Washington State Health Care Authority

Washington Apple Health (Medicaid)

Inpatient Hospital Services Billing Guide

January 1, 2020

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect January 1, 2020, and supersedes earlier guides to this program.

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

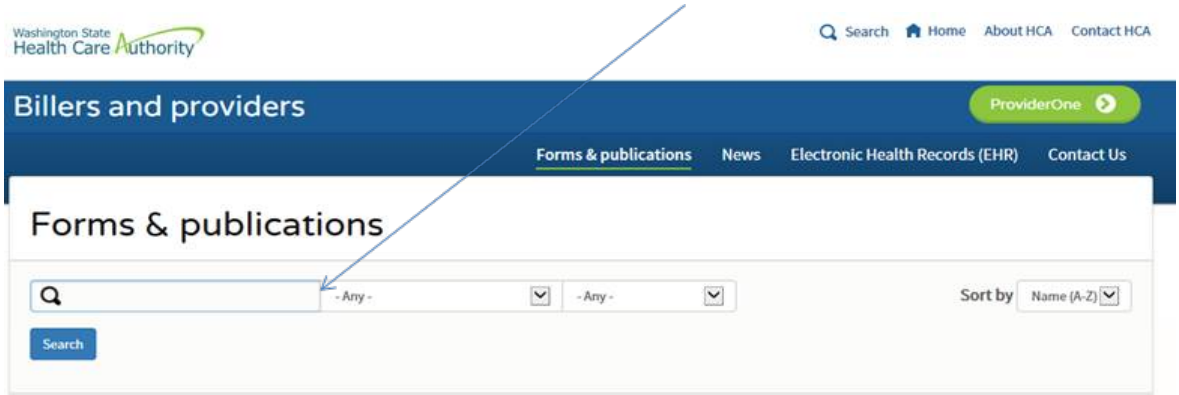
Refer also to the agency's ProviderOne Billing and Resource Guide for valuable information to help you conduct business with the agency.

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

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

Where can I download agency forms?

To download an agency provider form, go to the agency's Forms & publications webpage. Type the agency form number into the **Search box** as shown below (Example: 13-835).



* This publication is a billing instruction.

What has changed?

Subject	Change	Reason for Change
Are clients enrolled in an agency-contracted managed care organization (MCO) eligible?	Added dental surgical procedures to the list of services paid for by MCOs	Revised to align with current MCO coverage
Behavioral Health Organization (BHO)	Removed this section and other references to BHOs throughout the guide	Effective January 1, 2020, behavioral health services in all regions will be provided under integrated managed care.
Integrated Managed Care Regions	Effective January 1, 2020, integrated managed care is being implemented in the last three regions of the state: • **Great Rivers** (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties) • **Salish** (Clallam, Jefferson, and Kitsap counties) • **Thurston-Mason** (Mason and Thurston counties)	Effective January 1, 2020, HCA completed the move to whole person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (IMC).
Medical record requests for retrospective UR	The time allowed to submit requested medical records is the time period stated in the request.	Revised to align with WAC 182-502A-0401
Interim Billing	Added a note box stating that effective January 1, 2020, hospital and ASC facility fees for clients enrolled in a managed care organization must be billed directly through the client's MCO.	Revised to align with current MCO coverage.

Table of Contents

Resources Available **8**

Definitions **9**

Client Eligibility **22**

How do I verify a client's eligibility? 22
Are clients enrolled in an agency-contracted managed care organization (MCO) eligible? 23
Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160 24
Managed care enrollment 24
Apple Health – Changes for January 1, 2020 25
Clients who are not enrolled in an agency-contracted managed care plan for physical health services 25
Integrated managed care 26
Integrated managed care regions 27
Integrated Apple Health Foster Care (AHFC) 28
What if a client has third-party liability (TPL)? 28

Payment for Services **29**

How do I get paid? 29
Payment adjustments 29
General payment policies 30
Psychiatric services 30
Inpatient hospital psychiatric transfers 30
Transfers 30
Hospital readmissions 32
Provider preventable readmissions 32
Dispute resolution process for provider preventable readmissions 35
What are the agency's payment methods? 36
What are the agency's payment methods for state-administered programs? 37
Diagnosis related group (DRG) payment method (inpatient primary payment method) 38
Validation of DRG assignment 39
Valid DRG codes 40
DRG relative weights 40
DRG conversion factors 40
High outliers (DRG) 40
Qualifying for high outlier payment using DRG payment method 40
Calculating Medicaid high outlier payment 41
Calculating state-only-funded program high outlier for state administered program (SAP) claims 42

Alert! This **Table of Contents** is automated. Click on a page number to go directly to the page.

Transfer information for DRG payment method 42
Per diem payment method 43
Services paid using the per diem payment method....44
Hospitals paid using the per diem payment method 44
Transfers (per diem)....45
Fixed per diem payment method – (LTAC) 45
Transfers (per diem - LTAC)....45
Ratio of costs-to-charges (RCC) payment method 45
Hospitals paid using the RCC payment method 46
Certified public expenditure (CPE) 46
Payment for services provided to clients eligible for Medicare and Medicaid....46
Recoupment of payments....47
Noted Exceptions 47

Program Limitations 48

Medical necessity....48
Unbundling 48
Routine supplies....48
Components of room and board....49
Lab and pharmacy services 49
Equipment 49
Respiratory therapy 50
Specific items/services not covered 51
Administrative days 52
Rate guideline for new hospitals....52
Major trauma services....52
Increased payments for major trauma care 52
How does a hospital qualify for TCF payments from the agency?....53
TCF payments to hospitals for transferred trauma cases 54
TCF payment calculation....54
Cap on TCF payments 55
Use appropriate condition codes when billing for qualified trauma cases 55
Contacts....56

Authorization....58

General authorization....58
Authorization requirements for selected surgical procedures....59
"Write or fax" PA 59
How does the agency approve or deny PA requests? 60
Expedited prior authorization (EPA) 61
Surgical policies....61
Authorization requirements for surgical procedures....61
Surgical procedures that require a medical necessity review by the agency 61
Transgender health services....61
Surgical procedures that require a medical necessity review by Comagine Health 62
Breast Surgeries 63

Alert! This **Table of Contents** is automated. Click on a page number to go directly to the page.

Deliveries 63
Approved bariatric hospitals and associated clinics 63
Acute physical medicine and rehabilitation (PM&R) 64
Long-term acute care (LTAC) 64
Out-of-state hospital admissions (does not include hospitals in designated bordering cities) 65
Out-of-country hospital admissions 65
Hospitals approved for detoxification services through the Division of Behavioral Health and Recovery (DBHR) 66
Chemical-using pregnant (CUP) women 66
Medical inpatient detoxification (MID) services 66
What are the MID criteria? 66
What is MID authorization? 67
What authorization number is used when billing for MID? 67
What is the agency's allowed length of stay (LOS) for MID claims? 68
How do I bill the agency for MID services exceeding the 3 or 5-day LOS limitation? 68
Payment methods 71
For MID claims paid using the per diem payment method 71
For MID claims paid using the CPE payment method 71
Agency-approved centers of excellence (COE) 71
Experimental transplant procedures 72
Payment limitations 72
Ventricular assist device (VAD) and percutaneous ventricular assist device (PVAD) services 73
Transcatheter aortic valve replacement (TAVR) 73

Utilization Review 74

What is utilization review (UR)? 74
Agency program integrity retrospective UR 75
Changes in admission status 75
What is admission status? 75
When is a change in admission status required? 76
Change from inpatient to outpatient observation admission status 76
Change from outpatient observation to inpatient admission status 77
Change from inpatient or outpatient observation to outpatient admission status 77
Change from outpatient surgery/procedure to outpatient observation or inpatient admission status 78
Acute care transfers 78
Coding and DRG validations 78
DRG outliers 79
Length-of-stay (LOS) reviews 79
Hospital readmissions 79
Provider preventable conditions (PPCs) 80
Medical record requests for retrospective UR 80
Hospital-issued notice of noncoverage (HINN) 81

