Outpatient Hospital Services Provider Guide

October 1, 2015

About this guide∗

This publication takes effect October 1, 2015, and supersedes earlier guides to this program.

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

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

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

What has changed?

Subject	Change	Reason for Change
All	Fixed broken links, clarified language, etc.	Housekeeping
ICD	Changed references to "ICD-9 diagnosis code" to "ICD diagnosis code." Updated ICD diagnosis codes to ICD-10 diagnosis codes.	**Effective for claims with dates of service on and after October 1, 2015**, the agency requires the use of ICD-10 coding. ICD-9 codes may only be used for claims with dates of service before October 1, 2015.
Breast Imaging	Added new section on 3-D breast imaging	Policy change
Dental surgeries and MCOs	Added clarification about dental surgical procedures to Are managed care clients covered?	Policy clarification
Bariatric surgery	Bariatric surgery is covered by managed care plans	Policy clarification
Carotid Artery Stenting	Added new section	Policy clarification
Facet Neurotomy, cervical and lumbar	Added to list of procedures that require review by Qualis Health	Policy clarification
Hyaluronic acid/Viscosupplem	Added new section	Policy clarification

∗ This publication is a billing instruction.

Subject	Change	Reason for Change
entation		
Family Planning	Added new link to information on long-acting reversible contraceptives (LARC)	New Policy

Additional resources

To download and print agency provider notices and provider guides, see the agency's Provider Publications. For additional resources, see the agency's list of Resources Available.

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Table of Contents

Definitions **6**

About the Program **9**

What is the purpose of the outpatient hospital services program? 9
How does the agency pay for outpatient hospital services? 9
How does the agency determine the payment method for OPPS? 10
What is the outpatient prospective payment system (OPPS) payment calculation? 10
OPPS payment enhancements 11

What are packaged (bundled) services? 11
Does the agency pay separately for robotic assisted surgery? 12
How does medical necessity apply to outpatient hospital services? 12
What about outpatient hospital services provided within one calendar day of DRG-paid inpatient admission? 12
What are the criteria for an outpatient short stay? 13
What is admission status? 13
When to change admission status 14

Changing status from inpatient to outpatient observation 14

Changing status from outpatient observation to inpatient 15

Changing status from inpatient or outpatient observation to outpatient 15

Changing status from outpatient surgery/procedure to outpatient observation or inpatient 16

Authorization **17**

Prior authorization (PA) 17
What is PA? 17

How does the agency determine PA? 18

Services requiring PA 18

Documentation requirements for PA or LE 18

Written or fax PA 19
Expedited prior authorization (EPA) 21
EPA guidelines 22

Limitation extension (LE) 22
What is an LE? 22

How do I request an LE? 22

EPA Criteria Coding List 23

Medical Policy Updates **26**

Policy updates effective 7/1/2015 26
Policy updates effective 4/1/2015 26
Policy updates effective 1/1/2015 26
Policy updates effective 10/1/2014 26

Related Programs 27

Does the agency pay for diabetes education? 27
Does the agency pay for sleep studies? 27
Does the agency pay for the shingles vaccine when administered in outpatient hospitals? 28
Does the agency pay for cochlear implants and BAHAs? 28
Does the agency pay for transgender health services? 28
How does the agency pay for cervical spinal fusion arthrodesis? 28
Who does the agency reimburse for providing medical nutrition therapy? 29
How does the agency pay for occupational therapy, physical therapy, or speech/audiology services? 29
How does the agency pay for services provided by certified neurodevelopmental providers? 30
What are the agency's radiology guidelines? 30
Stereotactic Radiation Surgery 30
Stereotactic Body Radiation Therapy 31
Screening & Monitoring Tests for Osteopenia/Osteoporosis 31
What are the agency's pathology/laboratory guidelines? 31
What are the agency's testosterone testing guidelines? 32
What are the agency's Suboxone guidelines? 32
Where can I find the agency's sterilization and hysterectomy procedures? 32
Where can I find the agency's surgical and medical procedures and evaluations? 32
What are the agency's authorization requirements for surgical procedures? 32
Bariatric surgery 32

What surgical procedures require medical necessity review by the agency? 33
What surgical procedures require medical necessity review by Qualis Health? 33
What imaging procedures require medical necessity review by Qualis Health? 34
Functional neuroimaging for primary degenerative dementia or mild cognitive impairment 34

