

# Health and Recovery Services Administration (HRSA)



# Outpatient Hospital Services

## Billing Instructions

Chapter 388-550 WAC

## About this publication

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

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

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# Important Contacts

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

## How can I use the Internet to...

### Find information on becoming a DSHS provider?

Visit Provider Enrollment at:  
<http://hrsa.dshs.wa.gov/provrel>

Click *Sign up to be a DSHS WA state Medicaid provider* and follow the on-screen instructions.

### Ask questions about the status of my provider application?

Visit Provider Enrollment at:  
<http://hrsa.dshs.wa.gov/provrel>

- Click *Sign up to be a DSHS WA state Medicaid provider*
- Click *I want to sign up as a DSHS Washington State Medical provider*
- Click *What happens once I return my application?*

### Submit a change of address or ownership?

Visit Provider Enrollment at:  
<http://hrsa.dshs.wa.gov/provrel>

- Click *I'm already a current Provider*
- Click *I want to make a change to my provider information*

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

Visit the Customer Service Center for Providers at:  
<http://hrsa.dshs.wa.gov/provrel>

- Click *I'm already a current Provider*
- Click *Frequently Asked Questions*

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

or write to:

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

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

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

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

or write to:

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

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

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

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

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

Visit:  
WinASAP and WAMedWeb:  
<http://www.acs-gcro.com>

Click *Medicaid* then *Washington State*.

All other HIPAA transactions:  
<https://wamedweb.acs-inc.com>

To enroll with ACS EDI Gateway for HIPAA Transactions and/or WinASAP 2003, visit:  
<http://www.acs-gcro.com>

Click *Medicaid*, then *Washington State*, then *Enrollment*.

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

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

Call ACS at:  
1-800-833-2051 (toll free)

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

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

**How do I contact HRSA for information on, or to request...**

Limitation Extension (LE) or Exception to Rule (ETR)?

Fax: 1-360-586-1471  
Telephone: 1-360-725-1583  
Or mail to:  
Attn: LE Request or ETR Request  
PO Box 45506  
Olympia, WA 98504-5506

**Where do I send paper claims?**

Claims Processing  
PO Box 9248  
Olympia WA 98507-9248

**How do I obtain copies of billing instructions or numbered memoranda?**

To obtain DSHS/HRSA provider numbered memos and billing instructions, go to the DSHS/HRSA website at:

<http://hrsa.dshs.wa.gov>

(Click the *Billing Instructions and Numbered Memorandum* link). These documents may be downloaded and printed.

**How do I obtain DSHS forms?**

To **view and download** DSHS forms, visit DSHS Forms and Records Management Service online at:

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

# Definitions & Abbreviations

This section defines terms and abbreviations (includes acronyms) used in these billing instructions. Please refer to the DSHS/HRSA [General Information Booklet \(http://hrsa.dshs.wa.gov/download/BillingInstructions/General\\_Information\\_BI.pdf\)](http://hrsa.dshs.wa.gov/download/BillingInstructions/General_Information_BI.pdf) for other definitions.

**Allowed Amount** – The maximum amount for any procedure or service that DSHS allows as the basis for payment computation.

**Ambulatory Payment Classification (APC)** - A grouping that categorizes outpatient visits according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed.

**Authorization Requirement** – DSHS’s requirement that a provider present proof of medical necessity evidenced either by obtaining a prior authorization number or by using the expedited authorization process to create an authorization number.

**Budget Target Adjustor** - The DSHS established component of the APC payment calculation applied to all payable Ambulatory Payment Classifications (APCs) to allow DSHS to reach and not exceed the established budget target.

**Bundled Services** – Means interventions that are integral to the major procedure and are not paid separately.

**By Report (BR)** – A method of payment in which DSHS determines the amount it will pay for a service when the rate for that service is not included in the DSHS/HRSA published fee schedules. Upon request the provider must submit a "report" which describes the nature, extent, time, effort and/or equipment necessary to deliver the service.

**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.

**Emergency Services** – Healthcare services required by and provided to a patient after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

*For DSHS payment to a hospital, inpatient maternity services are treated as emergency services.*



**Expedited Prior Authorization Number (EPA)** – An authorization number created by the provider that certifies that the DSHS-published criteria for the medical/dental procedure or supply or services have been met.

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

**Hospital's Outpatient RCC Rate** - DSHS calculates a hospital's outpatient RCC rate by multiplying the hospital's inpatient RCC rate and the OPPS outpatient adjustment factor (OAF).