Adverse determination appeal process....82

General Billing 83

What are the general billing requirements? 83
How do I bill for clients who are eligible for only a part of the hospital stay? 83
How are outpatient hospital services prior to admission paid?....84
How are outpatient hospital services during an inpatient admission paid? 85
How do I bill for neonates/newborns?....85
Neonatal/newborn coding 85
Birth weight coding....85
Newborn eligibility and billing....85
Neonate revenue code descriptions....89
How do I bill for immediate postpartum long acting reversible contraception (LARC)? 91
Submitting adjustments to a paid inpatient hospital claim 92
Present on admission indicators....92
How to indicate a POA on a direct data entry claim....92
How to indicate a POA on an electronic claim....92

Billing Specific to Hospital Services 94

Interim billing 94
Inpatient hospital stays without room charges....94
How do I bill for administrative days? 95
How do hospitals bill for acute inpatient stay when a client elects hospice? 96
How do CPE hospitals bill for services provided to blind and disabled clients enrolled in managed care?....96
How do effective dates for procedure and/or diagnosis codes affect processing of my claims? 96
How do I bill for clients covered by Medicare Part B only (No Part A), or has exhausted Medicare Part A benefits prior to the stay? 97
What the agency pays the hospital:....97
How do I bill for clients when Medicare coverage begins during an inpatient stay or Medicare Part A has been exhausted during the stay?....98
Required consent forms for hysterectomies....99

Completing the Claim....100

How do I bill claims electronically? 100
What does the agency require from the provider-generated explanation of Medicare benefit (EOMB) to process a claim?....100
Specific instructions for Medicare crossover claims 101
How do I submit institutional services on a crossover claim?....101
How do I submit institutional services for inpatient clients who are eligible for Medicare Part B Benefits but not eligible for Medicare Part A Benefits or Medicare Part A benefits are exhausted?....101

Resources Available

Topic	Resource Information
Substance Use Disorder service providers	Directory of Certified Mental Health, Substance Use Disorder, and Problem & Pathological Gambling Services
Division of Behavioral Health and Recovery (DBHR)-certified hospitals for substance use disorder during pregnancy	See DBHR's *Pregnant Women Substance Use Disorder Resource Guide* on the agency's webpage.
Pregnancy Services	See the agency's Pregnancy Services webpage.
Sterilization	See the agency's Sterilization Supplemental Provider Guide.
Additional Medicaid agency resources	See the agency's ProviderOne Resources webpage.

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

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

Acute care - Care provided for patients who are not medically stable or have not attained a satisfactory level of rehabilitation. These patients require frequent monitoring by a health care professional to maintain their health status. (WAC 182-550-1050)

Acute physical medicine and rehabilitation (Acute PM&R) - A comprehensive inpatient rehabilitative program coordinated by an interdisciplinary team at an agency-approved rehabilitation facility. The program provides 24-hour specialized nursing services and an intense level of therapy for specific medical conditions for which the client shows significant potential for functional improvement. Acute PM&R is a 24-hour inpatient comprehensive program of integrated medical and rehabilitative services provided during the acute phase of a client's rehabilitation. (WAC 182-550-1050)

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

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

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

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

Allowable - The calculated amount for payment, after exclusion of any "nonallowed service or charge," based on the applicable payment method before final adjustments, deductions, and add-ons. (WAC 182-550-1050)

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

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

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

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

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

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

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

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

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

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

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

Authorization number - A nine-digit number, assigned by the agency that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Current Procedural Terminology (CPT) - A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians. CPT is copyrighted and published annually by the American Medical Association (AMA). (WAC 182-550-1050)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Emergency services - Health care services required by and provided to a client after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. For agency payment to a hospital, inpatient maternity services are treated as emergency services. (WAC 182-550-1050)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

High outlier claim--State-administered program DRG – A claim paid under the DRG payment method that does not meet the definition of administrative day, and has extraordinarily high costs as determined by the agency. See WAC 182-550-3700.

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

Hospice - A medically-directed, interdisciplinary program of palliative services for terminally ill clients and the clients' families. Hospice is provided under arrangement with a Washington state-licensed and Title XVIII-certified Washington state hospice. (WAC 182-550-1050)

Hospital - An entity that is licensed as an acute care hospital in accordance with applicable state laws and regulations, or the applicable state laws and regulations of the state in which the entity is located when the entity is out-of-state, and is certified under Title XVIII of the federal Social Security Act. The term “hospital” includes a Medicare- or state-certified distinct rehabilitation unit, a “psychiatric hospital” as defined in this section, or any other distinct unit of the hospital. (WAC 182-550-1050)

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

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

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

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

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

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

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

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

Intermediary – See **Fiscal intermediary.**

International Classification of Diseases (ICD) - The systematic listing of diseases, injuries, conditions, and procedures as numerical or alpha numerical designations (coding).

Length of stay (LOS) - The number of days of inpatient hospitalization, determined by counting the total number of days from the admission date to the discharge date, and subtracting one day. (WAC 182-550-1050)

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

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

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

Medically necessary – See WAC 182-500-0070.

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

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

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

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

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

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

Mental health designee - A professional contact person authorized by the Division of Behavioral Health and Recovery, who operates under the direction of a prepaid inpatient health plan (PIHP). See WAC 182-550-2600. (WAC 182-550-1050)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Principal diagnosis – The condition chiefly responsible for the admission of the patient to the hospital. (WAC 182-550-1050)
Prior authorization (PA) – See WAC 182-500-0085.

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

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

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

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

Psychiatric hospital - A Medicare-certified distinct psychiatric unit, a Medicare-certified psychiatric hospital, or a state-designated pediatric distinct psychiatric unit in a Medicare-certified acute care hospital. Eastern State Hospital and Western State Hospital are excluded from this definition. (WAC 182-550-1050)

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

Ratio of costs-to-charges (RCC) - A method used to pay hospitals for some services exempt from the DRG payment method. It also refers to the percentage applied to a hospital's allowed covered charges for medically necessary services to determine estimated costs, as determined by the agency, and payment to the hospital for some DRG-exempt services. (WAC 182-550-1050)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Swing bed day - A day in which a client is receiving skilled nursing services in a hospital designated swing bed at the hospital's census hour. (WAC 182-550-1050)

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

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

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

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

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

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

Client Eligibility

Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the agency's Apple Health managed care webpage for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health.** For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's ProviderOne Billing and Resource Guide.

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's Program Benefit Packages and Scope of Services webpage.

Note: Patients who are not Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's webpage at: www.wahealthplanfinder.org

2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)

3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

Are clients enrolled in an agency-contracted managed care organization (MCO) eligible?

(WAC 182-538-060 and 182-538-095)

Yes. Most Medicaid-eligible clients are enrolled in one of the agency-contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne. All services must be requested directly through the client's primary care provider (PCP). Clients can contact their MCO by calling the telephone number provided to them.

All medical services covered under an agency-contracted MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for payment of:

- Covered services
- Services referred by a provider participating with the MCO to an outside provider
- Dental surgical procedures

For certified public expenditure (CPE) hospitals that provide medical services to Categorically Needy Medicaid Blind/Disabled clients, bill those services fee-for-service to the agency. (For more information on billing for services provided to these clients, refer to the RAC eligibility codes.) In order to process those claims, the CPE hospital must obtain prior authorization from the MCO and submit that information to the agency in the *Claim Note* field on the claim in the manner shown below:

PA from [MCO Name]: [Authorization number]

Note: To prevent billing denials, 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 agency-contracted MCO, if appropriate. Providers must receive authorization from the client's MCO primary care provider before providing services, **except for emergency services**. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for. However, some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's Get Help Enrolling page.
- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Apple Health – Changes for January 1, 2020

Effective January 1, 2020, the Health Care Authority (HCA) completed the move to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

IMC is implemented in the last three regions of the state:

- **Great Rivers** (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties)
- **Salish** (Clallam, Jefferson, and Kitsap counties)
- **Thurston-Mason** (Mason and Thurston counties)

These last three regions have plan changes, with only Amerigroup, Molina, and United Healthcare remaining. There are changes to the plans available in these last three regions. The only plans that will be in these regions are Amerigroup, Molina, and United Healthcare. If a client is currently enrolled in one of these three health plans, their health plan will not change.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:
  Go to Washington HealthPlanFinder website.

