Washington State Health Care Authority

Medicaid Provider Guide

Inpatient Hospital Services

[Refer to Chapter 182-550 WAC]

Washington State Health Care Authority

A Billing Instruction

About this Guide

This guide is a companion document that applies to the Inpatient Hospital Services program. Please refer to the Agency *ProviderOne Billing and Resource Guide* for valuable information to help you conduct business with the agency.

This guide supersedes all previous Inpatient Hospital Medicaid Provider Guide and related Provider Notices published by the Agency.

What Has Changed?

Reason for Change	Effective Date	Page No.	Subject	Change
Provider Notice 12-118	January 1, 2013	C.8	Program Limitations.	Added robotic assisted surgery criteria.
	January 1, 2013	D.15	Authorization.	Added criteria for authorization of transcatheter aortic valve replacement (TAVR).
	January 1, 2013	F.3	Medicaid Emergency Psychiatric Demonstration (MEPD) Project	List of institutions that are included in the project.
	January 1, 2013	F.11	Changes in status.	Removed blue note box explaining separate authorization segments.
	January 1, 2013	F.16	Authorization procedures for hospital inpatient psychiatric care.	Removed blue note box explaining responsibility of the institutions for mental disease (IMD) and RSN responsibilities.
	January 1, 2013	F.23	Billing for Inpatient Hospital Psychiatric Care	Added billing instructions specific to institution for mental disease IMDs.
	January 1, 2013	F.30	Inpatient hospital psychiatric admissions.	Added criteria for qualifying emergency.
	January 1, 2013	F.30	Inpatient hospital psychiatric admissions.	Added criteria for adverse events.

Related Medicaid Provider Guides

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

How Can I Get Agency Provider Documents?

To download and print Agency Provider Notices and Medicaid Provider Guides, go to the Agency's Provider Publications website

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Important Contacts

Note: This section contains important contact information relevant to inpatient hospital services. For more contact information, see the Agency *Resources Available* web page

Topic	Contact Information
Becoming a provider, or submitting a change of address or ownership, or contacting Provider Relations	See the Agency *Resources Available* web page
Finding out about payments, denials, claims processing, or the Agency MCOs	
Electronic or paper billing	
Finding the Agency documents (e.g., provider guide, provider notices, fee schedules)	
Private insurance or third-party liability, other than the Agency managed care	
Prior authorization, limitation extensions, or exception to rule	
What forms are available to submit my authorization request?	• Fax/Written Request Basic Information Form, #13-756 • Bariatric Surgery Request Form, #13-785 • Out of State Medical Services Request Form, #13-787 To download these forms visit Medicaid forms
Additional important information and contacts	List of Acute Rehabilitation Facilities A list of the DBHR Certified Hospitals providing intensive inpatient care for chemical using pregnant women is located on the Agency's website at: http://www.dshs.wa.gov/dbhr/datreatmentprogram.shtml Regional Support Network Contacts for Psychiatric Hospitalization http://www.dshs.wa.gov/dbhr/providerinformation.shtml#dbhr Directory for chemical dependency service providers http://www.dshs.wa.gov/pdf/dbhr/da/APPNDXF.pdf Visit the Division of Behavioral Health and Recovery's (DBHR's), Regional Support Networks (RSNs) Services Information on the web at: http://www.dshs.wa.gov/dbhr/rsn.shtml.

Definitions & Abbreviations

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

Acute – A medical condition of severe intensity with sudden onset. See WAC 182-550-2511 for the definition of "acute" for the Acute Physical Medicine and Rehabilitation (Acute PM&R) program. [WAC 182-550-1050]

Acute Care - Care provided for patients who are not medically stable or have not attained a satisfactory level of rehabilitation. These patients require frequent monitoring by a health care professional in order to maintain their health status.
Refer to WAC 248-27-015. [WAC 182-550-1050]

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

Administrative Day - A day of a hospital stay in which an acute inpatient level of care is no longer necessary and non-inpatient hospital placement is appropriate. [WAC 182-550-1050]

Administrative Day Rate - The statewide Medicaid average daily nursing facility rate as determined by the Agency. [WAC 182-550-1050]

Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) - The law and the state-administered program it established which provides medical services for persons who are incapable of gainful employment due to alcoholism or substance addiction. [WAC 182-550-1050]

Alcoholism and/or Alcohol Abuse Treatment - The provision of medical social services to an eligible client designed to mitigate or reverse the effects of alcoholism or alcohol abuse and to reduce or eliminate alcoholism or alcohol abuse behaviors and restore normal social, physical, and psychological functioning. Alcoholism or alcohol abuse treatment is characterized by the provision of a combination of alcohol education sessions, individual therapy, group therapy, and related activities to detoxified alcoholics and their families. [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. [WAC 182-550-1050]

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 maximum amount for any procedure or service that the Agency allows as the basis for payment computation. [WAC 182-550-1050]

Allowed Covered Charges - The maximum amount of charges on a hospital claim recognized by the Agency as charges for "hospital covered service" and payment computation, after exclusion of any "nonallowed service or charge," and before final adjustments, deductions, and add-ons. [WAC 182-550-1050]

Ancillary Hospital Costs - The expenses incurred by a hospital to provide additional or supporting services to its patients during their hospital stay. See **"ancillary services."** [WAC 182-550-1050]

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

- Laboratory;
- Radiology;
- Drugs;
- Delivery room;
- Operating room;
- Postoperative recovery rooms; and
- Other special items and services. [WAC 182-550-1050]

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

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

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

Beneficiary - A recipient of Social Security benefits, or a person designated by an insuring organization as eligible to receive benefits. [WAC 182-550-1050]

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

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]

Bundled Services - Interventions that are integral to the major procedure and are not paid separately. [WAC 182-550-1050]

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

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

Capital costs due solely to changes in ownership of the provider's capital assets are excluded. [WAC 182-550-1050]

Case Mix - From the clinical perspective, the condition of the treated patients and the difficulty associated with providing care. Administratively, it means the resource intensity demands that patients place on an institution. [WAC 182-550-1050]

Case Mix Index (CMI) - The arithmetical index that measures the average relative weight of all cases treated in a hospital during a defined period. [WAC 182-550-1050]

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

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

Children's Hospital - A hospital primarily serving children. [WAC 182-550-1050]

CMS - Centers for Medicare and Medicaid 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]

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]

Cost-Based Conversion Factor (CBCF) - For dates of admission before August 1, 2007, a hospital-specific dollar amount that reflects a hospital's average cost of treating Medicaid and CHIP 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. See also **"hospital conversion factor"** and **"negotiated conversion factor."** [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 medical assistance program, and is within the scope of an eligible client's medical assistance program.

Critical Border Hospital - On and after August 1, 2007, 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 healthcare for the Agency's medical assistance 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]

Day Outlier - An inpatient case with a date of admission before August 1, 2007, that requires the Agency to make additional payment to the hospital provider, but which does not qualify as a high-cost outlier. See **"day outlier payment"** and **"day outlier threshold."** the Agency's day outlier policy no longer exists for dates of admission on and after August 1, 2007. [WAC 182-550-1050]

Day Outlier Payment - The additional amount paid to a disproportionate share hospital for inpatient claims with dates of admission before August 1, 2007, for a client five years of age or younger who has a prolonged inpatient stay which exceeds the day outlier threshold, but whose covered charges for care fall short of the high cost outlier threshold. The amount is determined by multiplying the number of days in excess of the day outlier threshold and the administrative day rate. [WAC 182-550-1050]

Day Outlier Threshold - For inpatient claims with dates of admission before August 1, 2007, the average number of days a client stays in the hospital for an applicable DRG before being discharged, plus 20 days. [WAC 182-550-1050]

Deductible - The amount a beneficiary is responsible for, before Medicare starts paying; or the initial specific dollar amount for which the applicant or client is responsible. [WAC 182-550-1050]

Detoxification - Treatment provided to persons who are recovering from the effects of acute or chronic intoxication or withdrawal from alcohol or other drugs. [WAC 182-550-1050]

Diagnosis Code - A set of numeric or alphanumeric characters assigned by the ICD-9-CM, or successor document, as a shorthand symbol to represent the nature of a disease. [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, i.e., similar treatments and statistically similar lengths of stay for patients with related medical conditions. Classification of patients is based on the International Classification of Diseases (ICD-9), the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. [WAC 182-550-1050]

Discharging Hospital - The institution releasing a client from the acute care hospital setting. [WAC 182-550-1050]

Disproportionate Share Hospital (DSH) payment - A supplemental payment(s) 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 gives consideration to hospitals that serve a disproportionate number of low-income patients with special needs by making payment adjustment(s) to eligible hospitals in accordance with legislative direction and established payment methods. See 1902(a)(13)(A)(iv) of the Social Security Act. See also WAC 182-550-4900 through 182-550-5400.

Distinct Unit - A Medicare-certified distinct area for psychiatric or rehabilitation services within an acute care hospital or an Agency-designated unit in a children's hospital. [WAC 182-550-1050]

DRG - See **"diagnosis related group."** [WAC 182-550-1050]

DRG Average Length-of-Stay - For dates of admission on and after August 1, 2007, the Agency's average length-of-stay for a DRG classification established during an Agency DRG rebasing and recalibration project. [WAC 182-550-1050]

DRG-Exempt Services - Services which are paid through other methodologies than those using inpatient Medicaid conversion factors, inpatient state-administered program conversion factors, cost-based conversion factors (CBCF) or negotiated conversion factors (NCF). Some examples are services paid using a per diem rate, a per case rate, or a ratio of costs-to-charges (RCC) method. [WAC 182-550-1050]

DRG Payment - The payment made by the Agency for a client's inpatient hospital stay. This DRG payment allowed amount is calculated by multiplying the hospital's conversion factor by the DRG relative weight assigned by the Agency to the provider's inpatient claim before any outlier payment calculation. [WAC 182-550-1050]

DRG Relative Weight - The average cost or charge of a certain DRG classification divided by the average cost or charge, respectively, for all cases in the entire data base for all DRG classifications. [WAC 182-550-1050]

Drug Addiction and/or Drug Abuse Treatment - The provision of medical and rehabilitative social services to an eligible client designed to mitigate or reverse the effects of drug addiction or drug abuse and to reduce or eliminate drug addiction or drug abuse behaviors and restore normal physical and psychological functioning. Drug addiction or drug abuse treatment is characterized by the provision of a combination of drug and alcohol education sessions, individual therapy, group therapy and related activities to detoxified addicts and their families. [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 Expense Requirement (EMER) - A specified amount of expenses for ambulance, emergency room or hospital services, including physician services in a hospital that a client must incur for an emergency medical condition prior to certification for the psychiatric indigent inpatient (PII) program. [WAC 182-550-1050]

Emergency Room or **Emergency Facility** or **Emergency Department** - An organized, distinct hospital-based facility available 24 hours a day for the provision of unscheduled episodic services to patients who present for immediate medical attention, and is capable of providing emergency services including trauma care. [WAC 182-550-1050]

