Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Health and Recovery Services Administration

Inpatient Hospital Services

Billing Instructions

Chapter 388-550 WAC

About this publication

This publication supersedes all previous Inpatient Hospital Billing Instructions and related Numbered Memoranda published by the Health and Recovery Services Administration Washington State Department of Social and Health Services

> **Note:** The effective date and publication date for any particular page of this document may be found at the bottom of the page.

Related Billing Instructions

- Acute Physical Medicine & Rehabilitation (PM&R).
- Ambulance and Involuntary Treatment Act Transportation;
- Long Term Acute Care;
- Outpatient Hospital; and
- Physician-Related Services (RBRVS).

Copyright Disclosure

DSHS's Billing Instructions and Numbered Memoranda

How Do I Conduct Business Electronically With DSHS?

You may conduct business electronically with DSHS by accessing the WAMedWeb at http://wamedweb.acs-inc.com.

Later in 2009, DSHS will replace its current Medicaid Management Information System with a new payment processing system named ProviderOne. When fully operational, ProviderOne will pay about 100,000 providers who serve the one million people qualifying for DSHS services each year. Please visit http://hrsa.dshs.wa.gov/ProviderOne for more information.

How Can I Get DSHS/HRSA Provider Documents?

To obtain DSHS/HRSA provider numbered memos and billing instructions, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link). These documents may be downloaded and printed.

Table of Contents

Table of Contents (cont.)

Section C: Program Limitations

Section D: Authorization

Table of Contents (cont.)

Table of Contents (cont.)

Table of Contents (cont.)

Section J: UB-04 Claim Form

Important Contacts

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

How can I use the Internet to…

Find information on becoming a DSHS provider?

Visit Provider Enrollment at:
http://hrsa.dshs.wa.gov/ProviderEnroll

Click ***Become a Washington Medicaid provider*** in the left hand column and follow the on-screen instructions.

Ask questions about the status of my provider application?

Visit Provider Enrollment at:
http://hrsa.dshs.wa.gov/ProviderEnroll

- Click ***contact HRSA in the left hand column or***
- ***Call 1-800-562-3022, option 2, and then option 5.***

Submit a change of address or ownership?

Visit Provider Enrollment at:
http://hrsa.dshs.wa.gov/ProviderEnroll

- Click ***Update your personal or business information***

Payments, denials, claims processing, or DSHS managed care organizations?

Call or fax:

1-800-562-3022, Option 2 (toll free)
1-360-725-2144 (fax)

or write to:

HRSA Customer Service Center
PO Box 45562
Olympia, WA 98504-5562

If I don't have access to the Internet, how do I find information on…

Becoming a DSHS provider, ask questions about the status of my provider application, or submit a change of address or ownership?

Call Provider Enrollment at:
1-800-562-3022 (toll free)

or write to:

HRSA Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

If I don't have access to the Internet, how do I find information on… (cont.)

Private insurance or third-party liability, other than DSHS managed care?

Office of Coordination of Benefits
PO Box 45565
Olympia, WA 98504-5565
1-800-562-6136 (toll free)

How do I find out about Internet billing (electronic claims submission)?

Call the DSHS/HIPAA E-Help Desk at: 1-800-562-3022 (toll free) and choose option #2, then option #4

or e-mail to:
hipaae-help@dshs.wa.gov

To enroll with ACS EDI Gateway for HIPAA Transactions and/or WinASAP 2003, **call ACS EDI Gateway, Inc. at:** 1-800-833-2051 (toll free)

After you submit the completed EDI Provider Enrollment form, ACS will send you the link and information necessary to access the web site. If you are already enrolled but cannot access the website, please call ACS toll free at 1-800-833-2051.

How do I check on a client's eligibility status?

Call HRSA at:
1-800-562-3022 (toll free) and choose option #2

You may also access the WAMedWeb Online Tutorial at:
http://hrsa.dshs.wa.gov/wamedwebtutor

How do I contact DSHS for information on, or to request…

Authorization or Prior Authorization, Limitation Extension (LE), or Exception to Rule (ETR)?

Mail to:
Health and Recovery Services Administration
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506

or

Fax: 1-360-586-1471

Acute PM&R Prior Authorization (Admission or Extension)?
Fax: 1-360-725-1966

What forms are available to submit my authorization request?

- Fax/Written Request Basic Information Form (DSHS #13-756)
- Bariatric Surgery Request Form (DSHS #13-785)
- Out of State Medical Services Request Form (DSHS #13-787)

To download these forms visit DSHS at http://www.dshs.wa.gov/msa/forms/eforms.html

Additional important information and contacts:

List of Acute Rehabilitation Facilities: http://hrsa.DSHS.wa.gov/Download/BillingInstructions/Acute_Rehab_Facilities.pdf

A list of the DASA Certified Hospitals providing intensive inpatient care for chemical using pregnant women is located on DSHS's website at: http://www.dshs.wa.gov/pdf/hrsa/dasa/Directory/APPNDXF.pdf

Regional Support Network Contacts for Psychiatric Hospitalization
http://www.dshs.wa.gov/mentalhealth/rsnmap.shtml

Greenbook directory for chemical dependency service providers
http://www.dshs.wa.gov/dasa/services/certification/directory/directory.shtml

Visit the Division of Behavioral Health and Recovery's (DBHR's), Regional Support Networks (RSNs) Services Information on the web at: http://www.dshs.wa.gov/Mentalhealth/rsnmap.shtml.

Where do I send paper claims?

Claims Processing
PO Box 9248
Olympia WA 98507-9248

How do I obtain DSHS forms?

To **view and download** DSHS forms, visit DSHS Forms and Records Management Service on the web: http://www1.dshs.wa.gov/msa/forms/eforms.html

Definitions & Abbreviations

This section defines terms and abbreviations (including acronyms) used in these billing instructions. Please refer to DSHS's General Information Booklet (http://hrsa.dshs.wa.gov/download/BillingInstructions/General_Information_BI.pdf) for other definitions.

Acute – A medical condition of severe intensity with sudden onset. See WAC 388-550-2511 for the definition of "acute" for the Acute Physical Medicine and Rehabilitation (Acute PM&R) program.

Acute care - Care provided for patients who are not medically stable or have not attained a satisfactory level of rehabilitation. These patients require frequent monitoring by a health care professional in order to maintain their health status.
Refer to WAC 248-27-015.

Acute physical medicine and rehabilitation (Acute PM&R) - A comprehensive inpatient rehabilitative program coordinated by an interdisciplinary team at a DSHS-approved rehabilitation facility. The program provides 24-hour specialized nursing services and an intense level of therapy for specific medical conditions for which the client shows significant potential for functional improvement. Acute PM&R is a 24-hour inpatient comprehensive program of integrated medical and rehabilitative services provided during the acute phase of a client's rehabilitation.

Administrative day - A day of a hospital stay in which an acute inpatient level of care is no longer necessary, and non-inpatient hospital placement is appropriate.

Administrative day rate - The statewide Medicaid average daily nursing facility rate as determined by DSHS.

Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) - The law and the state-administered program it established which provides medical services for persons who are incapable of gainful employment due to alcoholism or substance addiction.

Alcoholism and/or alcohol abuse treatment - The provision of medical social services to an eligible client designed to mitigate or reverse the 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.

All-patient DRG grouper (AP-DRG) - A computer software program that determines the medical and surgical diagnosis related group (DRG) assignments.

Allowable - The calculated amount for payment, after exclusion of any "nonallowed service or charge," based on the applicable payment method before final adjustments, deductions, and add-ons.

Allowed amount - The initial calculated amount for any procedure or service, after exclusion of any "nonallowed service or charge," that DSHS allows as the basis for payment computation before final adjustments, deductions, and add-ons.

Allowed charges - The maximum amount for any procedure or service that DSHS allows as the basis for payment computation.

Allowed covered charges - The maximum amount of charges on a hospital claim recognized by DSHS as charges for "covered hospital services" and payment computation, after exclusion of any "nonallowed service or charge," and before final adjustments, deductions, and add-ons.

Ancillary hospital costs - The expenses incurred by a hospital to provide additional or supporting services to its patients during their hospital stay. See **"ancillary services."**

Ancillary services - Additional or supporting services provided by a hospital to a patient during the patient's hospital stay. These services include, but are not limited to:

- Laboratory;
- Radiology;
- Drugs;
- Delivery room;
- Operating room;
- Postoperative recovery rooms; and
- Other special items and services.

Appropriate level of care - The level of care required to best manage a client's illness or injury based on the severity of illness presentation and the intensity of services received.

Assignment - A process in which a doctor or supplier agrees to accept the Medicare program's payment as payment in full, except for specific deductible and coinsurance amounts required of the patient.

Audit - An assessment, evaluation, examination, or investigation of a health care provider's accounts, books and records, including:

- Health, financial and billing records pertaining to billed services paid by DSHS through Medicaid, SCHIP, or other state programs, for the purpose of verifying the service was provided as billed and was allowable under program regulations; and

- Health, financial, and statistical records, including mathematical computations and special studies conducted in support of the Medicare cost report (Form 2552-96), submitted to DSHS for the purpose of establishing program rates for payment to hospital providers.

Authorization - An official approval for action taken for or on behalf of an eligible medical assistance client. This approval is valid only if the client is eligible on the date of service.

Authorization Number - A nine-digit number, assigned by the Health and Recovery Services Administration (HRSA), that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Beneficiary - A recipient of Social Security benefits, or a person designated by an insuring organization as eligible to receive benefits.

Billed charge - The charge submitted to DSHS by the provider.

Bordering city hospital - A hospital located outside Washington State and located in one of the bordering cities listed in WAC 388-501-0175.

Bundled services - Interventions that are integral to the major procedure and are not paid separately.

Capital-related costs or capital costs - The component of operating costs related to capital assets, including, but not limited to:

- Net adjusted depreciation expenses;
- Lease and rentals for the use of depreciable assets;
- The costs for betterment and improvements;
- The cost of minor equipment;
- Insurance expenses on depreciable assets;
- Interest expense; and
- Capital-related costs of related organizations that provide services to the hospital.

Capital costs due solely to changes in ownership of the provider's capital assets are excluded.

Case mix - From the clinical perspective, the condition of the treated patients and the difficulty associated with providing care. Administratively, it means the resource intensity demands that patients place on an institution.

Case mix index (CMI) - The arithmetical index that measures the average relative weight of all cases treated in a hospital during a defined period.

Change of Ownership - Occurrence of the following events describes common forms of changes of ownership, but is not intended to represent an exhaustive list of all possible situations:

- A change in composition of a partnership;
- A sale of an unincorporated sole proprietorship;
- The statutory merger or consolidation of two or more corporations;
- Leasing of all or part of a provider's facility if the leasing affects utilization, licensure or certification of the provider entity;
- The transfer of a government-owned institution to a governmental entity or to a governmental corporation;
- Donation of all or part of a provider's facility if the donation affects licensure or certification of the provider entity;
- A disposition of all or some portion of a provider's facility or assets through sale, scrapping, involuntary conversion, demolition, or abandonment if the disposition affects licensure or certification of the provider entity.

Children's hospital - A hospital primarily serving children.

Client - A person who receives or is eligible to receive services through DSHS programs.

CMS - Centers for Medicare and Medicaid Services.

Coinsurance - The portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not pay. Under Part A, coinsurance is a per day dollar amount. Under Part B, coinsurance is 20% of reasonable charges.

Comorbidity - Of, relating to, or caused by a disease other than the principal disease.

Complication - A disease or condition occurring subsequent to or concurrent with another condition and aggravating it.

Cost report - See "Medicare cost report."

Costs - DSHS-approved operating, medical education, and capital-related costs (capital costs) as reported and identified on the "cost report."

Cost-based conversion factor (CBCF) - For dates of admission before August 1, 2007, a hospital-specific dollar amount that reflects a hospital's average cost of treating Medicaid and SCHIP clients. It is calculated from the hospital's cost report by dividing the hospital's costs for treating Medicaid and SCHIP clients during a base period by the number of Medicaid and SCHIP discharges during that same period and adjusting for the hospital's case mix. See also **"hospital conversion factor"** and **"negotiated conversion factor."**

Covered services – See WAC 388-501-0060.

Covered hospital service - A service that is provided by a hospital, covered under a medical assistance program, and is within the scope of an eligible client's medical assistance program.

Critical border hospital - On and after August 1, 2007, determined by analyzing bordering city hospitals base period claims data during the rebasing process, and annually thereafter. [WAC 388-550-3900]

Current procedural terminology (CPT) - A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians. CPT is copyrighted and published annually by the American Medical Association (AMA).

Day outlier - An inpatient case with a date of admission before August 1, 2007, that requires DSHS to make additional payment to the hospital provider, but which does not qualify as a high-cost outlier. See **"day outlier payment"** and **"day outlier threshold."** DSHS's day outlier policy no longer exists for dates of admission on and after August 1, 2007.

Day outlier payment - The additional amount paid to a disproportionate share hospital for inpatient claims with dates of admission before August 1, 2007, for a client five years of age or younger who has a prolonged inpatient stay which exceeds the day outlier threshold, but whose covered charges for care fall short of the high cost outlier threshold. The amount is determined by multiplying the number of days in excess of the day outlier threshold and the administrative day rate.

Day outlier threshold - For inpatient claims with dates of admission before August 1, 2007, the average number of days a client stays in the hospital for an applicable DRG before being discharged, plus 20 days.

Deductible - The amount a beneficiary is responsible for, before Medicare starts paying; or the initial specific dollar amount for which the applicant or client is responsible.

Departmental weighted costs-to-charges (DWCC) rate - A rate DSHS uses to determine a Critical Access Hospital (CAH) payment. See WAC 388-550-2598 for how DSHS calculates a DWCC rate.

Detoxification - Treatment provided to persons who are recovering from the effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

Diagnosis code - A set of numeric or alphanumeric characters assigned by the ICD-9-CM, or successor document, as a shorthand symbol to represent the nature of a disease.

Diagnosis related group (DRG) - A classification system that categorizes hospital patients into clinically coherent and homogenous groups with respect to resource use, i.e., similar treatments and statistically similar lengths of stay for patients with related medical conditions. Classification of patients is based on the International Classification of Diseases (ICD-9), the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria.

Discharging hospital - The institution releasing a client from the acute care hospital setting.

Disproportionate share hospital (DSH) payment - A supplemental payment(s) made by DSHS to a hospital that qualifies for one or more of the disproportionate share hospital programs identified in the state plan.

Disproportionate share hospital (DSH) program - A program through which DSHS gives consideration to hospitals that serve a disproportionate number of low-income patients with special needs by making payment adjustment(s) to eligible hospitals in accordance with legislative direction and established payment methods. See 1902(a)(13)(A)(iv) of the Social Security Act. See also WAC 388-550-4900 through 388-550-5400.

Distinct unit - A Medicare-certified distinct area for psychiatric or rehabilitation services within an acute care hospital or a DSHS-designated unit in a children's hospital.

Division of alcohol and substance abuse (DASA) -The division within DSHS responsible for providing alcohol and drug-related services to help clients recover from alcoholism and drug addiction.

DRG - See **"diagnosis related group."**

DRG average length-of-stay - For dates of admission on and after August 1, 2007, DSHS's average length-of-stay for a DRG classification established during a DSHS DRG rebasing and recalibration project.

DRG-exempt services - Services which are paid through other methodologies than those using inpatient Medicaid conversion factors, inpatient state-administered program conversion factors, cost-based conversion factors (CBCF) or negotiated conversion factors (NCF). Some examples are services paid using a per diem rate, a per case rate, or a ratio of costs-to-charges (RCC) rate.

DRG payment - The payment made by DSHS for a client's inpatient hospital stay. This DRG payment allowed amount is calculated by multiplying the hospital's conversion factor by the DRG relative weight assigned by DSHS to the provider's inpatient claim before any outlier payment calculation.

DRG relative weight - The average cost or charge of a certain DRG classification divided by the average cost or charge, respectively, for all cases in the entire data base for all DRG classifications.

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.

Elective procedure or surgery - A non-emergency procedure or surgery that can be scheduled at the client's and provider's convenience.

Emergency medical expense requirement (EMER) - A specified amount of expenses for ambulance, emergency room or hospital services, including physician services in a hospital that a client must incur for an emergency medical condition prior to certification for the psychiatric indigent inpatient (PII) program.

Emergency room or **emergency facility** or **emergency department** - An organized, distinct hospital-based facility available 24 hours a day for the provision of unscheduled episodic services to patients who present for immediate medical attention, and is capable of providing emergency services including trauma care.

Emergency services - Healthcare services required by and provided to a patient after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. For DSHS payment to a hospital, inpatient maternity services are treated as emergency services.

Expedited prior authorization (EPA) – The DSHS-delegated process of creating an authorization number for selected medical/dental procedures and related supplies and services in which providers use a set of numeric codes to indicate which DSHS-acceptable indications, conditions, diagnoses, and/or DSHS-defined criteria are applicable to a particular request for service.

Expedited prior authorization (EPA) number - An authorization number created by the provider. By submitting an EPA, the provider certifies that DSHS-published criteria for the medical/dental procedure or supply or service have been met.

Experimental - A procedure, course of treatment, drug, or piece of medical equipment, which lacks scientific evidence of safety and effectiveness. See WAC 388-531-0050. A service is not "experimental" if the service:

- Is generally accepted by the medical profession as effective and appropriate; and
- Has been approved by the Food and Drug Administration (FDA) or other requisite government body if such approval is required.

Fee-for-service (FFS) - The general payment process DSHS uses to pay a hospital provider's claim for covered medical services provided to medical assistance clients when the payment for these services is through direct payment to the hospital provider, and is not the responsibility of one of DSHS's managed care organization (MCO) plans or a Mental Health Division designee.

Fixed per diem rate - A daily amount used to determine payment for specific services provided in long-term acute care (LTAC) hospitals.

Grouper - See "All-patient DRG grouper (AP-DRG)."

Health and Recovery Services Administration (HRSA) - The administration within DSHS authorized by the Secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (SCHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

High-cost outlier - For dates of admission before August 1, 2007, a claim paid under the DRG payment-method that did not meet the definition of "administrative day," and has extraordinarily high costs when compared to other claims in the same DRG. For dates of admission on and after January 1, 2001, to qualify as a high-cost outlier, the billed charges minus the noncovered charges reported on the claim must exceed three times the applicable DRG payment and exceed $33,000. DSHS's high-cost outliers are not applicable for dates of admission on and after August 1, 2007.

High outlier claim--Medicaid/SCHIP DRG - For dates of admission on and after August 1, 2007, a claim paid under the DRG payment method that does not meet the definition of "administrative day," and has extraordinarily high costs as determined by DSHS. See WAC 388-550-3700.

High outlier claim--Medicaid/SCHIP per diem - For dates of admission on and after August 1, 2007, a claim that:

- Is classified by DSHS as being allowed a high outlier payment that is paid under the per diem payment method;
- Does not meet the definition of "administrative day,"; and
- Has extraordinarily high costs as determined by DSHS. See WAC 388-550-3700.

High outlier claim—state-administered program DRG - For dates of admission on and after August 1, 2007, a claim paid under the DRG payment method that does not meet the definition of "administrative day," and has extraordinarily high costs as determined by DSHS. See WAC 388-550-3700.

High outlier claim—state-administered program per diem - For dates of admission on and after August 1, 2007, a claim that:

- Is classified by DSHS as being allowed as a high outlier payment;
- Is paid under the per diem payment method;
- Does not meet the definition of "administrative day,"; and
- Has extraordinarily high costs as determined by DSHS. See WAC 388-550-3700.

Hospice - A medically-directed, interdisciplinary program of palliative services for terminally ill clients and the clients' families. Hospice is provided under arrangement with a Washington state-licensed and Title XVIII-certified Washington state hospice.

Hospital - An entity that is licensed as an acute care hospital in accordance with applicable state laws and regulations, or the applicable state laws and regulations of the state in which the entity is located when the entity is out-of-state, and is certified under Title XVIII of the federal Social Security Act. The term "hospital" includes a Medicare- or state-certified distinct rehabilitation unit or a "psychiatric hospital" as defined in this section.

Hospital conversion factor - A hospital-specific dollar amount that reflects the average cost for a DRG-paid case of treating Medicaid and SCHIP clients in a given hospital. See cost-based conversion factor (CBCF) and negotiated conversion factor (NCF).

Hospital covered service - A service that is provided by a hospital, covered under a medical assistance program, and is within the scope of an eligible client's medical assistance program.

Hospital cost report – See Medicare **cost report.**

ICD-9-CM (International Classification of Diseases, 9th Revision Clinical Modification Edition) – The systematic listing that transforms verbal descriptions of diseases, injuries, conditions and procedures into numerical or alphanumerical designations (coding).

Informed consent - An individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

- Disclosed and discussed the patient's diagnosis;
- Offered the patient an opportunity to ask questions about the procedure and to request information in writing;
- Given the patient a copy of the consent form;
- Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. 441.257; and
- Given the patient oral information about all of the following:
  - ✓ The patient's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure;

- ✓ Alternatives to the procedure including potential risks, benefits, and consequences; and
- ✓ The procedure itself, including potential risks, benefits, and consequences.

Inpatient hospital - A hospital authorized by the Department of Health to provide inpatient services.

Inpatient hospital admission - An admission to a hospital based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary inpatient care, including assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury, and that is documented in the client's health record.

Inpatient Medicaid conversion factor - A dollar amount that represents selected hospitals' average costs of treating Medicaid and SCHIP clients. The conversion factor is a rate that is multiplied by a DRG relative weight to pay Medicaid and SCHIP claims under the DRG payment method. See WAC 388-550-3450 for how this conversion factor is calculated.

Inpatient services – Healthcare services provided directly or indirectly to a client subsequent to the client's inpatient hospital admission and prior to discharge.

Inpatient state-administered program conversion factor - The DRG conversion factor is reduced by the equivalency factor (EF) to calculate payments for inpatient services provided to clients eligible for state-administered programs (WAC 388-550-4800). The inpatient conversion factor for state-administered programs is multiplied by a DRG relative weight to pay claims for clients under state only programs.

Institution for Mental Diseases (IMD) – A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Edition - The systematic listing that transforms verbal descriptions of diseases, injuries, conditions and procedures into numerical or alpha-numerical designations (coding).

Length of stay (LOS) - The number of days of inpatient hospitalization, determined by counting the total number of days from the admission date to the discharge date, and subtracting one day.

Length of stay extension request - A request from a hospital provider for DSHS to approve a client's hospital stay when that stay exceeds length of the admission is exceeding the number of days authorized at the time of admission; In the case of an acute PM&R, or LTAC admission, the hospital provider submits a request to DSHS; In the case of a psychiatric admission the hospital contacts the

- The DBHR designee, to approve additional days of a client's hospital stay, when;
- When the
- At a previous concurrent review; or
- During a previous concurrent review.

Send to Carolyn to rework this

Long term acute care (LTAC) services - Inpatient intensive long term care services provided in department-approved LTAC hospitals to eligible medical assistance clients who meet criteria for Level 1 or Level 2 services. See WAC 388-550-2565 through 388-550-2596.

Low-cost outlier - A case having a date of admission before August 1, 2007, with extraordinarily low costs when compared to other cases in the same DRG. For dates of admission on and after January 1, 2001, to qualify as a low-cost outlier, the allowed charges must be less than the greater of ten percent of the applicable DRG payment or four hundred and fifty dollars. DSHS's low-cost outliers are not applicable for dates of admission on and after August 1, 2007.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

Medicaid - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the:

- Categorically needy program; or
- Medically needy program.

