Washington State Health Care Authority

Washington Apple Health (Medicaid)

Outpatient Hospital Services Billing Guide

October 1, 2025

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, check the most recent version of the guide. If the broken link is in the most recent guide, notify us at askmedicaid@hca.wa.gov.

About this guide[1]

This publication takes effect **October 1, 2025**, and supersedes earlier guides to this program. Unless otherwise specified, the program(s) in this guide is governed by the rules found in Chapter 182-550 WAC.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, call 1-800-562-3022. People who have hearing or speech disabilities, call 711 for relay services.

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

Services, equipment, or both, related to any of the programs listed below must be billed using their specific billing guides:

- Inpatient Hospital Services
- Physician-Related Services/Health Care Professional Services

How can I get HCA provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Health care privacy toolkit

The Washington Health Care Privacy Toolkit is a resource for providers required to comply with health care privacy laws.

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[1] This publication is a billing instruction.

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Where can I download HCA forms?

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

Copyright disclosure

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Entire guide	Grammar/punctuation changes	To improve usability and clarity
How do I bill for hospital IOP/PHP services?	Added a note box stating, "All hospital claims must be submitted with a hospital taxonomy to be eligible for payment."	To improve clarity. Not a policy change.

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Table of Contents

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC and WAC 182-550-1050 for a complete list of definitions for Washington Apple Health.

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

Budget target adjustor – A multiplier applied to the Outpatient Prospective Payment System (OPPS) payment to ensure aggregate payments do not exceed the established budget target.

Bundled services – Interventions integral to or related to the major procedure.

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

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

Alert: Inpatient maternity services are treated as emergency services when HCA pays a hospital for those services.

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

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

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

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

OPPS – See Outpatient Prospective Payment System.

Outpatient care – See Outpatient hospital services.

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

Outpatient hospital services – Those health care services that are within a hospital's licensure and provided to a client who is designated as an outpatient.

Outpatient Prospective Payment System (OPPS) – The payment system used by HCA to calculate reimbursement to hospitals for the facility component of outpatient services. This system uses enhanced ambulatory patient groups (EAPGs) as the primary basis of payment.

Outpatient Prospective Payment System (OPPS) conversion factor – See Outpatient Prospective payment system (OPPS) rate.

Outpatient Prospective Payment System (OPPS) rate - A hospital-specific multiplier calculated by HCA that is one of the components of the EAPG payment calculation.

Pass-throughs – Certain drugs, devices, and biologicals, as identified by centers for Medicare and Medicaid Studies (CMS), for which providers are entitled to additional separate payment until the drugs, devices, or biologicals are paid per the OPPS fee schedule.

Principal diagnosis – The condition chiefly responsible for the admission of the patient to the hospital.

Policy adjustor – A payment factor that increases the reimbursement of EAPGs for clients age 17 and younger.

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

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

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About the Program

What is the purpose of the outpatient hospital services program?

The purpose of the outpatient hospital services program is to provide outpatient services, emergency outpatient surgical care, and other emergency care administered to eligible clients and performed on an outpatient basis in a hospital.

How does medical necessity apply to outpatient hospital services?

(WAC 182-500-0070)

HCA pays only for covered services and items that are medically necessary.

What about outpatient hospital services provided within one calendar day of paid inpatient admission?

Providers must bill the following outpatient hospital services on the inpatient hospital claim when provided within one calendar day of a client's inpatient hospital stay:

- Preadmission
- Emergency room
- Observation services related to an inpatient hospital stay

Where can I find information on Social Determinants of Health (SDOH)?

See HCA's Physician-Related Services/Health Care Professional Services Billing Guide for information on social determinates of health.

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Client Eligibility

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

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

How do I verify a client's eligibility?

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

Verifying eligibility is a two-step process:

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

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

Step 2. Verify service coverage under the Apple Health client's benefit package. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's **Program benefit packages and scope of services** webpage.

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

- **Online**: Go to **Washington Healthplanfinder** - select the "Let's get started" button. For patients age 65 and older or on Medicare, go to **Washington Connections** select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 1-855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Support (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

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

Yes. Most Apple Health clients are enrolled in one of HCA's contracted MCOs. For these clients, managed care enrollment is displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. The MCO is responsible for payment of:

- Covered services
- Services referred by a provider participating with the plan to an outside provider
- Dental procedures when billed with a CDT or CPT procedure code with Operating Room Services revenue code 0360 or 0361.

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

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

> **Note:** To prevent billing denials, check the client's eligibility **before** scheduling services and at the **time of the service**, and make sure proper authorization or referral is obtained from HCA-contracted MCO, if appropriate. Providers must receive authorization from the client's MCO primary care provider before providing services, **except for emergency services**. See HCA's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

> Hospital and ambulatory surgery center facility fees for dental surgeries for eligible clients enrolled in an HCA-contracted MCO must be billed directly through the client's MCO. When a prior authorization (PA) is required or when using an expedited prior authorization (EPA) for dental surgeries, enter the PA or EPA number on your claim to the MCO.

Managed care enrollment

Most Apple Health clients are enrolled in an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may start their first month of eligibility in the fee-for-service (FFS) program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination.

