Washington State Health Care Authority

Washington Apple Health (Medicaid)

Chemical-Using Pregnant (CUP) Women Program Billing Guide

January 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[1]

This publication takes effect January 1, 2017, and supersedes earlier guides to this program.

HCA 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.

What has changed?

Subject	Change	Reason for Change
Where can I download agency forms?	Added new section to help providers more easily find the agency's forms on the new web page.	Clarification
Are clients enrolled in an agency-managed care plan eligible?	Removed: "If the client delivers during the 26-day stay, or during an approved extension, then delivery and newborn care must be billed fee-for-service."	Correction
How do I bill for CUP Women services?	Removed: "Charges for delivery, premature labor, or any another acute medical inpatient stay must be billed on a separate institutional claim."	Correction
Fee-for-service clients with other primary health insurance to be enrolled into managed care	Added new section regarding changes occurring for some fee-for-service clients.	Policy change

[1] This publication is a billing instruction.

How do I bill for physician/ARNP services?	Removed CPT codes 99431 and 99433 Removed the following section: Physicians and ARNPs may provide continuation of medical services to pregnant clients on an outpatient basis separate from the CUP Women Program. To bill the agency in this instance, use the CPT code from the current Agency *Physician-Related Services/Healthcare Professional Services Medicaid Billing Guide* **(CPT codes 99201 through 99215)**, that most closely describes the service provided.	Invalid CPT codes Correction

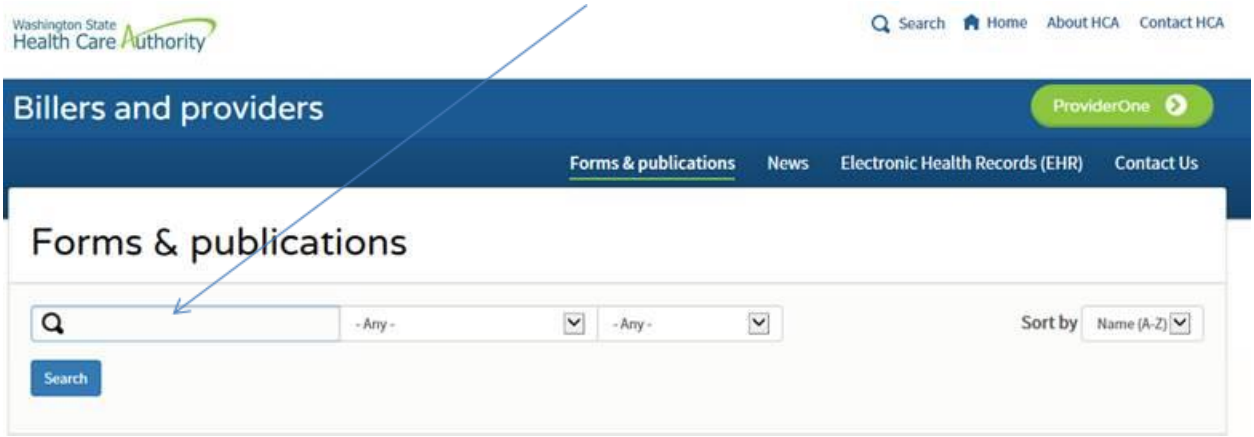
How can I get agency provider documents?

To access provider alerts, go to the agency's provider alerts web page.

To access provider documents, go to the agency's provider billing guides and fee schedules web page.

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and providers web page, select Forms & publications. Type the form number you are looking for into the **Search box** as shown below.



Additional Resource Material

This guide provides information used to develop CUP Women program policies and procedures in the provider facility's program manuals (See WAC 182-533-0300). Additional resource material can be found in:

- The Division of Behavioral Health and Rehabilitation's (DBHR) "Directory of Certified Chemical Dependency Services in Washington State"
- The agency's *First Steps Website*; and
- The Department of Health's (DOH) "*Substance Abuse During Pregnancy: Guidelines for Screening and Management*" revised edition 2015.