- **Available to all Apple Health clients:**

  ✓ Visit the ProviderOne Client Portal website:

  ✓ Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

  ✓ Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

For online information, direct clients to HCA's Apple Health Managed Care web page.

Clients who are not enrolled in an agency-contracted managed care plan for physical health services

Some Medicaid clients do not meet he qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health

treatment for those clients. Clients who are not enrolled in an agency-contracted managed care plan are automatically enrolled in a BHSO, with the exception of American Indian/Alaska Native clients. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care

Clients qualified for managed care enrollment and living in integrated managed care (IMC) regions will receive all physical health services, mental health services, and substance use disorder treatment through their agency-contracted managed care organization (MCO).

Clients living in an integrated managed care region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care; or
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FSS]).

If a client does not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's American Indian/Alaska Native webpage.

For more information about the services available under the FFS program, see the agency's Mental Health Services Billing Guide and the Substance Use Disorder Billing Guide.

For full details on integrated managed care, see the agency's Apple Health managed care webpage and scroll down to "Changes to Apple Health managed care."

Integrated managed care regions

Clients residing in integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency's Apple Health managed care webpage.

Region	Counties	Effective Date
Great Rivers	Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum	January 1, 2020
Salish	Clallam, Jefferson, Kitsap	January 1, 2020
Thurston-Mason	Thurston, Mason	January 1, 2020
North Sound	Island, San Juan, Skagit, Snohomish, and Whatcom	July 1, 2019
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman	January 1, 2019
King	King	January 1, 2019
Pierce	Pierce	January 1, 2019
Spokane	Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties	January 1, 2019
North Central	Grant, Chelan, Douglas, and Okanogan	January 1, 2018 January 1, 2019 (Okanogan)
Southwest	Clark, Skamania, and Klickitat	April 2016 January 1, 2019 (Klickitat)

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as
"**Coordinated Care Healthy Options Foster Care.**"

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact the agency's Foster Care Medical Team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see the agency's Mental Health Services Billing Guide, under *How do providers identify the correct payer*?

What if a client has third-party liability (TPL)?

If the client has third-party liability (TPL) coverage (excluding Medicare), prior authorization must be obtained before providing any service requiring prior authorization. For more information on TPL, refer to the agency's ProviderOne Billing and Resource Guide.

Payment for Services

How do I get paid?

You must follow the general billing requirements in the agency ProviderOne Billing and Resource Guide. Also see General Billing for specific hospital inpatient information. The revenue code grid is available under the Inpatient Prospective Payment System (IPPS) heading on the agency's Hospital Reimbursement webpage.

Payment adjustments

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

- A claim qualifies as a high outlier.
- A claim is paid by the DRG method and a client transfers from one acute care hospital or distinct unit.
- A client is not eligible for a Washington Apple Health program on one or more days of the hospital stay.
- A client has third-party liability coverage at the time of admission to the hospital or distinct unit.
- A client is eligible for Part B Medicare, the hospital submitted a timely claim to Medicare for payment, and Medicare has made a payment for the Part B hospital charges.
- A client has state-only funded eligibility as indicated by the client's Recipient Aid Category (RAC), the hospital's payment methodology, and the service provided. Payments for inpatient state-administered programs may be reduced for these clients. See WAC 182-550-4800.
- The agency identifies an enhanced payment due to a provider preventable condition, hospital-acquired condition, serious reportable event, or a condition not present on admission.
- A client is discharged from an inpatient hospital stay and, within fourteen calendar days, is readmitted as an inpatient to the same hospital or an affiliated hospital. See Hospital readmissions for more information.
- A readmission is due to a complication arising from a previous admission. See Provider preventable readmissions for more information.

General payment policies

Psychiatric services

Policy and billing information about the following inpatient psychiatric admissions and hospital-based outpatient services at community hospitals are located in the agency's Mental Health Services Billing Guide:

- Those under the Involuntary Treatment Act (ITA)
- Involuntary admissions under the Alien Emergency Medical Program

Inpatient hospital psychiatric transfers

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

- Contact the appropriate mental health designee to obtain the following:
  - ✓ Prior approval of post-stabilization care
  - ✓ An authorization number
- Include the authorization number in the client's records for the receiving hospital and on the claim submitted by the receiving hospital (refer to the Mental Health Services Billing Guide).

> **Exception:** The transferring hospital does not need PA for clients who are enrolled in one of the recipient aid categories (RAC) listed in the agency's Mental Health Services Billing Guide.

Transfers

(WAC 182-550-3600)

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

The agency does not pay:

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

Note: For specific billing examples, see information under How do I bill for clients who are eligible for only a part of the hospital stay?

Note: When a client's eligibility has changed from fee-for-service (FFS) to managed care during a continuous hospital stay, or if the client becomes eligible for Medicaid and enrolled with an agency-contracted managed care organization (MCO) on the first day of the same month after the admission date but during the admission, the claim must include a comment in the following format:

"Continuous hospital stay MM/DD/YYYY- MM/DD/YYYY"

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

If on the initial admission date the client is FFS, the agency is responsible for payment for a continuous stay including transfers. Conversely, if on the initial admission date the client is managed care enrolled, the MCO is responsible for payment for a continuous stay including transfers.

See the examples below:

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

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

Example B:
A client is admitted to the hospital on 06/28/2016 and discharged on 07/15/2016, but the client's eligibility for Medicaid and managed care enrollment does not begin until 07/01/2016. The agency covers this admission. The claim note would say:

"Continuous hospital stay 06/28/2016 – 07/15/2016"

Hospital readmissions

(WAC 182-550-2900)

The agency does not pay for two separate inpatient hospitalizations if a client is readmitted to the same or an affiliated hospital or distinct unit within 14 calendar days of discharge, and the agency determines one inpatient hospitalization does not qualify for a separate payment.

The agency or an agency-contracted MCO may perform a retrospective prepayment utilization review of hospital readmissions for clients who are readmitted as an inpatient to the same hospital or an affiliated hospital within 14 calendar days. (Refer to your client's MCO for details specific to that MCO.) The agency may request medical records for the retrospective utilization review.

Note: When the agency requests medical records, do not resubmit the claim(s).

Submit the requested records to:

Clinical Review Unit
P.O. Box 45503
Olympia, WA 98504-5503

Medical records that the agency requests must be received within 60 days of the agency's request date to avoid further denial and/or recoupment of all associated claims.

Provider preventable readmissions

(WAC 182-550-2950)

Applicability

This section applies only to payments made for medically necessary inpatient hospital services provided to Medicaid fee-for-service (FFS) clients and managed care enrollees**.**

This section does not apply to:

- Critical access hospitals, which are excluded under WAC 182-550-2598.
- Psychiatric admissions.
- Professional claims submitted for services rendered in the inpatient setting during a readmission.

Note: The client's MCO will determine provider preventability as a post payment review, and if indicated, payment will be recouped. Patients are not liable for payment of provider preventable readmissions.

Provider preventable readmissions

The agency considers a readmission "preventable" if there was a reasonable expectation that it could have been caused by one or more of the following:

- The quality of care provided during the initial admission (a specific quality concern, known at the time of treatment, and resulting in the readmission, must be identified.)
- Inadequate post-discharge follow-up, planning, and care

> **Note:** Providers must create a complete and thorough discharge plan that addresses all aspects of home care and follow-up. See WAC 182-550-2950 for additional details.

