Washington State Health Care Authority

Washington Apple Health (Medicaid)

Community Health Worker (CHW) Services

October 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, check the most recent version of the guide. If the broken link is in the most recent guide, notify us at askmedicaid@hca.wa.gov.

About this guide*

This new publication takes **effect October 1, 2025**.

The Health Care Authority 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.

Health care privacy toolkit

The Washington Health Care Privacy Toolkit 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
Entire guide	Plain talk and other clarifying changes	To improve clarity and usability
Early periodic screening, diagnosis, and treatment (EPSDT)	Added a new section with information regarding the services available through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit	To provide information about EPSDT services and accessibility
PA requirements for CHW services	Removed section	PA is not required for any of the procedure codes in this guide. This section was included erroneously.

Washington State Health Care Authority

Table of Contents

Resources Available

Topic	Contact
Policy or program questions	• Visit HCA's Community Health Worker webpage • Contact HCA via the Billers, providers, and partners "Contact us" webpage • Contact the Apple Health Clinical Policy Inbox
CHW services being provided through MSS/ICM	See HCA's Maternity Support Services/Infant Case Management Billing Guide
Additional HCA resources	Visit HCA's Billers, providers, and partners webpage or contact the Medical Assistance Customer Service Center (MACSC)

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.

Audio-only telemedicine – The delivery of health care services using audio-only technology, permitting real-time communication between the client at the originating site and the provider, for the purposes of diagnosis, consultation, or treatment.

Auxiliary personnel - Individuals who are supervised by physicians or other billing practitioners, including community health workers (CHWs), that perform complementary services to the professional services of the practitioner. These individuals can be employees, leased employees, or independent contractors of the billing practitioner. For this guide, this covers only CHWs.

Care coordination and health system navigation - Helping clients to do the following:

- Identify providers to receive services
- Make appointments for services, arrange transportation to health care appointments, and attend appointments with clients for health care services
- Find other relevant community resources such as support groups

Client – Refer to WAC 182-500-0020.

Community health integration (CHI) - Personalized and supportive services provided to clients with unmet social determinants of health (SDOH) needs that interfere with, or present a barrier to, the diagnosis, treatment, and self-management of illnesses, diseases, or conditions.

Community health representative (CHR) - Well-trained, medically guided, tribal and Native community people, who provide a variety of health services within American Indian and Alaska Native communities. CHRs are recognized as CHWs for the purposes of CHW services.

Community health worker (CHW) - A frontline public health worker who is a trusted member, or has a close understanding, or both, of the community served. This trusting relationship enables the CHW to provide direct services as well as serve as a liaison, link, or intermediary between health or social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

Community health worker services - A type of preventive health services that does the following:

- Helps prevent disease, disability, and other health conditions or their progression; prolongs life; and promotes physical and mental health and efficiency
- Provides tailored support and system navigation to help address unmet health-related social needs that significantly limit a practitioner's ability to carry out a medically necessary treatment plan

- Provides navigation in the treatment of a serious, high-risk condition or illness. These services help guide the client through their course of care including addressing any unmet social needs that significantly limit the client's ability to engage and follow their plan of care

Current Procedural Terminology (CPT®) – Refer to WAC 182-531-0050.

Face-to-face – Care delivered either in person or via audio-visual technology.

General supervision – The Medicaid-enrolled, licensed practitioner who is responsible for providing guidance, support, and oversight to ensure that CHWs and CHRs are effectively performing their roles, monitoring the course of care, and delivering quality services to the community.

Health education and promotion - Helping clients:

- Contextualize health education provided by the client's treatment team with the client's individual needs, goals, and preferences, in the context of the principal illness and/or SDOH need(s) and educating the client on how to best participate in medical decision making
- Build client self-advocacy skills, so that the client can interact with members of the health care team and related community-based services addressing the principal illness and SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment

Health-related social needs (HRSN) - An individual's unmet, adverse social conditions (e.g., housing instability, homelessness, nutrition insecurity) that contribute to poor health and are a result of underlying social determinants of health (conditions in which people are born, grow, work, and age).