Exceptions:

- Apple Health Expansion clients are enrolled in managed care and will not start their first month of eligibility in the FFS program. For more information, visit Apple Health Expansion. Providers must check eligibility to determine enrollment for the month of service.
- Clients who are eligible to receive Reentry Initiative services and who are eligible for enrollment in an HCA-contracted managed care organization (MCO) will not start their first month of eligibility in the FFS program. Providers must check eligibility to determine enrollment for the month of service.

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

Checking eligibility

Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to HCA's **Apply for or renew coverage webpage**.

Clients' options to change plans

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account:**
- Go to **Washington Healthplanfinder website**.
- **Available to all Apple Health clients:**
  - Visit the **ProviderOne Client Portal website**.
  - Request a change online at **ProviderOne Contact Us** (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

For online information, direct clients to HCA's **Apple Health Managed Care webpage**.

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

Some Apple Health clients do not meet the qualifications for managed care enrollment. These clients are eligible for physical health services under the fee-for-service (FFS) program.

In this situation, each managed care organization (MCO) will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in integrated managed care. The BHSO covers only behavioral health treatment for clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO, except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS Medicaid program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into an integrated managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care Alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

Integrated Apple Health Foster Care (AHFC)

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

Clients under this program are:

- Age 17 and younger who are in foster care (out of home placement) or in the Unaccompanied Refugee Minors (URM) program
- Age 20 and younger who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

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

The Apple Health Customer Services team can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAS) team at 1-800-562-3022, Ext. 15480.

Apple Health Expansion

Individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs and who receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contract health plan. For more information, visit **Apple Health Expansion**.

Reentry Initiative

The Reentry Demonstration Initiative (Reentry Initiative) is a new Apple Health (Medicaid) initiative under the Medicaid Transformation Project (MTP). Under this initiative, incarcerated people who are Apple Health-eligible may receive a limited set of health care services through fee-for-service (FFS) or their HCA-contracted managed care organization (MCO) for up to 90 days before their release from carceral facilities within Washington State. For more information, visit **Reentry from a carceral setting**.

Fee-for-service Apple Health Foster Care

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

American Indian/Alaska Native (AI/AN) Clients

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

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

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) **American Indian/Alaska Native webpage**.

Admissions

What are the criteria for an outpatient short stay?

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

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

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

What is admission status?

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.

Some examples of typical types of admission status are:

- Inpatient
- Outpatient observation
- Medical observation
- Outpatient surgery or short stay surgery
- Outpatient (e.g., emergency room)

When to change admission status

A change in admission status is required when a client's symptoms/condition and 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. HCA does not pay for any of the following:

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

Changing status from inpatient to outpatient observation

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

- The attending physician/practitioner or the hospital's utilization review staff, or both, determine 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 before, or on the next business day following, discharge.
- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the document must:
    - Be dated with the date of the change.
    - Contain the reason the change was not made before discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Changing status from outpatient observation to inpatient

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

- The attending physician/practitioner or the hospital's utilization review staff, or both, determine 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 before, or on the next business day following, discharge.
- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:
    - Be dated with the date of the change.
    - Contain the reason the change was not made before discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Changing status from inpatient or outpatient observation to outpatient

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

- The attending physician/practitioner or the hospital's utilization review staff, or both, determine 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 before, or on the next business day following, discharge.
- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:
  - Be dated with the date of the change.
  - Contain the reason the change was not made before discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Changing status from outpatient surgery/procedure to outpatient observation or inpatient

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 or the hospital's utilization review staff, or both, determine that the client's symptoms/condition or treatment, or both, 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 before, or on the next business day following, discharge.
- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:
  - Be dated with the date of the change.
  - Contain the reason the change was not made before discharge (e.g., due to the discharge occurring on the weekend or a holiday).

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

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Major Trauma Services

Increased payments for major trauma care

For information on increased payments for major trauma care, see the **Inpatient Hospital Services Billing Guide** or the **Physician-Related Services/Health Care Professional Services Billing Guide**:

Surgery

Surgical procedures, medical procedures, and evaluations

See HCA's Physician-Related Services/Health Care Professional Services Billing Guide for more information on HCA's surgical procedures, medical procedures, and evaluations, including but not limited to the following:

- Carotid artery stenting
- Cervical spinal fusion arthrodesis
- Coronary artery calcium scoring
- Drug eluting or bare metal cardiac stents
- Facet neurotomy, cervical and lumbar
- Hip resurfacing
- Hip surgery for femoroacetabular impingement syndrome
- Implantable ventricular assist devices
- Percutaneous kyphoplasty, vertebroplasty and sacroplasty
- Sacroiliac Joint Fusion
- Sterilization and hysterectomy (also see HCA's Sterilization Supplemental Billing Guide)
- Transgender Surgery (also see HCA's Transhealth Program Billing Guide)

Cochlear implants and bone conduction hearing devices

See the Physician-Related Services/Health Care Professional Services Billing Guide and the Hearing Services Billing Guide.

Replacement parts or repairs for cochlear implants and bone conduction hearing devices

See HCA's Hearing Services Billing Guide.