If issues with quality of care, discharge planning or follow-up occurred, but cannot be reasonably considered the cause of the readmission, the agency does not recoup payment.

If a readmission is determined to be "preventable," the agency may request medical records to review both the index admission and any readmission(s) for consideration of appropriate payment. The initial request for medical records will include instructions on how to submit the medical records to the agency.

Exclusions

The agency excludes readmissions under the following circumstances from provider preventable readmissions:

- Readmission for reasons unrelated to conditions or care from the first admission
- Hospitalization with a discharge status of "left against medical advice" for prior admission
- Planned readmissions, including but not limited to:
  - ✓ Required treatments for cancer, including treatment related sequelae as well as care for advanced stage cancer
  - ✓ Repetitive, planned treatments or procedures for conditions such as chronic anemia, burn therapy, and renal failure
  - ✓ Planned therapeutic or procedural admissions following diagnostic admissions, when the therapeutic treatment clinically could not occur during the same admit

- Planned admission to a different hospital or hospital unit for continuing care (can include mental health/substance use disorder transfers, rehabilitation transfers, etc., which may be technically coded as discharge/admission for billing reasons)
- End of life and hospice care
- Readmission due to patient nonadherence to the discharge plan, despite appropriate discharge planning and supports. This also includes cases where the recommended discharge plan was refused by the patient, and a less appropriate alternative plan was made to accommodate patient preferences; this must be clearly documented in the client's record
- Obstetrical readmissions for birth after an antepartum admission
- Admissions with a primary diagnosis of mental health or substance abuse disorder issue
- Neonatal readmissions
- Transplant readmissions within 180 days of the transplant
- Readmissions when the first admission occurred in a different hospital system

Billing for planned readmissions

Example on how to bill for planned readmissions

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

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

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

- The subsequent admission claim must include "SCI=PR" (planned readmission) in the *Billing Note* section.
- In situations where the claim must be prepared using the *Billing Note* section for both required data elements described above, submit the claim using this format: "SCI=PR" "81"

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

Dispute resolution process for provider preventable readmissions

If a hospital disputes a determination for recoupment for a fee-for-service client, the agency follows the process in WAC 182-502-0050.

If a hospital disputes a recoupment determination for an agency-contracted managed care organization (MCO) client, the hospital must follow the MCO's internal dispute resolution process. If the hospital exhausts the MCO's internal dispute resolution process and continues to dispute the determination, the agency follows the 14-day readmission review program described in the Apple Health contract.

What are the agency's payment methods?

(WAC 182-550-3000)

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

Payment Method	General Description of Payment Formula	WAC Reference
DRG (Diagnostic Related Group)	The DRG specific relative weight times hospital specific DRG	182-550-3000
Per Diem	The hospital-specific daily rate for the service (psych, rehab, detoxification, or CUP) times covered allowable days	182-550-2600 and 182-550-4400
Fixed Per Diem for Long Term Acute Care (LTAC)	The fixed LTAC rate per day times the allowed days plus the RCC times the allowable covered ancillaries not included in the daily rate	182-550-2595 and 182-550-2596
Ratio of Costs-to-Charges (RCC)	The RCC times the covered allowable charges	182-550-4500
Cost Settlement with RCC	The RCC times the covered allowable charges (subject to hold harmless and other settlement provisions of the Certified Public Expenditure program)	182-550-4650 and 182-550-4670
Cost Settlement with Weighted Costs-to-Charges (WCC)	The WCC times the covered allowable charges subject to Critical Access Hospital settlement provisions	182-550-2598
Military	Depending on the revenue code billed by the hospital, both of the following: • The RCC times the covered allowable charges • The military subsistence per diem	182-550-4300
Administrative Day	The standard administrative day rate times the days authorized by the agency, added to the RCC times the ancillary charges allowable and covered for administrative days	182-550-3381 and 182-550-4550

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

(WAC 182-550-4800)

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

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

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

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

(WAC 182-550-3000)

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

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

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

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

- The inpatient hospital stay
- Outpatient hospital services, including preadmission, emergency department, and observation services related to an inpatient hospital stay and provided within one calendar day of a client's inpatient hospital stay. These outpatient services must be billed on the inpatient hospital claim
- Any hospital-covered service for which the admitting hospital sends the client to another facility or provider during the client's inpatient hospital stay, and the client returns as an inpatient to the admitting hospital
- The DRG payment method is based on all of the following:
  - ✓ The DRG code assigned to the claim by ProviderOne
  - ✓ The relative weight assigned to the DRG code
  - ✓ The hospital's specific DRG conversion factor

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

- Per diem
  - ✓ Psychiatric
  - ✓ Rehabilitation
  - ✓ Detoxification
  - ✓ Chemical-using pregnant (CUP) women
  - ✓ Long-term acute care (LTAC)
  - ✓ Administrative day
- RCC
  - ✓ Certified public expenditure (CPE) hospital
  - ✓ Military hospital

Validation of DRG assignment

(WAC 182-550-2900 (5))

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

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

- In accordance with the national uniform billing data element specifications in effect for the dates of service:
  - ✓ Developed by the National Uniform Billing Committee (NUBC).
  - ✓ Approved or modified, or both, by the Washington payer group or the agency.
  - ✓ In effect on the date of the client's admission.
- In accordance with the published International Classification of Diseases Clinical Modification (ICDCM) coding guidelines.

Valid DRG codes

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

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

DRG relative weights

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

DRG conversion factors

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

High outliers (DRG)

(WAC 182-550-3700)

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

Qualifying for high outlier payment using DRG payment method

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

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

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

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

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

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

Calculating Medicaid high outlier payment

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

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

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

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

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

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

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

- The agency uses the SAP DRG rate instead of the Medicaid DRG rate to calculate the DRG allowed amount.

- The agency multiplies the high outlier payment by the hospital's ratable.

The examples in the table below assume the following:

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

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

Transfer information for DRG payment method

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

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

The agency pays a transferring hospital a per diem rate when one of the transfer discharge status codes listed above is used in the *Discharge Status* field of the institutional electronic claim.

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

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

- Total DRG payment allowed amount calculation for the claim.

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

Example:
A client is admitted to Hospital A, transferred to Hospital B, then transferred back to Hospital A and is discharged. In this case, Hospital A, as a discharging hospital, is paid a full DRG allowed amount for the claim minus any final adjustments. Hospital B is paid a per diem amount.

Per diem payment method

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

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

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

Services paid using the per diem payment method

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

- Psychiatric, rehabilitation, detoxification, and Chemical-Using Pregnant (CUP) Women program services provided in inpatient hospital settings. The payment calculation is based on the per diem payment rate and the client's length of stay.

  - ✓ No outlier adjustment is made for per diem services.

  - ✓ Chemical-Using Pregnant (CUP) Women services are identified by revenue code 129, not by APR-DRG classification. Refer to the Chemical-Using Pregnant (CUP) Women Program Billing Guide for more information.

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

Note: For psychiatric admission rules, refer to the Mental Health Services Billing Guide. For information on the Acute PM&R program, refer to the Acute Physical Medicine and Rehabilitation (PM&R) Billing Guide.

Hospitals paid using the per diem payment method

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

- **Psychiatric hospitals**

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

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

  - ✓ Eastern State Hospital
  - ✓ Western State Hospital
  - ✓ Psychiatric evaluation and treatment facilities

- **Rehabilitation hospitals**

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

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

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

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

Transfers (per diem)

See Transfers.

Note: No transfer payment policy is applied to services paid using the per diem payment methods. Other policies to transfers may apply (refer to the Mental Health Services Billing Guide).

Fixed per diem payment method – (LTAC)

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

Transfers (per diem - LTAC)

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

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

(WAC 182-550-4500)

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

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

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

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

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

Hospitals paid using the RCC payment method

The agency uses the RCC payment method to pay the following types of hospitals:

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

Certified public expenditure (CPE)

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

Payment for services provided to clients eligible for Medicare and Medicaid

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

Recoupment of payments

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

Noted Exceptions

For medical inpatient detoxification (MID) see Utilization Review.