Table of Contents

Alert! The page numbers in this table of contents are now "clickable"—do a "control + click" on a page number to go directly to a spot. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks on the left side of the document. If you don't immediately see the bookmarks, right click on the gray area next to the document and select Page Display Preferences. Click on the bookmark icon on the left.)

Resources Available

Note: This section contains important contact information relevant to the Chemical Using Pregnant (CUP) Women program.

Topic	Resource 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., Medicaid billing guides, provider notices, and fee schedules)	
Private insurance or third-party liability, other than Agency managed care	
Who do I contact if I'm interested in becoming a CUP Women program provider or have questions regarding CUP Women program policy?	**Community Services Manager** Division of Behavioral Health and Recovery (DBHR) 360-438-8087 **CUP Women Program Manager** 360-725-1293
Who do I contact if I want to request an extended stay?	**CUP Women Program Manager** Medicaid Program Operations and Integrity Community Services Section PO Box 45530 Olympia, WA 98504-5530 360-725-1293

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.

Assessment - The set of activities conducted on behalf of a new patient for the purpose of determining eligibility, evaluating treatment needs, and making necessary referrals and completing forms. The assessment includes the requirements in all applicable sections of Chapter 388-805 WAC.

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

Chemical-Using Pregnant (CUP) Women Program – The CUP Women program is a Medicaid-funded, hospital-based, intensive detoxification and medical stabilization program for alcohol or drug using/ dependent pregnant women and their exposed fetuses.

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.

Division of Behavioral Health and Recovery (DBHR) – The Department of Social and Health Services (DSHS), Division of Behavioral Health and Recovery (DBHR) provides support for Mental Health, Chemical Dependency, and Problem Gambling Services. The public mental health programs promote recovery and resiliency and reduces the stigma associated with mental illness. The substance abuse prevention and chemical dependency treatment programs promote strategies that support healthy lifestyles by preventing the misuse of alcohol, tobacco, and other drugs, and support recovery from the disease of chemical dependency. The problem gambling program mitigates the effects of problem gambling on the family and helps families remain economically self-sufficient without requiring assistance from other state programs. DBHR brings operational elements like medical assistance, chemical dependency and mental health into closer working relationships that serve clients more effectively and efficiently than before.

Hospital-Based Medical Stabilization - Medical hospital inpatient care to medically manage the acute detoxification and medical stabilization of a pregnant woman and her fetus.

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

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 a certain service or equipment. This rate *may not exceed:*

- The usual and customary charge that you bill the general public for the same services; or
- 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 CUP Women program?

[Refer to WAC 182-533-0701]

The intent of the CUP Women program is to:

- Reduce harm to a mother and her fetus who need medical stabilization for obstetric and perinatal complications often present in chemically-dependent pregnant women; and

- Provide all of the following services in one setting to improve the health of the woman and the fetus:

  - ✓ Immediate access to care;
  - ✓ Medical detoxification/stabilization; and
  - ✓ Chemical dependency treatment.

The CUP Women program is designed to change the behavior of pregnant women and improve birth outcomes. Chemical-using pregnant women are high-risk for medical complications and struggle with the same challenges with recovery as other women with addictions. However, during pregnancy, they are more likely to accept treatment and successfully change their behavior. Substance abuse remains one of the most overlooked obstetric complicating factors during prenatal care. Prenatal substance abuse screening, treatment, and medical care should be initiated as early as possible during pregnancy. When a pregnant woman is ready to enter treatment, the ability to place her quickly into a safe and clinically appropriate environment is critical.

How is the CUP Women program different from other chemical dependency programs?

The CUP Women program is the only program that offers all of the following services **in a hospital setting:**

- Acute, medical detoxification;
- Stabilization;
- Medical treatment; and
- Chemical dependency treatment.

Note: Claims for CUP Women program services are paid by the agency, not by any other state or county program.

This acute level of care does not exist in other intensive inpatient treatment facilities. Due to the potential for serious health risks when detoxifying a chemical-using pregnant woman and fetus, acute medical services must be present. Once the client is medically stabilized, chemical dependency treatment begins.