Corneal tissue

HCA pays for corneal tissue processing (HCPCS procedure code V2785) by acquisition cost (AC). To receive payment, providers must:

- Bill the amount paid to the eye bank for the processed eye tissue.
- Attach invoice to claim.

HCA will update the **Outpatient Prospective Payment System (OPPS) and Outpatient Hospitals Fee Schedule** to reflect this change.

Robotic assisted surgery (RAS)

Robotic assisted surgery (RAS) may be considered medically necessary. However, HCA does not pay separately for HCPCS code S2900 and reimburses only for the underlying procedure.

When billing for the underlying procedure, HCA requests billing providers to include RAS on the claim to track utilization and outcome. HCA monitors RAS through retrospective auditing of billing and the review of operative reports.

Skin substitutes

HCA pays for skin substitutes. See HCA's **Outpatient Hospital Fee Schedule**.

Vagal nerve stimulator

HCA pays the acquisition cost (AC) for the vagal nerve stimulator device when EPA criteria has been met as listed in HCA's **Physician-Related Services/Health Care Professional Services Billing Guide**. If EPA criteria is not met, PA is required (see **Prior authorization**). Manufacturer's invoices are required for payment. Refer to the following table as a reference for applicable codes:

Procedure code	Short description	Comments
C1767	Gen, neuro, hf, rechg bat	Pay AC when billed with CPT® code 61885, 61886, or 64568; Otherwise EAPG
C1778	Lead, neurostimulator	Pay AC when billed with CPT® code 61885, 61886, or 64568; Otherwise EAPG
C1822	Gen, neuro, hf, rechg bat	Pay AC when billed with CPT® code 61885, 61886, or 64568; Otherwise EAPG

Procedure code	Short description	Comments
L8679	Imp neurosti pls gn any type	Pay AC when billed with CPT® code 61885, 61886, or 64568; Otherwise EAPG
L8680	Implt neurostim elctr each	Pay AC when billed with CPT® code 61885 or 61886; Otherwise EAPG
L8682	Implt neurostim radiofq rec	Pay AC when billed with CPT® code 61885, 61886, or 64568; Otherwise EAPG
L8683	Radiofq trsmtr for implt neu	Pay AC when billed with 61885 or 61886; Otherwise EAPG
L8685	Implt nrostm pls gen sng rec	Pay AC when billed with CPT® code 61885 or 61886; Otherwise EAPG
L8686	Implt nrostm pls gen sng non	Pay AC when billed with CPT® code 61885 or 61886; Otherwise EAPG
L8687	Implt nrostm pls gen dua rec	Pay AC when billed with CPT® code 61885 or 61886; Otherwise EAPG
L8688	Implt nrostm pls gen dua non	Pay AC when billed with CPT® code 61885 or 61886; Otherwise EAPG

Note: To be considered for payment, the invoice for the devices must be attached to the claim.

HCA pays for a vagal stimulator only when the device is implanted during surgery.

Radiology

Radiology guidelines and procedures

For specific information regarding the following radiology procedures, see HCA's Physician-Related Services/Health Care Professional Services Billing Guide:

- Functional neuroimaging for primary degenerative dementia or mild cognitive impairment
- Mammograms
- Osteopenia/osteoporosis screening and monitoring tests
- Proton beam radiation therapy
- Stereotactic body radiation therapy
- Stereotactic radiation surgery

Pathology and Laboratory

HCA bundles laboratory services as ancillary services under enhanced ambulatory patient groups (EAPG). See HCA's Physician-Related Services/Health Care Professional Services Billing Guide for information on the following services:

- Breast and/or ovarian genetic testing
- Gene expression profile testing
- Pathology and laboratory guidelines
- Pharmacogenetic testing guidelines
- Testosterone testing
- Whole exome sequencing

Office and Other Outpatient Services

When billing for the following services, follow the individual program guidelines as described in the program-specific billing guides or fee schedules listed in this section.

Diabetes education

See HCA's Diabetes Education Billing Guide for more information.

Drugs professionally administered

See the Physician-Related Services/Health Care Professional Services Fee Schedule.

How do I bill for Avastin® (*bevacizumab*)?

Retroactive to dates of service on and after April 1, 2022, HCA reimburses for Avastin® (*bevacizumab*) when billed following the requirements in HCA's Prescription Drug Program Billing Guide.

Kidney centers

Certified kidney centers:

- Are exempt from the Outpatient Prospective Payment System (OPPS) reimbursement methodology.
- Must bill using their NPI and kidney center taxonomy code.
- For information about kidney centers and billing, see HCA's Kidney Center Services Billing Guide.

Medical nutrition therapy

HCA pays outpatient hospitals for medical nutrition therapy according to HCA's Medical Nutrition Therapy Billing Guide.

National drug code format

All providers are required to use the 11-digit National Drug Code (NDC) when billing HCA for professionally administered drugs.

- **National Drug Code (NDC)** – The 11-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging. The 11-digit NDC is composed of a 5-4-2 grouping. The first 5 digits comprise the labeler code assigned to the manufacturer by the Food and Drug Administration (FDA). The second grouping of 4 digits is assigned by the manufacturer to describe the ingredients, dose form, and strength. The last grouping of 2 digits describes the package size. (WAC 182-530-1050)
- The NDC **must** contain 11-digits to be recognized as a valid NDC. It is not uncommon for the label attached to a drug's vial to be missing leading zeros.

