

**Department of Health (DOH)
and
Health and Recovery Services
Administration (HRSA)**



**Title XIX (Medicaid)
HIV/AIDS Case Management
Billing Instructions**

Chapter 388-539-0300 and 0350 WAC

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About this publication

This publication supersedes all previous *HIV/AIDS Case Management Billing Instructions* and Numbered Memorandum 03-35 MAA, 04-54 MAA, 05-47 MAA, 06-05, and 06-88.

This document is to be used for billing purposes only. Please refer to the Department of Health's Case Management: A Guide for Assisting Person's Living with HIV/AIDS (DOH publication #410-014) for a complete guide to the HIV/AIDS Case Management Program. Refer to the **Important Contacts** section of this document to find out how to order this DOH publication.

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Important Contacts

A provider may use HRSA's toll-free lines for questions regarding its program. However, HRSA's response is based solely on the information provided to HRSA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern HRSA's programs. [WAC 388-502-0020(2)].

How do I become a DSHS provider?

Call the Department of Health to request a provider application be sent to you:

HIV Client Services
360.236.3453

Where do I send my claims?

Division of Program Support
PO Box 9253
Olympia WA 98507-9253

Electronic Billing?

Go to:

Where can I view and download HRSA's Billing Instructions or Numbered Memorandum?

Go to HRSA's website at:

<http://maa.dshs.wa.gov>

Click on "Provider Publications/Fee Schedules".

Where do I write/call if I have questions on...?

Provider participation, case management standards and reporting requirements?

Department of Health
HIV Client Services
PO Box 47841
Olympia, WA 98504-7841
360.236.3453

Payments, denials, general questions regarding claims processing, Healthy Options?

HRSA Customer Service Center
800.562.6188

Private insurance or third party liability, other than Healthy Options?

Division of Customer Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
800.562.6136

Where can I obtain a copy of the DOH's Case Management: A Guide for Assisting Persons Living with HIV/AIDS?

Write/call:

HIV Client Services
PO Box 47841
Olympia, WA 98504-7841
360.236.3453

Definitions & Abbreviations

The section defines terms and abbreviations (includes acronyms) used in these billing instructions.

AIDS - Acquired Immunodeficiency Syndrome. A disease caused by the Human Immunodeficiency Virus (HIV).

Client - An applicant for, or recipient of, DSHS medical care programs.

Core Provider Agreement - The basic contract that HRSA holds with providers serving HRSA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Department - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

Department of Health (DOH) - The state Department of Health which, in accordance with an interagency agreement, administers the daily operations of Title XIX targeted HIV/AIDS case management.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Health and Recovery Services Administration (HRSA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain

nonmedical services for persons with chronic disabilities.

HIV - Human Immunodeficiency Virus.

HIV/AIDS Case Management - Services which assist persons infected with HIV to: live as independently as possible; maintain and improve health; reduce behaviors that put the client and others at risk; and gain access to needed medical, social, and educational services.

HIV Client Services - The office of the Division of Community & Family Health, Department of Health, which oversees the daily operation of the Title XIX HIV/AIDS Case Management Program.

ISP – Individual Service Plan – Identifies and documents the client's unmet needs and the resources needed to assist in meeting the client's needs.

Maximum Allowable - The maximum dollar amount that HRSA will reimburse a provider for specific services, supplies, and equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs. (Medicaid is also called Title XIX)

Medical Identification (ID) card – The document that identifies a client's eligibility for a medical program. This card was formerly known as the medical assistance identification (MAID) card or medical coupon.

Medically Necessary - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medical Assistance client consisting of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the

department. [WAC 388-500-0005]

Remittance And Status Report (RA) - A report produced by HRSA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

- 1) The usual and customary charge that you bill the general public for the same services; or
- 2) If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

About the Program

What is the purpose of the Title XIX (Medicaid) HIV/AIDS Case Management Program?

The purpose of the Title XIX HIV/AIDS case management program is to assist persons infected with HIV to:

- Live as independently as possible;
- Maintain and improve health;
- Reduce behaviors that put the client and others at risk; and
- Gain access to needed medical, social, and educational services.

[Refer to WAC 388-539-0300]

HRSA (the administration within DSHS that administers the acute care portion of the Title XIX Medicaid program) has an interagency agreement with the Department of Health (DOH) to administer the HIV/AIDS case management program for eligible Medicaid clients.

[Refer to WAC 388-539-0300(2)]

Who provides Title XIX HIV/AIDS Case Management Services? [Refer to WAC 388-539-0300(3)]

Agencies approved by the Department of Health's HIV Client Services.

How does an agency request approval from DOH to provide these services?

An agency requests approval from DOH by completing all of the steps in the Title XIX Provider Application Process and submitting all required documents to DOH.

Where can an agency get the information needed to complete the provider application process?