Program Limitations

Medical necessity

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

Unbundling

The agency does not pay separately for unbundled services billed on an inpatient claim by a hospital. These services are accommodation costs and are considered part of the "bundled services" under the diagnosis code billed on the claim, per WAC 182-550-1050**.** The following are general categories and examples of inpatient facility charges that are not separately billable or reimbursable.

Routine supplies

Routine supplies that are not separately billable or reimbursable include, but are not limited to:

- Supplies that are included in the cost of the room, such as linens, personal protective equipment, reusable equipment, floor stock items
- Items commonly available to clients in a particular setting
- Items ordinarily used for or on most clients in that area or department
- Not reusable or representative of a cost for each preparation
- Kits that contain routine stock items, such as an IV start kit or urine catheter kit

For an item to be separately billable and reimbursable, it must be both of the following:

- Directly identifiable to the individual client with specific documentation or easily inferred documentation
- Furnished at the direction of a physician because of specific medical needs

Components of room and board

Bedside nursing services (defined in WAC 182-550-1050) that are included in the room and board services paid to regular and special care hospitals are not separately billable or reimbursable. Examples include, but are not limited to:

- Blood and blood components, under the conditions described in WAC 182-550-6500
- Dressing changes
- Hemodynamic monitoring
- Incremental nursing care (1:1 in ICU, CCU, etc.)
- IV insertion Medication administration and infusion of fluids
- Performance of point of care testing
- Respiratory treatments
- Tube feedings
- Urinary catheterization

Lab and pharmacy services

Lab and pharmacy services that are included in the bundled charge and are therefore not separately billable or reimbursable include, but are not limited to:

- Blood draws from venous or arterial devices, regardless of the practitioner doing the draw
- Capillary blood collection (heel sticks or finger sticks)
- Low osmolar contrast for radiology procedures
- Pharmacy consultations for medication management or education

Equipment

The following equipment is not separately billable or reimbursable:

- Equipment commonly available to clients in a particular setting or ordinarily furnished to clients during the course of a procedure, whether hospital-owned or rented, and supplies used in conjunction with this equipment

- Equipment that is used to provide services to multiple clients and has an extended life

- Equipment that is required for the level of care being provided, such as cardiac monitoring, oximetry, as well as leads, batteries, maintenance and calibration of this equipment

Examples of equipment not separately billable or reimbursable include, but are not limited to:

- Anesthesia machines
- Arterial/Swan Ganz monitors
- Automatic blood pressure machines and/or monitors
- Cameras
- Cardiac monitors
- Cautery machines
- Cell Saver equipment
- CO_2 End Tidal monitors
- Fetal monitor
- Instruments
- IV pumps
- Lasers
- Microscopes
- Neurological Monitors
- Oximetry monitors
- Rental equipment
- Scopes
- Thermometers
- Ventilators

Respiratory therapy

The care of a client with respiratory needs and all related equipment, oxygen, services, and supplies, as described in WAC 182-552-0005, are not separately billable or reimbursable. Examples include, but are not limited to:

- Client's own CPAP/BiPAP equipment

- Respiratory assessments and suctioning when done as part of a treatment or when client is on a ventilator

- Ventilator setting changes, checks, weaning and extubation

Specific items/services not covered

The agency does not pay for an inpatient or outpatient hospital service, treatment, equipment, drug, or supply that is not described as a covered service in Chapter 182-550 WAC. Noncovered items and services include, but are not limited to:

- Ancillary services, such as respiratory and physical therapy, performed by regular nursing staff assigned to the floor or unit
- Cafeteria charges
- Crisis counseling
- Handling fees and portable X-ray charges
- Medical photographic or audio/videotape records
- Personal care items such as, but not limited to, slippers, toothbrush, comb, hair dryer, and make-up
- Psychiatric day care
- Robotic assisted surgery (RAS)
- Room and equipment charges ("rental charges") for use periods concurrent with another room or similar equipment for the same client
- Routine hospital medical supplies and equipment such as bed scales
- Services and supplies provided to nonclients, such as meals and "father packs”
- Standby personnel and travel time
- Telephone/telegraph services or television/radio rentals

Note: Although RAS may be considered medically necessary, the agency does not pay separately for HCPCS code S2900 and reimburses only for the underlying procedure. The agency requires billing providers to bill for RAS in order to track utilization and outcome. The agency will monitor RAS through retrospective auditing of applicable ICD 10 procedure codes, and review of operative reports.

Administrative days

Administrative days are days of an inpatient hospital stay when an acute inpatient or observational level of care is no longer medically necessary and one of the following is true:

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

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

Rate guideline for new hospitals

(WAC 182-550-4100)

New hospitals are those entities that do not have base year costs on which to calculate a rate. A change in ownership does not constitute the creation of a new hospital. See WAC 182-550-4200 for information on change of ownership.

Major trauma services

Increased payments for major trauma care

The Washington State Legislature established the Trauma Care Fund (TCF) in 1997 to help offset the cost of operating and maintaining a statewide trauma care system. The Department of Health (DOH) and the agency receive funding from the TCF to help support provider groups involved in the state's trauma care system.

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

A hospital is eligible to receive trauma supplemental payments only for a patient who is a **Medicaid (Title XIX)** client. The client must have an Injury Severity Score (ISS) of:

a. 13 or greater for adults (age 15 or older)

b. 9 or greater for pediatric clients (age 14 or younger)

c. Less than (a) or (b) when **received** in transfer by a Level **I, II, or III** trauma service center from a lower-level facility. (The receiving facility is eligible for TCF payment regardless of the ISS; the transferring facility is eligible only if the case met the ISS criteria above.)

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

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

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

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

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

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

TCF payments to hospitals for transferred trauma cases

When a trauma case is transferred from one hospital to another, the agency makes TCF payments to hospitals according to the ISS, as follows:

- If the transferred case meets or exceeds the appropriate ISS threshold (ISS of 13 or greater for adults and 9 or greater for pediatric clients), **both** transferring and receiving hospitals are eligible for TCF payments. The transfer must have been to a higher-level designated trauma service center, and the transferring hospital must be a Level II or Level III hospital. Transfers from a higher-level to a lower-level designated trauma service center are not eligible for TCF payments.

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

TCF payment calculation

The agency has an annual TCF appropriation. The agency distributes its TCF appropriation for hospital services in five periodic supplemental payments. Hospitals receive a percentage of a fixed periodic distribution amount. Each hospital's percentage share depends on the total qualified trauma care provided by the hospital during the service year to date, measured against the total qualified trauma care provided by designated Levels I-III trauma service centers during the same period.

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

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

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

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

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

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

Cap on TCF payments

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

Use appropriate condition codes when billing for qualified trauma cases

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

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

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

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

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

Trauma claim adjustments

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

The agency does not make any TCF payment for a trauma claim adjusted after 365 days from the date of the qualifying service. The deadline for making adjustments to a trauma claim is the same as the deadline for submission of the initial claim. WAC 182-502-0150(7) and 182-502-0150(8) do not apply to TCF payments; see WAC 182-502-0150(11).

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

Injury severity score (ISS)

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

The ISS is a summary severity score for anatomic injuries.

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

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

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

Contacts

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

Department of Health
Office of Community Health Systems
Trauma System Webpage

For information on **payment**, contact:

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

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

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

Authorization

General authorization

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

> The agency's authorization process applies to medically necessary covered health care services only and is subject to client eligibility and program limitations. Not all categories of eligibility receive all health care services. **For example:** Therapies are not covered under the Family Planning Only Program. All covered health care services are subject to retrospective utilization review to determine if the services provided were medically necessary and at the appropriate level of care. **Authorization does not guarantee payment.** Requests for noncovered services may be reviewed under the exception to rule policy. See WAC 182-501-0160.

