

Washington Apple Health (Medicaid)

Diabetes Education Program Billing Guide

October 1, 2017

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, 2017, 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.

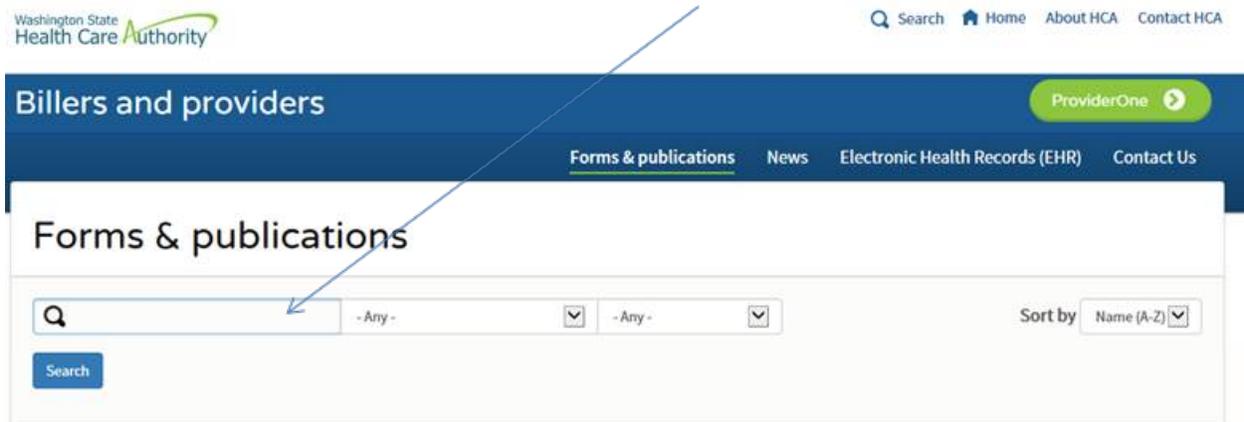
What has changed?

Subject	Change	Reason for Change
<p><u>Fully Integrated Managed Care (FIMC)</u></p>	<p>Effective January 1, 2018, the agency is implementing a second FIMC region, the North Central (NC) region, which includes Douglas, Chelan, and Grant Counties.</p> <p>The agency has updated and consolidated the FIMC information in this guide and provided several hyperlinks to the agency's Managed Care webpage, the agency's Integrated physical and behavioral health care webpage, and the agency's Regional resource webpage.</p>	<p>Notification of new region moving to fully integrated managed care (FIMC)</p>

* This publication is a billing instruction.

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and provider's webpage, select [Forms & publications](#). Type the HCA form number into the **Search box** as shown below (Example: 13-835).



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Resources Available

Topic	Contact Information
Information on becoming a provider or submitting a change of address or ownership	<p>See the agency ProviderOne Resources webpage</p>
Information about payments, denials, claims processing, or agency-contracted managed care organizations	
Electronic 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	<p>Department of Health Heart Disease, Stroke, and Diabetes Prevention Unit PO Box 47855 Olympia, WA 98504 360- 236-3750</p> <p>Download and complete the reimbursement application from the Department of Health’s Diabetes Prevention and Management webpage</p>

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).

FIMC “Fully Integrated Managed Care” – A term used to refer to those designated regions where all Apple Health physical behavioral health benefits are administered by managed care organization.

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. For additional information or more details, contact diabetes@doh.wa.gov or call 360-236-3750.

What providers and settings are eligible for this program?

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
Olympia, WA 98504
360-236-3750

The [reimbursement application](#) can be downloaded and completed from the Department of Health's [Diabetes Prevention and Management](#) webpage.

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](http://www.wa.gov/wahealthplanfinder)(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](#) webpage.

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 webpage 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.

Effective July 1, 2017, not all Apple Health clients were enrolled in a BHO/FIMC/BHSO

On July 1, 2017, some Apple Health clients were not enrolled in a behavioral health organization (BHO), fully integrated managed care (FIMC), or behavioral health services only (BHSO) program. For these clients, substance use disorder (SUD) services are covered under the fee-for-service (FFS) program.

Effective January 1, 2017, some fee-for-service clients who have other primary health insurance were enrolled into managed care

On January 1, 2017, the agency enrolled some fee-for-service Apple Health clients who have other primary health insurance into an agency-contracted managed care organization (MCO).