Neurodevelopmental providers

(WAC 182-545-900)

HCA pays certified neurodevelopmental centers according to HCA's Neurodevelopmental Centers Billing Guide. A hospital must bill for neurodevelopmental services provided to outpatient clients using appropriate billing codes listed in HCA billing guides. HCA does not pay outpatient hospitals a facility fee for these services.

Do not bill more than one bill for a single client for the same services (same revenue code, procedure code, and medical provider).

Occupational therapy, physical therapy, or speech/audiology services

HCA pays for outpatient rehabilitation (which includes occupational therapy, physical therapy, and speech/audiology) provided to eligible clients as an outpatient hospital service according to WAC 182-545-200 and 182-550-6000.

When services for adults in the outpatient hospital setting are provided by physical therapists, occupational therapists, or speech therapists, benefit limits are per client, per calendar year regardless of setting (example: home health, free-standing clinic, or outpatient hospital).

See HCA's Outpatient Rehabilitation Billing Guide for information about these therapies, and limitations for 19–20-year-olds with Medical Care Services (MCS) or Alcohol and Drug Addiction Treatment Act (ADATSA) coverage.

A hospital must bill outpatient hospital occupational therapy, physical therapy, or speech/audiology using appropriate billing codes listed in HCA's billing guides. HCA does not pay outpatient hospitals a facility fee for such services.

Note: The maximum number of visits allowed is based on appropriate medical justification. HCA does not allow duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure(s). If the client requires more than one therapist in the residence on the same day, HCA requires the therapist to document the therapeutic benefit of having more than one therapist for specialized therapy on the same day.

Physician-related services/Health care professional services

For the following services, see HCA's Physician-Related Services/Health Care Professional Services Billing Guide:

- Drug screening for medication assisted treatment (MAT) and substance use disorders (SUD)*
- Fecal microbiota transplantation
- Foot care services
- Imaging for rhinosinusitis
- Medical genetics and genetic counseling services
- Rabies immune globulin (RIG)
- Radiopharmaceutical diagnostic imaging agents
- Stem cell therapy for musculoskeletal conditions
- Telemedicine (refer to the Health Care Authority's Provider Billing Guides and Fee Schedules webpage, under Telehealth, for current telemedicine policy.)
- Tinnitus: non-invasive, non-pharmacologic treatments
- Treatment of chronic migraine and chronic tension-type headache
- Varicose vein treatment
- Vision care services

Sleep medicine testing (sleep apnea)

(WAC 182-531-1500)

See HCA's Sleep Centers Billing Guide.

Spinraza™

HCA requires prior authorization for Spinraza™. Providers must bill for Spinraza™ on a UB-04 claim form, listing the units used on each line of the claim. Bill using the actual acquisition cost and include the invoice with the claim.

Telemedicine

Refer to HCA's **Provider billing guides and fee schedules webpage**, under *Telehealth*, for more information on the following:

- Telemedicine policy, billing, and documentation requirements, under *Telemedicine policy and billing*
- Audio-only procedure code lists, under *Audio-only telemedicine*

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Intensive Outpatient and Partial Hospitalization Programs

About the programs

The Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP) are distinct and structured behavioral health programs that provide intensive outpatient services through active treatment as an alternative to inpatient care. The program models are more intense than those ordinarily received in a doctor's or therapist's office, but the client returns home after each treatment period.

These programs provide active treatment that incorporates an individualized treatment plan and includes a multidisciplinary approach to a client's care at the direction of a physician. The programs offer an array of services, including individual and group counseling, as well as family counseling when appropriate. Medical and wellness services, such as medical monitoring, medication management, and nutritional support may also be offered.

The intensity (i.e., frequency and duration of services, as well as the array or menu of services) differs depending on the behavioral health condition(s) being treated and the client's unique person-driven treatment needs. Intensive outpatient models average at least 9-12 hours of service per week. There must be at least three sessions each week, occurring on separate days. Partial hospitalization models average 15-20 hours, with an average of 4-5 hours per day, 4 to 5 days per week.

Payment

HCA pays for IOP/PHP services using the enhanced ambulatory patient group (EAPG) payment method. Acute care hospitals may also bill for professional services outside of EAPG by following the billing instructions in HCA's **Physician-Related Services/Health Care Professional Services Billing Guide** for the appropriate service completed.

Exclusions

Clients receiving the following services are not eligible to receive IOP/PHP services at the same time:

- Wraparound and Intensive Services (WISe)
- Washington Program of Assertive Community Treatment (WA-PACT)
- New Journeys Programs
- High Intensity Treatment
- Intensive Residential Treatment
- Mental Health Services Provided in a residential setting
- Day support

How do I bill for hospital IOP/PHP services?

Note: All hospital claims must be submitted with a hospital taxonomy to be eligible for payment.