The CUP Women program is an entry point into a greater opportunity for the client to receive care. Other substance abuse treatment programs exist for pregnant women who do not need medical detoxification or medical stabilization. These women can be served in a non-hospital based setting. Intensive inpatient treatment models such as social detoxification, outpatient services, or residential facilities often link with prenatal care providers, but are not equipped to meet the acute medical needs associated with these high-risk pregnancies. The CUP Women program is a unique partnership among providers from many disciplines for services. The program provides immediate access to care by removing the barriers of Medicaid eligibility, or limited referral sources existing in other programs.

How are hospitals paid for CUP Women services?

In order to get paid for CUP services, hospitals must be certified by the Division of Behavioral Health and Recovery (DBHR). Hospitals are paid based on a per diem rate assigned by the agency.

Where are CUP Women services provided?

CUP Women services are provided at acute care hospital-based inpatient facilities approved by DBHR. The agency does not cover CUP Women services provided out-of-state.

Who may refer clients to the CUP Women program?

Referrals to the CUP Women program may be made by, but are not limited to, the following:

- The client or family member;
- A local substance abuse outreach program;
- A First Steps provider;
- A First Steps social worker;
- The Department of Social and Health Services' Children's Administration ;
- A Medical provider; or
- DBHR-certified agencies.

The CUP Women hospital facility coordinates with all agencies that provide services to a referred client.

Client Eligibility

How can I verify a patient's eligibility?

[Refer to WAC 182-533-0710 (1)]

Adult and adolescent women are eligible for CUP Women services if they are:

- Pregnant.
- Have a medical need (including observation or monitoring).
- Have a substance abuse history and are screened "at risk."
- Have a current Services Card (or have a pending application for one).

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 applicable 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 current 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, see the agency's Program Benefit Packages and Scope of Services web page.

Note: Patients who are not Washington Apple Health clients may submit an application for health care coverage in one of the following ways. Initiate the application within five days of admission:

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.

Note: The CUP provider must complete a chemical dependency assessment of the client prior to admission.

Note: If a client is not eligible for the CUP Women program, refer them to the local chemical dependency center, or call the 24-hour DBHR Help Line to inquire about local resources at 1-800-562-1240.

The following are examples of clients who are ***not*** eligible for CUP Services:

- Clients who are not pregnant at admission.
- Clients who are receiving three-day or five-day detoxification services through DBHR.

Three- to five-day detoxification is funded at the county level and contains no medical component. **(See WAC 182-533-0710 (3).)**

Are clients enrolled in an agency-managed care plan eligible?

[Refer to WAC 182-533-0710 (2)]

Yes, but they receive services outside of their managed care plan through the agency's fee-for-service system. Coverage and billing guidelines found in this billing guide apply to managed care clients. Bill the agency directly.

When verifying eligibility using ProviderOne, if the client is enrolled in an agency managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen.

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

Effective January 1, 2017, some fee-for-service clients who have other primary health insurance will be 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 web site, under Providers and Billers.

Coverage

What is covered?

[Refer to WAC 182-533-0730 (1)-(3)]

The maximum length of treatment per inpatient stay that the agency pays for is 26 days. An approval for extended days may be requested due to medical necessity through the limitation extension submittal process .

The agency pays for the following covered services for a pregnant client and her fetus under the CUP Women program:

- **Acute Detoxification/Medical Stabilization/Rehabilitation Services**

  ✓ **Primary Acute Detoxification/Medical Stabilization** - approximately 3-5 days.

  ✓ **Secondary Sub-Acute Detoxification/Medical Stabilization** - approximately 7-10 days.

  ✓ **Rehabilitation/Treatment** - remainder of stay may include the following:

  - Assessment for ongoing treatment/clean and sober housing;
  - Referrals and linkage to all providers and case managers;
  - Chemical dependency education;
  - Ongoing medical attention including obstetrical appointments;
  - Ultrasounds or medical services;
  - Methadone maintenance when appropriate;
  - Reintegration/reentry into the community;
  - Ongoing treatment if need assessed;
  - Referrals as appropriate;
  - Partial hospitalization/day treatment; and
  - Outpatient services.

