Washington State Health Care Authority

Washington Apple Health (Medicaid)

Ambulatory Surgery Centers Billing Guide

May 1, 2025

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[1]

This publication takes effect **May 1, 2025**, 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 the Washington State Health Care Authority.

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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[1] This publication is a billing instruction.

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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
Resources Available	Added a new row to include a link to the ASC fee schedule	Ease of finding information
Definitions	Added links to WAC reference for definitions for "actual acquisition cost", and "Revised Code of Washington".	Clarification
Ambulatory Surgery Centers	Removed reference to WAC and RCW	Reference to a Department of Health WAC – not necessary
What is the purpose of this program	Removed the word surgical throughout guide	Clarify that procedures performed in ASCs aren't restricted to surgical procedures.
	Added a note box to clarify that CMS requires that ASC facilities be Medicare certified	Clarification on certification requirements

Subject	Change	Reason for Change
What is covered	Removed language "not solely used for cosmetic treatment or surgery"	Unnecessary information
	Removed "Centers of Excellence (COE) provider lists"	There is no COE provider list – unnecessary information
Integrated Apple Health Foster Care (AHFC)	Corrected acronym for Coordinated Care (CCW). Also added Unaccompanied Refugee Minors (URM) program to the list of clients under the AHFC program	Housekeeping and updating the list of clients under the AHFC program
Procedures requiring a medical necessity review by Comagine Health	Removed the categories.	To align with the Physician-Related Services/Health Care Professional Services Billing Guide
	Removed language in note box regarding prior authorization from the PCP.	No longer valid.
What is included in the facility payment	Added language "Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver."	Clarification that laboratory testing is included in the facility payment.
	Added link to the fee schedule.	Ease of finding information.

Subject	Change	Reason for Change
Payment for multiple surgical procedures	Changed language to "The procedure with the highest payment group is considered the primary procedure. The primary procedure is paid at 100% of the maximum allowable or the billed amount, whichever is less. The second procedure is paid at 50% of the maximum allowable or the billed amount, whichever is less. HCA does not make additional reimbursement for more than two surgical procedures."	No policy or payment change. Rewritten for clarification and understanding.
How do providers get paid for implantable devices	Added note box "If multiple procedures are completed during the same episode of care, follow coding guidelines."	Clarification for provider to refer to coding guidelines.
How do I bill claims electronically	Removed the ASC modifier SG from the table.	No longer needed for payment.

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Resources Available

Topic	Resources Information
Request for prior authorization	See HCA's ProviderOne Resources webpage.
Additional information regarding this program	Contact the Customer Service Center.
Additional HCA resources	See HCA's ProviderOne Resources webpage.
ASC Fee Schedule	See HCA's Provider billing guides and fee schedules webpage

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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.

Actual Acquisition Cost (AAC) – See WAC 182-530-1050

Ambulatory Surgery Center (ASC) - Any distinct entity certified by Medicare as an ASC that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

Coinsurance-Medicare – The portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not pay. Under Part A, coinsurance is a per day dollar amount. Under Part B, coinsurance is 20 percent of reasonable charges.

Health Care Financing Administration Common Procedure Coding System (HCPCS) – Coding system established by the Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services [CMS]) to define services and procedures.

Revised Code of Washington (RCW) – See Washington State Laws

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Ambulatory Surgery Centers

What is the purpose of this program?

The purpose of the ambulatory surgery centers (ASC) program is to reimburse providers for the facility costs of procedures that can be performed safely on an ambulatory basis in an ASC.

> **Note**: The Center for Medicare and Medicaid Services (CMS) requires that ASC facilities be Medicare certified.

What is covered?

HCA covers the procedure codes listed in the fee schedule when the procedures are medically necessary. See the **Providers billing guides and fee schedules** webpage for the ASC fee schedule.

The following may be found in the appropriate program publications:

- Authorization requirements
- Coverage criteria (such as age, diagnostic, Medical Care Services client eligibility)
- Expedited prior authorization (EPA) lists
- Sterilization requirements and forms
- Unit limitations

For example:

- **Dental-Related Services Billing Guide**
- **Family Planning Billing Guide**
- **Physician-Related Services/Health Care Professional Services Billing Guide**
- **Sterilization Billing Guide**

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Client Eligibility

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

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 determine if the requested service is a covered benefit under the Apple Health client's benefit 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 1-855-627-9604 (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 Support (HCA 18-005)* form.

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit the **Washington Healthplanfinder's website** or call the Customer Support Center.

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 will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained by the client 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
- Facility fees associated with dental CDT® and CPT® procedures as designated by modifier SG

Note: Site of service prior authorization (PA) for eligible managed care clients will continue to be determined by HCA for facilities associated with dental procedure codes.

HCA continues to pay for the following through fee-for-service (FFS):

- Professional fees for dental procedures using CDT codes
- Professional fees using CPT codes only when the provider's taxonomy starts with 12

See the Dental-Related Services Billing Guide or the Physician-Related Services/Health Care Professional Services Billing Guide for how to bill professional fees.

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 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 MC 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**:
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.
  - 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."

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 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 except

for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into an integrated 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 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 (CCW) Apple Health Core Connections Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 18 who are in foster care (out of home placement) or in the Unaccompanied Refugee Minors program
- 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.

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.

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*?

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**.

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Authorization

What are the general guidelines for authorization?

Authorization requirements are not a denial of service.

When a service requires authorization, the provider must properly request written authorization under HCA's rules and this Medicaid billing guide.

When the provider does not properly request authorization, HCA returns the request to the provider for proper completion and resubmission. HCA does not consider the returned request to be a denial of service.

Prior authorization

When prior authorization (PA) is required for services performed in an ambulatory surgery center (ASC), a provider must send or fax a request for authorization along with medical justification to HCA. (See Resources Available).

