Washington State Health Care Authority

Washington Apple Health (Medicaid)

Diabetes Education Program Billing Guide

October 1, 2016

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect October 1, 2016, and supersedes earlier guides to this program.

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Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the Children's Health Insurance Program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

What has changed?

Subject	Change	Reason for Change
Billing and Claim Forms	Effective October 1, 2016, all claims must be filed electronically. See blue box notification.	Policy change to improve efficiency in processing claims

* This publication is a billing instruction.

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Important Changes to Apple Health Effective April 1, 2016

These changes are important to all providers because they may affect who will pay for services.

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client's Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. See the Southwest Washington Provider Fact Sheet on the agency's Early Adopter Region Resources web page**.**

New MCO enrollment policy – earlier enrollment

Beginning April 1, 2016, Washington Apple Health (Medicaid) implemented a new managed care enrollment policy placing clients into an agency-contracted MCO **the same month** they are determined eligible for managed care as a new or renewing client. This policy eliminates a person being placed temporarily in fee-for-service while they are waiting to be enrolled in an MCO or reconnected with a prior MCO.

- **New clients** are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health Managed Care.

- **Renewing clients** are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Clients currently in fee-for-service or currently enrolled in an MCO are not affected by this change. Clients in fee-for-service who have a change in the program they are eligible for may be enrolled into Apple Health Managed Care depending on the program. In those cases, this enrollment policy will apply.

How does this policy affect providers?

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's **Get Help Enrolling** page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's new policies.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs will replace the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the Mental Health Billing Guide. BHOs use the Access to Care Standards (ACS) for mental health conditions and American Society of Addiction Medicine (ASAM) criteria for SUD conditions to determine client's appropriateness for this level of care.

Fully Integrated Managed Care (FIMC)

Clark and Skamania Counties, also known as SW WA region, is the first region in Washington State to implement the FIMC system. This means that physical health services, all levels of mental health services, and drug and alcohol treatment are coordinated through one managed care plan. Neither the RSN nor the BHO will provide behavioral health services in these counties.

Clients must choose to enroll in either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW). If they do not choose, they are auto-enrolled into one of the two plans. Each plan is responsible for providing integrated services that include inpatient and outpatient behavioral health services, including all SUD services, inpatient mental health and all levels of outpatient mental health services, as well as providing its own provider credentialing, prior authorization requirements and billing requirements.

Beacon Health Options provides mental health crisis services to the entire population in Southwest Washington. This includes inpatient mental health services that fall under the Involuntary Treatment Act for individuals who are not eligible for or enrolled in Medicaid, and short-term substance use disorder (SUD) crisis services in the SW WA region. Within their available funding, Beacon has the discretion to provide outpatient or voluntary inpatient mental health services for individuals who are not eligible for Medicaid. Beacon Health Options is also

responsible for managing voluntary psychiatric inpatient hospital admissions for non-Medicaid clients.

In the SW WA region some clients are not enrolled in CHPW or Molina for FIMC, but will remain in Apple Health fee-for-service managed by the agency. These clients include:

- Dual eligible – Medicare/Medicaid
- American Indian/Alaska Native (AI/AN)
- Medically needy
- Clients who have met their spenddown
- Noncitizen pregnant women
- Individuals in Institutions for Mental Diseases (IMD)
- Long-term care residents who are currently in fee-for-service
- Clients who have coverage with another carrier

Since there is no BHO (RSN) in these counties, Medicaid fee-for-service clients receive complex behavioral health services through the Behavioral Health Services Only (BHSO) program managed by MHW and CHPW in SW WA region. These clients choose from CHPW or MHW for behavioral health services offered with the BHSO or will be auto-enrolled into one of the two plans. A BHSO fact sheet is available online.

Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18th birthday

American Indian/Alaska Native (AI/AN) children will not be auto-enrolled, but may opt into CCW. All other eligible clients will be auto-enrolled.

AHCC complex mental health and substance use disorder services

AHCC clients who live in Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will use the BHO Access to Care Standards

to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.

AHCC clients who live outside Skamania or Clark County will receive complex mental health and substance use disorder services from the BHO and managed by DSHS.

Contact Information for Southwest Washington

Beginning on April 1, 2016, there will not be an RSN/BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to an individual who is not eligible for or enrolled in Medicaid.