Health care record - See WAC 182-502-0020 for health care record requirements.

Healthcare Common Procedure Coding System (HCPCS) - Refer to WAC 182-531-0050.

In person – The client and the provider are in the same location.

Limitation extension – See WAC 182-501-0169.

Lived experience - Having first-hand knowledge and insight gained from navigating challenges similar to those faced by the people in the community. This can include shared experiences like cultural backgrounds, socioeconomic status, health conditions, or barriers accessing the health and social service systems.

Medically necessary – See WAC 182-500-0070.

Person-centered assessment – An assessment used to understand the client's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs to establish a plan of care.

Preventive services - Services that help prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health efficiency.

Principle illness navigation (PIN) – Personalized and supportive services provided to clients with high-risk conditions and health care navigation needs.

Prior authorization – See WAC 182-500-0085.

Provider – See WAC 182-500-0085.

Supervision - Key aspects of supervision include, but are not limited to, the following:

- Training and professional development
- Performance monitoring
- Support and mentorship
- Problem-solving and conflict resolution

Telemedicine – See WAC 182-501-0300.

Washington apple health - See WAC 182-500-0120.

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 webpage** 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 "Let's get started" 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**: 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 (MCOs). 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 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.

Note: 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, or both, for how to bill professional fees.

Managed care enrollment

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.

Exceptions:

- 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.
- Clients who are eligible to receive Reentry Initiative services and who are eligible for enrollment in an HCA-contracted managed care organization (MCO) will not start their first month of eligibility in the FFS program. 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 the 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 plan 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 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 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:

- Age 17 and younger who are in foster care (out of home placement) or in the Unaccompanied Refugee Minors (URM) program
- Age 20 and younger 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 staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care 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?*

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**.

Early periodic screening, diagnosis, and treatment (EPSDT)

Early periodic screening, diagnosis, and treatment (EPSDT) includes all services that are medically necessary to address health conditions for clients age 20 and younger. Providers may reference program-specific billing guides for services and equipment not covered by this billing guide and must follow the rules for the EPSDT program described in Chapter 182-534 WAC. Published limits for services covered under EPSDT, if any, may be exceeded based on agency review of medical necessity described in WAC 182-501-0165.

Reentry Initiative

The Reentry Demonstration Initiative (Reentry Initiative) is a new Apple Health (Medicaid) initiative under the Medicaid Transformation Project (MTP). Under this initiative, incarcerated people who are Apple Health-eligible may receive a limited set of health care services through fee-for-service (FFS) or their HCA-contracted managed care organization (MCO) for up to 90 days before their release from carceral facilities within Washington State. These services will ensure a person's healthy and successful reentry into their community. For more information, visit Reentry from a carceral setting.

What if a client has third-party liability (TPL)?

If the client has third-party liability (TPL) coverage (excluding Medicare), prior authorization must be obtained before providing any service requiring prior authorization. For more information on TPL, refer to HCA's ProviderOne Billing and Resource Guide.

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Community Health Worker (CHW) Services—General

About the services

Community health workers (CHWs) are frontline public health workers who are trusted members, or have a close understanding, or both, of the community served. This trusting relationship enables CHWs to serve as liaisons, links, or intermediaries between health or social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

Levels of service

CHWs may provide preventive services at any of the following three levels:

- **Primary prevention.** This level focuses on preventing the onset of disease or injury before it occurs by reducing risk factors and promoting healthy behaviors.
- **Secondary prevention.** This level focuses on early detection and prompt intervention to halt the progress of a disease, injury, or event during its initial phase. This includes conducting appropriate screenings and assessments for conditions.
- **Tertiary prevention.** This level focuses on reducing the impact of an ongoing disease or injury and on managing and improving the quality of life for individuals with established diseases or conditions.