Medical Identification (ID) Card – The form DSHS uses to identify clients of medical programs. Medical ID cards are good only for the dates printed on them. Clients will receive a Medical ID card in the mail each month they are eligible.

Medical assistance program - Any healthcare program administered through HRSA.

Medical care services - The state-administered limited scope of care provided to general assistance-unemployable (GA-U) recipients, and recipients of alcohol and drug addiction services provided under chapter 74.50 RCW.

Medical education costs - The expenses incurred by a hospital to operate and maintain a formally organized graduate medical education program.

Medical Management Information System (MMIS) – The systems, structures, and programs HRSA uses to process medical claims.

Medically necessary – See WAC 388-500-0005.

Medical stabilization - A return to a state of constant and steady function. It is commonly used to mean the patient is adequately supported to prevent further deterioration.

Medicare – Refer to the General Information Booklet.

Medicare cost report - The Medicare cost report (Form 2552-96), or successor document, completed and submitted annually by a hospital provider:

- To Medicare intermediaries at the end of a provider's selected fiscal accounting period to establish hospital reimbursable costs for per diem and ancillary services; and

- To Medicaid to establish appropriate DRG and other rates for payment of services rendered.

Medicare crossover - A claim involving a client who is eligible for both Medicare benefits and Medicaid.

Division of Behavioral Health and Recovery designee - A professional contact person authorized by the Division of Behavioral Health and Recovery, who operates under the direction of a Regional Support Network (RSN) or a prepaid inpatient health plan (PIHP). See WAC 388-550-2600.

Negotiated conversion factor (NCF) - For dates of admission before July 1, 2007, a negotiated hospital-specific dollar amount used in lieu of the cost-based conversion factor as the multiplier for the applicable DRG weight to determine the DRG payment for a selective contracting program hospital. See also **"hospital conversion factor"** and **"cost-based conversion factor."** DSHS's hospital selective contracting program no longer exists for dates of admission on and after July 1, 2007.

Newborn or neonate or neonatal - A person younger than 29 days old.

Non-allowed service or charge - A service or charge that is not recognized for payment by DSHS, and cannot be billed to the client except under the conditions identified in WAC 388-502-0160.

Noncovered charges - Billed charges submitted to DSHS by a provider and indicated by the provider on the claim as noncovered WAC 388-502-0160. Data element on UB-04 form defined by National Uniform Billing Committee.

Noncovered service or charge - A service or charge that is not considered or paid by DSHS as a "covered hospital service," and cannot be billed to the client except under the conditions identified in WAC 388-502-0160.

Observation services - Healthcare services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by hospital staff, which are reasonable and necessary to evaluate an outpatient client's condition or determine the need for possible admission of the client to the hospital as an inpatient.

Operating costs - All expenses incurred in providing accommodation and ancillary services, excluding capital and medical education costs.

Orthotic device or **orthotic** - A corrective or supportive device that:

- Prevents or corrects physical deformity or malfunction; or
- Supports a weak or deformed portion of the body.

Out-of-state hospital - Any hospital located outside the state of Washington and outside the designated bordering cities in Oregon and Idaho (see WAC 388-501-0175). For medical assistance clients requiring psychiatric services, "out-of-state hospital" means any hospital located outside the state of Washington.

Outliers - Cases with extraordinarily high or low costs when compared to other cases in the same DRG.

Outpatient client- A patient who is receiving healthcare services in other than an inpatient hospital setting.

Outpatient hospital - A hospital authorized by the Department of Health (DOH)to provide outpatient services.

Outpatient hospital services - Those healthcare services that are within a hospital's licensure and provided to a client who is designated as an outpatient.

Outpatient observation - See **"observation services."**

Outpatient short stay - See **"observation services"** and **"outpatient hospital services."**

Outpatient surgery - A surgical procedure that is not expected to require an inpatient hospital admission.

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

a) First and middle initials (or a dash (-) must be entered 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); and
d) Alpha or numeric character (tiebreaker).

Per diem rate - A daily rate used to calculate payment for services provided as a "covered hospital service."

PM&R - See **"Acute PM&R."**

Plan of treatment or **plan of care** – The written plan of care for a patient which includes, but is not limited to, the physician's order for treatment and visits by the disciplines involved, the certification period, medications, and rationale indicating need for services.

Primary care case management (PCCM) - Means the coordination of healthcare services under DSHS's Indian health center or tribal clinic managed care program. See WAC 388-538-068.

Principal diagnosis – The condition established after study to be chiefly responsible for the admission of the patient to the hospital for care.

Prior authorization (PA) - A process by which clients or providers must request and receive DSHS or a DSHS designee's approval for certain healthcare services, equipment, or supplies, based on medical necessity, before the services are provided to clients, as a precondition for payment to the provider. Expedited prior authorization and limitation extension are forms of prior authorization.

Professional component - The part of a procedure or service that relies on the physician's professional skill or training, or the part of a payment that recognizes the physician's cognitive skill.

Prosthetic device or **prosthetic** - A replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner, within the scope of his or her practice as defined by state law, to:

- Artificially replace a missing portion of the body;
- Prevent or correct physical deformity or malfunction; or
- Support a weak or deformed portion of the body.

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

- Who has a signed agreement with DSHS to furnish medical [dental] care, goods and/or services to clients; and
- Is eligible to receive payment from DSHS.

Psychiatric hospital - A Medicare-certified distinct psychiatric unit, a Medicare-certified psychiatric hospital, or a state-designated pediatric distinct psychiatric unit in a Medicare-certified acute care hospital. Eastern State Hospital and Western State Hospital are excluded from this definition.

Psychiatric indigent inpatient (PII) program - A state-administered program established by DSHS specifically for mental health clients identified in need of voluntary emergency inpatient psychiatric care by a DBHR designee. See WAC 388-865-0217.

Ratio of costs-to-charges (RCC) - A method used to pay hospitals for some services exempt from the DRG payment method. It also refers to the factor or rate applied to a hospital's allowed covered charges for medically necessary services to determine estimated costs, as determined by DSHS, and payment to the hospital for some DRG-exempt services.

RCC - See **"ratio of costs-to-charges."**

Rebasing - The process of recalculating the conversion factors, per diems, per case rates, or RCC rates using historical data.

Recalibration - The process of recalculating DRG relative weights using historical data.

Regional support network (RSN) - A county authority or a group of county authorities recognized and certified by DSHS, that contracts with DSHS per chapters 38.52, 71.05, 71.24, 71.34, and 74.09 RCW and chapters 275-54, 275-55, and 275-57 WAC, to manage the provision of mental health services to medical assistance clients.

Rehabilitation units - Specifically identified rehabilitation hospitals and designated rehabilitation units of hospitals that meet department and/or Medicare criteria for distinct rehabilitation units.

Relative weights - See **"DRG relative weight."**

Revenue code - A nationally-assigned coding system for billing inpatient and outpatient hospital services, home health services, and hospice services.

Room and board - The services a hospital facility provides a patient during the patient's hospital stay. These services include, but are not limited to, a routine or special care hospital room and related furnishings, routine supplies, dietary and nursing services, and the use of certain hospital equipment and facilities.

Secondary diagnosis – A diagnosis other than the principal diagnosis for which an inpatient client is admitted to a hospital.

Seven-day readmission - The situation in which a client who was admitted as an inpatient and discharged from the hospital has returned to inpatient status to the same or a different hospital within seven days.

State Children's Health Insurance Program (SCHIP) - The federal Title XXI program under which medical care is provided to uninsured children younger than age 19.

State plan - The plan filed by DSHS with the Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services (DHHS), outlining how the state will administer Medicaid and SCHIP services, including the hospital program.

Surgery - The medical diagnosis and treatment of injury, deformity or disease by manual and instrumental operations. For reimbursement purposes, surgical procedures are those designated in CPT as procedure codes 10000 to 69999.

Swing-bed day - A day in which a client is receiving skilled nursing services in a hospital designated swing bed at the hospital's census hour. The hospital swing bed must be certified by the Centers for Medicare and Medicaid Services (CMS) for both acute care and skilled nursing services.

Technical component - The part of a procedure or service that relates to the equipment set-up and technician's time, or the part of a procedure and service payment that recognizes the equipment cost and technician time**.**

Transfer - To move a client from one acute care facility or distinct unit to another acute care or a non acute care setting.

Transferring hospital - The hospital or distinct unit that transfers a client to another acute care or non acute care setting facility.

Trauma care facility - A facility certified by the Department of Health as a level I, II, III, IV, or V facility. See chapter 246-976 WAC. Only levels I, II, and III trauma-designated hospitals are eligible for supplemental trauma payments from DSHS.

Trauma care service - See Department of Health's WAC 246-976-935.

UB-04 - The uniform billing document required for use nationally, beginning on May 23, 2007, by hospitals, nursing facilities, hospital-based skilled nursing facilities, home health agencies, and hospice agencies in billing third party payers for services provided to patients. This includes the current national uniform billing data element specifications developed by the National Uniform Billing Committee and approved and/or modified by the Washington State Payer Group or DSHS.

Unbundled services - Interventions that are not integral to the major procedure and that are paid separately.

Usual and customary charge (UCC) - The charge customarily made to the general public for a healthcare procedure or service, or the rate charged other contractors for the service if the general public is not served.

Washington Administrative Code (WAC) Codified rules of the state of Washington.

Payment for Services

Payment Methods and Limits for Inpatient Hospitals

[Refer to Chapter 388-550 WAC]

Note: Unless otherwise specified, all payment information provided in this document is applicable for inpatient hospital claims with dates of admission on and after August 1, 2007.

How To Get Paid

Providers must follow the general billing requirements in **DSHS's *General Information Booklet*** (http://hrsa.dshs.wa.gov/download/BillingInstructions/General_Information_BI.pdf). Also see Section H, General Billing, of these billing instructions for specific hospital inpatient information.

Hospital revenue codes are updated every six months in January and July. The revenue code grid is available online at http://hrsa.dshs.wa.gov//HospitalPymt/Outpatient/Index.htm

Payment Methods

The Department of Social and Health Services (DSHS) pays for inpatient hospital services using several payment methods including, but not limited to, the following:

- Diagnosis Related Group (DRG) method (the primary payment method);
- Certified Public Expenditure Full Cost method;
- Cost Settlement method;
- Per Diem method;
- Per Diem method – LTAC;
- Per Case method; or
- Ratio of Costs-to-Charges (RCC).

Payment Method Table

The table below briefly describes the methods DSHS uses to pay hospitals for Medicaid and SCHIP inpatient hospital services:

Payment method used for Medicaid inpatient hospital claims	Applicable providers/services	Process to adjust for third-party liability insurance and any other client responsibility
Certified Public Expenditure (CPE) Full Cost method	Hospitals eligible to be paid through the certified public expenditure (CPE) payment program	For the "hold harmless" settlement, the lesser of the billed amount minus the third-party payment amount and any client responsibility amount, or the allowed amount minus the third-party payment amount and any client responsibility amount. The payment made is the federal share only.
Cost settlement	Department of Health (DOH)-approved critical access hospitals (CAHs)	The allowable amount, subject to retrospective cost settlement, minus the third-party payment amount and any client responsibility amount.
Diagnosis Related Group (DRG) method (the primary payment method)	Hospitals and services not exempt from the DRG payment method	Lesser of: (1) The DRG billed amount minus the third-party payment amount and any client responsibility amount; or (2) The allowed amount, minus the third-party payment amount and any client responsibility amount. **Note:** High outlier provision apply, if claim qualifies.
Per Case rate	Hospitals eligible to provide bariatric surgery to medical assistance clients	Lesser of: (1) The billed amount minus the third-party payment amount and any client responsibility amount; or (2) The single case rate allowed amount minus the third-party payment amount and any client responsibility amount.

Payment method used for Medicaid inpatient hospital claims	Applicable providers/services	Process to adjust for third-party liability insurance and any other client responsibility
Per Diem rate	Some providers/services exempt from the DRG payment methods	Per diem allowable amount, and high outlier amount, if any minus the third-party payer amount, if any, and any client responsibility amount. **Note:** high outlier provisions apply for medical, surgical, neonate, burn services, if claim qualifies
Per Diem rate - LTAC	Long-term acute care (LTAC) hospitals	Lesser of the (1) Billed amount minus the third-party payment amount and any client responsibility amount; or (2) The fixed per diem allowed amount minus the third-party payment amount and any client responsibility amount.
Ratio of Costs-to-Charges (RCC)	Organ Transplant services	The allowable minus the third-party payment amount and any client responsibility amount.

Note: The payment methods listed in the preceding table use the hospital rates and/or client eligibility in effect on the date of admission.

*The term "allowable" or “allowed” used in this table and this section means the calculated allowed amount for payment based on the applicable payment method before adjustments, deductions, or add-ons.

When mandated by the State Legislature, DSHS may apply an adjustment factor to the DRG conversion factor, High Cost Outlier Threshold, Outlier Adjustment Factor, Per Diem, RCC, Bariatric Case Rate and other rates for the purpose of achieving the legislature’s targeted expenditure levels. Critical Access Hospital rates are not affected. The inpatient adjustment factor is calculated by DSHS and applied to existing inpatient hospital rates.

Payment for State-Administered Programs
[Refer to WAC 388-550-4800]

- DSHS uses various payment methods for inpatient hospital services provided to clients eligible under state-administered programs. State-administered programs include:

  - ✓ The Psychiatric Indigent Inpatient (PII) program; and
  - ✓ The following medical care services programs:

    - ➢ General Assistance-Unemployable (GA-U) program;
    - ➢ Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) program; and
    - ➢ "Q" Involuntary Treatment Act (ITA) program.

- **Payment rates**
  DSHS pays claims for state-administered programs by using the rates for state-administered programs rather than Medicaid or SCHIP rates. Use the state-administered program rates when comparing the lesser of either:

  - ✓ The billed amount minus the third-party payment and any client responsibility amount; or
  - ✓ The allowed amount minus the third-party payment amount and any client responsibility amount.

- **To determine the allowed amount**
  On an inpatient hospital claim for services provided to clients eligible for a state-administered program, DSHS applies a reduction factor to the applicable Medicaid rate.

- **Third-party liability (TPL) and/or Client Responsibility Payments.**
  DSHS's policy for payment on state-administered program claims involving third-party liability (TPL) and/or client responsibility payments is the same policy described in the preceding table titled *Payment Methods for Inpatient Hospital Claims*.

Payment Adjustments

DSHS may adjust payment due to the following:

- **Validation of DRG Assignment**
  DSHS may review the DRG classification on claims for appropriate coding, place of service, and medical necessity. If DSHS determines the DRG to be inappropriate, the hospital will be notified and an adjustment or payment recoupment may be made. Providers must resubmit their claims with diagnosis codes, procedure codes and place of service codes that group to an appropriate DRG and provide proof of medical necessity.

To ensure the appropriate DRG is assigned and paid, providers must bill inpatient hospital claims in accordance with:

- ✓ National uniform billing data elements; and
- ✓ Published International Classification of Diseases Clinical Modification (ICDCM) coding guidelines.

Valid Diagnosis Related Group (DRG) Codes

DSHS does not pay for inpatient hospital stays that group to DRG codes 469 or 470. Providers must resubmit claims using diagnosis and procedure codes that group to a valid DRG.

- **Transfers**
  The transferring acute care facility or distinct unit may receive a pro-rated DRG payment if the length of stay (LOS) plus one day is less than DSHS's established DRG average LOS. Refer to "Transfer Information for the DRG Payment Method" in this section. Transfers must be coded with the appropriate patient status code defined in the UB-04 Manual.

- **Inpatient Hospital Psychiatric Transfers**
  The transferring hospital must contact the appropriate mental health designee or RSN for prior approval and a condition code obtain a 13-821 form with auth number. The condition code must be noted A copy of the RSN completed 13-821 form with authorization number should be included in the client's records to be shared with the receiving hospital and placed on the claim submitted by the receiving hospital (refer to the Inpatient Hospital Psychiatric Admission section).

- **Seven-Day Readmissions [Refer to WAC 388-550-2900]**
  DSHS does not pay for two separate inpatient hospitalizations if a client is readmitted to the same or different hospital or distinct unit within seven calendar days of discharge, unless the readmission is due to conditions unrelated to the previous admission.

DSHS:

- May perform a retrospective utilization review as described in WAC 388-550-1700 to determine the appropriate payment for the readmission; and

- Determines if the combined hospital stay for the admission qualifies to be paid as an outlier. See WAC 388-550-3700 for DRG high-cost outliers and per diem high outliers for dates of admission on and after August 1, 2007.

Diagnosis Related Group (DRG) Payment Method

[Refer to WAC 388-550-3000]

DRG payment method (Inpatient Primary Payment Method)
On August 1, 2007, DSHS began using AP-DRG Grouper Version 23 to assign DSHS's recognized DRG classification to each inpatient claim processed through DSHS's Medical Management Information System (MMIS) for payment.

The DRG payment method is based on:

- The DRG classification that a claim is assigned by DSHS's MMIS; and
- The cost-based relative weight assigned to the DRG classification and the hospital's specific DRG conversion factor.

DSHS pays hospitals excluded from the DRG payment method using one of the other payment methods listed in the table on previous pages and described in applicable WAC.

DRG Relative Weights
In DSHS's DRG payment method, a DRG relative weight is the average cost of cases in a certain DRG classification during the rebasing process divided by the average cost, respectively, for all cases in DSHS's database used to calculate the DRG relative weights.

DRG Conversion Factors [**Refer to WAC 388-550-3000 and 388-550-3450**]
The conversion factor is also referred to as the DRG rate. DSHS establishes the DRG allowed amount for payment by multiplying the hospital's conversion factor (CF) by the assigned DRG relative weight for that admission.

Reduction in payment for cesarean sections - [Refer to WAC 388-550-3000(7)]
As mandated by the legislature for dates of admission on and after July 1, 2009, DSHS pays inpatient claims assigned by the all-patient DRG grouper (AP-DRG) as cesarean section without complications and comorbidities, at the same rate as the vaginal birth with complicating diagnoses.

[Hospital's conversion factor] x [Assigned DRG relative weight] = [DRG payment allowed amount]

High Outliers (DRG) [Refer to WAC 388-550-3700]
For dates of admission on and after August 1, 2007, DSHS no longer identifies a claim paid using the DRG payment method that formerly would have been considered for a low-cost outlier or day outlier payment using those methods. Instead, such claims are processed and paid using the DRG payment method or other applicable method.

When a claim paid using the DRG payment method meets the qualifying criteria to be paid a DRG high outlier payment, DSHS adjusts the claim payment as follows:

Qualifying for High Outlier Payment for Diagnosis Related Group (DRG) payment method
For dates of admission on and after August 1, 2007, DSHS allows a high outlier payment for a claim paid using the DRG payment method when high outlier qualifying criteria for a high outlier claim are met. The estimated costs of a claim are calculated by multiplying the total submitted charges, minus the noncovered charges on the claim, by the hospital's ratio of costs-to-charges (RCC) rate.

- **High Outlier Claim Qualification Criteria**
  A claim is a high outlier if the DSHS-determined claim cost (claim covered charges multiplied by RCC) is greater than both:

  ✓ The fixed outlier threshold of $50,000; and
  ✓ 175% of the initial claim payment allowed amount (inlier payment allowed amount) for claims with admission dates prior to July 1, 2009; or
  ✓ 182.3% of the initial claim payment allowed amount (inlier payment allowed amount) for claims with admission dates on and after July 1, 2009.

- **High outlier Claim Qualification Criteria for Neonatal and Pediatric DRG Classifications (Per Diem).**
  For Seattle Children's Hospital and Medical Center, Mary Bridge Children's Hospital, and claims grouped into neonatal and pediatric DRG classifications, a claim is a high outlier if the claim cost (claim covered charges multiplied by RCC) is greater than both:

  ✓ The fixed outlier threshold of $50,000; and
  ✓ 150% of the initial claim payment allowed amount (inlier payment allowed amount) for claims with admission dates prior to July 1, 2009; or
  ✓ 156.3% of the initial claim payment allowed amount (inlier payment allowed amount) for claims with admission dates on and after July 1, 2009

Note: These criteria are also used to determine if a transfer claim qualifies for high outlier payment when a transfer claim is submitted to DSHS by a transferring hospital.

Calculating High Outlier Payment - Diagnosis Related Group (DRG) Payment Method
The high outlier payment allowed amount is equal to the difference between DSHS's estimated cost of services associated with the claim and the high outlier threshold for payment, the resulting amount being multiplied by a percent of outlier adjustment factor as follows:

- 85% for claims with admission dates between August 01, 2007 and June 30, 2009 and 81.6 % for claims with admission dates on or after July 01, 2009; or

- 90% for claims for burn services with admission dates between August 01, 2007 and June 30, 2009 and 86.4 % for claims with admission dates on or after July 01, 2009; or

- 95% for claims for neonate services or any claims at Children's or Mary Bridge with admission dates between 8/1/07 and 6/30/09 and 91.2 % for claims with admission dates on or after July 01, 2009.

The high outlier threshold when calculating the high outlier adjustment portion of the total payment allowed amount on the claim is explained in WAC 388-550-3700 (17)(d).

The percent of outlier adjustment factor is used as indicated in WAC 388-550-4800 to calculate payment for state-administered program claims that are eligible for a high outlier payment.

> **Note:** For hospitals paid with the payment method used for out-of-state hospitals, DSHS pays for outlier claims that fall into one of the neonatal or pediatric AP-DRG classifications using 85% as the percent of outlier adjustment factor for claims with admission dates between August 1, 2007, and June 30, 2009 and 81.6% for claims with admission dates on and after July 1, 2009.

Transfer Information for Diagnosis Related Group (DRG) Payment Method

- For claims with admission dates prior to July 01, 2009, transfers are defined as discharges from one acute care facility or distinct unit to another acute care facility or distinct unit (i.e. claims with discharge status 2, 5, 43, 62, 65, 70).

- For claims with admission dates on and after July 01, 2009, transfers are defined as discharges from one acute care facility or distinct unit to another acute care facility or distinct unit or to a non hospital setting (i.e. claims with discharge status 2, 5, 43, 62, 65, 70 AND 3, 4, 6, 50, 51, 61, 63, 64) including the following:

  - ✓ Skilled nursing facility;
  - ✓ Intermediate care facility;
  - ✓ Long term acute care facility;
  - ✓ Home care under home health program;
  - ✓ Hospice in a facility or the client's home;
  - ✓ Hospital based Medicare approved swing bed; and
  - ✓ Nursing facility certified under Medicare but not Medicaid.

The following payment guidelines apply when a client is transferred:

A. When a hospital transfers a client, DSHS pays the transferring hospital a per diem rate when an appropriate patient status code (refer to the UB Manual) is used in form locator 22 on the UB-04 claim form.

The transfer payment policy is applied to claims billed with patient status indicated as transferred cases and the service provided to the patient is paid based on a stable DRG and the DRG payment method. The payment allowed amount calculation is the lesser of the:

1. Per diem (total DRG payment allowed amount calculation divided by the claim's DRG classification benchmark for average length of stay) multiplied by the patient's length of stay plus 1 day; or
2. Total DRG payment allowed amount calculation for the claim.

