Washington State Health Care Authority

Washington Apple Health (Medicaid)

Hospital-Based Inpatient Detoxification Billing Guide

January 1, 2018

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 January 1, 2018, 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.

* This publication is a billing instruction.

What has changed?

Subject	Change	Reason for Change
Client Eligibility	This section is reformatted and consolidated for clarity and hyperlinks have been updated. **Effective January 1, 2018,** the agency is implementing another **FIMC region**, known as the North Central region, which includes Douglas, Chelan, and Grant Counties.	Housekeeping and notification of new region moving to FIMC

Table of Contents

Alert! This Table of Contents is automated. Click on a page number to go directly to the page.

Resources Available

Note: This section contains important contact information relevant to the Hospital-Based Inpatient Detoxification program. For more contact information, see the agency's Billers and Providers web page.

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the agency's ProviderOne Resources web page.
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic billing	
Finding agency documents (e.g., billing instructions, fee schedules)	
Private insurance or third-party liability, other than agency managed care	
Contacting DBHR or submitting claims for Involuntary Treatment Act (ITA) extended detoxification	Division of Behavioral Health and Recovery PO Box 45330 Olympia, WA 98504 1-800-446-0259

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.

Chemical Dependency - An alcohol or drug addiction, or dependence on alcohol and one or more other psychoactive chemicals.

Detoxification - Care and treatment in a residential or hospital setting of persons intoxicated or incapacitated by alcohol or other drugs during the period in which the person is recovering from the transitory effects of intoxication or withdrawal. Acute detoxification provides medical care and physician supervision; subacute detoxification is non-medical.

Free-Standing Detox Center - A facility that is not attached to a hospital and in which care and treatment is provided to persons who are recovering from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

Intensive Inpatient Treatment- Nonhospital, DBHR-certified facilities for sub-acute, or detoxified clients, or both, focused on primary chemical dependency services in residential or outpatient settings.

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by the agency for specific services, supplies, or equipment.

Rehabilitation Services - Hospital-based intensive inpatient substance abuse treatment, medical care, and assessment and linkages.

Usual and Customary Fee - The rate that may be billed to the agency for certain services or equipment. This rate may not exceed the following:

- The usual and customary charge that a provider bills 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 Hospital-Based Inpatient Detoxification program?

The Hospital-Based Inpatient Detoxification program provides services to clients receiving hospital-based alcohol, or drug detoxification services, or both, in counties where no free-standing detoxification centers are available.

Note: If a provider's facility is certified to treat pregnant women under a chemically using pregnant (CUP) women agreement, the provider must use the agency's Chemically Using Pregnant (CUP) Women billing guide.

Client Eligibility

Most Apple Health clients are enrolled in an agency-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 the agency's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Is the client enrolled in an agency-contracted managed care organization (MCO), in a behavioral health organization (BHO), or is the client receiving services through fee-for-service (FFS) Apple Health?

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 the agency'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 the agency's Program Benefit Packages and Scope of Services web page.

Note: Patients who are not Apple Health clients may submit an application for health care coverage 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.

Are clients enrolled in an agency managed care plan eligible?

WAC 182-538-060 and 095, or WAC 182-538-063 for MCS clients

Yes. Providers can use ProviderOne to easily check if the client is enrolled in a 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 a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for the following:

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

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

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for.

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 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 policies.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health services (mental health and substance use disorder) for eight of the Regional Service Areas (RSAs) in the state. The remaining regions have fully integrated managed care (FIMC).

See the agency's Mental Health Services Billing Guide for details.

Fully Integrated Managed Care (FIMC)

For clients who live in an FIMC region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted MCO. The 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 may 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 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 behavioral health services. See the agency's American Indian/Alaska Native webpage.

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, see the agency's Changes to Apple Health managed care webpage.

FIMC Regions

Clients who reside in either of the following two FIMC regions and who are eligible for managed care enrollment must choose an available MCO in their region. Specific details, including information about mental health crisis services, can be found on the agency's Apple Health managed care webpage.

North Central Region – Douglas, Chelan and Grant Counties
Effective January 1, 2018, the agency will implement the second FIMC region known as the North Central Region, which includes Douglas, Chelan, and Grant Counties.

Southwest Washington Region – Clark and Skamania Counties
Effective April 1, 2016, the agency implemented the first FIMC region known as the Southwest Washington 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.

Apple Health Foster Care (AHFC)

Coordinated Care of Washington (CCW) provides all physical health care (medical) benefits, lower-intensity outpatient mental health benefits and care coordination for all Washington State foster care enrollees through a single, statewide managed care plan known as Apple Health Core Connections (AHCC).