What breast imaging procedures does the agency cover? 34
Carotid artery stenting 35
Hyaluronic acid/viscosupplementation 35
How does the agency pay for services provided in certified kidney centers? 35
What are the billing requirements for providing organ transplants? 35

Billing and Claim Forms 36

What are the general billing requirements? 36
What additional outpatient hospital billing requirements are there? 36
How is billing different for outpatient hospital services in hospital-based clinics? 37
Where can I find applicable procedure codes? 38

What modifiers do I bill with? 38
Modifier PO, department of a provider, and provider-based entities 39
Where can I find the revenue code grids? 39
How do I bill for services provided to CHAMPUS clients? 40
How do I bill for noncovered services? 41
How do I bill for single-dose vials? 42
How do I bill for multi-dose vials? 42
How do independent labs bill for pathology services? 43
How does the agency pay for outpatient observation? 43
Observation EAPG payment policy 44
How do I bill for neonates/newborns? 45
Are managed care clients covered? 46
When does the agency pay for an outpatient hospital visit provided to a managed care client with a psychiatric principle diagnosis? 47
How do I bill an ER visit for an MCO client transferring to a different hospital for an RSN-authorized admission? 47
How do I complete the UB-04 claim form? 47
How do I submit institutional services on a UB-04 crossover claim? 48
What does the agency require from the provider-generated Explanation of Medicare Benefits (EOMB) to process a crossover claim? 48

Definitions

This list defines terms and abbreviations, including acronyms, used in this provider guide. See the agency's Washington Apple Health Glossary for a more complete list of definitions.

Authorization requirement – The agency's requirement that a provider present proof of medical necessity evidenced either by obtaining a prior authorization number or by using the expedited 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.
(WAC 182-550-1050)

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

Discount factor – The percentage applied to additional significant procedures when a claim has multiple significant procedures or when the same procedure is performed multiple times on the same day. Not all significant procedures are subject to a discount factor. (WAC 182-550-1050)

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

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

Enhanced ambulatory patient groupings (EAPG) – The payment system used by the agency to calculate reimbursement to hospitals for the facility component of outpatient services on and after October 1, 2014. This system uses 3M's EAPGs as the primary basis for payment.
(WAC 182-550-1050)

Hospital's outpatient RCC – The agency calculates a hospital's outpatient ratio of costs-to-charges (RCC) by multiplying the hospital's inpatient RCC and the OPPS outpatient adjustment factor (OAF).

International classification of diseases (ICD) – The systematic listing of diseases, injuries, conditions, and procedures as numerical or alpha numerical designations (coding). (WAC 182-550-1050)

Modifier – A two-digit alphabetic and/or numeric identifier that is added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting hospital can describe or indicate that a performed service or procedure has been altered by some specific circumstance, but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules. (WAC 182-550-1050)

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

OPPS – See **Outpatient prospective payment system**. (WAC 182-550-1050)

Outpatient care – See **Outpatient hospital services**. (WAC 182-550-1050)

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

Outpatient prospective payment system (OPPS) – The payment system used by the agency to calculate reimbursement to hospitals for the facility component of outpatient services. This system uses enhanced ambulatory patient groups (EAPGs) as the primary basis of payment. (WAC 182-550-1050)

Outpatient prospective payment system (OPPS) conversion factor – See **Outpatient prospective payment system (OPPS) rate**. (WAC 182-550-1050)

Outpatient prospective payment system (OPPS) rate - A hospital-specific multiplier calculated by the agency that is one of the components of the EAPG payment calculation.

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

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. (WAC 182-550-1050)

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. (WAC 182-550-1050)

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. (WAC 182-550-1050)

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

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 the agency pay for outpatient hospital services?

The agency 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
- Ratio of costs-to-charges (RCC)

The agency's Outpatient Prospective Payment System (OPPS) uses an EAPG-based reimbursement method as its primary reimbursement method. The agency uses the EAPG software provided by 3M™ Health Information Systems to group OPPS claims based on services performed and resource intensity.

Note: Only hospitals paid by the agency using the Critical Access Hospital payment methodology are exempt from OPPS. See WAC 182-550-7000.

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How does the agency determine the payment method for OPPS?

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

- The EAPG method is used to pay for covered services for which 3M™ 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.
- The hospital's outpatient RCC, as described in WAC 182-550-4500, is used to pay for the covered services for which the agency has not established a maximum allowable fee.