Payment to the transferring hospital will not exceed the DRG allowed amount that would have been paid for the claim, less any final adjustments, had the client been discharged. The hospital that ultimately discharges the client receives a DRG payment that equates to the allowed amount for the claim less any final adjustments. If a transfer case qualifies as an outlier, DSHS will apply the outlier payment method to the payment.

B. When a client is admitted to Hospital A, transferred to Hospital B, then transferred back to Hospital A and is discharged, Hospital A, as a discharging hospital, is paid a full DRG allowed amount for the claim minus any final adjustments. Hospital B is paid a per diem amount as described in A above.

C. For inpatient hospital psychiatric transfers, the transferring hospital must contact the appropriate DBHR designee/RSN for approval and a condition code. The condition code must be noted in the client's records to be shared with the receiving hospital to be placed on the claim submitted by the receiving hospital (refer to the *Inpatient Hospital Psychiatric Admission* sections).

Per Diem Payment Method

[Refer to WAC 388-550-3010 and 3460]

DSHS bases the allowed amount for the per diem payment method on the hospital's specific per diem rate assigned to the particular DRG classification, unless otherwise specified.

DSHS establishes the per diem allowed amount for payment by multiplying the hospital's per diem rate for the particular claim by the number of covered days for the claim based on DSHS's medical necessity review.

[Per Diem payment allowed amount] = [Hospital's per diem rate for the claim] **x** [Number of DSHS-determined covered medically necessary days]

Services Paid Using the Per Diem Payment Method

DSHS pays for the following services using the per diem payment method:

- Unstable and low volume AP-DRGs identified as surgical, medical, burns, and neonate services**.** The payment calculation is based on the per diem payment rate and the client's length of stay (LOS). Outlier adjustments are made for claims qualifying as an outlier grouped to surgical, medical, burns, and neonate services.

- Specialty services defined as psychiatric, rehabilitation, detoxification, and Chemical-Using Pregnant (CUP) Women program services provided in inpatient hospital settings.

  The payment calculation is based on the per diem payment rate and the client's length of stay.

  - ✓ No outlier adjustment is made for specialty services.

  - ✓ Chemical-Using Pregnant (CUP) Women services are identified by revenue code 129, not by AP-DRG classification. Refer to DSHS's *Chemical-Using Pregnant (CUP) Women program Billing Instructions* for more information.

  - ✓ Psychiatric admissions and acute physical medicine and rehabilitation (Acute PM&R) services require Prior Authorization (PA). See the Authorization section for information on the authorization process.

Note: For psychiatric admission rules refer to the Inpatient Hospital Psychiatric Admissions section.

Note: For information on the Acute PM&R program, refer to DSHS's *Acute Physical Medicine and Rehabilitation (PM&R) Billing Instructions*.

Hospitals Paid Using the Per Diem Payment Method
DSHS pays the following types of hospitals using the per diem payment method:

- **Psychiatric hospitals**

  - ✓ Freestanding psychiatric hospitals;
  - ✓ State-designated, distinct pediatric psychiatric units; and
  - ✓ Medicare-certified, distinct psychiatric units in acute care hospitals.

The freestanding psychiatric hospitals referenced above do ***not*** include the following:

- ✓ Eastern State Hospital;
- ✓ Western State Hospital; or
- ✓ Psychiatric evaluation and treatment facilities.

- **Rehabilitation hospitals**

  - ✓ St. Luke's Rehabilitation Institute; and
  - ✓ Medicare-certified, distinct rehabilitation units in acute care hospitals.

The hospitals referenced (Rehabilitation hospitals) above do ***not*** include the following:

- ✓ Long term acute care hospitals; or
- ✓ Freestanding detoxification facilities.

> **Note:** The payment methods for long term acute care (LTAC) hospitals and freestanding detoxification facilities are paid differently from rehabilitation hospitals. For LTAC see "Fixed Per Diem – LTAC below and for freestanding detoxification facilities see *Chemical Dependency billing instructions.*

Transfers (Per Diem)
See "General Information" in this section.

> **Note:** No transfer payment policy is applied to services paid using the per diem payment methods. Other policies pertain to transfers may apply (refer to the *Inpatient Hospital Psychiatric Admission* sections).

High Outliers (Per Diem)
[Refer to WAC 388-550-3700]

For claims in one of the acute, unstable, and/or low volume DRG service categories (i.e., surgical, medical, burns, and neonate services) paid using the per diem payment method, when the claim meets the qualifying criteria to be paid a per diem high outlier payment, DSHS adjusts the claim payment as follows:

Qualifying for High Outlier Payment (Per Diem)
For dates of admission on and after August 1, 2007, DSHS may allow an adjustment for a high outlier for per diem claims grouped to a DRG classification in one of the acute unstable and/or low volume DRG service categories.

DSHS identifies high outlier per diem claims for medical, surgical, burn, and neonatal DRG service categories based on the claim estimated costs. The claim estimated costs are the total submitted charges, minus the noncovered charges for the claim, multiplied by the hospital's ratio of costs-to-charges (RCC) related to the admission.

- **High Outlier Claim Qualification Criteria.**
  A claim is a high outlier if the DSHS-determined claim cost (claim covered charges multiplied by RCC) is greater than both:

  ✓ The fixed outlier threshold of $50,000; and

  ✓ 175% of the initial claim payment allowed amount (inlier payment allowed amount). for claims with admission dates prior to July 1, 2009; or

  ✓ 182.3% of the initial claim payment allowed amount (inlier payment allowed amount) for claims with admission dates on and after July 1, 2009.

- **High Outlier Claim Qualification Criteria for Neonatal and Pediatric DRG Classifications.**
  For Seattle Children's Hospital and Medical Center, Mary Bridge Children's Hospital, and claims grouped into neonatal and pediatric DRGs classifications, a claim is a high outlier if the claim cost (claim covered charges multiplied by RCC) is greater than both:

  ✓ The fixed outlier threshold of $50,000; and

  ✓ 150% of the initial claim payment allowed amount (inlier payment allowed amount). for claims with admission dates prior to July 1, 2009; or

  ✓ 156.3% of the initial claim payment allowed amount (inlier payment allowed amount) for claims with admission dates on and after July 1, 2009.

Note: DSHS may perform retrospective utilization reviews on all per diem outlier claims that exceed the DSHS determined DRG average length of stay (ALOS). If DSHS determines the entire LOS or part of the LOS is not medically necessary, the claim will be denied or the payment will be adjusted.

Calculating High Outlier Payment (Per Diem)

The high outlier payment allowed amount is equal to the difference between DSHS's estimated cost of services associated with the claim, and the high outlier threshold for payment, the resulting amount being multiplied by a percent of outlier adjustment factor as follows:

- 85% for claims with admission dates between August 1, 2007, and June 30, 2009 and 81.6 % for claims with admission dates on and after July 1, 2009 or
- 90% for claims for burn services with admission dates between August 1, 2007 and June 30, 2009 and 86.4 % for claims with admission dates on and after July 1, 2009 or
- 95% for claims for neonate services or any claims at Children's or Mary Bridge with admission dates between August 1, 2007, and June 30, 2009 and 91.2 % for claims with admission dates on and after July 1, 2009.

The high outlier threshold when calculating the high outlier adjustment portion of the total payment allowed amount on the claim is explained in WAC 388-550-3700 (17) (d).

The percent of outlier adjustment factor is used as indicated in WAC 388-550-4800 to calculate payment for state-administered program claims that are eligible for a high outlier payment.

Note: Out-of-state hospitals are paid according to WAC 388-550-4000.

Fixed Per Diem Payment Method – (LTAC)

DSHS-approved LTAC hospitals are paid using the fixed per diem payment method for services included in the fixed per diem rate.

Transfers (Per Diem - LTAC)

All transfers to and from LTAC hospitals require prior authorization by DSHS. Refer to DSHS's *Long Term Acute Care (LTAC) Billing Instructions*. When the claim for the transferring hospital is paid by the DRG payment method, charges on that claim must meet or exceed the DRG allowed amount prior to the transfer. The DRG allowed amount equals the hospital's DRG rate times the relative weight for the DRG code on the claim.

Hospitals Paid Using the Fixed Per Diem Payment Method – LTAC

DSHS-approved LTAC hospitals are paid using the fixed per diem payment method for services included in the fixed per diem rate.

Per Case Payment Method

[Refer to WAC 388-550-3020 and 388-550-3470]

Bariatric Surgery

The allowed amount for the bariatric surgery per case payment method is based on the hospital's specific bariatric surgery per case rate. No outlier adjustment is made to bariatric surgery claims.

Per case rate calculation, bariatric surgery claims are identified by the primary diagnosis of 278.01 plus one of the following ICD-9-CM procedure codes: 44.31, 44.38, 44.39, 44.68, or 44.95. Payable bariatric surgery claims are from the University of Washington Medical Center, Providence Sacred Heart Medical Center, and Oregon Health Sciences University Hospital only.

Hospitals must obtain prior authorization (PA) from DSHS for all bariatric surgeries and related services. DSHS denies payment for bariatric surgery and related services when PA is not received. Bariatric surgery must be provided in an inpatient hospital setting, and only by those hospitals authorized by DSHS to provide those services.

Ratio of Costs-to-Charges (RCC) Payment Method

[Refer to WAC 388-550-4500]

DSHS uses the RCC payment method to pay some hospitals and services that are exempt from the DRG payment method. The RCC method is based on each hospital's specific RCC rate. The RCC allowed amount for payment is calculated by multiplying the hospital's allowed covered charges for the claim by the hospital's RCC rate. The RCC methodology is not based on conversion factors, per diem rates, etc.

Note: If a client is not eligible for some of the days in the hospital stay, the following is required when billing:

- Bill covered and noncovered charges on separate lines;
- Bill the entire stay from the admission date to the discharge date, including the dates the client was not eligible;
- Bill all diagnosis and procedure codes for the entire stay.

Bill the entire stay from admittance to discharge. Show charges for dates of service for which the client is not eligible as "noncovered." Put noncovered charges for each revenue code on its own line. Do not put noncovered charges on the same revenue code line with covered charges.

[RCC payment allowed amount] =
[Hospital's allowed covered charges for the claim] **x** [Hospital's RCC rate]

Hospitals Paid Using the RCC Payment Method
DSHS uses the RCC payment method to pay the following types of hospitals:

- Military hospitals;
- Hospitals participating in the certified public expenditure "full cost" payment method; and
- Long term acute care (LTAC) hospitals for covered inpatient services not covered in the per diem rate.

Certified Public Expenditure

Certified public expenditure hospitals, as follows:

Most Medicaid (Title XIX) and state-administered program claims are paid using the RCC payment method, and the hospital receives only the federal portion of the claim payment.

Exceptions include:

- State Children's Health Insurance Program (SCHIP) (Title XXI) claims are paid using the RCC payment method and the hospital receives the federal and state portions of the claim payment.
- Some bariatric services claims are paid using the case rate payment method and the hospital receives only the federal portion of the claim payment.

Program Limitations

Medical Necessity

DSHS will only pay for covered services and items that are medically necessary and the least costly, equally effective treatment for the client.

Administrative Days

Administrative days are days of an inpatient hospital stay when an acute inpatient level of care is not medically necessary and one of the following is true:

- Observation or outpatient level of care is not applicable;
- Appropriate non-hospital placement is not readily available; or
- The admission is primarily due to psychosocial issues.

Administrative days are paid at the administrative day rate (refer to the Payment for Services section). DSHS may perform retrospective utilization reviews on inpatient hospital admissions to determine appropriate use of administrative days.

Rate Guideline for New Hospitals **[WAC 388-550-4100]**

New hospitals are those entities that do not have base year costs on which to calculate a rate. **A change in ownership does not constitute the creation of a new hospital. See WAC 388-550-4200 for information on change of ownership.**

Psychiatric Services

Refer to the *Inpatient Hospital Psychiatric Admissions* section.

Major Trauma Services

Increased Payments for Major Trauma Care

The Washington State Legislature established the Trauma Care Fund (TCF) in 1997 to help offset the cost of operating and maintaining a statewide trauma care system. The Department of Health (DOH) and the Department of Social and Health Services (DSHS) receive funding from the TCF to help support provider groups involved in the state's trauma care system. DSHS uses its TCF funding to get federal matching funds. DSHS pays enhanced rates to designated trauma services and physicians for trauma cases that meet specified criteria.

Supplemental payments to hospitals and enhanced rates for physicians are available for trauma services provided to fee-for-service Medical Assistance clients with Injury Severity Scores (ISS) of 13 or greater for adults and 9 or greater for pediatric clients (15 years of age and younger).

TCF Payments to Hospitals

A **hospital** is eligible to receive TCF payments from DSHS if the hospital:

- Is designated by DOH as a trauma service center (or "recognized" if located in a designated bordering city);
- Is designated as a Level 1, Level 2, or Level 3 trauma service center;
- Meets the provider requirements in WAC 388-550-5450 and other applicable WAC;
- Meets the billing requirements in WAC 388-550-5450 and other applicable WAC;
- Submits all information DOH requires for the Trauma Registry; and
- Submits all information DSHS requires to ensure trauma services are being provided.

For a list of the Designated Trauma Services, check DOH's website at:
http://www.doh.wa.gov/hsqa/emstrauma/download/designation_list.pdf

TCF Payments to Hospitals and Physicians for Transfer Cases

When a trauma case is transferred from one hospital to another, DSHS makes TCF payments to hospitals and physicians/other eligible clinical providers, according to the ISS as follows:

- If the transferred case meets or exceeds the appropriate ISS threshold (ISS of 13 or greater for adults and 9 or greater for pediatric clients), **both** transferring and receiving hospitals and the eligible providers on their teams who furnished qualified trauma care services are eligible for increased payments from the TCF. The transfer must have been to a higher level designated trauma service center, and the transferring hospital must be at least a level 3 hospital. Transfers from a higher level to a lower level designated trauma service center are not eligible for the enhanced payments.

- If the transferred case is below the ISS threshold, only the **receiving** hospital and the eligible providers on its team who furnished qualified trauma care services are eligible for increased payments from the TCF. The receiving hospital and clinical team are eligible for enhanced payments regardless of the ISS for the transferred case. The receiving hospital must be at least a level 3 hospital.

Payment

Physicians and clinical providers are paid on a claim-specific basis for qualified trauma care services they provide. DSHS uses the lesser of its maximum allowable fee or the billed amount as the base rate to which the enhancement percentage is applied.

Hospitals receive a percentage of a fixed quarterly amount. Each hospital's percentage depends on the total qualified trauma care provided by the hospital during the service year to date, measured against the total qualified trauma care provided by designated Levels 1-3 trauma service centers during the same period.

The total payments from the TCF for a biennium cannot exceed the TCF amount appropriated by the legislature for that biennium. DSHS has the authority to take whatever actions are needed to ensure DSHS stays within its current TCF appropriation.

DSHS distributes increased payments from the TCF only when eligible trauma claims are submitted with the appropriate trauma modifier (for physician/other clinician claims) or condition code (for hospital claims) within the time frames specified by DSHS.

Note: See WAC 388-550-5450 for a complete description of the payment methodology to designated trauma centers and other policies pertaining to HRSA's trauma program.

Claims Excluded from Enhanced Payment for Trauma Services

Claims for trauma care provided to clients enrolled in DSHS's managed care organizations are **not** eligible for increased payments from the TCF.

Laboratory and pathology charges are **not** eligible for increased payments from the TCF.

What Condition Codes Must Hospitals Use to Identify Qualified Trauma Cases to DSHS?

A designated trauma hospital must use the applicable condition code from the table below to identify a hospital trauma claim eligible for the supplemental TCF payment.

Condition Code	Description
MP	Indicates a pediatric client (through age 14 only) with an Injury Severity Score (ISS) in the range of 9-12
MT	Indicates a transferred client with an ISS that is less than 13 for adults or less than 9 for pediatric clients
MV	Indicates an ISS in the range of 13 to 15
MW	Indicates an ISS in the range of 16 to 24
MX	Indicates an ISS in the range of 25 to 34
MY	Indicates an ISS in the range of 35 to 44
MZ	Indicates an ISS of 45 or greater

Where Are the Condition Codes Entered on the UB-04 Claim Form?

Condition codes may be entered in form locators 18-28. However, please use form locator 18 when billing DSHS for an eligible trauma case.

Adjusting Trauma Claims

DSHS considers a provider's request for an adjustment to a trauma claim only if DSHS receives the adjustment request within one year from the date of service for the initial traumatic injury.

DSHS does not make any TCF payment for an otherwise eligible claim after 365 days from the date of the qualifying trauma service. The deadline for making adjustments to a trauma claim is the same as the deadline for submission of the initial claim. WAC 388-502-0150(7) and 388-502-0150(8) do not apply to TCF payments; see WAC 388-502-0150(11).

All claims and claim adjustments are subject to federal and state audit and review requirements.

Injury Severity Score (ISS)

> **Note:** The current qualifying ISS is 13 or greater for adults, and 9 or greater for pediatric clients (through 14 years of age only).

The ISS is a summary severity score for anatomic injuries.

- It is based upon the Abbreviated Injury Scale (AIS) severity scores for six body regions:

  - ✓ Head and neck;
  - ✓ Face;
  - ✓ Chest;
  - ✓ Abdominal and pelvic contents;
  - ✓ Extremities and pelvic girdle; and
  - ✓ External.

- The ISS values range from 1 to 75.

- Generally, the higher the score, the more serious are the patient's injuries.

For information on **trauma service designation, trauma registry, and/or injury severity scores (ISS)**, contact:

Department of Health
Office of Emergency Medical & Trauma Prevention
1-360-236-2871 or 1-800-458-5281.

For information on **payment**, contact:

Office of Hospital Rates
Health and Recovery Services Administration
1-360-725-1835

For information on a specific **Medicaid trauma claim**, contact:

HRSA's Provider Relations
1-800-562-3022 (option 2)

Physician/Clinical Provider List

Members of a designated trauma center's trauma team are eligible for enhanced payment for trauma care services. Eligible providers include, but are not limited to, the following:

Advanced Registered Nurse Practitioner
Anesthesiologist
Cardiologist
Certified Registered Nurse Anesthetist
Critical Care Physician
Emergency Physician
Family/General Practice Physician
Gastroenterologist
General Surgeon
Gynecologist
Hand Surgeon
Hematologist
Infectious Disease Specialist
Internal Medicine
Nephrologist
Neurologist
Neurosurgeon
Obstetrician
Ophthalmologist
Oral/Maxillofacial Surgeon
Orthopedic Surgeon
Pediatric Surgeon
Pediatrician
Physiatrist
Physician Assistant
Plastic Surgeon
Pulmonologist
Radiologist
Thoracic Surgeon
Urologist
Vascular Surgeon

Unbundling

DSHS does not pay separately for unbundled services billed on an inpatient claim by a hospital. DSHS does not pay hospitals for the professional components of services that are paid to the practitioner. When independent practitioners bill separately, only the technical component is included in DSHS's payment to the hospital. The technical component includes any supplies that might be provided by a physician or other professional when the same service is provided outside the hospital. **Bill the excluded services on the appropriate claim form.**

Indicator Legend

I = Cost of service is included in inpatient rate. Do not bill separately.
E = Cost of service is excluded from inpatient rate. Bill excluded professional components/service on appropriate claim form.
NC = Not covered by DSHS
P = Professional component may be billed on appropriate claim form; all other components included in inpatient rate.

Service Description		Service Description	
Ambulance (Ground and Air)[1]	I	Nurse Anesthetist	E
Audiology	P	Nurse Practitioner	E
Whole Blood	I*	Oxygen	I
Blood Administration	I*	Specialized Therapies (PT, OT, ST)	I
Blood Components	I*	Physician Specialties	E
Certified Registered Nurse (Does not include Certified Registered Nurse Anesthetist or RN First Assistant)	I	Podiatry	E
Hearing Aids	E	Prosthetic/Orthotic (except joints)	I
Implants (Joints, Tissue, Pacemakers)	E	Psychiatrist	E
Inhalation/Respiratory Therapy	I	Psychology	I[2]
Laboratory	I	Radiologist	P
Midwife	E	Take-home supplies, equipment, drugs	NC

* Blood products are not covered by DSHS associated processing/administration and storage fees are covered.

[1] Excluded when transportation occurs: 1) before admission; or 2) after discharge or transfer out of that hospital. When the patient is transported as a part of the impatient services by DSHS approved neonatal transport teams, bill with ambulance revenue code 0546.

[2] Assumes practitioner is not billing DSHS.

Other Noncovered Items

Following are examples of "other" noncovered items for hospitals. If one of these items has a Revenue Code, please put the appropriate code in the appropriate field on the UB-04 Claim Form or the "Revenue Code" field when billing electronically. Enter the noncovered charge amount in the appropriate form locator on the UB-04 Claim Form or the "Noncovered Charges" field when billing electronically. Services not identified by a revenue code should be placed under subcategory "General Classification."

- Bed scales
- Blood components (administration of blood is covered. These charges must clearly indicate administration fees.)
- Cafeteria
- Circumcision Tray (routine circumcisions)
- Crutches
- Entertainment services (e.g., rental of TV, radio, VCR, DVD, video games, etc.)
- Experimental or investigational medical services & supplies
- Family convenience items (e.g., shaving kit)
- Home Health Services
- Incremental Nursing
- Lab Handling Charges (including cab fares)
- Medical record copying fees
- Nonpatient Room Rentals
- Operating Room Set-Up (when not utilized)
- Oxygen Equipment Set-Up (when not utilized)
- Personal Care Items (e.g., slippers, toothbrush, combs)
- Personnel charge, additional (payment for hospital staff is included in room and board.)
- Portable X-ray Charges (portable charge fee is included in fee-for-service procedures)
- Private Duty Nursing (nursing care is included in room and board)
- Psychiatric Day Care
- Recreational Therapy
- Standby Equipment Charges (for oxygen, anesthesia, and surgery when no actual service is performed)
- Routine tests and procedures (e.g., pre-anesthesia chest x-rays, fetal monitoring, etc.) are only covered only if DSHS determines them as medically necessary and they are approved by a physician.
- Take Home Drugs/Supplies
- Telephone-Telegraph/Fax
- Transportation (provided during hospital stay)
- Travel Time

Authorization

General Authorization

Certain authorization requirements are published in specific program or service documents. Please refer to the specific program or service document for more details.

DSHS's authorization process applies to medically necessary covered healthcare services only and is subject to client eligibility and program limitations. Not all categories of eligibility receive all healthcare services. **For example:** Therapies are not covered under the Family Planning Only Program. All covered healthcare services are subject to retrospective utilization review to determine if the services provided were medically necessary and at the appropriate level of care. **Authorization does not guarantee payment.** Requests for noncovered services may be reviewed under the exception to rule policy. See WAC 388-501-0160.

DSHS's authorization requirements are met through the following processes:

- "Write or fax" for prior authorization (PA), concurrent authorization, or retro-authorization;
- Evidence-based Decision Making; and
- Utilization Review (UR).

Note: For psychiatric admission rules. Refer to the *Inpatient Hospital Psychiatric Admissions section.*

Note: For information on the Acute PM&R and LTAC programs, refer to *Acute Physical Medicine and Rehabilitation (PM&R) Billing Instructions* and *Long Term Acute Care (LTAC) Billing Instructions*.

"Write or Fax" Prior Authorization (PA)

"Write or fax" PA is an authorization process available to providers when a covered procedure requires PA. DSHS does not retrospectively authorize any healthcare services that require PA after they have been provided except when a client has delayed certification of eligibility.

