupational therapy services, refer to the Outpatient Rehabilitation Billing Guide.

What is a limitation extension (LE)?

A limitation extension (LE) is an authorization of services beyond the designated benefit limit allowed in Washington Administration Code (WAC) and HCA billing guides. Note: A request for an LE must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

How do I request an LE authorization?

Some LE authorizations are obtained by using the EPA process. Refer to the EPA criteria list for criteria. If the EPA process is not applicable, an LE must be requested in writing and receive HCA approval prior to providing the service. The written request must state all the following forms of authorization:

- The name and ProviderOne Client ID of the client

- The provider's name, ProviderOne Client ID, and fax number
- Additional service(s) requested
- The primary diagnosis code and CPT® code
- Client-specific clinical justification for additional services

HCA limits the amount, frequency, or duration of certain services and reimburses up to the stated limit without requiring PA. HCA requires a provider to request PA for a limitation extension (LE) to exceed the stated limits.

See **Resources Available** for the fax number and specific information (including forms) that must accompany the request for LE.

HCA evaluates requests for LE under the provisions of WAC **182-501-0169**.

How do I obtain written authorization?

Send your request to HCA's Authorization Services Office. For more information on requesting authorization, see HCA's **ProviderOne Billing and Resource Guide**.

Billing for case management or intensive case management

Providers must not bill for case management or intensive case management if the client is:

- Pregnant and receiving Maternity Support Services (MSS) or Infant Case Management (ICM) services under HCA's First Steps Program.
- Receiving Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) case management services through the Department of Health (DOH).
- A youth on parole in a non-residential setting and under Department of Children, Youth and Families (DCYF) supervision.
- A youth in foster care through DCYF.
- Receiving case management services through any other funding source from any other agency system (e.g., a person enrolled in Mental Health with a Primary Health Provider).

Billing for case management for the above situations is prohibited because federal financial participation is being collected by HCA or HCA designee, DOH, or DCYF for these clients.

Peer Support Services

The purpose of the Peer Support Services Program is to promote behavioral health recovery to Medicaid clients.

Peer Support Services pairs people in recovery with trained individuals who share their life experiences. Certified peer counselors provide recovery support in a variety of behavioral health settings, including but not limited to community

behavioral health agencies, peer-run agencies, homeless outreach programs, evaluation and treatment programs and hospitals.

To be paid for by HCA, peer support services must:

- Be medically necessary.
- Be ordered in a service plan that must specify the frequency, duration, and expected recovery goals.
- Be provided at locations that are both:
  - Convenient to the client.
  - Within the client's community regional service area.

See Coverage Limitations Table for information on Peer Support Services.

What certification is required for peer support providers?

Peer counselors who provide services must:

- Be grounded in recovery for behavioral health for more than one year before serving as a peer counselor.
- Be willing to share their recovery story with peer support clients.
- Pass a test for reading comprehension and writing composition.
- Receive HCA-approved certified peer counselor training and pass subsequent testing.
- Obtain and maintain an agency-affiliated counselor credential through the Department of Health.

A provider can only bill when providing therapeutic treatment services as indicated in the client's treatment plan under the clinical supervision of a supervisor experienced in recovery and rehabilitation who is either:

- A mental health professional if the peer counselor is providing mental health services.

  OR

- A certified substance use disorder professional if the peer counselor is providing substance use disorder treatment.

Note: See the Coverage Table and Billing sections of this guide for information on billing for peer support services.

Inpatient and withdrawal management SUD facilities: Medication for Opioid Use Disorder

Residential and inpatient licensed SUD behavioral health treatment agencies must:

- Develop policies and procedures to offer Medication for Opioid Use Disorder on-site or facilitate off-site access.
- Ensure services are not denied to clients prescribed any FDA-approved medications to treat all substance use disorders.
- Assure there is enough network capacity that SUD clients receiving or desiring SUD medication can have it prescribed while engaged in any level of American Society of Addiction and Medicine (ASAM) SUD treatment.
- Not mandate titration or limit the total acceptable daily dose or length of time on any prescribed FDA-approved SUD medications. Decisions concerning medication adjustment are based on medical necessity and in coordination with the prescribing provider.
- Allow clients to seek FDA-approved medication for any SUD at any point in their course of treatment. The SUD agency must provide or facilitate the use of any prescribed FDA-approved medications for any SUD.

Withdrawal Management and Stabilization

Withdrawal management (previously referred to as detox) services are provided to help people safely withdraw from the physical effects of psychoactive substances. The need for withdrawal management (WM) services is determined by patient assessment and using the American Society of Addiction Medicine (ASAM) criteria to determine level of care.

There are three levels of withdrawal management facilities recognized in Washington. Assessment of severity, medical complications, and specific drug or alcohol withdrawal risk determines placement within each level of service. All programs are licensed by the Department of Health (DOH) under chapters 246-322, -324 or -337 WAC.