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

Expedited Prior Authorization (EPA) - The Agency-delegated process of creating an authorization number for selected medical/dental procedures and related supplies and services in which providers use a set of numeric codes to indicate which Agency-acceptable indications, conditions, diagnoses, and/or Agency-defined criteria are applicable to a particular request for service. [WAC 182-550-1050]

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

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

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

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]

Grouper - See "All-patient DRG grouper (AP-DRG)." [WAC 182-550-1050]

High-Cost Outlier - For dates of admission before August 1, 2007, a claim paid under the DRG payment-method that did not meet the definition of "administrative day," and has extraordinarily high costs when compared to other claims in the same DRG. For dates of admission on and after January 1, 2001, to qualify as a high-cost outlier, the billed charges minus the noncovered charges reported on the claim must exceed three times the applicable DRG payment and exceed $33,000. The Agency's high-cost outliers are not applicable for dates of admission on and after August 1, 2007. [WAC 182-550-1050]

High Outlier Claim--Medicaid/CHIP DRG - For dates of admission on and after August 1, 2007, a claim paid under the DRG payment method that does not meet the definition of "administrative day," and has extraordinarily high costs as determined by the Agency. See WAC 182-550-3700. [WAC 182-550-1050]

High Outlier Claim--Medicaid/CHIP Per Diem - For dates of admission on and after August 1, 2007, a claim that:

- Is 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. [WAC 182-550-1050]

High Outlier Claim—State-Administered Program DRG - For dates of admission on and after August 1, 2007, a claim paid under the DRG payment method that does not meet the definition of "administrative day," and has extraordinarily high costs as determined by the Agency. See WAC 182-550-3700. [WAC 182-550-1050]

High Outlier Claim—State-Administered Program Per Diem - For dates of admission on and after August 1, 2007, a claim that:

- Is classified by the Agency as being allowed as a high outlier payment;
- Is paid under the per diem payment method;
- Does not meet the definition of "administrative day,"; and
- Has extraordinarily high costs as determined by the Agency. See WAC 182-550-3700. [WAC 182-550-1050]

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 or a “psychiatric hospital” as defined in this section. [WAC 182-550-1050]

Hospital Conversion Factor - A hospital-specific dollar amount that reflects the average cost for a DRG-paid case of treating Medicaid and CHIP clients in a given hospital. See cost-based conversion factor (CBCF) and negotiated conversion factor (NCF). [WAC 182-550-1050]

Hospital Covered Service - A service that is provided by a hospital, covered under a medical assistance program, and is within the scope of an eligible client's medical assistance program. [WAC 182-550-1050]

Hospital Cost Report – See **"**cost report.**"** [WAC 182-550-1050]

ICD-9-CM – See "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Edition."

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

- Disclosed and discussed the patient's diagnosis;
- Offered the patient an opportunity to ask questions about the procedure and to request information in writing;
- Given the patient a copy of the consent form;
- Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. 441.257; and
- Given the patient oral information about all of the following:
  - ✓ The patient's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure;
  - ✓ Alternatives to the procedure including potential risks, benefits, and consequences; and
  - ✓ The procedure itself, including potential risks, benefits, and consequences. [WAC 182-550-1050]

Inpatient Hospital - A hospital authorized by the Department of Health to provide inpatient services. [WAC 182-550-1050]

Inpatient Hospital Admission - An admission to a hospital based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary inpatient care, including assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury, and that is documented in the client's health record. [WAC 182-550-1050]

Inpatient Medicaid Conversion Factor - A dollar amount that represents selected hospitals' average costs of treating Medicaid and CHIP clients. 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 182-550-3450 for how this conversion factor is calculated. [WAC 182-550-1050]

Inpatient Services – Healthcare services provided directly or indirectly to a client subsequent to the client's inpatient hospital admission and prior to discharge. [WAC 182-550-1050]

Inpatient State-Administered Program Conversion Factor - The DRG conversion factor is reduced by the equivalency factor (EF) to calculate payments for inpatient services provided to clients eligible for state-administered programs (WAC 182-550-4800). The inpatient conversion factor for state-administered programs is multiplied by a DRG relative weight to pay claims for clients under state only programs. [WAC 182-550-1050]

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

Internal Control Number (ICN) – See "Transaction Control Number (TCN)."

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

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]

Length Of Stay Extension Request - A request from a hospital provider for the Agency, or in the case of psychiatric admission, the appropriate Division of Behavioral Health and Recovery-designee, to approve a client's hospital stay exceeding the average length of stay for the client's diagnosis and age. [WAC 182-550-1050]

Long Term Acute Care (LTAC) services - Inpatient intensive long term care services provided in Agency-approved LTAC hospitals to eligible medical assistance clients who meet criteria for Level 1 or Level 2 services. See WAC 182-550-2565 through 182-550-2596. [WAC 182-550-1050]

Low-Cost Outlier - A case having a date of admission before August 1, 2007, with extraordinarily low costs when compared to other cases in the same DRG. For dates of admission on and after January 1, 2001, to qualify as a low-cost outlier, the allowed charges must be less than the greater of ten percent of the applicable DRG payment or four hundred and fifty dollars. The Agency's low-cost outliers are not applicable for dates of admission on and after August 1, 2007. [WAC 182-550-1050]

Medical Identification Card(s) – See *Services Card*.

Medical Assistance Program - Any healthcare program administered through the Agency. [WAC 182-550-1050]

Medical Care Services - The state-administered limited scope of care provided to general assistance-unemployable (GA-U) recipients, and recipients of alcohol and drug addiction services provided under chapter 74.50 RCW. [WAC 182-550-1050]

Medical Education Costs - The expenses incurred by a hospital to operate and maintain a formally organized graduate medical education program. [WAC 182-550-1050]

Medical Management Information System (MMIS) – See ProviderOne.

Medically Necessary – See WAC 182-500-0005.

Medical Stabilization - A return to a state of constant and steady function. It is commonly used to mean the patient is adequately supported to prevent further deterioration. [WAC 182-550-1050]

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

- To Medicare intermediaries at the end of a provider's selected fiscal accounting period to establish hospital reimbursable costs for per diem and ancillary services; and
- To Medicaid to establish appropriate DRG and other rates for payment of services rendered. [WAC 182-550-1050]

Medicare Crossover - A claim involving a client who is eligible for both Medicare benefits and Medicaid. [WAC 182-550-1050]

Division of Behavioral Health and Recovery Designee - A professional contact person authorized by the Division of Behavioral Health and Recovery, who operates under the direction of a Regional Support Network (RSN) or a prepaid inpatient health plan (PIHP). See WAC 182-550-2600. [WAC 182-550-1050]

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

Negotiated Conversion Factor (NCF) - For dates of admission before July 1, 2007, a negotiated hospital-specific dollar amount used in lieu of the cost-based conversion factor as the multiplier for the applicable DRG weight to determine the DRG payment for a selective contracting program hospital. See also **"hospital conversion factor"** and **"cost-based conversion factor."** The Agency's hospital selective contracting program no longer exists for dates of admission on and after July 1, 2007. [WAC 182-550-1050]

Newborn or Neonate or Neonatal - A person younger than 29 days old. However, a person who has been admitted to an acute care hospital setting as a newborn and is transferred to another acute care hospital setting is still considered a newborn for payment purposes. [WAC 182-550-1050]

Non-Allowed Service or Charge - A service or charge that is not recognized for payment by the Agency, and cannot be billed to the client except under the conditions identified in WAC 182-502-0160. [WAC 182-550-1050]

Noncovered Charges - Billed charges submitted to the Agency by a provider and indicated by the provider on the claim as noncovered. [WAC 182-550-1050]

Noncovered Service or Charge - A service or charge that is not considered or paid by the Agency as a "covered hospital service," and cannot be billed to the client except under the conditions identified in WAC 182-502-0160. [WAC 182-550-1050]

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

- Prevents or corrects physical deformity or malfunction; or
- 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 outside the designated bordering cities in Oregon and Idaho (see WAC 182-501-0175). For medical assistance clients requiring psychiatric services, "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 Client- A patient who is receiving healthcare services in other than an inpatient hospital setting.

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

Outpatient Hospital Services - Those healthcare 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 Short Stay - See "observation services" and "outpatient hospital services." [WAC 182-550-1050]

Outpatient Surgery - A surgical procedure that is not expected to require an inpatient hospital admission. [WAC 182-550-1050]

Patient Identification Code (PIC) – See "ProviderOne Client ID."

Per Diem Rate - A daily rate used to calculate payment for services provided as a "covered hospital service." [WAC 182-550-1050]

PM&R - See "Acute PM&R." [WAC 182-550-1050]

Plan of Treatment or **Plan of Care** – The written plan of care for a patient which includes, but is not limited to, the physician's order for treatment and visits by the disciplines involved, the certification period, medications, and rationale indicating need for services. [WAC 182-550-1050]

Primary Care Case Management (PCCM) - Means the coordination of healthcare 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 established after study to be chiefly responsible for the admission of the patient to the hospital for care. [WAC 182-550-1050]

Prior Authorization (PA) - A process by which clients or providers must request and receive the Agency's or an Agency designee's approval for certain healthcare services, equipment, or supplies, based on medical necessity, before the services are provided to clients, as a precondition for payment to the provider. Expedited prior authorization and limitation extension are forms of prior authorization. [WAC 182-550-1050]

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

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

Psychiatric Indigent Inpatient (PII) Program - A state-administered program established by the Agency specifically for mental health clients identified in need of voluntary emergency inpatient psychiatric care by an RSN representative on behalf of the Agency. See WAC 182-865-0217. [WAC 182-550-1050]

Ratio of Costs-to-Charges (RCC) - A method used to pay hospitals for some services exempt from the DRG payment method. [WAC 182-550-1050]

RCC - See "ratio of costs-to-charges." [WAC 182-550-1050]

Rebasing - The process of recalculating the conversion factors, per diems, or per case rates using historical data. [WAC 182-550-1050]

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

Regional Support Network (RSN) – a county authority or a group of county authorities recognized and certified by the Agency, that contracts with the Agency per chapters 38.52, 71.05, 71.24, 71.34, and 74.09 RCW and chapters 275-54, 275-55, and 275-57 WAC, to manage the provision of mental health services to medical assistance clients. [WAC 182-550-1050]

Rehabilitation Units - Specifically identified rehabilitation hospitals and designated rehabilitation units of hospitals that meet Agency and/or 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 - The services a hospital facility provides a patient during the patient's hospital stay. These services include, but are not limited to, a routine or special care hospital room and related furnishings, routine supplies, dietary and nursing services, and the use of certain hospital equipment and facilities. [WAC 182-550-1050]

Secondary Diagnosis – A diagnosis other than the principal diagnosis for which an inpatient client is admitted to a hospital. [WAC 182-550-1050]

Seven-Day Readmission - The situation in which a client who was admitted as an inpatient and discharged from the hospital has returned to inpatient status to the same or a different hospital within seven days. [WAC 182-550-1050]

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]

State Plan - The plan filed by the Agency with the Centers for Medicare and Medicaid Services (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]

Surgery - The medical diagnosis and treatment of injury, deformity or disease by manual and instrumental operations. For reimbursement purposes, surgical procedures are those designated in CPT as procedure codes 10000 to 69999. [WAC 182-550-1050]

Swing-Bed Day - A day in which a client is receiving skilled nursing services in a hospital designated swing bed at the hospital's census hour. The hospital swing bed must be certified by the Centers for Medicare and Medicaid Services (CMS) for both acute care and skilled nursing services. [WAC 182-550-1050]

Technical Component - The part of a procedure or service that relates to the equipment set-up and technician's time, or the part of a procedure and service payment that recognizes the equipment cost and technician time**.** [WAC 182-550-1050]

Taxonomy Code - A unique, 10-digit, alphanumeric code that allows a provider to identify their specialty category. Providers applying for their NPI will be required to submit their taxonomy information. Providers may have one or more than one taxonomy associated to them. Taxonomy Codes can be found at http://www.wpc-edi.com/codes/Codes.asp.