Refer to the Department of Health's Case Management: A Guide for Assisting Persons Living with HIV/AIDS for specifics on provider requirements, or call HIV Client Services at 360.236.3453. Refer to the **Important Contacts** section of this billing instruction for information on ordering a copy of this DOH publication.

Client Eligibility

Who is eligible to receive Title XIX HIV/AIDS Case Management? [Refer to WAC 388-539-0300(1)]

To be eligible for Title XIX-reimbursed HIV/AIDS case management services, an individual must:

- Have a current medical diagnosis of HIV or AIDS;
- **Not be receiving** concurrent Title XIX HIV/AIDS case management services through another program;
- Require:
 - ✓ Assistance to obtain and effectively use necessary medical, social, and educational services; or
 - ✓ 90 days of continued monitoring (see page C.2 for more information).

-AND-

- Present a DSHS Medical Identification card with one the following medical program identifiers:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP – CHIP	Children’s Health Insurance Program
LCP-MNP	Limited Casualty Program - Medically Needy Program
LCP-MNP	Limited Casualty Program/MNP
LCP-MNP	Limited Casualty Program/MNP
Emergency Medical Only	Emergency Medical Only
Title XIX HIV/AIDS Case Management services are not covered if the medical program identifier on the client’s DSHS Medical ID card is not listed in this table.	

The client's DSHS Medical ID card must show eligibility for the date(s) services are rendered.

Are clients who are enrolled in an HRSA managed care plan eligible for Title XIX HIV/AIDS Case Management?

Yes! A client enrolled in an HRSA managed care plan is eligible for Title XIX HIV/AIDS Case Management **provided the client meets the criteria listed on the previous page.** These services do not require a referral from the client's managed care plan. Use these billing instructions and bill HRSA directly. **Be sure to use the appropriate billing form and mailing address as specified in this billing instruction.**

Billable Services

What services are billable?

HRSA reimburses Title XIX HIV/AIDS case management providers for the following three services:

1. Comprehensive Assessment

HRSA reimburses for only one comprehensive assessment per client unless the client's situation changes as follows:

- ✓ There is a 50% change in need from the initial assessment; or
- ✓ The client transfers to a new case management provider.

The assessment must cover the areas outlined in DOH's **Case Management: A Guide for Assisting Persons Living with HIV/AIDS**. [Also listed in WAC 388-539-0300(1) and (5)]

HRSA reimburses for a comprehensive assessment in addition to a monthly charge for case management (either full-month or partial-month) if the assessment is completed during a month the client is eligible for Medical Assistance and the ongoing case management has been provided.

2. HIV/AIDS Case Management – Full Month

HRSA reimburses for one full-month case management fee per client, per month.

Providers may request the full-month reimbursement for any month in which the criteria listed in DOH's Case Management: A Guide for Assisting Persons Living with HIV/AIDS have been met and the case manager has an individual service plan (ISP) in place for 20 or more days in that month. [The criteria are also listed in WAC 388-539-0300.] Monitoring can be billed under this service (see page C2).

3. HIV/AIDS Case Management – Partial Month

Providers may request the partial-month reimbursement for any month in which the criteria in WAC 388-539-0300 have been met and an ISP has been in place for fewer than 20 days in that month. Monitoring can be billed under this service (see page C2).

Partial month reimbursement allows for payment of two case management providers when a client changes from one provider to another during the month.

When is monitoring a billable service?

Monitoring is a term used when a client becomes stabilized and no longer needs an Individual Service Plan (ISP) with active elements. This applies to clients who have a history of recurring need and instability and will likely require further assistance at a later date.

Case management providers may bill HRSA for up to 90 days of monitoring past the time the last active service element of the ISP has been completed and the following criteria have been met:

- Document the client’s history of recurring need;
- Assess the client for possible future instability; and
- Provide monthly monitoring contacts.

What procedure codes must be used to bill HRSA for monitoring?

Use the following procedure codes and modifiers to bill HRSA for monitoring:

HCPCS Code	Modifier	Description
T2022 Limited to dx 042 or V08	U8*	Case management, per month. Full month case management services
T2022 Limited to dx 042 or V08	U9*	Case management, per month. Partial month case management services

*Modifiers U8 and U9 are payer-defined modifiers. HRSA [defines modifier U8](#) as “full month” and U9 as “partial month.”

When can a client be reinstated from a monitoring status to active case management?

A client can shift from monitoring status (ISP without active elements) to active case management status upon documentation of need(s). Providers must meet the requirements in WAC 388-539-0300 when a client is reinstated to active case management.