Billing for hospital IOP treatment services

Revenue code	Procedure code	Short description	Comments
0905	S9480	Intensive outpatient psychia	Revenue code and CPT® code must be billed together. One unit = one day of service

Billing for hospital PHP treatment services

Revenue code	Procedure code	Short description	Comments
0913	H0035	Mh partial hosp tx under 24h	Revenue code and HCPCS code must be billed together. One unit = one day of service

Vaccines/Toxoids (Immunizations)

General information

Apple Health covers **all** vaccines administered according to the current Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommended Immunization Schedule.

For more information, refer to the sections on vaccines/immunizations in the following HCA billing guides:

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Billing Guide
- Physician-Related Services/Health Care Professional Services Billing Guide

Centers of Excellence (COEs)

Where can I find HCA-approved COEs?

See HCA's approved centers of excellences (COEs) for sleep centers and organ transplants:

- COEs for sleep study centers
- COEs for organ transplants

What services must be performed in HCA-approved COEs?

The following services must be performed in HCA-approved centers of excellence (COEs). See HCA's Physician-Related Services/Health Care Professional Services Billing Guide for more information:

- Bariatric surgeries
- Hemophilia treatment
- Organ transplants
- Sleep studies

Washington State Health Care Authority

Medical Necessity Review by Comagine Health

What is a medical necessity review by Comagine Health?

HCA contracts with Comagine Health to provide web-based access for reviewing for medical necessity for procedures including, but not limited to, the following:

- Outpatient advanced imaging services
- Select surgical procedures
- Outpatient advanced imaging
- Spinal injections, including diagnostic selective nerve root blocks
- Botox injections (OnabotulinumtoxinA)
- Varicose veins

Comagine Health conducts the review of the request to establish medical necessity but **does not** issue authorizations. Comagine Health forwards its recommendations to HCA for final authorization determination. The procedure codes that require review by Comagine Health can be found in HCA's Physician-Related/Professional Health Care Services fee schedule.

> **Note:** This process through Comagine Health is for Washington Apple Health (Medicaid) clients enrolled in fee-for-service **only**. Authorization requests for managed care clients will **not** be authorized.

> **Note:** To prevent billing denials, check the client's eligibility **before** scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained. Providers must receive authorization from the client's primary care provider before providing services, **except for emergency services**. See HCA's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

What imaging procedures require medical necessity review by Comagine Health?

HCA and Comagine Health have contracted to provide web-based submittal for utilization review services to establish the medical necessity of selected procedures. Comagine Health conducts the review of the request to establish medical necessity but **does not** issue authorizations. Comagine Health forwards its recommendations to HCA for final authorization determination. For additional information see Medical Necessity Review by Comagine Health in HCA's **Physician-Related Services/Health Care Professional Services Billing Guide**.

Authorization

(WAC 182-531-0200)

Authorization is HCA's approval for covered services, equipment, or supplies before the services are provided to clients, as a precondition for provider reimbursement. **Prior authorization (PA), expedited prior authorization (EPA), and limitation extensions (LE) are forms of authorization.**

Prior authorization (PA)

What is PA?

PA is the process HCA uses to authorize a service **before it is provided** to a client. The PA process applies to covered services and is subject to client eligibility and program limitations. Bariatric surgery is an example of a covered service that requires PA. PA does not guarantee payment.

For psychiatric inpatient authorizations, see HCA's current Mental Health Services Billing Guide.

> **Note:** In addition to receiving PA, the client must be on an eligible program. For example, a client on the Family Planning Only program would not be eligible for bariatric surgery.

For examples on how to complete a PA request, see HCA's Billers, providers, and partners webpage.

> **Note:** HCA reviews requests for payment for noncovered health care services according to WAC 182-501-0160 as an exception to rule (ETR).

How does HCA determine PA?

For information on how HCA determines PA, see HCA's current Physician-Related Services/Health Care Professional Services Billing Guide.

Services requiring PA

For services requiring PA, see HCA's current Physician-Related Services/Health Care Professional Services Billing Guide.

How do I request PA?

When a procedure's EPA criteria has not been met or the covered procedure requires PA, providers must request prior authorization from HCA. Procedures that require PA are listed in the fee schedule. HCA does not retrospectively authorize any health care services that require PA after they have been provided except when a client has delayed certification of eligibility.

Online submission by direct data entry into ProviderOne

Providers may submit a prior authorization request by direct data entry into ProviderOne or by submitting the request in writing (see HCA's **Prior authorization webpage** for details).

Fax request

Providers who choose to submit a fax PA request must provide all the following with the request:

- The General Information for Authorization form. This form must be page one of the faxed request and must be typed. See **Where can I download HCA forms?**
- The program form. This form must be attached to the request.
- Charts and justification to support the PA request.

Submit fax PA requests (with forms and documentation) to: (866) 668-1214

For a list of forms and where to send them, see **Documentation requirements for PA or LE**. Be sure to complete all information requested. HCA returns incomplete requests to the provider.

Submission of photos and X-rays for medical and DME requests

If not submitting photos or X-rays via the ProviderOne online portal, submit photos and x-rays for medical and DME requests using the FastLook™ and FastAttach™ services provided by Vyne Medical. Register **online** with Vyne Medical. Contact Vyne Medical at 865-293-4111 with any questions.

