**MEDICAL ASSISTANCE ADMINISTRATION**

**Division of Provider Services**

# HOSPITAL-BASED INPATIENT DETOXIFICATION

## Billing Instructions

**August 1994**

# TABLE OF CONTENTS

**DESCRIPTION** **PAGE**

Preface .......... ii

Definition Guide .......... 1

Medical Assistance Administration -
General Information and Policy .......... 5

Division of Alcohol and Substance Abuse (DASA) Programs .......... 8

Section I: Alcohol Detoxification Services .......... 9
Section II: Drug Detoxification Services .......... 10
Section III: Alcohol/Drug Detoxification for Clients Detained or Involuntarily Committed .......... 12

Physician Billing .......... 14

Instructions for Completing the UB-92 Claim Form .......... 16
Completed Sample Form UB-92: Alcohol Detox Claim .......... 20A
Completed Sample Form UB-92: Drug Detox Claim .......... 20B

Instructions for Completing the HCFA-1500 Claim Form .......... 21
Completed Sample Form HCFA-1500: Physician Billing .......... 24A

Completed Sample Form A-19: Involuntary Commitment and Treatment .......... 24B

# PREFACE

***This publication supersedes all previous Hospital-Based Inpatient Detoxification Billing Instructions.***

Send claims for services provided to Washington State Medical Assistance clients, *except for Involuntary Treatment Act (ITA) Extended Detoxification*, to the Department of Social and Health Services, Medical Assistance Administration (MAA):

**UB-92 Claim Forms:**

**DIVISION OF PROVIDER SERVICES**
**PO BOX 9246**
**OLYMPIA WA 98507-9246**

**HCFA-1500 Claim Forms:**

**DIVISION OF PROVIDER SERVICES**
**PO BOX 9248**
**OLYMPIA WA 98507-9248**

Send claims for ***Involuntary Treatment Act (ITA) extended detoxification services*** to the address below, and/or for questions regarding ***policy*** and/or ***payment for (ITA) Detoxification***, or to obtain ***A-19 forms*** call:

**DIVISION OF ALCOHOL AND SUBSTANCE ABUSE**
**FISCAL SECTION**
**PO BOX 45330**
**OLYMPIA WA 98504-5330**
**(360) 438-8200**

If you have questions regarding MAA ***policy, payments, denials***, or have ***general questions*** regarding claims processing call:

**PROVIDER INQUIRY HOTLINE**
**Toll Free: 1-800-562-6188**

For questions regarding ***private insurance*** and ***third-party liability*** call:

**THIRD-PARTY RECOVERY PROGRAM**
**Toll-Free: 1-800-562-6136**

For information on ***electronic billing*** call:

**CLAIMS CONTROL**
**(360) 753-0318**
**Or**
**(360) 586-6825**

# DEFINITION GUIDE

The *Definition Guide* contains definitions, abbreviations, and acronyms used in these billing instructions which relate to the Medical Assistance Program.

**ADATSA** - Alcohol and Drug Addiction Treatment and Support Act. Persons eligible under the ADATSA program are entitled to medical care services. Participation in this program will be indicated on the medical ID card with a ***W*** legend.

**ALCOHOL ABUSE** - Use of alcohol in amounts hazardous to individual health or safety.

**ALCOHOLISM** - A disease characterized by a dependence on alcoholic beverages or the consumption of alcoholic beverages; loss of control over the amount and circumstances of use; symptoms of tolerance; physiological or psychological withdrawal, or both, if use is reduced or discontinued; and impairment of health or disruption of social or economic functioning.

**ALCOHOLISM AND/OR ALCOHOL ABUSE TREATMENT** - The provision of medical social services to an eligible client designed to mitigate or reverse the untoward effects of alcoholism or alcohol abuse and to reduce or eliminate alcoholism or alcohol abuse behaviors and restore normal social, physical, and psychological functioning. Alcoholism or alcohol abuse treatment is characterized by the provision of a combination of alcohol education sessions, individual therapy, group therapy, and related activities to detoxified alcoholics and their families.

**CATEGORICALLY NEEDY PROGRAM -** A program providing maximum benefits to persons who qualify for Medical Assistance. Participation in this program will be indicated on the medical ID card with the ***CNP*** legend.

**CHEMICAL DEPENDENCY** - An alcohol or drug addiction, or dependence on alcohol and one or more other psychoactive chemicals.

**CLIENT -** A person who has been determined to be eligible for one of the Medical Assistance Administration's medical care programs.