ASAM 3.2-WM – Sub-acute withdrawal management: Clinically managed residential facilities are considered sub-acute detox.

- Limited medical coverage by staff and counselors who monitor patients.
- Generally, any treatment medications are self-administered. DOH regulates both the facility and the program.

ASAM 3.7-WM – Acute withdrawal management: Medically monitored inpatient programs are considered acute detox.

- Medical coverage by nurses with physicians on-call 24/7 for consultation. They have "standing orders" and available medications to help with withdrawal symptoms.
- Licensed as Residential Treatment Facilities (RTF) or qualified behavioral health facilities.
- Required to have formal referral relationships with higher levels of care. DOH regulates both the facility and the program.

ASAM 4.0-WM – Acute hospital withdrawal management: Medically managed Intensive Inpatient services are considered acute hospital detox.

- Have medical services provided 24/7 by registered nurses (RNs) and doctors. There is full access to medical acute care including ICU, if needed. Doctors, nurses, and counselors work as a part of an interdisciplinary team who medically manage the care of the patient.
- Facilities are regulated by DOH and hospital license. This level of care is considered hospital care and not part of the behavioral health benefits provided through BH-ASOs/MCOs. (Fact Sheet: Adult Withdrawal Management (previously detox) Services. Authority: RCW 71.24.520 WAC 246-341-1100, and WAC 246-341-1104.)
- See HCA's **Inpatient Hospital Services Billing Guide** for more information on withdrawal management services.

What is secure withdrawal management and stabilization?

Secure withdrawal management is provided for people who meet Involuntary Treatment Act (ITA) criteria due to a substance use disorder (RCW 71.05). An adult or minor may be committed for involuntary substance use disorder treatment upon petition of a designated crisis responder (DCR) if the person is "gravely disabled or presenting the likelihood of serious harm to self or others due to a substance use disorder."

Secure withdrawal management and stabilization (SWMS) facilities are specifically certified by DOH to provide this ASAM 3.7-WM service (adults under WAC 246-341-1104). Facilities without this specific license certification are unable to provide and/or bill for this service.

Who is eligible to provide and bill for secure withdrawal management and stabilization services?

To be eligible to provide and bill HCA for secure withdrawal management and stabilization services described above, the provider must:

- Be licensed and certified by the Department of Health (DOH) to provide the services;
- Be in good standing without restriction;
- Have a current core provider agreement (CPA) with HCA and national provider identifier (NPI). For more information about completing the CPA, see the **Provider Enrollment webpage** for new providers; and
- Be registered with the provider entry portal (PEP). See the **Contractor and provider resources** webpage.

What authorization is required?

Authorization is not required for Apple Health-eligible clients with the recipient aid categories (RACs) referenced in the **Who is Eligible for Substance Use Disorder Treatment Services?** section.

Billing for secure withdrawal management facilities

When billing for secure withdrawal management for a client who is not enrolled in managed care, facilities must list:

- The appropriate expedited prior authorization (EPA) number;
- Room and board revenue code 1002;
- Taxonomy code 324500000X; and
- In the claim note section, either SCI=I for involuntary admission or SCI=V for voluntary admission.

Services provided in a secure withdrawal management facility must be in APR DRG 740-760, 770, and 772-776 and must include a primary and admitting diagnosis on the claim.

EPA for Secure Withdrawal Management

EPA Number	Criteria
870001652	**Voluntary Admissions for clients without a managed care plan into secure withdrawal management** Use this EPA when the client agrees to admission for treatment for secure withdrawal and management and is without a managed care plan. All of the following must apply: • Must be medically necessary (as defined in WAC 182-500-0070) • Admission with secure withdrawal and management needs as the focus of treatment • Less restrictive placements are not available • Approved (ordered) by the professional in charge of the facility Services must be provided in a secure withdrawal management facility and be in APR DRG 740-760, 770, and 772-776 A new authorization or EPA must be used when there is a change in any of the below: • Legal status • Principal covered diagnosis • Facility

EPA Number	Criteria
870001653	**Involuntary Admission for Apple Health clients without a managed care plan into secure withdrawal management** Use this EPA when the client agrees to admission for treatment for secure withdrawal and management and is not enrolled in a managed care plan. All of the following must apply: • Must be medically necessary (as defined in WAC 182-500-0070) • Admissions with secure withdrawal and management needs as the focus of treatment • Less restrictive placements are not available • Approved (ordered) by the professional in charge of the facility Services must be provided in a secure withdrawal management facility and be in APR DRG 740-760, 770, and 772-776 A new authorization or EPA must be used when there is a change in any of the below: • Legal status • Principal covered diagnosis • Facility

How do I bill for secure withdrawal management and stabilization services?

