Inpatient Hospital Services
Provider Guide

January 1, 2016

About this guide*

This publication takes effect January 1, 2016, and supersedes earlier guides to this program.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

Refer also to the agency's ProviderOne Billing and Resource Guide for valuable information to help you conduct business with the agency.

Services and equipment related to any of the following programs must be billed using their specific billing instructions:

- Acute Physical Medicine & Rehabilitation (PM&R)
- Ambulance and Involuntary Treatment Act Transportation
- Long Term Acute Care (LTAC)
- Outpatient Hospital Services
- Physician-Related Services/Health Care Professional Services

What has changed?

Subject	Change	Reason for Change
All	Fixed broken links, clarified language, etc.	Housekeeping
Expedited Prior Authorization (EPA)	Added new section: EPA	Clarification
Early Elective Deliveries	Added new section: Early elective deliveries	New policy
Potentially Preventable Readmissions	Added new sections: Potentially preventable readmissions prospective reimbursement policy Billing for planned readmissions Removed section: Hospital readmissions	New policy
Billing	Replaced old section with new material: How do I bill for clients when Medicare coverage begins during an inpatient stay or Part A has exhausted during the stay?	Clarification

* This publication is a billing instruction.

Administrative Days	Revised sentence to include instructions for a claim note under How do I bill for administrative days? that says: For the acute care stay claim the provider must bill with inpatient status code 30 to indicate the provider will be submitting a separate claim for administrative days and include claim note stating "Admin. days claim to follow".	

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Resources Available

Topic	Resource Information
Acute rehabilitation facilities	List of Acute Rehabilitation Facilities.
Substance Use Disorder service providers	Directory of Certified Chemical Dependency Services in Washington State
Division of Behavioral Health and Recovery (DBHR)-certified hospitals	List of the DBHR-certified hospitals providing intensive inpatient care for chemical using pregnant women
DBHR's Regional Support Networks	Contacts for: • Psychiatric Hospitalization • Services Information
Sterilization	See the agency's Sterilization Supplemental Provider Guide.
Additional Medicaid agency resources	See the agency's online list of Resources Available.

Definitions

This section defines terms and abbreviations, including acronyms, used in this provider guide. Please refer to the Washington Apple Health Glossary for a more complete list of definitions.

Acute – A medical condition of severe intensity with sudden onset. For the purposes of the acute physical medicine and rehabilitation (Acute PM&R) program, acute means an intense medical episode, not longer than three months. (WAC 182-550-1050)

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. (WAC 182-550-1050)

Acute physical medicine and rehabilitation (Acute PM&R) - A comprehensive inpatient rehabilitative program coordinated by an interdisciplinary team at an agency-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. (WAC 182-550-1050)

Administrative day – One or more days of a hospital stay in which an acute inpatient or observation level of care is not medically necessary, and a lower level of care is appropriate. (WAC 182-550-1050)

Administrative day rate - The statewide Medicaid average daily nursing facility rate as determined by the agency. (WAC 182-550-1050)

All-Patient DRG Grouper (AP-DRG) - A computer software program that determines the medical and surgical diagnosis related group (DRG) assignments used by the agency for inpatient admissions between August 1, 2007, and June 30, 2014. (WAC 182-550-1050)

All-Patient Refined DRG Grouper (APR-DRG) - A computer software program that determines the medical and surgical diagnosis related group (DRG) assignments used by the agency for inpatient admissions on and after July 1, 2014.

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. (WAC 182-550-1050)

Allowed amount - The initial calculated amount for any procedure or service, after exclusion of any "nonallowed service or charge," that the agency allows as the basis for payment computation before final adjustments, deductions, and add-ons. (WAC 182-550-1050)

Allowed charges – The total billed charges for allowable services. (WAC 182-550-1050)

Allowed covered charges – The total billed charges for allowable services minus the billed charges for noncovered services. (WAC 182-550-1050)

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

- Laboratory
- Radiology
- Drugs
- Delivery room
- Operating room
- Postoperative recovery rooms
- Other special items and services (WAC 182-550-1050)

Appropriate level of care - The level of care required to best manage a client's illness or injury based on either of the following:

- The severity of illness presentation and the intensity of services received
- A condition-specific episode of care (WAC 182-550-1050)

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 both of the following:

- Health, financial and billing records pertaining to billed services paid by the agency through Washington Apple Health by a person not employed or affiliated with the provider, for the purpose of verifying the service was provided as billed and was allowable under program regulations
- Health, financial, and statistical records, including mathematical computations and special studies conducted in support of the Medicare cost report (Form 2552-96 and 2552-10 or successor form), submitted to the agency for the purpose of establishing program rates for payment to hospital providers (WAC 182-550-1050)

Authorization – See **Prior authorization** and **Expedited prior authorization (EPA)**. (WAC 182-550-1050)

Authorization number - A nine-digit number, assigned by the agency 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.

Bedside nursing services – Services included under the room and board services paid to the facility. These services include, but are not limited to: medication administration, IV hydration and IV medication administration, vaccine administration, dressing applications, therapies, glucometry testing, catheterizations, tube feedings and irrigations, and equipment monitoring services. (WAC 182-550-1050)

Billed charge - The charge submitted to the agency by the provider. (WAC 182-550-1050)

Bordering city hospital - A hospital located outside Washington State and located in one of the bordering cities listed in WAC 182-501-0175. (WAC 182-550-1050)

Budget neutral – Aggregate payments to hospitals stay the same regardless of any changes made to the payment method. See also **Budget neutrality factor** (WAC 182-550-1050)

Budget neutrality factor - A multiplier used by the agency to ensure that modifications to the payment method and rates are budget neutral. See also **Budget neutral**. (WAC 182-550-1050)

Budget target – Funds appropriated by the legislature or through the agency's budget process to pay for a specific group of services, including anticipated caseload changes or vendor rate increases. (WAC 182-550-1050)

Budget target adjuster - A multiplier to the outpatient prospective payment system (OPPS) payment to ensure aggregate payments do not exceed the established budget target. (WAC 182-550-1050)

Bundled services - Interventions integral to or related to the major procedure. (WAC 182-550-1050)

Case mix – A relative value assigned to a DRG or classification of patients in a medical care environment representing the resource intensity demands placed on an institution. (WAC 182-550-1050)

Case mix index (CMI) - The average relative weight of all cases treated in a hospital during a defined period. (WAC 182-550-1050)

Centers for Medicare and Medicaid Services (CMS) – See WAC 182-500-0020.

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 Health Insurance Program (CHIP) - The federal Title XXI program under which medical care is provided to uninsured children younger than age 19. (WAC 182-550-1050)

Children's hospital - A hospital primarily serving children. (WAC 182-550-1050)

Client – A person who receives or is eligible to receive services through agency programs. (WAC 182-550-1050)

CMS PPS input price index - A measure, expressed as a percentage, of the annual inflationary costs for hospital services (WAC 182-550-1050)

Comorbidity - Of, relating to, or caused by a disease other than the principal disease. (WAC 182-550-1050)

Complication - A disease or condition occurring subsequent to or concurrent with another condition and aggravating it. (WAC 182-550-1050)

Comprehensive hospital abstract reporting system (CHARS) - The Department of Health's (DOH's) inpatient hospital data collection, tracking, and reporting system. (WAC 182-550-1050)

Condition-specific episode of care – Care provided to a client based on the client's primary condition, complications, comorbidities, standard treatments, and response to treatments. (WAC 182-550-1050)

Conversion factor - A hospital-specific dollar amount that represents a hospital's average cost of treating clients. It is calculated from the hospital's cost report by dividing the hospital's costs for treating Medicaid and CHIP clients during a base period by the number of Medicaid and CHIP discharges during that same period and adjusting for the hospital's case mix. (WAC 182-550-1050)

Core provider agreement (CPA) – The basic contract the agency holds with providers serving Washington Apple Health clients. (WAC 182-550-1050)

Cost report - See **Medicare cost report**. (WAC 182-550-1050)

Costs - Agency-approved operating, medical education, and capital-related costs (capital costs) as reported and identified on the "cost report." (WAC 182-550-1050)

Covered services – See WAC 182-501-0060. (WAC 182-550-1050)

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

Critical border hospital - An acute care hospital located in a bordering city that the agency has, through analysis of admissions and hospital days, designated as critical to provide elective health care for the agency's Washington Apple Health clients. (WAC 182-550-1050)

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). (WAC 182-550-1050)

Deductible - The amount a client is responsible for, before an insurer, such as Medicare, starts paying; or the initial specific dollar amount for which the client is responsible. (WAC 182-550-1050)

Diagnosis code - A set of numeric or alphanumeric characters assigned by the current published ICD coding guidelines used by the agency as a shorthand symbol to represent the nature of a disease or condition. (WAC 182-550-1050)

Diagnosis related group (DRG) – A classification system that categorizes hospital patients into clinically coherent and homogenous groups with respect to resource use. Classification of patients is based on the current published ICD coding guidelines used by the agency, the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. (WAC 182-550-1050)

Direct medical education costs - The direct costs of providing an approved medical residency program as recognized by Medicare.

Discharging hospital - The institution releasing a client from the acute care hospital setting. (WAC 182-550-1050)

Discount factor – The percentage applied to additional significant procedures when a claim has multiple significant procedures or when the same procedure is performed multiple times on the same day. Not all significant procedures are subject to a discount factor.

Disproportionate share hospital (DSH) payment - A supplemental payment made by the agency to a hospital that qualifies for one or more of the disproportionate share hospital programs identified in the state plan. (WAC 182-550-1050)

Disproportionate share hospital (DSH) program - A program through which the agency makes payment adjustment(s) to eligible hospitals that serve a disproportionate number of low-income clients in accordance with legislative direction and established payment methods. See 1902(a)(13)(A)(iv) of the Social Security Act. See also WAC 182-550-4900 through 182-550-5400.

Distinct unit - A Medicare-certified distinct area for psychiatric, rehabilitation, or detoxification services which has been certified by Medicare within an acute care hospital or approved by the agency within a children's hospital. (WAC 182-550-1050)

DRG - See **Diagnosis related group.** (WAC 182-550-1050)

DRG allowed amount – The DRG relative weight multiplied by the conversion factor.

DRG average length-of-stay - The agency's average length-of-stay for a DRG classification established during an agency DRG rebasing and recalibration project. The agency uses 3M Health Information System's national APR-DRG relative weights and average lengths of stay. (WAC 182-550-1050)

DRG-exempt services - Services paid through methods other than DRG, such as per diem rate, a per case rate, or a ratio of costs-to-charges (RCC). (WAC 182-550-1050)

DRG payment - The total payment made by the agency for a client's inpatient hospital stay. The DRG payment is the DRG allowed amount plus the high outlier minus any third-party liability, client participation, Medicare payment, and any other adjustments applied by the agency. (WAC 182-550-1050)

Elective procedure or surgery - A non-emergency procedure or surgery that can be scheduled at the client's and provider's convenience. (WAC 182-550-1050)

Emergency medical condition – See WAC 182-500-0030.

Emergency room or **emergency facility** or **emergency department** - A distinct hospital-based facility which provides unscheduled services to clients who require immediate medical attention. An emergency department must be capable of providing emergency medical, surgical, and trauma care services twenty-four hours a day, seven days a week. A physically separate extension of an existing hospital emergency department may be considered a freestanding emergency department as long as the extension provides comprehensive emergency medical, surgical, and trauma care services twenty-four hours a day, seven days a week. (WAC 182-550-1050)

Emergency services - Health care services required by and provided to a client 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 client's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. For agency payment to a hospital, inpatient maternity services are treated as emergency services. (WAC 182-550-1050)

Enhanced ambulatory patient groupings (EAPG) – The payment system used by the agency to calculate reimbursement to hospitals for the facility component of outpatient services on and after July 1, 2014. This system uses 3M Health Information System's EAPGs as the primary basis for payment.

Equivalency factor (EF) - A factor that may be used by the agency in conjunction with other factors to determine the level of a state-administered program payment. See WAC 182-550-4800.

Exempt hospital—DRG payment method - A hospital that for a certain client category is reimbursed for services to Washington Apple Health clients through methodologies other than those using DRG conversion factors.

Expedited prior authorization (EPA) - See WAC 182-500-0030

Experimental service - A procedure, course of treatment, drug, or piece of medical equipment, which lacks scientific evidence of safety and effectiveness. See WAC 182-531-0050. A service is not "experimental" if the service is both of the following:

- Is generally accepted by the medical profession as effective and appropriate
- Has been approved by the Federal Food and Drug Administration (FDA) or other requisite government body if such approval is required (WAC 182-550-1050)

Fee-for-service – See WAC 182-500-0035.

Fiscal intermediary - Medicare's designated fiscal intermediary for a region or category of service, or both.

Fixed per diem rate - A daily amount used to determine payment for specific services provided in long-term acute care (LTAC) hospitals. (WAC 182-550-1050)

Formal release – When a client does one of the following:

- Discharges from a hospital or distinct unit
- Dies in a hospital or distinct unit
- Transfers from a hospital or distinct unit as an acute care transfer
- Transfers from the hospital or distinct unit to a designated psychiatric unit or facility, or a designated acute rehabilitation unit or facility

Global surgery days - The number of preoperative and follow-up days that are included in the payment to the physician for the major surgical procedure.

Graduate medical education costs - The direct and indirect costs of providing medical education in teaching hospitals. See **Direct medical education costs** and **Indirect medical education costs**.

Grouper - See **All-patient DRG grouper (AP-DRG)** and **All-patient refined DRG grouper (APR-DRG).**

Health Care Authority (Medicaid agency) - The Washington State agency that administers Washington Apple Health programs.

High outlier - A DRG claim that is classified by the agency as being allowed a high outlier payment that is paid under the DRG payment method, does not meet the definition of **administrative day**, and has extraordinarily high costs as determined by the agency. See WAC 182-550-3700.

High outlier claim--Medicaid/CHIP per diem – A claim classified by the agency 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 the agency. See WAC 182-550-3700.

High outlier claim--State-administered program DRG – 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 the agency. See WAC 182-550-3700.

High outlier claim--State-administered program per diem - A claim that is classified by the agency as being allowed as 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 the agency. See WAC 182-550-3700.