**CODE OF FEDERAL REGULATIONS (CFR)** - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

**COMMUNITY SERVICES OFFICE(S) (CSO)** - Field offices of the Department of Social and Health Services located in communities throughout the State which administer various services of the department at the community level.

**CORE PROVIDER AGREEMENT** - A basic contract that the Medical Assistance Administration (MAA) holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program. (WAC 388-87-007)

**DASA** - The Division of Alcohol and Substance Abuse within DSHS.

**DEPARTMENT or DSHS** - The Washington State Department of Social and Health Services.

**DIAGNOSIS, PRINCIPAL** - The condition established *after study* to be chiefly responsible for necessitating the admission of a client to a health care facility.

**DRUG ABUSE** - The use of a drug in amounts hazardous to a person's health or safety.

**DRUG ADDICTION** - A disease characterized by a dependency on psychoactive chemicals; loss of control over the amount and circumstances of use; symptoms of tolerance; physiological or psychological withdrawal, or both, if use is reduced or discontinued; and impairment of health or disruption of social or economic functioning.

**DRUG ADDICTION AND/OR DRUG ABUSE TREATMENT** - The provision of medical and rehabilitative social services to an eligible client designed to mitigate or reverse the effects of drug addiction or drug abuse and to reduce or eliminate drug addiction or drug abuse behaviors and restore normal physical and psychological functioning. Drug addiction or drug abuse treatment is characterized by the provision of a combination of drug and alcohol education sessions, individual therapy, group therapy and related activities to detoxified addicts and their families.

**ELECTRONIC MEDIA CLAIMS (EMC) -** Medical claim data, client eligibility data, third-party insurance data, and remittance data transmitted between Medical Assistance providers, or their intermediaries, and the MAA Division of Provider Services by means of personal computer, magnetic tape, mainframe, and the direct entry system.

**EXPLANATION OF BENEFITS (EOB)** - A coded message on the Medical Assistance Remittance and Status Report (RA) that gives detailed information regarding the claim associated with that report.

When **EOB** is referred to in relation to ***third-party liability*** instructions, it is most likely referencing the *insurance payor's* Explanation of Benefits – the result of the provider's having billed a *third party*. MAA's Third Party Recovery (TPR) Program requires a copy of an insurance company's EOB prior to paying a claim's balance.

**FRAUD -** A deliberate, intentional, and willful act with the specific purpose of deceiving the department with respect to any material fact, condition, or circumstance affecting eligibility or need. (WAC 388-22-030)

**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.

**MAXIMUM ALLOWABLE -** The maximum dollar amount for which a provider may be reimbursed by MAA for specific services, supplies, or equipment.

**MEDICAID -** The federal aid Title XIX program under which medical care is provided to:

(a)Categorically needy as defined in chapters 388-503-0310 and 388-503-1105 WAC; or
(b)Medically needy as defined in chapter 388-503-0320 WAC.
(WAC 388-500-0005)

**MEDICAL ASSISTANCE ADMINISTRATION (MAA) -** The unit within the department of social and health services authorized to administer the Title XIX Medicaid and the state-funded medical care programs. (WAC 388-500-0005)

**MEDICALLY NECESSARY** - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and 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)

**PARTICIPATING HOSPITAL** - A hospital that is: (1) located outside of a selective contracting area (SCA); or (2) located within a SCA and the facility and/or services it provides are considered exempt; or (3) located within a SCA and the facility has a contract with DSHS.

**PATIENT IDENTIFICATION CODE (PIC)** - An alphanumeric code assigned to each Medical Assistance client which consists of:

a) First and middle initials (*or* a dash (-) if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha character (tie breaker).

**PROVIDER or PROVIDER OF SERVICE -** An institution, agency, or person: (1) Having a signed agreement with the department to furnish medical care and goods and/or services to clients; and (2) Eligible to receive payment from the department. (WAC 388-500-0005)

**PROVIDER SERVICES, DIVISION OF (DPS)** - The division within the Medical Assistance Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

**RATIO OF COST-TO-CHARGE (RCC)** - The RCC payment method is used to reimburse peer group A hospitals for their costs and other DRG exempt services. RCCs are updated annually. Out-of-state hospitals are paid a weighted average of in-state hospitals' RCC.

**REMITTANCE AND STATUS REPORT (RA) -** A report produced by the claims processing system in the MAA Division of Provider Services that provides detailed information concerning submitted claims and other financial transactions.