When this option is chosen, fax the request to HCA and indicate the MEA# in the NEA field (box 18) on the *PA Request form*. **There is an associated cost, which will be explained by the MEA services.**

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

Limitation extension (LE)

What is an LE?

LE is an authorization of services beyond the designated benefit limit allowed in Washington Administration Code (WAC) and HCA billing guides.

How do I request an LE?

For information on how to request an LE, see Documentation requirements for PA or LE and HCA's Physician-Related Services/Health Care Professional Services Billing Guide.

Documentation requirements for PA or LE

How do I obtain PA or LE?

To obtain PA or LE, providers must do either of the following:

- **Submit by direct data entry into ProviderOne**. See HCA's Prior authorization webpage for details.
- **Submit request by fax** along with the following documentation:
  - A completed, TYPED *General Information for Authorization* form. This request form MUST be the initial page of the request.
  - A completed *Fax/Written Request Basic Information* form, if there is not a form specific to the service being requested, and all the documentation is listed on this form with any other medical justification.

    To obtain a copy, see Where can I download HCA forms? **Fax the request to:** (866) 668-1214.

Forms available to submit authorization requests

- *Application for Chest Wall Oscillator*
- *Bariatric Surgery Request* form
- *Fax/Written Request Basic Information* form
- *Oral Enteral Nutrition Worksheet*
- *Out of State Medical Services Request* form

Forms available to submit authorization requests for medication

See HCA's current Physician-Related Services/Health Care Professional Services Billing Guide.

Washington State Health Care Authority

Outpatient prospective payment system (OPPS)

How does HCA pay for outpatient hospital services?

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

- Enhanced ambulatory patient group (EAPG)
- Maximum allowable fee schedule

HCA's outpatient Prospective payment system (OPPS) uses an EAPG-based reimbursement method as its primary reimbursement method. HCA uses the EAPG software provided by 3MTM Health Information Systems to group OPPS claims based on services performed and resource intensity.

> **Note:** Only hospitals paid by HCA using the Critical Access Hospital payment methodology are exempt from OPPS. These hospitals are paid using the weighted costs-to-charges (WCC) payment method. See WAC 182-550-2598.

How does HCA determine the payment method for OPPS?

HCA's payment method for OPPS is generally determined by the procedure and revenue codes on the claim line(s). HCA pays OPPS hospitals using the following methods in the following order:

- The EAPG method is used to pay for covered services for which 3MTM Health Information Systems has established an EAPG weight.
- The fee schedule is used to pay for covered services for which there is no established EAPG weight and for services exempted from EAPG payment.

What is the OPPS payment calculation?

HCA calculates the EAPG payment as follows:

EAPG payment =	EAPG relative weight **x** Hospital-specific conversion factor **x** Discount factor (if applicable) **x** Policy adjustor (if applicable)

The total OPPS claim payment is the sum of the EAPG payments plus the sum of the allowed amounts for each non-EAPG service.

If a client's third-party liability insurance has made a payment on a service, HCA subtracts any such payments made from the Medicaid allowed amount.

OPPS payment enhancements

HCA has established policy adjustors for the following services effective July 1, 2014:

Adjustment	Service	Adjustor
Pediatric	EAPG services for clients under age 18 years	1.35
Chemotherapy and Combined Chemotherapy/ Pharmacotherapy	Services grouped as chemotherapy drugs or combined chemotherapy and pharmacotherapy drugs	1.1

When billing for chemotherapy and/or pharmacotherapy drugs, HCA may allow for billing more than one service line for the same date of service, revenue code, CPT/HCPCS code, and NDC.

Billing

Note: All claims must be submitted electronically to HCA, except under limited circumstances. For more information, see HCA's ProviderOne Billing and Resource Guide webpage and scroll down to Paperless billing at HCA. For providers approved to bill paper claims, visit the same webpage and scroll down to Paper Claim Billing Resource.

What are the general billing requirements?

Providers must follow HCA's ProviderOne Billing and Resource Guide. These billing requirements include, but are not limited to, all the following:

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

What additional outpatient hospital billing requirements are there?

National correct coding initiative (NCCI)

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

Information on NCCI can be found online.

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

Medically Unlikely Edits (MUEs) - Part of the NCCI policy are MUEs. MUEs are the maximum unit of service per HCPC or CPT code that can be reported by a provider under most circumstances for the same patient on the same date of service. Items billed above the established number of units are automatically denied as a "Medically Unlikely Edit." Not all HCPCS or CPT codes are assigned an MUE. HCA follows the CMS MUEs for all codes.

> **Note:** HCA may have units of service edits that are more restrictive than MUEs. MUEs are based on CMS guidelines and do not guarantee Apple Health coverage. See the fee schedule for Apple Health coverage.

All hospitals must bill all claims in a completely OPPS-ready format, as outlined by CMS, and:

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

Hospitals are required to bill using applicable revenue codes, CPT® codes, HCPCS codes, and modifiers. All hospitals must use these codes and the line-item date of service regardless of Outpatient Prospective Payment System (OPPS) participation. For a list of all procedures and their associated fees, see HCA's Outpatient Prospective Payment System (OPPS) and Outpatient Hospitals Fee Schedule.