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. (WAC 182-550-1050)

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, a "psychiatric hospital" as defined in this section, or any other distinct unit of the hospital. (WAC 182-550-1050)

Hospital cost report – See **Medicare cost report**. (WAC 182-550-1050)

Hospital covered service – Any service, treatment, equipment, procedure, or supply provided by a hospital, covered under a Washington Apple Health program, and is within the scope of an eligible client's Washington Apple Health program. (WAC 182-550-1050)

Indirect medical education costs - The indirect costs of providing an approved medical residency program as recognized by Medicare.

Inflation adjustment - For cost inflation, this is the hospital inflation adjustment. This adjustment is determined by using the inflation factor method approved by the legislature. For charge inflation, this is the inflation factor determined by comparing average discharge charges for the industry from one year to the next, as found in the Comprehensive Hospital Abstract Reporting System (CHARS) Hospital Census and Charges Payer report.

Inpatient hospital admission - A formal admission to a hospital, based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary, acute inpatient care. These indicators include assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury. All applicable indicators must be documented in the client's health record. The decision to admit a client to inpatient status should be based on the condition-specific episode of care, severity of illness presented, and the intensity of services rendered. The agency does not consider inpatient hospital admissions as covered or noncovered solely on the basis of the length of time the client actually spends in the hospital. Generally, a client remains overnight and occupies a bed. Inpatient status can apply even if the client is discharged or transferred to another acute hospital and does not actually use a hospital bed overnight. For the agency to recognize a stay as inpatient, there must be a physician admission order in the client's medical record indicating the status as inpatient. (WAC 182-550-1050)

Inpatient Medicaid DRG conversion factor - The conversion factor is a rate that is multiplied by a DRG relative weight to pay Medicaid and CHIP claims under the DRG payment method. See WAC 182-550-3800 for how this conversion factor is calculated. (WAC 182-550-1050)

Inpatient services – Health care services provided to a client whose condition warrants formal admission and treatment in a hospital. (WAC 182-550-1050)

Inpatient state-administered program conversion factor - A DRG conversion factor reduced from the inpatient Medicaid DRG conversion factor to pay a hospital for inpatient services provided to a client eligible under a state-administered program. The conversion factor is multiplied by a DRG relative weight to pay claims for clients under the DRG payment method. (WAC 182-550-1050)

Intermediary – See **Fiscal intermediary.**

International Classification of Diseases (ICD) - The systematic listing of diseases, injuries, conditions, and procedures as 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. (WAC 182-550-1050)

Long term acute care (LTAC) services - Inpatient intensive long term care services provided in agency-approved LTAC hospitals to eligible Washington Apple Health clients who meet criteria for Level 1 or Level 2 services. See WAC 182-550-2565 through 182-550-2596. (WAC 182-550-1050)

Major diagnostic category (MDC) - One of the mutually exclusive groupings of principal diagnosis areas in the AP-DRG and APR-DRG classification systems.

Medical education costs - The expenses incurred by a hospital to operate and maintain a formally organized graduate medical education program. (WAC 182-550-1050)

Medically necessary – See WAC 182-500-0070.

Medical visit – Diagnostic, therapeutic, or consultative services provided to a client by a health care professional in an outpatient setting.

Medicare cost report - The Medicare cost report (Form 2552-10), or successor document, completed and submitted annually by a hospital provider. (WAC 182-550-1050)

Medicare crossover - A claim involving a client who is eligible for both Medicare benefits and Medicaid. (WAC 182-550-1050)

Medicare Part A - See WAC 182-500-0070.

Medicare Part B - See WAC 182-500-0070.

Medicare payment principles - The rules published in the federal register regarding payment for services provided to Medicare clients.

Mental health 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 182-550-2600. (WAC 182-550-1050)

Military hospital - A hospital reserved for the use of military personnel, their dependents, and other authorized users.

Modifier - A two-digit alphabetic and/or numeric identifier added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting hospital can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules.

National correct coding initiative (NCCI) – A national standard for the accurate and consistent description of medical goods and services using procedural codes. The standard is based on coding conventions defined in the American Medical Associations' Current Procedural Terminology (CPT®) manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practices. The centers for Medicare and Medicaid services (CMS) maintain NCCI policy.

NCCI edit - A software step used to determine if a claim is billing for a service that is not in accordance with federal and state statutes, federal and state regulations, agency fee schedules, billing instructions, and other publications. The agency has the final decision whether the NCCI edits allow automated payment for services that were not billed in accordance with governing law, NCCI standards, or agency policy.

Newborn or neonate or neonatal - A person younger than 29 days old. (WAC 182-550-1050)

Non-allowed service or charge - A service or charge billed by the provider as noncovered or denied by the agency. This service or charge cannot be billed to the client except under the conditions identified in WAC 182-502-0160. (WAC 182-550-1050)

Noncovered charges - Billed charges a provider submits to the agency on the claim and indicates them on the claim as noncovered. (WAC 182-550-1050)

Noncovered service or charge - A service or charge the agency does not consider or pay for as a hospital covered service. This service or charge may not be billed to the client, except under the conditions identified in WAC 182-502-0160. (WAC 182-550-1050)

Observation services – A well-defined set of clinically appropriate services furnished while determining whether a client will require formal inpatient admission or be discharged from the hospital. Services include ongoing short-term treatment, monitoring, assessment, and reassessment. Rarely do reasonable and necessary observation services exceed forty-eight hours. The agency or its designee may determine through the retrospective utilization review process that an inpatient hospital service should have been billed as an observation service. (WAC 182-550-1050)

Operating costs - All expenses incurred in providing accommodation and ancillary services, excluding capital and medical education costs. (WAC 182-550-1050)

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

- Prevents or corrects physical deformity or malfunction.
- Supports a weak or deformed portion of the body. (WAC 182-550-1050)

Out-of-state hospital - Any hospital located outside the state of Washington and the designated bordering cities (see WAC 182-501-0175). For Washington Apple Health clients requiring psychiatric services, an out-of-state hospital means any hospital located outside the state of Washington. (WAC 182-550-1050)

Outliers - Cases with extraordinarily high or low costs when compared to other cases in the same DRG. (WAC 182-550-1050)

Outpatient care – See **Outpatient hospital services**.

Outpatient hospital - A hospital authorized by the Department of Health (DOH) to provide outpatient services.
(WAC 182-550-1050)

Outpatient hospital services - Those health care services that are within a hospital's licensure and provided to a client who is designated as an outpatient.
(WAC 182-550-1050)

Outpatient observation - See **Observation services**. (WAC 182-550-1050)

Outpatient prospective payment system (OPPS) – The payment system used by the agency to calculate reimbursement to hospitals for the facility component of outpatient services.

Outpatient surgery - A surgical procedure that is not expected to require an inpatient hospital admission. (WAC 182-550-1050)

Per diem - A method which uses a daily rate to calculate payment for services provided as a hospital covered service. (WAC 182-550-1050)

PM&R - See **Acute PM&R**. (WAC 182-550-1050)

Primary care case management (PCCM) - The coordination of health care services under the agency's Indian health center or tribal clinic managed care program. See WAC 182-538-068. (WAC 182-550-1050)

Principal diagnosis – The condition chiefly responsible for the admission of the patient to the hospital. (WAC 182-550-1050)

Prior authorization (PA) – See WAC 182-500-0085.

Private room rate - The rate customarily charged by a hospital for a one-bed room.

Prospective payment system (PPS) - A payment system in which what is needed to calculate payments (methods, types of variables, and other factors) is set in advance and is knowable by all parties before care is provided. In a retrospective payment system, what is needed (actual costs or charges) is not available until after care is provided. (WAC 182-550-1050)

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 do one of the following:

- Artificially replace a missing portion of the body
- Prevent or correct physical deformity or malfunction
- Support a weak or deformed portion of the body (WAC 182-550-1050)

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. (WAC 182-550-1050)

Ratable - A factor used to calculate inpatient payments for state-administered programs.

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 percentage applied to a hospital's allowed covered charges for medically necessary services to determine estimated costs, as determined by the agency, and payment to the hospital for some DRG-exempt services. (WAC 182-550-1050)

Rebasing - The process used by the agency to update hospital payment policies, related variables (rates, factors, thresholds, multipliers, and caps) and system processes (edits, adjudication, grouping, etc.). (WAC 182-550-1050)

Recalibration - The process of recalculating DRG relative weights using historical data. (WAC 182-550-1050)

Regional support network (RSN) – See WAC 182-500-0095

Rehabilitation units - Specifically identified rehabilitation hospitals and designated rehabilitation units of hospitals that meet agency and Medicare criteria for distinct rehabilitation units. (WAC 182-550-1050)

Relative weights - See **DRG relative weight**. (WAC 182-550-1050)

Revenue code - A nationally-assigned coding system for billing inpatient and outpatient hospital services, home health services, and hospice services. (WAC 182-550-1050)

Room and board - Routine supplies and services provided to a client during the client's hospital stay. This includes, but is not limited to, a regular or special care hospital room and related furnishings, room supplies, dietary and bedside nursing services, and the use of certain hospital equipment and facilities. (WAC 182-550-1050)

Rural hospital - An acute care health care facility capable of providing or assuring availability of inpatient and outpatient hospital health services in a rural area.

Semi-private room rate - A rate customarily charged for a hospital room with two to four beds; this charge is generally lower than a private room rate and higher than a ward room.

Significant procedure – A procedure, therapy, or service provided to a client that constitutes one of the primary reasons for the visit to the health care professional, and represents a substantial portion of the resources associated with the visit.

Specialty hospitals - Children's hospitals, psychiatric hospitals, cancer research centers or other hospitals which specialize in treating a particular group of patients or diseases.

State plan - The plan filed by the agency with the CMS, Department of Health and Human Services (DHHS), outlining how the state will administer Medicaid and CHIP services, including the hospital program. (WAC 182-550-1050)

Status indicator (SI) - A code assigned to each medical procedure or service by the agency that contributes to the selection of a payment method.

Subacute care - Care provided to a client which is less intensive than that given at an acute care hospital. Skilled nursing, nursing care facilities, and other facilities provide subacute care services.

Substance Use Disorder (SUD) – An alcohol or drug addiction, or a dependence on one or more substances. (WAC 182-550-1050)

Survey – An inspection or review conducted by a federal, state, or private agency to evaluate and monitor a facility's compliance with program requirements.

Swing bed – An inpatient hospital bed certified by CMS for either acute inpatient hospital or skilled nursing services.

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. (WAC 182-550-1050)

Total patient days - All patient days in a hospital for a given reporting period, excluding days for skilled nursing, nursing care, and observation days.

Transfer - To move a client from one acute care setting to a higher level acute care setting for emergency care or to a post-acute, lower level care setting for ongoing care. (WAC 182-550-1050)

Transferring hospital - The hospital or distinct unit that transfers a client to another acute care or subacute facility or distinct unit, or to a nonhospital setting. (WAC 182-550-1050)

UB-04 - The uniform billing document required for use nationally by hospitals, nursing facilities, hospital-based skilled nursing facilities, home health agencies, and hospice agencies in billing for services provided to patients. This document includes the current national uniform billing data element specifications developed by the National Uniform Billing Committee and approved and modified by the Washington State Payer Group or the agency. (WAC 182-550-1050)

Vendor rate increase - An adjustment determined by the legislature that may be used to periodically increase rates for payment to vendors, including health care providers that do business with the state.

Washington Apple Health program - Any health care program administered through the agency.

Payment for Services

How do I get paid?

You must follow the general billing requirements in the agency ProviderOne Billing and Resource Guide. Also see General Billing for specific hospital inpatient information. The revenue code grid is available online.

Payment adjustments

The agency may adjust payment when one or more of the following occur:

- A claim qualifies as a high outlier.
- A claim is paid by the DRG method and a client transfers from one acute care hospital or distinct unit.
- A client is not eligible for a Washington Apple Health program on one or more days of the hospital stay.
- A client has third-party liability coverage at the time of admission to the hospital or distinct unit.
- A client is eligible for Part B Medicare, the hospital submitted a timely claim to Medicare for payment, and Medicare has made a payment for the Part B hospital charges.
- A client is discharged from an inpatient hospital stay and, within fourteen calendar days, is readmitted as an inpatient to the same hospital or an affiliated hospital. The agency or its designee performs a retrospective utilization review on the initial admission and the readmission(s) to determine which inpatient hospital stay(s) qualify for payment.
- A readmission is due to a complication arising from a previous admission (e.g., provider preventable condition). The agency or its designee performs a retrospective utilization review to determine if both admissions are appropriate and qualify for individual payments.
- The agency identifies an enhanced payment due to a provider preventable condition, hospital-acquired condition, serious reportable event, or a condition not present on admission.

General payment policies

Transfers

(WAC 182-550-3600)

The transferring acute care facility or distinct unit may receive a pro-rated Diagnosis-Related Group (DRG) payment if the length of stay (LOS) plus one day is less than the agency's established DRG average LOS. The agency requires use of the patient status code for "transfers" as defined in the UB-04 Manual. See Transfer information for the DRG payment method.

The agency does not pay:

- A transferring hospital for a non-emergency case when the transfer is to another acute care hospital.
- Any additional amount if a hospital transfers to another acute care hospital or distinct unit and the receiving facility or distinct unit transfers the client back to the original transferring hospital or distinct unit.

Note: When a client's eligibility has changed from fee-for-service to managed care during a continuous hospital stay, the claim must include a comment in the following format:

"Continuous hospital stay 00/00/00-00/00/00"

The first date is the date of the initial admission for the current episode of care. The second date is the date of the client's discharge for the current episode of care.

For example:
A client is admitted to Hospital A on 01/01/2001, then is transferred to Hospital B on 01/15/2001, and finally discharged from Hospital B on 01/30/2001. The claim note would say:

"Continuous hospital stay 01/01/2001-01/30/2001"

Inpatient hospital psychiatric transfers

The agency requires a transferring hospital to obtain prior authorization (PA) and include the authorization number in the client's records as explained below:

- Contact the appropriate mental health designee or Regional Support Network (RSN) to obtain the following:
  - ✓ Prior approval of post-stabilization care
  - ✓ An authorization number
- Include the authorization number in the client's records for the receiving hospital and on the claim submitted by the receiving hospital (refer to Inpatient Hospital Psychiatric Admission).