**REVISED CODE OF WASHINGTON (RCW) -** Washington State laws.

**THIRD PARTY** - Any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. (CFR 433.136)

**USUAL & CUSTOMARY FEE -** This is the rate that may be billed to the department for a certain service or equipment. This rate *shall 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 for the same services normally offered to other contractors.

**WASHINGTON ADMINISTRATIVE CODE (WAC) -** Codified rules of the State of Washington.

# MEDICAL ASSISTANCE ADMINISTRATION (MAA)
## GENERAL INFORMATION AND POLICY

**I.BILLING TIME LIMIT**: State law requires that you present your final bill to MAA for reimbursement no later than 365 days after providing medical services.

**II.PAYMENT**: MAA may be billed only *after* you provide a service to an eligible client. Delivery of a service does not guarantee payment. For example, MAA will not make payment when:

·The request for payment is not presented within the 365-day billing limit;
·The service is not medically necessary or is not covered by MAA; OR
·A third party pays as much as, or more than, MAA allows.

If you provide services to a person who is *not* eligible for a medical program and who is later determined to be eligible, you may be paid by MAA when:

·The service is determined to be medically necessary, it is within MAA's scope of care, and it is a service covered by MAA policy; AND
·The client provides you with a medical ID card which covers the date of service *and* that covered service is billed within 365 days of the date it was provided; OR
·Your claim is presented within 365 days from the *retroactive* or *delayed certification* date indicated on the MAA medical ID card.

The *delayed certification* legend appears on the medical ID card when a person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service.

When the *retroactive certification* legend appears on a medical ID card, it indicates that the applicant received a service and applies in a *later* month for a medical program. Upon approval of the application, the person was found to be eligible for the medical program at the time he or she received the service.

(Refer to the MAA *General Information Booklet* for more specific information on medical ID card legends.)

**III**.**FEES**: Bill MAA your *usual and customary fee* (the fee you bill the general public). MAA's payment will be the lower of the billed charges, or MAA's maximum allowable rate, and is *payment in full*. State law allows you to bill clients for MAA medical programs' emergency medical expense requirement (EMER) and/or spend-down requirements.

MAA does not cover certain services. If you provide any noncovered service, the client is responsible for payment *only* under conditions defined in the MAA General Information Booklet section entitled "Billing the Medical Assistance Client."

**IV**.**THIRD PARTY LIABILITY**: Although the billing time limit for MAA is 365 days, an insurance carrier's time limit for claim submissions may be different. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA. If you would like assistance in identifying an insurance carrier in order to obtain information from them on their time limitations, you may call the *Third Party Recovery Program at 1-800-562-6136*.

You must bill any insurance carrier indicated on the medical ID card. The MAA 365-day billing time limit must be met even though you may not have received notification of action by the insurance carrier. If your claim is denied due to any existing third party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment, submit a completed claim form to MAA. Attach the insurance carrier's statement. If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial. If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

If you have any questions regarding third party liability, refer to the *General Information Booklet* or call the *Third Party Recovery Program at 1-800-562-6136*.

**V**.**CHARTS/RECORDS**: You must maintain legible, accurate, and complete charts and records in order to support and justify the services you provide. ***Chart*** means a compendium of medical records on an individual patient. ***Record*** means dated reports supporting claims submitted to the Washington Medical Assistance Administration for medical services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service.

Records of service shall be entered in chronological order by the practitioner who rendered the service. For reimbursement purposes, such records shall be legible and shall include but not be limited to:

1. Date(s) of service.
2. Patient's name and date of birth.
3. Name and title of person performing the service, when it is someone other than the billing practitioner.
4. Chief complaint or reason for each visit.
5. Pertinent medical history.
6. Pertinent findings on examination.
7. Medications and/or equipment/supplies prescribed or provided.
8. Description of treatment (when applicable).
9. Recommendations for additional treatments, procedures, or consultations.
10. X-rays, tests, and results.
11. Plan of treatment/care/outcome.

Records must be available to DSHS and to the U.S. Department of Health and Human Services upon request. Documentation must be timely, complete, and consistent with the bylaws and medical policies of the facility where the service is provided. DSHS conducts provider audits in order to determine compliance with the various rules governing its medical programs. (WAC 388-87-007)

**VI. ADVANCE DIRECTIVES: 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 patients*** written information about their rights, under state law, to make their own health care decisions. The patient's rights include: the right to accept or refuse medical treatment, the right to make decisions concerning their own medical care, and the right to formulate an advance directive, such as a living will or durable power of attorney, for their health care, except when a patient is detained under the provisions of 70.96 RCW, relating to ITA (Involuntary Treatment Act).