> Note: Please see HCA's ProviderOne Billing and Resource Guide for more information on requesting authorization.

What are the specific authorization requirements for procedures?

(See WAC 182-531-1700)

Procedures requiring a medical necessity review by HCA

To implement the prior authorization requirement for selected procedures (including hysterectomies and other surgeries of the uterus), HCA will conduct medical necessity reviews. For details about the prior authorization (PA) requirements for these procedures, refer to either:

- Physician-Related Services/Health Care Professional Services Billing Guide
- Physician-Related/Professional Services Fee Schedule (Select a procedure code and refer to the comments field for the accompanying authorization submittal requirement.)

Procedures requiring a medical necessity review by Comagine Health

HCA and Comagine Health have contracted to provide web-based submittal for utilization review services to establish the medical necessity of selected procedures.

Comagine Health conducts the review of the request to establish medical necessity for procedures but does not issue authorizations. Comagine Health forwards its recommendations to HCA. HCA must authorize any procedures.

Requests initiated electronically require supporting documentation to be included with the electronic submission or faxed per the instructions found at **Comagine Health**.

For more information about the requirements for submitting medical necessity reviews for authorization refer to HCA's current **Physician-Related Services/Health Care Professional Services Billing Guide**.

> **Note**: To prevent billing denials, check the client's eligibility **before** scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained. See HCA's **ProviderOne Billing and Resource Guide** for instructions on how to verify a client's eligibility or see the **client eligibility** section of this guide.

Payment

What is included in the facility payment?

The facility payment (maximum allowable fee) includes all the following:

- The client's use of the facility, including the operating room and recovery room
- Nursing services, technician services, and other related services
- Drugs, biologicals, dressings, supplies, splints, casts, appliances, and equipment related to the care provided
- Diagnostic or therapeutic items and services directly related to the procedure
- Administrative, recordkeeping, and housekeeping items and services
- Materials and supplies for anesthesia
- Any laboratory testing performed under **Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver**.

See HCA's **Provider billing guides and fee schedules** webpage for the ASC fee schedule.

Payment for multiple surgical procedures

For providers performing multiple surgical procedures in a single operative session, HCA reimburses as follows:

- The procedure with the highest payment group is considered the primary procedure.
- The primary procedure is paid at 100% of the maximum allowable or the billed amount, whichever is less.
- The second procedure is paid at 50% of the maximum allowable or the billed amount, whichever is less.
- HCA does not make additional reimbursement for more than two surgical procedures.

To expedite payment of claims, bill all surgeries performed during the same operative session on the same claim. This includes secondary claims with payment by a primary commercial insurance and Medicare crossover claims.

What is not included in the facility payment?

The following services are not included in the facility payment:

- Physicians' professional services
- The sale, lease, or rental of durable medical equipment to clients for use in their homes
- Prosthetic devices (for example, intraocular lens)
- Ambulance or other transportation services

- Leg, arm, back, and neck braces
- Artificial legs, arms, and eyes
- Implantable devices

How do providers get paid for implantable devices?

If the implantable device is a necessary supply, not an "over and above" supply, CPT considers it inclusive to the procedure code billed, and HCA does not reimburse separately. For example, to place the tympanostomy tube, the tube is a necessary supply, not an "over and above" supply. Under CPT, this supply is included in the procedure code billed. In cases where items are over and above those usually included with the procedure, bill using a specific CPT/HCPCS code.

To receive payment for implantable devices, providers must:

- Use an appropriate HCPCS procedure code (must be covered on the HCA ASC fee schedule) when billing for an implantable device.
- If a specific appropriate code is not available, you may bill using HCPCS code L8699 with prior authorization.
- Bill for implantable devices on the same claim as the primary procedure code associated with the device. The primary procedure code must be covered on HCA's ASC fee schedule. Claims may be denied without a primary procedure code appearing on the claim.
- Use a HCPCS procedure code only once per claim. Bill multiple units if appropriate.

> **Note**: If multiple procedures are completed during the same episode of care, follow coding guidelines.

- Bill HCA the acquisition cost (AC) by attaching to the claim the manufacturer's invoice for the implantable device that includes the client's name and date of purchase. AC means the cost of an item excluding shipping, handling, and any applicable taxes as indicated by a manufacturer's invoice (See WAC 182-531-0050).

How do providers get paid for corneal tissue?

Effective for claims with dates of service on and after January 1, 2016, HCA pays for corneal tissue processing (HCPCS procedure code V2785) by acquisition cost (AC). To receive payment, providers must:

- Bill the amount paid to the eye bank for the processed eye tissue.
- Attach the invoice to the claim.

See the Ambulatory Surgery Centers Fee Schedule.

Where is the fee schedule located?

To view or download a fee schedule, see HCA's **online fee schedule**.

The notations in the code status column of the fee schedule are intended to alert providers that there is specific policy, regulation, or criteria related to the use of the code noted. Providers should review the program-specific publications for details (such as, **Dental – Related Services Billing Guide**, **Physician-Related Services/Health Care Professional Services Billing Guide**, and **Family Planning Billing Guide**).

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Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this, 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?

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

Note: **Effective on or after January 1, 2020**, hospital and ASC facility fees for eligible clients enrolled in an HCA-contracted managed care organization must be billed directly through the client's MCO. When PA is required or when using an expedited prior authorization (EPA) number, providers must enter the PA or EPA number on the claim submitted to the MCO.

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.

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

The following claim instructions relate to ambulatory surgery centers:

Name	Entry
Prior Authorization Number	When applicable. If the service you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.
Place of Service	Enter 24 (ambulatory surgery center).
Taxonomy Code	Enter 261QA1903X

To prevent claim denials, you must submit claims with HCA-designated taxonomy.