Washington State Health Care Authority

Medicaid Provider Guide

Outpatient Hospital Services
[Chapter 182-550 WAC]

A Billing Instruction

About this publication

This publication supersedes all previous *Outpatient Hospital Medicaid Provider Guide* and related Provider Notices published by the Washington State Health Care Authority.

> **Note:** The Agency now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

The effective date of this publication is: **04/01/2012**

What Has Changed?

Reason for Change	Effective Date	Section/ Page No.	Subject	Change
Provider Notice 12-24	April 1, 2012	Page B.1	Authorization Requirements for Surgical Procedures	Add language regarding submitting authorization requests through Qualis Health for selected surgical procedures and spinal injections.
Provider Notice 12-24	April 1, 2012	Page D.4	Authorization Requirements for Surgical Procedures	Add hyperlink to Physician-Related Services/Healthcare Professional Services.

Copyright Disclosure

How Can I Get Agency Provider Documents?

To download and print the Agency's provider notices and Medicaid provider guides, go to the Agency's website at http://hrsa.dshs.wa.gov (click the ***Medicaid Provider Guides and Provider Notices*** link).

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Section D: Other Related Programs

Section E: Billing and Claim Forms

Important Contacts

Note: This section contains important contact information relevant to outpatient hospitals. For more contact information, see the Agency's *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Agency's *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Finding out about payments, denials, claims processing, or Agency managed care organizations	
Electronic or paper billing	
Finding Agency documents (e.g., provider guides, provider notices,and fee schedules)	
Private insurance or third-party liability, other than Agency managed care	
Prior authorization, limitation extensions, or exception to rule information and where to fax or send authorization forms	

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in this provider guide. Please refer to the Agency's Medical Assistance Glossary for a more complete list of definitions.

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 – The Agency'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 Agency-established component of the APC payment calculation applied to all payable Ambulatory Payment Classifications (APCs) to allow the Agency 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 the Agency determines the amount it will pay for a service when the rate for that service is not included in the Agency's 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. [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.

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 the Agency payment to a hospital, inpatient maternity services are treated as emergency services. [WAC 182-550-1050]

Expedited Prior Authorization Number (EPA) – An authorization number created by the provider that certifies that the Agency-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." [WAC 182-550-1050]

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

ICD-9-CM - International Classification of Diseases, 9th Revision, Clinical Modification Edition - The systematic listing that transforms verbal descriptions of diseases, injuries, conditions and procedures into numerical or alpha numerical designations (coding). [WAC 182-550-1050]

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).

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. [WAC 182-550-1050]

OPPS – See "Outpatient Prospective Payment System." [WAC 182-550-1050]

OPPS outpatient adjustment factor – The outpatient adjustment factor reduced by the OPPS and adjustment factor as a result of legislative mandate. [WAC 182-550-1050]

Outpatient – A patient who is receiving healthcare services in other than an inpatient hospital setting. [WAC 182-550-1050]

Outpatient Care – Health care provided other than inpatient services in a hospital setting. [WAC 182-550-1050]

Outpatient Code Editor (OCE) - Software program that the Agency uses for classifying and editing claims in ambulatory payment classification (APC) based OPPS.

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 the Agency 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. [WAC 182-550-1050]

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 the Agency 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. [WAC 182-550-1050]

Principal Diagnosis - The condition established after study to be chiefly responsible for the admission of the patient to the hospital for care. [WAC 182-550-1050]

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

Short Stay - See "Program Limitations-Outpatient Care" in this provider guide.

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 182-550-7050]

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

Transfer – To move a client from one acute care facility or distinct unit to another. [WAC 182-550-1050]

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 the Agency. [WAC 182-550-1050]

About the Program

What is the Purpose of the Outpatient Hospital Services Program?