# DIVISION OF ALCOHOL AND SUBSTANCE ABUSE (DASA) PROGRAMS

The following information is intended to assist hospital and physician billing staff working with clients receiving hospital-based alcohol and/or drug detoxification services in counties where no free-standing detoxification centers are available.

> **NOTE: If your facility is certified to treat pregnant women under a Chemically Using Pregnant (CUP) Women agreement, *do not use Hospital Based Inpatient Detoxification Billing Instructions*. You should bill for those services using the instructions in the MAA *Chemically Using Pregnant (CUP) Women Billing Instructions*, which are available through the MAA Division of Provider Services.**

## ELIGIBILITY

Hospital-based alcohol and/or drug detoxification services are available to all eligible Medical Assistance clients. If the person is not currently eligible for Medical Assistance but may qualify, the hospital must contact the local DSHS Community Services Office (CSO) on the first working day following admission to initiate an application. Reimbursement cannot be made until eligibility is established.

## REIMBURSEMENT RATES

Reimbursement for all detoxification services addressed in these billing instructions will be based on rates set by applying the allowable Ratio of Cost-to-Charge (RCC) percentage for each hospital (see page 4 for a definition of RCC). Physicians will be reimbursed according to the current Medical Assistance Resource Based Relative Value Scale (RBRVS) Billing Instructions and Fee Schedule.

## SECTION 1: ALCOHOL DETOXIFICATION SERVICES

**Description:** Alcohol Detoxification provides up to three days of inpatient hospital detoxification services. These services must be performed in a participating hospital enrolled with the Medical Assistance Administration.

**Billing:** Hospitals must submit their claims on the UB-92 claim form. Send claims to:

**DIVISION OF PROVIDER SERVICES**
**PO BOX 9246**
**OLYMPIA WA 98507-9246**

**Diagnosis Codes:** You *must use* one or more diagnosis codes for ***alcohol detoxification*** when completing the UB-92 claim form. Use the code that most closely describes the diagnosis. The following diagnoses relate to **alcohol** detox.

291.0 Alcohol withdrawal delirium
291.1 Alcohol induced persisting amnestic disorder
291.2 Alcohol induced persisted dementia
291.3 Alcohol induced psychotic disorder with hallucinations
291.4 Idiosyncratic alcohol intoxication
291.5 Alcohol induced psychotic disorder with delusions
291.81 Alcohol withdrawal
291.89 Other specified alcohol induced mental disorders
291.9 Unspecified alcohol induced mental disorder
303.0 Acute alcoholic intoxication
303.9 Other and unspecified alcohol dependence
305.0 Alcohol abuse
790.3 Excessive blood level of alcohol

**ADD THE APPROPRIATE FIFTH-DIGIT ICD-9-CM SUBCLASSIFICATION BELOW TO CATEGORIES *303* AND *305*:**

**0 UNSPECIFIED**
**1 CONTINUOUS**
**2 EPISODIC**
**3 IN REMISSION**

## SECTION 2: DRUG DETOXIFICATION SERVICES

**Description:** Drug Detoxification provides up to five days of inpatient hospital detoxification services. These services must be performed in a participating hospital enrolled with the Medical Assistance Administration.

**Billing:** Hospitals must submit their claims on the UB-92 claim form. Send claims to:

**DIVISION OF PROVIDER SERVICES**
**PO BOX 9246**
**OLYMPIA WA 98507-9246**

**Diagnosis Codes:** You *must use* one or more diagnosis codes for ***drug detoxification*** when co detox.

292.0 Drug withdrawal
292.11 Drug induced psychotic disorder with delusions
292.12 Drug induced psychotic disorder with hallucinations
292.2 Pathological drug intoxication
292.81 Drug induced delirium
292.83 Drug induced persisting amenstic disorder
292.84 Drug induced mood disorder
292.89 Other specified drug induced mental disorders
292.9 Unspecified drug induced mental disorder
304.0 Opioid type dependence
304.1 Sedative, hypnotic or anxiolytic dependence
304.2 Cocaine dependence
304.3 Cannabis dependence
304.4 Amphetamine and other psychostimulant dependence
304.5 Hallucinogen dependence
304.6 Other specified drug dependence
304.7 Combinations of opioid type drug with any other
304.8 Combinations of drug dependence excluding opioid type drug
304.9 Unspecified drug dependence
305.2 Cannabis abuse
305.3 Hallucinogen abuse
305.4 Sedative, hypnotic or anxiolytic abuse
305.5 Opioid abuse
305.6 Cocaine abuse