**ICD-9-CM - International Classification of Diseases, 9th Revision** - Clinical Modification Edition, classifies morbidity, and mortality information for statistical purposes, and for the indexing of hospital records by disease and operations, for data storage and retrieval, as well as the accurate and timely payment of medical claims. Providers are required by law to submit diagnosis codes for Medicare reimbursement and CMS has designated ICD-9-CM as the system to be used.

**Medically necessary** - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

**Modifier** - A two-digit alphabetic and/or numeric identifier that is 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.

**National payment rate (NPR)** - A rate for a given procedure code, published by the Centers for Medicare and Medicaid Studies (CMS), that does not include a state or location specific adjustment.

**Nationwide rate** - See National payment rate (NPR).

**National Provider Number (NPI)** – A unique 10 digit NPI numeric identifier. Covered health providers and all health plans and health care clearinghouses use the NPI number in the administrative and financial transactions adopted under HIPAA.

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

**OPPS outpatient adjustment factor** – The outpatient adjustment factor reduced by the OPSS and adjustment factor as a result of legislative mandate.

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

**Outpatient Care** – Health care provided other than inpatient services in a hospital setting.

**Outpatient Code Editor (OCE)** - Software program that DSHS uses for classifying and editing claims in ambulatory payment classification (APC) based OPSS.

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

**Outpatient prospective payment system (OPPS)** - The payment system used by DSHS to calculate reimbursement to hospitals for the facility component of outpatient services. This system uses ambulatory payment classifications (APCs) as the primary basis of payment.

**Outpatient prospective payment system (OPPS) conversion factor** – See outpatient prospective payment system (OPPS) rate.

**Outpatient prospective payment system (OPPS) rate** - A hospital-specific multiplier assigned by DSHS that is one of the components of the APC payment calculation.

**Outpatient RCC Rate** – See Hospital's Outpatient RCC Rate.

**Pass-throughs** - Certain drugs, devices, and biologicals, as identified by centers for Medicare and Medicaid Studies (CMS), for which providers are entitled to additional separate payment until the drugs, devices, or biologicals are assigned their own ambulatory payment classification (APC).

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

**Principal Diagnosis** - The condition established after study to be chiefly responsible for the admission of the patient to the hospital for care.

**Principal Procedure** - A procedure performed for definitive treatment, rather than diagnostic or exploratory purposes, or because it was necessary due to a complication.

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

- Who has a signed agreement with DSHS to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from DSHS.

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

**Short Stay** - See “Program Limitations-Outpatient Care” in these billing instructions.

**SI** - See status indicator.

**Significant Procedure** - A procedure, therapy, or service provided to a client that constitutes the primary reason for the visit to the healthcare professional.  
[Refer to WAC 388-550-7050]

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

**Third Party** - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client.

**Transfer** – To move a client from one acute care facility or distinct unit to another.

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

# About the Program

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## What is the Purpose of the Outpatient Hospital Services Program?

The Department of Social and Health Services (DSHS) covers outpatient services, emergency outpatient surgical care, and other emergency care administered to eligible clients and performed on an outpatient basis in a hospital.

## Payment Methods

DSHS pays for outpatient hospital services using several payment methods including, but not limited to, the following:

- Ambulatory Payment Classifications (APCs);
- Maximum Allowable Fee Schedule; and
- Ratio of Costs-to-Charges (RCC).

DSHS's Outpatient Prospective Payment System (OPPS) uses an APC-based reimbursement method as its primary reimbursement method. DSHS has modeled its OPPS after the Centers for Medicare and Medicaid Services (CMS) Prospective Payment System for Hospital Outpatient Department Services to pay certain hospitals for covered outpatient services provided to Medical Assistance clients.

**Note:** For a complete description of the CMS OPPS, including the assignment of status indicators (SIs), see 42 CFR, Chapter IV, Part 419, et al. The Code of Federal Regulations (CFR) is available from the CFR website online at: <http://www.gpoaccess.gov/cfr/index.html> and the Government Printing Office, Seattle office. The document is also available for public inspection at the Washington state library (a copy of the document may be obtained upon request, subject to any pertinent charge).