Potentially preventable readmissions prospective reimbursement policy

(WAC 182-550-3840)

Defining a potentially preventable readmission (PPR)

A PPR is an inpatient readmission within 30 days after discharge that is clinically related to the initial admission. A PPR is a readmission meets all of the following:

- Is potentially preventable through appropriate care consistent with accepted standards in the prior discharge or during the postdischarge follow-up period
- Is for a condition or procedure related to the care provided during the prior discharge or during the period immediately after the prior discharge
- Is within thirty days after the initial admission, and the 30-day time frame begins again at the discharge of the most recent readmission (known as a "PPR chain")
- Is to the same or to any other hospital

Adjusting payment rate

The agency annually adjusts the payment rate to a hospital with an excessive number of PPRs.

Calculating number of excess PPRs

The agency calculates the number of excessive PPRs for each hospital using a risk-adjusted comparison between the hospital's actual number of PPRs versus the hospital's expected number of PPRs, and then prospectively reduces the reimbursement rate for all inpatient claims paid in the subsequent year.

The agency is will provide hospitals data that allows them to monitor their readmission occurrences and trends. The agency will provide quarterly reports to each hospital.

Admissions and readmissions excluded from the PPR analysis

Admissions and readmissions under the following circumstances are excluded from the data set that identifies initial admissions and potentially preventable readmissions, and therefore are not part of a PPR chain:

- Admission to an acute care hospital for clients assigned to the base APR DRG for rehabilitation, aftercare, and convalescence
- Behavioral health DRGs
- Chemotherapy
- Claims occurring at out-of-state, noncritical border hospitals
- Dually eligible Medicare/Medicaid enrollees
- Enrollees in state-only programs
- Hospital-to-hospital transfers
- Hospitalization with a discharge status of "left against medical advice"
- Leukemia
- Lymphoma
- Malignancy and selected disorders or diseases with chemotherapy or radiotherapy procedures (for example: Connective tissue or coagulation and platelet disorders)
- Medicare crossover claims
- Mental health and chemical dependency claims covered by the division of behavioral health and recovery (DBHR)
- Neonatal admissions
- Newborn cases with the mother's patient information reported in the claim
- Newborn jaundice cases
- Out-of-state admissions at non-critical border hospitals
- Planned readmissions
- Same-day transfer to an acute care hospital for nonacute care (for example: Hospice care)
- State program claims
- Transplant diagnosis-related group DRG initial admissions or admissions within 180 days of a transplant DRG
- Trauma claims qualifying for supplemental payments for approved trauma service centers under WAC 182-550-5450
- Ungroupable DRG cases

In addition, the PPR analysis makes adjustments for claims submitted with mental health diagnoses that do not group to a behavioral health DRG, and pediatric admissions.

Billing for planned readmissions

Effective January 1, 2017, planned readmissions will be excluded from the analysis of the 2016 readmission claims data. However, the reimbursement rates established for January 1, 2016 are based on the readmission experience in 2015 compared to 2014. Therefore, the 2016 rates do not reflect the exclusion of planned readmissions that occurred in 2015.

Note: Effective January 1, 2016, to ensure planned readmissions are excluded from future PPR analyses hospitals must submit claims as described below.

To bill initial admission:
A client is admitted with cholecystitis for medical management, discharged with a plan to readmit within 30 days for surgical intervention.

- If an agency payment policy (e.g., transfers) **does not** specify a requirement for a different discharge status, the initial admission claim must include discharge status code "81" (planned readmission).
- If an agency payment policy (e.g., transfers) **does** specify a requirement for a different discharge status, the initial admission claim must be submitted with "81" in the comment/claim note field.

To bill planned readmission:
The client above is admitted to the hospital for the planned readmission for surgical intervention.

- The subsequent admission claim must include "SCI=PR" (planned readmission) in the comment/claim note field.

In situations where the claim must be prepared using the comment/claim note field for both required data elements described above, submit the claim using this format:

"SCI=PR" "81"

To support data collection related to socio-economic status (SES), hospitals are asked to include diagnosis codes Z59.0 and Z59.1 related to homelessness on claims billed to the agency.

What are the agency's payment methods?

(WAC 182-550-3000)

The agency's claim payment for an inpatient stay is determined by the payment method. The agency pays hospitals for inpatient hospital covered services provided to clients using the following methods:

Payment Method	General Description of Payment Formula	WAC Reference
DRG (Diagnostic Related Group)	The DRG specific relative weight times hospital specific DRG	182-550-3000
Per Diem	The hospital-specific daily rate for the service (psych, rehab, detoxification, or CUP) times covered allowable days	182-550-2600 and 182-550-4400
Single Case Rate	The hospital specific bariatric case rate per stay	182-550-3470
Fixed Per Diem for Long Term Acute Care (LTAC)	The fixed LTAC rate per day times the allowed days plus the RCC times the allowable covered ancillaries not included in the daily rate	182-550-2595 and 182-550-2596
Ratio of Costs-to-Charges (RCC)	The RCC times the covered allowable charges	182-550-4500
Cost Settlement with RCC	The RCC times the covered allowable charges (subject to hold harmless and other settlement provisions of the Certified Public Expenditure program)	182-550-4650 and 182-550-4670
Cost Settlement with Weighted Costs-to-Charges (WCC)	The WCC times the covered allowable charges subject to Critical Access Hospital settlement provisions	182-550-2598
Military	Depending on the revenue code billed by the hospital, both of the following: • The RCC times the covered allowable charges • The military subsistence per diem	182-550-4300
Administrative Day	The standard administrative day rate times the days authorized by the agency, added to the RCC times the ancillary charges allowable and covered for administrative days	182-550-3381

What are the agency's payment methods for state-administered programs?

(WAC 182-550-4800)

The agency's claim payment for an inpatient stay is determined by the payment method. The agency pays hospitals for inpatient hospital covered services provided to state-administered program (SAP) clients using the following methods described in WAC 182-550-4800:

Payment Method	General Description of Payment Formula
SAP DRG (Diagnostic Related Group)	The DRG- specific relative weight times the hospital-specific SAP DRG rate plus outlier if applicable. Total payment cannot exceed billed charges.
SAP Per Diem	The hospital-specific SAP daily rate for the service (psych, rehab, detox, or CUP) times the covered allowable days
SAP Single Case Rate	The hospital- specific SAP bariatric case rate per stay for pre-authorized bariatric services at agency approved hospitals
Medicaid Fixed Per Diem for Long Term Acute Care (LTAC)	The Medicaid fixed LTAC rate per day times the allowed days plus the ratio of cost to charges (RCC) times the allowable covered ancillaries not included in the daily rate
SAP Ratio of Cost-to-Charges (RCC)	The SAP RCC times the billed covered allowable charges
SAP Cost settlement with Ratio of Cost-to-Charges	The initial ProviderOne payment equals Medicaid RCC times the covered allowable charges. For hold harmless settlement base payment calculations, payment equals the SAP RCC times the allowed covered charges
Cost Settlement with Weighted Cost-to-Charges (WCC)	SAP pricing does not apply
Administrative day	The standard administrative day rate times the days authorized by the agency, combined with the SAP RCC times the ancillary charges that are allowable and covered for administrative days

The agency provides inpatient hospital services to SAP clients, including incapacity-based and aged, blind, and disabled medical care services as described in WAC 182-508-0005. The agency pays SAP claims using SAP rates rather than Medicaid or CHIP rates.

Diagnosis related group (DRG) payment method (Inpatient primary payment method)

(WAC 182-550-3000)

As of July 1, 2014, the agency assigns a DRG code to each claim for pricing in ProviderOne for an inpatient hospital stay, using 3M™ APR-DRG software. That DRG code determines the method used to pay claims for prospective payment system (PPS) hospitals. PPS hospitals include all in-state and border area hospitals, except both of the following:

- Critical access hospitals (CAH), which the agency pays per WAC 182-550-2598
- Military hospitals, which the agency pays using the following payment methods depending on the revenue code billed by the hospital:
  - ✓ Ratio of costs-to-charges (RCC)
  - ✓ Military subsistence per diem

For each DRG code, the agency establishes an average length of stay (ALOS). The agency may use the DRG ALOS as part of its authorization process, retrospective utilization review process, and payment methods as specified in this guide.

An inpatient claim payment includes all hospital-covered services provided to a client during days the client is eligible. This includes, but is not limited to:

- The inpatient hospital stay.
- Outpatient hospital services, including preadmission, emergency department, and observation services related to an inpatient hospital stay and provided within one calendar day of a client's inpatient hospital stay. These outpatient services must be billed on the inpatient hospital claim.
- Any hospital-covered service for which the admitting hospital sends the client to another facility or provider during the client's inpatient hospital stay, and the client returns as an inpatient to the admitting hospital.

The DRG payment method is based on all of the following:

- The DRG code assigned to the claim by ProviderOne
- The relative weight assigned to the DRG code
- The hospital's specific DRG conversion factor

The agency pays prospective payment system (PPS) hospitals for services excluded from the DRG payment method using the following rates:

- Per diem
  - ✓ Psychiatric
  - ✓ Rehabilitation
  - ✓ Detoxification
  - ✓ Chemical-using pregnant (CUP) women
  - ✓ Long-term acute care (LTAC)
  - ✓ Administrative day

- Case
  - ✓ Bariatric

- RCC
  - ✓ Certified public expenditure (CPE) hospital
  - ✓ Military hospital

Validation of DRG assignment

(WAC 182-550-2900 (5))

The agency uses 3M Corporation's APR-DRG software for grouping and assigning a DRG code to each claim for payment purposes. The DRG code that the agency assigns is the one used to pay the claim. The agency may review claims to verify appropriate diagnosis and procedure codes, place of service, medical necessity, and other information. If the agency determines information is inappropriate, the agency may make an adjustment or recoup payment. Providers must submit claims with information that allows the claim to group to an appropriate DRG and that provides proof of medical necessity.

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

- In accordance with the national uniform billing data element specifications in effect for the dates of service:

  - ✓ Developed by the National Uniform Billing Committee (NUBC).
  - ✓ Approved or modified, or both, by the Washington payer group or the agency.
  - ✓ In effect on the date of the client's admission.

- In accordance with the published International Classification of Diseases Clinical Modification (ICDCM) coding guidelines.

Valid DRG codes

(WAC 182-550-4400 (2)(g))

The agency does not pay for inpatient hospital stays that group to APR DRG codes 955 or 956. To get paid, providers must use diagnosis and procedure codes that group to a valid DRG.

DRG relative weights

The agency uses 3M Health Information System's national relative weights to price claims in ProviderOne.

DRG conversion factors

The conversion factor is also referred to as the DRG rate. The agency establishes the DRG allowed amount for payment for that admission by multiplying the hospital's conversion factor (CF) by the assigned DRG relative weight.

High outliers (DRG)

(WAC 182-550-3700)

When a claim paid using the DRG payment method qualifies as a high outlier payment, the agency adjusts the claim payment.

Qualifying for high outlier payment using DRG payment method

A claim is a high outlier if the claim's estimated cost is greater than the DRG allowed amount plus $40,000.

The estimated costs equal the total submitted charges minus any noncovered and nonallowed charges multiplied by the hospital's ratio of costs-to-charges (RCC). The DRG allowed amount equals the hospital's DRG rate multiplied by the relative weight.

The agency uses 3M Health Information Systems national relative weights.

These criteria are also used to determine if a transfer claim qualifies for high outlier payment for claims with admission dates before July 1, 2014. For transfer claims submitted on or after July 1, 2014, the agency uses the prorated DRG amount to determine if the transfer claim qualifies for high outlier payment. The prorated DRG amount is the lesser of:

- The per diem DRG allowed amount (hospital's rate times relative weight for the DRG code assigned to the claim by the agency) divided by the average length of stay (for the DRG code assigned by the agency for the claim) multiplied by the client's length of stay plus 1 day.

- The total DRG payment allowed amount calculation for the claim.

Calculating Medicaid high outlier payment

The high outlier payment is the difference between the agency's estimated cost of services associated with the claim and the high outlier threshold multiplied by a percentage. The percentage varies according to the severity of illness (SOI) for the DRG assigned to the claim:

- SOI 1 or 2 get 80%
- SOI 3 or 4 get 95%

High outlier examples by SOI are in the table below. They assume the following:

- DRG Allowed Amount = $10,000
- $10,000 = DRG Medicaid rate of $5,000 multiplied by a relative weight of 2.0
- Billed covered allowed charges = $250,000
- Hospital specific RCC = 0.40

DRG SOI	Base DRG Allowed Amount	Billed Charges	RCC	Cost	Threshold	Cost Above Threshold	Outlier Percent	Outlier	Total Claim Payment
A	**B**	**C**	**D**	**F**	**E**	**G**	**H**	**I**	**J**
				*C * D*	*$40,000 + B*	*F - E*		*G * H*	*B + I*
1,2	$10,000	$250,000	0.40	$100,000	$50,000	$50,000	0.80	$40,000	$50,000
3,4	$10,000	$250,000	0.40	$100,000	$50,000	$50,000	0.95	$47,500	$57,500

Calculating state-only-funded program high outlier for state administered program (SAP) claims

These high outlier payment rules are the same as for Medicaid claims except for the following differences:

- The agency uses the SAP DRG rate instead of the Medicaid DRG rate to calculate the DRG allowed amount.
- The agency multiplies the high outlier payment by the hospital's ratable.

The examples in the table below assume the following:

- DRG Allowed Amount = $10,000
- $10,000 = DRG SAP rate of $1,000 multiplied by a relative weight of 10
- Billed covered allowed charges = $250,000
- Hospital specific RCC = 0.40
- Hospital ratable = 0.5

DRG SOI	Base DRG Allowed Amount	Billed Charges	RCC	Cost	Threshold	Cost Above Threshold	Outlier Percent	Ratable	Outlier	Total Claim Payment
A	**B**	**C**	**D**	**F**	**E**	**G**	**H**		**I**	**J**
			(1)	*C * D (2)*	*$40,000 + B*	*F - E*			*G * H*	*B + I*
1,2	$10,000	$250,000	0.40	$100,000	$50,000	$50,000	0.80	0.50	$20,000	$30,000
3,4	$10,000	$250,000	0.40	$100,000	$50,000	$50,000	0.95	0.50	$23,750	$33,750

Transfer information for DRG payment method

Hospital transfers are when an eligible client transfers from an acute care hospital or distinct unit to any of the following settings (noted on the claim with one of the following discharge status codes: 02, 03, 04, 05, 06, 43, 50, 51, 61, 62, 63, 64, 65, 66, 70, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95):

- Another acute care hospital or distinct unit
- A skilled nursing facility (SNF)
- An intermediate care facility (ICF)
- Home care under the agency's home health program
- A long-term acute care facility (LTAC)
- Hospice (facility-based or in the client's home)
- A hospital-based, Medicare-approved swing bed or another distinct unit such as a rehabilitation or psychiatric unit
- A nursing facility certified under Medicaid but not Medicare

The agency pays a transferring hospital a per diem rate when one of the transfer discharge status codes listed above 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. The service provided to the client is paid based on the DRG payment method. The payment allowed amount calculation is the lesser of the:

- Per diem DRG allowed amount (hospital’s rate times relative weight for the DRG code assigned to the claim by the agency) divided by the average length of stay (for the DRG code assigned by the agency for the claim) multiplied by the client’s length of stay plus 1 day.