Transaction Control Number (TCN) - A unique field value that identifies a claim transaction assigned by ProviderOne.

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

Transferring Hospital - The hospital or distinct unit that transfers a client to another acute care or non acute care setting facility. [WAC 182-550-1050]

Trauma Care Facility - A facility certified by the Department of Health as a level I, II, III, IV, or V facility. See chapter 246-976 WAC. [WAC 182-550-1050]

Note: Only levels I, II, and III trauma-designated hospitals are eligible for supplemental trauma payments from the Agency.

Trauma care service - See Department of Health's WAC 246-976-935. [WAC 182-550-1050]

UB-04 - The uniform billing document required for use nationally, beginning on May 23, 2007, by hospitals, nursing facilities, hospital-based skilled nursing facilities, home health agencies, and hospice agencies in billing third party payers for services provided to patients. This includes the current national uniform billing data element specifications developed by the National Uniform Billing Committee and approved and/or modified by the Washington State Payer Group or the Agency. [WAC 182-550-1050]

Unbundled Services - Interventions that are not integral to the major procedure and that are paid separately. [WAC 182-550-1050]

Usual and Customary Charge (UCC) - The charge customarily made to the general public for a healthcare procedure or service, or the rate charged other contractors for the service if the general public is not served. [WAC 182-550-1050]

Payment for Services

Payment Methods and Limits for Inpatient Hospitals

[Refer to Chapter 182-550 WAC]

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

How to Get Paid

Providers must follow the general billing requirements in the current agency ProviderOne Billing and Resource Guide. Also see Section H, General Billing, of this Medicaid provider guide for specific hospital inpatient information.

Hospital revenue codes are updated every six months in January and July. The revenue code grid is available online at http://www.medicaid.hca.wa.gov/hospitalpymt/

Payment Methods

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

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

Payment Method Table

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

Payment method used for Medicaid inpatient hospital claims	Applicable providers/services	Process to adjust for third-party liability insurance and any other client responsibility
Certified Public Expenditure (CPE) Full Cost method	Hospitals eligible to be paid through the certified public expenditure (CPE) payment program	The allowed amount minus the third-party payment amount and any client responsibility amount. The payment made is the federal share only. The program is subject to Hold Harmless Settlement.
Cost settlement	Department of Health (DOH)-approved critical access hospitals (CAHs)	The allowable amount, subject to retrospective cost settlement, minus the third-party payment amount and any client responsibility amount.
Diagnosis Related Group (DRG) method (the primary payment method)	Hospitals and services not exempt from the DRG payment method	For DRG paid claims without a third-party payment: The allowed amount including outlier (if applicable), minus the third-party payment amount and any client responsibility amount. For drg paid claims with a third-party payment amount: Lesser of: (1) The DRG billed amount minus the third-party payment amount and any client responsibility amount; or (2) The allowed amount including outlier (if applicable), minus the third-party payment amount and any client responsibility amount.

Payment method used for Medicaid inpatient hospital claims	Applicable providers/services	Process to adjust for third-party liability insurance and any other client responsibility
Bariatric Per Case rate	Sacred Heart and Oregon Health Sciences, (and University of Washington for Hold Harmless Settlement Only) for preauthorized inpatient stays for morbid obesity related procedures	(1) The single case rate allowed amount minus the third-party payment amount and any client responsibility amount.
Per Diem rate	Some providers/services exempt from the DRG payment methods	Per diem allowable amount, and high outlier amount, if applicable, minus the third-party payer amount, if any, and any client responsibility amount. **Note:** high outlier provisions apply for medical, surgical, neonate, burn services, if claim qualifies
Per Diem rate - LTAC (Per Diem Rate and RCC method combined)	Long-term acute care (LTAC) hospitals	(1) The fixed per diem for each allowed day combined with RCC allowed amount for covered services not included in the fixed per diem rate minus the third-party payment amount and any client responsibility amount.
Ratio of Costs-to-Charges (RCC)	Organ Transplant services	The allowable minus the third-party payment amount and any client responsibility amount.

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

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

When mandated by the State Legislature, the Agency may apply an adjustment factor to payment methods, rates, and/or factors to achieve the legislature’s targeted expenditure levels. Critical Access Hospital rates are not affected. The inpatient adjustment factor is calculated by the Agency and applied to existing inpatient hospital rates.

Payment for State-Administered Programs
[Refer to WAC 182-550-4800]

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

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

    - ➢ Aged, Blind, Disabled Assistance (ABD) (formerly Disability Lifeline);
    - ➢ Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) program; and
    - ➢ "Q" Involuntary Treatment Act (ITA) program.

- **Payment rates**
  The Agency pays claims for state-administered programs by using the rates for state-administered programs rather than Medicaid or CHIP rates.

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

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

Payment Adjustments

The Agency may adjust payment due to the following:

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

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

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

- **Valid Diagnosis Related Group (DRG) Codes**

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

- **Transfers – [Refer to WAC 182-550-3600]**

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

  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.

- **Inpatient Hospital Psychiatric Transfers**

  The Agency requires a transferring hospital to contact the appropriate mental health designee or RSN to obtain the following:

  ✓ Prior approval of post-stabilization care; and
  ✓ 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 Inpatient Hospital Psychiatric Admission section within this Medicaid Provider Guide).

- **Seven-Day Readmissions [Refer to WAC 182-550-2900]**

  The Agency does not pay for two separate inpatient hospitalizations if a client is readmitted to the same hospital or distinct unit within seven calendar days of discharge, unless the readmission is due to conditions unrelated to the previous admission.

  The Agency may request medical records and perform a retrospective utilization review as described in WAC 182-550-1700 to determine the appropriate payment(s) for the readmission and associated admission(s).

  Note: When the Agency requests medical records, DO NOT resubmit the claim(s).

  Submit the requested records to:

  Clinical Review Unit – Seven Day Re-admit
  PO 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 claim(s).

Diagnosis Related Group (DRG) Payment Method

[Refer to WAC 182-550-3000]

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

The DRG payment method is based on:

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

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

DRG Relative Weights

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

DRG Conversion Factors [**Refer to WAC 182-550-3000 and 182-550-3450**]

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

Reduction in payment for cesarean sections - [**Refer to WAC 182-550-3000(7)]**

As mandated by the legislature for dates of admission on and after July 1, 2009, the Agency pays inpatient claims assigned by the all-patient DRG grouper (AP-DRG) as cesarean section without complications and comorbidities, at the same rate as the vaginal birth with complicating diagnoses.

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

High Outliers (DRG) [Refer to WAC 182-550-3700]

For dates of admission on and after August 1, 2007, the Agency no longer identifies a claim paid using the DRG payment method that formerly would have been considered for a low-cost outlier or day outlier payment using those methods. Instead, such claims are processed and paid using the DRG payment method or other applicable method.

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

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

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

  - ✓ The fixed outlier threshold of $50,000; and
  - ✓ For claims with admission dates prior to July 1, 2009 - 175% of the initial claim payment allowed amount (inlier payment allowed amount equal to hospital specific rate times the relative weight for the DRG code determined by the Agency for the claim); or
  - ✓ For claims with admission dates between July 1, 2009 and January 31, 2011 - 182.3% of the initial claim payment allowed amount (inlier payment allowed amount equal to hospital specific rate times the relative weight for the DRG code determined by the Agency for the claim); or
  - ✓ For claims with admission dates on or after February 1, 2011 - 175% of the initial claim payment allowed amount (inlier payment allowed amount equal to hospital specific rate times the relative weight for the DRG code determined by the Agency for the claim)

- **High outlier Claim Qualification Criteria for Neonatal and Pediatric DRG Classifications (Per Diem)**

  For Seattle Children's Hospital and Medical Center, Mary Bridge Children's Hospital, and claims grouped into neonatal and pediatric DRG classifications, a claim is a high outlier if the claim cost (claim covered charges multiplied by RCC) is greater than both:

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

  ✓ For claims with admission dates prior to July 1, 2009 - 150% of the initial claim payment allowed amount (inlier payment allowed amount equal to hospital specific rate times the relative weight for the DRG code determined by the Agency for the claim); or

  ✓ For claims with admission dates between July 1, 2009 and January 31, 2011 - 156.3% of the initial claim payment allowed amount (inlier payment allowed amount equal to hospital specific rate times the relative weight for the DRG code determined by the Agency for the claim); or

  ✓ For claims with admission dates on or after February 1, 2011 - 150% of the initial claim payment allowed amount (inlier payment allowed amount equal to hospital specific rate times the relative weight for the DRG code determined by the Agency for the claim).

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

Calculating High Outlier Payment - Diagnosis Related Group (DRG) Payment Method

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

- For claims with admission dates between August 01, 2007 and June 30, 2009 - 85%. For claims with admission dates between July 01, 2009 and January 31, 2011 - 81.6 %. For claims with admission dates on and after February 1, 201185%; or

- For claims for burn services with admission dates between August 01, 2007 and June 30, 2009 - 90%, 86.4 % for claims with admission dates between July 01, 2009 and January 31, 2011, and 90% for claims with admission dates on and after February 1, 2011; or

- 95% for claims for neonate services or any claims at Children's or Mary Bridge with admission dates between 8/1/07 and 6/30/09, 91.2 % for claims with admission dates between July 01, 2009 and January 31, 2011, and 95% for claims with admission dates on and after February 1, 2011.

The high outlier threshold when calculating the high outlier adjustment portion of the total payment allowed amount on the claim is explained in WAC 182-550-3700 (17)(d).

The percent of outlier adjustment factor is used as indicated in WAC 182-550-4800 to calculate payment for state-administered program claims that are eligible for a high outlier payment.