The Health Care Authority (the Agency) 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

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

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

The Agency's Outpatient Prospective Payment System (OPPS) uses an APC-based reimbursement method as its primary reimbursement method. The Agency has modeled its OPPS after the Centers for Medicare and Medicaid Services (CMS) Prospective Payment System for Hospital Outpatient Agency 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: Only critical access hospitals are exempt from OPPS. **[Refer to WAC 182-550-7100]**

Payment Method Determination

The Agency's payment method is generally determined by the procedure and revenue codes on the claim line(s). The Agency will pay OPPS 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 (including Maximum Fee, By Report, Acquisition Cost, Injection Fee Schedule, and ASC methods) 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 182-550-4500, 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 (OPPS) Payment Calculation [Refer to WAC 182-550-7600]

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

APC payment =
APC national payment rate x the hospital OPPS rate x Discount factor (if applicable) x
Units of service (if applicable) x
Budget target adjustor

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

The Agency 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.
- 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. The Agency makes no separate payment for ancillary services. In establishing weights and payments rates, CMS and Agency 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.
- Which combinations of procedure codes appear on the same claim.

The Agency 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 the Agency determines that an ancillary procedure should have been bundled with a procedure that was not covered.

By Report Procedures

The Agency may require a special report for certain services provided to Agency 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

The Agency will only pay for covered services and items that are medically necessary. (Refer to WAC 182-500-0070).

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 182-550-6000 (3)(c)*).

Outpatient Short Stay

The Agency 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. The Agency 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. The Agency 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.

The Agency 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 Agency pays for observation services under the CMS rules for Extended Assessment and Management composites APC 8002 and APC 8003.

Details of the policy are described in the Medicare Claims Processing Manual: Chapter 4.

http://www.cms.gov/manuals/downloads/clm104c04.pdf

Composite APC policies, including Extended Assessment and Management, are described in §10.2.1. Observation services are described in detail in §290 of Chapter 4.

Some key elements of the CMS policy are:

Composite APC	Composite APC Description	Criteria for Composite Payment
8002	Level I Extended Assessment and Management Composite	1) Eight or more units of Healthcare Common Procedure Coding System (HCPCS) code G0378 are billed-- a) On the same day as HCPCS code G0379*; or b) On the same day or the day after CPT codes 99205 or 99215; and 2) There is no service with SI=T on the claim on the same date of service or 1 day earlier than G0378
8003	Level II Extended Assessment and Management Composite	1) Eight or more units of HCPCS code G0378** are billed on the same date of service or the date of service after 99284, 99285 or 99291; and 2) There is no service with SI=T on the claim on the same date of service or 1 day earlier than G0378

* Payment for direct admission to observation care (HCPCS code G0379) is made either under APC 0604 (Level 1 Hospital Clinic Visits) or APC 8002 (Level I Extended Management and Assessment Composite) or is packaged into payment for other separately payable services. See §290.5.2 of Chapter 4 for additional information and the criteria for payment of HCPCS code G0379.

** For additional reporting requirements for observation services reported with HCPCS code G0378, see §290.5.1 of Chapter 4.

- Observation hours (G0378) are always packaged;
  Composite payment may be made for G0379, 99205, 99215, 99284, 99285 or 99291 if criteria are met;

- All observation hours must be claimed on a single line of G0378, with a "from service date" corresponding to the date of the observation order, and units equal to the number of hours of active observation provided;

- Direct admission for hospital observation care (G0379) must always be claimed in conjunction with at least one unit of G0378;

- Direct admission units should reflect the number of direct admissions, not the number of observation hours.

Observation services must be reasonable and medically necessary to be covered. Only in rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

The Agency:

- Allows procedure code G0379 to be claimed with labor and delivery or other appropriate revenue codes;
- Continues to cover fetal monitoring w/report (59050) as a separate payable service;
- Requires observation hours (G0378) to be claimed with revenue code 0762; and
- Pays Critical Access Hospitals for observation services using the Outpatient Agency Weighted Cost to Charges payment method when the service is allowed.

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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:

- 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.

Authorization

General Authorization

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

Surgical Procedures that Require Medical Necessity Review by Qualis Health

The Agency and Qualis Health have contracted to provide web-based submittal for utilization review services to establish the medical necessity of selected surgical procedures in the following categories:

Spinal, including facet injections	Upper and lower extremities	Thoracic outlet release
Major joints	Carpal tunnel 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 more information about the requirements for submitting medical necessity reviews for authorization please refer to the Agency's current published *Physician-Related. Services/Healthcare Professional Services Medicaid Provider Guide* online at: http://hrsa.dshs.wa.gov/download/Billing_Instructions_Webpages/Physician-Related_Services.html.