- 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, the agency will apply the outlier payment method to the payment.

Example:
A client is admitted to Hospital A, transferred to Hospital B, then transferred back to Hospital A and is discharged. In this case, 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.

Per diem payment method

The agency 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.

The agency 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 the agency's medical necessity review.

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

Services paid using the per diem payment method

The agency pays for the following services using the per diem payment method:

- 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 per diem services.
  - ✓ Chemical-Using Pregnant (CUP) Women services are identified by revenue code 129, not by APR-DRG classification. Refer to the Chemical-Using Pregnant (CUP) Women Program Provider Guide for more information.
  - ✓ Psychiatric admissions and acute physical medicine and rehabilitation (Acute PM&R) services require PA. See Authorization for information on the authorization process.

Note: For psychiatric admission rules, refer to Inpatient Hospital Psychiatric Admissions. For information on the Acute PM&R program, refer to the Acute Physical Medicine and Rehabilitation (PM&R) Provider Guide.

Hospitals paid using the per diem payment method

The agency pays the following types of hospitals using the per diem payment method:

- **Psychiatric hospitals**

  - ✓ Freestanding psychiatric hospitals
  - ✓ State-designated, distinct pediatric psychiatric units
  - ✓ 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
  - ✓ Psychiatric evaluation and treatment facilities

- **Rehabilitation hospitals**

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

  The hospitals referenced (rehabilitation hospitals) above do ***not*** include either of the following:

  - ✓ Long term acute care hospitals
  - ✓ Freestanding detoxification facilities

> **Note:** The payment methods for long term acute care (LTAC) hospitals and freestanding detoxification facilities are different from rehabilitation hospitals. For LTAC see "Fixed Per Diem – LTAC" below, and for freestanding detoxification facilities, see the agency's Substance Use Disorder Provider Guide.

Transfers (per diem)

See Transfers.

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

Single case rate (bariatric) payment method

(WAC 182-550-3470)

To qualify to receive the bariatric case rate, hospitals must:

- Be agency-approved to receive the bariatric case rate.
- Receive PA from the agency to provide the bariatric service to the client.
- Provide eligible bariatric services in the inpatient hospital setting.

In addition, when billing for bariatric services, the claim must include the appropriate diagnosis and procedure codes. See the agency's Program Policy Approved Diagnosis Codes for Inpatient Hospital Services.

The following hospitals are agency approved to receive the bariatric case rate:

- Sacred Heart Medical Center
- Oregon Health Sciences University Hospital

The agency will not make outlier adjustments for bariatric surgery claims.

The University of Washington Medical Center (UWMC) is also an agency-approved hospital for the bariatric case rate, but the bariatric case rate is only used for baseline pricing for estimating the Hold Harmless Settlement. The agency pays all inpatient claims at UWMC, including bariatric claims, using the RCC method.

For a bariatric claim to be paid by the case rate method, hospitals must obtain PA from the agency. Claims will be denied without PA. Bariatric surgery paid by bariatric case rate must be provided in an inpatient hospital setting.

Fixed per diem payment method – (LTAC)

The agency pays approved LTAC hospitals a per diem rate for agency approved days. For other covered services listed on the claim (which are not already included in the per diem rate) the agency uses the ratio of cost-to-charges (RCC) method

Transfers (per diem - LTAC)

All transfers to and from LTAC hospitals require PA by the agency. Refer to the agency's Long Term Acute Care (LTAC) Provider Guide. 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 assigned by the agency.

Ratio of costs-to-charges (RCC) payment method

(WAC 182-550-4500)

The agency 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. The RCC allowed amount for payment is calculated by multiplying the hospital's allowed covered charges for the claim by the hospital's RCC. 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, all of the following are 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]

Hospitals paid using the RCC payment method

The agency 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
- Long term acute care (LTAC) hospitals for covered inpatient services not covered in the per diem rate

Certified public expenditure (CPE)

The agency uses the RCC payment method to pay CPE hospitals billing Medicaid (Title XIX) and state-administered program claims. The hospital receives only the federal portion of the claim payment.

Payment for services provided to clients eligible for Medicare and Medicaid

The ProviderOne system derived payment amount will be the true claim payment amount using the appropriate OPPS, DRG, fee schedule, fixed case rate, per diem or RCC reimbursement methodology that applies to the claim. Using that payment amount, for Medicaid clients who are entitled to Medicare Part A and/or Medicare Part B, the agency pays the difference between the Medicare paid amount and the ProviderOne-derived payment amount or the deductible and/or coinsurance amounts on the claim, whichever is less.

Program Limitations

Medical necessity

The agency will pay only 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 or observational level of care is no longer medically necessary and one of the following is true:

- Outpatient level of care is not applicable.
- Appropriate non-hospital placement is not readily available.

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

Rate guideline for new hospitals

(WAC 182-550-4100)

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 182-550-4200 for information on change of ownership.**

Psychiatric services

See Inpatient Hospital Psychiatric Admissions.

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 agency receive funding from the TCF to help support provider groups involved in the state's trauma care system.

The agency uses its TCF funding to draw federal matching funds. The agency makes supplemental payments to designated trauma service centers for trauma cases that meet specified criteria.

A hospital is eligible to receive trauma supplemental payments only for a patient who is a **Medicaid (Title XIX)** client. The client must:

- Have an Injury Severity Score (ISS) of:
  - a. 13 or greater for adults (age 15 or older)
  - b. 9 or greater for pediatric patients (age 14 or younger)
  - c. Less than (a) or (b) when **received** in transfer by a Level **I, II, or III** trauma service center from a lower-level facility. (The receiving facility is eligible for TCF payment regardless of the ISS; the transferring facility is eligible only if the case met the ISS criteria above.)

Designated trauma service centers will receive supplemental payments for services provided to Medicaid fee-for-service and managed care enrollees.

Note: The agency does not make supplemental payments to a hospital for trauma care provided to a client who is not a Medicaid client

How does a hospital qualify for TCF payments from the agency?

A **hospital** is eligible to receive TCF payments from the agency when the hospital meets all of the following criteria. The hospital:

- Is *designated* by DOH as a trauma service center (or "*recognized*" by DOH if the hospital is located in a designated bordering city).
- Is a Level I, Level II, or Level III trauma service center.
- Meets the provider requirements in WAC 182-550-5450 and other applicable WAC.
- Meets the billing requirements in WAC 182-550-5450 and other applicable WAC.
- Submits all information required by DOH for the Trauma Registry.
- Provides all information the agency requires to monitor, manage, and audit the trauma program.

See DOH's website for a list of the Washington State Designated Trauma Service Centers.

TCF payments to hospitals for transferred trauma cases

When a trauma case is transferred from one hospital to another, the agency makes TCF payments to hospitals 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 are eligible for TCF payments. The transfer must have been to a higher-level designated trauma service center, and the transferring hospital must be a Level II or Level III hospital. Transfers from a higher-level to a lower-level designated trauma service center are not eligible for TCF payments.

- If the transferred case is below the ISS threshold, only the **receiving** hospital is eligible for TCF payments. The receiving hospital is eligible for TCF payments regardless of the ISS for the transferred case. The receiving hospital must be a Level III hospital or higher.

TCF payment calculation

The agency has an annual TCF appropriation. The agency distributes its TCF appropriation for hospital services in five periodic supplemental payments. Hospitals receive a percentage of a fixed periodic distribution amount. Each hospital's percentage share 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 I-III trauma service centers during the same period.

The payment an eligible hospital receives from the periodic TCF payment pool is determined as follows:

- The agency's payments to each designated hospital for qualifying trauma claims from the beginning of the service year is summed.

- Using this amount as a percentage of total payments made by the agency to all Level I, II, and III hospitals for qualifying trauma claims for the service year-to-date, each eligible hospital's payment percentage share for the service year-to-date is multiplied by the trauma supplemental funds available for the service year-to-date.

- The agency then subtracts previous periodic payments made to the individual hospital for the service year-to-date to determine the amount (if any) that the hospital will receive from the current periodic payment pool.

The agency includes in the TCF payment calculation only those eligible trauma claims submitted with the appropriate condition code within the time frames specified by the agency.

Note: See WAC 182-550-5450 for a complete description of the payment methodology to designated trauma service centers and other policies pertaining to the agency's trauma program.

Cap on TCF payments

The total payments from the TCF for a state fiscal year cannot exceed the TCF amount appropriated by the legislature for that fiscal year. The agency has the authority to take whatever actions are needed to ensure its TCF appropriation is not exceeded.

Use appropriate condition codes when billing for qualified trauma cases

A designated trauma service center must use an agency-assigned condition code on the UB-04 form to indicate that a hospital claim is eligible for the TCF payment. Select the appropriate condition code from the table below:

Condition Code	Description
TP	Indicates a pediatric client (through age 14 only) with an Injury Severity Score (ISS) in the range of 9-12
TT	Indicates a transferred client with an ISS that is less than 13 for adults or less than 9 for pediatric clients
TV	Indicates an ISS in the range of 13 to 15
TW	Indicates an ISS in the range of 16 to 24
TX	Indicates an ISS in the range of 25 to 34
TY	Indicates an ISS in the range of 35 to 44
TZ	Indicates an ISS of 45 or greater

Note: Remember that when you put a trauma condition code on a hospital claim, you are certifying that the claim meets the criteria published in WAC 182-550-5450.

The "TT" condition code should be used only by a Level I, Level II, or Level III receiving hospital. A Level II or Level III transferring hospital must use the appropriate condition code indicating the Injury Severity Score of the qualifying trauma case. See WAC 182-550-5450(4)(c)(ii).

Trauma condition codes may be entered in form locators 18-28, but the agency prefers that hospitals use form locator 18 for trauma cases.

Trauma claim adjustments

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

The agency does not make any TCF payment for a trauma claim adjusted after 365 days from the date of the qualifying service. The deadline for making adjustments to a trauma claim is the same as the deadline for submission of the initial claim. WAC 182-502-0150(7) and 182-502-0150(8) do not apply to TCF payments; see WAC 182-502-0150(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 age 14 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
  - ✓ External

The ISS values range from 1 to 75 and generally, a higher ISS indicates more serious injuries.

Contacts

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

Department of Health
Office of Community Health Systems
Trauma System Web Page

For information on **payment**, contact:

Office of Hospital Finance
Health Care Authority
360-725-1835

For information on a specific **Medicaid trauma claim**, email the Medical Assistance Customer Service Center (MACSC) or call MACSC at 1-800-562-3022.

Note: See the Physician-Related Services/Health Care Professionals Provider Guide for the list of Physicians/Clinical Providers eligible to receive enhanced rates for trauma care services.

Unbundling

The agency does not pay separately for unbundled services billed on an inpatient claim by a hospital. The agency 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 the agency'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 the agency
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 the agency. 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 inpatient services by the agency approved neonatal transport teams, bill with ambulance revenue code 0546.

[2] Assumes practitioner is not billing the agency.

Other noncovered items

Following are examples of "other" noncovered items for hospitals. If one of these items has a revenue code, 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
- Robotic assisted surgery*
- Routine tests and procedures (e.g., pre-anesthesia chest x-rays, fetal monitoring, etc.) are only covered only if the agency determines them as medically necessary and they are approved by a physician.
- Standby equipment charges (for oxygen, anesthesia, and surgery when no actual service is performed)
- Take home drugs/supplies
- Telephone-telegraph/fax
- Transportation (provided during hospital stay)
- Travel time

*Although Robotic Assisted Surgery (RAS) may be considered medically necessary, the agency does not pay separately for HCPCS code S2900 and reimburses only for the underlying procedure.

The agency requires billing providers to bill for RAS in order to track utilization and outcome. The agency will monitor RAS through retrospective auditing of applicable ICD 10 procedure codes, and review of operative reports.

Authorization

General authorization

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

The agency's authorization process applies to medically necessary covered health care services only and is subject to client eligibility and program limitations. Not all categories of eligibility receive all health care services. **For example:** Therapies are not covered under the Family Planning Only Program. All covered health care 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 182-501-0160.

The agency'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
- Utilization review (UR)

Note: For psychiatric admission rules, refer to Inpatient Hospital Psychiatric Admissions. For information on the Acute PM&R program, refer to the Acute Physical Medicine and Rehabilitation (PM&R) Provider Guide.

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

Changes in authorization requirements for selected surgical procedures

Effective for dates of service on and after April 15, 2012, the agency is expanding its PA requirements to include selected surgical procedures. The medical necessity review for these procedures will be conducted by the agency or Qualis Health.

For more information about the requirements for submitting medical necessity reviews for authorization, refer to the agency's Physician-Related Services/Health Care Professional Services Provider Guide.

"Write or fax" PA

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

The following forms are available to providers requesting PA from the agency:

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

These forms are available at the Medicaid forms web site.

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 the agency (see Resources Available).

How does the agency approve or deny PA requests?

The agency reviews PA requests in accordance with WAC 182-501-0165 and uses evidence-based medicine to evaluate each request. The agency 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, the agency 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
- Requests the provider to submit additional justifying information within 30 days. When the additional information is received, the agency 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, the agency denies the requested service.

When the agency 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 the agency 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 the agency took the action.
- Is in sufficient detail to determine what additional or different information might be provided to challenge the agency'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.
- Includes example(s) of lesser cost alternatives that permit the affected party to prepare an appropriate response.

Expedited prior authorization (EPA)

Expedited prior authorization (EPA) is designed to eliminate the need for written authorization. The agency establishes authorization criteria and identifies the criteria with specific codes, enabling providers to create an EPA number using those codes. Enter the EPA number on the billing form in the authorization number field, or in the "authorization" or "comments" section when billing electronically.