If a provider does not know which MCO a client is enrolled in, this information can located by looking up the patient assignment in ProviderOne.

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

MOLINA HEALTHCARE	Molina Healthcare of Washington, Inc. 1-800-869-7165

COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009

Beacon Health Options	Beacon Health Options 1-855-228-6502

Resources Available

Topic	Contact Information
Information on becoming a provider or submitting a change of address or ownership	See the agency ProviderOne Resources web page
Information about payments, denials, claims processing, or agency-contracted managed care organizations	
Electronic or paper billing	
Finding agency documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than agency-contracted managed care	
Information on becoming a diabetes education provider and obtaining an application	Department of Health Heart Disease, Stroke, and Diabetes Prevention Unit PO Box 47855 310 Israel Rd SE Tumwater, WA 98501 360- 236-3750 Download and complete the reimbursement application from the Department of Health's Diabetes Prevention and Management web page

Definitions

This list 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.

Authorization – Washington State Health Care Authority's (the agency's) official approval for action taken for, or on behalf of, an eligible Washington Apple Health client. This approval is only valid if the client is eligible on the date of service.

Fee-for-service – The general payment method the agency uses to reimburse providers for covered medical services provided to medical assistance clients when those services are not covered under agency-contracted managed care plans or the Children's Health Insurance Program (CHIP).

Health Care Common Procedure Coding System (HCPCS) – A standardized coding system used primarily to identify products, supplies, and services not included in the Current Procedural Terminology (CPT) codes. This includes ambulance services, durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician's office.

Maximum allowable fee – The maximum dollar amount that the agency reimburses a provider for specific services, supplies, and equipment.

Usual and customary fee – The rate that may be billed to the agency for certain services, supplies, or equipment. This rate may not exceed either of the following:

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

About the Program

What is the purpose of the Diabetes Education Program?

The purpose of the Diabetes Education Program is to provide medically necessary diabetes education to eligible clients**.**

What are the provider qualifications?

Physicians, advanced registered nurse practitioners, physician assistants, registered nurses, registered dietitians, pharmacists, clinics, hospitals, and federally qualified health centers (FQHCs) can apply to the Washington State Department of Health (DOH) to become an approved diabetes education provider under this program. Other health professionals who are certified diabetes educators (CDEs) can also apply.

For more information on becoming a diabetes education provider, contact:

Department of Health
Heart Disease, Stroke, and Diabetes Prevention Unit
PO Box 47855
310 Israel Rd SE
Tumwater, WA 98501
360-236-3750

The reimbursement application can be downloaded and completed from the Department of Health's Diabetes Prevention and Management web page.

Once DOH gives its approval, your National Provider Identifier (NPI) will acknowledge you as an approved diabetes education provider. When billing the agency (HCA) for diabetes education services, use your NPI.

Client Eligibility

How can I verify a patient's eligibility?

(WAC 182-547-0700(1))

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

Verifying eligibility is a two-step process:

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

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

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, refer to the agency's Program Benefit Packages and Scope of Services web page.

Note: Patients who wish to apply for Washington Apple Health can do so in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org

2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)

3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

Clients who want to participate in the Diabetes Education Program must be referred by a licensed primary health care provider.

Are clients enrolled in an agency-contracted managed care plan eligible for diabetes education?

(WAC 182-538-060 , 063 , and 095)

YES. When verifying eligibility using ProviderOne, if the client is enrolled in an agency-contracted managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their managed care plan by calling the telephone number provided to them.

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

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

Primary care case management (PCCM)

For the client who has chosen to obtain care with a PCCM provider, this information will be displayed on the Client Benefit Inquiry screen in ProviderOne. These clients must obtain services from, or be referred for services by, a PCCM provider. The PCCM provider is responsible for coordinating care just like the PCP would be in a plan setting.

Note: To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper referral is obtained from the agency-contracted managed care plan or the PCCM provider. Please refer to the agency ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Coverage

What is covered?

The agency covers up to six hours of diabetes education and diabetes management per client, per calendar year.

- You must provide a minimum of 30 minutes of diabetes education/management per billed unit.
- You may:
  - ✓ Bill procedure codes as a single unit, in multiple units, or in combinations for a maximum of six hours (12 units). You may use any combination of the codes to meet the individual needs of the client.
  - ✓ Provide diabetes education in a group or individual setting, or a combination of both, depending on the client's needs.