Criteria for receiving CHW services

To receive CHW services, eligible Apple Health (Medicaid) clients must be recommended by a physician or other licensed practitioner of the healing arts, as specified in 42 C.F.R. 440.130, following an initiating visit that identifies that the client exhibits **one of the following** criteria:

- An unmet health-related social need (HRSN) that limits the ability to engage in health care services
- A positive adverse childhood experiences (ACEs) screening
- One serious, high-risk condition that places the client at risk of **any of the following**:
  - Hospitalization
  - Institutionalization/out-of-home placement
  - Acute exacerbation or decompensation
  - Functional health decline or death
- Two or more missed health care appointments within the previous six months
- The client, client's spouse, or client's family member expressed a need for support in health system navigation or resource coordination services.

- A need for recommended preventive services
- A condition that requires monitoring or revision of a disease-specific care plan and may require frequent adjustment of the medication or treatment regimen or substantial assistance from a caregiver.

Appeal process

HCA gives clients written notice of an action under chapter 182-518 WAC. Clients have the right to appeal HCA's adverse action according to Chapter 182-526 WAC.

Initiation and recommendation

CHW services must be initiated and recommended by a physician or other licensed practitioner of the healing arts, as specified in 42 C.F.R. 440.130.

During the initiating visit, the health care professional does all the following:

- Identifies that the client exhibits one of the criteria found in WAC 182-562-0200(2)
- Establishes a care plan
- Provides a written recommendation for the client to see a CHW or community health representative (CHR). A written recommendation for services may be provided in physical or electronic form including, but not limited to, electronic health records (EHRs), secure digital forms, or other compliant electronic documentations.

The initiating visit must be personally performed by the licensed practitioner of the healing arts, as specified in 42 C.F.R. 440.130.

Telehealth

Refer to HCA's Provider billing guides and fee schedules webpage, under *Telehealth*, for more information on the following:

- Telemedicine policy, billing, and documentation requirements, under *Telemedicine policy and billing*
- Audio-only procedure code lists, under *Audio-only telemedicine*

Telemedicine limitations for CHW services

Policy area	Applicable HCPCS code	Telemedicine (audio-visual or audio-only) limitations	Examples
First visit requirement	G0019 G0023	The first CHI (HCPCS G0019) or PIN (HCPCS G0023) visit each month with the CHW may be delivered in person or via audio-visual or audio-only telemedicine. Prior authorization is not required.	A client receives CHI services both in person and via telemedicine each month for this visit.
Education	S9446	Service is allowed via audio-video telemedicine only.	A CHW hosts a virtual diabetes education class via Zoom with eight clients. Each client attends by video and signs a confidentiality agreement before the session begins.
Secure telemedicine platforms	G0019 G0022 G0023 G0024 S9446	Only HIPAA-compliant platforms may be used for telemedicine services.	A provider wants to conduct CHI sessions via a nonsecure video call platform. This would violate HIPAA rules.

Community Health Workers (CHW)

Provider requirements

To be paid for providing community health worker (CHW) services to Washington Apple Health clients, a CHW must:

- Deliver the CHW services under the general supervision of a Medicaid-enrolled, licensed practitioner within the scope of their licensure as described in state law
- Have lived experience that aligns with and provides a connection between the CHW and the community being served
- Have 2,000 supervised hours working as a CHW in paid or volunteer positions within the previous three years and demonstrated skills and practical training in the areas listed in this section
- Possess the following **skills or core competencies**:
  - Communication
  - Interpersonal and relationship-building
  - Service coordination and navigation
  - Advocacy
  - Capacity building
  - Professional conduct
  - Outreach
  - Individual and community assessment
  - Knowledge base in public health principles and social determinants of health (SDOH)
  - Education and facilitation
  - Evaluation and research

- Demonstrate minimum qualifications through one of the following:
  - **CHW/Community health representative (CHR) certificate.** A certificate of completion including, but not limited to, any certificate issued by the Washington State Department of Health, or its designee, or by Indian Health Services of a curricula that attests to demonstrated skills or competencies, or both, listed in this section
  - **Supervisor attestation.** Medicaid-enrolled, licensed supervisors may demonstrate the CHW's skills and competencies by conducting a CHW assessment and attesting to the CHW's skills and competencies. The supervising provider must maintain documentation of the CHW assessment. Trainings may also include health-specific topics including, but not limited to:
    - Health coaching and motivational interviewing
    - Immunization across the lifespan
    - Family planning and wellness
    - Cardiovascular health and heart disease
    - Understanding disparities and social determinants
    - Behavioral health care
    - Cancer screening and prevention
    - Conducting food insecurity screening
    - Child development/early relational health
    - Mental health first aid
    - Substance use

What if a CHW does not meet the skills or practical training?