Surgical policies

Authorization requirements for surgical procedures

(WAC 182-531-1700)

Surgical procedures that require a medical necessity review by the agency

To implement the PA requirement for selected surgical procedures (including hysterectomies and other surgeries of the uterus), the agency conducts medical necessity reviews for selected surgical procedures. The agency began accepting requests for these medical necessity reviews April 1, 2012. For details about the PA requirements for these procedures, refer to both of the following:

- Physician-Related Services/Health Care Professional Services Provider Guide
- Physician-Related/Professional and Emergency Oral Health Care Services Fee Schedule. Select the most current fee schedule link, then select a procedure code and refer to the comments field for the accompanying submittal requirement.

Transgender health services

For details about these services and PA requirements, refer to the Physician-Related Services/Health Care Professional Services Provider Guide.

How does a client update their gender field?

A client should call the Medical Eligibility Determination Services call center toll-free at (855) 623-9357 to change their gender identification in Washington Healthplanfinder.

Any Washington Apple Health client can call and choose a gender. Clients should be aware that other state agencies, such as the Department of Licensing, have different requirements.

How does a client update or change their name?

A client should call the Medical Eligibility Determination Services call center toll-free at (855) 623-9357 to change or update their name in Washington Healthplanfinder.

Before making a name change in Washington Healthplanfinder, the client should first obtain a name change with Social Security. If the client's name in Washington Healthplanfinder does not match the client's name in Social Security, the system will generate an error and this could affect the client's coverage.

Managed care clients

Covered by the MCO: If a client is enrolled in managed care, the MCO is responsible for all medical care including hormone and mental health services to treat gender dysphoria. Contact the MCO for requirements for those services. Some clients may meet the access to care standards, therefore these mental health care services may be provided by a community mental health agency under the RSN (See Chapter 388-865 WAC). The MCO is not responsible for surgical procedures related to gender reassignment surgery, including electrolysis and postoperative complications.

Covered through fee-for-service: The agency pays for surgical procedures related to gender reassignment surgery and electrolysis and postoperative complications through fee-for-service (FFS). PA is required from the agency for these procedures.

> **Note:** If the client is being seen for postoperative complications from a gender reassignment surgery or procedure, the provider must put "GRS complication surgery" in the *Comments* field. These services are covered by the agency through fee-for-service for managed care clients.

Surgical procedures that require a medical necessity review by Qualis Health

The agency contracts with Qualis Health to provide web-based access for reviewing medical necessity of selected surgical procedures in the following categories:

Spinal, including facet injections	Major joints	Upper and lower extremities
Carpal tunnel release	Thoracic outlet release	

Qualis Health conducts the review of the request to establish medical necessity for surgeries, but **does not** issue authorizations. Qualis Health forwards its recommendations to the agency for final determination.

For more information about the requirements for submitting medical necessity reviews for authorization, refer to the agency's Physician-Related Services/Health Care Professional Services Provider Guide.

Breast Surgeries

Refer to the agency's published Physician-Related Services/Health Care Professional Services Provider Guide.

Inpatient admissions are billable only when the stay meets the definition of inpatient admissions (see Definitions). Refer to the Physician-Related Services/Health Care Professional Services Provider Guide for EPA criteria.

Early elective deliveries

The agency does not reimburse for early elective deliveries. An early elective delivery is defined in WAC 182-500-0030 as any nonmedically necessary induction or cesarean section before 39 weeks gestation.

The agency considers an early elective delivery to be medically necessary if the mother or fetus has a diagnosis listed in the Joint Commission's current table of Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation (WAC 182-533-0400), or if the provider documents a clinical situation that supports medical necessity. If the client meets these criteria, bill using EPA #870001375.

If the early elective delivery does not meet medical necessity, the agency will reimburse only for the antepartum and postpartum professional services. Providers must unbundle the services when billing. The agency will not pay for the delivery services and the hospital not receive payment for this nonmedically necessary early elective delivery as defined in WAC 182-500-0030.

For an elective delivery performed for a client who is over 39 weeks gestation, bill using EPA #870001378.

Agency-approved bariatric hospitals and associated clinics

(WAC 182-531-1600, 182-550-2301 and 182-550-3020)

Agency-Approved Bariatric Hospital and Associated Clinics	Location
University of Washington Medical Center, University of Washington Specialty Surgery Center	Seattle, WA

The agency covers medically necessary bariatric surgery for clients age 21-59 in an approved hospital with a bariatric surgery program in accordance with WAC 182-531-1600. The agency covers bariatric surgery for clients age 18-20 for the laparoscopic gastric band procedure only (ICD 0DV64CZ). All bariatric surgeries require PA, and are approved when the client meets the criteria in WAC 182-531-1600.

Note: The agency does not cover bariatric surgery for clients age 17 and younger.

To begin the authorization process, providers must fax a completed Bariatric Surgery Request form, 13-785, and the Basic Information form, 13-756 to the agency.

Clients enrolled in an agency-contracted managed care organization (MCO) may be eligible for bariatric surgery. Clients enrolled in an agency-contracted MCO must contact their MCO for information regarding the bariatric surgery benefit.

Note: The agency pays agency-approved hospitals a bariatric case rate, except for Certified Public Expenditures (CPE) hospitals. CPE hospitals are paid by the ratio of cost-to-charges (RCC) method. The bariatric case rate is used only for baseline pricing for the Hold Harmless settlement.

Acute physical medicine and rehabilitation (PM&R)

(WAC 182-550-2561)

The agency requires prior and concurrent authorization for admissions and continued stays in agency-approved acute PM&R facilities. To facilitate ProviderOne billing, provide room charges with one of the following revenue code 0128.

> **Note:** See approved list Acute PM&R facilities on the agency's Acute PM&R web page.

Refer to the agency's Acute Physical Medicine and Rehabilitation (PM&R) Provider Guide for program specifics.

Long-term acute care (LTAC)

(WAC 182-550-2590)

The agency requires PA for all admissions to the agency -approved LTAC hospitals.
See the agency's Long-Term Acute Care Program Provider Guide 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.

Claims must meet or exceed the DRG allowed amount prior to the transfer. The agency 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. To facilitate ProviderOne billing, bill room charges with revenue code 0100.

Out-of-state hospital admissions (does not include hospitals in designated bordering cities)

(WAC 182-550-6700, 182-501-0160, and 182-501-0180, 182-501-0184, 182-502-0120)

The agency pays for emergency care at an out-of-state hospital for Medicaid and CHIP clients only.

> **Note:** The agency considers hospitals in designated bordering cities, listed in WAC 182-501-0175, as in-state hospitals for coverage and as out-of-state hospitals for payment, except for critical border hospitals. The agency considers critical border hospitals "in-state" for both coverage and payment.

The agency 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. Example: Aged, Blind, Disabled (ABD) Assistance (formerly Disability Lifeline clients) have no out-of-state benefit except in designated bordering cities.
- The service is for a covered medically necessary service that is unavailable in the State of Washington (see WAC 182-501-0060).

Providers requesting elective, out-of-state care must send a completed Out-of-State Medical Services Request form, 13-787, with the additional documentation required on the form, to the address listed on the form.

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

Out-of-state air and ground ambulance transportation

(Chapter 182-546 WAC, WAC 182-546-0800, WAC 182-546-0900)

The agency requires PA for all out-of-state non-emergency air ambulance transports. See Resources Available for information on requesting PA. Designated bordering cities, as defined by WAC 182-501-0175, 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.

The agency does not cover ambulance transportation for eligible Washington Apple Health clients traveling outside of the United States and U.S. territories. See WAC 182-501-0184 for ambulance coverage in British Columbia, Canada.

Out-of-country hospital admissions

(WAC 182-501-0184)

The agency 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.
- 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.

Hospitals approved for detoxification services through the Division of Behavioral Health and Recovery (DBHR)

Hospitals that are approved for detoxification services through DBHR must submit billing provider taxonomy 276400000X and revenue code 0126.

For more information about alcohol and drug abuse services, visit DBHR.

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.
See the agency's Chemical-Using Pregnant (CUP) Women Program Provider Guide for details.
A list of the DBHR Certified Hospitals providing intensive inpatient care for chemical using pregnant women is located on the Department of Social and Health Services' website.

Medical inpatient detoxification (MID) services

(WAC 182-550-4300)

In order to bill the agency and get paid, hospitals that are not DBHR-approved detoxification facilities and have provided detoxification services to Washington Apple Health clients must meet the following criteria:

- Acute inpatient severity of illness criteria
- All of the MID criteria listed below

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*

*excluding diagnosis with a 5th digit of "3"

3. The client is not participating in the agency's Chemical-Using Pregnant (CUP) Women Program.

4. The care is provided in a medical unit, not a detoxification unit.

5. Inpatient psychiatric care is not medically necessary, and an approval from the DBHR designee or Regional Support Network (RSN) is not appropriate.

6. The hospital is not a DBHR-approved detoxification facility.

7. Nonhospital based detoxification is not medically appropriate.

What is MID authorization?

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

Note: Do not use billing provider taxonomy 276400000X and Revenue Code 0126 when billing for MID services. See the agency's Hospital-Based Inpatient Detoxification Provider Guide for these services.

Note: If the client is covered by an MCO, the claim must be submitted to the client's managed care plan. Do not send these claims to the Health Care Authority.

What authorization number is used when billing for MID?

All MID claims must meet the MID criteria and be billed using one of the following EPA numbers:

Description	EPA Number
For acute alcohol detoxification use	870000433**
For acute drug detoxification use	870000435**

**MID claims submitted without one of the above EPA numbers will be denied.

What is the agency's allowed length of stay (LOS) for MID claims?

(WAC 182-550-4300(7))

The agency limits payment for medical inpatient detoxification days to the following:

- **Three** days for acute alcohol detoxification
- **Five** days for acute drug detoxification

How do I bill the agency for MID services exceeding the 3 or 5 day LOS limitation?

When a MID stay exceeds the 3 or 5 day LOS limitation, bill all charges incurred during the stay (from admission through discharge) on one claim.

The charges for the initial 3 or 5 days plus any other days for which you are requesting an extension must be billed in the "total charges" column of the claim. Bill the amount for any days that are not to be evaluated for an extension in the noncovered charges column of a separate line of the claim.

Break out covered and noncovered charges on separate lines as in the following examples:

Example 1

The client is withdrawing from alcohol, meets the MID criteria, and is in the hospital for the allowed 3 days.

Room and Board Revenue Code	Unit	Total Charges	Noncovered Charges	Notes
012x	3 Days	$xx.xx		

Example 2

The client is actively withdrawing from alcohol, meets MID criteria, and is in the hospital for 5 days and *does not* meet InterQual® Acute Level of Care criteria during the last 2 days of the stay.

Room and Board Revenue Code	Unit	Total Charges	Noncovered Charges	Notes
012x	3 Days	$xx.xx		Charges for total days requested
012x	2 Days	$xx.xx	$xx.xx	Charges for days not to be evaluated

Example 3

The client is actively withdrawing from cocaine, meets MID criteria, and InterQual® Acute Level of Care criteria for 7 days. The hospital bills for the allowed 5 days as well as an extension approved for the last 2 days.

Room and Board Revenue Code	Unit	Total Charges	Noncovered Charges	Notes
012x	7 Days	$**xx.xx**		Charges for total days requested

Example 4

The client is actively withdrawing from alcohol, meets MID criteria, and is in the hospital for 10 days. The stay meets InterQual® Acute Level of Care criteria for the first 7 days. The hospital bills for the allowed 3 days as well as an extension for 4 additional days. The client does not meet InterQual® Acute Level of Care criteria during the last 3 days of the stay (last 3 days not to be evaluated for payment).

Room and Board Revenue Code	Unit	Total Charges	Noncovered Charges	Notes
012x	7	$xx.xx		Charges for total days requested
012x	3	$xx.xx	$xx.xx	Charges for days not to be evaluated

Extensions will automatically be reviewed for acute level of care when medical records are submitted with the claim **and** when an EPA is on the claim for MID Services.

Submit the following medical records demonstrating the medical necessity for additional days with the claim:

- History and physical
- Pertinent physician notes
- Physician progress notes
- Discharge summary

For more information for submitting attachments, go to the ProviderOne Billing and Resource Guide.

Payment methods

For MID claims paid using the per diem payment method

The agency will adjudicate the claims, making payment for the approved days only.

For MID claims paid using the CPE payment method

If the agency determines one or more of the requested extension days do not meet the intensity of service criteria, the entire claim will be denied with adjustment code 152. If the claim is denied for this reason, resubmit the claim and insert the charges for days that do not qualify for an extension, into the **noncovered column**. Insert the covered 3 or 5 days extension days into the **covered column**. EPA MUST still appear on the claim and “prev rev” MUST appear in the comments field. Under these circumstances do not void or adjust a denied claim.

Agency-approved centers of excellence (COE)

(WAC 182-531-0650, 182-550-1900, 182-550-2100 and 182-550-2200)

Transplant services must be performed in an agency-approved COE. **When performed in an agency-approved COE, these services do not require PA**. See the list of agency-approved COEs on the agency's Hospital Finance Rates and Information web page.

The agency covers transplant procedures when:

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

When the above is true, the agency covers:

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

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

Experimental transplant procedures

The agency does not pay for experimental transplant procedures. The agency considers services as experimental, 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
- 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

The agency considers organ procurement fees as part of the payment to the transplant hospital. However, the agency 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 the agency will pay separately for the organ procurement.

The agency 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 the agency as secondary insurance, the agency does not require PA or that the transplant, sleep study, or bariatric surgery be done in a COE or agency-approved hospital. As required by federal law, organ transplants and services related to an organ transplant procedure are not covered under the AEM program.

Note: For a list of agency-approved organ transplant centers, see Organ Transplants Centers of Excellence on the agency's hospital finance rates web page.

Ventricular assist device (VAD) services

VAD services must be performed in an agency-approved hospital. When performed in an agency-approved hospital, these services do not require PA.

Agency-approved hospitals are facilities which are Medicare approved to perform VAD implantation and Joint Commission certified to provide VAD therapy.

Agency-Approved Hospitals	
Sacred Heart Medical Center	Spokane, WA
Tacoma General-Allenmore Hospital	Tacoma, WA
University of Washington Medical Center	Seattle, WA
Oregon Health and Sciences University	Portland, OR
Providence St. Vincent Medical Center	Portland, OR

Percutaneous ventricular assist device (PVAD)

PVAD services are exempt from VAD hospital requirements and do not require PA.