What is the outpatient prospective payment system (OPPS) payment calculation?

(WAC 182-550-7600)

The agency 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, the agency subtracts any such payments made from the Medicaid allowed amount.

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OPPS payment enhancements

The agency 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

What are packaged (bundled) services?

Using the EAPG system, the agency 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:** The agency 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.

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Does the agency pay separately for robotic assisted surgery?

No. Robotic assisted surgery (RAS) may be considered medically necessary. However, the agency does not pay separately for Healthcare Common Procedure Coding System (HCPCS) code S2900 and reimburses only for the underlying procedure.

When billing for the underlying procedure, the agency requests billing providers to include RAS on the claim in order to track utilization and outcome. The agency will monitor RAS through retrospective auditing of billing and the review of operative reports.

How does medical necessity apply to outpatient hospital services?

(WAC 182-500-0070)

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

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

(WAC 182-550-6000 (3)(c))

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 paid by the diagnostic-related group (DRG) method:

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

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What are the criteria for an outpatient short stay?

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

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

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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. The agency 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).

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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).

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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, 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.

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Authorization

(**WAC 182-531-0200**)

Authorization is the agency'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 prior authorization.**

Prior authorization (PA)

What is PA?

PA is the process the agency 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 the agency's current Inpatient Hospital Billing Provider 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 Authorization for Services.

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

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How does the agency determine PA?

For information on how the agency determines PA, see the Physician-Related Services/Health Care Professional Services Provider Guide.

Services requiring PA

(**WAC 182-531-0200 (4)-(6)**)

See the agency's Physician-Related Services/Health Care Professional Services Provider Guide.

Documentation requirements for PA or LE

Authorization Documentation	
How do I obtain PA or an LE?	The following documentation is required for all PA and LE requests: • A completed, TYPED *General Information for Authorization* form, 13-835. This request form MUST be the initial page of the request. • A completed *Fax/Written Request Basic Information* form, 13-756, 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. Fax the request to: (866) 668-1214. See the agency's Resources Available web page.
Forms Available to Submit Authorization Requests	
• *Botulinum Toxin Provider Questionnaire*, 13-003 • *Application for Chest Wall Oscillator*, 13-841 • *Bariatric Surgery Request* form, 13-785 • *Fax/Written Request Basic Information* form, 13-756 • *Insomnia Referral Worksheet*, 13-850 • *Oral Enteral Nutrition Worksheet*, 13-743 • *Out of State Medical Services Request* form, 13-787	

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Forms Available to Submit Authorization Requests for Medication
• Acetaminophen Injection, J0131, use *Basic Information* form, 13-756 • Alglucosidase alfa (lumizyme) 10 mg, J0221, use *Basic Information* form, 13-756 • Belimumab injection, J0490, use *Basic Information* form, 13-756 • Cimzia (Certolizumab pegol Inj.), J0718, use *CIMZIA J0718 Request* form, 13-885 • Ceftaroline fosamil injection, J0712, use *Fax/Written Request Basic Information* form, 13-756 • Ipilimumab injection, J9228, use *Fax/Written Request Basic Information* form, 13-756 • Mannitol for inhaler, J7665, use *Fax/Written Request Basic Information* form, 13-756 • Pegloticase injection, J2507, use *Fax/Written Request Basic Information* form, 13-756 • Photofrin (Porfimer Sodium Inj.) 75mg, J9600, use *Fax/Written Request Basic Information* form, 13-756 • Prolia (Denosumab Inj.), J0897, use *Fax/Written Request Basic Information* form, 13-756 • Tysabri (Natalizumab Inj.) J2323, use *TYSABRI J2323 Request* form, 13-832

Written or fax PA

Written or fax PA is available to providers when a procedure's EPA criteria have not been met or the covered procedure requires PA. Procedures that require PA are listed in the fee schedule. The agency does not retrospectively authorize any health care services that require PA after they have been provided except when a client has delayed certification of eligibility.

When submitting a written or fax PA request, provide:

- The *General Information for Authorization* form, 13-835. This form must be page one of the mailed/faxed request and must be typed.
- The program form. This form must be attached to the request.
- Charts and justification to support the PA request.

Submit written or fax PA requests (with forms and documentation) to:

- **By Fax:** (866) 668-1214

- **By Mail:**
  Authorization Services Office
  PO Box 45535
  Olympia, WA 98504-5535

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

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

For submitting photos and X-rays for medical and DME requests, use the FastLook™ and FastAttach™ services provided by Medical Electronic Attachment, Inc. (MEA).