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- HRSA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. HRSA has two timeliness standards: (1) for initial claims; and (2) for resubmitted claims.
 - The provider must submit claims as described in HRSA's billing instructions.
 - HRSA requires providers to submit an **initial claim** to HRSA and obtain an ICN within 365 days from any of the following:
 - ✓ The date the provider furnishes the service to the eligible client;
 - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
 - ✓ The date a court orders HRSA to cover the services; or
 - ✓ The date DSHS certifies a client eligible under delayed¹ certification criteria.
 - Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.
- Note:** HRSA does not accept any claim for resubmission, modification, or adjustment after the timeperiod listed above.
- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument such as a bank check.

¹ **Delayed Certification** - According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:
 - ✓ The provider fails to meet these listed requirements; and
 - ✓ HRSA does not pay the claim.

What fee must I bill HRSA?

Bill HRSA your usual and customary fee.

Fee Schedule

You may view HRSA's **HIV/AIDS & Services Fee Schedule** on-line at

<http://maa.dshs.wa.gov/RBRVS/Index.html>

What records must be kept?

Specific to the Title XIX HIV/AIDS Case Management program

Please refer to the Department of Health's **Case Management: A Guide for Assisting Persons Living with HIV/AIDS** for required documentation specific to the Title XIX HIV/AIDS Case Management Program.

General to **all** providers [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:
 - ✓ Patient's name and date of birth;
 - ✓ Dates of service(s);
 - ✓ Name and title of person performing the service, if other than the billing practitioner;
 - ✓ Chief complaint or reason for each visit;
 - ✓ Pertinent medical history;
 - ✓ Pertinent findings on examination;
 - ✓ Medications, equipment, and/or supplies prescribed or provided;
 - ✓ Description of treatment (when applicable);
 - ✓ Recommendations for additional treatments, procedures, or consultations;
 - ✓ X-rays, tests, and results;
 - ✓ Dental photographs/teeth models;
 - ✓ Plan of treatment and/or care, and outcome; and
 - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, *for at least six years from the date of service* or more if required by federal or state law or regulation.

HIV/AIDS Coverage Table

Use the following procedure codes with the appropriate modifiers when billing for Title XIX HIV/AIDS case management services:

Procedure Code	Modifier	Diagnosis Code	Brief Description	Policy/Comments
T2022	U8	Limited to 042 or V08	Case management, per month.	[Full Month] A full-month rate applies when: A. The criteria in WAC 388-539-0300 have been met; and B. An individual service plan (ISP) has been in place 20 days or more in that month.
T2022	U9	Limited to diagnosis 042 or V08	Case management, per month.	[Partial Month] A partial month rate applies when: A. The criteria is WAC 388-539-0300 have been met; and B. An ISP has been in place fewer than 20 days in that month.
Note: HRSA reimburses full or partial month fees during monitoring per WAC 388-539-0350. See page C2 for a complete description of these services.				
T1023		Limited to diagnosis 042 or V08	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter.	(Use this code for the comprehensive assessment) This service must meet the requirements of WAC-539-0300 (1) and (5) and is reimbursed only <i>once</i> unless the client's condition changes as follows: A. There is a 50% change in need from the initial assessment; or B. The client transfers to a new case management provider. A comprehensive assessment is reimbursed in addition to a monthly charge (either full or partial) if the assessment is completed during the month a client is Medicaid eligible and ongoing case management has been provided.

Completing the 1500 Claim Form

Attention! HRSA now accepts the new 1500 Claim Form.

- **On November 1, 2006**, HRSA began accepting the new 1500 Claim Form (version 08/05).
- **As of April 1, 2007**, HRSA will no longer accept the old HCFA-1500 Claim Form.

Note: HRSA encourages providers to make use of electronic billing options.
For information about electronic billing, refer to the *Important Contacts* section.

Refer to HRSA’s current *General Information Booklet* for instructions on completing the 1500 claim form. You may download this booklet from HRSA’s website at:
<http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html>

The following 1500 claim form instructions relate to **HIV/AIDS Case Management Billing Instructions**. Click the link above to view general 1500 claim form instructions.

For questions regarding claims information, call HRSA toll-free:

800.562.3022

1500 Claim Form Field Descriptions

Field No.	Name	Field Required	Entry
17.	Name of Referring Physician or Other Source	When applicable	Enter the referring physician or Primary Care Case Manager (PCCM) name. This field <i>must</i> be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).
21.	Diagnosis or Nature of Illness or Injury		Enter Diagnosis 042 or V08, whichever is appropriate) in areas 1, 2, 3, and 4.

HIV/AIDS Case Management

Field No.	Name	Field Required	Entry
24B.	Place of Service	Yes	<p>The following is the only appropriate code(s) for Washington State Medicaid:</p> <p style="text-align: center;"><u>Code Number</u> <u>To Be Used For</u></p> <p style="text-align: center;">11 Office 12 Client's residence.</p>
24E.	Diagnosis Code	Yes	Enter the ICD-9-CM diagnosis code 042 or V08, whichever is appropriate.