Note: For hospitals paid by the payment method used for out-of-state hospitals, the Agency pays for outlier claims that fall into one of the neonatal or pediatric AP-DRG classifications using 85% as the percent of outlier adjustment factor

- For claims with admission dates between August 1, 2007 and June 30, 2009, 85%.
- For claims with admission dates between July 1, 2009 and January 31, 2011, 81.6%.
- For claims with admission dates on and after February 1, 2011, 85%

Transfer Information for Diagnosis Related Group (DRG) Payment Method

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

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

  Nonhospital settings include the following:

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

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

- The transfer payment policy is applied to claims billed with patient status indicated as transferred cases. The service provided to the client is paid based on a stable DRG and 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 on the claim) divided by the average length of stay (for the DRG code determined by the Agency for the claim) multiplied by the client's length of stay plus 1 day; or

  - ✓ 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.

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

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

Per Diem Payment Method [Refer to WAC 182-550-3010 and 3460]

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:

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

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

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

  - ✓ No outlier adjustment is made for specialty services.

  - ✓ Chemical-Using Pregnant (CUP) Women services are identified by revenue code 129, not by AP-DRG classification. Refer to the current the Agency *Chemical-Using Pregnant (CUP) Women Program Medicaid Provider Guide* for more information.

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

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

Note: For information on the Acute PM&R program, refer to the current the Agency *Acute Physical Medicine and Rehabilitation (PM&R) Medicaid Provider Guide*.

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

- **Psychiatric hospitals**

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

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

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

- **Rehabilitation hospitals**

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

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

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

Note: The payment methods for long term acute care (LTAC) hospitals and freestanding detoxification facilities are different from rehabilitation hospitals. For LTAC see "Fixed Per Diem – LTAC" below, and for freestanding detoxification facilities see the Agency's current *Chemical Dependency Medicaid Provider Guide.*

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

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

High Outliers (Per Diem) [Refer to WAC 182-550-3700]

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

Qualifying for High Outlier Payment (Per Diem)

For dates of admission on and after August 1, 2007, the Agency may allow an adjustment for a high outlier for per diem claims grouped to a DRG classification in one of the acute unstable and/or low volume DRG service categories.

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

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

  - ✓ The fixed outlier threshold of $50,000; and
  - ✓ 175% of the initial claim payment allowed amount (inlier payment allowed amount). for claims with admission dates prior to July 1, 2009; or
  - ✓ 182.3% of the initial claim payment allowed amount (inlier payment allowed amount) for claims with admission dates between July 1, 2009 and January 31, 2011; or
  - ✓ 175% of the initial claim payment allowed amount (inlier payment allowed amount) for claims with admission dates on and after February 1, 2011.

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

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

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

  ✓ 156.3% of the initial claim payment allowed amount (inlier payment allowed amount) for claims with admission dates between July 1, 2009 and January 31, 2011; or

  ✓ 150% of the initial claim payment allowed amount (inlier payment allowed amount). For claims with admission dates on and after February 1, 2011.

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

Calculating High Outlier Payment (Per Diem)

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

- 85% for claims with admission dates between August 1, 2007, and June 30, 2009 and 81.6 % for claims with admission dates between July 1, 2009 and January 31, 2011, and 85% for claims with admission dates on and after February 1, 2011; or
- 90% for claims for burn services with admission dates between August 1, 2007 and June 30, 2009 and 86.4 % for claims with admission dates between July 1, 2009 and January 31, 2011, and 90% for claims with admission dates on and after February 1, 2011; or
- 95% for claims for neonate services or any claims at Children's or Mary Bridge with admission dates between August 1, 2007and June 30, 2009, 91.2 % for claims with admission dates between July 1, 2009 and January 31, 2011, and 95% for claims with admission dates on and after February 1, 2011.

The high outlier threshold when calculating the high outlier adjustment portion of the total payment allowed amount on the claim is explained in WAC 182-550-3700 (17) (d).

The percent of outlier adjustment factor is used as indicated in WAC 182-550-4800 to calculate payment for state-administered program claims that are eligible for a high outlier payment.

Note: Out-of-state hospitals are paid according to WAC 182-550-4000.

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 method

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

Per Case Payment Method **[Refer to WAC 182-550-3020 and 182-550-3470]**

Bariatric Surgery

To qualify to receive the bariatric case rate hospitals must:

- Be Agency-approved to receive the bariatric case rate;
- Receive prior authorization from the Agency to provide the bariatric service to the client; and
- Provide eligible bariatric services in the inpatient hospital setting.

In addition, when billing for bariatric services, the claim must include the following diagnosis and procedure codes:

- Primary diagnosis code 27801
- Procedure codes 4431, 4438, 4439, 4468, or 4495

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

- Sacred Heart Medical Center;
- Oregon Health Sciences University Hospital.

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

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

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

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

[Refer to 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, the following is required when billing:

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

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

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

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; and
- Long term acute care (LTAC) hospitals for covered inpatient services not covered in the per diem rate.

Certified Public Expenditure

Certified public expenditure hospitals are paid, as follows:

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

Payment for Services Provided to Clients Eligible for Medicare and Medicaid

The ProviderOne system derived payment amount will be the true claim payment amount using the appropriate OPPS, DRG, Fee Schedule, Fixed Case Rate, Per Diem or RCC reimbursement methodology that applies to the claim. Using that payment amount, for Medicaid clients who are entitled to Medicare Part A and/or Medicare Part B, the Agency pays the difference between the Medicare paid amount and the ProviderOne-derived payment amount or the deductible and/or coinsurance amounts on the claim, whichever is less.

Program Limitations

Medical Necessity

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

Administrative Days

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

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

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

Rate Guideline for New Hospitals [WAC 182-550-4100]

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

Psychiatric Services

Refer to the *Inpatient Hospital Psychiatric Admissions* section.

Major Trauma Services

Increased Payments for Major Trauma Care

The Washington State Legislature established the Trauma Care Fund (TCF) in 1997 to help offset the cost of operating and maintaining a statewide trauma care system. The Department of Health (DOH) and the 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 (15 years of age or older);
  b. 9 or greater for pediatric patients (14 years of age or younger); **or**
  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; and
- Provides all information the Agency requires to monitor, manage, and audit the trauma program.

For a list of the Designated Trauma Service Centers, check DOH's website at: http://www.doh.wa.gov/Portals/1/Documents/Pubs/530101.pdf

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:

- Agency's payments to each designated hospital for qualifying trauma claims from the beginning of the service year is summed, and

- Using this amount as a percentage of total payments made by the Agency to all Level I, II, and III hospitals for qualifying trauma claims for the service year-to-date.

- Each eligible hospital's payment percentage share for the service year-to-date is multiplied by the trauma supplemental funds available for the service year-to-date.

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

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

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

Cap on TCF Payments

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

Use Appropriate Condition Codes When Billing for Qualified Trauma Cases

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

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

Notes: 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 14 years of age only).

The ISS is a summary severity score for anatomic injuries.

- It is based upon the Abbreviated Injury Scale (AIS) severity scores for six body regions:
  - ✓ Head and neck;
  - ✓ Face;
  - ✓ Chest;
  - ✓ Abdominal and pelvic contents;
  - ✓ Extremities and pelvic girdle; and
  - ✓ External.

The ISS values range from 1 to 75 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

http://www.doh.wa.gov/PublicHealthandHealthcareProviders/EmergencyMedicalServicesEMSSystems/TraumaSystem.aspx.

For information on **payment**, contact:

Office of Hospital Finance
Health Care Authority
1-360-725-1835

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

Medical Assistance Customer Service Center
1-800-562-3022
Or email https://fortress.wa.gov/dshs/p1contactus/

NOTE: See the *Physician-Related Services/Healthcare Professionals Medicaid Provider Guide* for the list of Physicians/Clinical Providers eligible to receive enhanced rates for trauma care services.

Unbundling

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

Indicator Legend

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

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

* Blood products are not covered by the Agency. Associated processing/administration and storage fees are covered.

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

[2] Assumes practitioner is not billing the Agency.

Other Noncovered Items

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

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

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

The Agency requires billing providers to bill for RAS in order to track utilization and outcome. The Agency will monitor RAS through retrospective auditing of HCPCS code S2900, ICD 9 procedure code 14.42, and review of operative reports.

Authorization

General Authorization

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

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

The Agency's authorization requirements are met through the following processes:

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

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

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

Note: Please see the Agency *ProviderOne Billing and Resource Guide* for more information on requesting authorization.

Changes in Authorization Requirements for Selected Surgical Procedures

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

For more information about the requirements for submitting medical necessity reviews for authorization, please refer to the Agency's current published *Physician-Related. Services/Healthcare Professional Services Medicaid Provider Guide*.

"Write or Fax" Prior Authorization (PA)

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

Forms available to providers to request PA include:

- Basic Information form, 13-756;
- Bariatric Surgery Request form, 13-785; and
- 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" in this section for more information.

These forms are available at the Medicaid forms web site.

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

Send one of the completed fax forms listed above to the Agency (see *Important Contacts*).

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

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

- Faxes an approval letter to the provider and mails a copy of the letter to the client;
- Denies the request if the requested service is not medically necessary, and notifies the provider and client of the denial; or
- 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; and
- Includes example(s) of lesser cost alternatives that permit the affected party to prepare an appropriate response.

Surgical Policies

Authorization Requirements for Surgical Procedures

[Refer to WAC 182-531-1700]

Surgical Procedures that Require Medical Necessity Review by the Agency

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

- Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide or
- Rates Development Fee Schedules and scroll down to Physicians-Related/Professional and Emergent Oral Healthcare Services, then select the most current Physician and Related Services fee schedule link. Select a procedure code and refer to the comments field for the accompanying submittal requirement.

Surgical Procedures that Require Medical Necessity Review by Qualis Health

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

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

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

For more information about the requirements for submitting medical necessity reviews for authorization please refer to the Agency's current published *Physician-Related. Services/Healthcare Professional Services Medicaid Provider Guide*.

Breast Surgeries

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

Inpatient admissions are billable only when the stay meets the definition of inpatient admissions (see *Definitions & Abbreviations* section). Refer to Section I of the Agency *Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide* for EPA criteria.

Agency-Approved Bariatric Hospitals and Their Associated Clinics [WAC 182-531-1600, 182-550-2301 and 182-550-3020]

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

The Agency covers medically necessary bariatric surgery for clients age 21-59 in an approved hospital with a bariatric surgery program in accordance with WAC 182-531-1600. Agency covers bariatric surgery for clients age 18-20 for the laparoscopic gastric band procedure only (ICD-9-CM procedure 44.95). All bariatric surgeries require prior authorization (PA), and are approved when the client meets the criteria in WAC 182-531-1600.

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

To begin the authorization process, providers should fax a completed "Bariatric Surgery Request" form, 13-785, and the Basic Information form, 13-756 to the Agency (see *Important Contacts*).

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

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

Acute Physical Medicine and Rehabilitation (PM&R)

[Refer to 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, please provide room charges with one of the following revenue code 0128.

> **Note:** See approved Acute PM&R facilities on-line at: http://www.dshs.wa.gov/pdf/dbhr/da/APPNDXO.pdf.

Refer to the current Agency *Acute Physical Medicine and Rehabilitation (PM&R) Medicaid Provider Guide* for program specifics.