**Note: Effective for dates of service on and after July 1, 2009, only critical access hospitals are exempt from OPPS. [Refer to WAC 388-550-7100]**

## Payment Method Determination

DSHS's payment method is generally determined by the procedure and revenue codes on the claim line(s). DSHS will pay OPSS hospitals using the following methods in the following order:

- The APC method is used to pay for covered services for which CMS has established an APC weight or a national payment rate.
- The fee schedule is used to pay for covered services for which there is no established APC weight or nationwide payment rate and for services exempted from APC payment.
- The hospital's outpatient RCC rate, as described in WAC 388-550-4500, is used to pay for the covered services for which neither a nationwide payment rate nor a fee has been established.

## Outpatient Prospective Payment System (OPSS) Payment Calculation [Refer to WAC 388-550-7600]

DSHS follows CMS's discounting and modifier policies and calculates the APC payment as follows:

$$\text{APC payment} = \text{APC national payment rate} \times \text{the hospital OPSS rate} \times \text{Discount factor (if applicable)} \times \text{Units of service (if applicable)} \times \text{Budget target adjustor}$$

The total OPSS claim payment is the sum of: the APC payments and the lesser of billed charges or allowed charges for all non-APC services.

DSHS pays hospitals for claims that involve clients who have third-party liability (TPL) insurance, the lesser of either the:

- Billed amount minus the third-party payment amount; or
- Allowed amount minus the third-party payment amount.

### Packaged (Bundled) Services

Some ancillary (subordinate or secondary) services are packaged (bundled) for payment with a primary service. DSHS makes no separate payment for ancillary services. In establishing weights and payments rates, CMS and DSHS included payments for ancillary services in the payments for associated primary services.

The services packaged on a claim will depend on:

- The revenue code used with a given procedure;
- The status indicator assigned to given procedure;
- The status indicator assigned to other procedures on the same claim; and
- Which combinations of procedure codes appear on the same claim.

DSHS packaging practices generally follow those of CMS, which are complex but well described in federal rule. For a detailed history see Federal Register, 42 CFR Parts 410, 416, and 419.

**Note:** Payment to a provider may be denied or recouped if DSHS determines that an ancillary procedure should have been bundled with a procedure that was not covered.

### By Report Procedures

DSHS may require a special report for certain services provided to DSHS clients. These services are identified in the fee schedule by the listing **BR** (By Report). This special report must include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary for the procedure or service. You may also be required to provide additional information.

## Program Limitations

### Medical Necessity

DSHS will only pay for covered services and items that are medically necessary (see *Definitions & Abbreviations* section).

## Outpatient Hospital Services Provided Within One Calendar Day of DRG Paid Inpatient Admission

Outpatient hospital services must be billed on the inpatient hospital claim. This includes preadmission, emergency room, and observation services related to an inpatient hospital stay and provided within one calendar day of a client's inpatient hospital stay paid DRG method, (see WAC [388-550-6000](#) (3)(c)).

## Outpatient Short Stay

DSHS applies level of care and intensity of service criteria to determine if a hospital visit should be considered an inpatient stay or as an outpatient stay. DSHS determines if the level of care and intensity of service criteria are met.

A visit that does not meet level of care and intensity of service criteria as an inpatient claim will not be treated as or paid as an inpatient claim, even if the patient has been admitted as an inpatient. DSHS may treat such a claim as an outpatient short stay, but only if level of care and intensity of service criteria as an outpatient claim is met.

A visit that does not meet level of care and intensity of service criteria as an outpatient claim will not be treated as or paid as an outpatient claim.

**Effective for dates of service on and after July 1, 2009**, DSHS pays observation services procedure codes (G0378 and G0379) with the *maximum allowable fee payment method*. There are no changes in other policies related to observation services.



### Observation Services

The Department of Social and Health Services (the Department) pays Outpatient Prospective Payment System (OPPS) hospitals separately for observation when the stay is medically necessary for 8 or more hours. For stays less than 8 hours, the Department may pay for the direct admit if applicable.

The Department pays Critical Access Hospitals for observation services using the Outpatient Department Weighted Cost to Charges payment method when the service is allowed.

G0378 (observation) should be billed in accordance with Current Procedural Terminology (CPT), units = hours of service provided.

All observation services claimed with G0378 should be billed on one line. The line must have the date of service that was written on the observation order and include all hours for the incident of care.