Forms available to providers to request PA include:

- Basic Information form, -756;
- Bariatric Surgery Request form, DSHS 13-785; and
- Out of State Medical Services Request form, DSHS 13-787 (for elective, non-emergency out-of-state medical services). Refer to "Out-of-State Hospital Admissions" in this section for more information.

These forms are available at http://www.dshs.wa.gov/msa/forms/eforms.html

Be sure to complete all information requested. Requests that are incomplete will be returned to the provider.

Send one of the completed fax forms listed above to:

Health and Recovery Services Administration
Attn: Provider Request/Client Notification Unit
PO Box 45506
Olympia, WA 98504-5506
FAX: 1-360-586-1471

How Does DSHS Approve or Deny Prior Authorization (PA) Requests?

DSHS reviews PA requests in accordance with WAC 388-501-0165 and utilizes evidence-based medicine to evaluate each request. DSHS evaluates and considers all available clinical information and credible evidence relevant to the client's condition. At the time of the request, the provider responsible for the client's diagnosis and/or treatment must submit credible evidence specifically related to the client's condition. Within 15 days of receiving the request from the client's provider, DSHS reviews all evidence submitted and does one of the following:

- Faxes an approval letter to the provider and mails a copy of the letter to the client;
- Denies the request if the requested service is not medically necessary, and notifies the provider and client of the denial; or
- Requests the provider to submit additional justifying information within 30 days. When the additional information is received, DSHS approves or denies the request within 5 business days of the receipt of the additional information. If the additional information is not received within 30 days, DSHS denies the requested service.

When DSHS denies all or part of a request for a covered service or equipment, it sends the client and the provider written notice within 10 business days of the date the complete requested information is received. The denial letter:

- Includes a statement of the action DSHS intends to take;
- Includes the specific factual basis for the intended action;
- Includes references to the specific WAC provision upon which the denial is based;
- Is in sufficient detail to enable the recipient to learn why DSHS took the action;
- Is in sufficient detail to determine what additional or different information might be provided to challenge DSHS's determination;
- Includes the client's administrative hearing rights;
- Includes an explanation of the circumstances under which the denied service is continued or reinstated if a hearing is requested; and
- Includes example(s) of lesser cost alternatives that permit the affected party to prepare an appropriate response.

Surgical Policies

Breast Surgeries

The following surgeries which include breast removal and breast reconstruction for clients who have breast cancer or a history of breast cancer, open wounds, or congenital anomalies of the breast are allowed without prior authorization **only** with the following diagnoses: V10.3, 174.0-175.9, 233.0, 757.6, 759.9, 879.0-879.1, 906.0, 906.8, or 942.00-942.59. Otherwise the service requires prior authorization. Removal of failed breast implants requires PA. DSHS pays to remove the breast implants but does not replace them if they were placed for cosmetic reasons.

Description of Service
Insertion of tissue expander(s)
Replacement of tissue expander w/permanent prosthesis
Removal of tissue expander(s) without insertion of prosthesis
Mastectomy, partial
with axillary lymphadenectomy
Mastectomy, simple, complete
Mastectomy, subcutaneous
Mastopexy
Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
Delayed insertion breasts prosthesis
Nipple/areola reconstruction
Breast reconstruction w/tissue expander
Breast reconstruction w/free flap
Breast reconstruction w/other technique
Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site
with microvascular anastomosis (super charging)
Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
Open periprosthetic capsulotomy, breast
Periprosthetic capsulectomy, breast
Revision of reconstructed breast
Correct skin color defects in breast reconstruction use diagnosis code V10.3

Inpatient admissions are billable only when the stay meets the definition of inpatient admissions (see *Definitions & Acronyms* section). DSHS requires EPA for reduction mamoplasties and for mastectomy for gynecomastia for men. Refer to Section I of DSHS's Physician-Related Services Billing Instructions for EPA criteria.

DSHS-Approved Bariatric Hospitals and Their Associated Clinics [WAC 388-531-1600, 388-550-2301 and 388-550-3020]

DSHS Approved Bariatric Hospital and Associated Clinics	Location
University of Washington Medical Center, University of Washington Specialty Surgery Center	Seattle, WA
Oregon Health Sciences University, OHSU Surgery Center	Portland, OR
Providence Sacred Heart Medical Center and Children's Hospital	Spokane, WA

DSHS covers medically necessary bariatric surgery for clients age 21-59 in an approved hospital with a bariatric surgery program in accordance with WAC 388-531-1600. DSHS covers bariatric surgery for clients age 18-20 for the laparoscopic gastric band procedure only (ICD-9 CM procedure 44.95). All bariatric surgery requires PA and is approved when the client meets the criteria in WAC 388-531-1600.

Note: DSHS does not cover bariatric surgery for clients 17 years of age and younger.

To begin the authorization process, providers should fax a completed "Bariatric Surgery Request" form, DSHS # 13-785, to:

Health and Recovery Services Administration
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
FAX: 1-360-586-1471

Clients enrolled in a managed care organization (MCO) are eligible for bariatric surgery under fee-for-service when prior authorized. Clients enrolled in an MCO who have had their surgery prior authorized by DSHS and who have complications following bariatric surgery are covered fee-for-service for these complications 90 days from the date of the DSHS-approved bariatric surgery. DSHS requires authorization for these services. Claims without authorization will be denied.

Note: DSHS pays DSHS-approved hospitals a bariatric surgery case rate.

Other Surgical Policies

- Salpingostomies are payable only when the claim is billed with a diagnosis of tubal pregnancy.
- Sterilizations and hysterectomies require a properly completed consent form. Refer to the Billing section for more information.

Acute Physical Medicine and Rehabilitation (PM&R)

[Refer to WAC 388-550-2561]

DSHS requires prior and concurrent authorization for admissions and continued stays in DSHS-approved acute PM&R facilities.

> **Note:** See approved Acute PM&R facilities on-line at: http://hrsa.DSHS.wa.gov/Download/BillingInstructions/Acute_Rehab_Facilities.pdf.

Refer to DSHS's *Acute Physical Medicine and Rehabilitation (PM&R) Billing Instructions* for program specifics.

Long Term Acute Care (LTAC) [Refer to WAC 388-550-2590]

DSHS requires PA for all admissions to DSHS-approved LTAC hospitals.
See DSHS's *Long Term Acute Care Program Billing Instructions* for more program specifics.
Approved long term acute care hospitals are:

- Regional Hospital –Seattle, WA
- Kindred Hospital for Respiratory and Complex Care - Seattle, WA
- Northern Idaho Advanced Care Hospital – Post Falls, ID
- Vibra Specialty Hospital – Portland, OR.

For claims with admission dates on and after August 1, 2007, DSHS no longer uses DRG high outlier payment status as a criterion for approving transfers from acute care to LTAC for individuals who are otherwise eligible.

Out-of-State Hospital Admissions (Does Not Include Hospitals in Designated Bordering Cities)

[Refer to WAC 388-550-6700, 388-501-0160, and 388-501-0180, 388-501-0184, 388-502-0120]

DSHS pays for emergency care at an out-of-state hospital for Medicaid and SCHIP clients only.

> **Note:** DSHS considers hospitals in designated bordering cities, listed in WAC 388-501-0175, as in-state hospitals for coverage and as out-of-state hospitals for payment, except for critical border hospitals. DSHS considers critical border hospitals "in-state" for both coverage and payment.

DSHS requires PA for elective, non-emergency care. Providers should request PA when:

- The client is on a medical program that pays for out-of-state coverage (for example, GA-U clients have no out-of-state benefit except in designated bordering cities); and
- The service is for a covered medically necessary service that is unavailable in the State of Washington (refer to WAC 388-501-0060).

Providers requesting elective, out-of-state care must send a completed Out-of-State Medical Services Request form, DSHS 13-787, with the additional documentation required on the form, to the Provider Request/Client Notification Unit (see *Important Contacts* section).

Refer to the "Inpatient Hospital Psychiatric" Admissions section for information on out-of-state psychiatric care.

Out-of-State Air and Ground Ambulance Transportation

Refer to Chapter 388-546, WAC 388-546-0800, WAC 388-546-0900

DSHS requires PA for all out-of-state non-emergency air ambulance transports. See the *Important Contacts* section for the telephone number to call for PA. Designated bordering cities, as defined by WAC 388-501-0175, are considered in-state, except for purposes of the Involuntary Treatment Act (ITA).

Clients eligible under state-only programs do not have any out-of-state coverage.

DSHS does not cover ambulance transportation for eligible medical assistance clients traveling outside of the United States and U.S. territories. See WAC 388-501-0184 for ambulance coverage in British Columbia, Canada.

Out-of-Country Hospital Admissions

Refer to Chapter 388-501-0184

DSHS does not cover out-of-country hospital admissions or emergency room visits. The exception to this is Medicaid clients who reside in Point Roberts or Washington communities along the border with British Columbia, Canada. These clients are covered for hospital admissions or emergency room visits in British Columbia, Canada when:

- The Canadian provider is the closest source of care; and
- Needed medical services are more readily available in Canada and the aggregate cost of care is equal to or less than the aggregate cost of the same care when provided within the state. See WAC 388-501-0184.

Medical Inpatient Detoxification (MID) Services

[Refer to WAC 388-550-4300]

Pregnant clients may be eligible to receive acute detoxification, medical stabilization, and rehabilitation through the Chemical-Using Pregnant (CUP) Women Program. Please see DSHS's *Chemical-Using Pregnant (CUP) Women Program Billing Instructions* for details. A list of the DASA Certified Hospitals providing intensive inpatient care for chemical using pregnant women is located on DSHS's website at: http://www.dshs.wa.gov/dasa/services/certification/directory/directory.shtml

Hospitals that are approved to provide detoxification services and have a specific detoxification provider number must use their provider number to bill DSHS for detoxification services. Detoxification services at these facilities do not require PA.

Hospitals that do not have a specific detoxification provider number and have provided detoxification services to medical assistance clients must meet all of the MID criteria listed below in order to bill DSHS and get paid for services provided.

What Is MID Authorization?

MID authorization is the use of an authorization number and a condition code to indicate the services provided meet the MID criteria and are provided in a hospital medical unit.

What Are the MID Criteria?

The MID criteria are listed below. All of these MID criteria must be met:

1. The stay meets the intensity of service, severity of illness, and medical necessity standards necessary to qualify as an inpatient;
2. The principal diagnosis is in one of the following ranges:

291.00 – 292.9
303.00 – 303.92
304.00 – 304.92
305.00 – 305.92

3. The client is not participating in DSHS's Chemical-Using Pregnant (CUP) Women Program;
4. The care is provided in a medical unit;
5. Inpatient psychiatric care is not medically necessary, and an approval from the Division of Behavioral Health and Recovery (DBHR) designee or Regional Support Network (RSN) is not appropriate;
6. The hospital does not have a detoxification-specific provider number (detoxification-specific provider numbers start with "36"); and
7. Non-hospital based detoxification is not medically appropriate.

What Condition Code/Authorization Number Is Used When Billing for MID?

Description	Condition Code	Authorization Number
For Acute alcohol detoxification use	M3*	640233143
For Acute drug detoxification use	M5*	640233045

*Note – M3 and M5 are Payer assigned Condition codes. DSHS has assigned M3 and M5 to MID to distinguish MID claims from Psych claims. Claims with the Condition Codes M3 and M5 should not be billed to the RSN.

Note: DSHS denies MID claims submitted without the MID condition code.

When Is the MID Condition Code Used?

Use the applicable MID condition code only when all of the MID criteria have been met. Use of the MID condition code acts as the hospital's certification that the stay meets MID criteria. Documentation in the client's medical record must prove that all the criteria were met. The documentation must be made available to DSHS upon request.

When the Stay Meets MID Criteria, Where Does the Condition Code Go on the Claim?

Enter the appropriate MID condition code in the *form locator 18-28 "Condition Codes"* field on the claim.

What Is DSHS's Allowed Length of Stay for MID Claims Reimbursed Using the RCC Reimbursement Methodology?

In accordance with WAC 388-550-4300(4)(a) and (b), DSHS limits payment for medical inpatient detoxification days to:

- **Three** days for acute alcohol detoxification; and
- **Five** days for acute drug detoxification.

How Do I Bill DSHS for MID Services that Exceed the Three or Five-Day Limitation?

When an MID stay exceeds the three- or five-day length-of-stay limitation, bill all charges incurred during the stay (from admission through discharge) on one claim. Bill covered and noncovered accommodation charges on separate lines. Enter all charges for noncovered days in the noncovered field.

To appeal the three- or five-day limitation because of the intensity of medical services required, send a copy of the UB-04 claim form, history, physical, physician progress notes, and discharge summary to the following address:

Health and Recovery Services Administration
Attn: Med/Psych Program Manager
PO Box 45506
Olympia, WA 98504-5506
FAX: 360-725-1966

Chemical-Using Pregnant (CUP) Women

Pregnant clients may be eligible to receive acute detoxification, medical stabilization, and rehabilitation services through the Chemical-Using Pregnant (CUP) Women Program. Please see DSHS's *Chemical-Using Pregnant (CUP) Women Program Billing Instructions* for details. A list of the Division of Alcohol and Substance Abuse (DASA) Certified Hospitals providing intensive inpatient care for chemical using pregnant women is located on DSHS's website at:

http://www.dshs.wa.gov/dasa/services/certification/directory/directory.shtml.

DSHS-Approved Centers of Excellence (COE)

[Refer to WAC 388-531-0650, 388-550-1900, 388-550-2100 and 388-550-2200]

Transplant services must be performed in a DSHS-approved Center of Excellence (COE). **When performed in a DSHS approved COE, these services do not require prior authorization (PA)**. See the list of DSHS approved COEs within these billing instructions.

DSHS covers transplant procedures when:

- The transplant procedures are performed in a hospital designated by DSHS as a "Center of Excellence" for transplant procedures; and
- The client meets the transplant hospital's criteria for appropriateness and medical necessity of the procedure(s).

When the above is true DSHS covers

Solid Organs	Non-Solid Organs
Heart	Peripheral stem cell
Kidney	Bone marrow* ***See below for PA information.***
Liver	
Lung	
Heart-lung	
Pancreas	
Kidney-pancreas	
Small bowel	

Note: DSHS pays **any** qualified hospital for skin grafts and corneal transplants when medically necessary.

Experimental Transplant Procedures

DSHS does not pay for experimental transplant procedures. DSHS considers as experimental those services including, but not limited to, the following:

- Transplants of three or more different organs during the same hospital stay;
- Solid organ and bone marrow transplants from animals to humans; and
- Transplant procedures used in treating certain medical conditions that use procedures not generally accepted by the medical community, or that efficacy has not been documented in peer-reviewed medical publications.

Payment Limitations

DSHS considers organ procurement fees as part of the payment to the transplant hospital. However, DSHS may make an exception to this policy. If an eligible client is covered by a third-party payer which will pay for the organ transplant procedure, but not the organ procurement, then DSHS will pay separately for the organ procurement.

DSHS pays for a solid organ transplant procedure only once per client's lifetime, except in cases of organ rejection by the client's immune system during the original hospital stay.

Note: PA is required for transplants not performed in a COE. When private insurance or Medicare has paid as primary insurance and you are billing DSHS as secondary insurance, DSHS does not require PA or that the transplant, sleep study, or bariatric surgery be done in a Center of Excellence or DSHS-approved hospital. As required by federal law, organ transplants and services related to an organ transplant procedure are not covered under the AEM program.

List of DSHS-Approved Organ Transplant - Centers of Excellence (COE)

APPROVED TRANSPLANT HOSPITALS	ORGAN(S)
Seattle Children's Hospital and Medical Center, Seattle WA	• Bone Marrow (BMT) (autologous & allogenic) • Peripheral Stem Cell Transplant (PSC-T) • Heart • Liver • Kidney • Small Bowel
Doernbecher Children's Hospital/Portland NW Marrow Transplant Program	• BMT • PSC-T
Good Samaritan Hospital/Puyallup	• PSC-T
Providence Sacred Heart Medical Center and Children's Hospital/Spokane	• PSC-T
Legacy Good Samaritan Hospital and Medical Center/Portland (Northwest Marrow Transplant Program)	• BMT • PSC-T
Mary Bridge Children's Hospital and Health Center/Tacoma	• PSC-T (autologous only)
Oregon Health Sciences University and Hospital (OHSU)/Portland	• Heart • Liver • Kidney • Pancreas
Providence Portland Medical Center/Portland	• PSC-T (autologous only)
Providence St. Peter Hospital/Olympia	• PSC-T
Providence Sacred Heart Medical Center and Children's Hospital/Spokane	• Kidney • Heart • PSC-T
Seattle Cancer Care Alliance/Seattle	• BMT • PSC-T
St. Joseph's Medical Center/Tacoma	• BMT (autologous only) • PSC-T
Swedish Medical Center/Seattle	• Kidney • PSC-T

Continued on next page

APPROVED TRANSPLANT HOSPITALS	ORGAN(S)
University of Washington Medical Center/Seattle	• BMT • PSC-T • Heart • Heart/Lung(s) • Lung • Kidney • Liver • Pancreas
Virginia Mason Medical Center/Seattle	• Kidney • Pancreas • BMT • PSC-T

Utilization Review

[Refer to WAC 388-550-1700]

What Is Utilization Review (UR)?

UR is a prospective, concurrent, and/or retrospective (including post-pay and pre-pay) formal evaluation of a client's documented medical care to assure that the healthcare services provided are proper, necessary, and of good quality. The review considers the appropriateness of the place of service, level of care, and the duration, frequency, or quantity of healthcare services provided in relation to the condition(s) being treated.

- Prospective UR (prior authorization) is performed prior to the provision of healthcare services;

- Concurrent UR is performed during a client's course of care; and

- Retrospective UR is primarily an audit function and is performed following the provision of healthcare services. It includes both post-payment utilization review and pre-payment utilization review. DSHS uses InterQual® ISD Level of Care criteria, for the same year as the client's date of admission, as a guideline in the retrospective utilization review process.

  - ✓ Post-payment retrospective UR is performed after healthcare services are provided and reimbursed.

  - ✓ Pre-payment retrospective UR is performed after healthcare services are provided but prior to reimbursement.

Note: For more information on prospective and concurrent UR, refer to the *Authorization* and *Inpatient Hospital Psychiatric Admissions* sections.

DSHS Retrospective Utilization Review (UR)

In accordance with 42 CFR 456, DSHS performs retrospective UR to safeguard against unnecessary utilization of care and services. Retrospective UR also provides a method to assure appropriate disbursement of medical assistance funds. Payment to a hospital may be adjusted, denied or recouped, if DSHS determines that inpatient hospital services were not:

- Medically necessary for all or part of the client's length of stay;
- Provided at the appropriate level of care for all or part of the client's length of stay;
- Coded accurately; or
- Medically necessary for a transfer from one acute care hospital to another acute care hospital.

Changes in Admission Status

What Is Admission Status?

Admission status is the level of care a client needs at the time of admission. Some examples of typical types of admission status are: inpatient, outpatient observation, medical observation, outpatient surgery or short-stay surgery, or outpatient (e.g., emergency room).

Admission status is determined by the admitting physician or practitioner. Continuous monitoring, such as telemetry, can be provided in an observation or inpatient status. Consider overall severity of illness and intensity of service in determining admission status rather than any single or specific intervention. Specialty inpatient areas (including ICU or CCU) can be used to provide observation services. Level of care, not physical location of the bed, dictates admission status.

When Is a Change in Admission Status Required?

A change in admission status is required when a client's symptoms/condition and/or treatment does not meet medical necessity criteria for the level of care the client is initially admitted under. The documentation in the client's medical record must support the admission status and the services billed. DSHS does not pay for:

- Services that do not meet the medical necessity of the admission status ordered;
- Services that are not documented in the hospital medical record; and
- Services greater than what is ordered by the physician or practitioner responsible for the client's hospital care.

Change from Inpatient to Outpatient Observation Admission Status

The attending physician or practitioner may make an admission status change from inpatient to outpatient observation when:

- The attending physician/practitioner and/or the hospital's utilization review staff determines that an inpatient client's symptoms/condition and treatment do not meet medical necessity criteria for an acute inpatient level of care and do meet medical necessity criteria for an observation level of care;

- The admission status change is made prior to, or on the next business day following, discharge; and

- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the document must:

  - ✓ Be dated with the date of the change; and
  - ✓ Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Change from Outpatient Observation to Inpatient Admission Status

The attending physician or practitioner may make an admission status change from outpatient observation to inpatient when:

- The attending physician/practitioner and/or the hospital's utilization review staff determines that an outpatient observation client's symptoms/condition and treatment meet medical necessity criteria for an acute inpatient level of care;

- The admission status change is made prior to, or on the next business day following, discharge; and

- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:

  - ✓ Be dated with the date of the change; and
  - ✓ Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Change from Inpatient or Outpatient Observation to Outpatient Admission Status

The attending physician or practitioner may make an admission status change from inpatient or outpatient observation to outpatient when:

- The attending physician/practitioner and/or the hospital's utilization review staff determines that an outpatient observation or inpatient client's symptoms/condition and treatment **do not** meet medical necessity criteria for observation or acute inpatient level of care;
- The admission status change is made prior to, or on the next business day following, discharge; and
- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:
  - ✓ Be dated with the date of the change; and
  - ✓ Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Change from Outpatient Surgery/Procedure to Outpatient Observation or Inpatient Admission Status

The attending physician or practitioner may make an admission status change from outpatient surgery/procedure to outpatient observation or inpatient when:

- The attending physician/practitioner and/or the hospital's utilization review staff determines that the client's symptoms/condition and/or treatment require an extended recovery time beyond the normal recovery time for the surgery/procedure and medical necessity for outpatient observation or inpatient level of care is met;
- The admission status change is made prior to, or on the next business day following, discharge; and
- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:
  - ✓ Be dated with the date of the change; and
  - ✓ Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Note: During post-payment retrospective utilization review, DSHS may determine the admission status ordered is not supported by documentation in the medical record. DSHS may consider payment made in this circumstance an overpayment and payment may be recouped or adjusted.

Acute Care Transfers

DSHS may retrospectively review acute care transfers for appropriateness. If DSHS determines the acute care transfer was unnecessary, an adjustment in payment may be taken.

Coding and DRG Validations

DSHS may retrospectively review inpatient hospital claims for appropriate coding and DRG assignment. DSHS follows national coding standards using the National Uniform Billing Data Element Specifications, the Uniform Hospital Discharge Data Set, and the ICD-9-CM Committee Coding Guidelines.

DRG and Per Diem Outliers

DSHS may retrospectively review outliers to verify:

- Correct coding and DRG assignment;
- Medical necessity for inpatient level of care; and
- Medical necessity for continued inpatient hospitalization.

Length-of-Stay (LOS) Reviews

DSHS may perform a retrospective utilization review of non-DRG paid claims that exceed DSHS's DRG average LOS. Hospital medical records may be requested to verify medical necessity and appropriate level of care for the client's entire LOS.

> **Note:** Admissions requiring authorization for LOS extensions are psychiatric, acute physical medicine and rehabilitation (PM&R), and long-term acute care (LTAC) admissions.
>
> Refer to program-specific publications for more information.
> Psychiatric admission, prior authorization, and length of stay requirements are located in the *Inpatient Hospital Psychiatric Admissions* section of these billing instructions.

The DRG average LOS review applies only to:

- Claims paid by the per diem payment method;
- The critical access hospital (CAH) payment methods;
- Certified Public Expenditure (CPE) payment method; and
- The ratio of costs-to-charges (RCC) payment method for organ transplants.