PVADs are covered under limited conditions. The agency covers PVADs only if external counter pulsation (intra-aortic balloon pump, IABP) is not expected to be sufficient, and if one of the following life-threatening situations applies:

- Cardiogenic shock
- Severe decompensated heart failure with threatening multi-organ failure. This may include:
    - ✓ Acute systolic heart failure
    - ✓ Acute on chronic systolic heart failure
    - ✓ Acute on chronic combined systolic and diastolic heart failure
    - ✓ Functional disturbances following cardiac surgery
    - ✓ Cardiac complications not elsewhere classified

This service will be covered only if the provider adheres to the FDA approval guidelines.

Transcatheter aortic valve replacement (TAVR)

TAVR is considered medically necessary only for the treatment of severe symptomatic aortic valve stenosis when all of the following occur:

- PA is obtained.
- The heart team and hospital must be participating in a prospective, national, audited registry approved by CMS.
- Conditions of the CMS Medicare National Coverage Determination must be met.

Note: The agency does not pay for TAVR for indications not approved by the FDA, unless treatment is being provided in the context of a clinical trial and PA has been obtained.

Utilization Review

(WAC 182-550-1700)

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 health care 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 health care services provided in relation to the condition(s) being treated.

- Prospective UR (prior authorization) is performed prior to the provision of health care services.
- Concurrent UR is performed during a client's course of care.
- Retrospective UR is primarily an audit function within the agency's Office of Program Integrity and is performed following the provision of health care services. It includes both post-payment utilization review and pre-payment utilization review. The agency uses InterQual® Level of Care criteria, in effect on the client's date of admission, as a guideline in the retrospective utilization review process.
  - ✓ Post-payment retrospective UR is performed after health care services are provided and reimbursed.
  - ✓ Pre-payment retrospective UR is performed after health care services are provided but prior to reimbursement.

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

Agency program integrity retrospective UR

In accordance with 42 CFR 456, the agency's Office of Program Integrity performs retrospective UR to safeguard against unnecessary utilization of care and services. Retrospective UR also provides a method to assure appropriate disbursement of Washington Apple Health funds. Payment to a hospital may be adjusted, denied or recouped, if the agency determines that inpatient hospital services were not any of the following:

- 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
- Medically necessary for a transfer from one acute care hospital to another acute care hospital

If the agency requests it, a hospital must provide the agency proof of compliance with 42 CFR 456 to include, but not limited to, all of the following:

- A written UR Plan in effect that provides for review of each client's need for services the hospital provides to that client

- Details of the organization and composition of the hospital's UR committee

- The written medical care criteria developed by the hospital's UR committee to assess the need for a client's admission

- The hospital UR committee's process for written notice of any adverse final decision on the need for admission (see Hospital-issued notice of noncoverage (HINN))

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. The agency does not pay for any of the following:

- Services that do not meet the medical necessity of the admission status ordered
- Services that are not documented in the hospital medical record
- 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.

- 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.

  - ✓ 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.

- 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.

  - ✓ 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.

- 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.

  - ✓ 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.

- 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.

  - ✓ 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, the agency may determine the admission status ordered is not supported by documentation in the medical record. The agency may consider payment made in this circumstance an overpayment and payment may be recouped or adjusted.

Acute care transfers

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

Coding and DRG validations

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

DRG outliers

The agency may retrospectively review outliers to verify the following:

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

Length-of-stay (LOS) reviews

The agency may perform a retrospective utilization review of non-DRG paid claims that exceed the agency'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, PA, and length of stay requirements are located in Inpatient Hospital Psychiatric Admissions.

The DRG average LOS review applies only to the following:

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

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

Provider preventable conditions (PPCs)

(WAC 182-502-0022)

Hospitals must report to the agency within 45 calendar days of the confirmed PPC. Notification must be in writing, addressed to the agency's Office of Program Integrity – Clinical Review, and include the PPC, date of service, client identifier, and the claim number (TCN) if a claim is submitted to the agency. Hospitals and health care professionals must complete their portion of the Provider Preventable Conditions Notification form, HCA 12-200, and send it with the notification.

The agency may request medical records to retrospectively review PPCs, reported or non-reported, to determine if a claim requires denial, adjustment, or recoupment.

Medical record requests for retrospective UR

If the agency requests medical records during the retrospective utilization review process, submit a complete copy of the medical records within 60 calendar days from the date of request to:

Health Care Authority
Attn: Clinical Review Unit - Readmission
PO Box 45503
Olympia WA 98504-5503

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

- Face sheet
- Coding summary
- 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
- UB-04 claim form

Failure to submit a complete medical record and billing record may impede the utilization review process and delay the agency's determination. Failure to comply with the record request timeline may result in claim denial or recovery. There are no appeal rights for claims denied for untimely record request submission.

Hospital-issued notice of noncoverage (HINN)

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

- **Notifying a Washington Apple Health 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 Washington Apple Health client that the client no longer needs inpatient hospital medical care. The hospital is ***not required*** to obtain approval from the agency or the agency'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 the agency if a Washington Apple Health client decides to stay in the hospital when it is not medically necessary. A copy of this written notice must be sent to:

  Health Care Authority
  Attn: Clinical Review Unit - HINN
  PO Box 45503
  Olympia, WA 98504-5503

- **Reimbursement for services that are not medically necessary**

  The agency does not reimburse for hospital services beyond the period of medical necessity. A Washington Apple Health client who chooses to remain in the hospital beyond the period of medical necessity may choose to pay for continued inpatient care as an agency noncovered service. The client must accept financial responsibility. In order to bill the client for any noncovered service, providers must comply with the requirements in WAC 182-502-0160. These requirements are also published in the agency's ProviderOne Billing and Resource Guide.

  If a client refuses to leave the hospital once the client no longer needs inpatient hospital level of care, it is the responsibility of the hospital officials, not the agency, 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 the agency or the agency'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 PA process:

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

   a. Specifics as to what the dispute is regarding
   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 the following:

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

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

Health Care Authority
Attn: Provider Request/Client Notification Unit
PO Box 45506
Olympia, WA 98504-5506
Fax: 360-586-1471

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

   The hospital provider must submit a written dispute request with the following:

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

Send written dispute requests regarding #3 above to:

Health Care Authority
Attn: Clinical Review Unit - Disputes
PO Box 45503
Olympia, WA 98504-5503
Fax: 360-586-0212

Inpatient Hospital Psychiatric Admissions

Inpatient hospital psychiatric care criteria

Inpatient psychiatric care for all Washington Apple Health clients, including managed care enrollees (i.e., those on Title XIX and state programs), must be all of the following:

- Medically necessary (as defined in WAC 182-500-0070)
- For a principal covered diagnosis (see Diagnostic Categories)
- Approved (ordered) by the professional in charge of the hospital or hospital unit
- Certified/authorized by an RSN representative on behalf of the agency

Provider requirements

This provider guide does not apply to any of the following:

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

The agency 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 Division of Behavioral Health and Recovery (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

- Hospitals that provide active psychiatric treatment (see WAC 246-322-170) outside of a Medicare-certified or state-designated psychiatric unit, under the supervision of a physician

- State-designated pediatric psychiatric units

In addition to DOH licensure, hospitals providing **involuntary** hospital inpatient psychiatric care must be **certified** by the Department of Social and Health Services, Division of Behavioral Health and Recovery (DBHR) in accordance with WAC 388-865-0511 and must meet the general conditions of payment criteria in WAC 182-502-0100.

If a client is detained for involuntary care and a bed is not available in a facility certified by 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 RSN representative prior to commencement of the detention order.

Noncoverage

The psychiatric indigent inpatient program (PII) program does not cover ancillary charges for physicians, pharmacies, transportation (including ambulance), or other costs associated with a voluntary hospital inpatient psychiatric hospitalization (see WAC 388-865-0217). The PII program covers usual and customary charges for voluntary hospital inpatient psychiatric hospitalization submitted with a UB-04 form/data set type of bill 111. WAC 388-865-0217 defines the Psychiatric indigent inpatient program as a state funded, limited casualty (LCP) program specifically for mental health clients identified in need of inpatient psychiatric care by the regional support network (RSN).

Voluntary treatment

The RSN representative may authorize and pay for voluntary hospital inpatient psychiatric hospitalization services provided to clients who are receiving or have applied and are eligible for Washington Apple Health programs (e.g., Categorically Needy Program). For more information on Washington Apple Health programs, see the agency's ProviderOne Billing and Resource Guide.

Age of consent for voluntary inpatient hospital psychiatric care

Minors age 12 and younger:	May be admitted to treatment only with the permission of the minor's parent/legal guardian.
Minors age 13 and older:	May be admitted to treatment with the permission of any of the following: • The minor and the minor's parent/guardian • The minor without parental consent • The minor's parent/legal guardian without the minor's consent
Age 18 years 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 age 12 and older (see age of consent for voluntary inpatient hospital psychiatric care above) may be detained under the provisions of the Involuntary Treatment Act (ITA) as defined by chapters 71.05 and 71.34 RCW. The RSN representative authorizes and pays for services provided to clients who are receiving medical assistance. When the client is in the process of applying for Washington Apple Health, payment by the RSN representative is subject to the eligibility determination.

The RSN representative 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 Washington Apple Health program as described. These inpatient stays are paid for through the use of state funds.

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

Note: With ProviderOne and the elimination of PIC codes, PIC codes ending in Q (ITA-Q PICs) can no longer be improvised by hospital or RSN staff. When a hospital contacts an RSN for authorization of an involuntary patient without active eligibility whose need for services result from DMHP-petitioned or court ordered ITA status, the RSN will request creation of an ITA-based eligibility segment which will create a ProviderOne Client ID. Agency staff will need the following information:

1. **Name:** First, Last, Middle Initial
2. **Date of birth**
3. **Social Security Number** (if available.)
4. **WA county of residence**
5. **A brief summary of services and care to date (if possible.)**

Consent for involuntary admissions

Involuntary admissions occur in accordance with ITA in Chapters 71.05 and 71.34 RCW. Therefore, no consent is required. Only persons age 12 and older 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 for voluntary inpatient psychiatric care rules.

Authorization Requirements for Inpatient Hospital Psychiatric Care

The hospital must obtain PA from the appropriate RSN representative for *all* inpatient hospital psychiatric admissions when the agency is the primary payer. To view RSN information, visit the Department of Social and Health Services web site for Information for Mental Health Providers.

> **Note:** Information indicating which RSN is associated with an active recipient is available in the managed care section of the Client Benefit Level page under the Client tab in ProviderOne or through the Interactive Voice Response System.

This PA requirement includes clients eligible for both Medicare and Washington Apple Health 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, the agency will not pay for the services rendered. The RSN representative may not withhold its decision pending eligibility for Washington Apple Health and must issue a documented authorization decision within the timelines of this section upon hospital request regardless of whether or not third party liability (TPL) is present.

To determine which RSN to contact when RSN responsibility is unclear, refer to the designee flow chart.

Time frames for submission

Time frames for submission of PA requests are as follows:

- Hospitals must request authorization prior to admission. This PA requirement includes clients eligible for both Medicare and Washington Apple Health 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 RSN representative 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. RSN representatives are required to respond to requests for authorization within 2 hours and make a determination within 12 hours.

Length of Stay Extension: Unless the RSN representative specifies otherwise within the PA record, hospitals must submit requests for continued stay at least 24 hours prior to the expiration of the authorization period. A hospital may choose to submit a request more than 24 hours prior to an expiration of an authorization period. Whenever possible, hospitals are encouraged to submit extension requests during regular business hours. RSN representatives 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 RSN representative 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). RSN representatives 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 Washington Apple Health 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. RSN representatives acting as the PIHP have the authority to consider requests 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 182-550-2600.

- ✓ 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 RSN representative 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 RSN representative was contacted), the hospital must submit a separate request for authorization. The RSN representative 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 RSN representative within 30 days of discharge. The RSN representative 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 health care coverage under both Medicare and Washington Apple Health. In such cases, the following applies:

- Although hospitals are not required to seek the RSN representative's authorization for Medicare inpatient services, they *are* required to notify the RSN representative of a client's dual eligibility at the time of admission via phone or fax within the same calendar day as the admission. The RSN representative is responsible for the client's deductible, co-insurance, or co-payment, up to the agency 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 RSN representative at admission. RSN representatives 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 RSN representative prior to the anticipated benefit exhaustion for the remaining expected days. RSN representatives 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 RSN representative at admission if a client has commercial or private insurance that pays for hospital inpatient psychiatric care and has Washington Apple Health as a secondary payer. Hospitals are required to seek the RSN representative'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 RSN representative 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. RSN representatives 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. RSN representatives 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 RSN representative 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 RSN representative because a DMHP is required for detention and thus the RSN representative would already be notified. The RSN representative 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. RSN representatives 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. RSN representatives 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 RSN representative 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 RSN representative 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 RSN representative 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 RSN representative 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 RSN representative 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. RSN representatives 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 RSN representative, hospitals must notify the RSN representative 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 RSN representative will add the discharge date information to the ProviderOne PA record.

Denials

A denial must be issued by the RSN representative if the hospital believes medical necessity is met for a hospital level of inpatient care and the RSN representative 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 RSN representative 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 RSN representative 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 RSN representative may be appealed. Hospitals that disagree with a particular RSN representative's medical necessity determination for admission or number of days authorized must utilize the appeal process established by the RSN representative 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 42 CFR 431. The psychiatrist conducting the second review may not be part of the RSN representative's provider network. The review conducted by the second psychiatrist is final.

Administrative disputes

Concerns regarding an RSN representative on behalf of the agency'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 RSN representative must utilize the administrative dispute resolution process established by the RSN representative involved. If not resolved at the RSN representative level, hospitals may contact the Department of Social and Health Services' Division of Behavioral Health & Recovery (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 RSN representative so the designee may construct an accurate PA record within the following required timelines:

- **PA:** Hospitals must request authorization prior to admission. This 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 RSN representative 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. RSN representatives are required to respond to requests for authorization within 2 hours and make a determination within 12 hours.

  The PA record generated by the RSN provides the RSN representative's authorization of the:

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

  These days are important for billing purposes (see Billing 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 RSN representative for changes in all of the following:

- ✓ Legal status
- ✓ Principal covered diagnosis
- ✓ Hospital of service (see changes in status)

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

> **Note:** A PA record may be created for voluntary services before eligibility is established; however, a valid ProviderOne Client ID is required for payment. If the patient establishes eligibility, provide the ProviderOne Client ID to the RSN, then the RSN will add the ProviderOne Client ID to the PA record and payment may proceed.