Long Term Acute Care (LTAC) [Refer to WAC 182-550-2590]

The Agency requires PA for all admissions to the Agency -approved LTAC hospitals. See the current Agency *Long Term Acute Care Program Medicaid Provider Guide* for more program specifics. Approved long term acute care hospitals are:

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

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

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

[Refer to WAC 182-550-6700, 182-501-0160, and 182-501-0180, 182-501-0184, 182-502-0120]

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

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

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

- The client is on a medical program that pays for out-of-state coverage (for example, Aged, Blind, Disabled Assistance (ABD), formerly Disability Lifeline clients have no out-of-state benefit except in designated bordering cities); and

- The service is for a covered medically necessary service that is unavailable in the State of Washington (refer to WAC 182-501-0060).

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

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

Out-of-State Air and Ground Ambulance Transportation

Refer to Chapter 182-546, WAC 182-546-0800, WAC 182-546-0900

The Agency requires prior authorization (PA) for all out-of-state non-emergency air ambulance transports. See the *Important Contacts* section for the telephone number to call for PA. Designated bordering cities, as defined by WAC 182-501-0175, are considered in-state, except for purposes of the Involuntary Treatment Act (ITA).

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

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

Out-of-Country Hospital Admissions

Refer to Chapter 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; and
- Needed medical services are more readily available in Canada and the aggregate cost of care is equal to or less than the aggregate cost of the same care when provided within the state. See WAC 182-501-0184.

Division of Behavioral Health and Recovery (DBHR) Detoxification

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 go to DBHR

Chemical-Using Pregnant (CUP) Women

Pregnant clients may be eligible to receive acute detoxification, medical stabilization, and rehabilitation services through the Chemical-Using Pregnant (CUP) Women Program. Please see the current Agency *Chemical-Using Pregnant (CUP) Women Program Medicaid Provider Guide* for details. A list of the Division of Behavioral Health and Recovery (DBHR) Certified Hospitals providing intensive inpatient care for chemical using pregnant women is located on The Agency's website at: http://www.dshs.wa.gov/pdf/dbhr/da/APPNDXF.pdf.

Medical Inpatient Detoxification (MID) Services

[Refer to WAC 182-550-4300]

In order to bill the Agency and get paid, hospitals that are not Division of Behavioral Health and Recovery (DBHR) approved detoxification facilities and have provided detoxification services to medical assistance clients must meet the following criteria:

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

What Are the MID Criteria?

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

1. The stay meets the intensity of service, severity of illness, and medical necessity standards necessary to qualify as an inpatient;

2. The principal diagnosis is in one of the following ranges:

291.00 - 292.9
303.00 - 303.92
304.00 - 304.92*
305.00 - 305.92*

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

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

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

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

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

7. Non-hospital 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.

What Authorization Number is Used When Billing for Medical Inpatient Detoxification (MID)?

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

Description	EPANumber
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 for MID Claims?

The Agency limits payment for medical inpatient detoxification days to:

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

See WAC 182-550-4300(7)

How Do I Bill the Agency for MID Services Exceeding the Three or Five Day Limitation?

When a MID stay exceeds the 3 or 5 day length-of-stay 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 non-covered 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	Non-covered Charges	Notes
Rev Code 012x	3Days	$**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	Non-covered Charges	Notes
Rev Code 012x	3 Days	$**xx.xx**		Charges for total days requested.
Rev Code 012x	2 Days	$xx.xx	$xx.xx	Charges for Days not to be evaluated.

Example 3

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

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

Example 4

The client is actively withdrawing from alcohol, meets MID criteria, and is in the hospital for 10 days. The stay meets InterQual® Acute Level of Care criteria for the first seven days. The hospital wants payment 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	Non-covered Charges	Notes
Rev Code 012x	7	$xx.xx		Charges for total days requested
Rev Code 012x	3	**$xx.xx**	**$xx.xx**	Charges for Days not to be evaluated.

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

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

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

For more information for submitting attachments go to the *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/billing/providerone_billing_and_resource_guide.html

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 Certified Public Expenditure (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 **non-covered column**. Insert the covered 3 or 5 days extension days into the **covered column**. EPA MUST still appear on the claim and "prev rev" MUST appear in the comments field. Under these circumstances do not void or adjust a denied claim.

Agency-Approved Centers of Excellence (COE)

[Refer to WAC 182-531-0650, 182-550-1900, 182-550-2100 and 182-550-2200]

Transplant services must be performed in an Agency-approved Center of Excellence (COE). **When performed in an Agency approved COE, these services do not require prior authorization (PA)**. See the list of Agency approved COEs within this Medicaid provider guide.

The Agency covers transplant procedures when:

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

When the above is true the Agency covers:

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

Note: 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; and
- Transplant procedures used in treating certain medical conditions that use procedures not generally accepted by the medical community, or that efficacy has not been documented in peer-reviewed medical publications.

Payment Limitations

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

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

Note: PA is required for transplants not performed in a COE. When private insurance or Medicare has paid as primary insurance and you are billing the Agency as secondary insurance, the Agency does not require PA or that the transplant, sleep study, or bariatric surgery be done in a Center of Excellence 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 of Excellence, go to Washington State Medicaid office of hospital finance rates and information fee-for-service Trauma DSH.

Ventricular Assist Device (VAD) Services

VAD services must be performed in an Agency-approved Hospital. When performed in an Agency-approved hospital, these services do not require prior authorization (PA).

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

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

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:

- Prior authorization (PA) is obtained;
- The heart team and hospital must be participating in a prospective, national, audited registry approved by CMS; and
- Conditions of the CMS Medicare National Coverage Determination must be met. For more information about CMS Medicare National Coverage Determination, please go to : http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R147NCD.pdf.

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

[Refer to 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 healthcare services provided are proper, necessary, and of good quality. The review considers the appropriateness of the place of service, level of care, and the duration, frequency, or quantity of healthcare services provided in relation to the condition(s) being treated.

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

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

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

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

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

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

Agency Retrospective Utilization Review (UR)

In accordance with 42 CFR 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 medical assistance funds. Payment to a hospital may be adjusted, denied or recouped, if the Agency determines that inpatient hospital services were not:

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

Changes in Admission Status

What Is Admission Status?

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

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

When Is a Change in Admission Status Required?

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

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

Change from Inpatient to Outpatient Observation Admission Status

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

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

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

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

  - ✓ Be dated with the date of the change; and

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

Change from Outpatient Observation to Inpatient Admission Status

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

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

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

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

  - ✓ Be dated with the date of the change; and

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

Change from Inpatient or Outpatient Observation to Outpatient Admission Status

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

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

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

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

  - ✓ Be dated with the date of the change; and

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

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

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

- The attending physician/practitioner and/or the hospital's utilization review staff determines that the client's symptoms/condition and/or treatment require an extended recovery time beyond the normal recovery time for the surgery/procedure and medical necessity for outpatient observation or inpatient level of care is met;

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

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

  ✓ Be dated with the date of the change; and

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

Note:	During post-payment retrospective utilization review, 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-9-CM Committee Coding Guidelines.

DRG and Per Diem Outliers

The Agency may retrospectively review outliers to verify:

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

Length-of-Stay (LOS) Reviews

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, prior authorization, and length of stay requirements are located in the *Inpatient Hospital Psychiatric Admissions* section of this Medicaid provider guide.

The DRG average LOS review applies only to:

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

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

Seven-Day Readmissions

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

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

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

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

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

Medical Record Requests

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

Health Care Authority
Attn: Hospital Retrospective Utilization Review Unit
PO Box 45503
Olympia WA 98504-5503

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

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

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

Hospital-Issued Notice of Noncoverage (HINN)

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

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

  A hospital's Utilization Review (UR) Committee must comply with the Code of Federal Regulations 42 CFR 456.11 through 42 CFR 456.135 prior to notifying a medical assistance client that he or she no longer needs inpatient hospital medical care. The hospital is ***not required*** to obtain approval from 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 medical assistance client decides to stay in the hospital when it is not medically necessary. A copy of this written notice must be sent to:

  Health Care Authority
  Attn: Hospital Retrospective Utilization Review Unit
  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 medical assistance client who chooses to remain in the hospital beyond the period of medical necessity may choose to pay for continued inpatient care as 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 Washington Administrative Code (WAC) 182-502-0160. These requirements are also published in the current the Agency *ProviderOne Billing and Resource Guide*.

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

Hospital Dispute and Appeal Process

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

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

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

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

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

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

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

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

Health Care Authority
Attn: Provider Request/Client Notification Unit
PO Box 45506
Olympia, WA 98504-5506
Fax: 1-360-586-1471

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

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

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

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

Health Care Authority
Attn: Hospital Retrospective Utilization Review Unit
PO Box 45503
Olympia, WA 98504-5503
Fax: 1-360-586-0212

Inpatient Hospital Psychiatric Admissions

Inpatient Hospital Psychiatric Care Criteria

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

- **Medically necessary** (as defined in WAC 182-500-0070);
- **For a principal covered diagnosis** (see "Diagnostic Categories" in the *Billing Procedures* section);
- **Approved (ordered)** by the professional in charge of the hospital or hospital unit; and
- **Certified**/authorized by an RSN representative on behalf of the Agency (as listed within this Medicaid provider guide in the Important Contacts section).

Provider Requirements

This Medicaid provider guide does not apply to:

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

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

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

- Medicare-certified, distinct psychiatric units;

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

- State-designated pediatric psychiatric units.

In addition to DOH licensure, hospitals providing **involuntary** hospital inpatient psychiatric care must be **certified** by The Department of Social and Health Services, Division of Behavioral Health and Recovery (DBHR) in accordance with WAC 388-865-0500 through 388-865-0504 and must meet the general conditions of payment criteria in WAC 182-502-0100.

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

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

Psychiatric Indigent Inpatient (PII) Program

Eligibility

The PII program affects indigent clients who receive voluntary hospital inpatient psychiatric care. Individuals must apply for this program. Individuals receive a Services Card but the benefit service package provides for and is described as inpatient psychiatric care only (IPCO). Indigent clients who are involuntarily hospitalized under chapters 71.05 and 71.34 RCW may be covered under other programs. Clients may qualify for the PII program only after they are determined ineligible for other medical programs.

Coverage

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

Medicaid Emergency Psychiatric Demonstration (MEPD) Project

Washington State has been selected to participate in a CMS Medicaid Emergency Psychiatric Demonstration (MEPD) project to study the impact and cost effectiveness of permitting federal funds to pay for evaluation and stabilization treatment of qualifying emergency medical conditions when adults 22-64 years of age are treated in institution(s) for mental diseases (IMDs). Evaluation and treatment are subject to Emergency Medical Treatment and Active Labor Act (EMTALA) admission requirements. Under the current operational plan, three specific IMDs are included as follows:

- Fairfax;
- Lourdes Counseling Center; and
- Navos.