## Changes in Admission Status

### What Is Admission Status?

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

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



## When Is a Change in Admission Status Required?

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

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

## Change from Inpatient to Outpatient Observation Admission Status

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

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

## Change from Outpatient Observation to Inpatient Admission Status

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

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

## Change from Inpatient or Outpatient Observation to Outpatient Admission Status

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

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

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

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

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

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

# Authorization

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## General Authorization

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

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

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

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

## “Write or Fax” Prior Authorization (PA)

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

Forms available to providers to request PA include:

- Fax/Written Request Basic form, DSHS 13-756; and
- Out of State Medical Services Request form, DSHS 13-787 (for elective, non-emergency out-of-state medical services). Refer to “Out-of-State Hospital Admissions” in this section for more information. DSHS forms are available online at <http://www.dshs.wa.gov/msa/forms/eforms.html>

**Note:** Be sure to provide all information. Incomplete forms will be returned to the provider.

Mail or fax the completed forms to:

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

## **Prior Authorization (PA) Requests**

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

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

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

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

# Specialty Services

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## Sleep Studies [Refer to WAC 388-531-1500]

### How Does a Sleep Lab Become a DSHS Center of Excellence?

A sleep lab must send DSHS verification of the following:

1. Sleep Lab Accreditation by the American Academy of Sleep Medicine;
2. Physician’s Board Certification by the American Board of Sleep Medicine; and
3. At least one Registered Polysomnograph Technician certification.

Send the verification to:

**Request for Sleep Lab Center of Excellence  
PO Box 45510  
Olympia, WA 98504-5510**

According to the standards of the Association of Polysomnographic Technicians, there must be one Registered Polysomnograph Technician (RPSGT) in the sleep lab when studies are being performed.

When the director of the sleep lab or the facility changes, providers must send DSHS copies of the accreditation for the new facility and/or certification of the new director.

### Billing for Sleep Studies

Providers must:

- Use CPT codes 95805 and 95807-95811 for sleep study services;
- Obtain an ENT consult for children younger than 10 years of age prior to study; and
- Documentation that the sleep study is performed to rule out obstructive sleep apnea or narcolepsy.

The following is a list of approved diagnosis codes for sleep studies:

DSHS Approved Sleep Study Diagnosis Codes							
327.10	327.12	327.20	327.23	327.27	327.51	780.51	780.54
327.11	327.14	327.21	327.26	327.42	347.00-347.11	780.53	780.57

## Organ Transplants

For details about the organ transplant program and bill please see the *Physician Related Services Billing Instructions* online at <http://hrsa.dshs.wa.gov/download/BI.html#p>.

### Services Performed in DSHS-Approved Centers of Excellence (COE)

[Refer to WAC 388-531-0650]

To view the DSHS Approved Centers of Excellence list for both Sleep Study and Transplant Centers of Excellence visit DSHS on line at:

<http://hrsa.dshs.wa.gov/HospitalPymt/>

## Certified Outpatient Diabetes Education

### Billing for Diabetes Education Services

- DSHS requires diabetes education services to be billed using revenue code 0942.

**Note:** DSHS requires authorized diabetes education programs to bill with revenue code 0942. Use of HCPCS procedure codes G0108 and G0109 will cause a denial of the claim.

- DSHS reimburses a maximum of **six (6) hours, or 12 one-half hour units, of patient education/diabetes management per client, per calendar year.**
- A minimum of **30 minutes of education/management must be provided** per session.
- Diabetes education may be provided in a group or individual setting, or a combination of both, depending on the client's needs.

**Note:** DSHS does not reimburse for diabetes education if those services are an expected part of another program provided to the client (e.g. school-based health services or adult day health services).

**Provider Qualifications/Requirements**

- All hospitals are eligible to apply to be a diabetes education provider. The Diabetes Control Program (DCP) at the Department of Health (DOH) develops the application criteria and evaluates all applications for this program.
- For more information on becoming a certified diabetes education provider and to obtain an application, write or call:

Department of Health  
Diabetes Prevention and Control Program  
PO Box 47855  
111 Israel Rd. SE  
Tumwater, WA 98501  
1-360-236-3695

**Other Requirements for Billing and Reimbursement**

- In order to participate in the diabetes education program, a licensed primary health care provider must refer the client.
- Hospitals must be approved by the Department of Health as a diabetes education provider.

DSHS reimburses hospital providers for diabetes education at the hospital's current RCC rate.



# Other Related Programs

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When billing for the following services, follow the individual program guidelines at:

<http://hrsa.dshs.wa.gov/download/BI.html>

## Medical Nutrition Therapy

DSHS reimburses the following provider types when medical nutrition therapy is provided by certified dietitians to DSHS-eligible clients following provider types:

- Advanced Registered Nurse Practitioners (ARNP);
- Certified Dietitians;
- Durable Medical Equipment (DME) suppliers;
- Health Departments;
- Outpatient Hospitals; and
- Physicians.