Register with MEA by:

- Going to www.mea-fast.com/.
- Selecting Provider Registration (on the menu bar below the banner).
- Entering "FastWDSHS" in the blue promotional code box.

Contact MEA at 888-329-9988, ext. 2, with any questions.
When this option is chosen, fax the request to the agency 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 the agency's ProviderOne Billing and Resource Guide for more information on requesting authorization.

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Expedited prior authorization (EPA)

EPA is designed to eliminate the need for written authorization. The agency establishes authorization criteria and identifies the criteria with specific codes, enabling providers to create an EPA number using those codes.

To bill the agency for diagnostic conditions, procedures and services that meet the EPA criteria on the following pages, the provider must **create a 9-digit EPA number.** The first five or six digits of the EPA number must be **87000 or 870000**. The last 3 or 4 digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria (see EPA Criteria Coding List for codes). Enter the EPA number on the billing form in the authorization number field, or in the **Authorization** or **Comments** section when billing electronically.

Example: The 9-digit authorization number for a client with the following criteria would be **870000421:**

Client is age 11 through 55 and is in one of the at-risk groups because the client meets one of the following:

1) Has terminal complement component deficiencies
2) Has anatomic or functional asplenia
3) Is a microbiologist who is routinely exposed to isolates of **Neisseria meningitides**
4) Is a freshman entering college who will live in a dormitory

870000 = first six digits of all EPA numbers. **421**= last three digits of an EPA number indicating that the above criteria is met.

The agency denies claims submitted without a required EPA number.

The agency denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.

The billing provider must document in the client's file how the EPA criteria were met and make this information available to the agency on request. If the agency determines the documentation does not support the criteria being met, the claim will be denied.

Note: The agency requires written/fax PA when there is no option to create an EPA number.

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EPA guidelines

Documentation

The provider must verify medical necessity for the EPA number submitted. The client's medical record documentation must support the medical necessity and be available upon the agency's request. If the agency determines the documentation does not support the EPA criteria requirements, the claim will be denied**.**

> **Note:** For enteral nutrition EPA requirements, refer to the *Prior Authorization* section in the agency's Enteral Nutrition Provider Guide.

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 agency provider guides.

How do I request an LE?

For information on how to request an LE, see the agency's Physician-Related Services/Health Care Professional Services Provider Guide.

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EPA Criteria Coding List

A complete EPA number is 9 digits. The first five or six digits of the EPA number must be **87000 or 870000**. The last 3 or 4 digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria.

If the client does not meet the EPA criteria, PA is required (see Prior Authorization).

EPA Code 87000-	Service Name	CPT/HCPCS/ Dx Code	Criteria
050	Office visit related to prescribing buprenorphine/ naloxone (SUBOXONE®) opiate dependency. Drug Screening related to prescribing buprenorphine/ naloxone (SUBOXONE®) opiate dependency.	**CPT codes:** 99201-99215, 99354-99357 See the agency's Program Policy Approved Diagnosis Codes for Physician-Related Services/Health Care Professionals Drug Screening: **HCPCS code:** G0434 QW – limited to one per day and **CPT codes:** 80302, 81025, 84703 See the agency's Program Policy Approved Diagnosis Codes for Physician-Related Services/Health Care Professionals	The provider must be certified and approved to prescribe buprenorphine/naloxone (Suboxone®). The provider must have a CLIA waiver Urine drug screens for benzodiazepines, amphetamine/methamphetamine, cocaine, methadone, opiates, and barbiturates must be done before each prescription is dispensed during the first month of therapy. Clients must be enrolled in DBHR-certified treatment

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EPA Code 87000-	Service Name	CPT/HCPCS/ Dx Code	Criteria
1363	Bone mineral density testing with dual x-ray absorptiometry (DXA) - initial screening	**CPT codes:** 77080, 77081	Bone mineral density testing with dual x-ray absorptiometry (DXA) is a covered benefit with the following conditions: *Asymptomatic women* • Women 65 years of age and older or • Women 64 years of age and younger with equivalent ten year fracture risk to women age 65 as calculated by FRAX (Fracture Risk Assessment) tool or other validated scoring tool *Men or women* • Long term glucocorticoids (i.e. current or past exposure to glucocorticoids for more than 3 months) or Androgen deprivation or other conditions known to be associated with low bone mass
1364	Bone mineral density testing with dual x-ray absorptiometry (DXA) - repeat test	**CPT codes:** 77080, 77081	Repeat bone mineral density testing with dual x-ray absorptiometry (DXA) is a covered benefit when the client meets one of the following: • T-score** > -1.5, 15 years to next screening test • T-score -1.5 to -1.99, 5 years to next screening test • T-score ≤ -2.0, 1 year to next screening test Or Use of medication associated with low bone mass or presence of a condition known to be associated with low bone mass