To request a prior authorization (PA), concurrent authorization, or retroactive authorization, **providers may submit a request online through direct data entry into ProviderOne** (see the agency's Prior authorization webpage for details).

Providers may also use the written or fax authorization process. Providers must complete:

- A *General Information for Authorization* form 13-835. This request form must be the initial page when you submit your request
- Evidence-based decision making
- Utilization review (UR)
- Any medical justification to support the request

Fax all documentation to **866-668-1214**

> **Note:** For psychiatric admission rules, refer to the Mental Health Services Billing Guide. For information on the Acute PM&R program, refer to the Acute Physical Medicine and Rehabilitation (PM&R) Billing Guide.

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

Authorization requirements for selected surgical procedures

The agency's PA requirements include selected surgical procedures. Medical necessity reviews for surgical procedures are conducted by the agency or Comagine Health.

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

"Write or fax" PA

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

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

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

To access these forms, see Where can I download agency forms?

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

Send one of the completed fax forms listed above to the agency to the fax number listed on the form.

How does the agency approve or deny PA requests?

The agency reviews PA requests in accordance with WAC 182-501-0165 and uses evidence-based medicine to evaluate each request. The agency evaluates and considers all available clinical information and credible evidence relevant to the client's condition. At the time of the request, the provider responsible for the client's diagnosis and/or treatment must submit credible evidence specifically related to the client's condition. Within 15 days of receiving the request from the client's provider, the agency reviews all evidence submitted and does one of the following:

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

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

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

Expedited prior authorization (EPA)

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

Surgical policies

Authorization requirements for surgical procedures

(WAC 182-531-1700)

Surgical procedures that require a medical necessity review by the agency

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

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

Transgender health services

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

How do clients update their gender field?

- Clients who applied through the Healthplanfinder must call the agency's Medical Eligibility Determination Section toll free 1-855-623-9357.
- Clients who applied through the Community Service Office (CSO) must call toll-free 1-877-501-2233 or report online at Washington Connection.

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

How do clients update or change their name?

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

- Clients who applied through the Healthplanfinder must call toll-free 1-855-623-9357.
- Clients who applied through the Community Service Office (CSO) must call toll-free 1-877-501-2233 or report online at Washington Connection.

Managed care clients

Covered by a managed care organization (MCO): If a client is enrolled in managed care, the MCO is responsible for all medical care including hormone and mental health services to treat gender dysphoria. Contact the MCO for requirements for those services. The MCO is not responsible for surgical procedures related to gender reassignment surgery, including electrolysis and postoperative complications.

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

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

Surgical procedures that require a medical necessity review by Comagine Health

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

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

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

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

Breast Surgeries

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

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

Deliveries

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

An early elective delivery is considered medically necessary if the mother or fetus has a diagnosis listed in the Joint Commission's current table of Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation (WAC 182-533-0400). If the client meets the medical necessity criteria, bill using EPA #870001375. **This EPA also needs to be used for clients who deliver naturally prior to 39 weeks.**

If the early elective delivery does not meet medical necessity criteria, the agency will pay only for the antepartum and postpartum professional services. When billing, these services must be unbundled. The agency will not pay for the delivery services.

For all deliveries for a client equal to or over 39 weeks gestation, bill using EPA #870001378. This applies to both elective and natural deliveries for clients equal to or over 39 weeks gestation.

Approved bariatric hospitals and associated clinics

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

The agency covers medically necessary bariatric surgery for clients age 21-59 in a facility that is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP), on the American College of Surgeons website, in accordance with WAC 182-531-1600. The agency covers bariatric surgery for clients age 18-20 for the laparoscopic gastric band procedure only (ICD 0DV64CZ). All bariatric surgeries require PA, and are approved when the client meets the criteria in WAC 182-531-1600. Inpatient bariatric surgery is paid on a DRG basis, not on a per case rate basis.

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

To begin the authorization process, providers must fax a completed Bariatric Surgery Request form and the Basic Information form to the agency. (See Where can I download agency forms?)

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

Acute physical medicine and rehabilitation (PM&R)

(WAC 182-550-2561)

The agency requires prior and concurrent authorization for admissions and continued stays in agency-approved acute PM&R facilities. To facilitate ProviderOne billing, provide room charges with one of the following revenue codes: 0128 or 0169.

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

Long-term acute care (LTAC)

(WAC 182-550-2590)

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

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

Claims must meet or exceed the DRG allowed amount prior to the transfer. The agency no longer uses DRG high outlier payment status as a criterion for approving transfers from acute care to LTAC for individuals who are otherwise eligible. To facilitate ProviderOne billing, bill room charges with revenue code 0100.

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

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

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

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

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

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

Providers requesting elective, out-of-state care must send a completed Out-of-State Medical Services Request form with the additional documentation required on the form, to the address listed on the form. (See Where can I download agency forms?)

Refer to Mental Health Services Billing Guide for information on out-of-state psychiatric care.

Out-of-country hospital admissions

(WAC 182-501-0184)

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

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

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

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

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

Chemical-using pregnant (CUP) women

Pregnant clients may be eligible to receive acute detoxification, medical stabilization, and rehabilitation services through the Chemical-Using Pregnant (CUP) Women Program. See the agency's Chemical-Using Pregnant (CUP) Women Program Billing Guide for details. A list of the DBHR Certified Hospitals providing intensive inpatient care for chemical using pregnant women is located on the agency's website.

Medical inpatient detoxification (MID) services

(WAC 182-550-4300)

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

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

What are the MID criteria?

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

1. The MID stay cannot be a scheduled admission due to the acute nature of intoxication and the need for immediate detoxification.

2. The stay meets criteria for severity and intensity of illness, and medical necessity standards to qualify as an inpatient admission.

3. The principal diagnosis is related to the use or abuse of alcohol, hypnotic, hallucinogen, stimulant, opioid, or other psychoactive substance.

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

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

6. This is a medical stay and not a psychiatric stay. The client does not meet medically necessary criteria for inpatient psychiatric care, and an approval from the DBHR designee is not appropriate.

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

8. Nonhospital-based detoxification is not medically appropriate.

What is MID authorization?

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

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

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

What authorization number is used when billing for MID?

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

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

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

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

(WAC 182-550-4300(5))

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

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

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

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

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

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

Example 1

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

Room and Board Revenue Code	Unit	Total Charges	Noncovered Charges	Notes
0111, 0121, 0131, 0141	3 Days	$xx.xx		

Example 2

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

Room and Board Revenue Code	Unit	Total Charges	Noncovered Charges	Notes
• Depending on the revenue code billed by the hospital: ✓ Ratio of costs-to-charges (RCC) ✓ Military subsistence per diem	3 Days	$xx.xx		Charges for total days requested
0111, 0121, 0131, 0141	2 Days	$xx.xx	$xx.xx	Charges for days not to be evaluated

Example 3

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

Room and Board Revenue Code	Unit	Total Charges	Noncovered Charges	Notes
0111, 0121, 0131, 0141	7 Days	**$xx.xx**		Charges for total days requested

Example 4

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

Room and Board Revenue Code	Unit	Total Charges	Noncovered Charges	Notes
• Depending on the revenue code billed by the hospital: ✓ Ratio of costs-to-charges (RCC) ✓ Military subsistence per diem	7	$xx.xx		Charges for total days requested
0111, 0121, 0131, 0141	3	$xx.xx	$xx.xx	Charges for days not to be evaluated

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

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

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

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

Payment methods

For MID claims paid using the per diem payment method

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

For MID claims paid using the CPE payment method

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

Agency-approved centers of excellence (COE)

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

Transplant services must be performed in an agency-approved COE. **When performed in an agency-approved COE, these services do not require PA**. See the list of agency-approved COEs on the agency's Billers and Providers webpage.