  ✓ **Other Services** - In addition to the core services of detoxification, medical stabilization, and rehabilitation, other services **may** include, but are not limited to:

  - Medical nutrition therapy;
  - Childbirth preparation and delivery;
  - Art and movement therapy;
  - Drug education and awareness for family;
  - Self-reliance education;
  - Parenting education in the care of alcohol/drug-affected infants;
  - Family dynamics education; and
  - Vocational counseling.

✓ **Other Services** (cont.)

- Psychological counseling;
- Psychotherapy and group therapy;
- Life skills, including use of Medicaid transportation;
- Financial management;
- Household management;
- Physical appearance consultation; and
- Day Treatment - Outpatient Treatment.

Note: In the event that needed services are not available on-site, refer clients to applicable community services. In these situations, the client remains an inpatient and is not discharged and then re-admitted to the CUP Women program. Often a case manager or attendant escorts the client off-site or the service visit occurs at the hospital.

What if the pregnancy ends before the client completes the CUP Women program?

[Refer to WAC 182-533-0730 (3)]

If the pregnancy ends before completing the CUP Women program, regardless of the reason, providers may continue a client's treatment if recommended by a physician, physician assistant, nurse practitioner, or clinical nurse specialist. If a less restrictive alternative treatment option is more appropriate, refer the client to the most suitable setting. Make every effort to keep the mother and child together.

Length of Treatment – Request for Prior Authorization for a Limitation Extension

The maximum length of treatment without prior authorization is 26 days. There is no minimum length of stay. If a limitation extension is needed, a request must be submitted to the agency at least 6 days prior to discharge. The agency may approve additional days when medically justified.

A limitation extension may be considered when a physician or physician assistant, nurse practitioner, or clinical nurse specialist shows that a pregnant client requires:

- Medical care that can only be provided in a hospital setting, and
- That this level of special care is necessary to reduce harm to the client and the fetus.

Determinations for limitation extension will be based upon:

- Needs of the mother and fetus;
- Progress made while in the CUP program;
- Current medical status; and
- The individualized treatment plan.

Limitation extension submittal process

Limitation extension requests must be submitted to the agency no later than 6 days prior to the 26th day of treatment (the last day).

The next pages to fax are the request for General Information for Authorization form (13-835), which must be completed and faxed as the first page of the request to the agency at: 1-866-668-1214. See Where can I download agency forms?

The CUP Pre-authorization for Limitation Extension form (12-344) is the next document followed by the supporting medical documentation below:

Medical documentation required to support a limitation extension

- Admission history and physical exam;
- Care and treatment plan;
- Client problem list;
- Detox protocol;
- Fetal monitoring notes;
- Chart notes;
- Most current progress notes;
- Discharge plan;

If approved by the agency, additional days will be paid at the CUP Program per diem rate for that provider. When billing for a limitation extension, bill with *revenue code 0129* and attach the limitation extension approval letter or include the authorization 'reference number' on the claim.

Limitation Extension Requests for Reasons Other Than Medical Stabilization

If a request for prior authorization for a limitation extension is received and does not meet the criteria for medical necessity, the request will be reviewed for possible approval of a limited number of additional days at the hospital administrative day rate.

Additional documentation for these requests must include complete chart notes showing:

- Dates of initial calls to the treatment facility;
- Name of person called or spoken with at the treatment facility;
- Dates of any follow up calls made to the treatment facility; and
- Estimated wait time for placement at a treatment facility.

Submit all of the required documentation above to the agency by fax at: 1-866-668-1214.

If approved by the agency, the additional days for these limitation extensions will be paid at the current hospital administrative day rate for a maximum of five days. (See the Inpatient Provider Payment System (IPPS)). Bill with *revenue code 0169* for day rate reimbursement and include the limitation extension letter or include the authorization reference number on the claim.

These limitation extensions paid at hospital administrative day rate **must** be billed on a separate institutional claim, along with any other charges associated with the administrative days.

Provider Requirements

Who is approved to provide CUP Women services?