The three IMDs above must submit claims to the Agency with MEPD special claim indicators when Medicaid enrollees are: 22-64 years of age, with an emergency medical condition that requires evaluation and stabilization services determined necessary by the treating physician or ARNP.

Note: In addition to the MEPD criteria listed above, participants must meet the same inpatient hospital psychiatric care criteria as all other Medical Assistance clients.

Non Coverage

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

Voluntary Treatment

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

Age of Consent for Voluntary Inpatient Hospital Psychiatric Care

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

Involuntary Treatment

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

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

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

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

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

Consent for Involuntary Admissions

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

Tribal Affiliation

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

Authorization Requirements for Inpatient Hospital Psychiatric Care

The hospital must obtain prior authorization (PA) from the appropriate RSN representative for *all* inpatient hospital psychiatric admissions when the Agency is the primary payor. To view RSN information, visit DBHR on the web at: http://www.dshs.wa.gov/dbhr/providerinformation.shtml#dbhr.

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

This PA requirement includes clients eligible for both Medicare and medical assistance who have exhausted their lifetime Medicare benefits at admission or during the course of hospitalization. This also includes clients with primary commercial or private insurance and who have secondary Medicaid coverage when their primary insurance has been exhausted at admission or during the course of hospitalization. Unless the hospital receives this authorization, the Agency will not pay for the services rendered. The RSN representative may not withhold its decision pending eligibility for medical assistance and must issue a documented authorization decision within the timelines of this section upon hospital request regardless of whether or not third party liability (TPL) is present. To determine which RSN to contact when RSN responsibility is unclear, refer to the flow chart at the end of this section.

Time Frames for Submission

Time frames for submission of PA requests are as follows:

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

Length of Stay Extension: Unless the RSN representative specifies otherwise within the PA record, hospitals must submit requests for continued stay at least 24 hours prior to the expiration of the authorization period. A hospital may choose to submit a request more than 24 hours prior to an expiration of an authorization period. Whenever possible, hospitals are encouraged to submit extension requests during regular business hours. RSN representatives are required to provide determination within 24 hours of the receipt of the extension request.

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

- **Retrospective:** Retrospective authorization may occur if the client becomes eligible for medical assistance after admission or in rare situations where circumstances beyond the control of the hospital prevented the hospital from requesting an authorization prior to admission. Hospitals may request authorization after the client is admitted, or admitted and discharged. RSN representatives acting as the PIHP have the authority to consider requests for retrospective certification for a client's voluntary inpatient psychiatric admission, length of stay extension, or transfer when hospital notification did not occur within the timeframes stipulated in **WAC 182-550-2600**.

  - ✓ For retrospective certification requests ***prior to discharge***, the hospital must submit a request for authorization for the current day and days forward. For these days, the RSN representative must respond to the hospital or hospital unit within 2 hours of the request and provide certification and authorization or denial within 12 hours of the request. For days prior to the current day (i.e. admission date to

the day before the RSN representative was contacted), the hospital must submit a separate request for authorization. The RSN representative must provide a determination within 30 days upon receipt of the required clinical documentation for the days prior to notification.

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

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

Medicare/Medicaid Dual Eligibility

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

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

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

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

Commercial (Private) Insurance

As with Medicare and Medicaid dual eligibility, hospitals are required to notify the RSN representative at admission if a client has commercial or private insurance that pays for hospital inpatient psychiatric care and has medical assistance as a secondary payer. Hospitals are required

to seek the RSN representative's authorization 24 hours prior to the benefit exhaustion of the commercial or private insurance for any anticipated days past the benefit exhaustion date. The RSN representative may provide authorization retrospectively in cases where a delay has occurred in the commercial or private insurer's notification to the hospital that the benefit is exhausted. RSN representatives are required to respond to requests within 2 hours and make a determination within 12 hours.

Changes in Status

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

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

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

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

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

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

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

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

Notification of Discharge

For clients who have been authorized for inpatient care by the RSN representative, hospitals must notify the RSN representative within 24 hours when a client has been discharged or has left against medical advice prior to the expiration of the authorized period. Authorized days which extend past the date the client was discharged or left the facility are not covered. The RSN representative will add the discharge date information to the ProviderOne PA record.

Denials

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

Diversions

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

Clinical Appeals

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

Administrative Disputes

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

Authorization Procedures for Inpatient Hospital Psychiatric Care

Documentation

To receive authorization for hospital inpatient psychiatric care, the hospital intending to provide the service must contact the appropriate RSN representative so the designee may construct an accurate prior authorization (PA) record within the following required timelines:

- **Prior Authorization (PA):** Hospitals must request authorization prior to admission. This PA requirement includes; clients with Medicare dual eligibility; clients with commercial or private insurance with Medicaid as secondary when: The client has exhausted their lifetime Medicare benefits at admission; or the commercial or private insurance has been exhausted at admission.

- For clients with Medicare dual eligibility and clients with commercial or private insurance who exhaust their lifetime benefits during the course of hospitalization, authorization must be sought within the calendar day of benefit exhaustion. If the hospital chooses to admit a client without PA due to staff shortages, the hospital must submit a request for initial authorization the same calendar day (which begins at midnight) as the admission. In these cases, the hospital assumes the risk for denial as the RSN representative may or may not authorize the care for that day. If there is disparity between the date of admission and date of authorization, the disparate days will not be covered. RSN representatives are required to respond to requests for authorization within 2 hours and make a determination within 12 hours.

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

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

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

Hospitals must request **subsequent/new authorizations** from the RSN representative for changes in:

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

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

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

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

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

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

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

- **Retrospective Certification for Admission to Inpatient Psychiatric Care (PA):** The PA subsystem is also used for retrospective certifications and provides the RSN representative's authorization for:

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

  Retrospective authorization may occur if the client becomes eligible for medical assistance after admission or in rare situations where circumstances beyond the control of the hospital prevented the hospital from requesting an authorization prior to admission. Hospitals may request authorization after the client is admitted, or admitted and discharged. An RSN representative on behalf of the Agency has the authority to render authorization decisions for retrospective certification for a client's voluntary inpatient psychiatric admission, length of stay extension, or transfer when hospital notification did not occur within the timeframes stipulated in **WAC 182-550-2600**.

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

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

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

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

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

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

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

Additional Requirements

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

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

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

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

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

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

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

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

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

  Note: See the *Clinical Data Required for PA* requests and "Clinical Data Required for Extension PA requests" sections farther along in this section.

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

- ✓ The Agency's RSN representative flow chart at the end of this section.
- ✓ RSN contact information available at: http://www.dshs.wa.gov/dbhr/rsn.shtml.
- ✓ CSO and HCS Office Information List at: http://www.dshs.wa.gov/onlinecso/findservice.shtml.

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

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

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

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

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

  The following information is expected:

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

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

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

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

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

  - ✓ A certified copy of the court order: 180-day commitment petition with supporting affidavits from a physician and the psychiatrist or a children's mental health specialist;
  - ✓ A diagnosis by a Psychiatrist including Axis I-V related to the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
  - ✓ An admission evaluation including:
    - ➢ Medical evaluation; and
    - ➢ Psychosocial evaluation;
  - ✓ The hospital record face sheet;
  - ✓ Other information about medical status including:
    - ➢ Laboratory work;
    - ➢ Medication records; and
    - ➢ Consultation reports;

- ✓ An outline of the child's entire treatment history;
- ✓ All transfer summaries from other hospitals where the child has been admitted during the current commitment as well as discharge summaries from any prior facility; and
- ✓ A brief summary of child's progress in treatment to date including hospital course, family involvement, special treatment needs, and recommendations for long-term treatment/assignment.

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

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

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

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

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

Billing for Inpatient Hospital Psychiatric Care

General Billing for Inpatient Hospital Psychiatric Care

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

- Hospitals must contact the appropriate RSN so that the RSN may construct a valid PA record for voluntary or involuntary hospital inpatient psychiatric admission in accordance with the current the Agency *Inpatient Hospital Services Medicaid Provider Guide*.

- For ***all*** hospital inpatient psychiatric admissions, including clients with Medicare dual eligibility (when Medicare lifetime benefit has exhausted) as well as clients with commercial or private insurance with Medicaid as secondary payer (when primary insurance is exhausted), hospitals must obtain authorization from the appropriate RSN representative.

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

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

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

- The PA record provide the hospital with authorization for:

  - ✓ Authorized days (covered REV code days);
  - ✓ Administrative days, if applicable (paid at the administrative payment methodology);
  - ✓ Non-authorized days (non-covered) for the **initial** or **extended** stay respectively; and
  - ✓ Date when the hospital must contact the RSN representative for an extension request.

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

Note: The Agency *ProviderOne Billing and Resource Guide* provides information on how to "Check Status of an Authorization" in Appendix F.

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

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

Example:

Revenue Code	Covered Days	Non-covered Days
Rev Code 0xx4	$**xx.xx**	
Rev Code 0xx4		$**xx.xx**

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

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

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

Note: The claim must indicate in the *Comments* section of the claim form whether the days billed were **voluntary** or **involuntary. Use the following special claims indicator to show how the client was admitted:**

- **"SCI=V" for voluntary; or**
- **"SCI=I" for involuntary**.

Claims for voluntary or involuntary portions of an episode of care must be authorized separately and billed separately.

Claims for Psychiatric Services When the Principle Diagnosis Falls Outside of the RSN Psychiatric Diagnosis Range

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

- An inpatient psychiatric admission to the hospital occurs on an involuntary, or voluntary basis;
- The admission is authorized by an RSN representative on behalf of the agency; and
- The principal diagnosis on the hospital claim is a medical diagnosis (e.g. 648.43 or 331.00),

Billing Instructions Specific to Involuntary Treatment

- The Agency will process claims for services provided to detained clients who have applied for medical assistance and were denied if the RSN representative requests the creation of an ITA related eligibility segment (previously called ITA-Q).
- **Out-of-state hospitals** must obtain authorization from the appropriate the Agency's RSN representative for all **Medicaid** clients. Neither the Agency nor the RSN representative pays for inpatient services for non-Medicaid clients if provided outside of the State of Washington. An exception is for clients who are qualified for the ABD (formerly Disability Lifeline and GAU). For these clients, the Agency and the RSN representative pays for inpatient psychiatric services provided in bordering cities and critical border hospitals. All claims for admissions to **out-of-state hospitals** are paid as **voluntary** legal status as the Involuntary Treatment Act applies only within the borders of Washington State.
- For all clients involuntarily detained under Chapter 71.34 or 71.05 RCW, the Agency does *not* provide payment for hospital inpatient psychiatric care past the **20th calendar day** from the date of initial detention *unless* a length of stay extension certification request is authorized by the RSN representative.
- **Psychologist services** are covered *only* for provision of a psychological evaluation of detained clients. (See the current the Agency's *Psychologist Medicaid Provider Guide* for related policy and/or procedure codes). As with all other claims, an authorization form must accompany the claim. Attaching the authorization form serves as verification of the involuntary status.