For additional information please see the DSHS/HRSA *Medical Nutrition Therapy Billing Instructions* at: <http://hrsa.dshs.wa.gov/download/BI.html#M>

## Physical Therapy [WAC 388-545-500]

DSHS pays for physical therapy provided to eligible clients as an outpatient hospital service according to WAC 388-545-500 and 388-550-6000.

A hospital must bill outpatient hospital physical therapy services using appropriate billing codes listed in the DSHS/HRSA current published billing instructions. DSHS does not pay outpatient hospitals a facility fee for such services.

**Note:** There should never be more than one bill for a single client for the same services (same revenue code, procedure code, and medical provider).

## Occupational Therapy [WAC 388-545-0300]

DSHS pays for occupational therapy provided as an outpatient hospital service to eligible clients according to WAC 388-545-300 and 388-550-6000.

The hospital must bill outpatient hospital occupational therapy services using appropriate billing codes listed in the DSHS/HRSA current published billing instructions. DSHS does not pay outpatient hospitals a facility fee for such services.

**Note:** There should never be more than one bill for a single client for the same services (same revenue code, procedure code (CPT/HCPCS), medical provider, and Date of Service.)

## Speech/Audiology Services [WAC 388-545-0700]

DSHS pays for speech therapy services and audiology provided to eligible clients as an outpatient hospital service according to this section and WAC 388-545-700 and 388-550-6000.

A hospital must bill outpatient hospital speech therapy services and audiology using appropriate billing codes listed in the DSHS/HRSA current published billing instructions. DSHS does not pay the outpatient hospital a facility fee for these services.

**Note:** There should never be more than one bill for a single client for the same services (same revenue code, procedure code (CPT/HCPCS), medical provider, and date of service.)

## Radiology Guidelines

Refer to the DSHS/HRSA *Physician-Related Services Billing Instructions* at: <http://hrsa.dshs.wa.gov/download/BI.html#p>.

## Pathology/Laboratory Guidelines

Refer to the DSHS/HRSA *Physician-Related Services Billing Instructions* at: <http://hrsa.dshs.wa.gov/download/BI.html#p>.

## Sterilization and Hysterectomy Procedures

Refer to the DSHS/HRSA *Physician-Related Services Billing Instructions* at: <http://hrsa.dshs.wa.gov/download/BI.html#p>.

## **Surgical and Medical Procedures & Evaluations**

Refer to the DSHS/HRSA *Physician-Related Services Billing Instructions* at:  
<http://hrsa.dshs.wa.gov/download/BI.html#p>.

## **Certified Neurodevelopmental Providers**

DSHS pays certified neurodevelopmental centers according to the DSHS/HRSA *Neurodevelopmental Centers Billing Instructions* at:  
<http://hrsa.dshs.wa.gov/download/BI.html#n>.

A hospital must bill for neurodevelopmental services provided to outpatient using appropriate billing codes listed in DSHS/HRSA current published billing instructions. DSHS does not pay outpatient hospitals a facility fee for such services.

There should never be more than one bill for a single client for the same services (same revenue code, procedure code, and medical provider).

## **Certified Kidney Centers**

Certified kidney centers:

- Are exempt from OPPS reimbursement methodology;
- Should bill using a kidney center provider number; and
- Bill using bill type 072x.

Bill type 072x is reimbursed according to the DSHS/HRSA *Kidney Center Services Billing Instructions*.

# Billing

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## What Are the General Billing Outpatient Hospital Requirements?

Providers must follow the general billing requirement in the DSHS/HRSA [General Information Booklet](http://hrsa.dshs.wa.gov/download/BillingInstructions/General%20Information%20BI.pdf) ([http://hrsa.dshs.wa.gov/download/BillingInstructions/General Information BI.pdf](http://hrsa.dshs.wa.gov/download/BillingInstructions/General%20Information%20BI.pdf)).

These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims;
- What fee to bill DSHS for eligible clients;
- When providers may bill a client;
- Billing for clients eligible for both Medicare and Medicaid; and
- Record keeping requirements.

## What Are Additional Outpatient Hospital Billing Requirements?

Providers are required to bill according to National Correct Coding Initiative (NCCI) standards. NCCI standards are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT®) manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practices. CMS maintains NCCI policy.