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EPA Code 87000-	Service Name	CPT/HCPCS/ Dx Code	Criteria
1368	Testosterone testing	**CPT codes:** 84402, 84403	For males age 19 and older and at least one of the following conditions are met: • Suspected or known primary hypogonadism • Suspected or known secondary hypogonadism with organ causes such as: ✓ Pituitary disorder ✓ Suprasellar tumor ✓ Medications suspected to cause hypogonadism ✓ HIV with weight loss ✓ Osteoporosis • Monitoring of testosterone therapy
1370	Services rendered in the ER to an MCO client		All of the following conditions must be met: • The client is seen in the ER • The client was transferred to a different hospital for an inpatient admission that was authorized by the RSN • The client's primary diagnosis is in the psychiatric range. See the agency's Program Policy Approved Diagnosis Codes for Physician-Related Services/Health Care Professionals for this EPA number.

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Medical Policy Updates

In accordance with WAC 182-501-0055, the agency has reviewed the recommendations of the Health Technology Assessment Clinical Committee (HTACC) (RCW 70.14.080 through 70.14.140) and has made the decision to adopt recommendations for the following technologies.

Policy updates effective 7/1/2015

- Testosterone testing

Policy updates effective 4/1/2015

- Screening and monitoring tests for osteopenia and osteoporosis
- Bilateral cochlear implants

Policy updates effective 1/1/2015

- Carotid artery stenting
- Facet neurotomy, cervical and lumber
- Proton beam radiation therapy
- Stereotactic radiation surgery
- Stereotactic body radiation therapy

Policy updates effective 10/1/2014

- Hyaluronic acid/viscosupplementation

For additional details and medical necessity criteria, see Health Technology Assessment Findings.

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Related Programs

When billing for the following services, follow the individual program guidelines as described in the program-specific Provider Guides.

Does the agency pay for diabetes education?

Yes. In order for a client to participate in the diabetes education program, a licensed primary health care provider must refer the client to a program for diabetes education. Hospitals must be approved by the Washington State Department of Health (DOH) as a diabetes education provider.

For diabetes education services provided in a hospital outpatient setting, the provider must:

- Bill using revenue code 0942.
- Provide a minimum of 30 minutes of education/management per session.

Note: Services provided in an outpatient hospital department or hospital-based clinic must be billed on a UB-04 claim form. Services provided in a non-hospital based clinic or a physician's office must be billed on a CMS-1500 claim form.

Note: The agency requires authorized hospital outpatient diabetes education programs to bill with revenue code 0942. Claims submitted using HCPCS codes G0108 and G0109 will be denied.

See the agency's Diabetes Education Provider Guide for more information.

Does the agency pay for sleep studies?

Yes. See *Sleep medicine testing* in the Physician-Related Services/Health Care Professional Services Provider Guide for more information.

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Does the agency pay for the shingles vaccine when administered in outpatient hospitals?

Yes. The agency pays for the administration of the Herpes Zoster (shingles) vaccine (CPT® codes 90471 and 90736) provided in outpatient hospitals and administered according to the guidelines in the agency's Physician-Related Services/Health Care Professional Services Provider Guide.

Does the agency pay for cochlear implants and BAHAs?

Yes. Cochlear implants and BAHAs are covered for clients under the age of 21 with PA. For more information, see the Physician-Related Services/Health Care Professional Services Provider Guide and the Hearing Hardware for Clients Age 20 and Younger Provider Guide.

The agency covers replacement parts or repair for cochlear implants and BAHAs through the agency's Hearing Aids and Services Program **only**.

Does the agency pay for transgender health services?

Yes. See the agency's Physician-Related Services/Health Care Professional Services Provider Guide.

How does the agency pay for cervical spinal fusion arthrodesis?