Note:	In order to be paid, all claims must be accurate, complete, and include the required documents as indicated in this section. Incorrectly or partially completed claims, or claims not associated with at valid PA record, will be denied and require resubmission which will delay payment.

Billing Instructions Specific to IMDs participating in the Medicaid Emergency Psychiatric Demonstration Project Providing Stabilizing Treatment Related to An Emergency Medical Condition

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

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

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

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

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

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

Billing When Medicare Part A Benefits Run Out During the Stay

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

Billing for Medical Admissions with Psychiatric Principle Diagnosis

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

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.

Diagnostic Categories

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

Organic Psychotic Conditions (290-294)

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

Other Psychoses (295-299)

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

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

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

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

Non-psychotic Mental Disorders (302-316)

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

Mental Retardation (317-319)

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

Noted Exceptions:

- The requirements in this section do not apply to 3- and 5-day detoxification program admissions associated with the Division of Behavioral Health and Recovery (DBHR). Please reference the current *Hospital-Based Inpatient Detoxification Medicaid Provider Guide*.

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

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

- For medical inpatient detoxification (MID) see the *Utilization Review* section of this Medicaid provider guide.

Clinical Data Required For Initial Certification

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

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

Clinical Data Required For Extension Certification

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

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

Clinical Data Required for MEPD participants

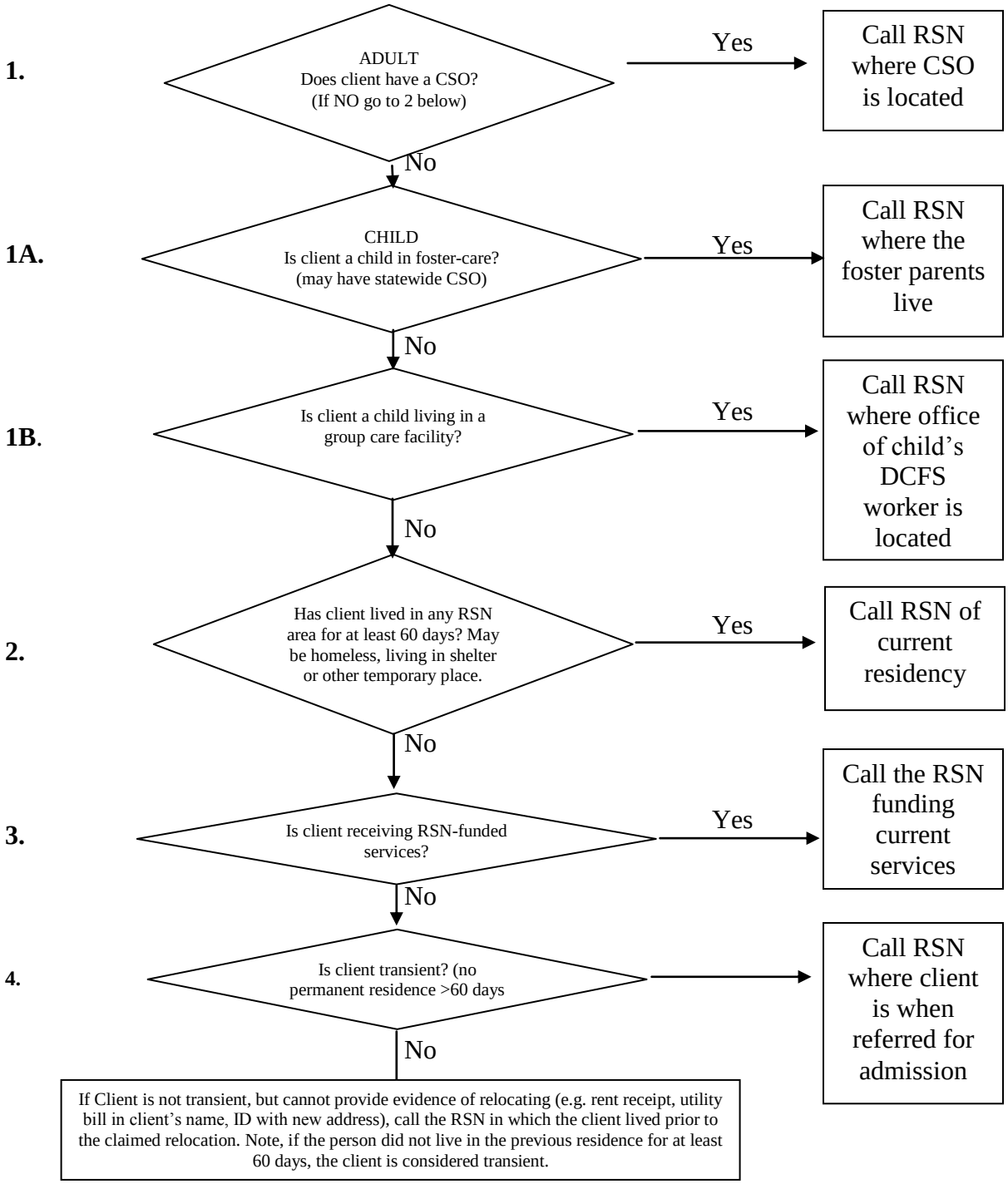
IMD hospitals participating in the MEPD must also provide the following data elements directly to the state in quarterly implements:

Qualifying Emergency	
Emergency Admission Reason	1 = Suicidal thoughts and/or gestures. 2 = Homicidal thoughts and/or gestures. 3 = Both suicidal and homicidal thoughts and/or gestures. 4 = Determined to be a danger to self or others by means other than suicidal or homicidal.
Adverse Events	
Emergency Admission to an Acute Care Hospital	If the patient is transferred to an acute-care hospital, is the transfer due to an emergency condition? For each occurrence record: 1 = Yes. 2 = No. 8 = Not Applicable. 9 = Information not available.
Injury or infection	Report whether a patient injury or infection occurs during the IMD stay using the following data elements: 1 = Self-inflicted injury. 2= Nosocomial injury only. 3 = Nosocomial infection only.' 4 = Both nosocomial injury and infection. *5* = Neither injury nor infection. 8 = Not applicable. 9 = Do not know/Refused.
Serious Adverse Events	Report any serious adverse events occurring during an IMD stay for an MEPD participant: i.e., death, physical injury whether self-induced or accidental, nosocomial infection, or illness and any emergency admission to an acute care hospital for any reason. More detailed information is available from the National Quality Forum's (NQF) serious reportable events at: (http://www.qualityforum.org/News_And_Resources/Press_Releases/2011/NQF_Releases_Updated_Serious_Reportable_Events.aspx). Please report the following information on any serious adverse events that occurred in your hospital: • Name of the affected patient; • Detailed reasons for the adverse events; and • Corrective actions taken by the hospital.

Note: For claims processing to occur, data elements on the PA record and billing record submitted by the hospital must match. This includes the NPI of the hospital and the valid ProviderOne Client ID.

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

For intended purpose, see *Billing Procedures* section.



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

General Billing

What Are the General Billing Requirements?

Providers must follow the general billing requirements. See the *ProviderOne Billing and Resource Guide* online. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims;

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

- What fee to bill the Agency for eligible clients;
- When providers may bill a client;
- Billing for clients eligible for both Medicare and Medicaid
- Billing for services provided to managed care clients, and primary care case management (PCCM) clients; and
- Record keeping requirements.

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

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

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

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

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

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

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

How Are Outpatient Hospital Services Prior to Admission Paid?

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

How Are Outpatient Hospital Services During an Inpatient Admission Paid?

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

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

Billing for Neonates/Newborns

For services provided to a newborn who has not yet received his/her Services Card, bill the Agency using the mom's ProviderOne Client ID in the appropriate fields on the UB-04 Claim Form.

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

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

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

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

Neonatal/Newborn Coding

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

Newborn Births Billed Using Paper Claims

For UB-04 claims:

- Newborn birth weights must be included on claims that use a neonate DRG code.
- Use Code "54" for the birth weight;
- Use form locater 39-41Value Codes;
- Provide the weight in grams in whole numbers.

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

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

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

Procedure Codes and Diagnosis Codes Effective Dates

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

Submitting Adjustments to a Paid Inpatient Hospital Claim

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

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

Present on Admission Indicators

The Agency requires present on admission (POA) indicators on all inpatient claims. All inpatient claims will be reviewed for hospital acquired conditions (HAC) consistent with Medicare policy and will not receive additional payment related to treatment of the HAC. For more information. (See WAC 182-550-1650)

How to Indicate a POA

On a UB-04 Claim, the POA indicator is the eighth digit of the Field Locator (FL) 67, Principal Diagnosis, and the eighth digit of each of the Secondary Diagnosis fields, FL 67 A-Q.

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

How to Indicate a POA on a Direct Data Entry Claim

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

For each diagnosis entered there is a box to enter the Present on Admission Indicator.

Present on Admission Valid Values:

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

How to Indicate a POA on an Electronic Claim

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

Principle 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

Present on Admission Valid Values:

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

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:

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

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

Billing for Administrative Day(s)

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

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

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

On a separate claim form, bill:

- The date span the client qualified for the administrative day(s);
- Revenue code 0169 for the accommodation room and board.

Inpatient Hospital Stays Without Room Charges

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

Billing Acute Inpatient Stay When Client Elects Hospice

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

Questions and Answers from NUBC Manual

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

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

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

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

Description	DRG	Per Diem	RCC	CPE	CAH
Bill Medicare Part B for qualifying services delivered during the hospital stay.	Yes	Yes	Yes	Yes	Yes
Bill the Agency for hospital stay as primary.	Yes	Yes	Yes	Yes	Yes
Show as noncovered on the Agency 's bill what was billed to Medicare under Part B.	Yes	Yes	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*

* The Agency pays line item by line item on some claims (RCC, CPE, CAH). The Agency does not pay for line items that Medicare has already paid. 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.

What the Agency Pays the Hospital:

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

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

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

Required Consent Forms for Hysterectomies

[Refer to WAC 182-531-1550(10)]

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

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

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

- Submit the claim and completed the Agency -approved consent form to the Agency (see *Important Contacts*).

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

Medicaid Forms

Sterilization

What Is Sterilization? [Refer to WAC 182-531-1550(1)]

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

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

What Are the Agency's Payment Requirements for Sterilizations? [Refer to WAC 182-531-1550(2)]

The Agency covers sterilization when all of the following apply:

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

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

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

> To **download** agency forms, go to Medicaid forms scroll down to Sterilization Consent form, 13-364.

Additional Requirements for Sterilization of Mentally Incompetent or Institutionalized Clients

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

- Court orders that include the following:
  - ✓ A statement that the client is to be sterilized; **and**
  - ✓ The name of the client's legal guardian, who will be giving consent for the sterilization.
- Sterilization Consent form, 13-364, signed by the client's legal guardian.

When Does the Agency Waive the 30-day Waiting Period?