Information on NCCI can be found at: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

DSHS payment systems require consistent input to operate correctly. Providers are required to comply with these standards for DSHS to make accurate and timely payment.

All hospitals must bill all claims in a completely OPPS-ready format, as outlined by Centers for Medicare and Medicaid Services (CMS) and:

- Use CMS acceptable procedure codes where required;
- Use appropriate modifier;
- Use appropriate units of service; and
- Ensure all services provided on a single date of service are billed on the same claim form.

Hospitals are required to bill using applicable Revenue Codes, CPT® codes, HCPCS codes, and modifiers. All hospitals must use these codes and the line item date of service regardless of OPPS participation. For a list of all procedures and their associated fees see the DSHS/HRSA OPPS fee schedule available online at: <http://hrsa.dshs.wa.gov/hrates/opps/index.html>.

## Procedure Codes and Revenue Codes for Outpatient Hospital Services

DSHS/HRSA fee schedule for outpatient hospital services is a systematic listing and coding of procedures and services provided in outpatient settings. The fee schedule is based on the Physician's Current Procedural Terminology (CPT) and Level II HCPCS. Each procedure is identified by a five-character code to simplify reporting.

Located on the second tab of the fee schedule is legend outlining coverage indicators. The "Auth" column outlines potential limitations. Please refer to the parent program guidelines for additional information.

If an individual provider has contracted with the hospital to perform the professional component, the **hospitals must contact Provider Enrollment at 1-800-562-3022, press 2, select option 5** to be issued a *professional component provider number* to be reimbursed for services.

*Professional components* must be billed on a CMS-1500 claim form. Refer to the current DSHS/HRSA *Physician-Related Services Billing Instructions*.

You may view the DSHS/HRSA Outpatient Fee Schedules on-line at <http://hrsa.dshs.wa.gov/RBRVS/Index.html>

## Modifiers

DSHS follows the CCI guidelines for the use of modifiers, and accepts only the following CPT-approved modifiers on outpatient claims:

Modifiers						
25	50	58	73	76	78	91
27	52	59	74	77	79	

Inappropriate use of modifiers may result in claim line denials.

## Revenue Code Table

To view the DSHS/HRSA current Revenue Code Table, go online at:  
<http://hrsa.dshs.wa.gov/HospitalPymt/Outpatient/Index.htm>.

Use only the revenue and/or procedure codes that appear in the revenue code tables on the website above when billing for any outpatient hospital services. Use of any other codes will result in delay and/or denial of your claim.

## National Drug Code (NDC) Requirement

The National Drug Code (NDC) is an 11 digit code the manufacturer or labeler assigns to a pharmaceutical product.

The code's digits are ordered in a 5-4-2 grouping. [WAC 388-530-1050]

- The first group, comprised of five digits, contains the labeler code assigned to the manufacturer by the Federal Drug Administration (FDA).
- The second group, comprised of four digits, describes the ingredients, dose form, and strength.
- The last group, comprised of two digits, describes the package size. The NDC must contain 11 digits to be recognized as valid.

**Note:** Manufacturers commonly take off the NDC code's "leading zeros." It is important to re-insert these leading zeros when submitting a claim.

## Limitations and Other Requirements

Outpatient short stay, emergency room facility charges, and labor room charges are covered in combination when time periods **do not** overlap.

Hospitals must:

1. Report the line item service date, the admit hour, and the discharge hour on every outpatient claim.
2. Multiple visits on the same day must be unrelated in order to receive more than one payment.
3. Emergency room physicians' professional fees must be billed on a CMS-1500 claim form (refer to the current DSHS/HRSA *Physician-Related Service (RBRVS) Billing Instructions and Fee Schedule*) and must be billed under the emergency room physician provider number.
4. Civilian Health and Medical Programs of the Uniformed Services (CHAMPUS) clients must obtain a non-availability statement (NAS) for certain services not available at a military hospital before they can receive those services as an outpatient at a civilian hospital. The Department of Social and Health Services (DSHS) will not pay for any services that are included in NAS provisions. CHAMPUS' noncovered services may be billed to DSHS with appropriate documentation. (An NAS is used to bill CHAMPUS for payment.) This requirement is in addition to the NAS requirement already established for inpatient admissions.