305.7 Amphetamine or related acting sympathomimetic abuse
305.8 Antidepressant type abuse
305.9 Other, mixed, or unspecified drug abuse

**ADD THE APPROPRIATE FIFTH-DIGIT ICD-9-CM SUBCLASSIFICATION TO CATEGORIES *304* AND *305*:**

**0 UNSPECIFIED**
**1 CONTINUOUS**
**2 EPISODIC**
**3 IN REMISSION**

## SECTION 3: ALCOHOL/DRUG DETOXIFICATION FOR CLIENTS DETAINED OR INVOLUNTARILY COMMITTED

**Description: Protective Custody/Detention of Persons Incapacitated by Alcohol or Other Drugs:**

*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. Providers of services to clients who are (1) detained under the protective custody provisions of RCW 70.96A.120, and (2) are not being judicially committed to further care, must follow the instructions outlined in the Hospital-Based Inpatient Alcohol/Drug Detoxification sections. See Sections 1 & 2, pages 9-11.

**Involuntary Commitment for Chemical Dependency:**

*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 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 on pages 9-11 in these instructions.

Therefore, if a Petition is filed or a Temporary Order for Treatment is invoked, the three-/five-day limitations may be extended up to an additional six days. In this event, DASA will reimburse up to a maximum of nine days for Alcohol ITA Extended Detoxification or eleven days for Drug ITA Extended Detoxification.

Rates are set by applying the allowable RCC (Ratio of Cost-to-Charge) percentage for a given hospital.

**Billing:** All billings for ITA extended detoxification are to be submitted to:

**DIVISION OF ALCOHOL AND SUBSTANCE ABUSE**
**FISCAL SECTION**
**PO BOX 45330**
**OLYMPIA WA 98504-5330**

Submit the following forms, in addition to the completed UB-92 claim form, in order to receive payment:

1. An A-19 billing form with a statement on the form that the services are *ITA Extended Detoxification*; and

2. A copy of the cover page from the client's Temporary Order for Treatment or Petition for Commitment to Chemical Dependency Treatment.

**Diagnosis Codes:** Use the diagnosis codes listed under Sections 1 or 2: Alcohol Detoxification Services (page 9) or Drug Detoxification Services (page 10-11).

# PHYSICIAN BILLING

## HOSPITAL INPATIENT ALCOHOL OR DRUG DETOXIFICATION SERVICES

### A. DETOXIFICATION - VOLUNTARY (NON-ITA)

**Description:** Physicians billing for services rendered to inpatient alcohol or drug detox clients must complete a HCFA-1500 claim form using the appropriate *procedure codes* from the MAA RBRVS (Resource Based Relative Value Scale) Billing Instructions and Fee Schedule.

To receive reimbursement for these services, the appropriate alcohol or drug *diagnosis codes* listed under the DASA Program (pages 9-11) section must also be used and entered in *field 24E*. **Do not use diagnosis code 303.5.**

The RBRVS detox procedure codes are listed below:

| PROCEDURE CODE | DESCRIPTION | MAXIMUM ALLOWABLE |
|---|---|---|
| 0025M | Detox - Hospital Admit | $31.35 |
| 0026M | Detox - Hospital Follow-ups | $15.90 |

For alcohol detoxification services, the Department will allow:

(a) one Detox - Hospital Admit **(0025M)** per admission and
(b) two Detox - Hospital Follow-ups **(0026M)** per admission.

For drug detoxification services, the Department will allow:

(a) one Detox - Hospital Admit **(0025M)** per admission and
(b) four Detox - Hospital Follow-ups **(0026M)** per admission.

**Billing:** Submit claims to:

**DIVISION OF PROVIDER SERVICES**
**PO BOX 9248**
**OLYMPIA WA 98507-9248**

## B. DETOXIFICATION - INVOLUNTARY COMMITMENT (ITA)

**Description:** When billing for services to clients being committed for further treatment, submit claims directly to DASA. Submit the following forms ***in addition to*** the completed HCFA-1500 claim form:

1. An A-19 billing form with a note that the services are for *ITA Extended Detoxification*; and

2. A copy of the cover page from the client's Temporary Order for Treatment or Petition for Commitment to Chemical Dependency Treatment.