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

Hospitals must report the line-item service date, the admit hour, and the discharge hour on every outpatient claim.

Multiple visits on the same day must be unrelated to receive more than one payment.

Physicians' professional fees must be billed on a professional claim (see HCA's Physician-Related Services/Health Care Professional Services Billing Guide and Fee Schedule) and must be billed under the physician NPI.

> **Note:** All services for the same episode of care or visit must be on the same claim.

How are outpatient hospital services prior to admission paid?

Related 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 is billing different for outpatient hospital services in hospital-based clinics?

HCA requires clinics to bill for outpatient services in one of the following ways:

- If the Department of Health (DOH) has designated the clinic as a hospital-based entity, for HCA to reimburse the clinic and the associated hospital for services provided to Washington Apple Health clients, the hospital must submit to HCA an institutional claim with the facility fees in the Total Claim Charge field.
- If DOH has not designated the clinic as a hospital-based entity, the clinic must submit to HCA a professional claim containing both of the following:
  - The facility and the professional fees in the Submitted Charges field
  - The place of service (POS) 11 (office setting) in the Place of Service field

Medicare and Medicaid policy prohibit the hospital from billing a facility fee in this circumstance. HCA will reimburse the clinic the nonfacility-setting fee.

In both the above circumstances, clinics must follow the current instructions in this billing guide related to billing for outpatient services in an office setting.

What are packaged (bundled) services?

Using the EAPG system, HCA packages (bundles) some ancillary services. This simply means these services are included in the EAPG payment rate for a significant procedure or medical visit, rather than being separately reimbursed.

> **For example:** A chest X-ray may be packaged into the payment for a pneumonia visit. Although the detail of the packaged ancillary will show an allowed amount of $0, the packaging of ancillary services does not imply that there is no payment associated with the packaged ancillary. The cost of the packaged ancillaries is included in the payment amount for the significant procedure or medical visit EAPG.

The ancillary services to be packaged are selected primarily on clinical grounds, as established by the EAPG system. So, only ancillaries clinically expected to be a routine part of the specific procedure or medical visit are packaged.

> **Note:** HCA will deny ancillary services not separately reimbursable if the primary procedure is denied and there is no significant procedure or medical visit to which the ancillary service can be packaged.

Where can I find applicable procedure codes?

HCA's **Outpatient Prospective Payment System (OPPS) and Outpatient Hospitals Fee Schedule** is a systematic listing and coding of procedures and services provided in outpatient settings. This fee schedule is based on both CPT and Level II HCPCS books. Each procedure is identified by a five-character code to simplify reporting.

A legend outlining coverage indicators is located on the second tab of the fee schedule. The *Auth* column outlines potential limitations. See the parent program guidelines for additional information.

Professional components must be billed on a professional claim. See HCA's Physician-Related Services/Health Care Professional Services Billing Guide.

What modifiers do I bill with?

HCA follows the NCCI guidelines for the use of modifiers, and accepts only the following CPT® approved modifiers on outpatient claims:

- 25
- 50
- 58
- 73
- 76
- 78
- 91
- 27
- 52
- 59
- 74
- 77
- 79
- AF
- CA
- GP
- XE
- XP
- XS
- XU
- G0

Inappropriate use of modifiers may result in claim line denials.

> **Note:** Do not bill modifier 59 in combination with modifiers XE, XP, XS, or XU.

Multiple service locations

Outpatient service providers must report the service facility location for off-campus, outpatient, provider-based departments of hospital facilities.

PO/PN modifiers

Providers must bill with modifier PO when it is appropriate. See 42 CFR § 419.48 – for a description of excepted items and services.

Modifier	Definition
PO	Excepted services, procedures, and surgeries provided at off-campus, provider-based outpatient departments of a hospital
PN	Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital

Where can I find the revenue code grids?

The revenue code grids are located on HCA's Hospital reimbursement website.

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

How do I bill for services provided to CHAMPUS clients?

See HCA's ProviderOne Billing and Resource Guide to get information about billing for Civilian Health and Medical Programs of the Uniformed Service (CHAMPUS) clients.

How do I bill for noncovered services?

HCA requires all services to be listed on an institutional claim, whether they are covered or noncovered, per requirements by CMS and UB-04.

The following are examples of **other** noncovered items for hospitals. If one of these items has a revenue code, report the appropriate code and enter the charges in the Noncovered Line Charges field on the electronic institutional claim. Services not identified by a revenue code should be placed under the subcategory **General Classification**.

- Bed scales (if person is ambulatory)
- Cafeteria
- Circumcision tray (routine circumcisions)
- Crisis counseling

- Crutches (rental only is covered, no instruction)
- Experimental or investigational medical services and supplies
- Father's pack (not medically necessary)
- Food supplements (except for qualified providers)
- Home health services
- Lab handling charges
- Medical photographic electronic and video records
- Non-patient room rentals
- Operating room set-up (when not utilized)
- Oxygen equipment set-up (when not utilized)
- Personal care items (e.g., slippers, toothbrush, combs)
- Portable x-ray charges (portable charge fee is included in fee for procedures)
- Psychiatric day care
- Recreational therapy
- Routine tests and procedures (e.g., admission batteries, pre-anesthesia chest x rays, fetal monitoring, etc.) are only covered if medically necessary* and approved by physician.
- 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
- Whole blood (Administration of blood is covered. These charges must clearly indicate administration fees.)