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as
"**Coordinated Care Healthy Options Foster Care.**"

See the agency's Apple Health managed care page, Apple Health Foster Care for further details.

Coverage

What services does the agency cover?

The agency covers the following hospital-based inpatient detoxification services only when performed in participating, agency-enrolled hospitals:

- Alcohol detoxification
- Drug detoxification
- Alcohol and drug detoxification for clients detained or involuntarily committed

Alcohol and drug detoxification

When billing, providers must use one or more of the diagnosis codes that most closely describes the diagnosis. Providers are required to use the code of *highest specificity* (five digit codes) from ICD ***whenever possible and applicable***.

Service	ICD Diagnosis Codes	Policy
Alcohol detoxification	See the agency's Approved Diagnosis Codes by Program web page for Hospital-Based Inpatient Detoxification	Covered for up to three days
Drug detoxification		Covered for up to five days

Note: Submit claims for alcohol or drug detoxification to the agency (see Resources Available). When submitting claims, follow the billing instructions found in the Billing section.

Alcohol and drug detoxification for clients detained or involuntarily committed

Service	ICD Diagnosis Codes	Policy
Protective custody, or detention, or both, of persons incapacitated by alcohol or other drugs	Same codes found in Alcohol and Drug Detoxification	RCW 70.96A.120 provides for the protective custody and emergency detention of persons who are found to be incapacitated or gravely disabled by alcohol or other drugs in a public place. Follow the guidelines in Alcohol and Drug Detoxification when providing services to clients who are both of the following: • Detained under the protective custody provisions of RCW 70.96A.120; and • Not being judicially committed to further care.
Involuntary commitment for chemical dependency	Same codes found in Alcohol and Drug Detoxification	RCW 70.96A.140 provides for the involuntary commitment (ITA) of persons incapacitated by chemical dependency. When a Petition for Commitment to Chemical Dependency Treatment is filed or a Temporary Order for Treatment is invoked on a client under care in a hospital, there may be a need to hold the client beyond the three- to five-day limitations described in Alcohol and Drug Detoxification. In these situations, the three-day and five-day limitations may be extended up to an additional six days. In this event, DBHR will pay for the following: • Up to a maximum of nine days for Alcohol ITA Extended Detoxification • Eleven days for Drug ITA Extended Detoxification

Note: Submit claims for alcohol or drug detoxification to the agency (see Resources Available). When submitting claims, follow the billing instructions found in the Billing section.

Authorization

See the agency's ProviderOne Billing and Resource Guide for more information about requesting authorization.

Payment

For which services does the agency pay?

WAC 182-550-2650 (5)

The agency pays for services only when they meet all of the following conditions. The services must be:

- Provided to eligible persons (see Client Eligibility).
- Directly related to detoxification.
- Performed by a certified detoxification center or by a general hospital that has a contract with the agency to provide detoxification services.

The agency limits payment for detoxification services to one of the following:

- Three days for an acute alcoholic condition
- Five days for acute drug addiction

The agency pays for detoxification services only when notified *within ten days of the date* detoxification began and all eligibility factors are met.

Payment for hospital-based inpatient detoxification services is based on the following:

Hospitals	Per diem. View current per diem rates at Inpatient Hospital Rates
Physicians	Physician-Related/Health Care Professional Services Fee Schedule

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 ProviderOne Billing and Resource Guide. These billing requirements include:

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

How do hospitals bill?

When billing for detoxification services, use the following revenue codes **only**:

Revenue Code	Description
126	Room & Board – Semi-Private (Two Beds) Detoxification
136	Room & Board – Semi-Private (Three and Four Beds) Detoxification
156	Room & Board – Ward Detoxification
250	Pharmacy
260	IV Therapy
270	Medical/Surgical Supplies & Devices
300	Laboratory
320	Radiology – Diagnostic
450	Emergency Room
730	EKG/ECG (Electrocardiogram)
740	EEG (Electroencephalogram)

How do physicians bill?

Physicians wishing to bill for detoxification services provided to the agency clients must follow the instructions found in the agency's Physician-Related/Health Care Professional Services Provider Guide.

How do I bill for services provided to clients with an involuntary commitment for chemical dependency (ITA)?

To receive payment, submit both of the following forms in addition to the completed institutional claim:

- A DSHS 13-628 billing form with a statement on the form that the services are "ITA Extended Detoxification"
- A copy of the **cover page** from the client's Temporary Order for Treatment or Petition for Commitment to Chemical Dependency Treatment

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 web page, 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) web page.

The following claim instructions relate to hospital-based inpatient detoxification:

Name	Entry
Place of Service	Enter "21".