- **Extension certification for admission to inpatient psychiatric care (extension certification):** The RSN representative must be contacted for requests for extension at least 24 hours prior to expiration of the currently authorized period, unless otherwise indicated by the RSN representative. A hospital may request an extension more than 24 hours prior to the expiration of the currently authorized period. The extension certification provides the RSN representative's authorization of the:

  - ✓ Authorized days (covered).
  - ✓ Administrative days, if applicable (paid at the administrative day rate).
  - ✓ Nonauthorized days (non-covered) for the extended stay.

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

  The RSN representative 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 RSN representatives 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 specific to Involuntary Treatment).

- **Retrospective certification for admission to inpatient psychiatric care (PA):** The PA subsystem is also used for retrospective certifications and provides the RSN representative's authorization for:

  - ✓ Authorized days (covered REV code units).
  - ✓ Administrative days, if applicable (paid at the administrative day rate).
  - ✓ Non-authorized days (noncovered) for the **extended** stay.

  Retrospective authorization may occur if the client becomes eligible for Washington Apple Health 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. An RSN representative on behalf of the agency has the authority to render authorization decisions 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 182-550-2600.

  - ✓ 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 RSN representative 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 RSN representative was contacted), the hospital must submit a separate request for authorization. The RSN representative 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 RSN representative within 30 days of discharge. The RSN representative must provide a determination within 30 days of the receipt of the required clinical documentation for the entire episode of care.

- **Administrative days:** The RSN representative 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.
  - ✓ The hospital and RSN representative mutually agree to the appropriateness of the administrative day.

- **Extensions for youth waiting for children's long-term inpatient program (CLIP):** The RSN representative 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 previously noted, 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 RSN representative may authorize or deny extensions or authorize administrative days. Hospitals and RSN representatives 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 the RSN representative may *not* authorize administrative days. The hospitals and RSN representatives 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).

- For the purpose of Inpatient Hospital Psychiatric Admissions, "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 Mental Disorders* published by the American Psychiatric Association) that is considered a principal covered diagnosis (see Diagnostic Categories) 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 RSN representative to make medical necessity determination, the hospital must provide the requisite DBHR - **required clinical data** for initial and extended authorizations. While RSN representatives may use different formats for collection of this clinical data, the data set that is required is the same regardless of which RSN representative is certifying the need for inpatient psychiatric care.

Note:	See the clinical data required for initial certification and clinical data required for extension certification requests.

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

  ✓ The RSN representative flow chart
  ✓ RSN contact information on the RSNs Services Information web page
  ✓ CSO and HCS Office Information List on the Community Services Offices web site

> **Note:** If the client is eligible for mental health services, their Regional Support Network (RSN) may appear under "Managed Care Information." See Key Step 2 "Identify the Primary Payer" of the ProviderOne Billing and Resource Guide.

- **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 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 RSN representative (see the agency's RSN representative designee flow chart.)

  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.

  The agency 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 required:

  ✓ 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
  206.298.9654

  Under the conditions of the At Risk/Runaway Youth Act, as defined in chapter 71.34 RCW, hospitals must provide the RSN representative 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 RSN representative. The RSN representative 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 Mental Disorders published by the American Psychiatric Association

  - ✓ An admission evaluation including:

    - ➢ Medical evaluation
    - ➢ Psychosocial evaluation

  - ✓ The hospital record face sheet

  - ✓ Other information about medical status including:

    - ➢ Laboratory work
    - ➢ Medication records
    - ➢ 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
- ✓ 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 all of the following 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
  - ✓ The agency 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
  - ✓ Immunization record, copy of social security card and birth certificate

- **Interfacility transfer reports -** When a youth who has been involuntarily detained is transferred from one facility to another, an interfacility 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, visit the Children's Long Term Inpatient Program for Washington State (CLIP) website.

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 contact the appropriate RSN so that the RSN may construct a valid PA record for voluntary or involuntary hospital inpatient psychiatric admission in accordance with the agency's Inpatient Hospital Services Provider Guide.

- 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 from the appropriate RSN representative.

- Each claim for inpatient psychiatric care must include an **authorization number**. The RSN representative that authorized the hospital admission must provide an authorization number. In order to receive payment, hospitals must ensure the authorization number appears in form locator 63 on the UB-04 claim. In addition, SCI=I or SCI=V (reflecting involuntary or voluntary legal status) must be noted in the "comments" section of the UB-04 claim form.

- Hospitals must obtain a **subsequent/new authorization** from the agency's RSN representative on an Initial Certification Authorization for Admission to Inpatient Psychiatric Care form, when there is a change in any of the following:

  - ✓ Legal status
  - ✓ Principal covered diagnosis
  - ✓ Hospital of service

- The PA record provides the hospital with authorization for all of the following:

  - ✓ Authorized days (covered REV code days)
  - ✓ Administrative days, if applicable (paid at the administrative payment methodology)
  - ✓ Nonauthorized days (non-covered) for the **initial** or **extended** stay respectively

- ✓ Date when the hospital must contact the RSN representative for an extension request

- An episode of inpatient care may require more than one certification or authorization record. To allow concurrent review, if the inpatient care requires additional days of care, authorization must be requested at least one day before the current authorization ends.

> **Note:** The agency's ProviderOne Billing and Resource Guide provides information on how to "Check Status of an Authorization."

- **Authorized (covered) days**: Authorized days are determined by the RSN representative utilizing legal status and clinical presentation. Authorized (covered) days on the billing claim form must match authorized days in the ProviderOne PA record.

- Days not authorized are considered noncovered. Hospitals must bill the covered and noncovered days on separate lines.

Example:

Revenue Code	Covered Days	Noncovered Days
0xx4	$xx.xx	
0xx4		$xx.xx

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

- Hospitals must bill approved psychiatric room charges using one of the following revenue codes: 0114, 0124, 0134, 0144 or 0204.

- Per coding standards, hospitals must report **all ICD 10 diagnosis codes at the highest level of specificity**.

> **Note:** The claim must indicate in the *Comments* section of the claim form whether the days billed were **voluntary** or **involuntary. Use one of the following special claims indicator to show how the client was admitted:**
>
> - **"SCI=V" for voluntary**
> - **"SCI=I" for involuntary**
>
> Claims for voluntary or involuntary portions of an episode of care must be authorized separately and billed separately.

Claims for psychiatric services when the principal diagnosis falls outside of the RSN psychiatric diagnosis range

For certain psychiatric diagnosis codes, coding rules require the associated neurological or medical condition be coded first. Such claims are reviewed and manually processed for payment when:

- An inpatient psychiatric admission to the hospital occurs on an involuntary or voluntary basis.
- The admission is authorized by an RSN representative on behalf of the agency.
- The principal diagnosis on the hospital claim is a medical diagnosis.

Billing instructions specific to involuntary treatment

- The agency will process claims for services provided to detained clients who have applied for Washington Apple Health and were denied if the RSN representative requests the creation of an ITA related eligibility segment (previously called ITA-Q).

- **Out-of-state hospitals** must obtain authorization from the appropriate RSN representative for all **Medicaid** clients. Neither the agency nor the RSN representative 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 Aged, Blind, or Disabled (ABD) program (formerly Disability Lifeline and GAU). For these clients, the agency and the RSN representative 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, the agency 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 RSN representative.

- **Psychologist services** are covered *only* for provision of a psychological evaluation of detained clients. (See the agency's Mental Health Services Provider Guide 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 not associated with at valid PA record, will be denied and require resubmission which will delay payment.

Billing instructions specific to IMDs participating in the MEPD project providing stabilizing treatment related to an emergency medical condition

Medicaid emergency psychiatric demonstration (MEPD) project stabilization care days must be billed separately from post stabilization care days. For the purpose of the MEPD project, the term ‘‘stabilized’’ means that the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

For the purpose of the MEPD project, the definition of **emergency medical condition** means an individual who expresses suicidal or homicidal thoughts or gestures or is determined dangerous to self or others by other means.

Note: If an MEPD emergency medical condition arises after an initial period of stabilization, MEPD cannot be billed for those days.

MEPD Note: The claim must indicate in the *claim notes/comments* section of the claim form whether the days billed were **voluntary stabilization** or **involuntary stabilization days.** Use one of the following special claims indicators to show that the services were provided for stabilization of an MEPD participant:

- **“SCI=V1” for voluntary stabilization service days**
- **“SCI=I1” for involuntary (ITA) stabilization service days**

Claims for stabilization services must be billed separately from post stabilization services. Post stabilization services must be billed with the special claims indicators of SCI=I, or SCI=V.

Billing when Medicare Part A benefits run out during the stay

If a client's Medicare coverage ends while receiving inpatient psychiatric care (due to limits on psychiatric inpatient coverage in IMDs) use an occurrence code with qualifier A3 and provide the last Medicare Part A payable date. Enter "Medicare benefits exhausted during stay" in claim comments field.

Billing for medical admissions with psychiatric principal diagnosis

If a client had a medical admission and the principal diagnosis is a psychiatric diagnosis (290-319), the claim will be reviewed prior to a payment decision. Providers must submit the claim with adequate documentation to support payment as a medical necessity (i.e., history and physical, discharge summary, and physician orders).

Note: If the client is covered by a managed care organization (MCO), the required documentation and claim must be submitted to the client's MCO. Do not send these claims to the Health Care Authority.

Recoupment of payments

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

Noted Exceptions

- The requirements in this section do not apply to three-day and five-day detoxification program admissions associated with the Division of Behavioral Health and Recovery (DBHR). See the Hospital-Based Inpatient Detoxification Provider Guide.
- For persons admitted involuntarily under Chapter 71.05 or 71.34 RCW, the exclusion of Non-psychotic Mental Disorders and Intellectual Disabilities do not apply.
- For persons with Medicare and Medicaid dual eligibility, the exclusion of Non-psychotic Mental Disorders and Intellectual Disabilities does not apply until the lifetime Medicare benefit has been exhausted.
- For medical inpatient detoxification (MID) see Utilization Review.

Clinical data required for initial certification

In addition to the information required for the PA record**,** the hospital must also provide the following data elements when seeking initial certification and authorization. While RSN representatives may use different formats for collection of this clinical data, the elements that are required are the same regardless of which RSN representative is certifying and authorizing the need for inpatient psychiatric care. RSN representatives 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 for the PA record**,** hospitals must also provide the following data elements when seeking an extension certification and authorization. While RSN representatives may use different formats for collection of this clinical data, the elements that are required are the same regardless of which RSN representative is certifying and authorizing the need for inpatient psychiatric care. RSN representatives use this information to determine medical necessity and (if authorized) the number of days authorized.

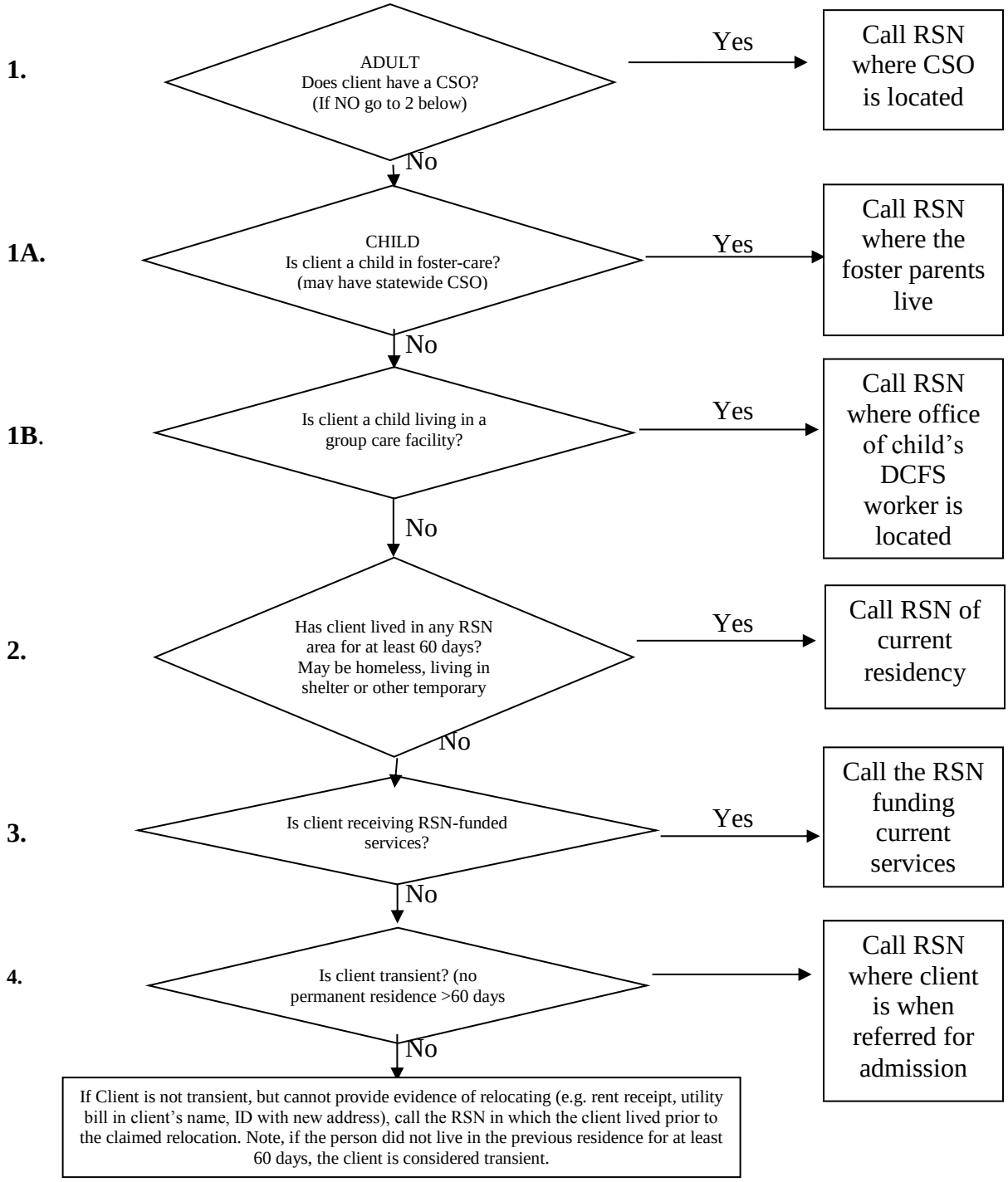
Course of Care	
Treatment Rendered	*All* inpatient services rendered since admission (medical and psychiatric tests, therapies, and interventions performed including type and frequency) and client response to treatment thus far.
Changes	Changes in diagnoses, legal status, TX plan, or discharge plan.
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.