CHWs that do not meet any of the identified skills or practical training areas listed in this section must obtain the necessary training within 18 months of employment during which CHW services may still be billed. Once the 18 months have been completed, if the CHW does not meet the necessary training requirements, HCA will no longer pay for services billed until the training requirements are met.

Continuing education

CHWs must complete a minimum of six hours of additional training annually. The supervising provider must maintain documentation of the CHW's completion of continuing education requirements.

Documentation requirements

CHWs must document the following in the client's health record:

- **Advance client consent.** Consent must be obtained by the licensed, qualified health care professional or CHW before rendering services and billing for CHW/CHR services. Consent may be verbal or in writing.
- The date and time/duration spent with the client and the nature of the activities
- The location of services
- The services performed specifying the following:
  - Whether they were provided to an individual or a group
  - If they were provided to a group, the number of clients in the group
- All identified needs of the client served including, but not limited to, health-related social needs that services are addressing (e.g., the client's diagnosis as defined by the current revision of the International Statistical Classification of Diseases and Related Health Problems)
- The name of the CHW or CHR rendering the services.

Note: Providers must comply with the following when providing behavioral health or substance use disorder services to clients age 13 and older:

- RCW 70.02.240, Mental health services—Minors—Permitted disclosures
- RCW 71.34.500, Self-admission of adolescent for inpatient behavioral health treatment or substance use disorder treatment—Requirements
- RCW 7.70.065(2)(b), Informed consent—Persons authorized to provide for patients who do not have capacity—Priority—Unaccompanied homeless minors

Covered services

Note: Clinics bill using the clinic's NPI.

What services are covered?

HCA covers the following services when performed by a CHW:

- Conducting person-centered assessments within their focus to:
  - Identify personal health goals and preferences
  - Assess for physical, mental, behavioral, and social challenges
  - Collaborate with the client to establish health goals
- Care coordination and health system navigation including the following:
  - Coordinating additional supports or specialty services
  - Managing the client's care plan
  - Assisting the client in identifying and accessing resources
- Facilitating behavior change and client self-advocacy including the following:
  - Promoting client motivation to participate in care and reach person-centered diagnosis or treatment goals
  - Teaching techniques for self-monitoring and self-advocacy
- Health education and promotion including the following:
  - Helping clients to contextualize health education provided by the client's treatment team with the client's individual needs, goals, and preferences, in the context of the principal illness and/or SDOH need(s) and educating the client on how to best participate in medical decision making
  - Building client self-advocacy skills, so that the client can interact with members of the health care team and related community-based services addressing the principal illness and SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment

Community Health Integration (CHI) services

CHI services are services that auxiliary personnel, including CHWs, may perform under general supervision to complement the professional services a physician or other billing practitioner provides. The billing practitioner initiates CHI services during an initiating visit where the practitioner identifies unmet SDOH needs that significantly limit their ability to diagnose or treat the client. The same practitioner bills for the subsequent CHI services provided by the auxiliary personnel.

> **Note**: Only one practitioner may bill per month for a referral to CHI services for any given SDOH or serious high-risk condition. Claims must be submitted using the clinic's NPI.

Initiating visits are personally performed by the practitioner and include the following:

- An evaluation and management (E/M) visit which:
  - Must not be a low-level (level 1) E/M visit performed by clinical staff
  - May be the E/M visit provided as part of transitional care management services
- An annual wellness visit (AWV)

HCA currently makes separate payments under HCA's **Physician-related services/professional health care services fee schedule** for several care management and other services that may include aspects of CHI services. Those care management services focus heavily on clinical, rather than social, aspects of care. CHWs/CHRs may furnish CHI services in addition to other care management services if they:

- Do not count time and effort more than once
- Meet requirements to bill the other care management services
- Perform services that are medically necessary and reasonable

CHW/CHRs must document the client's unmet social needs that CHI services are addressing in the client's health care record. Documenting ICD Z-codes may count as the appropriate documentation.