For information regarding this requirement contact either of the following:

1. **Managed Care Division  
Madigan Army Hospital  
1-253-968-3491 or 1-253-968-0643**
2. **Your CHAMPUS Provider Relations Representative.**

## Noncovered Services

**DSHS requires all services to be listed on the UB-04 claim form, whether they are covered or noncovered, per requirements by CMS & UB-04.**

Following are examples of “other” noncovered items for hospitals. If one of these items has a revenue code, please report the appropriate code in the Noncovered field. Services not identified by a revenue code should be placed under subcategory, “General Classification.”

Bed Scales (if person is ambulatory)  
Cafeteria  
Circumcision Tray (routine circumcisions)  
Crisis Counseling  
Crutches (rental only is covered) No instruction  
Experimental or investigational medical services & supplies  
Father's Pack (not medically necessary)  
Food Supplements (except for qualified providers)  
Home Health Services  
Lab Handling Charges  
Medical Photographic Electronic & Video Records  
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)  
Portable X-ray Charges (portable charge fee is included in fee for procedures)  
Psychiatric Day Care  
Recreational Therapy  
Standby Equipment Charges (for oxygen, anesthesia, and surgery when no actual service is performed)

Routine tests and procedures (e.g., admission batteries, pre-anesthesia chest x-rays, fetal monitoring, etc.) are only covered if medically necessary\* and approved by physician.  
Take Home Drugs/Supplies  
Telephone-Telegraph/Fax  
Transportation (provided during hospital stay)  
Travel Time  
Whole Blood  
(Administration of blood is covered. These charges must clearly indicate administration fees.)



## Billing for Neonates/Newborns

For services provided to a newborn who has not yet received his/her Medical ID Card, bill DSHS using the parent's personal identification code (PIC) in the appropriate fields on the UB-04 Claim Form. When billing *electronically* for twins, enter twin identifying information in the comment or remarks area of the UB-04. For example, "Twin A", "baby on Mom's PIC", "Twin B." When billing on a *paper claim* for twins, enter the twin identifying information in the remarks box (box 80) in the lower left corner of the UB-04 form. Use a separate UB-04 claim form for each newborn. The claim will be denied if there is no identifying information for the twin.

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

## What is the Time Limit for Billing?

Initial claims and resubmitted claims are each subject to separate timeliness standards. These standards are specified in WAC 388-502-0150.

For more information about DSHS timeliness standards refer to the DSHS/HRSA *General Information Booklet* online at:

[http://hrsa.dshs.wa.gov/download/BillingInstructions/General\\_Information\\_BI.pdf](http://hrsa.dshs.wa.gov/download/BillingInstructions/General_Information_BI.pdf).

## Managed Care Clients

Clients with an identifier in the HMO column are enrolled in a Healthy Options managed health care plan and must request all outpatient hospital services under their designated plan. The plan's telephone number is located in the bottom right hand corner of the client's Medical ID card. Providers must receive authorization from the client's HMO primary care provider prior to providing services, **except for emergency services**.

## How Do I Bill for Clients Eligible for Medicare and Medical Assistance?

Please refer to the DSHS/HRSA *General Information Booklet* online at:

[http://hrsa.dshs.wa.gov/download/BillingInstructions/General\\_Information\\_BI.pdf](http://hrsa.dshs.wa.gov/download/BillingInstructions/General_Information_BI.pdf).

# UB-04 Claim Form

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Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the National Uniform Billing Committee at: <http://www.nubc.org/index.html>.

**Note:** When billing for clients make sure to include patient status.

## Specific Instructions for Medicare Crossovers

### How do I submit institutional services on a UB-04 crossover claim?

- Complete the claim form as if billing for a non Medicare client;
- Always attach the Explanation of Medicare Benefits (EOMB);
- Enter the third party (e.g. Blue Cross) supplement plan name in the appropriate. Enter **only** payments by a third party (e.g. Blue Cross) supplement plan and attach the EOMB.

### What Does DSHS Require From the Provider-Generated EOMB to Process a Crossover Claim?

#### Header level information on the EOMB must include all the following:

- Medicare as the clearly identified payer;
- The Medicare claim paid or process date;
- The client's name (if not in the column level);
- Medicare Reason codes; and
- Text in font size 12 or larger.

#### Column level labels on the EOMB for the UB-04 must include all the following:

- The client's name;
- From and through dates of service;
- Billed amount;
- Deductible;
- Co-insurance;
- Amount paid by Medicare (PROV PD);
- Medicare Reason codes; and
- Text that is font size 12.