DSHS will continue to retrospectively post-pay review the LOS on claims of hospitals paid using the Certified Public Expenditure (CPE) payment method.

Seven-Day Readmissions

DSHS may perform a retrospective prepayment utilization review of seven-day readmissions for clients who are readmitted as an inpatient to the same hospital or a different hospital for the same condition within seven calendar days.

In the above circumstances, DSHS may request medical records to review both the admission and readmission(s) for consideration of payment. Admissions and readmissions that DSHS determines to be unavoidable will be paid as individual payments.

Examples of cases in which individual payments would not be allowed:

- Continuation of same episode of care;
- Complication(s) from the first admission;
- A planned readmission following discharge, which includes a therapeutic admission following a diagnostic admission; and
- A premature hospital discharge.

> **Note:** This utilization review does not apply to psychiatric admissions. All psychiatric admissions require authorization through the appropriate RSN.

Medical Record Requests

If DSHS requests medical records during the retrospective utilization review process, submit a complete copy of the medical records to:

Health and Recovery Services Administration
Attn: Hospital Retrospective Utilization Review Unit
PO Box 45503
Olympia WA 98504-5503

A complete copy of the medical record includes, but is not limited to:

- Face sheet;
- Admission record;
- Discharge summary;
- History and physical;
- Multidisciplinary progress notes;
- Physician orders;
- Radiology interpretations;
- Laboratory test results;
- Consultations/referrals;
- Operative reports;
- Medication administration records;
- Itemized billing statement; and
- UB-04.

Failure to submit a complete medical record and billing record may impede the utilization review process and delay DSHS's determination.

Hospital-Issued Notice of Noncoverage (HINN)

When a medical assistance client no longer requires medically necessary, inpatient hospital medical care but chooses to remain in the hospital past the period of medical necessity, DSHS requires hospital providers to adhere to the following guidelines for hospital issued notices of noncoverage:

- ## Notifying a Medical Assistance Client that Medical Care Is no Longer Needed

  A hospital's Utilization Review (UR) Committee must comply with the Code of Federal Regulations 42 CFR 456.11 through 42 CFR 456.135 prior to notifying a medical assistance client that he or she no longer needs inpatient hospital medical care. The hospital is ***not required*** to obtain approval from DSHS or DSHS's contracted Quality Improvement Organization (QIO) at the client's discharge. Clients who have dual Medicare/Medicaid coverage are governed by Medicare's noncoverage rules.

  According to 42 CFR 456.136, a hospital's UR plan must provide written notice to DSHS if a medical assistance client decides to stay in the hospital when it is not medically necessary. A copy of this written notice must be sent to:

  Health and Recovery Service Administration
  Attn: Hospital Retrospective Utilization Review Unit
  PO Box 45503
  Olympia, WA 98504-5503

- ## Reimbursement for Services that Are not Medically Necessary

  DSHS does not reimburse for hospital services beyond the period of medical necessity. A medical assistance client who chooses to remain in the hospital beyond the period of medical necessity may choose to pay for continued inpatient care as a DSHS noncovered service. The client must accept financial responsibility. In order to bill the client for any DSHS noncovered service, providers must comply with the requirements in Washington Administrative Code (WAC) 388-502-0160. These requirements are also published in DSHS's *General Information Booklet* under "Billing a DSHS Client on a Fee-For-Service Program."

  If a client refuses to leave the hospital once he or she no longer needs inpatient hospital level of care, it is the responsibility of the hospital officials, not DSHS, to decide on a plan of action for the client.

Hospital Dispute and Appeal Process

If a provider disagrees with an adverse determination made by DSHS or DSHS's contracted Quality Improvement Organization (QIO), the following processes must be followed:

1. To dispute and request an appeal of an adverse determination made prospectively during the prior authorization process:

   The hospital provider must submit a written dispute/appeal request with:

   a. Specifics as to what the dispute is regarding; and
   b. Documentation to support the provider's position.

2. To dispute and request an appeal of an adverse determination made concurrently during the continued stay authorization process:

   The hospital provider must submit a written dispute/appeal request with:

   a. Specifics as to what the dispute is regarding; and
   b. Documentation to support the provider's position.

Send written dispute/appeal requests regarding #1 and #2 above to:

Health and Recovery Services Administration
Attn: Provider Request/Client Notification Unit
PO Box 45506
Olympia, WA 98504-5506
Fax: 1-360-586-1471

3. To dispute and request an appeal of an adverse determination made retrospectively during the retrospective utilization review audit process:

   The hospital provider must submit a written dispute/appeal request with:

   a. Specifics as to what the dispute is regarding; and
   b. Documentation to support the provider's position.

Send written dispute/appeal requests regarding #3 above to:

Health and Recovery Services Administration
Attn: Hospital Retrospective Utilization Review Unit
PO Box 45503
Olympia, WA 98504-5503
Fax: 1-360-586-0212

Inpatient Hospital Psychiatric Admissions

Inpatient Hospital Psychiatric Care Criteria

Inpatient psychiatric care for all Medical Assistance clients, including managed care enrollees (e.g., those on Title XIX and state programs), must be:

- **Medically necessary** (as defined in WAC 388-500-0005);
- **For principal covered diagnosis** (see "Diagnostic Categories" in the *Billing Procedures* section);
- **Approved (ordered)** by the professional in charge of the hospital or hospital unit; and
- **Certified** by a DBHR designee (as listed within these billing instructions in the important contacts section).

Provider Requirements

These billing instructions do not apply to:

- Freestanding Evaluation and Treatment (E&T) facilities;
- Children's Long-term Inpatient Program (CLIP) facilities;
- Eastern State Hospital;
- Western State Hospital; and
- Residential treatment facilities.

DSHS pays for hospital inpatient psychiatric care, as defined in Chapters 246-320 and 246-322 WAC, only when provided by one of the following Department of Health (DOH) **licensed hospitals or units:**

- Free-standing psychiatric hospitals determined by DBHR to meet the federal definition of an Institution for Mental Diseases (IMD), which CMS defines as: "a hospital, nursing facility, or other institution of more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services;"

- Medicare-certified, distinct psychiatric units;

(Provider Requirements Continued on next page)

(Provider Requirements Continued from previous page)

- Hospitals that provide active psychiatric treatment (see WAC 246-322-0170) outside of a Medicare-certified or state-designated psychiatric unit, under the supervision of a physician; or

- State-designated pediatric psychiatric units.

In addition to DOH licensure, hospitals providing **involuntary** hospital inpatient psychiatric care must be **certified** by DSHS's Division of Behavioral Health and Recovery (DBHR) in accordance with WAC 388-865-0500 through 388-865-0504 and must meet the general conditions of payment criteria in WAC 388-502-0100.

If a client is detained for involuntary care and a bed is not available in an facility, certified by DSHS's DBHR the state psychiatric hospitals (under the authority of DBHR) may, at their discretion, issue a **single bed certification** which serves as temporary certification (see WAC 388-865-0526) allowing for inpatient admission to occur in that setting.

Requests for single bed certification are made by the DBHR designee prior to commencement of the detention order.

Psychiatric Indigent Inpatient (PII) Program

Eligibility

The PII program affects indigent clients who receive voluntary hospital inpatient psychiatric care. Individuals must apply for this program. Individuals receive a Medical Assistance Identification (ID) Card with the identifier **"MIP-EMER No out of state care."** Indigent clients who are involuntarily hospitalized under chapters 71.05 and 71.34 RCW may be covered under other programs. Clients may qualify for the PII program only after they are determined ineligible for other medical programs.

Coverage

The PII program covers voluntary emergent hospital inpatient psychiatric care in community hospitals within the state of Washington. A client is limited to a single three-month period of PII eligibility each 12-month period. These clients are also subject to the $2,000 Emergency Medical Expense Requirement (EMER) during the same 12-month period.

Non Coverage

The PII program does not cover ancillary charges for physicians, pharmacies, transportation (including ambulance), or other costs associated with a voluntary hospital inpatient psychiatric hospitalization. **[Refer to WAC 388-865-0217]** The PII program covers usual and customary charges for voluntary hospital inpatient psychiatric hospitalization billed on a hospital billing form (UB-04).

Voluntary Treatment

The DBHR designee may authorize and pay for voluntary hospital inpatient psychiatric hospitalization services provided to clients who are receiving or have applied and are eligible for medical assistance programs (e.g., Categorically Needy Program). Please see DSHS's *General Information Booklet* for more information on medical assistance programs.

Age of Consent for Voluntary Inpatient Hospital Psychiatric Care

Minors 12 and younger:	May be admitted to treatment only with the permission of the minor's parent/legal guardian.
Minors 13 and older:	May be admitted to treatment with the permission of: • The minor and the minor's parent/guardian; • The minor without parental consent; or • The minor's parent/legal guardian without the minor's consent.
18 and older:	May be admitted to treatment only with the client's voluntary and informed, written consent. In cases where the client has a legal guardian, the guardian's consent is required.

Involuntary Treatment

Only persons over the age of 12 (see "Age of Consent" above) may be detained under the provisions of the Involuntary Treatment Act (ITA) as defined by chapters 71.05 and 71.34 RCW. The DBHR designee authorizes and pays for services provided to clients who are receiving medical assistance. When the client is in the process of applying for medical assistance, payment by the DBHR designee is subject to the eligibility determination.

The DBHR designee also authorizes services that are provided to clients detained under ITA law when the client either refuses to apply for, or does not qualify for, any medical assistance program as described. These inpatient stays are paid for through the use of state funds.

Unlike the PII program, under ITA, DSHS ***does*** cover the ancillary charges for physicians, transportation (including ambulance) or other costs associated with an involuntary hospital inpatient psychiatric hospitalization.

Involuntary Admissions

Involuntary admissions occur in accordance with ITA; Chapters 71.05 and 71.34 RCW. Therefore, no consent is required. Only persons over the age of 12 are subject to the provisions of these laws.

Tribal Affiliation

For children and adults who are members of a Native American tribe, the age of consent of the associated tribe supersedes the age of consent rules above.

Authorization Requirements for Inpatient Hospital Psychiatric Care

The hospital must obtain prior authorization (PA) from the appropriate DBHR designee for *all* inpatient hospital psychiatric admissions. To view RSN information, visit DBHR on the web at: http://www.dshs.wa.gov/Mentalhealth/rsnmap.shtml.

This PA requirement includes clients eligible for both Medicare and medical assistance who have exhausted their lifetime Medicare benefits at admission or during the course of hospitalization. This also includes clients with primary commercial or private insurance and who have secondary Medicaid coverage when their primary insurance has been exhausted at admission or during the course of hospitalization. Unless the hospital receives this authorization, DSHS will not pay for the services rendered. The DBHR designee may not withhold its decision pending eligibility for medical assistance and must issue a documented authorization decision within the timelines of this section upon request. To determine the appropriate DBHR designee, refer to the flow chart at the end of this section.

Time Frames for Submission

Time frames for submission of requests are as follows:

- **Initial:** Hospitals must request authorization prior to admission. This PA requirement includes clients eligible for both Medicare and medical assistance who have exhausted their lifetime Medicare benefits at admission or during the course of hospitalization and for clients with primary commercial or private insurance and secondary Medicaid coverage when their primary insurance has been exhausted at admission or during the course of hospitalization. If Medicare or primary benefits are exhausted during the course of hospitalization, PA must be sought within the calendar day of benefit exhaustion. If the hospital chooses to admit a client without PA due to staff shortages, the hospital must submit a request for initial authorization the same calendar day (which begins at midnight) as the admission. In these cases, the hospital assumes the risk for denial as the DBHR designee may or may not authorize the care for that day. If there is disparity between the date of admission and date of authorization, the disparate days will not be covered. DBHR designees are required to respond to requests for authorization within 2 hours and make a determination within 12 hours.

Length of Stay Extension: Unless the DBHR designee specifies otherwise on the current authorization form, hospitals must submit requests for continued stay at least 24 hours prior to the expiration of the currently authorized period. A hospital may choose to submit a request more than 24 hours prior to the expiration of the currently authorized period. Whenever possible, hospitals are encouraged to submit extension requests during regular business hours. DBHR designees are required to provide determination within 24 hours of the receipt of the extension request.

- **Transfer:** If the admitted client is to be transferred from one hospital to another hospital during the course of hospital inpatient psychiatric care, the hospital from which the client is being transferred must contact the DBHR designee to request a new authorization for services to be provided in the new hospital at least 24 hours prior to the change in hospital of service (transfer). DBHR designees are required to provide a determination on the request within 24 hours of the receipt of the transfer request.

- **Retrospective:** Retrospective authorization may occur if the client becomes eligible for medical assistance after admission or in rare situations where circumstances beyond the control of the hospital prevented the hospital from requesting an authorization prior to admission. Hospitals may request authorization after the client is admitted, or admitted and discharged. A DBHR designee has the authority to approve or deny a request for retrospective certification for a client's voluntary inpatient psychiatric admission, length of stay extension, or transfer when hospital notification did not occur within the timeframes stipulated in **WAC 388-550-2600**.

  - ✓ For retrospective certification requests ***prior to discharge***, the hospital must submit a request for authorization for the current day and days forward. For these days, the DBHR designee must respond to the hospital or hospital unit within 2 hours of the request and provide certification and authorization or denial within 12 hours of the request. For days prior to the current day (i.e. admission date to the day before the DBHR designee was contacted), the hospital must submit a separate request for authorization. The DBHR designee must provide a determination within 30 days upon receipt of the required clinical documentation for the days prior to notification.

  - ✓ For retrospective certification requests ***after the discharge***, the hospital must submit a request for authorization as well as provide the required clinical information to the DBHR designee within 30 days of discharge. The DBHR designee must provide a determination within 30 days of the receipt of the required clinical documentation for the entire episode of care.

  All retrospective certifications must be in accordance with the requirements of this section and an authorization or denial must be based upon the client's condition and services rendered at the time of admission and over the course of the hospital stay until the date of notification or discharge, as applicable.

Medicare/Medicaid Dual Eligibility

For the purposes of this section, "Medicare dual eligibility" refers to cases when a client has healthcare coverage under both Medicare and medical assistance. In such cases, the following applies:

- Although hospitals are not required to seek the DBHR designee's authorization for Medicare inpatient services, they *are* required to notify the DBHR designee of a client's dual eligibility at the time of admission via phone or fax within the same calendar day as the admission. The DBHR designee is responsible for the client's deductible, co-insurance, or co-payment, up to the DSHS determined allowed amount.

- If the client with Medicare dual eligibility has exhausted their Medicare lifetime benefit at admission, the hospital is required to seek authorization from the DBHR designee at admission. DBHR designees are required to respond within 2 hours and provide determination within 12 hours.

- If the client with Medicare dual eligibility has exhausted their Medicare lifetime benefit during the course of hospital inpatient psychiatric care, the hospital is required to seek authorization from the DBHR designee prior to the anticipated benefit exhaustion for the remaining expected days. DBHR designees are required to respond within 2 hours and provide determination within 12 hours.

Commercial (Private) Insurance

As with Medicare and Medicaid dual eligibility, hospitals are required to notify the DBHR designee at admission if a client has commercial or private insurance that pays for hospital inpatient psychiatric care and has medical assistance as a secondary payer. Hospitals are required to seek the DBHR designee's authorization 24 hours prior to the benefit exhaustion of the commercial or private insurance for any anticipated days past the benefit exhaustion date. The DBHR designee may provide authorization retrospectively in cases where a delay has occurred in the commercial or private insurer's notification to the hospital that the benefit is exhausted. DBHR designees are required to respond to requests within 2 hours and make a determination within 12 hours.

Changes in Status

There may be more than one authorization needed during an episode of hospitalization. A request for authorization is required when there has been a change in a client's legal status, principal diagnosis, or hospital of service as indicated below. DBHR designees must respond to hospital requests for authorization within the timelines below when there has been a change in client's legal status, principal diagnosis, or hospital of service as follows:

- **Change in legal status**: If a client's legal status changes from involuntary to voluntary, the hospital must contact the DBHR designee within 24 hours to request a new authorization reflecting the changed legal status. A subsequent authorization may be issued if the stay is authorized. If a client's legal status changes from voluntary to involuntary, the hospital is not required to notify the DBHR designee because a DMHP is required for detention and thus the DBHR designee would already be notified. The DBHR designee will issue a separate authorization for the involuntary days. Any previously authorized days under the previous legal status that are past the date of the change in legal status are not covered. DBHR designees are required to respond to requests within 2 hours and make a determination within 12 hours.

- **Change in Principal Diagnosis**: The situations below outline different scenarios and corresponding expectations when a change in principal diagnosis occurs. DBHR designees must respond within 2 hours and provide determinations within 12 hours for requests related to changes in principal diagnosis:

  - ✓ If a client's principal diagnosis changes from a physical health condition to a covered mental health condition, the hospital must contact the DBHR designee within the calendar day to request an authorization related to the new principal covered diagnosis.

  - ✓ If a client's principal diagnosis changes from a covered mental health diagnosis to a physical health diagnosis, the hospital must notify the authorizing DBHR designee within 24 hours of this change. Any previously authorized days under the previous principal covered diagnosis that are past the date of the change in principal covered diagnosis are not covered.

  - ✓ If a client's principal diagnosis changes from a covered mental health diagnosis to another covered mental health diagnosis, a new authorization is *not* required, though this change should be communicated to the DBHR designee within 24 hours of the change as a matter of best practice.

  - ✓ If a client is authorized for hospital inpatient psychiatric care, is discharged, admitted to medical care and then discharged from the medical care and readmitted to psychiatric care during the course of their hospitalization, the DBHR designee must be notified of the initial discharge from psychiatric care and a new authorization is required for the readmission to psychiatric care for that day forward.

- **Change in Hospital of Service (transfer)**: If the client is to be transferred from one hospital to another hospital during the course of inpatient psychiatric care, the hospital from which the client is being transferred must contact the DBHR designee to request a new authorization for services to be provided in the new hospital 24 hours prior to the change in hospital of service (transfer). A subsequent authorization may be issued if the stay is approved. Hospitals must ensure that when a client who has been involuntarily detained is transferred from one facility to another, the client's current medical, psychiatric, and copies of any ITA or court papers accompany the client. DBHR designees are required to provide a determination on the request within 24 hours of receipt of the request.

Notification of Discharge

For clients who have been authorized for inpatient care by the DBHR designee, hospitals must notify the DBHR designee within 24 hours when a client has been discharged or has left against medical advice prior to the expiration of the authorized period. Authorized days which extend past the date the client was discharged or left the facility are not covered. The DBHR designee will add the discharge date information to the current authorization form and ensure the hospital receives a copy within 3 business days of hospital notification.

Denials

A denial must be issued by the DBHR designee if the hospital believes medical necessity is met for a hospital level of inpatient care and the DBHR designee disagrees and therefore does not authorize the care. Free standing evaluation and treatment (E&T) facilities also provide acute psychiatric care. E&Ts are considered a lower level of inpatient care than a hospital. If the DBHR designee believes a Freestanding E&T is the more appropriate level of inpatient care and the hospital *agrees*, it is NOT a denial, it is a diversion from hospital level of care. If the DBHR designee believes an E&T is the more appropriate level of acute care and the hospital does *not* agree, it ***is*** a denial. A transfer from one community hospital to another community hospital is not a denial.

Diversions

A diversion is considered to be any time a community hospital *agrees* to alternative level of inpatient care (Freestanding E&T) or any other alternative level of care (e.g. community-based crisis stabilization placement) A diversion can occur prior to admission or during continued stay review if it is determined that another level of care is medically indicated.

Clinical Appeals

Medical necessity determinations resulting in denials of authorization by the DBHR designee may be appealed. Hospitals that disagree with a particular DBHR designee's medical necessity determination for admission or number of days authorized must utilize the appeal process established by the DBHR designee who issued the decision. Clinical appeals will be conducted by a different psychiatrist than the psychiatrist that issued the original decision, per WAC 284-43-322 and CFR 42 431. The psychiatrist conducting the second review may not be part of the DBHR designee's provider network. The review conducted by the second psychiatrist is final.

Administrative Disputes

Concerns regarding a DBHR designee's compliance with published requirements may be addressed through an administrative dispute process. Hospitals that have administrative issues (i.e. NOT medical necessity) with a particular DBHR designee must utilize the administrative dispute resolution process established by the DBHR designee involved. If not resolved at the DBHR designee level, hospitals may contact DBHR for instructions regarding a second level review. The DBHR review is final.

Authorization Procedures for Inpatient Hospital Psychiatric Care

Documentation

To receive authorization for hospital inpatient psychiatric care, the hospital intending to provide the service must contact the appropriate DBHR designee within the following required timelines:

- **Initial Certification for Admission to Hospital Inpatient Psychiatric Care (Initial Certification):** Hospitals must request authorization prior to admission. This prior authorization (PA) requirement includes; clients with Medicare dual eligibility; clients with commercial or private insurance with Medicaid as secondary when: The client has exhausted their lifetime Medicare benefits at admission; or the commercial or private insurance has been exhausted at admission.
- For clients with Medicare dual eligibility and clients with commercial or private insurance who exhaust their lifetime benefits during the course of hospitalization, authorization must be sought within the calendar day of benefit exhaustion. If the hospital chooses to admit a client without PA due to staff shortages, the hospital must submit a request for initial authorization the same calendar day (which begins at midnight) as the admission. In these cases, the hospital assumes the risk for denial as the DBHR designee may or may not authorize the care for that day. If there is disparity between the date of admission and date of authorization, the disparate days will not be covered. DBHR designees are required to respond to requests for authorization within 2 hours and make a determination within 12 hours.

The initial certification provides the DBHR designee's authorization of the:

- ✓ Authorized days (covered);
- ✓ Administrative days, if applicable (paid at the administrative day rate);
- ✓ Non-authorized days (non-covered) for the **initial** stay; and
- ✓ Date when the hospital must contact the DBHR designee for an extension request.

These days are important for billing purposes (see *Billing Procedures for Inpatient Psychiatric Care* for instructions on how to use the Initial Certification form in the billing process.)

Hospitals must request **subsequent/new authorizations** from the DBHR designee for changes in:

- ✓ Legal status;
- ✓ Principal covered diagnosis; and
- ✓ Hospital of service. (See "Changes in Status" earlier in this section.)

- **Application for Medical Assistance**: If an application is made for determination of a client's medical assistance eligibility, the DBHR designee must be contacted within the calendar day. The DBHR designee may not withhold its decision pending the outcome of the client's medical assistance eligibility. DBHR designees are required to respond to requests within 2 hours and communicate a determination within 12 hours.

  Note: Hospitals must be prepared to present to the DBHR designee client information. This information is found on the Initial Certification for Admission to Inpatient Psychiatric Care DSHS form 13-821 at the time of the request for initial certification. DBHR designees complete the form and ensure that the hospital receives a copy for its billing purposes.

- **Extension Certification for Admission to Inpatient Psychiatric Care (Extension Certification):** The DBHR designee must be contacted for requests for extension at least 24 hours prior to expiration of the currently authorized period, unless otherwise indicated by the DBHR designee. A hospital may request an extension more than 24 hours prior to the expiration of the currently authorized period. The extension certification provides the DBHR designee's authorization of the:

  - ✓ Authorized days (covered);
  - ✓ Administrative days, if applicable (paid at the administrative day rate);
  - ✓ Non-authorized days (non-covered) for the extended stay; and
  - ✓ Date when the hospital must contact the DBHR designee for an extension request.