> **Note:** CHWs/CHRs may perform CHI services face-to-face (in person or via audio-visual technology) or via audio-only telemedicine.

Principle Illness Navigation (PIN) services

A health care practitioner initiates PIN services during an initiating visit where the practitioner addresses the serious, high-risk condition. During this initiating visit, the practitioner establishes the treatment plan, specifies how PIN services are reasonable and medically necessary to help accomplish that plan, and establishes the PIN services as incidental to their professional services. PIN services are billable only by the health care practitioner.

> **Note**: Only one practitioner may bill per month for a referral to PIN services for any given SDOH or serious high-risk condition. Claims must be submitted using the clinic's NPI.

The practitioner personally performs initiating visits including the following:

- An E/M visit, other than a low-level (level 1) E/M visit done by clinical staff
- A Medicare AWV provided by a practitioner who meets the requirements to furnish subsequent PIN services
- A psychiatric diagnostic evaluation (CPT® code 90791) or the Health Behavior Assessment and Intervention (HBAI) services described by CPT® codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168

The CHW/CHR may perform PIN services after the initiating visit.

> **Note:** The CHW/CHR may perform PIN services in person or via audio-visual technology; however, many service elements such as PIN-peer support (PS) may be most impactful when provided in person.

Coverage table

The following HCPCS codes may be used for all the services listed in Covered services.

HCPCS code	Short description	Services covered	Limitations/ Comments	Consent	Claim submission guidelines	Documentation requirements
G0019	Comm hlth intg svs sdoh 60mn	• Person-centered assessment and planning • Care coordination and health system navigation • Facilitating behavior change and client self-advocacy • Health education and promotion	Limited to 60 minutes per calendar month. Services must be provided for a minimum of 60 minutes per calendar month to bill for the primary code. Services may be provided directly and indirectly. Billable once per calendar month.	The licensed practitioner or the auxiliary personnel under supervision must get advance patient consent before furnishing CHI services. Consent may be written or verbal, so long as it is documented in the client's health care record. Additional consent is not necessary unless the practitioner furnishing and billing CHI changes.	Must be billed once per month. All CHI services for the month must include HCPCS code G0019.	Must document the following: • Identified SDOH • Relevant treatment plan details • Patient consent (verbal or written) • All other documentation requirements outlined in WAC 182-562-0500

HCPCS code	Short description	Services covered	Limitations/ Comments	Consent	Claim submission guidelines	Documentation requirements
G0022	Comm hlth intg svs add 30 m	• Person-centered assessment and planning • Care coordination and health system navigation • Facilitating behavior change and client self-advocacy • Health education and promotion	Add-on code for G0019 Limited to an additional 30 minutes per calendar month. Billing practitioners may bill CHI services monthly as medically necessary and reasonable, billing for the first 60 minutes of CHI services (G0019) and then subsequently for the additional 30 minutes (G0022). Services may be provided directly and indirectly. Billable up to 3x per calendar month.	The licensed practitioner or the auxiliary personnel under supervision must get advance patient consent before furnishing CHI services. Consent may be written or verbal, so long as it is documented in the client's health care record. Additional consent is not necessary unless the practitioner furnishing and billing CHI changes.	Must be submitted on the same claim as HCPCS code G0019. HCPCS code G0022 must not be billed alone. Hold claim submission until all visits for the month are complete.	Must justify the need for additional time and other details including: • Identified SDOH • Relevant treatment plan details • Patient consent (verbal or written) • All other documentation requirements outlined in WAC 182-562-0500

HCPCS code	Short description	Services covered	Limitations/ Comments	Consent	Claim submission guidelines	Documentation requirements
G0023	Pin service 60m per month	• Person-centered assessment and planning • Care coordination and health system navigation • Facilitating behavior change and client self-advocacy	Limited to 60 minutes per calendar month. Services must be provided for a minimum of 60 minutes per calendar month to bill for the primary code. Services may be provided directly and indirectly. Billable once per calendar month.	The licensed practitioner or the auxiliary personnel under supervision must get advance patient consent before furnishing PIN services and annually thereafter. Consent may be written or verbal, so long as it is documented in the client's health care record.	Must be billed once per month for specific PIN services.	Must document the following: • Identified chronic or high-risk condition • Relevant treatment plan details • Patient consent (verbal or written) • All other documentation requirements outlined in WAC 182-562-0500