The agency pays for cervical spinal fusion for degenerative disc disease with limitations.

See the agency's Physician-Related Services/Health Care Professional Services Provider Guide.

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Who does the agency reimburse for providing medical nutrition therapy?

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

- Advanced registered nurse practitioners (ARNP)
- Certified dietitians
- Durable medical equipment (DME) suppliers
- Health departments
- Outpatient hospitals
- Physicians

For additional information, see the agency's Medical Nutrition Therapy Provider Guide.

How does the agency pay for occupational therapy, physical therapy, or speech/audiology services?

The agency 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 the agency's Outpatient Rehabilitation Provider Guide for information about these therapies, and new 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 the agency's provider guides. The agency does not pay outpatient hospitals a facility fee for such services.

Note: The maximum number of visits allowed is based on appropriate medical justification. The agency 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, the agency requires the therapist to document the therapeutic benefit of having more than one therapist for specialized therapy on the same day.

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How does the agency pay for services provided by certified neurodevelopmental providers?

(WAC 182-545-900)

The agency pays certified neurodevelopmental centers according to the agency's Neurodevelopmental Centers Provider Guide.

A hospital must bill for neurodevelopmental services provided to outpatients using appropriate billing codes listed in agency provider guides. The agency does not pay outpatient hospitals a facility fee for these services.

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

What are the agency's radiology guidelines?

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

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

Stereotactic Radiation Surgery

Stereotactic Radiation Surgery (SRS) for Central Nervous System (CNS) primary and metastatic tumors require PA.

The agency pays for SRS for adults and children when both of the following criteria are met:

- Patient functional status score (i.e., Karnofsky score) is greater than or equal to 50
- Evaluation includes multidisciplinary team analysis (e.g., tumor board), including surgical input

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Stereotactic Body Radiation Therapy

Stereotactic Body Radiation Therapy (SBRT) is covered for adults and children for the following conditions only:

- For cancers of spine/paraspinal structures
- For inoperable non-small cell lung cancer, stage 1

Evaluation includes multidisciplinary team analysis (e.g., tumor board), including surgical input.

Screening & Monitoring Tests for Osteopenia/Osteoporosis

The agency covers bone mineral density testing and repeat testing with dual x-ray absorptiometry (DXA) with limitations. These tests require EPA. See EPA #870001363 and EPA #870001364 for criteria. If the EPA criteria are not met, PA is required.

What are the agency's pathology/laboratory guidelines?

The agency bundles laboratory services as ancillary services under EAPG. See the agency's Physician-Related Services/Health Care Professional Services Provider Guide for additional information.

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What are the agency's testosterone testing guidelines?

The agency covers testosterone testing for males age 19 and older. These tests require EPA. See EPA #870001368 for criteria. If the EPA criteria are not met, PA is required. See the agency's Physician-Related Services/Health Care Professional Services Provider Guide.

What are the agency's Suboxone guidelines?

The procedure code G0463 is in the guidelines for Suboxone are in the agency's Physician-Related Services/Health Care Professional Services Provider Guide under *Suboxone drug screen policy*. These services require EPA. See EPA #870000050 for criteria. If the EPA criteria are not met, PA is required.

Where can I find the agency's sterilization and hysterectomy procedures?

See the agency's Physician-Related Services/Health Care Professional Services Provider Guide.

Where can I find the agency's surgical and medical procedures and evaluations?

See the agency's Physician-Related Services/Health Care Professional Services Provider Guide.

What are the agency's authorization requirements for surgical procedures?

See What surgical procedures require medical necessity review by the agency? and What surgical procedures require medical necessity review by Qualis Health?

Bariatric surgery

See the agency's Physician-Related Services/Health Care Professional Services Provider Guide.

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What surgical procedures require medical necessity review by the agency?

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

- Physician-Related Services/Health Care Professional Services Provider Guide
- Physician-Related Services/Professional Health Care Services Fee Schedule

What surgical procedures 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:

- Carpal tunnel release
- Major joints
- Spinal, including facet injections
- Thoracic outlet release
- Upper and lower extremities
- Facet neurotomy, cervical and lumbar

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, see the agency's Physician-Related Services/Health Care Professional Services Provider Guide.

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What imaging procedures 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 procedures. Qualis Health conducts the review of the request to establish medical necessity, but **does not** issue authorizations. Qualis Health forwards its recommendations to the agency for final authorization determination. For additional information see *Medical Necessity Review by Qualis Health* in the agency's Physician-Related Services/Health Care Professional Services Provider Guide.