Use the following procedure codes when billing:

| PROCEDURE CODE | DESCRIPTION | MAXIMUM ALLOWABLE |
|---|---|---|
| 0025M | Detox - Hospital Admit | $31.35 |
| 0026M | Detox - Hospital Follow-ups | $15.90 |

Only one Detox - Hospital Admit **(0025M)** and up to ten Detox - Hospital Follow-ups **(0026M)** will be allowed per admission.

**Billing:** Submit claims for ITA extended detoxification services to:

**DIVISION OF ALCOHOL AND SUBSTANCE ABUSE**
**FISCAL SECTION**
**PO BOX 45330**
**OLYMPIA WA 98504-5330**

# INSTRUCTIONS FOR COMPLETING THE UB-92 CLAIM FORM

The numbered boxes on the UB-92 are called ***form locators***. *Only form locators that pertain to MAA are addressed here.*

***FORM LOCATOR NAME AND INSTRUCTIONS FOR COMPLETION***:

**1.PROVIDER NAME, ADDRESS & TELEPHONE NUMBER** - Enter the provider name, address, and telephone number as filed with DPS.

**3.PATIENT CONTROL NUMBER** - Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Control Number*.

**4.TYPE OF BILL** - Enter a code indicating the specific type of bill.

**6.STATEMENT COVERS PERIOD** - Enter the beginning and ending dates of the service(s) covered by this bill.

**12.PATIENT NAME** - Enter the client's last name, first name, and middle initial as shown on his/her medical ID card.

**13.PATIENT'S ADDRESS** - Enter the client's address.

**14.PATIENT'S BIRTHDATE** - Enter the client's birthdate.

**17.ADMISSION DATE** - Enter the date of admission (MMDDYY).

**18.ADMISSION HOUR** - Enter the hour the client was admitted. Use the two-character codes shown below:

| CODE | TIME (A.M.) | CODE | TIME (P.M.) | CODE | TIME |
|---|---|---|---|---|---|
| 00 | 12:00-12:59 (Midnight) | 12 | 12:00-12:59 (noon) | 99 | Hour Unknown |
| 01 | 01:00-01:59 | 13 | 01:00-01:59 | | |
| 02 | 02:00-02:59 | 14 | 02:00-02:59 | | |
| 03 | 03:00-03:59 | 15 | 03:00-03:59 | | |
| 04 | 04:00-04:59 | 16 | 04:00-04:59 | | |
| 05 | 05:00-05:59 | 17 | 05:00-05:59 | | |
| 06 | 06:00-06:59 | 18 | 06:00-06:59 | | |
| 07 | 07:00-07:59 | 19 | 07:00-07:59 | | |
| 08 | 08:00-08:59 | 20 | 08:00-08:59 | | |
| 09 | 09:00-09:59 | 21 | 09:00-09:59 | | |
| 10 | 10:00-10:59 | 22 | 10:00-10:59 | | |
| 11 | 11:00-11:59 | 23 | 11:00-11:59 | | |

**19.TYPE OF ADMISSION** - Enter type of admission:

1 - Emergent
2 - Urgent
3 - Elective
4 - Newborn

**20.SOURCE OF ADMISSION** - Enter Source of admission:

1 - Physician Referral
2 - Clinic Referral
3 - HMO Referral
4 - Transfer from a Hospital
5 - Transfer from a Skilled Nursing Facility
6 - Transfer from Another Health Care Facility
7 - Emergency Room
8 - Court/Law Enforcement
9 - Information Not Available

**21.DISCHARGE HOUR** - Enter the hour of discharge. Use the two-character coding shown on form locator 18.

**22.PATIENT STATUS** - Enter one of the following codes to describe the client at discharge:

| CODE | DESCRIPTION |
|---|---|
| 01 | Discharged to home or self care (routine discharge) |
| 02 | Discharged/transferred to another short-term general hospital for inpatient care |
| 03 | Discharged/transferred to skilled nursing facility (SNF) |
| 04 | Discharged/transferred to an intermediate care facility (ICF) |
| 05 | Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution |
| 06 | Discharged/transferred to home under care of home health service organization |
| 07 | Left against medical advice or discontinued care |
| 08 | Discharged/transferred to home under care of a Home IV provider |
| 09 | Admitted as an inpatient to this hospital |
| 10-19 | Discharge to be defined at state level, if necessary |
| 20 | Expired |
| 21-29 | Expired to be defined at state level, if necessary |
| 30 | Still patient or expected to return for outpatient services |
| 31-39 | Still patient to be defined at state level, if necessary |

**42.REVENUE CODE** - Enter the appropriate revenue code(s).

**43.<u>REVENUE OR PROCEDURE DESCRIPTION</u>** - Enter a narrative description of services performed.

**44. <u>HCPCS/RATES</u>** - Enter the accommodation rate for hospital bills or the HCFA code applicable to ancillary service and outpatient bills.