This change did not affect all fee-for-service Apple Health clients who have other primary health insurance. The agency continues to cover some clients under the fee-for-service Apple Health program, such as dual-eligible clients whose primary insurance is Medicare.

For additional information, see the agency's [Managed Care webpage](#), under Providers and Billers.

Effective April 1, 2016, important changes to Apple Health

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 agency's [Regional Resources webpage](#).

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 replaced the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the [Mental Health Services 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)

For clients who live in a fully integrated managed care (FIMC) region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted managed care organization (MCO). The Behavioral Health Organization (BHO) will not provide behavioral health services in these counties.

Clients living in an FIMC region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

Effective July 1, 2017, American Indian/Alaska Native (AI/AN) clients living in an FIMC region of Washington must choose to enroll in one of the agency-contracted MCOs available in that region; or they may choose to receive all these services through Apple Health fee-for-service (FFS). If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavior health services. For more information about the services available under the FFS program, see the agency's [Mental Health Services Billing Guide](#) and the [Substance Use Disorder Billing Guide](#).

For full details on FIMC, including which clients residing in an FIMC region are not enrolled with an MCO and information on complex behavioral health services for foster children in an FIMC region, see the agency's [Managed Care webpage](#), the agency's [Integrated physical and behavioral health care webpage](#), and the agency's [Regional resource webpage](#).

FIMC Regions

North Central Region (NC) – Douglas, Chelan and Grant Counties

Effective January 1, 2018, the agency will implement the second FIMC region known as the NC region which includes Douglas, Chelan, and Grant Counties. Clients eligible for managed care enrollment will choose to enroll in an available MCO in their region. Specific details,

including information about mental health crisis services can be found on the agency's [Managed Care webpage](#), the agency's [Integrated physical and behavioral health care webpage](#), and the agency's [Regional resource webpage](#).

Southwest Washington Region (SW WA) – Clark and Skamania Counties

Effective April 1, 2016, the agency implemented the first FIMC region known as the SW WA region which includes Clark and Skamania Counties. Clients eligible for managed care enrollment choose to enroll in one of two available MCOs in this region: Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW).

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 automatically 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 is not a 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 be 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
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 COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009
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Beacon Health Options	Beacon Health Options 1-855-228-6502
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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. For more information, see [How can I request a limitation extension \(LE\)?](#)

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 an electronic professional claim.
- Bill using the main clinic NPI in the Billing Provider NPI field along with the individual practitioner's NPI in the Rendering (Performing) Provider NPI field on an electronic professional claim. 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 a professional claim to receive payment. Services provided in the outpatient setting, but not in the clinic, must be submitted on an institutional claim 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, see [Where can I download agency forms?](#))
 - ✓ This request form **MUST** be the first page when you submit your request.
- A completed *Fax/Written Request Basic Information* form (HCA 13-756, see [Where can I download agency forms?](#)), 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

Effective for claims billed on and after October 1, 2016

All claims must be submitted electronically to the agency, except under limited circumstances.

For more information about this policy change, see [Paperless Billing at HCA](#).

For providers approved to bill paper claims, see the agency's [Paper Claim Billing Resource](#).

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 bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's [Billers and Providers](#) webpage, under [Webinars](#).

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the [HIPAA Electronic Data Interchange \(EDI\)](#) webpage.

The following claim instructions relate to the Diabetes Education Program:

Name	Entry						
Place of Service	Enter the appropriate two digit code as follows: <table data-bbox="669 737 1117 905" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="text-align: center;"><u>Code Number</u></th> <th style="text-align: center;"><u>To Be Used For</u></th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">11</td> <td style="text-align: center;">Office</td> </tr> <tr> <td style="text-align: center;">22</td> <td style="text-align: center;">Outpatient Hospital</td> </tr> </tbody> </table>	<u>Code Number</u>	<u>To Be Used For</u>	11	Office	22	Outpatient Hospital
<u>Code Number</u>	<u>To Be Used For</u>						
11	Office						
22	Outpatient Hospital						
Billing Provider	Enter the provider's <i>Provider NPI</i> and <i>Taxonomy Code</i> .						
Rendering (Performing) Provider	Enter the individual practitioner's <i>Provider NPI</i> and <i>Taxonomy Code</i> .						