[Refer to WAC 182-533-0720 (1)]

The agency pays only those providers who:

- Have been approved by the agency to provide CUP Women program services;
- Have been certified as chemical dependency service providers by the Division of Behavioral Health and Recovery (DBHR) as described in Chapter 388-877 WAC;
- Meet the Department of Health hospital accreditation standards in Chapter 246-320 WAC;
- Meet the general provider requirements in Chapter 182-502 WAC; and
- Are not licensed as an Institution for Mental Disease (IMD) under Centers for Medicare and Medicaid (CMS) criteria.

Program administration

[Refer to WAC 182-533-0720 (2)]

CUP Women program service providers must:

- Report any changes in certification, level of care, or program operation to the agency's CUP Women Program Manager. (See *Resources Available*.) Prior to providing CUP Women services, an application must be submitted to, and approval received from, DBHR and the Division of Healthcare Services (DHS) (see *Resources Available*);
- Have written policies and procedures that include a working statement describing the purpose and methods of treatment for chemical-using/chemical-dependent pregnant women;
- Provide guidelines and resources for current medical treatment methods by specific chemical type;
- Work collaboratively with state and community providers to ensure a working knowledge exists of current medical and substance abuse resources; and

- Ensure that a chemical dependency assessment has been completed by a chemical dependency professional under Chapter 246-811 WAC no earlier than six months before, and no later than five days after, the client's admission to the CUP Women program using the following criteria:

  ✓ Using the latest criteria of the American Society of Addiction Medicine (ASAM), which may include:

  - Pregnancy, post-pregnancy, and parenting status;
  - Number of children, custody status, residence, and visitation schedule;
  - History of Child Protective Service intervention;
  - History of death or loss of children;
  - Childcare needs;
  - Family Planning practices and needs;
  - Suicidal/homicidal ideation;
  - Domestic violence history;
  - Sexual assault history;
  - Ongoing mental health needs;
  - Current and past history of chemical use during pregnancy;
  - Previous pregnancy prenatal care;
  - Relationship addiction;
  - Family dynamics;
  - Family reunification plans;
  - Living situation/housing;
  - Legal issues; and
  - Eating disorders.

Notifying clients of their rights (advance directives)

(42 CFR, Subpart I)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

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, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the agency 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; and
- Record-keeping requirements.

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.

How do I bill for CUP Women services?

Use an electronic institutional claim to bill the hospital-based intensive CUP Women Services provided to the client. Ancillary (e.g., lab, pharmacy, etc.) charges related to the CUP Women's Services stay may be billed on the same claim with the CUP Women services.

Use the following guidelines when billing:

1. To facilitate processing of claims under this program, **the agency has established a daily room and board revenue code 0129.** This revenue code is used for the entire CUP Women Services stay. You must indicate this revenue code in the *Revenue Code field* of the electronic institutional claim. The agency reimburses for daily room rate charges ***only*** with this revenue code.

2. All claims for CUP Women Services must have a primary diagnosis code related to pregnancy and a secondary diagnosis code related to alcohol or drug abuse. When billing the agency for CUP Women Services, use the appropriate primary and secondary codes. See the agency's Approved Diagnosis Codes by Program web page for Chemical-Using Pregnant (CUP) Women Program services.

3. For all other (ancillary) revenue codes, refer to the agency's current Inpatient Hospital Services Billing Guide.

4. For additional billing information, refer to the agency's ProviderOne Billing and Resource Guide.

How do I bill for physician/ARNP services?

Physicians, physician assistants-certified (PACs), and advanced registered nurse practitioners (ARNPs) may provide inpatient hospital medical services during the CUP Women Services stay. To bill the agency, use the Current Procedural Technology (CPT®) code from the current Agency *Physician-Related Services/Healthcare Professional Services Medicaid Billing Guide* that most closely describes the service actually provided **(CPT codes 99221 through 99238)**. When billing for these services, you must use the appropriate primary and secondary ICD-10-CM diagnosis codes. See the agency's Approved Diagnosis Codes by Program when billing the agency for physician/ARNP services and use an electronic professional claim.

> **Note:** Prior to billing for CUP Women Services, providers must verify that the client meets eligibility requirements. (See Client Eligibility for more information.)