Note: **Authorization does not guarantee payment.** The Agency'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 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).

"Write or Fax" Prior Authorization (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 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, HCA 13-756.
- Out of State Medical Services Request form, HCA 13-787 (for elective, non-emergency out-of-state medical services). Refer to "Out-of-State Hospital Admissions" in this section for more information. Agency forms are available online at http://hrsa.dshs.wa.gov/mpforms.shtml.

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

Mail or fax the completed forms to the Agency (see Important Contacts).

Prior Authorization (PA) Requests

The Agency reviews PA requests in accordance with WAC 182-501-0165 and utilizes 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.
- 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 the Agency took the action.
- Sufficient detail to determine what additional or different information might be provided to challenge the Agency'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.
- Example(s) of lesser cost alternatives that permit the affected party to prepare an appropriate response.

Note: Please see the Agency's *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for more information on requesting authorization.

Specialty Services

Sleep Studies [Refer to WAC 182-531-1500]

How Does a Sleep Lab Become an Agency Center of Excellence?

A sleep lab must send the Agency 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.
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 the Agency 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.
- 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:

Agency-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/Healthcare Professional Services Medicaid Provider Guide* online at http://hrsa.dshs.wa.gov/download/BI.html#p.

Services Performed in Agency-Approved Centers of Excellence (COE)

To view the Agency-Approved Centers of Excellence lists for Sleep Study, Hysterscopic Sterilization, and Transplant Centers of Excellence visit the Agency online at: http://hrsa.dshs.wa.gov/HospitalPymt/

> **Note:** For information about becoming accredited as a Center of Excellence for Hysteroscopic Sterilization, see the Agency's *Physician Related Services/Healthcare Professional Services Medicaid Provider Guide* at: http://hrsa.dshs.wa.gov/download/BI.html#p.

Certified Outpatient Diabetes Education

Billing for Diabetes Education Services

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

> **Note:** The Agency 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.

- The Agency 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:** The Agency 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.

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

Refer to the Agency's current published Diabetes Education Medicaid Provider Guide for more information.

Other Related Programs

When billing for the following services, follow the individual program guidelines at: http://hrsa.dshs.wa.gov/download/BI.html

Medical Nutrition Therapy

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

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

For additional information please see the Agency's current published Medical Nutrition Therapy Medicaid Provider Guide.

Physical Therapy [WAC 182-545-200]

The Agency pays for physical therapy provided to eligible clients as an outpatient hospital service according to WAC 182-545-200 and 182-550-6000.

A hospital must bill outpatient hospital physical therapy services using appropriate billing codes listed in the Agency's current published Medicaid provider guides. The Agency 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 182-545-0200]

The Agency pays for occupational therapy provided as an outpatient hospital service to eligible clients according to WAC 182-545-300 and 182-550-6000.

The hospital must bill outpatient hospital occupational therapy services using appropriate billing codes listed in the Agency's current published Medicaid provider guides. The Agency 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 182-545-0200 and 182-550-1500]

The Agency pays for speech therapy services and audiology provided to eligible clients as an outpatient hospital service according to this section and WAC 182-545-200 and 182-550-6000.

A hospital must bill outpatient hospital speech therapy services and audiology using appropriate billing codes listed in the Agency's current published Medicaid provider guides. The Agency 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

Effective for dates of services on and after October 1, 2011, the Agency has increased the number of procedures which require authorization, and the process for obtaining authorization has changed. Hospitals are expected to request authorization for any advanced imaging performed in the outpatient setting using web based authorization requests. The authorization requirement is ***not*** applicable to imaging performed during an emergency room visit or an inpatient stay.

When a professional interpretation, referred to as a **"read- only"**, is performed on a hospital performed outpatient advanced image, the interpreting radiologist must be added to the Agency's authorization record in order to receive payment. Therefore, the hospital must assure a prior authorization record has been created either by obtaining the authorization itself or assuring the ordering physician has obtained the authorization.

Refer to the Agency's current published Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide.

Pathology/Laboratory Guidelines

Refer to the Agency's current published Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide.