**46.<u>UNITS OF SERVICE</u>** - Enter the number of days of service (up to 3 days for alcohol detoxification and up to five days for drug detoxification).

**47.<u>TOTAL CHARGES</u>** - Enter the charge for each line. After all line charges, enter the total of all charges.

**48.<u>NONCOVERED</u>** - Enter the noncovered charge, if any, for each line. After all line charges, enter the total of all noncovered charges.

**50.<u>PAYER IDENTIFICATION: A/B/C</u>** - Enter name of insurer(s) *<u>if</u>* other health insurance benefits are available.

**51.<u>MEDICAID PROVIDER NUMBER</u>** - Enter the provider number issued to you by DPS for hospital-based detox services. This is the seven-digit provider number which appears on your Remittance and Status Report.

**54.<u>PRIOR PAYMENTS: A/B/C</u>** - Enter the amount due or received from other insurance.

**55.<u>ESTIMATED AMOUNT DUE: A/B/C</u>** - Total charges *minus* any amount(s) entered in form locator(s) *48* and *54 (other insurance).*

**58.<u>INSURED'S NAME: A/B/C</u>** - If other insurance benefits are available and coverage is under another name, enter the *insured's* name here.

**59.<u>PATIENT'S RELATIONSHIP TO INSURED A/B/C</u>** - Enter one of the following two-digit codes indicating the relationship of the client to the identified insured:

01 = Patient is insured
02 = Spouse
03 = Natural child/insured has financial responsibility
04 = Natural child/insured does not have financial responsibility
05 = Step child
06 = Foster child
07 = Ward of court/patient ward of insured
08 = Employee/patient employed by insured
09 = Unknown
10 = Handicapped dependent
11 = Organ donor
12 = Cadaver donor
13 = Grandchild
14 = Niece/nephew
15 = Injured plaintiff/patient claiming insurance as result of injury covered by insured
16 = Sponsored dependent
17 = Minor dependent of minor dependent
18 = Parent
19 = Grandparent

**60.<u>INSURED'S ID NO. A/B/C</u>** - Enter the ***<u>PIC</u>*** (Patient Identification Code). This information is obtained from the client's current monthly ID card. It is an alphanumeric code assigned to each Medical Assistance client and consists of the client's:

a)First and middle initials (*or* a dash (-) if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c)First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha character (tie breaker).

**61.<u>INSURANCE GROUP NAME A/B/C</u>** - If other insurance benefits are available, enter the *name of the insurance group or plan* under which the insured is covered.

**62.<u>INSURANCE GROUP NUMBER A/B/C</u>** - If other insurance benefits are available, enter any identification number identifying the *group* through which the individual is insured.

**65.<u>EMPLOYER NAME A/B/C</u>** - If other insurance benefits are available through employment, enter the employer's name.

**67.<u>PRINCIPAL DIAGNOSIS CODE</u>** - Enter the ICD-9-CM diagnosis code describing the client's principal diagnosis.

**68-75.<u>OTHER DIAGNOSIS CODES</u>** - Enter any ICD-9-CM diagnosis codes indicating conditions *other than* the principal condition.

**76.<u>ADMITTING DIAGNOSIS CODE</u>** - Enter the IDC-9-CM diagnosis code listed in this booklet which indicates the condition requiring admission.

**82.<u>ATTENDING PHYSICIAN ID A/B</u>** - Enter the seven-digit provider identification number.

**83.<u>OTHER PROVIDER</u>** - When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name or DSHS provider number.

**84.<u>REMARKS</u>** - Enter any other pertinent information applicable to this claim that has not been entered in other form locators.

# INSTRUCTIONS FOR COMPLETING THE HCFA-1500 CLAIM FORM

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing MAA. (The numbered boxes on the claim form are referred to as ***fields***.) Use the instructions below to fill out the HCFA-1500 form. **Please enter only ONE (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 form.**

**DO NOT WRITE, PRINT, OR STAPLE ANY ATTACHMENTS IN THE BAR AREA AT THE TOP OF THE FORM.**

**FIELD DESCRIPTION/INSTRUCTIONS FOR COMPLETION**

**1a.INSURED'S ID NO.** - Required. Enter the Medicaid Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the medical ID card. This information is obtained from the client's current monthly medical ID card and consists of the client's:

a)First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b)Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c)First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d)An alpha character (tie breaker).