HCPCS code	Short description	Services covered	Limitations/ Comments	Consent	Claim submission guidelines	Documentation requirements
G0024	Pin srv add 30 min pr m	• Person-centered assessment and planning • Care coordination and health system navigation • Facilitating behavior change and client self-advocacy	Add-on code for G0023 Limited to an additional 30 minutes per calendar month. Billing practitioners may bill CHI services monthly as medically necessary and reasonable, billing for the first 60 minutes of CHI services (G0023) and then subsequently for the additional 30 minutes (G0024). Services may be provided directly and indirectly. Billable up to 3x per calendar month.	The licensed practitioner or the auxiliary personnel under supervision must get advance patient consent before furnishing PIN services and annually thereafter. Consent may be written or verbal, so long as it is documented in the client's health care record.	Must be submitted on the same claim as HCPCS code G0023. Must not be billed alone. Hold claim submission until all visits for the month are complete.	Must justify the need for additional time and other details including: • Identified chronic or high-risk condition • Relevant treatment plan details • Patient consent (verbal or written) • All other documentation requirements outlined in WAC 182-562-0500

HCPCS code	Short description	Services covered	Limitations/ Comments	Consent	Claim submission guidelines	Documentation requirements
S9446	Pt education noc group	Health education and promotion	Limited to two sessions per day with a monthly cap of eight sessions. If additional sessions are needed, submit a request for a limitation extension request.	The licensed practitioner or the auxiliary personnel under supervision must get advance patient consent before furnishing PIN services and annually thereafter. Consent may be written or verbal, so long as it is documented in the client's health care record.	Bill each group session separately, ensuring each session is tied to its own date of service. Bill using modifier HQ.	Must document the following: • Identified chronic or high-risk condition • Connect education to relevant treatment plan details • Group participation and engagement • Patient consent (verbal or written) • All other documentation requirements outlined in WAC 182-562-0500

Noncovered services

HCA does not cover the following services when provided by CHWs:

- Clinical care management services that require a state credential
- Childcare
- Chore services, including shopping and cooking
- Companion services
- Employment services
- Enrollment assistance for government programs or insurance not related to improving health
- Delivery of medication, medical equipment, or medical supplies
- Respite care
- Services that duplicate another Medicaid-covered service
- Socialization
- Transportation

Supervising providers

Provider requirements

A supervising provider must:

- Be an HCA-enrolled provider
- Be one of the following licensed practitioners:
  - Health care professional
  - Health care entity
  - Supplier
  - Contractor of service
- Meet the requirements under chapter 182-502 WAC
- Understand the specific roles, responsibilities, and focus for CHWs
- Provide or facilitate training and professional development for CHWs
- Maintain accurate and thorough records related to supervision, performance, and compliance

Documentation requirements

In addition to the requirements in WAC 182-502-0020, supervising providers must document the following:

- Required supervision records for CHWs
- Continued education verification and renewal of credentials for professional staff
- Consent forms and documentation for screening, assessments, care plans, case conferences, case management, care coordination, and health system navigation for each client

Payment

HCA pays supervising providers for the CHW services listed in Covered services when provided by CHWs according to the fee schedule.

Authorization

Authorization is HCA's approval for covered services, equipment, or supplies before the services are provided to clients, as a precondition for provider reimbursement. **Prior authorization (PA), and limitation extensions (LE) are forms of authorization**.

Prior authorization (PA)

What is prior authorization (PA)?

Prior authorization (PA) is the process HCA uses to authorize a service before it is provided to a client. The PA process applies to covered services and is subject to client eligibility and program limitations. PA does not guarantee payment.

For examples on how to complete a PA request, see HCA's **Billers, providers, and partners** webpage.

