

Washington Apple Health (Medicaid)

Diabetes Education Program Billing Guide

July 1, 2022

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and a Health Care Authority rule arises, the rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **July 1, 2022** and supersedes earlier billing guides to this program. Unless otherwise specified, the program in this guide is governed by the rules found in [WAC 182-550-6400](#).

The Health Care Authority 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.

Refer also to HCA's [ProviderOne billing and resource guide](#) for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's [provider alerts webpage](#).

To access provider documents, go to HCA's [provider billing guides and fee schedules webpage](#).

Where can I download HCA forms?

To download an HCA form, see HCA's [Forms & Publications](#) webpage. Type only the form number into the Search box (Example: 13-835).

* This publication is a billing instruction.

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What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Client eligibility – Clients who are not enrolled in an HCA-contracted managed care plan for physical health services	Clarified who pays if a client received Medicaid-covered services before being automatically enrolled in a BHSO	Program enrollment clarification
Client eligibility – Integrated managed care	Revised paragraph to reflect enrollment in an <u>integrated</u> managed care plan	Clarification
Client eligibility – American Indian/Alaska Native (AI/AN) Clients	Created new subsection and moved this information out of the <i>Integrated managed care</i> section	Create a stand-alone section for just AI/AN clients

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Resources Available

Topic	Contact Information
Information on becoming a provider or submitting a change of address or ownership	See HCA's ProviderOne Resources webpage
Information about payments, denials, claims processing, or HCA-contracted managed care organizations	See HCA's ProviderOne Resources webpage
Electronic billing	See HCA's ProviderOne Resources webpage
Finding HCA documents (e.g., billing instructions, # memos, fee schedules)	See HCA's ProviderOne Resources webpage
Private insurance or third-party liability, other than HCA-contracted managed care	See HCA's ProviderOne Resources webpage
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 (HCA’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 HCA uses to reimburse providers for covered medical services provided to medical assistance clients when those services are not covered under HCA-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 Health Care Authority reimburses a provider for specific services, supplies, and equipment.

Usual and customary fee – The rate that may be billed to the Health Care Authority 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 Health Care Authority (HCA) for diabetes education services, use your NPI.

Client Eligibility

Most Apple Health clients are enrolled in an HCA-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 HCA'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 HCA will not pay for.

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 HCA'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 following note box.
- 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 HCA's [Program Benefit Packages and Scope of Services](#) webpage.

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- By visiting the [Washington Healthplanfinder's website](#).
- By calling the Customer Support Center toll-free at: 855-WAFINDER
(855-923-4633) or 855-627-9604 (TTY)
- 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 the [Washington Healthplanfinder's website](#) 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 HCA-contracted managed care organization (MCO) eligible?

Yes. Most Medicaid-eligible clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

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

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

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Note: See the Coverage section of this guide for benefit details.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in [WAC 182-502-0160](#).

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Managed care enrollment

Apple Health (Medicaid) places clients into an HCA-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. However, some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination.

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.

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.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account:**
 - Go to [Washington Healthplanfinder website](#).
- **Available to all Apple Health clients:**
 - Visit the [ProviderOne Client Portal website](#):
 - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.
 - Request a change online at [ProviderOne Contact Us](#) (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

For online information, direct clients to HCA's [Apple Health Managed Care](#) webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an HCA-contracted managed care plan are automatically enrolled in a BHSO, except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS Medicaid program will reimburse providers for the covered services. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

For full details on integrated managed care, see HCA's [Apple Health managed care webpage](#) and scroll down to "Changes to Apple Health managed care."

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program receive both medical and behavioral health services from CCW.

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.**"

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care Medical Team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's [Mental Health Services Billing Guide](#), under *How do providers identify the correct payer?*

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) [American Indian/Alaska Native webpage](#).

Coverage

The Diabetes Education Program is a covered benefit for all clients (fee-for-service and enrolled in an HCA-contracted managed care organization) with diabetes mellitus. This includes clients with a current or past diagnosis of type 1, type 2, and gestational diabetes, whether well-controlled or complicated.

What is covered?

The Health Care Authority 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 Health Care Authority 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 Health Care Authority 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:

- For dates of service **prior to** July 1, 2021:
 - Bill using revenue code 0942.
 - Provide a minimum of 30 minutes of education/management per session.
- For dates of service **on or after** July 1, 2021:
 - Bill using HCPCS code G0108 or G0109.
 - 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: Effective with date of service July 1, 2021, the Health Care Authority requires authorized hospital outpatient diabetes education programs to bill using HCPCS codes G0108 or G0109. Use of revenue code 0942 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 Health Care Authority.

The Health Care Authority 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 HCA 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 HCA forms?](#)), all of the documentation listed on this form, and any other medical justification

Fax LE requests to: (866) 668-1214

Coverage Table

HCPCS Codes	Short Description	Maximum Allowable Fees
G0108*	Diab manage trn per indiv, per session One unit = 30 minutes	Rates Development Fee Schedules
G0109*	Diab manage trn ind/group One unit = 30 minutes	Rates Development Fee Schedules

*HCPCS codes G0108 and G0109 are for professional billing and for outpatient hospital billing.

Billing

All claims must be submitted electronically to the Health Care Authority (HCA), except under limited circumstances.

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

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

What are the general billing requirements?

Providers must follow HCA'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 Health Care Authority'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: 11 for Office 22 for 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>