How do I bill for take-home naloxone?

Retroactive to dates of service on and after January 1, 2022, hospital emergency departments (EDs), opioid treatment programs, and certified or licensed behavioral health agencies (BHAs) may be reimbursed for prepackaged opioid overdose reversal medication, naloxone, distributed to clients at risk of an opioid overdose. For billing requirements, see HCA's **Prescription Drug Program Billing Guide.**

How do I bill for single-dose vials?

For single-dose vials, bill for the total amount of the drug contained in the vial(s), including partial vials. Based on the unit definition for the HCPCS code, HCA pays providers for the total number of units contained in the vial.

> **For example:** If a total of 150 mg of Etoposide is required for the therapy, and two 100 mg single dose vials are used to obtain the total dosage, then the total of the two 100 mg vials is paid. In this case, the drug is billed using HCPCS code J9181 (Etoposide, 10 mg). If HCA's maximum allowable fee is $4.38 per 10 mg unit, the total allowable is $87.60 (200 mg divided by 10 = 20 units x $4.38).

For HCA requirements on splitting single dose vials, see *Billing for single-dose vials (SDV)* in HCA's **Prescription Drug Program Billing Guide**.

How do I bill for multi-dose vials?

For multi-dose vials, bill **only** for the amount of the drug administered to the client. Based on the unit definition (rounded up to the nearest whole unit) of the HCPCS code, HCA pays providers for only the amount of drug administered to the client.

> **For example:** If a total of 750 mg of Cytarabine is required for the therapy and is taken from a 2,000 mg multi-dose vial, then only the 750 mg administered to the client is paid. In this case, the drug is billed using HCPCS code J9110 (Cytarabine, 500 mg). If HCA's maximum allowable fee is $23.75 per 500 mg unit, the total allowable is $47.50 [750 mg divided by 500 = 2 (1.5 rounded) units x $23.75).

How do independent labs bill for pathology services?

HCA requires independent laboratories to bill hospitals for the technical component of anatomic pathology services provided to hospital inpatients and outpatients. To prevent duplicate payment, HCA will not pay independent laboratories if they bill HCA for these services.

> **Note:** HCA replaced CMS policy for type of bill 141 with the EAPG payment system. See **How does HCA determine the payment method for OPPS?**

How does HCA pay for outpatient observation?

HCA follows the logic of the EAPG grouper for outpatient observation services.

Observation EAPG payment policy

EAPG 450

Procedure code G0378 is present

- If there is also a Medical Visit Indicator (EAPG 491), and it is billed for at least 8 units, the line receives full payment.
- If procedure code G0378 is billed with less than 8 units, the line groups to EAPG 0999 and pays $0.
- If procedure code G0378 is billed with one of the following services, it packages and pays $0:
  - A significant procedure
  - Physical therapy or rehabilitation
  - Behavioral health or counseling
  - A dental procedure
  - A diagnostic, significant procedure
- If there is no Medical Visit Indicator, Observation Indicator, or no significant procedure, the line will group to EAPG 0999 and pay $0.

Note: Observation E/M codes are noted as CPT® codes 99217-99220, 99224-99226, and 99234-99236. The procedure code must be covered to qualify.

EAPG 0999 cannot be grouped and lines returning this value are not paid.

Observation is defined as an hourly code and has a maximum of 24 units per date of service. Units over this amount are not valid and may cause the line to deny.

How do I bill for neonates/newborns?

For services provided to a newborn who has not yet received a Services Card, bill HCA using the parent's ProviderOne Client ID in the appropriate fields on the claim. For more information on how to bill for neonates, including infants who will be placed in foster care, see the **Inpatient Hospital Services Billing Guide**.

When billing electronically for multiple births using the mother's ProviderOne number, enter each infant's identifying information in the Billing Note section of the claim. Use the following claim indicators to identify which infant is being served: SCI=BA for the first infant, SCI=BB for the second infant, and SCI=BC for the third infant, in the case of triplets. The claim may be denied if there is no identifying information for the twin/triplet.

> **Note:** Bill services for mothers on separate claims.

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

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's **Billers, providers, and partners webpage**, under Learn how to use ProviderOne, select **Webinars**.

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

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

How do I submit institutional services on a crossover claim?

- Mark "Yes" for the question, "Is this a Medicare Crossover Claim?" in the electronic claim. (If Medicare makes a payment or allows the services, Medicaid considers it a crossover.)
- See the **ProviderOne Billing and Resource Guide** and the **Fact Sheets webpage** to get more information about submitting Medicare payment information electronically and to find out when paper backup must be attached.
- Enter the third-party (e.g., Blue Cross) supplement plan name in the Other Insurance Information section of the electronic claim. See the **Submit an Institutional Claim with Primary Insurance other than Medicare webinar** for further assistance with submitting third-party insurance information.

What does HCA require from the provider-generated Explanation of Medicare Benefits (EOMB) to process a crossover claim?

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

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

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

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