For dates of service on and after July 1, 2018, submit claims for secure withdrawal management and stabilization services on an electronic institutional claim form (837i) using the following information:

Description	DOH Description	ASAM Level	HCPCS Code	Taxonomy	Rev Code	Authorization	POS	Modifiers	Average Length of Stay	Eligible
837p Billing Professional										
Subacute withdrawal management-clinically managed residential facility	246-341-1100	3.2	H0010	324500000X-Adult 3245S0500X-Youth	N/A	No prior authorization Length of stay is based on medical necessity	55	HF-Adult HA-Youth	2-4 days	
Acute Withdrawal Management – Medically Monitored (non-ITA)	246-341-1100	3.7	H0011	324500000X-Adult 3245S0500X-Youth	N/A	No prior authorization Length of stay is based on medical necessity	55, 56	HF-Adult HA-Youth		

837i Billing Institutional										
Secure Withdrawal Management Medically Monitored (ITA)	246-341-1104	3.7	N/A	324500000X	1002	No prior authorization Length of stay is based on medical necessity.			3-17 days	All people 18 years of age or older in Washington State
Non-secure Withdrawal Management Medically Monitored (Provided in a behavioral health hospital)		3.7	N/A	276400000X	0126	Length of stay is based on medical necessity				Eligible FFS clients

837i Billing Institutional										
Acute Withdrawal Management Medically Managed (Provided in an acute care hospital)		4.0	N/A	282N00000X *Any acute care hospital taxonomy	0120	Length of stay based on medical necessity				

Billing

- All claims must be submitted electronically to HCA, except under limited circumstances.
- For more information about this policy change, see **Paperless Billing at HCA**.
- For providers approved to bill paper claims, see HCA's **Paper Claim Billing Resource.**

What are the general billing requirements?

With the exception of Indian health care providers and Federally Qualified Health Centers (FQHCs) rendering outpatient SUD services, all providers must register through the Provider Entry Portal (PEP) on the **Contractor and provider resources** webpage in order to render SUD services to Apple Health clients.

Providers must follow HCA'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.

What are the recordkeeping requirements specific to substance use disorder (SUD) treatment providers?

- An SUD assessment and history of involvement with alcohol or other drugs
- Initial and updated individual treatment plans, including results of the initial assessment and periodic reviews
- Date, duration, and content of counseling and other treatment sessions
- HCA covers medically necessary SUD services rendered at Department of Health (DOH)-licensed and certified inpatient and residential treatment facilities. These services must be billed for using CPT® and HCPCS codes on a professional claim for or 837P. For secure withdrawal management and stabilization treatment facilities, services must be billed for using revenue codes on an institutional claim or 837i. For more information about coverage,

services, and codes, see HCA's **Contractor and provider resources webpage**. All providers must comply with the documentation requirements in Chapters 246-341 and 246-337 WAC.

- Release of information form signed by the client to share information with HCA
- A copy of the continuing care plan signed and dated by the certified substance use disorder professional (SUDP) and the client
- The discharge summary
- Providers for Apple Health clients without a managed care plan must document services provided to American Indian/Alaska Native (AI/AN) clients. Services must be documented in the Behavioral Health Data System through PEP.
- A residential facility must have an independent assessment*

* In accordance with Washington State's approved 1115 waiver with the Centers for Medicare & Medicaid Services (CMS), residential providers must ensure Medicaid clients have an independent assessment from an outpatient provider. The independent provider will determine whether the client meets the American Society of Addiction Medicine (ASAM) residential level of care.

What if a client has Medicare coverage?

Medicare does not pay for substance use disorder (SUD) treatment services provided in freestanding outpatient treatment centers unless the services are provided by a physician (not just overseen by a physician).

Do not bill Medicare prior to billing HCA or HCA designee for SUD treatment services, with the exception of opioid treatment program services; these services can be billed to Medicare for people with Medicare coverage. Outpatient and residential SUD services rendered by certified substance use disorder professionals (SUDPs) or substance use disorder professional trainees (SUDPTs) may be billed directly to HCA without attaching a Medicare explanation of benefits.

Where can I find substance use disorder fee schedules?

See HCA's **Substance Use Disorder Fee Schedule**.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's Billers and Providers webpage, 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) webpage.

The following claim instructions relate to billing Substance Use Disorder program services on a professional claim form:

Place of service

Place of Service: the following is the only appropriate code(s) entered for Washington State Medicaid for residential services:

Code number	To be used for
05	Indian Health Service free-standing facility
07	Tribal 638 free-standing facility
50	Federally Qualified Health Center (FQHC)
55	Residential Substance Abuse Disorder Treatment Facility

Rendering Provider: Do not add individual servicing NPIs to SUD claims. SUD claims are billed at the clinic level only. This includes both inpatient and outpatient billing.

Outpatient service codes

Place of service codes have been expanded to include all places or service (i.e. clinic, school, home) related to SUDPs providing SUD treatment for outpatient services. Outpatient services must be billed at the licensed and certified behavioral health agency level only. Do not add individual servicing NPIs to SUD claims.