Cardiac Imaging (SPECT)	
Ht muscle image spect sing	78451
Ht muscle image spect mult	78452
Ht muscle image planar sing	78453
Ht musc image planar mult	78454

Functional neuroimaging for primary degenerative dementia or mild cognitive impairment

The agency does not cover functional neuroimaging for primary degenerative dementia or mild cognitive impairment.

What breast imaging procedures does the agency cover?

The agency has adopted the National Cancer Institute (NCI) recommendations regarding screening mammograms (CPT codes 77052, 77057, and G0202). For clients age 40 and older, one annual screening mammogram is allowed per calendar year. Screening mammograms for clients age 39 and younger require prior authorization.

The agency covers digital breast tomosynthesis (DBT) when performed with a screening mammogram (G0202) in clients age 40-74 who are candidates for screening mammography. One annual screening is allowed per calendar year.

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Carotid artery stenting

The agency pays for extracranial carotid artery stenting with limitations. See the Physician-Related Services/Health Care Professional Services.

Hyaluronic acid/viscosupplementation

The agency covers hyaluronic acid/viscosupplementation for the treatment of pain associated with osteoarthritis of the knee (OA) with limitations. See the *Physician-Related Services/Health Care Professional Services*.

How does the agency pay for services provided in certified kidney centers?

Certified kidney centers:

- Are exempt from OPPS reimbursement methodology.
- Must bill using their NPI and kidney center taxonomy code.
- For information about kidney centers and billing, see the agency's Kidney Center Services Provider Guide.

What are the billing requirements for providing organ transplants?

For details about the organ transplant program and billing, see the agency's Physician-Related Services/Health Care Professional Services Provider Guide.

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Billing and Claim Forms

What are the general billing requirements?

Providers must follow the agency's ProviderOne Billing and Resource Guide. These billing requirements include, but are not limited to, all of 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?

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.

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

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

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Hospitals are required to bill using applicable revenue codes, CPT® codes, HCPCS codes, and modifiers. All hospitals must use these codes and the line item date of service regardless of OPPS participation. For a list of all procedures and their associated fees, see the agency's 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 in order to receive more than one payment.

Physicians' professional fees must be billed on a CMS-1500 claim form (see the agency's Physician-Related Services/Health Care Professional Services Provider 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 is billing different for outpatient hospital services in hospital-based clinics?

The agency 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 the agency to reimburse the clinic and the associated hospital for services provided to Washington Apple Health clients, the hospital must submit to the agency a UB-04 or 837I claim form with the facility fees in form locator 47.

- If DOH has not designated the clinic as a hospital-based entity, the clinic must submit to the agency a CMS-1500 or 837P claim form containing both of the following:

  - ✓ The facility and the professional fees in field 24F
  - ✓ The place of service (POS) 11 (office setting) in field 24B

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

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

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Where can I find applicable procedure codes?

The agency'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 CMS-1500 claim form. See the agency's Physician-Related Services/Health Care Professional Services Provider Guide.

What modifiers do I bill with?

The agency follows the CCI guidelines for the use of modifiers, and accepts only the following CPT® approved modifiers on outpatient claims:

Modifiers						
25	50	58	73	76	78	91
27	52	59	74	77	79	CA
XE	XP	XS	XU			

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.

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Modifier PO, department of a provider, and provider-based entities

For dates of service on and after January 1, 2015, providers must bill with modifier PO for any outpatient hospital service furnished in an off-campus department of a provider, or by an off-campus provider-based entity.

For these purposes, a "campus" includes both of the following:

- The physical area immediately adjacent to the provider's buildings
- Any other area or structure that is not strictly contiguous to the main building, but is located within 250 yards of the main building

> **Note:** For a definition of "department of a provider" or "provider-based entity," see 42 CFR 413.65(a) (2).
>
> Remote locations under 42 CFR 413.65(a) (2) and satellite facilities under 42 CFR 412.22(h) are exempt from the PO modifier billing requirement.

Where can I find the revenue code grids?

The revenue code grids are located on the agency's website (scroll down to the *Revenue Code Grids* heading).

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.

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How do I bill for services provided to CHAMPUS clients?