The agency covers transplant procedures when:

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

When the above is true, the agency covers:

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

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

Experimental transplant procedures

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

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

Payment limitations

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

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

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

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

Ventricular assist device (VAD) and percutaneous ventricular assist device (PVAD) services

The agency will cover services for ventricular assist device (VAD) and percutaneous ventricular assist device (PVAD under certain circumstances and in particular facilities. For more information regarding these services, please refer to the Physician-Related Services/Health Care Professional Services Billing Guide.

Transcatheter aortic valve replacement (TAVR)

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

- PA has been obtained.
- The NPI for each team surgeon is provided for payment.
- The heart team and hospital are participating in a prospective, national, audited registry approved by CMS.
- The conditions of the CMS Medicare National Coverage Determination are met.

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

Utilization Review

(WAC 182-550-1700)

What is utilization review (UR)?

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

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

Note: For more information on prospective and concurrent UR, refer to Authorization and the Mental Health Services Billing Guide.

Agency program integrity retrospective UR

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

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

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

- A written UR Plan in effect that provides for review of each client's need for services the hospital provides to that client
- Details of the organization and composition of the hospital's UR committee
- The written medical care criteria developed by the hospital's UR committee to assess the need for a client's admission
- The hospital UR committee's process for written notice of any adverse final decision on the need for admission (see Hospital-issued notice of noncoverage (HINN))

Changes in admission status

What is admission status?

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

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

When is a change in admission status required?

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

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

Change from inpatient to outpatient observation admission status

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

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

Change from outpatient observation to inpatient admission status

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

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

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

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

  - ✓ Be dated with the date of the change.

  - ✓ Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Change from inpatient or outpatient observation to outpatient admission status

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

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

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

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

  - ✓ Be dated with the date of the change.

  - ✓ Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Change from outpatient surgery/procedure to outpatient observation or inpatient admission status

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

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

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

Acute care transfers

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

Coding and DRG validations

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

DRG outliers

The agency may retrospectively review outliers to verify the following:

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

Length-of-stay (LOS) reviews

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

> **Note:** Admissions requiring authorization for LOS extensions are psychiatric, acute physical medicine and rehabilitation (PM&R), and long-term acute care (LTAC) admissions.
>
> Refer to program-specific publications for more information. Psychiatric admission, PA, and length of stay requirements are located in the Mental Health Services Billing Guide.

The DRG average LOS review applies only to the following:

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

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

Hospital readmissions

(WAC 182-550-2900)

The agency may perform a retrospective prepayment utilization review of hospital readmissions for clients readmitted to the same or an affiliated hospital within 14 calendar days.

When this occurs, the agency may deny or recoup a claim and request medical records to review both the admission and readmission(s) for consideration of payment. The agency will determine

if the admissions are appropriate for inpatient level of care and whether the claims will be paid as individual payments.

Examples of cases in which individual payments are not allowed include:

- Continuation of same episode of care
- Complication(s) from the first admission
- A planned readmission following discharge (e.g., a therapeutic admission following a diagnostic admission, readmission for patient or provider convenience)
- A premature hospital discharge)

Note: This utilization review does not apply to psychiatric admissions.

Provider preventable conditions (PPCs)

(WAC 182-502-0022)

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

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

Medical record requests for retrospective UR

If the agency requests medical records during the retrospective utilization review process, submit a complete copy of the medical records within the time period stated in the request to:

Health Care Authority
Attn: Section of Program Integrity
PO Box 45503
Olympia WA 98504-5503

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

- Face sheet
- Coding summary
- Admission record
- Discharge summary
- History and physical

- Multidisciplinary progress notes
- Physician orders
- Radiology interpretations
- Laboratory test results
- Consultations/referrals
- Operative reports
- Medication administration records
- Itemized billing statement
- UB-04 claim form

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

Hospital-issued notice of noncoverage (HINN)

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

- **Notifying a Washington Apple Health client that medical care is no longer needed**

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

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

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

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

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

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

Adverse determination appeal process

If a provider disagrees with an adverse determination made by the agency or the agency's contracted Quality Improvement Organization (QIO), the provider may appeal the determination by submitting a detailed written description of the dispute.

A provider may appeal an adverse determination made: 1) prospectively regarding the PA process; 2) concurrently during the continued stay authorization process; or 3) retrospectively during the retrospective utilization review audit process.

Submit appeals to the agency's Contact us –Medical provider webpage and select the topic "claim inquiry." Providers may be asked later to submit supporting documentation.

General Billing

All claims must be submitted electronically to the agency, except under limited circumstances. For more information about this policy change, see Paperless Billing at HCA. For providers approved to bill paper claims, see the agency's Paper Claim Billing Resource.

What are the general billing requirements?

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

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

How do I bill for clients who are eligible for only a part of the hospital stay?

The agency and the contracted managed care organizations can pay only for the days of an inpatient admission that fall within the client's eligibility period.

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

- Covered and noncovered charges on separate lines
- The entire stay from the admission date to the discharge date, including the dates the client was not eligible
- All diagnosis and procedure codes for the entire stay

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

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

Note: When a client's eligibility has changed from fee-for-service to managed care during a continuous hospital stay, or if the client becomes eligible for Medicaid and is enrolled with an agency-contracted managed care organization (MCO) on the first day of the same month during an admission, but the admission date was in a previous month, the claim must include a comment in the following format:

"Continuous hospital stay MM/DD/YYYY- MM/DD/YYYY"

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

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

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

Example B:
A client is admitted to the hospital on 06/28/2016 and discharged on 07/15/2016, but the client's eligibility for Medicaid and managed care enrollment doesn't begin until 07/01/2016. The agency covers this admission. The claim note would say:

"Continuous hospital stay 06/28/2016 – 07/15/2016"

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

How are outpatient hospital services prior to admission paid?

Outpatient hospital services, including pre-admission, emergency room, and observation services related to an inpatient hospital stay and provided within one calendar day of a client hospital stay, must be billed on the inpatient hospital claim. See WAC 182-550-6000 (3)(c). The "from" and "to" dates on the hospital claim should cover the entire span of billed services. The admit date is the actual date of admission.

How are outpatient hospital services during an inpatient admission paid?

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

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

How do I bill for neonates/newborns?

Neonatal/newborn coding

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

Birth weight coding

When billing, providers must:

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

Newborn eligibility and billing

The following crosswalk should be used to provide guidance in determining which program the infant is eligible to participate in, as well as continuing coverage based on the mother's eligibility status and post-birth placement status.

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

	Placed in Out of Home Placement?	
Eligibility Status ***(*Note* Family Medical as defined includes Newborn Medical (N10)[RAC 1202])***	**No *(Newborn is not going into foster care)***	**Yes *(Newborn is going into foster care)***
Mother is Apple Health eligible, enrolled in MCO	Newborn is opened on Family Medical for month of birth and enrolled in the same Managed Care Organization (MCO) as the birth mother to cover the first 21 days of life. If newborn is never deemed eligible, newborn has no continuing coverage after first 21 days of life. Mother's MCO is responsible to cover newborn nursery services as required for at least the first twenty-one days of life.	Newborn is opened on Family Medical and enrolled in mother's MCO for the month of birth. Apple Health Foster Care (AHFC) Medical enrollment is established prospectively the first of the month following the placement. Nursery services provided after birth are covered by mother's MCO. If the newborn remains in the hospital after the month of birth, the mother's MCO covers the hospital costs as a continuing health event.