*For example:*1.Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2.John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.
3.A PIC for Mary C. Johnson's newborn baby would look like this: MC010667JOHNSB and would show a **B** indicator in *field 19*.

***NOTE:*** The medical ID card is your proof of eligibility. Use the PIC code of either parent if a newborn has not been issued a PIC. Enter indicator **B** in *field 19*.

**2.PATIENT'S NAME** - Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

**3.PATIENT'S BIRTHDATE** - Required. Enter the birthdate of the Medicaid client.

**4.<u>INSURED'S NAME (Last Name, First Name, Middle Initial)</u>** - When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

**5.<u>PATIENT'S ADDRESS</u>** - Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

**9.<u>OTHER INSURED'S NAME</u>** - Secondary insurance. If the client has insurance secondary to the insurance listed in box 11, enter it here. When applicable, show the last name, first name, and middle initial of the insured.

**9a.** Enter the other insured's policy or group number *and* his/her Social Security Number.
**9b.** Enter the other insured's date of birth.
**9c.** Enter the other insured's employer's name or school name.
**9d.** Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

**Please note:** DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc. are <u>inappropriate</u> entries for this field.

**10.<u>IS PATIENT'S CONDITION RELATED TO</u>** - Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

**11.<u>INSURED'S POLICY GROUP OR FECA (Federal Employees Compensation Act) NUMBER</u>** - Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

**11a.<u>INSURED'S DATE OF BIRTH</u>** - Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

**11b.<u>EMPLOYER'S NAME OR SCHOOL NAME</u>** - Primary insurance. When applicable, enter the insured's employer's name or school name.

**11c.<u>INSURANCE PLAN NAME OR PROGRAM NAME</u>** - Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

**11d.IS THERE ANOTHER HEALTH BENEFIT PLAN?** - Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a. - d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d** is left blank, the claim may be processed and denied in error.

**17.NAME OF REFERRING PHYSICIAN OR OTHER SOURCE** - When applicable, enter the referring physician or Primary Care Case Manager name. This field *must* 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).

**17a.ID NUMBER OF REFERRING PHYSICIAN** - When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. *If the provider does not have an MAA provider ID number, be certain field 17 is completed.*

**19.RESERVED FOR LOCAL USE** - When applicable, enter indicator **B**, *Baby on parent's PIC.*

**21.DIAGNOSIS OR NATURE OF ILLNESS OR INJURY** - When applicable, enter the appropriate diagnosis code(s) in areas 1,2,3, and 4.

**22.MEDICAID RESUBMISSION** - When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

**23.PRIOR AUTHORIZATION NUMBER** - When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.

**24.Enter only ONE (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 form.**

**24A.DATE(S) OF SERVICE** - Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., January 04, 1994 = 010494).

**24B.PLACE OF SERVICE** - Required. Enter a **1** - *Inpatient hospital.*

**24C.TYPE OF SERVICE** - Required. Enter a **3** for all services billed.

**24D.PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS** - Required. Enter the appropriate Current Procedural Terminology (CPT) or HCFA Common Procedure Coding System (HCPCS) procedure code for the services being billed.

**24E.DIAGNOSIS CODE** - Required. Enter the ICD-9-CM diagnosis code related to the

procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM.

**24F.<u>$ CHARGES</u>** - Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

**24G.<u>DAYS OR UNITS</u>** - Required. Enter the total number of days or units for each line. These figures must be whole units.

**25.<u>FEDERAL TAX ID NUMBER</u> - Leave this field blank.**

**26.<u>YOUR PATIENT'S ACCOUNT NO.</u>** - Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Control Number.*

**28.<u>TOTAL CHARGE</u>** - Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

**29.<u>AMOUNT PAID</u>** - If you receive an insurance payment or client paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

**30.<u>BALANCE DUE</u>** - Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

**33.<u>PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #</u>** - Required. Put the *Name, Address,* and *Phone #* on all claim forms.

**<u>P.I.N.</u>** - Required when the performing provider belongs to a group or when the provider is an individual practitioner. When the seven-digit number is assigned to an individual practitioner, payment will be made under this number. Enter the seven-digit performing provider number assigned to you by the MAA when you signed your Core Provider Agreement.

**<u>GROUP</u>** - Enter the group number assigned by MAA. This is the seven-digit number identifying the entity (i.e., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number.