> **Note**: HCA reviews requests for payment for noncovered health care services according to WAC 182-501-0160 as an exception to rule (ETR).

How does HCA determine PA?

HCA reviews PA requests in accordance with WAC 182-501-0165. HCA uses evidence-based medicine to evaluate each request. HCA considers and evaluates all available clinical information and credible evidence relevant to the client's condition. At the time of the request, the provider responsible for the client's diagnosis or treatment must submit credible evidence specifically related to the client's condition. Within 15 days of receiving the request from the client's provider, HCA reviews all evidence submitted and will either:

- Approve the request.
- Deny the request if the requested service is not medically necessary.
- Request the provider to submit additional justifying information within 30 days. When the additional information is received, HCA will approve or deny the request within 5 business days of the receipt of the additional information. If the additional information is not received within 30 days, HCA will deny the requested service.

When HCA denies all or part of a request for a covered service or equipment, HCA sends the client and the provider written notice within 10 business days of the date the information is received that:

- Includes a statement of the action HCA intends to take.
- Includes the specific factual basis for the intended action.
- Includes references to the specific WAC provision upon which the denial is based.

- Is in sufficient detail to enable the recipient to learn why HCA's action was taken.
- Is in sufficient detail to determine what additional or different information might be provided to challenge HCA's determination.
- Includes the client's administrative hearing rights.
- Includes an explanation of the circumstances under which the denied service is continued or reinstated if a hearing is requested.
- Includes example(s) of lesser cost alternatives that permit the affected party to prepare an appropriate response.

Documentation requirements for PA or LE

Documentation

How do I obtain PA or an LE?

For all requests for PA or LEs, the following documentation is required:

- A completed, TYPED *General Information for Authorization* form, 13-835. This request form MUST be the initial page of the request.
- A completed *Fax/Written Request Basic Information* form, 13-756, if there is not a form specific to the service being requested, and all the documentation listed on the form with any other medical justification.

Fax the request to: (866) 668-1214.

See HCA's **Billers, provider, and partners** webpage.

See **Where can I download HCA forms?**

Requesting prior authorization (PA)

When a procedure's EPA criteria have not been met or the covered procedure requires PA, providers must request PA from HCA. Procedures that require PA are listed in the fee schedule. HCA does not retrospectively authorize any health care services that require PA after they have been provided except when a client has delayed certification of eligibility.

Online direct data entry into ProviderOne

Providers may submit a PA request by direct data entry into ProviderOne or by submitting the request in writing (see HCA's **prior authorization webpage** for details).

Fax

If providers choose to submit a faxed PA request, the following must be provided:

- The *General Information for Authorization* form, HCA 13-835. See **Where can I download HCA forms?** This form must be page one of the faxed request and must be typed.
- The program form, if available. This form must be attached to the request.
- Charts and justification to support the request for authorization.

Submit faxed PA requests (with forms and documentation) to (866) 668-1214.

For a list of forms and where to send them, see **Documentation requirements for PA or LE**. Be sure to complete all information requested. HCA returns incomplete requests to the provider.

Limitation extension (LE)

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. If the EPA process is not applicable, an LE must be requested in writing and receive HCA approval prior to providing the service.

The request must state the following:

- The name and ProviderOne Client ID of the client
- The provider's name, NPI, and fax number
- Client-specific clinical justification for additional services

Billing

Note: All claims must be submitted electronically to HCA, except under limited circumstances. For more information, see HCA's ProviderOne Billing and Resource Guide webpage and scroll down to *Paperless billing at HCA*. For providers approved to bill paper claims, visit the same webpage and scroll down to *Paper Claim Billing Resource*.

What are the general billing requirements?

Providers must follow HCA's ProviderOne Billing and Resource Guide.

These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments.
- What fee to bill HCA for eligible clients.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- Billing for clients eligible for both Medicare and Medicaid.
- Third-party liability.
- Record keeping requirements.

Note: When billing CHW services, providers must use their organization's national provider identifier (NPI).

Billing claims electronically

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's Billers, providers, and partners webpage, under Learn how to use ProviderOne, select 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.