  These days are important for billing purposes (see *Billing Procedures for Inpatient Psychiatric Care* for instructions on how to use the Initial Certification form in the billing process.)

  The DBHR designee cannot deny extension requests for adults who are detained under the Involuntary Treatment Act (ITA) law unless another less-restrictive alternative is available. The hospitals and DBHR designees are encouraged to work together to find less-restrictive alternatives for these clients. However, all alternative placements must be ITA certified (either as a facility or through the single bed certification). Additionally, since the ITA court papers indicate the name of the facility in which the client is to be detained, the court would need to be approached for a change of detention location if a less restrictive placement is found. (See "Billing Instructions for Involuntary Treatment" farther along in this section.)

Note:	Hospitals must be prepared to present to DBHR designee the client information found on the Extension Certification Authorization for Continued Inpatient Psychiatric Care DSHS form 13-822 at the time of the request for extension certification.

- **Retrospective Certification for Admission to Inpatient Psychiatric Care (Initial Certification):** The Initial Certification for Admission to Inpatient Psychiatric Care form DSHS 13-821. Form is also used for retrospective certifications and provides the DBHR designee's authorization for:

  - ✓ Authorized days (covered);
  - ✓ Administrative days, if applicable (paid at the administrative day rate); and
  - ✓ Non-authorized days (non-covered) for the **extended** stay.

  Retrospective authorization may occur if the client becomes eligible for medical assistance after admission or in rare situations where circumstances beyond the control of the hospital prevented the hospital from requesting an authorization prior to admission. Hospitals may request authorization after the client is admitted, or admitted and discharged. A DBHR designee has the authority to approve or deny a request for retrospective certification for a client's voluntary inpatient psychiatric admission, length of stay extension, or transfer when hospital notification did not occur within the timeframes stipulated in **WAC 388-550-2600**.

  - ✓ For retrospective certification requests ***prior to discharge***, the hospital must submit a request for authorization for the current day and days forward. For these days, the DBHR designee must respond to the hospital or hospital unit within 2 hours of the request and provide certification and authorization or denial within 12 hours of the request. For days prior to the current day (i.e. admission date to the day before the DBHR designee was contacted), the hospital must submit a separate request for authorization. The DBHR designee must provide a determination within 30 days upon receipt of the required clinical documentation for the days prior to notification.

  - ✓ For retrospective certification requests ***after the discharge***, the hospital must submit a request for authorization as well as provide the required clinical information to the DBHR designee within 30 days of discharge. The DBHR designee must provide a determination within 30 days of the receipt of the required clinical documentation for the entire episode of care.

- **Administrative Days:** The DBHR designee may issue approval for administrative days only when all of the following conditions are true:

  - ✓ The client has a legal status of voluntary;
  - ✓ The client no longer meets medical necessity criteria;
  - ✓ The client no longer meets intensity of service criteria;
  - ✓ Less restrictive alternatives are not available, posing a barrier to safe discharge; and
  - ✓ The hospital and DBHR designee mutually agree to the appropriateness of the administrative day.

- **Extensions for Youth Waiting for Children's Long-Term Inpatient Program (CLIP):** The DBHR designee cannot deny an extension request for a child or youth who has been detained under ITA and is waiting for a CLIP placement unless another less-restrictive alternative is available. As noted above, use of administrative days may be considered in voluntary cases only.

  - ✓ **Voluntary:** For a child waiting for CLIP placement who is in a community psychiatric hospital on a voluntary basis, the DBHR designee may authorize or deny extensions or authorize administrative days. Hospitals and DBHR designees are encouraged to work together to find less restrictive alternatives for these children.

  - ✓ **Involuntary:** For a youth waiting for CLIP placement who is in a community psychiatric hospital on an involuntary basis, extensions may *not* be denied and administrative days may *not* be authorized by the DBHR designee. The hospitals and DBHR designees are encouraged to work together to find less restrictive alternatives for these youths. However, any less-restrictive placements would need to be ITA-certified (either as a facility or through the single bed certification). Additionally, since the ITA court papers indicate the name of the facility in which the youth is to be detained, the court would need to be approached for a change of detention location if a less-restrictive placement is found.

Additional Requirements

In addition to timely requests for authorization and provision of required client information as indicated, admission must be determined to be **medically necessary** for treatment of a **covered principal diagnosis code**. (See "Diagnostic Categories" farther along in this section.)

- For the purpose of these Inpatient Hospital Psychiatric Admissions billing instructions, "Medically Necessary or Medical Necessity" is defined as follows:

  - ✓ Ambulatory care resources available in the community do not meet the treatment needs of the client; **AND**

  - ✓ Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician (according to WAC 246-322-170); **AND**

  - ✓ The services can reasonably be expected to improve the client's level of functioning or prevent further regression of functioning; **AND**

  - ✓ The client has been diagnosed as having an emotional/behavioral disorder or a severe psychiatric disorder (as defined in the current edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association) that is considered a principal covered diagnosis (see "Diagnostic Categories" farther along in this section) and warrants extended care in the most intensive and restrictive setting; **OR**

  - ✓ The client was evaluated and met the criteria for emergency involuntary detention (Chapter 71.05 or 71.34 RCW); **OR**

  - ✓ The client was evaluated and met the criteria for emergency involuntary detention (Chapter 71.05 or 71.34 RCW) but agreed to inpatient care.

- **Provision of required Clinical Data:** In order for the DBHR designee to make medical necessity determination, the hospital must provide the requisite DBHR **-required Clinical Data** for initial and extended authorizations. While DBHR designees may use different formats for collection of this clinical data, the data set that is required is the same regardless of which DBHR designee is certifying the need for inpatient psychiatric care.

Note:	See the "Clinical Data Required for Initial Certification" and "Clinical Data Required for Extension Certification" sections farther along in this section.

- **Determination of the appropriate DBHR designee to contact:** For assistance in determining which MHD designee is appropriate for authorization, see the following **resources:**

  ✓ DSHS's DBHR designee flow chart at the end of this section.
  ✓ RSN map at: http://www.dshs.wa.gov/Mentalhealth/rsnmap.shtml.
  ✓ CSO and HCS Office Information List at: http://www.dshs.wa.gov/manuals/eaz/sections/CaseRecords.shtml.

- **Referral to Children's Long-Term Inpatient Program (CLIP)**: When the court determines that a 180-day commitment to inpatient care in a state-funded facility is necessary for a juvenile, the committing hospital must notify the Children's Long-Term Inpatient Program (CLIP) Administration of the court's decision *by the end of the next working day following the court hearing*. (RCW 71.34.) Once the Committee is notified, authorization for additional care can be issued by the appropriate DBHR designee (see DSHS's DBHR designee flow chart at the end of this section.)

  When a hospital receives a client for the CLIP, they are expected to supply information as specified in the information requirements in the CLIP referral packet in this document.

  DSHS will ***not*** reimburse for services provided in a juvenile detention facility.

- **Initial Notification:** The committing hospital must notify the CLIP Administration by the end of the next working day of the 180-day court commitment to state-funded long-term inpatient care.

  The following information is expected:

  ✓ Referring staff, organization and telephone number.
  ✓ Client's first name and date of birth.
  ✓ Beginning date of 180-day commitment and initial detention date.
  ✓ Client's county of residence.

- **Discharge Summary and Review of Admissions:** Within two weeks of transfer from the hospital to a CLIP program, a copy of the completed discharge summary must be submitted to the CLIP Administration and to the facility where the child is receiving treatment. ***All*** *referral materials* should be sent to the CLIP Administration at the following address:

  Children's Long-Term Inpatient Program (CLIP)
  2142 10TH Avenue W
  Seattle, WA 98119
  1-206-298-9654

Under the conditions of the At Risk/Runaway Youth Act, as defined in chapter 71.34 RCW, hospitals must provide the DBHR designee access to review the care of any minor (regardless of source of payment) who has been admitted upon application of his/her parent or legal guardian. For the purposes of the Review of Admissions, all information requested must be made available to the DBHR designee. The DBHR designee must document in writing any subsequent determination of continued need for care. A copy of the determination must be in the minor's hospital record.

- **Referral Packet:** A referral packet concerning the ITA committed child must be submitted to the CLIP Administration within five (5) working days of telephone notification for the 180-day commitment. If the child is transferred to another facility for an interim placement until CLIP care is available, the referral packet must accompany the child. The following items are required components of the referral packet:

  - ✓ A certified copy of the court order: 180-day commitment petition with supporting affidavits from a physician and the psychiatrist or a children's mental health specialist;

  - ✓ A diagnosis by a Psychiatrist including Axis I-V related to the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;

  - ✓ An admission evaluation including:

    - ➢ Medical evaluation; and
    - ➢ Psychosocial evaluation;

  - ✓ The hospital record face sheet;

  - ✓ Other information about medical status including:

    - ➢ Laboratory work;
    - ➢ Medication records; and
    - ➢ Consultation reports;

  - ✓ An outline of the child’s entire treatment history;

  - ✓ All transfer summaries from other hospitals where the child has been admitted during the current commitment as well as discharge summaries from any prior facility; and

  - ✓ A brief summary of child's progress in treatment to date including hospital course, family involvement, special treatment needs, and recommendations for long-term treatment/assignment.

- **Submitting Other Background Information for CLIP referrals:**

  During the 20 days following the 180-day commitment hearing, the committing hospital must arrange to have the following background information submitted to the CLIP Administration. Submit this information prior to admission to the CLIP program:

  - ✓ Written formulation/recommendation of the local intersystem team responsible for the child's long-term treatment plan should include family's involvement, and detail of treatment history, as well as less restrictive options being considered;
  - ✓ DSHS case records, including placement history form, ISPs, court orders, etc. Include legal history regarding juvenile arrests, convictions, probation/parole status;
  - ✓ Complete records from all hospitalizations, including admission and discharge summaries, treatment plans, social history evaluations, consultations, and all other assessments (do not include daily progress notes);
  - ✓ Treatment summaries and evaluations from all foster or residential placements, and all day treatment and outpatient treatment summaries;
  - ✓ If not contained in other documents, a comprehensive social history, including developmental and family history;
  - ✓ School records, including special services assessments, transcripts, psychological evaluations, current IEP, current level of functioning; and
  - ✓ Immunization record, copy of social security card and birth certificate.

- **Inter-facility Transfer Reports -** When a youth who has been involuntarily detained is transferred from one facility to another, an inter-facility or hospital transfer report detailing the child's current medical, psychiatric, and legal status (in terms of both ITA commitment and custody) must accompany that child as well as a certified copy of the court order.

  For general information, about CLIP visit http://www.clipadministration.org/

Completing the "Authorization for Admission to Inpatient Psychiatric Care" Forms

Initial Certification Authorization for Admission to Inpatient Psychiatric Care DSHS Form 13-821

Where to Get the Form

To *view and download* the Initial Certification Authorization for Admission to Inpatient Psychiatric Care DSHS form 13-821, visit DSHS Forms and Records Management Service on the web: http://www.dshs.wa.gov/msa/forms/eforms.html

To download and print copies of other DSHS forms visit the DSHS forms website at: http://www.dshs.wa.gov/msa/forms/

How to Use the Form

- **Purpose:** The initial certification is the DBHR designee's approval for payment for the inpatient psychiatric admission. The DBHR designee certifies the professional's decision regarding the medical necessity for inpatient psychiatric care for a client. The DBHR designee will complete the form, make a determination, and share the determination with the hospital and the RSN/county management site identified by each RSN. The completed form will be provided to the hospital by the DBHR designee and is to be kept in the client's hospital file. Unless the hospital requires immediate receipt of the form prior to admission, the DBHR designee will ensure the form is provided to the hospital within 3 business days of the authorization. The DBHR designee will also keep a copy. In order to meet federal, state, and DBHR designee requirements, the form must be completed in its entirety.

  The initial certification form is to be utilized statewide. The information in the following table must be completed on each form and submitted with the associated claim or the claim cannot be processed and will be denied. The hospital must be prepared to provide the client information on the initial certification form as well as the clinical data identified in "Clinical Data Required for Initial Certification" farther along in this

section. At their discretion, a DBHR designee may require additional information from the hospital in order to make determinations.

- **Form distribution:** The hospital contacts the DBHR designee, providing the designee with all of the required client information and clinical data. The DBHR designee completes the form and sends it to the hospital, retaining necessary copies for designee use. Completed Initial Certification for Inpatient Psychiatric Care DSHS form 13-821 forms must accompany the claims related to the dates authorized for payment to be made.

INFORMATION TO BE PRESENTED TO DBHR DESIGNEE BY HOSPTIAL

Field Name	Description
Last Name	The client's last name.
First Name	The client's first name.
Medicaid ID (PIC)	This is the Patient Identification Code which is obtained from the medical identification card. It is a fourteen-digit figure. A birthday of January 10, 1960, for John A. Jones would appear as "**JA 011060 JONES A**".
Address	The client's address at time of hospitalization.
Resided at Address > 60 days	If client has resided at given address more than 60 days, check Yes. If not, check No.
Zip Code	The client's zip code at time of hospitalization.
County of Residence	The county from which the client's medical card was issued.
CSO (if known)	The DSHS Community Service Office from which the client's medical card was issued.
DOB	The client's date of birth.
SSN	The client's social security number.
Hospital Name	The name of the hospital where services are to be provided.
Date of Admission	The date the client was admitted to inpatient psychiatric care.
Legal Status	The client's current legal status which is either voluntary or involuntary. Involuntary legal status applies to only those clients who are older than the age of twelve (12) who are detained under the provisions of the Involuntary Treatment Act (ITA) as defined by chapters 71.05 and 71.34 RCW.
Eligibility Status REQUIRED FOR ITA CLAIMS	This section *replaces* the Involuntary Treatment Act Patient Claim form, DSHS 13-628. One of the following boxes must be checked for ITA claim payment. ❑ Currently receiving medical assistance ❑ Applied for public assistance eligibility on _____ date It appears that this blank is supposed to be here for someone's use. ❑ Mental state and condition prevents efforts to determine eligibility (72 hours allowed) ❑ Left facility prior to probable cause hearing and cannot be

Field Name	Description
	located to complete eligibility application (72 hours allowed) ❑ Client or responsible party refuses to apply for resources
Diagnosis	Diagnosis used to reflect the client's principal diagnosis and reason for admission.
Requested Length of Stay	The maximum number of days requested, followed by the start and end dates which reflect the number of days requested.

TO BE DETERMINED BY DBHR DESIGNEE:

Field Name	Description
Authorization Number	The number issued by the DBHR designee (RSN of residence) referencing the current episode of inpatient care.
Certification Statement	The proclamation by DBHR designee that the client does or does not meet Medical Necessity. For a client to be found to meet medical necessity, the following must be true: • Ambulatory care resources available in the community do not meet the treatment needs of the client; **AND** • Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician (according to WAC 246-322-170); **AND** • The services can reasonably be expected to improve the client's level of functioning or prevent further regression of functioning; **AND** • The client has been diagnosed as having an emotional/behavioral disorder or a severe psychiatric disorder (as defined in the current edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association) which is considered a principal covered diagnosis (see "Diagnostic Categories" farther along in this section) and warrants extended care in the most intensive and restrictive setting; **OR** • The client was evaluated and met the criteria for emergency involuntary detention (Chapter 71.05 or 71.34 RCW); **OR** • The client was evaluated and met the criteria for emergency involuntary detention (Chapter 71.05 or 71.34 RCW) but agreed to inpatient care.

Field Name	Description
Days Authorized	The maximum number of the requested days that are authorized by the DBHR designee for the episode of inpatient psychiatric care. This is followed by the start and end dates which reflect the maximum number of days authorized.
Administrative Days Authorized	If applicable, the maximum number of the requested days that are authorized by the DBHR designee at the administrative bed day rate (Revenue Code 0169) for the episode of inpatient psychiatric care. This is followed by the start and end dates which reflect the maximum number of administrative days authorized.
Days Not Authorized	The number of the requested days that are not authorized by the DBHR designee for the episode of inpatient psychiatric care. This is followed by the start and end dates which reflect the number of days not authorized.
Discharge Date	The date the client was discharged, specifying if discharge was early or against medical advice.
DBHR Designee Signature	The DBHR designee must sign and print/type their name and title, and date the form on the same date they sign it. A psychiatrist's signature is required for any denials (clients determined to *not* meet medical necessity).
Print/Type Name	The printed or typed name of the person who signed as the DBHR designee.
DBHR Designee Organization Name	The name of the Regional Support Network serving through contract as the DBHR designee.
Telephone	Telephone number of person who signed as the DBHR designee
Date	The date the form was signed.
Extension Request Due Date	The date a request for an extension must be submitted to the DBHR designee.

Extension Certification Authorization for Continued Inpatient Psychiatric Care DSHS form 13-822

Where to Get the Form

To view and download the Extension Certification Authorization for Continued Inpatient Psychiatric Care DSHS form 13-822, visit DSHS Forms and Records Management Service on the web: http://www.dshs.wa.gov/msa/forms/eforms.html

To download and print copies of other DSHS forms visit the DSHS forms website at: http://www.dshs.wa.gov/msa/forms/

How to Use the Form

- **Purpose:** The extension certification is the DBHR designee's approval for payment for continued inpatient psychiatric admission. The DBHR designee certifies the professional's decision regarding the medical necessity for inpatient psychiatric care for a client and authorizes care. The DBHR designee will complete the form, make a determination, and share that determination within the timelines identified in this section. The completed form will be provided to the hospital by the DBHR designee and is to be kept in the client's hospital file. Unless the hospital requires immediate reception of the form prior to admission, the DBHR designee will ensure the form is provided to the hospital within 3 business days of the authorization. The DBHR designee will also keep a copy. In order to meet federal, state, and DBHR designee requirements, the form must be completed in its entirety.

  The extension certification form is to be utilized statewide. The information in the following table must be completed on each form and submitted with the associated claim or the claim cannot be processed and will be denied. The hospital must be prepared to provide the client information on the initial certification form as well as the clinical data identified in "Clinical Data Required for Extension Certification" farther along in this section. At its discretion, a DBHR designee may require additional information from the hospital in order to make determinations.

- **Form distribution:** The hospital contacts the DBHR designee, providing the designee with all of the required client information and clinical data. The DBHR designee completes the form and sends it to the hospital, retaining necessary copies for designee use. Completed Extension Certification Authorization for Continued Inpatient Psychiatric Care DSHS form 13-822 must accompany the claims related to the dates authorized for payment to be made.

INFORMATION TO BE PRESENTED TO MH DESIGNEE BY HOSPITAL:

Field Name	Description
Last Name	The client's last name.
First Name	The client's first name.
Medicaid ID (PIC)	This is the Patient Identification Code which is obtained from the medical identification card. It is a fourteen-digit figure. A birthday of January 10, 1960, for John A. Jones would appear as "**JA 011060 JONES A**".
Address	The client's address at time of hospitalization.
Resided at Address > 60 days	If client has resided at given address more than 60 days, check Yes. If not, check No.
Zip Code	The client's zip code at time of hospitalization.
County of Residence	The county from which the client's medical card was issued.
CSO (if known)	The DSHS Community Service Office from which the client's medical card was issued.
DOB	The client's date of birth.
SSN	The client's social security number.
Hospital Name	The name of the hospital where services are to be provided.
Date of Admission	The date the client was admitted to inpatient psychiatric care.
Legal Status	The client's current legal status which is either voluntary or involuntary. Involuntary legal status applies to only those clients who are older than the age of twelve (12) who are detained under the provisions of the Involuntary Treatment Act (ITA) as defined by chapters 71.05 and 71.34 RCW.
Eligibility Status REQUIRED FOR ITA CLAIMS	This section *replaces* the Involuntary Treatment Act Patient Claim form, DSHS 13-628. One of the following boxes must be checked for ITA claim payment. ❑ Currently receiving medical assistance ❑ Applied for public assistance eligibility on _____ date ❑ Mental state and condition prevents efforts to determine eligibility (72 hours allowed) ❑ Left facility prior to probable cause hearing and cannot be located to complete eligibility application (72 hours allowed) ❑ Client or responsible party refuses to apply for resources
Diagnosis	Diagnosis used to reflect the client's principal diagnosis and reason for extension.
Requested Length of Stay	The maximum number of days requested, followed by the start and end dates which reflect the number of days requested.

TO BE DETERMINED BY DBHR DESIGNEE:

Field Name	Description
Authorization Number	The number issued by the DBHR designee (the RSN of residence) referencing the current episode of inpatient care.
Certification Statement	The proclamation by DBHR designee that the client does or does not meet Medical Necessity. For a client to be found to meet medical necessity, the following must be true: • Ambulatory care resources available in the community do not meet the treatment needs of the client; **AND** • Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician (according to WAC 246-322-170); **AND** • The services can reasonably be expected to improve the client's level of functioning or prevent further regression of functioning; **AND** • The client has been diagnosed as having an emotional/behavioral disorder or a severe psychiatric disorder (as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association) which is considered a principal covered diagnosis (see "Diagnostic Categories" farther along in this section) and warrants extended care in the most intensive and restrictive setting; **OR** • The client was evaluated and met the criteria for emergency involuntary detention (Chapter 71.05 or 71.34 RCW); **OR** • The client was evaluated and met the criteria for emergency involuntary detention (Chapter 71.05 or 71.34 RCW) but agreed to inpatient care.

Field Name	Description
Days Authorized	The maximum number of the requested days that are authorized by the DBHR designee for extension of the episode of inpatient psychiatric care. This is followed by the start and end dates which reflect the maximum number of days authorized.
Administrative Days Authorized	If applicable, the maximum number of the requested days that are authorized by the DBHR designee at the administrative bed day rate (Revenue Code 0169) for the episode of inpatient psychiatric care. This is followed by the start and end dates which reflect the maximum number of administrative days authorized.
Days Not Authorized	The number of the requested days that are not authorized by the DBHR designee for extension of the episode of inpatient psychiatric care. This is followed by the start and end dates which reflect the number of days not authorized.
Discharge Date	The date the client was discharged, specifying if discharge was early or against medical advice.
DBHR Designee Signature	The signature of the DBHR designee approving the number of extension days allowed. A psychiatrist's signature is required for any denials.
Print/Type Name	The printed or typed name of the person who signed as the DBHR designee.
Division of Behavioral Health and Recovery (DBHR) Designee Organization Name	The name of the Regional Support Network serving through contract as the DBHR designee.
Telephone	Telephone number of person who signed as DBHR designee.
Date	The date the form was signed.
Extension Request Due Date	The date a request for an extension must be submitted to the DBHR designee.

Billing for Inpatient Hospital Psychiatric Care

General Billing for Inpatient Hospital Psychiatric Care

All of the following must occur in order for hospitals to be paid for inpatient hospital psychiatric care:

- Hospitals must submit the most current **billing claim form** to DSHS for voluntary or involuntary hospital inpatient psychiatric admission in accordance with DSHS's *Inpatient Hospital Services Billing Instructions.*

- For ***all*** hospital inpatient psychiatric admissions, including clients with Medicare dual eligibility (when Medicare lifetime benefit has exhausted) as well as clients with commercial or private insurance with Medicaid as secondary payer (when primary insurance is exhausted), hospitals must obtain authorization in writing on the **Initial Certification Authorization for Admission to Inpatient Psychiatric Care DSHS form 13-821** (Initial Certification), and if necessary, the **Extension Certification Authorization for Continued Inpatient Psychiatric Care DSHS form 13-822** (Extension Certification) from the appropriate DBHR designee.