[WAC 182-531-1550(3) and (4)]

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

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

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

- The client became eligible for Medical Assistance during the last month of pregnancy (**Claim Form field 80:** *"NOT ELIGIBLE 30 DAYS BEFORE DELIVERY"*)*;* or
- The client did not obtain medical care until the last month of pregnancy (**Claim Form field 80:** *"NO MEDICAL CARE 30 DAYS BEFORE DELIVERY"*); or
- The client was a substance abuser during pregnancy, but is not using alcohol or illegal drugs at the time of delivery. (**Claim Form field 80:** *"NO SUBSTANCE ABUSE AT TIME OF DELIVERY."*)

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

When Does the Agency Not Accept a Signed Sterilization Consent Form? [Refer to WAC 182-531-1550(5) and (6)]

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

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

Why Do I Need an Agency-Approved Sterilization Consent Form?

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

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

To **download** agency forms, go to Medicaid forms scroll down to Sterilization Consent form, 13-364.

The Agency will deny a claim for a procedure received without the Sterilization Consent form, 13-364. The Agency will deny a claim with an incomplete or improperly completed Sterilization Consent form. Submit the claim and completed Sterilization Consent form, 13-364, to:

Health Care Authority
Washington Medicaid Program
PO Box 9248
Olympia WA 98507-9248

If you are submitting your sterilization claim form electronically, be sure to indicate in the comments section that you are sending in a hard copy of the Sterilization Consent form, 13-364. Then send in the form with the electronic claims Transaction Control Number (TCN).

Who Completes the Sterilization Consent Form?

- Sections I, II, and III of the Sterilization Consent Form are completed by the client, interpreter (if needed), and the physician/clinic representative more than 30 days, but less than 180 days, prior to date of sterilization. If less than 30 days, refer to: "When does the Agency waive the 30 day waiting period?" and/or section IV of the Sterilization Consent Form.

- The bottom right portion (section IV) of the Sterilization Consent Form is completed shortly before, on, or after the surgery date by the physician who performed the surgery.

- If the initial Sterilization Consent Form Sections I, II, and III are completed by one physician or group and a different physician or group performed the surgery. The physician performing the surgery completes another Sterilization Consent Form filling in section IV and the client signs and dates lines (7) and (8) of Section I. The client's date of signature can be the date of surgery or after. Send in both consent forms with the claim.

Frequently Asked Questions on Billing Sterilizations

1. **If I provide sterilization services to Family Planning Only clients along with a secondary surgical intervention, such as lysis of adhesions, will I be paid?**

   The scope of coverage for Family Planning Only clients is limited to contraceptive intervention only. The Agency does not pay for any other medical services unless they are medically necessary in order for the client to safely, effectively and successfully use or continue to use their chosen birth control method.

   Only claims submitted with diagnosis codes in the V25 series (excluding V25.3) will be processed for possible payment. All other diagnosis codes are noncovered and will not be paid.

   Note: Remember, you must submit all sterilization claims with the **completed,** federally approved Sterilization Consent Form.

2. **If I provide sterilization services to a Medicaid, full scope of care client along with a secondary surgical intervention, such as lysis of adhesions or Cesarean Section delivery, how do I bill?**

   CNP clients have full scope of care and are eligible for more than contraceptive intervention only. Submit the claim with a completed, federally approved Sterilization Consent Form for payment.

Sterilizations require a properly signed consent form.

Complete an additional consent form if:

- You do not have a signed consent form on file when the client is admitted for a delivery, but the client states she has signed a consent form; or

- Another physician is performing the surgery other than the one who signed the original consent form and complete section IV of the form of the Sterilization Consent Form. Have the client sign and date lines (7) and (8) of section I. She can sign on the date of surgery or after the date. Submit both consent forms with your claim.

Requesting an exception to policy for consideration of payment for sterilizations without a proper consent form and payment for other procedures.

If you do not have properly signed consent form and your claim was denied:

- Submit a Request for Exception to Policy for Consideration of Payment Basic Information form, 13-756, and explain the circumstances for why the consent was not signed properly, and include a copy of the:

- Sterilization Consent form, 13-364, or the hospital consent form;

- History and physical; and

- Discharge summary.

Send this information to the Agency at:

Family Planning Program Manager
P.O. Box 45530
Olympia WA 98504-5530
(360) 664-4371 (fax)

After review of the submitted information, the Agency may:

- Pay for the major procedure such as the delivery; and
- Pay for the sterilization out of state funds; or
- Deny sterilization. When sterilization is denied, to receive payment for the non-sterilization services, providers must split the bill, taking out the sterilization-related charges. The sterilization claim may be billed to the Agency, but will be denied.

How to Complete the Sterilization Consent Form

- All information on the Sterilization Consent form, 13-364, must be legible.
- All blanks on the Sterilization Consent form, 13-364, must be completed *except* race, ethnicity, and interpreter's statement (unless needed).
- The Agency does not accept "stamped" or electronic signatures.

The following numbers correspond to those listed on the Sterilization Consent form, 13-364:

Section I: Consent to Sterilization	
Item	**Instructions**
1. Physician or Clinic:	**Must be name of physician, ARNP, or clinic that gave client required information regarding sterilization.** This may be different than performing physician if another physician takes over. *Examples: Clinic – ABC Clinic. Physician – Either doctor's name, or doctor on call at ABC Clinic.*
2. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
3. Month/Day/Year:	Must be client's birth date.
4. Individual to be sterilized:	Must be client's first and last name. Must be same name as Items #7, #12, and #18 on Sterilization Consent form, 13-364.
5. Physician:	Can be group of physician or ARNP names, clinic names, or physician or ARNP on call at the clinic. This doesn't have to be the same name signed on Item # 22.
6. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
7. Signature:	Client signature. Must be client's first and last name. Must be same name as Items #4, #12, and #18 on Sterilization Consent form, 13-364. Must be signed in ink.

Item	Instructions
8. Month/Day/Year:	Date of consent. Must be date that client was initially counseled regarding sterilization. Must be more than 30 days, but less than 180 days, prior to date of sterilization (Item # 19). **Note**: This is true even of shorter months such as February. The first day of the 30 day wait period begins the day after the client signs and dates the consent form, line #8. Example: If the consent form was signed on 2/2/2005, the client has met the 30-day wait period on 3/5/2005. If less than 30 days, refer to: "When does the Agency waive the 30 day waiting period?" and section IV of Sterilization Consent form, 13-364.

Section II: Interpreter's Statement

Item	Instructions
9. Language:	**Must specify language into which sterilization information statement has been translated.**
10. Interpreter:	Must be interpreter's name. **Must be interpreter's original signature in ink.**
11. Date:	Must be date of interpreter's statement.

Section III: Statement of Person Obtaining Consent

Item	Instructions
12. Name of individual:	Must be client's first and last name. Must be same name as Items #4, #7, and #18 on Sterilization Consent Form.
13. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
14. Signature of person obtaining consent:	Must be first and last name signed in ink.
15. Date:	Date consent was obtained.
16. Facility:	Must be full name of clinic or physician obtaining consent. Initials are acceptable.
17. Address:	Must be physical address of physician's clinic or office obtaining consent.

Section IV: Physician's Statement

Item	Instructions
18. Name of individual to be sterilized:	Must be client's first and last name. Must be same name as Items #4, #7, and #12 on Sterilization Consent form, 13-364.
19. Date of sterilization:	Must be more than 30 days, but less than 180 days, from client's signed consent date listed in Item #8. If less than 30 days, refer to: "When does the Agency waive the 30 day waiting period?" and section IV of the Sterilization Consent form, 13-364.
20. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
21. Expected date of delivery:	When premature delivery box is checked, this date must be *expected* date of delivery. Do not use actual date of delivery.
22. Physician:	Physician's or ARNP's signature. Must be physician or ARNP who **actually** performed sterilization procedure. Must be signed in ink. Name must be the same name as on the claim submitted for payment.
23. Date:	Date of physician's or ARNP's signature. Must be completed either shortly before, on, or after the sterilization procedure.
24. Physician's printed name	Please print physician's or ARNP's name signed on Item #22.

How to Complete the Sterilization Consent Form for a Client Age 18-20

1. Use Sterilization Consent Form, 13-364.

2. Cross out "**age 21**" in the following three places on the form and write in "**18**":

   a. Section I: Consent to Sterilization: **"I am at least 21…"**

   b. Section III: Statement of Person Obtaining Consent: **"To the best of my knowledge… is at least 21…"**

   c. Section IV: Physician's Statement: **"To the best of my knowledge… is at least 21…"**

SAMPLE STERILIZATION CONSENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) **Dr. Tim Lu**
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized . If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) **tubal ligation**
Specify type of operation
The discomforts, risks, and

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 years of age and was born on (3) **August 1, 1971**
Month Day Year

I (4) **Jane Doe**
Individual to be sterilized
hereby consent of my own

free will to be sterilized by (5) **Dr. Tim Lu**
Physician

by a method called (6) **tubal ligation**
Specify type of operation
My consent

expires 180 days from the date of my signature below.
I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) **August 20, 2001**
Signature *Month Day Year*

You are requested to supply the following information, but it is not required.
Race and ethnicity designation (please check):

- ☒ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the

consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter *Date*

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SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) **Jane Doe**
Name of individual
signed the consent form, I

explained to him/her the nature of the sterilization operation,

(13) **tubal ligation**
Specify type of operation
the fact that it is intended to be

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) **August 20, 2001**
Signature of person obtaining consent *Date*

(16) **US Clinic**
Facility

(17) **PO Box 123, Anywhere, WA 98000**
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) **Jane Doe** (19) **October 1, 2001**
Name of individual to be sterilized *Date of sterilization operation*

I explained to him/her the nature of the sterilization operation

(20) **tubal ligation**
Specify type of operation
The fact that it is intended to be

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less that 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- ☐ Premature delivery
  Individual's expected date of delivery (21) _____
- ☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) **October 1, 2001**
Physician's Signature *Date*

(24) **Dr. Tim Lu**
Physician's Printed Name

Completing the UB-04 Claim Form

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

Specific Instructions for Medicare Crossovers

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

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

What does the Agency require from the provider-generated EOMB to process a crossover claim?

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

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

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

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

How do I submit institutional services on a UB 04 claim for inpatient clients who are eligible for Medicare Part B Benefits but not eligible for Medicare Part A Benefits or Medicare Part A benefits are exhausted?

All Claims:

Include comment in Remarks section

- "No Part A Benefits";
- "Part A Exhausted Prior to Stay"; or
- "Part A Exhausted During Stay".

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

When No Part A or Part A exhausted prior to stay follow the process as indicated.

- **If your facility is reimbursed using PPS method (DRG and Per Diem):**
  - ✓ Enter "Part B" in form locator 50 (A,B,C); and
  - ✓ Enter the amount Medicare paid for the Part B hospital charges in the corresponding line of for locator 54(A, B, C); and
  - ✓ Attach the Explanation of Medicare Benefit (EOMB) Parts A and B to the claim.

- **If Your Facility is Reimbursed Using RCC (Ratio of Cost to Charges) Method**

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

Claims will be denied if one of the following condition codes are submitted:

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