Clinical data required for MEPD participants

IMD hospitals participating in the MEPD must also provide the following data elements directly to the state in quarterly implements:

Qualifying Emergency	
Emergency Admission Reason	1 = Suicidal thoughts and/or gestures. 2 = Homicidal thoughts and/or gestures. 3 = Both suicidal and homicidal thoughts and/or gestures. 4 = Determined to be a danger to self or others by means other than suicidal or homicidal.
Adverse Events	
Emergency Admission to an Acute Care Hospital	If the patient is transferred to an acute-care hospital, is the transfer due to an emergency condition? For each occurrence record: 1 = Yes. 2 = No. 8 = Not Applicable. 9 = Information not available.
Injury or infection	Report whether a patient injury or infection occurs during the IMD stay using the following data elements: 1 = Self-inflicted injury. 2= Nosocomial injury only. 3 = Nosocomial infection only. 4 = Both nosocomial injury and infection. 5 = Neither injury nor infection. 8 = Not applicable. 9 = Do not know/Refused.
Other Provider Preventable Conditions (OPPCs) (Adverse Events)	Hospitals must notify the agency in writing using the agency's Provider Preventable Conditions Notification form, HCA 12-200, within 45 days of filing an Adverse Event report with the Department of Health (DOH) associated with a Medicaid client.

Division of Behavioral Health (DBHR) and Recovery designee flow chart – "Which RSN to Contact"



Visit the DBHR website for Regional Support Networks (RSNs) Services Information.

General Billing

What are the general billing requirements?

Providers must follow the agency's ProviderOne Billing and Resource Guide. These billing requirements include the following:

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

How do I bill 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. Enter all of the following on the claim:

- Covered and noncovered charges on separate lines
- The entire stay from the admission date to the discharge date, including the dates the client was not eligible
- 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 Washington Apple Health. 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 the agency "fee-for-service" at the time of admission, the agency "fee-for-service" program covers the hospital stay if medically necessary. This is the case even if the client becomes enrolled in an agency 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, the agency 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 182-550-6000 (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?

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

Exception: The agency 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.

How do I bill for neonates/newborns?

Neonatal/newborn coding

- The agency considers children between birth and 28 days to be neonates or newborns.
- Hospitals must bill neonatal claims in accordance with ICD coding guidelines.
- The agency pays neonatal inpatient hospital claims according to the payment method associated with the DRG assigned on discharge or transfer.

Birth weight coding

When billing, providers must:

- Include birth weight on the inpatient birth claim and on any claim for a newborn that is younger than 29 days on admission.
- Submit birth weight on the 837i transaction or UB-04 claim using value code 54.
- Bill birth weight in grams using whole numbers.

Newborn on mother's ID

If the newborn has a ProviderOne Client ID, bill using the newborn's ID.

For services provided to newborns who have not yet received their Services Card, bill the agency using the mother's ProviderOne Client ID in the appropriate fields on the 837i transaction or UB-04 Claim Form. When billing for a newborn claim using the mother's ProviderOne Client ID, enter the baby's name, baby's birthdate, and the baby's gender in the subscriber/client information fields instead of the mother's information. In addition, you must use "SCI=B" in the comments field of the 837i transaction, or in the remarks box (box 80) of the UB-04 claim.

When billing for twins, enter twin identifying information in the comment or remarks area. For example, "SCI=A, Twin A" on the claim for the first child, "SCI=B, Twin B" on the claim for the second child. Each newborn must have services provided to that newborn billed on a separate claim.

When using special claims indicator (SCI) entries, everything following the "=" symbol will be read as part of your indicator. Do not enter any additional data after that or ProviderOne will not recognize your entry. Do not put any spaces in the entry or the information will not be recognized when processed.

Bill any services provided to the mother on a separate claim.

Note:	When a newborn no longer needs an acute inpatient level of care and an appropriate placement outside the hospital is available, the agency does not pay the all-inclusive administrative day rate for any additional days of the hospital stay for the newborn. (WAC 182-550-2900 (7))

For information on family planning services, including long acting reversible contraceptives (LARC), see the Family Planning Provider Guide.

Neonate revenue code descriptions

The agency 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. Hospital must meet American Academy of Pediatrics Level I facility guidelines
0171	Newborn – Level I	Level I Nursery/General Nursery Observation. Healthy newborns (birth weight > 2000 gms. or gestational age ≥ 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 ≤ 2 days, drug withdrawal management new or continued from higher level and NAS score 1-8; isolette/warmer for thermoregulation of neonates ≥ 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. Hospital must meet American Academy of Pediatrics Level I facility 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. Hospital must meet American Academy of Pediatrics Level IIA facility 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. Hospital must meet American Academy of Pediatrics Level IIB/IIIA facility guidelines.
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;

REV CODE	REVENUE CODE DESCRIPTION	LEVEL OF CARE
		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. Hospital must meet American Academy of Pediatrics Level IIIB/IIIC/IIID facility 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.

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 all of the following:

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

Present on admission indicators

The agency requires present on admission (POA) indicators on all inpatient claims. All inpatient claims will be reviewed for health care acquired conditions (HCAC) and will not receive additional payment related to treatment of the HCAC. For more information, see WAC 182-502-0022.

How to indicate a POA

On a UB-04 claim, the POA indicator is the eighth digit of the field locator (FL) 67, principal diagnosis, and the eighth digit of each of the secondary diagnosis fields, FL 67 A-Q.

In other words, report the applicable POA indicator (Y, N, U, or W) for the principal and any secondary diagnoses and include this as the eighth digit. Leave this field blank if the diagnosis is exempt from POA reporting.

Present on admission valid values

- N – No
- U – Unknown
- W – Undetermined
- Y – Yes

How to indicate a POA on a direct data entry claim

When submitting a claim using Direct Data Entry (DDE), submit the POA indicator in Diagnosis Information and/or Other Diagnosis information.

For each diagnosis entered, there is a box to enter the POA indicator.

How to indicate a POA on an electronic claim

Using the 837i, submit the POA indicator as follows:

Principal diagnosis – Submit the POA indicator in Loop 2300

Segment HI data element HI01-9External Cause of Injury – submit the POA indicator in Loop 2300, segment HI	Segment HI Data element HI07-9
Segment HI data element HI02-9	Segment HI Data element HI08-9
Segment HI data element HI03-9	Segment HI Data element HI09-9
Segment HI data element HI04-9	Segment HI Data element HI10-9
Segment HI data element HI05-9	Segment HI Data element HI11-9
Segment HI Data element HI06-9	Segment HI Data element HI12-9

Other diagnosis information – Submit the POA indicator in Loop 2300 segment HI – Other Diagnosis Information repeats 2 times for up to 24 other diagnosis. Report POA indicator for each Other Diagnosis submitted.

Segment HI data element HI01-9	Segment HI Data element HI07-9
Segment HI data element HI02-9	Segment HI Data element HI08-9
Segment HI data element HI03-9	Segment HI Data element HI09-9
Segment HI data element HI04-9	Segment HI Data element HI10-9
Segment HI data element HI05-9	Segment HI Data element HI11-9
Segment HI Data element HI06-9	Segment HI Data element HI12-9

Billing Specific to Hospital Services

Interim billing

The agency 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 all of the following:

- 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
- 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. The agency may retrospectively review interim billed claims to verify medical necessity of inpatient level of care and continued inpatient hospitalization.

Inpatient hospital stays without room charges

The agency suspends or denies Inpatient Hospital UB-04 claims if the room charges are not listed on the claim.

How do I bill for administrative days?

To receive payment for medical administrative days the hospital must bill administrative days with revenue code 0191 and all associated charges for those days on a claim separate from the acute care stay. This does not require PA for FFS clients.

For the acute care stay claim the provider must bill with inpatient status code 30 to indicate the provider will be submitting a separate claim for administrative days and include a claim note that states "Admin. days claim to follow".

Payment Methodology	Revenue Code	PA required?	Notes
Prospective Payment System (PPS)	0191	NO	Submit on a separate claim from acute care stay
Certified Public Expenditure (CPE)	0191	NO	Submit on a separate claim from acute care stay
Critical Access Hospitals (CAH)	0191	NO	Submit on a separate claim from acute care stay

To qualify for payment for administrative days related to per-diem-paid services such as PM&R, LTAC, and inpatient psychiatric, the hospital must request PA and bill approved administrative days with rev code 0169 on a separate claim.

Service	Revenue Code	PA required?	Notes
PM&R	0169	YES	Submit on a separate claim from acute care stay
LTAC	0169	YES	Submit on a separate claim from acute care stay
Inpatient Psychiatric	0169	YES	Submit on a separate claim from acute care stay

Note: For administrative days qualifying for payment under revenue code 0169, refer to Inpatient Hospital Psychiatric Admissions. For information on the Acute PM&R program, refer to the Acute Physical Medicine and Rehabilitation (PM&R) Provider Guide.

Billing acute inpatient stay when client elects hospice

When a client elects hospice during an inpatient stay, the hospital must use discharge status code 51 according to the National Uniform Billing Code (NUBC) excerpt below.

Questions and Answers from NUBC Manual

If a patient is discharged from acute hospital care but remains at the same hospital under hospice care, what discharge status code should be used for preparing the UB 04 for the acute stay	Discharge status code 51 – Hospice – Medical Facilities (Certified) Providing Hospice Level of Care.
Are the codes 50 (hospice/home) and 51 (hospice/facility) used by the hospital when the patient is discharged from an inpatient bed or are they only to be used on hospice or home health type of bills?	Use 50 or 51 if the patient is discharged from an inpatient hospital to a hospice.

How do effective dates for procedure and/or diagnosis codes affect processing of my claims?

The agency 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 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 the agency for hospital stay as primary.	Yes	Yes	Yes	Yes	Yes
Show as noncovered on the agency 's bill what was billed to Medicare under Part B.	No	No	Yes	Yes	Yes
Expect the agency to reduce payment for the hospital stay by what Medicare paid on the Part B bill.	Yes	Yes	No	No	No
Expect the agency to recoup payment as secondary on Medicare Part B bill*.	Yes	Yes	No*	No*	No*
Report the Part B payment on the claim in the other payer field “Medicare Part B”	Yes	Yes	Yes	Yes	Yes
Include a claim note**	Yes	Yes	Yes	Yes	Yes

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

**The claim note should be one of the following:

- No Part A benefits
- Part A benefits exhausted prior to stay

What the agency pays the hospital:

DRG Paid Claims:
DRG allowed amount minus what Medicare paid under Part B. When billing, put the Part B payment amount in the TPL commercial insurance field and indicate the primary payer as Medicare Part B.

Per Diem Paid Claims:
Per diem allowed amount minus what Medicare paid under Part B. When billing, put the Part B payment amount in the TPL commercial insurance filed and indicate the primary payer as Medicare Part B.

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

How do I bill for clients when Medicare coverage begins during an inpatient stay or Medicare Part A has been exhausted during the stay?

Providers bill for clients when Medicare coverage begins or Medicare Part A has been exhausted during an inpatient stay using the steps below. These instructions are also available in the ProviderOne Billing and Resource Guide.

1. Bill Medicare
   - Medicare PPS Payment Manual, Chapter 3, Section 40A, bullet 3 states:

   "The beneficiary becomes entitled after admission. The hospital may not bill the beneficiary or other persons for days of care preceding entitlement except for days in excess of the outlier payment."

2. The agency must have a paid/billed inpatient crossover claim in the system.

3. After the inpatient crossover claim is paid, bill the primary claim for the entire stay to the agency:
   - If billing ratio of costs-to-charges (RCC), certified public expenditures (CPE), or are a critical access hospital (CAH), list the Medicare covered day's charges as non-covered.
   - If billing DRG or per diem, list all services (do not list noncovered services).

4. If Part A is exhausted during the stay, bill Medicare for the Part B charges.

5. The agency may pay an amount using the following formula:
   - The agency's allowed amount for the entire stay minus Medicare's payment minus the agency's crossover payments

6. Add the following claim note:
   - "Part A Benefits exhausted during stay;" or
   - "Medicare Part A coverage began during the stay;" or
   - Enter the Part A start date or the date benefits are exhausted in the "occurrence" fields using occurrence Code "A3".

7. Attach Part A and Part B Medicare explanation of benefits (EOMB)

8. These claims can be very complex and are addressed on a case-by-case basis and sometimes it is necessary for the agency to contact the biller for additional information.

Required consent forms for hysterectomies

(WAC 182-531-1550(10))

- The agency 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 the agency-approved consent form to attach to their claim.
- **ALL** hysterectomy procedures require a properly completed the agency-approved consent form, regardless of the client's age or the ICD diagnosis.
- Submit the claim and completed the agency-approved consent form to the agency.

Download the
Hysterectomy Consent and Patient Information form, HCA 13-365

Completing the UB-04 Claim Form

Providers may access online webinars demonstrating how to submit institutional fee-for-service claims using direct data entry and how to upload a HIPAA batch file.

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.

Specific instructions for Medicare crossover claims

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 the agency 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
- 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
- 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 or Medicare Part A benefits are exhausted?

For all claims:

Include one of the following comments in Remarks section:

- "No Part A benefits"
- "Part A exhausted prior to stay"
- "Part A exhausted during stay"

If Medicare benefits are exhausted, report the last Medicare Part A coverage date using Occurrence Code A3.

When including "No Part A benefits" or "Part A exhausted prior to stay," follow the process as indicated below:

- **If your facility is reimbursed using PPS method (DRG and Per Diem):**

  - ✓ Enter "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).
  - ✓ Attach the Explanation of Medicare Benefit (EOMB) Parts A and B to the claim.

- **If your facility is reimbursed using the RCC (Ratio of Cost to Charges) method**

  - ✓ **Do not** enter "Part B" in form locator 50 (A,B,C).
  - ✓ Bill using Type of Bill 111.
  - ✓ Enter the amount covered by Medicare Part B for each service in the Non Covered column at line level, as applicable.
  - ✓ Attach the Explanation of Medicare Benefit (EOMB) Parts A and B to the claim.

Note: The agency will deny your claim if one of the following condition codes is submitted:

- Condition Code 04 – Information Only Bill
- Condition Code 21 – Billing for Denial Notice