- Each admission to inpatient psychiatric care must be identified by the **unique authorization number**. The authorization number must be generated by the DBHR designee that authorized the admission. Hospitals must ensure this number appears in form locator 63 on the UB-04 claim form in order for payment to be made. In addition, legal status must be noted in the "comments" section of the UB-04 claim form.

  The authorization number must be comprised of 9 numerical digits. The **first two digits** of the number will always be **88**, indicating a psychiatric admission.

- Hospitals must obtain a **subsequent/new authorization** from the DSHS's DBHR designee on an Initial Certification Authorization for Admission to Inpatient Psychiatric Care DSHS form 13-821 when there is a change in:

  - ✓ Legal status;
  - ✓ Principal covered diagnosis; or
  - ✓ Hospital of service.

- The Initial Certification Authorization for Admission to Inpatient Psychiatric Care DSHS form 13-821and Extension Certification Authorization for Continued Inpatient Psychiatric Care DSHS form 13-822 provide the hospital with authorization for:

  - ✓ Authorized days (covered);
  - ✓ Administrative days, if applicable (paid at the administrative day rate);
  - ✓ Non-authorized days (non-covered) for the **initial** or **extended** stay respectively; and
  - ✓ Date when the hospital must contact the DBHR designee for an extension request.

- More than one certification or authorization may be needed during the episode of inpatient care.

- ***All*** submitted authorized claims (voluntary and involuntary) must include copies of all completed initial certification and extension forms.

- Hospitals must submit **separate claim forms** for voluntary authorized days, involuntary authorized days, and administrative days. In cases where a single certification form gives authorization for authorized days (voluntary or involuntary) and administrative days, hospitals may make a photocopy of the completed initial or extension certification form to complete these documentation requirements.

- **Authorized (covered) Days**: Authorized days are determined by the DBHR designee utilizing legal status and clinical presentation. Authorized (covered) days on the billing claim form must match authorized days on the initial certification form and any extension certification forms. Days not authorized are considered non-covered. Hospitals must bill the covered and non-covered days on separate lines.

Example:

Revenue Code	Covered Days	Non-covered Days
Rev Code	$**xx.xx**	
Rev Code		$**xx.xx**

- Hospitals must bill **Administrative days** and associated covered charges for services rendered on these days with revenue code **0169** on a separate claim.

- Per coding standards, hospitals must report **all ICD-9-CM diagnosis codes at the 5-digit level**, or highest level of specificity.

- If a client had a voluntary or involuntary hospital inpatient psychiatric admission authorized by a DBHR designee at admission, and the principal diagnosis on the hospital claim is a medical diagnosis (e.g. 648.43 or 331.00), the claim must be reviewed and manually processed for payment. Coding rules require the associated neurological or medical condition be coded first for certain psychiatric diagnosis codes.

- If a client had a medical admission and the principal diagnosis is a psychiatric diagnosis (290-319) the claim must be sent to the Med-Psych Program Manager for special handling for payment.

Mail a copy of the following:

- UB-04 hospital claim;
- History and physical; and
- Discharge summary.

To the Med-Psych Program Manager at :

Attention Med-Psych Program Manager
Division of Healthcare Services
PO Box 45506
Olympia, WA 98504-5506

Or fax to:

FAX 1-360-725-1966

Note: The claim must indicate in the *Comments* section of the claim form, whether the days billed were **voluntary** or **involuntary**. Claims for voluntary and involuntary portions of an episode of care must be authorized separately and billed separately.

Billing Instructions for Involuntary Treatment

- DSHS will process claims for services provided to detained clients who have applied for medical assistance and were denied. A copy of the authorization form(s) must be attached to the claim(s).

- **Out-of-state hospitals** must obtain authorization from the appropriate DSHS's DBHR designee for all **Medicaid** clients. Neither DSHS nor the DBHR designee pays for inpatient services for non-Medicaid clients if provided outside of the State of Washington. An exception is for clients who are qualified for the General Assistance–Unemployable (GA-U) program. For these clients, DSHS and the DBHR designee pays for inpatient psychiatric services provided in bordering cities and critical border hospitals. All claims for admissions to **out-of-state hospitals** are paid as **voluntary** legal status as the Involuntary Treatment Act applies only within the borders of Washington State.

- For all clients involuntarily detained under Chapter 71.34 or 71.05 RCW, DSHS does *not* provide payment for hospital inpatient psychiatric care past the **20th calendar day** from the date of initial detention *unless* a length of stay extension certification request is authorized by the DBHR designee.

- **Psychologist services** are covered *only* for provision of a psychological evaluation of detained clients. (See DSHS's *Psychologist Billing Instructions* for related policy and/or procedure codes). As with all other claims, an authorization form must accompany the claim. Attaching the authorization form serves as verification of the involuntary status.

> **Note:** In order to be paid, all claims must be accurate, complete, and include the required documents as indicated in this section. Incorrectly or partially completed claims, or claims without the required forms, will be denied and require resubmission which will delay payment.

Recoupment of Payments

DSHS recoups any inappropriate payments made to hospitals for unauthorized days or for authorized days that exceeded the actual date of discharge.

> Note: These billing instructions will be updated to coincide with the implementation of DSHS's new claims processing system called ProviderOne. For updates regarding ProviderOne, go to http://hrsa.dshs.wa.gov/providerone/providers.htm.

Diagnostic Categories

PSYCHIATRIC DIAGNOSTIC CATEGORIES WHICH *MAY* BE AUTHORIZED FOR INPATIENT PSYCHIATRIC CARE

Organic Psychotic Conditions (290-294)

290- Senile and pre-senile organic psychotic conditions
291- Alcoholic psychoses
292- Drug Psychoses
293- Transient organic psychotic conditions
294- Other organic psychotic conditions (chronic)

Other Psychoses (295-299)

295- Schizophrenic Psychoses
296- Affective Psychoses
297- Paranoid Psychoses
298- Other non organic psychoses
299- Psychoses with origin specific to childhood

Neurotic Disorders, personality disorders and other non psychotic mental disorders (300-314)

300- Neurotic disorders
301- Personality Disorders
306- Physiological malfunction arising from mental factors
307- Special symptoms or syndromes not elsewhere classified
308- Acute reaction to stress
309- Adjustment reaction
310- Specific non psychotic mental disorders due to organic brain damage
311- Depressive disorder, not elsewhere classified
312- Disturbance of conduct not elsewhere classified
313- Disturbance of emotions specific to childhood and adolescence
314- Hyperkinetic syndrome of childhood

PSYCHIATRIC DIAGNOSTIC CATEGORIES WHICH *CANNOT* BE AUTHORIZED FOR VOLUNTARY INPATIENT PSYCHIATRIC CARE

Non-psychotic Mental Disorders (302-316)

302- Sexual deviations/disorders
303- Alcohol dependence syndrome (1)
304- Drug Dependence (1)
305- Non dependent abuse of drugs (1)
315- Specific delays in development
316- Psychiatric factors associated with diseases classified elsewhere

Mental Retardation (317-319)

317- Mild Retardation
318- Other specified mental retardation
319- Unspecified mental retardation

Noted Exceptions:

- The requirements in this section do not apply to 3- and 5-day detoxification program admissions associated with the Division of Alcohol and Substance Abuse (DASA). Please reference DSHS's *Hospital-Based Inpatient Detoxification Billing Instructions*.

- For persons admitted involuntarily under Chapter 71.05 or 71.34 RCW, the exclusion of diagnoses codes 302-319 does not apply.

- For persons with Medicare and Medicaid dual eligibility, the exclusion of diagnoses codes 302-319 does not apply until the lifetime Medicare benefit has been exhausted.

- For medical inpatient detoxification (MID) see the *Utilization Review* section of these billing instructions.

Clinical Data Required For Initial Certification

In addition to the information required on the **Initial Certification Authorization for Admission to Inpatient Psychiatric Care DSHS form 13-82,** the hospital must also provide the following data elements when seeking initial certification and authorization. While DBHR designees may use different formats for collection of this clinical data, the elements that are required are the same regardless of which DBHR designee is certifying and authorizing the need for inpatient psychiatric care. DBHR designees use this information to determine medical necessity and (if authorized) the number of days authorized.

History	
Risk Factors by HX	Prior hospitalizations, CLIP, foster care, suicide attempts, ER use, legal system involvement, homelessness, substance abuse TX, and enrollment in MH system.
Presenting Problems	
Mental Status	Diagnosis, thought content, risk of harm to self or others, behavioral presentation.
Co-Morbidity Issues	Substance abuse HX/current, toxicity screen results, developmental disability, medical issues.
Other System Issues	Jail hold, other legal issues, DDD/MH Cross System Crisis Plan.
Actions Taken to Prevent Hospitalization	
Less Restrictives	Involvement of natural supports, outpatient services including medication management, CM, PACT team, WRAP-Around, etc. Consultation with Crisis Plan, DD/MH Cross-System Crisis Plan, or Advanced Directive.
Rule Outs	Malingering, medical causes, toxicity, hospitalization in lieu of homelessness or inability to access outpatient services.
Anticipated Outcomes for Initial Stay	
Proposed TX Plan	Medical interventions or tests planned, psychiatric interventions planned (individual, group, medications), goal of hospitalization.
Discharge Plan	Anticipated length of stay, involvement of client, CM, formal and natural supports in d/c planning including identification of barriers to discharge and plans to address these.

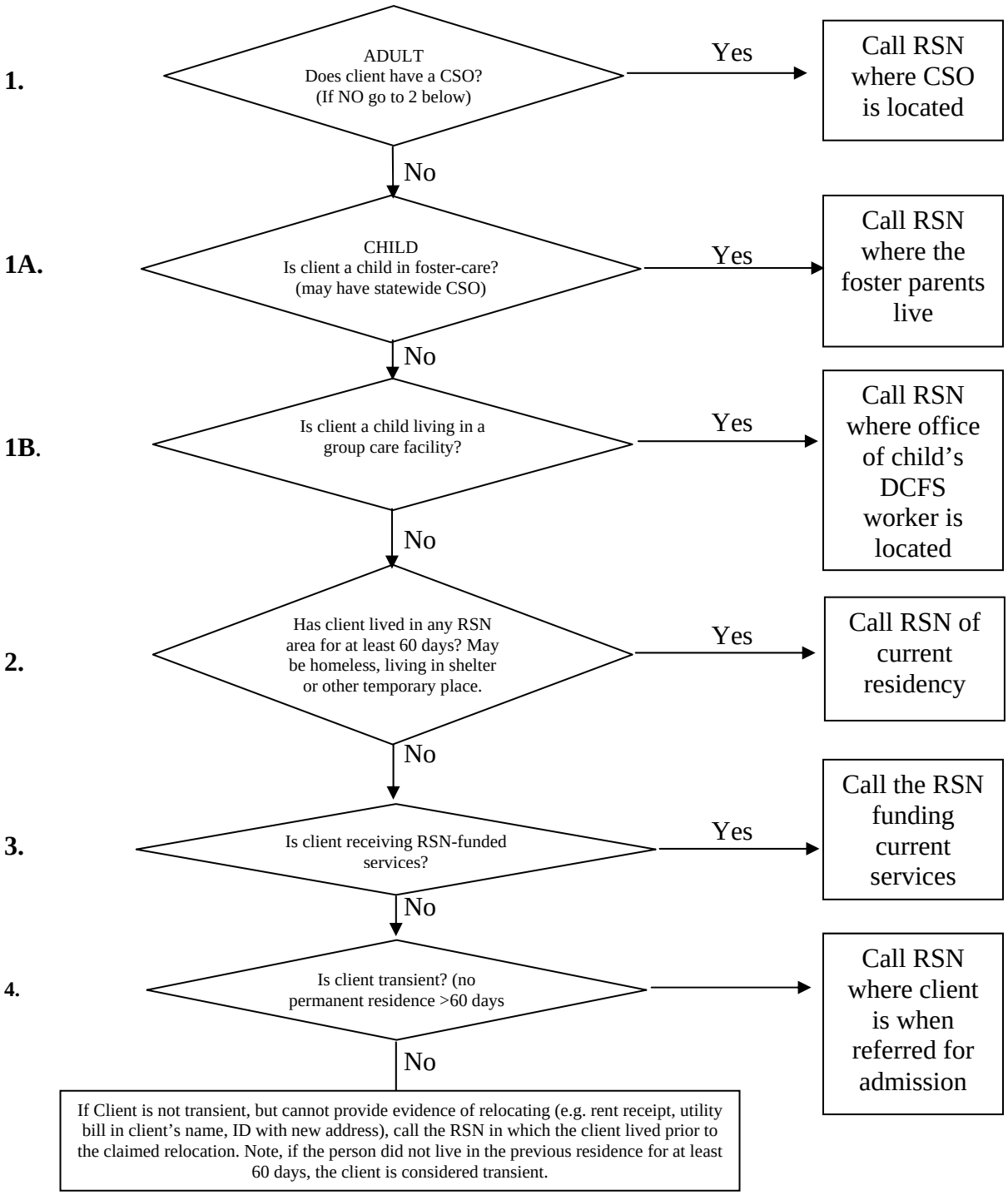
Clinical Data Required For Extension Certification

In addition to the information required on the **Extension Certification Authorization for Continued Inpatient Psychiatric Care DSHS form 13-822,** hospitals must also provide the following data elements when seeking an extension certification and authorization. While DBHR designees may use different formats for collection of this clinical data, the elements that are required are the same regardless of which DBHR designee is certifying and authorizing the need for inpatient psychiatric care. DBHR designees use this information to determine medical necessity and (if authorized) the number of days authorized.

Course of Care	
Treatment Rendered	*All* inpatient services rendered since admission (medical and psychiatric tests, therapies, and interventions performed including type and frequency) and client response to treatment thus far.
Changes	Changes in diagnoses, legal status, TX plan, or discharge plan.
Current Status	
Mental Status	Diagnoses Axis I-V, thought content, risk of harm to self or others, behavioral presentation.
Medical Status	Diagnoses, labs, behavioral presentation, withdrawal.
Anticipated Outcomes for Continued Stay	
Proposed TX Plan	Medical interventions or tests planned, psychiatric interventions planned (individual, group, medications), goal of continued stay and justification of why a less restrictive alternative is not appropriate at this time.
Discharge Plan	Anticipated length of continued stay, involvement of client, CM, formal and natural supports in d/c planning including identification of barriers to discharge and plans to address these.

Division of Behavioral Health (DBHR) and Recovery Designee Flow Chart – "Which RSN to Contact"

For intended purpose, see *Billing Procedures* section.



To view RSN information, visit DBHR on the web at: http://www.dshs.wa.gov/Mentalhealth/rsnmap.shtml.

General Billing

What are the General Billing Requirements?

Providers must follow the general billing requirements in **DSHS's *General Information Booklet*** (http://hrsa.dshs.wa.gov/download/BillingInstructions/General_Information_BI.pdf). These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims;

> **Note:** For inpatient hospital claims with admission dates on and after July 1, 2009, DSHS does not accept claims for:
>
> - Resubmission;
> - Modification; or
> - Adjustment
>
> After 24 months from the date of admission.
>
> ***Pharmacy and major trauma claims have shorter rebilling time limits, which are unchanged.***

- What fee to bill DSHS for eligible clients;
- When providers may bill a client;
- How to bill for services provided to managed care clients, and primary care case management (PCCM) clients; and
- Record keeping requirements.

How Do I Bill for Clients Who Are Eligible for Only a Part of the Hospital Stay?

The billing process is the same when a client becomes eligible or ineligible during a hospital stay the billing is the same. Enter the following:

- Bill covered and noncovered charges on separate lines;
- Bill the entire stay from the admission date to the discharge date including the dates the client was not eligible; and
- Bill all diagnosis and procedure codes for the entire stay.

Enter the" from and to" dates for the entire admission span including the dates the clients were not eligible. Enter the admission date as the date the client was admitted, even if the client was not eligible for medical assistance. Bill covered and noncovered accommodations charges on separate lines. Enter charges for noncovered days in the noncovered field.

The "date of admission" on the claim is the criterion by which inpatient hospital claims are paid and managed care payment responsibility is determined. For inpatient hospital stays for a client covered under DSHS "fee-for-service" at the time of admission, DSHS "fee-for-service" program covers the hospital stay if medically necessary. This is the case even if the client becomes enrolled in a DSHS managed care plan during the inpatient stay.

> **Example**: If a claim has February 29, 2008 as the date of admission and the client was enrolled with a managed care plan effective March 10, 2008, DSHS pays the entire claim as "fee for service" from date of admission through date of discharge.

The payment is based on the client's eligibility program on the date of admission.

How Are Outpatient Hospital Services Prior to Admission Paid?

Outpatient hospital services, including pre-admission, emergency room, and observation services related to an inpatient hospital stay and provided within one calendar day of a client hospital stay, must be billed on the inpatient hospital claim. See WAC 388-550-6000 (3)(c). The "From and To" dates on the hospital claim should cover the entire span of billed services. The admit date is the actual date of admission.

How Are Outpatient Hospital Services During an Inpatient Admission Paid?

DSHS payment for an inpatient claim is what DSHS pays for the client's stay. DSHS will not pay outpatient claim(s) for services when an inpatient claim has been billed for the same period.

> **Exception:** DSHS will pay for outpatient services for an eligible inpatient client when the client is in a free-standing psychiatric facility and is transported for acute outpatient care to a completely separate facility.

Billing for Neonates/Newborns

For services provided to a newborn who has not yet received his/her Medical ID Card, bill DSHS using the parent's PIC in the appropriate fields on the UB-04 Claim Form.

When billing ***electronically*** for twins, enter twin identifying information in the comment or remarks area of the UB-04. For example, "Twin A", "baby on Mom's PIC", "Twin B"

When billing on a ***paper claim*** for twins, enter the twin identifying information in the remarks box (box 80) in the lower left corner of the UB- 04 form. Use a separate UB-04 claim form for each newborn. The claim will be denied if there is no identifying information for the twin.

Bill services for mothers on separate UB-04 Claim Forms.

> **NOTE:** When a newborn no longer needs an acute inpatient level of care and an appropriate placement outside the hospital is available, DSHS does not pay the all-inclusive administrative day rate for any additional days of the hospital stay for the newborn. **[Refer to WAC 388-550-2900 (7)]**

Neonatal/Newborn Coding

- A neonate/newborn is defined as birth to 28 days of age.
- Hospitals must bill neonatal claims in accordance with ICD-9-CM coding guidelines.
- DSHS pays neonatal inpatient hospital claims according to the payment methodology associated with the DRG assigned on discharge or transfer.
- All previous letters of agreement that allowed RCC payment for a neonate who transfers between acute care hospitals are void and no longer in effect.

Newborn Births Billed Using Paper Claims

For UB-04 paper claims:

- Newborn birth weights must be included on claims that use a neonate DRG code.
- Use Code "54" for the birth weight;
- Use form locater 39-41Value Codes;
- Provide the weight in grams in whole numbers; and
- Right justify the weight in grams to the left of the dollars/cents delimiter.

Neonate Revenue Code Descriptions

DSHS has defined six levels of care for newborns and correlates each level to the nursery accommodation revenue codes. The billed accommodation revenue code must meet the associated level of care criteria and be supported by documentation in the medical record.

REV CODE	REVENUE CODE DESCRIPTION	LEVEL OF CARE
0170	General Classification Nursery	Normal Newborn Care – Normal healthy newborns with low complexity needs, are physiologically stable and are rooming with mom. InterQual Newborn Level I criteria; American Academy of Pediatrics Level I
0171	Newborn – Level I	Level I Nursery/General Nursery Observation. Healthy newborns (birth weight > 2000 gms. or gestational age $\underline{\geq}$ 35 wks.) with low complexity needs and who are physiologically stable and require routine evaluation and observation during the immediate post-partum period. Examples of care at this level are: routine bilirubin and blood glucose monitoring; initiation of phototherapy $\underline{\leq}$ 2 days, drug withdrawal management new or continued from higher level and NAS score 1-8; isolette/warmer for thermoregulation of neonates $\underline{\geq}$ 35 weeks gestation; diagnostic work-up/surveillance on otherwise stable neonate; services rendered to growing premature infant without supplemental oxygen or IV needs. InterQual Newborn Level I criteria; American Academy of Pediatrics Level I and some Level IIA guidelines.

REV CODE	REVENUE CODE DESCRIPTION	LEVEL OF CARE
0172	Newborn – Level II	Level II Special Care Nursery/Neonatal Intermediate Care. Newborns (birth weight < 2000 gms. or gestational age < 35 wks.) with moderately complex care needs or with physiological immaturity (apnea of prematurity, inability to maintain body temperature, or inability to take oral feedings) combined with medical instabilities. Examples of care at this level are: IV heplock meds; IV fluids; supplemental oxygen via hood or nasal cannula of less than 40%; or feeding via NG, OG, NJ or gastrostomy tube; intensive phototherapy; drug withdrawal therapy and NAS score >8; non-invasive hemodynamic monitoring; continuous monitoring of apnea/bradycardia that requires tactile stimulation or periodic oxygen; sepsis evaluation and treatment. InterQual Special Care Level II criteria; American Academy of Pediatrics Level IIA guidelines.
0173	Newborn – Level III	Level III Neonatal Intensive Care. Newborns (birth weight < 1500 gms., or gestational age < 32 weeks, or hemodynamically unstable) with complex medical conditions that require invasive therapies. Examples of care at this level are: supplemental oxygen via hood or nasal cannula of greater than 40%; intubation with mechanical ventilation; IV pharmacologic treatment for apnea and/or bradycardic episodes; services for apnea or other conditions requiring assisted respiration; positive pressure ventilatory assistance; exchange transfusion, partial or complete; central or peripheral hyperalimentation; chest tube; IV bolus or continuous drip therapy for severe physiologic or metabolic instability; or maintenance of umbilical artery catheters (UACs), peripheral artery catheters (PACs), umbilical vein catheters (UVCs), and/or central vein catheters (CVCs). InterQual Neonatal Intensive Care Level III criteria; American Academy of Pediatrics Level IIB/IIIA guidelines.

REV CODE	REVENUE CODE DESCRIPTION	LEVEL OF CARE
0174	Newborn – Level IV	Level IV Neonatal Intensive Care. Newborns with complex medical conditions that meet Level III criteria **and** require extracorpreal membrane oxygenation (ECMO); high frequency ventilation; nitric oxide (NO) or complex pre-surgical/surgical interventions for severe congenital malformations or acquired conditions that require use of advanced technology and support. InterQual Neonatal Intensive Care Level III criteria; American Academy of Pediatrics Level IIIB/IIIC/IIID guidelines.
0179	Other Nursery	Transitional Care. Newborns with low complexity care needs who are awaiting finalization of discharge plan to home or transfer to a lesser care setting, and are: hemodynamically stable, in an open crib, and gaining weight, some examples of appropriate treatments in this level of care that are planned to be continued in the home or lesser care setting are: IV anti-infective administration; apnea or bradycardia monitoring; drug withdrawal therapy; oxygen therapy; tube feedings < 50% of daily caloric requirement; and parent or caregiver discharge teaching;. InterQual Transitional Care Nursery criteria.

Procedure Codes and Diagnosis Codes Effective Dates

To avoid delays in processing, use diagnosis and procedure codes that are effective as of the admit date on the claim.

Until the new ProviderOne payment system is implemented, later in 2009, the legacy MMIS system processes only the first nine diagnosis codes.