Note: Additional units of diabetes education beyond these limits may be approved upon request based on medical necessity.

What is not covered?

The agency does not cover:

- Services provided by an individual instructor or facility that has not been approved by DOH.
- Services performed by providers that have not been approved to bill Medicaid for diabetes education.
- Services that are an expected part of another program provided to the client (e.g., school-based healthcare services or adult day health services).

How do I receive payment?

For diabetes education services provided in a **professional (non-hospital) setting**, you must:

- Bill either HCPCS code G0108 or G0109 using the CMS-1500 claim form, or
- Bill using the main clinic NPI in box 33 along with the individual practitioner's NPI in box 24J on the CMS-1500 claim form. The agency will only pay for diabetes education that is billed by an approved diabetes education provider.
- Provide a minimum of 30 minutes of education/management per session.

For services provided in a **hospital outpatient setting,** you must:

- Bill using revenue code 0942.
- Provide a minimum of 30 minutes of education/management per session.

Note: Services provided in the outpatient clinic must be submitted on an HCFA to receive payment. Services provided in the outpatient setting, but not in the clinic, must be submitted on a UB to receive payment.

Note: The agency requires authorized hospital outpatient diabetes education programs to bill with revenue code 0942. Use of HCPCS codes G0108 and G0109 will cause a denial of the claim.

How can I request a limitation extension (LE)?

When clients reach their benefit limit of diabetes education, a provider may request prior authorization for an LE from the agency.

The agency evaluates requests for prior authorization of covered diabetes education that exceed limitations in this billing guide on a case-by-case basis in accordance with WAC 182-501-0169. The provider must justify that the request is medically necessary (as defined in WAC 182-500-0070) for that client.

Note: Requests for an LE must be appropriate according to the client's eligibility or program limitations. Not all eligibility programs cover all services.

The following documentation is required for all LE requests:

- A completed *General Information for Authorization* form (HCA 13-835)
    - ✓ This request form MUST be the first page when you submit your request.
- A completed *Fax/Written Request Basic Information* form (HCA 13-756)**,** all of the documentation listed on this form, and any other medical justification

Fax LE requests to: (866) 668-1214

Coverage Table

Procedure/Revenue Codes	Short Description	Maximum Allowable Fee
Procedure code G0108*	Diab manage trn per indiv, per session One unit = 30 minutes	Rates Development Fee Schedules
Procedure code G0109*	Diab manage trn ind/group One unit = 30 minutes	
Revenue code 0942*	Diab manage trn per indiv per session or diab manage trn ind/group	

**Procedure codes G0108 and G0109 are for professional (non-hospital) billing, and revenue code 0942 is for outpatient hospital billing.*

Billing and Claim Forms

Effective for claims billed on and after October 1, 2016
All claims must be submitted electronically to the agency, except under limited circumstances.
For more information about this policy change, see Paperless Billing at HCA.
This billing guide still contains information about billing paper claims.
This information will be updated effective January 1, 2017.

What are the general billing requirements?

Providers must follow the agency's ProviderOne Billing and Resource Guide. These billing requirements include the following:

- What time limits exist for submitting and resubmitting claims and adjustments
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
- How to bill for clients eligible for both Medicare and Medicaid
- How to handle third-party liability claims
- What standards to use for record keeping

How do I complete the CMS-1500 claim form?

Note: Refer to the agency's ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 claim form.

The following CMS-1500 claim form instructions relate to the Diabetes Education Program:

Field No.	Name	Entry
24b.	Place of service	Enter the appropriate **two digit** code as follows: **Code Number** — **To Be Used For** 11 — Office 22 — Outpatient Hospital
24J.	Rendering provider ID	Enter the individual practitioner's NPI here.

Field No.	Name	Entry
33.	Provider billing name, address, ZIP code, and phone number	Enter the provider's *name* and *address* on all claim forms. Enter the main clinic's NPI here.

How do I complete the UB-04 claim form?

Instructions on how to bill professional claims and crossover claims electronically can be found on the agency's Billers and Providers web page, under Webinars. See Medical provider workshop.

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the National Uniform Billing Committee.