	Placed in Out of Home Placement?	
Eligibility Status ***(*Note* Family Medical as defined includes Newborn Medical (N10)[RAC 1202])***	**No *(Newborn is not going into foster care)***	**Yes *(Newborn is going into foster care)***
Mother is Apple Health eligible, not enrolled in MCO	Newborn is opened on Family Medical for the month of birth and enrolled into an MCO according to assignment rules. If Newborn is deemed eligible, Newborn will be retro-enrolled for the current month based on earlier enrollment rules. MCO may request a retro-eligibility determination up to 365 days after birth upon completion of a premium payment request report. Nursery services provided after birth are covered by assigned MCO. If the newborn remains in the hospital after the month of birth, the assigned MCO covers the hospital costs as a continuing health event.	Newborn is opened family medical and assigned to Apple Health Managed Care as of month of birth. Newborn is opened prospectively on AHFC beginning the 1st of the month following placement and enrolled in AHFC. Nursery services provided after birth are covered by assigned MCO. If the newborn remains in the hospital after the month of birth, the assigned MCO covers the hospital costs as a continuing health event.
Mother is enrolled in AHFC	Newborn is eligible for Family Medical the month of birth. The newborn will be enrolled with Apple Health Managed Care (AHMC) in same plan as the mother if available. Eligibility and enrollment will begin from the newborns' date of birth or mother's date of enrollment, whichever is sooner.	Newborn is eligible for AHFC and enrolled the month of birth. Nursery services provided after birth are covered by AHFC as a continuing health event.

	Placed in Out of Home Placement?	
Eligibility Status ***(*Note* Family Medical as defined includes Newborn Medical (N10)[RAC 1202])***	**No *(Newborn is not going into foster care)***	**Yes *(Newborn is going into foster care)***
Mother has NO Apple Health coverage and Does not have private insurance	Family must apply for eligibility. If deemed eligible, newborn is enrolled in AHMC according to assignment rules. If newborn eligibility is received in ProviderOne (P1) within the birth month, Newborn will be retro-enrolled to first of the month newborn is reported to HCA based on earlier enrollment rules. If newborn eligibility is not received in P1 birth month, Newborn is enrolled first of month deemed AHMC eligible. Eligibility back to birth month must be requested based on medical need and is Fee for Service (FFS).	Newborn is opened on FC as of month of placement. The newborn will be enrolled with AHFC MCO the first of the month of placement.

When billing for a newborn claim using the mother's ProviderOne Client ID, enter the baby's name, baby's birthdate, and the baby's gender in the subscriber/client information fields instead of the mother's information. In addition, you must use "SCI=B" in the *Billing Note* section of the electronic institutional claim.

When billing for multiple births, enter the infant's identifying information in the comment or remarks area. For example, the first infant would be "SCI=BA," the second infant would be "SCI=BB," and the third infant would be "SCI=BC." Each newborn must have services provided to that newborn billed on a separate claim.

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

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

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

Neonate revenue code descriptions

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

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

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

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

How do I bill for immediate postpartum long acting reversible contraception (LARC)?

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

Submitting adjustments to a paid inpatient hospital claim

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

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

Present on admission indicators

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

How to indicate a POA on a direct data entry claim

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

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

How to indicate a POA on an electronic claim

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

Principal diagnosis – Submit the POA indicator in Loop 2300

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

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

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

Billing Specific to Hospital Services

Interim billing

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

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

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

Note: Effective on or after January 1, 2020, hospital and ambulatory surgery center facility fees for eligible clients enrolled in an agency-contracted managed care organization must be billed directly through the client's MCO.

Inpatient hospital stays without room charges

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

How do I bill for administrative days?

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

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

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

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

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

Note: For administrative days qualifying for payment under revenue code 0169, refer to the Mental Health Services Billing Guide. For information on the Acute PM&R program, refer to the Acute Physical Medicine and Rehabilitation (PM&R) Billing Guide.

How do hospitals bill for acute inpatient stay when a client elects hospice?

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

Questions and Answers from NUBC Manual

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

How do CPE hospitals bill for services provided to blind and disabled clients enrolled in managed care?

For certified public expenditure (CPE) hospitals that provide medical services to Categorically Needy Medicaid Blind/Disabled clients, bill those services fee-for-service to the agency. (For more information on billing for services provided to these clients, refer to the RAC eligibility codes.) In order to process those claims, the CPE hospital must obtain prior authorization from the MCO and submit that information to the agency in the *Claim Note* field on the claim in the manner shown below:

PA from [MCO Name]: [Authorization number]

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

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

How do I bill for clients covered by Medicare Part B only (No Part A), or has exhausted Medicare Part A benefits prior to the stay?

Description	DRG	Per Diem	RCC	CPE	CAH
Bill Medicare Part B for qualifying services delivered during the hospital stay.	Yes	Yes	Yes	Yes	Yes
Bill the agency for hospital stay as primary.	Yes	Yes	Yes	Yes	Yes
Show as noncovered on the agency 's bill what was billed to Medicare under Part B.	No	No	Yes	Yes	Yes
Expect the agency to reduce payment for the hospital stay by what Medicare paid on the Part B bill.	Yes	Yes	No	No	No
Expect the agency to recoup payment as secondary on Medicare Part B bill*.	Yes	Yes	No*	No*	No*
Report the Part B payment on the claim in the other payer field “Medicare Part B”	Yes	Yes	Yes	Yes	Yes
Include a claim note**	Yes	Yes	Yes	Yes	Yes

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

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

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

What the agency pays the hospital:

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

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

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

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

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

1. Bill Medicare

   Medicare PPS Payment Manual, Chapter 3, Section 40A, bullet 3 states:

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

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

3. After the inpatient crossover claim is paid, bill the primary claim for the entire stay to the agency:

   a. If billing ratio of costs-to-charges (RCC), certified public expenditures (CPE), or are a critical access hospital (CAH), list the Medicare covered day's charges as noncovered.

   b. If billing DRG or per diem, list all services (do not list noncovered services).

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

5. The agency may pay an amount using the following formula:

   The agency's allowed amount for the entire stay minus Medicare's payment minus the agency's crossover payments

6. Add the following claim note:

    a. "Part A Benefits exhausted during stay;" or
    b. "Medicare Part A coverage began during the stay;" or
    c. Enter the Part A start date or the date benefits are exhausted in the "occurrence" fields using occurrence Code "A3".

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

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

Required consent forms for hysterectomies

(WAC 182-531-1550(10))

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

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

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

- Submit the claim and the completed agency-approved consent form to the agency.

To download the Hysterectomy Consent and Patient Information form HCA 13-365, see Where can I download agency forms?

Completing the Claim

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's Billers, providers, and partners webpage, under Webinars.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA Electronic Data Interchange (EDI) webpage.

What does the agency require from the provider-generated explanation of Medicare benefit (EOMB) to process a 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)
- Text in font size 12 or greater

Column level labels on the EOMB must include all the following:

- Date of service
- Billed amount
- Allowed amount if applicable
- Deductible amount if applicable
- Co-insurance/Co-pay amount if applicable
- Amount paid by Medicare (PROV PD) if Medicare paid
- Medicare Adjustment Reason codes and Remark codes

Specific instructions for Medicare crossover claims

How do I submit institutional services on a crossover claim?

- Mark "Yes" for the question, "Is this a Medicare Crossover Claim?" in the electronic claim. (If Medicare makes a payment or allows the services, Medicaid considers it a crossover.)
- See the ProviderOne Billing and Resource Guide and the Fact Sheets webpage to get more information about submitting Medicare payment information electronically and to find out when paper backup must be attached.

- Enter the third-party (e.g. Blue Cross) supplement plan name in the *Other Insurance Information* section of the electronic claim. See the Submit an Institutional Claim with Primary Insurance other than Medicare webinar for further assistance with submitting third-party insurance information.

How do I submit institutional services for inpatient clients who are eligible for Medicare Part B Benefits but not eligible for Medicare Part A Benefits or Medicare Part A benefits are exhausted?

For all claims:

Include one of the following comments in the *Billing Note* section:

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

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

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

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

  - ✓ Enter the Part B payment as if it is insurance. See the ProviderOne Billing and Resource Guide for instructions on how to bill other insurance information.

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

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

  ✓ Bill using Type of Bill 111.

  ✓ Enter the amount covered by Medicare Part B for each service in the Noncovered field at line level, as applicable.

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

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

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