Submitting Adjustments to a Paid Inpatient Hospital Claim

Each adjustment to a paid hospital claim (when not billed on the original paid claim) should be billed as a complete replacement of the previous claim, as if the claim was never billed. Each adjustment must provide complete documentation for the entire date span between the client's admission date and discharge date and include the following:

- All inpatient hospital services provided; and
- All applicable diagnosis codes and procedure codes.

Billing Specific Hospital Services

Interim Billing

DSHS requires hospitals to bill interim claims, using the appropriate patient status code for "still inpatient", in 60-day intervals unless the client is discharged prior to the next 60 days. Hospitals must bill each interim billed claim as an adjustment to the previous interim billed claim and must include:

- The entire date span between the client's admission date and the current date of service billed;
- All inpatient hospital services provided for the date span billed; and
- All applicable diagnosis codes and procedure codes for the date span billed.

Billing for administrative days is an exception to the interim billed claim policy. DSHS may retrospectively review interim billed claims to verify medical necessity of inpatient level of care and continued inpatient hospitalization.

Billing for Administrative Day(s)

DSHS requires hospitals to split-bill administrative day(s). This is an exception to DSHS's interim bill policy.

For the date span the client qualified as an inpatient hospital admission, bill:

- The appropriate patient status for "still inpatient"; and
- All diagnoses and procedures for the entire date span the client was hospitalized.

On a separate claim form, bill:

- The date span the client qualified for the administrative day(s);
- Revenue code 0169 for the accommodation room and board; and
- All diagnoses and procedures for the entire date span the client was hospitalized.

Inpatient Hospital Stays Without Room Charges

DSHS suspends or denies Inpatient Hospital UB-04 claims with admission dates on and after August 1, 2007, if the room charges are not listed on the claim.

How Do Effective Dates for Procedure and/or Diagnosis Codes Affect Processing of My Claims?

DSHS may suspend or deny claims with procedure codes and/or diagnosis codes that are not valid as of the date of admission shown on the claim. To avoid delays in processing, use codes that are effective on the admission date on the claim.

How Do I Bill for Clients Eligible for Both Medicare and Medicaid?

If a client is eligible for both Medicare and Medicaid and the services are covered by Medicare, **you must *first* submit a claim to Medicare and accept assignment within Medicare's time limitations**. DSHS may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill DSHS within six months of the date Medicare processes the claims.

- If Medicare denies payment of the claim, DSHS requires the provider to meet DSHS's initial 365-day billing requirement for initial claims.

Medicare Part A

Medicare Part A is a health insurance program for:

- Individuals who are 65 years of age and older;
- Certain individuals with disabilities (younger than 65 years of age); or
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Medicare Part A helps individuals pay for hospital stays, skilled nursing facilities, hospice and some home health care. Check the client's red, white, and blue Medicare card for the words "Part A (hospital insurance)" in the lower left corner of the card to determine if the client has Medicare Part A coverage.

Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate.

When billing DSHS for Medicare for Medicare Part A:

- Indicate *Medical Assistance* and include the patient identification code (PIC) on the claim form as shown on the Medical ID Card. Enter the Medical Assistance provider number;
- Accept assignment;
- If Medicare has allowed the service, in most cases Medicare will forward the claim to DSHS. DSHS then processes the claim for any supplemental payments;
- If Medicare does not forward the claim to DSHS **within 30 days** from its statement date, send the UB-04 claim form and a copy of the Part A Explanation of Medical Benefits (EOMB) to DSHS for processing. (See *Important Contacts* section); and
- When Medicare Part A runs out during the middle or before the beginning of a client's stay, you must bill DSHS for the entire stay from admit to discharge including all diagnosis/procedure codes. DSHS may process the claim for an entire primary stay from admit to discharge, and pay the allowed amount minus the Medicare payment made on the claim. The hospital must include documentation with the claim that proves the date that Medicare eligibility ended.
- When Part A services are totally disallowed by Medicare but are covered by DSHS, bill DSHS on the UB-04 claim form and attach copies of Medicare's EOMB with the denial reasons. See specific program billing instructions for information on using a UB-04 claim form.

DSHS requires that the hospital submit documentation with the UB-04 claim showing Medicare denied the services as noncovered. DSHS may consider the claims for payment on an individual basis after review of the following:

- Clinical circumstance;
- Medicare payment rules; and
- Medicaid payment rules.

Note: Medicare/Medicaid billing claims must be received by DSHS within six months of the Medicare EOMB paid date. A Medicare Remittance Notice or EOMB must be attached to each claim.

Medicare Part B

Benefits covered under Medicare Part B include:

- ✓ Physician services;
- ✓ Outpatient hospital services;
- ✓ Home health;
- ✓ Durable medical equipment; and
- ✓ Other medical services and supplies not covered under Part A.

Note: When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on the Medicare remittance notice, it means that the claim has been forwarded to DSHS or a private insurer for deductible and/or coinsurance processing.

If a provider receives a payment or denial from Medicare, but it does not appear on the DSHS Remittance and Status Report (RA), the provider bills DSHS directly with the Medicare EOMB attached. Submit a CMS-1500 Claim Form:

- If Medicare has made payment and there is a balance due from DSHS, bill only those lines Medicare paid. Do not submit paid lines with denied lines; this could cause a delay in payment.
- If Medicare denies services, but DSHS covers them, bill only those lines Medicare denied. Do not submit denied lines with paid lines; this could cause a delay in payment.
- If Medicare denies a service that requires prior authorization (PA) by DSHS, DSHS waives the PA requirement but still requires some form of DSHS authorization based on medical necessity.

DSHS's Payment Methodology – Medicare Part B

- DSHS compares DSHS's allowed amount to Medicare's allowed amount and selects the lesser of the two. Medicare's payment is deducted from the amount selected.
- For the Qualified Medicare Beneficiary (QMB), if there is no DSHS allowed amount, DSHS uses Medicare's allowed amount.
- If there is *no* balance due, the claim is denied because Medicare's payment exceeds DSHS's allowable.
- If there *is* a balance due, payment is made towards the Medicare deductible and/or coinsurance up to DSHS's maximum allowable.

- DSHS cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. DSHS *can* pay these costs to the provider on behalf of the client when:

  ✓ The provider **accepts** assignment; and
  ✓ The total combined reimbursement to the provider from Medicare and DSHS does not exceed Medicare or DSHS's allowed amount, whichever is less.

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their Medical ID card in addition to QMB)

- If Medicare **and** Medicaid cover the service, DSHS will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, DSHS will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

- If Medicaid covers the service and Medicare does not cover the service, DSHS will pay for the service.

QMB-Medicare Only

The reimbursement criteria for this program are as follows:

- If Medicare **and** Medicaid cover the service, DSHS will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** cover the service, DSHS will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

For QMB-Medicare Only: If **Medicare does not** cover the service, DSHS will not pay the service.

How Do I Bill for Clients Covered by Medicare Part B Only (No Part A), or Has Exhausted Medicare Part A Benefits Prior to the Stay?

Description	DRG	Per Diem	RCC	CPE	CAH
Bill Medicare Part B for qualifying services delivered during the hospital stay.	Yes	Yes	Yes	Yes	Yes
Bill DSHS for hospital stay as primary.	Yes	Yes	Yes	Yes	Yes
Show as noncovered on DSHS's bill what was billed to Medicare under Part B.	Yes	Yes	Yes	Yes	Yes
Expect DSHS to reduce payment for the hospital stay by what Medicare paid on the Part B bill.	Yes	Yes	No	No	No
Expect DSHS to recoup payment as secondary on Medicare Part B bill*.	Yes	Yes	No*	No*	No*

*DSHS pays line item by line item on some claims (RCC, CPE, CAH). HRSA does not pay for line items that Medicare has already paid. HRSA pays by the stay (DRG claims) or the day (Per Diem) on other claims. DSHS calculates the payment and then subtracts what Medicare has already paid. DSHS recoups what it paid as secondary on the Medicare claim.
What DSHS pays the hospital:

DRG Paid Claims:
DRG allowed amount minus what Medicare paid under Part B

Per Diem Paid Claims:
Per Diem allowed amount minus what Medicare paid under Part B

RCC, CPE and CAH claims:
Allowed amount for line items covered by HRSA (line items usually covered by Medicare under Part A, if client were eligible).

Required Consent Forms for Hysterectomies

[Refer to WAC 388-531-1550(10)]

- DSHS pays for hysterectomies only when performed for medical reasons ***unrelated*** to sterilization.

- Federal regulations prohibit payment for hysterectomy procedures until a properly completed consent form is received. To comply with this requirement, surgeons, anesthesiologists, and assistant surgeons must obtain a copy of a completed DSHS-approved consent form to attach to their claim.

- **ALL** hysterectomy procedures require a properly completed DSHS-approved consent form, regardless of the client's age or the ICD-9-CM diagnosis.

- Submit the claim and completed DSHS-approved consent form to the:

HRSA
PO BOX 9248
OLYMPIA WA 98507-9248

Download the Hysterectomy Consent form, DSHS 13-365 at:

http://www.dshs.wa.gov/msa/forms/eforms.html

Sterilization

What is sterilization? [Refer to WAC 388-531-1550(1)]

Sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing. This includes vasectomies and tubal ligations.

> **Note:** DSHS does **not** pay for hysterectomies performed solely for the purpose of sterilization.

What are DSHS's payment requirements for sterilizations?

[Refer to WAC 388-531-1550(2)]

DSHS covers sterilization when all of the following apply:

- The client has **voluntarily** given informed consent;
- The client is at least 18 years of age at the time consent is signed;
- The client is a mentally competent individual; and
- At least 30 days, but not more than 180 days, have passed between the date the client gave informed consent and the date of the sterilization.

> **Note:** DSHS pays providers for sterilizations for managed care clients 18 through 20 years of age under the fee-for-service system. All other managed care clients must obtain their sterilization services from their managed care provider.

DSHS pays providers (e.g., hospitals, surgeons) for a sterilization procedure only when the completed federally approved Sterilization Consent Form, DSHS 13-364, is attached to the claim.

> To **download** DSHS forms, visit: http://www.dshs.wa.gov/msa/forms/eforms.html
> Scroll down to form number 13-364.

Additional Requirements for Sterilization of Mentally Incompetent or Institutionalized Clients

Providers must meet the following additional consent requirements before DSHS will pay the provider for the sterilization of a mentally incompetent or institutionalized client. DSHS requires both of the following to be attached to the claim form:

- Court orders that include the following:

  - ✓ A statement that the client is to be sterilized; **and**
  - ✓ The name of the client's legal guardian, who will be giving consent for the sterilization.

- Sterilization Consent form, DSHS 13-364 signed by the client's legal guardian.

When Does DSHS Waive the 30-day Waiting Period?

[WAC 388-531-1550(3) and (4)]

DSHS does not require the 30-day waiting period, but does require at least a 72- hour waiting period, for sterilization in the following circumstances:

- At the time of premature delivery, the client gave consent at least 30 days before the *expected* date of delivery. The expected date of delivery must be documented on the consent form.

- For emergency abdominal surgery, the nature of the emergency must be described on the consent form.

DSHS waives the 30-day consent waiting period for sterilization when the client requests that sterilization be performed at the time of delivery, **and** completes a Sterilization Consent form, DSHS 13-364. One of the following circumstances must apply:

- The client became eligible for Medical Assistance during the last month of pregnancy (**Claim Form field 80:** *"NOT ELIGIBLE 30 DAYS BEFORE DELIVERY"*)*;* or

- The client did not obtain medical care until the last month of pregnancy (**Claim Form field 80:** *"NO MEDICAL CARE 30 DAYS BEFORE DELIVERY"*); or

- The client was a substance abuser during pregnancy, but is not using alcohol or illegal drugs at the time of delivery. (**Claim Form field 80:** *"NO SUBSTANCE ABUSE AT TIME OF DELIVERY."*)

The provider must note on the Claim Form in field 80 or on the backup documentation, which of the above waiver condition(s) has been met. Required language is shown in parenthesis above. Providers who bill electronically must indicate this information in the *Comments* field.

When Does DSHS Not Accept a Signed Sterilization Consent Form? [Refer to WAC 388-531-1550(5) and (6)]

DSHS does not accept informed consent obtained when the client is in any of the following conditions:

- In labor or childbirth;
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or other substances that affect the client's state of awareness.

Why do I need a DSHS-approved Sterilization Consent Form?

Federal regulations prohibit payment for sterilization procedures until a federally approved and accurately completed Sterilization Consent form, DSHS 13-364 is received. To comply with this requirement, surgeons, as well as the facility in which the surgery is being performed must obtain a copy of a completed Sterilization Consent form, DSHS 13-364 to attach to their claim.

You must use Sterilization Consent form, DSHS 13-364 in order for DSHS to pay your claim. **DSHS does not accept any other form**.

To **download** DSHS forms, visit: http://www.dshs.wa.gov/msa/forms/eforms.html
Scroll down to form number 13-364.

DSHS will deny a claim for a procedure received without the Sterilization Consent form, DSHS 13-364. DSHS will deny a claim with an incomplete or improperly completed Sterilization Consent form. Submit the claim and completed Sterilization Consent form, DSHS 13-364 to:

Health and Recovery Services Administration
PO Box 9248
Olympia WA 98507-9248

If you are submitting your sterilization claim form electronically, be sure to indicate in the comments section that you are sending in a hard copy of the Sterilization Consent form, DSHS 13-364. Then send in the form with the electronic claims ICN.

Who completes the Sterilization Consent Form?

- Sections I, II, and III of the Sterilization Consent Form are completed by the client, interpreter (if needed), and the physician/clinic representative more than 30 days, but less than 180 days, prior to date of sterilization. If less than 30 days, refer to page F.2: "When does DSHS waive the 30 day waiting period?" and/or section IV of the Sterilization Consent Form.

- The bottom right portion (section IV) of the Sterilization Consent Form is completed shortly before, on, or after the surgery date by the physician who performed the surgery.

- If the initial Sterilization Consent Form Sections I, II, and III are completed by one physician or group and a different physician or group performed the surgery:

  - ✓ The physician performing the surgery completes another Sterilization Consent Form filling in section IV and the client signs and dates lines (7) and (8) of Section I. The client's date of signature can be the date of surgery or after. It does not have to be the date of the procedure. Send in both consent forms with your claim.

Frequently Asked Questions on Billing Sterilizations

1. **If I provide sterilization services to Family Planning Only clients along with a secondary surgical intervention, such as lysis of adhesions, will I be paid?**

   The scope of coverage for Family Planning Only clients is limited to contraceptive intervention only. DSHS does not pay for any other medical services unless they are medically necessary in order for the client to safely, effectively and successfully use or continue to use their chosen birth control method.

   Only claims submitted with diagnosis codes in the V25 series (excluding V25.3) will be processed for possible payment. All other diagnosis codes are noncovered and will not be paid.

   > **Note:** Remember, you must submit all sterilization claims with the **completed,** federally approved Sterilization Consent Form.

2. **If I provide sterilization services to a Medicaid, full scope of care client along with a secondary surgical intervention, such as lysis of adhesions or Cesarean Section delivery, how do I bill?**

   CNP clients have full scope of care and are eligible for more than contraceptive intervention only. Submit the claim with a completed, federally approved Sterilization Consent Form for payment.

Sterilizations require a properly signed consent form.

Complete an additional consent form if:

- You do not have a signed consent form on file when the client is admitted for a delivery, but the client states she has signed a consent form; or

- Another physician is performing the surgery other than the one who signed the original consent form and complete section IV of the form of the Sterilization Consent Form. Have the client sign and date lines (7) and (8) of section I. She can sign on the date of surgery or after the date. Submit both consent forms with your claim.

Requesting an exception to policy for consideration of payment for sterilizations without a proper consent form and payment for other procedures.

If you do not have properly signed consent form and your claim was denied:

- Submit a Request for Exception to Policy for Consideration of Payment Basic Information form, DSHS 13-756 and explain the circumstances for why the consent was not signed properly, and include a copy of the:

- Sterilization Consent form, DSHS 13-364 or the hospital consent form;

- History and physical; and

- Discharge summary.

Fax the above information to the Medical Request Coordinator at 1-360-586-1471.

After review of the submitted information, DSHS may:

- Pay for the major procedure such as the delivery; and
- Pay for the sterilization out of state funds; or ; or
- Deny sterilization.

How to Complete the Sterilization Consent Form

- All information on the Sterilization Consent form, DSHS 13-364 must be legible.
- All blanks on the Sterilization Consent form, DSHS 13-364 must be completed *except* race, ethnicity, and interpreter's statement (unless needed).
- DSHS does not accept "stamped" or electronic signatures.

The following numbers correspond to those listed on the Sterilization Consent form, DSHS 13-364:

Section I: Consent to Sterilization	
Item	**Instructions**
1. Physician or Clinic:	**Must be name of physician, ARNP, or clinic that gave client required information regarding sterilization.** This may be different than performing physician if another physician takes over. *Examples: Clinic – ABC Clinic. Physician – Either doctor's name, or doctor on call at ABC Clinic.*
2. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
3. Month/Day/Year:	Must be client's birth date.
4. Individual to be sterilized:	Must be client's first and last name. Must be same name as Items #7, #12, and #18 on Sterilization Consent form, DSHS 13-364.
5. Physician:	Can be group of physician or ARNP names, clinic names, or physician or ARNP on call at the clinic. This doesn't have to be the same name signed on Item # 22.
6. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
7. Signature:	Client signature. Must be client's first and last name. Must be same name as Items #4, #12, and #18 on Sterilization Consent form, DSHS 13-364. Must be signed in ink.

Item	Instructions
8. Month/Day/Year:	Date of consent. Must be date that client was initially counseled regarding sterilization. Must be more than 30 days, but less than 180 days, prior to date of sterilization (Item # 19). **Note**: This is true even of shorter months such as February. The first day of the 30 day wait period begins the day after the client signs and dates the consent form, line #8. Example: If the consent form was signed on 2/2/2005, the client has met the 30-day wait period on 3/5/2005. If less than 30 days, refer to page F.2/F.3: "When does DSHS waive the 30 day waiting period?" and section IV of Sterilization Consent form, DSHS 13-364.
Section II: Interpreter's Statement	
Item	**Instructions**
9. Language:	**Must specify language into which sterilization information statement has been translated.**
10. Interpreter:	Must be interpreter's name. **Must be interpreter's original signature in ink.**
11. Date:	Must be date of interpreter's statement.
Section III: Statement of Person Obtaining Consent	
Item	**Instructions**
12. Name of individual:	Must be client's first and last name. Must be same name as Items #4, #7, and #18 on Sterilization Consent Form.
13. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
14. Signature of person obtaining consent:	Must be first and last name signed in ink.
15. Date:	Date consent was obtained.
16. Facility:	Must be full name of clinic or physician obtaining consent. Initials are acceptable.
17. Address:	Must be physical address of physician's clinic or office obtaining consent.

Section IV: Physician's Statement	
Item	**Instructions**
18. Name of individual to be sterilized:	Must be client's first and last name. Must be same name as Items #4, #7, and #12 on Sterilization Consent form, DSHS 13-364.
19. Date of sterilization:	Must be more than 30 days, but less than 180 days, from client's signed consent date listed in Item #8. If less than 30 days, refer to page F.2/F.3: "When does DSHS waive the 30 day waiting period?" and section IV of the Sterilization Consent form, DSHS 13-364.
20. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
21. Expected date of delivery:	When premature delivery box is checked, this date must be *expected* date of delivery. Do not use actual date of delivery.
22. Physician:	Physician's or ARNP's signature. Must be physician or ARNP who **actually** performed sterilization procedure. Must be signed in ink. Name must be the same name as on the claim submitted for payment.
23. Date:	Date of physician's or ARNP's signature. Must be completed either shortly before, on, or after the sterilization procedure.
24. Physician's printed name	Please print physician's or ARNP's name signed on Item #22.

How to Complete the Sterilization Consent Form for a Client Age 18-20

1. Use Sterilization Consent DSHS Form 13-364.
2. Cross out "**age 21**" in the following three places on the form and write in "**18**":

    a. Section I: Consent to Sterilization: **"I am at least 21…"**
    b. Section III: Statement of Person Obtaining Consent: **"To the best of my knowledge… is at least 21…"**
    c. Section IV: Physician's Statement: **"To the best of my knowledge… is at least 21…"**

SAMPLE STERILIZATION CONSENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) **Dr. Tim Lu**
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized . If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) **tubal ligation** The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 years of age and was born on (3) **August 1, 1971**
Month Day Year

I (4) **Jane Doe** hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) **Dr. Tim Lu**
Physician

by a method called (6) **tubal ligation** My consent
Specify type of operation

expires 180 days from the date of my signature below.
I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) **August 20, 2001**
Signature *Month Day Year*

You are requested to supply the following information, but it is not required.
Race and ethnicity designation (please check):

- ☒ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the

consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter *Date*

DSHS 13-364 (Rev. 12/2002)

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) **Jane Doe** signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation,

(13) **tubal ligation** the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) **August 20, 2001**
Signature of person obtaining consent *Date*

(16) **US Clinic**
Facility

(17) **PO Box 123, Anywhere, WA 98000**
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) **Jane Doe** (19) **October 1, 2001**
Name of individual to be sterilized *Date of sterilization operation*

I explained to him/her the nature of the sterilization operation

(20) **tubal ligation** The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less that 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- ☐ Premature delivery
  Individual's expected date of delivery (21) _____
- ☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) **October 1, 2001**
Physician's Signature *Date*

(24) **Dr. Tim Lu**
Physician's Printed Name

UB-04 Claim Form

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the National Uniform Billing Committee at: http://www.nubc.org/index.html.

Specific Instructions for Medicare Crossovers

How do I submit institutional services on a UB-04 crossover claim?

- Complete the claim form as if billing for a non Medicare client.
- Always attach the Medicare EOMB.
- Enter the third party (e.g. Blue Cross) supplement plan name in the appropriate space. Enter **only** payments by a third party (e.g. Blue Cross) supplement plan and attach the EOB.

What does DSHS require from the provider-generated EOMB to process a crossover claim?

Header level information on the EOMB must include all the following:

- Medicare as the clearly identified payer;
- The Medicare claim paid or process date;
- The client's name (if not in the column level);
- Medicare Reason codes; and
- Text in font size 12 or greater.

Column level labels on the EOMB for the UB-04 must include all the following:

- The client's name;
- From and through dates of service;
- Billed amount;
- Deductible;
- Co-insurance;
- Amount paid by Medicare (PROV PD);
- Medicare Reason codes; and
- Text that is font size 12.

How do I submit institutional services on a UB 04 claim for inpatient clients who are eligible for Medicare Part B Benefits but not eligible for Medicare Part A Benefits ? For claims that HRSA pays by DRG/Per Diem? For claims HRSA pays by RCC method?

Diagnosis Related Groups (DRG)/Per Diem payment methods

Hard copy claims:

- Enter Medicare Part B in form locator 50 (A,B,C);
- Enter the amount Medicare paid for the Part B hospital charges in the corresponding line of for locator 54(A, B, C); and
- Attach the Explanation of Medicare Benefit (EOMB) Parts A and B to the claim.

Electronic Claims:

- Enter the Medicare Part B in the appropriate Payer Identification field;
- Enter the amount that Medicare paid for the Part B charges in the appropriate Prior Payments field; and
- Attach the EOMB Parts A and B to the claim.