Sterilization and Hysterectomy Procedures

Refer to the Agency's current published Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide.

Surgical and Medical Procedures & Evaluations

Refer to the Agency's current published Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide.

Authorization Requirements for Surgical Procedures

[Refer to WAC 182-531-1700]

Changes in Authorization Requirements for Selected Surgical Procedures

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

Surgical Procedures that Require Medical Necessity Review by the Agency

To implement the prior authorization requirement for selected surgical procedures (including hysterectomies and other surgeries of the uterus), the Agency will also conduct medical necessity reviews for selected surgical procedures. The Agency will begin accepting requests for these medical necessity reviews April 1, 2012. For details about the PA requirements for these procedures, refer to:

- http://hrsa.dshs.wa.gov/download/Billing_Instructions_Webpages/Physician-Related_Services.html or

- http://hrsa.dshs.wa.gov/RBRVS/Index.html; and scroll down to Physicians-Related/Professional and Emergent Oral Healthcare Services, then select the most current Physician and Related Services fee schedule link. Select a procedure code and refer to the comments field for the accompanying submittal requirement.

Surgical Procedures that Require Medical Necessity Review by Qualis Health

The Agency and Qualis Health have contracted to provide web-based submittal for utilization review services to establish the medical necessity of selected surgical procedures in the following categories:

Spinal, including facet injections	Upper and lower extremities	Thoracic outlet release
Major joints	Carpal tunnel 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 more information about the requirements for submitting medical necessity reviews for authorization, please refer to the Agency's current published *Physician-Related. Services/Healthcare Professional Services Medicaid Provider Guide* online at: http://hrsa.dshs.wa.gov/download/Billing_Instructions_Webpages/Physician-Related_Services.html.

Certified Neurodevelopmental Providers

The Agency pays certified neurodevelopmental centers according to the Agency's current published Neurodevelopmental Centers Medicaid Provider Guide.

A hospital must bill for neurodevelopmental services provided to outpatient using appropriate billing codes listed in Agency's current published Medicaid provider guides. The Agency 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 their NPI and kidney center taxonomy code.
- Bill using bill type 072x.

Bill type 072x is reimbursed according to the Agency's Kidney Center Services Medicaid Provider Guide.

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Agency's *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments.
- What fee to bill the Agency for eligible clients.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- Billing for clients eligible for both Medicare and Medicaid.
- Third-party liability.
- Record keeping requirements.

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/

The Agency payment systems require consistent input to operate correctly. Providers are required to comply with these standards for the Agency 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.
- 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 Agency's OPPS fee schedule available online at: http://hrsa.dshs.wa.gov/hrates/opps/index.html.

Procedure Codes and Revenue Codes for Outpatient Hospital Services

The Agency's 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.

Professional components must be billed on a CMS-1500 claim form. Refer to the Agency's current published Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide.

You may view the Agency's Outpatient Fee Schedules on-line at http://hrsa.dshs.wa.gov/RBRVS/Index.html

Modifiers

The Agency 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.

The Agency does not currently use the *Ancillary Outpatient Services When Patient Expires* composite APC (0375). Use of the CA modifier will result in claim denial.

Revenue Code Table

To view the Agency's 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 182-530-1050]

- 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 Agency's current published Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide and Fee Schedule) and must be billed under the emergency room physician NPI.

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 Agency will not pay for any services that are included in NAS provisions. CHAMPUS' noncovered services may be billed to the Agency 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

The Agency 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 Services Card, bill the Agency using the parent's ProviderOne Client ID 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 ProviderOne Client ID", "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.

Are Clients Enrolled in an Agency Managed Care Plan Eligible? **[Refer to WAC 182-538-060 and 095]**

YES! When verifying eligibility using ProviderOne, if the client is enrolled in an Agency managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their managed care plan by calling the telephone number provided to them.

All medical services covered under a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

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

Note: To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. Providers must receive authorization from the client's HMO primary care provider prior to providing services, **except for emergency services**. See the Agency's *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Completing the UB-04 Claim Form

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

For more information, read # Memorandum 06-84.

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 form locator. Enter **only** payments by a third party (e.g. Blue Cross) supplement plan and attach the EOMB.

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 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.
- Text that is font size 12.