Civilian Health and Medical Programs of the Uniformed Services (CHAMPUS) clients must obtain a non-availability statement (NAS) for certain services not available at a military hospital before they can receive those services as an outpatient at a civilian hospital. The agency will not pay for any services that are included in NAS provisions. CHAMPUS' noncovered services may be billed to the agency with appropriate documentation. (An NAS is used to bill CHAMPUS for payment.) This requirement is in addition to the NAS requirement already established for inpatient admissions.

For information regarding this requirement, contact either of the following:

- **Managed Care Division**
  Madigan Army Hospital
  253-968-3491 or 253-968-0643

- **Your CHAMPUS Provider Relations Representative**

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How do I bill for noncovered services?

The agency requires all services to be listed on the UB-04 claim form, whether they are covered or noncovered, per requirements by CMS 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 in the *noncovered* field. 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.)

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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, the agency 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 the agency'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 agency requirements on splitting single dose vials, see *Billing for single-dose vials (SDV)* in the agency's Prescription Drug Program Provider 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, the agency 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 the agency'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).

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How do independent labs bill for pathology services?

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

Note: Effective July 1, 2014 the agency replaced CMS policy for type of bill 141 with the EAPG payment system. See How does the agency determine the payment method?

How does the agency pay for outpatient observation?

The agency follows the logic of the EAPG grouper for outpatient observation services.

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Observation EAPG payment policy

Under the EAPG system, there are five different observation EAPGs.

EAPG 450
G0378 is present

- If there is also a Medical Visit Indicator (EAPG 491) the line receives full payment
- If G0378 is billed with less than 8 units, the line groups to EAPG 0999
- If G0378 is billed with a signification procedure, the line is packaged
- If there is also an Observation Indicator (EAPG 492) then the line will group to EAPG 500, 501, or 502
- If no Medical Visit Indicator, Observation Indicator, or no significant procedure, the line will group to EAPG 0999

EAPG 492
G0379 or an observation E/M is present

- If billed with a significant procedure, this line is packaged
- If billed with G0378, then the line will group to EAPG 500, 501, or 502
- If billed without a significant procedure or G0378, the line groups to EAPG 0999

EAPG 500
This EAPG is assigned and receives full payment if all of the following criteria are met:

- There is an Observation Indicator present
- G0378 is present
- The principal diagnosis is obstetrical

EAPG 501
This EAPG is assigned and receives full payment if both of the following criteria are met:

- There is an Observation Indicator present
- G0378 is present

EAPG 502
This EAPG is assigned and receives full payment if all of the following criteria are met:

- There is an Observation Indicator present,
- G0378 is present
- The principal diagnosis is behavioral health

Note: Observation E/M codes are noted as 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 denied.

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.

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How do I bill for neonates/newborns?

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

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

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

Note: Bill services for mothers on separate UB-04 claim forms.

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

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Are managed care clients covered?

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

Yes. When verifying eligibility using ProviderOne, if the client is enrolled in an agency-contracted managed care organization (MCO), enrollment will be displayed on the client benefit inquiry screen. All services must be requested directly through the client's Primary Care Provider (PCP).

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

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

For dental surgical procedures, bill the agency directly. For a list of approved dental surgical diagnosis codes, see the Program Policy Approved Diagnosis Codes for Physician-Related Services/Health Care Professionals.

> **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 the plan. Providers must receive authorization from the client's HMO primary care provider before providing services, **except for emergency services**. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

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When does the agency pay for an outpatient hospital visit provided to a managed care client with a psychiatric principle diagnosis?

The agency pays outpatient hospital claims for **ER** visits for MCO clients with a principle diagnosis in the psychiatric range only if the visit results in an RSN-approved admission to a different hospital. See the agency's Program Policy Approved Diagnosis Codes for Physician-Related Services/Health Care Professionals for the appropriate EPA number.

How do I bill an ER visit for an MCO client transferring to a different hospital for an RSN-authorized admission?

A provider may bill the agency for an ER visit provided to an MCO client when all of the following criteria are met:

- The client is seen in the ER
- The ER visit results in a transfer to a different hospital for an RSN-authorized admission
- The client's principle diagnosis is in the psychiatric range. See the agency's Program Policy Approved Diagnosis Codes for Physician-Related Services/Health Care Professionals for the appropriate EPA number.

All other ER visits should be billed to the client's MCO.

For more information, see Expedited Prior Authorization (EPA).

How do I complete the UB-04 claim form?

Providers may access online webinars demonstrating how to submit institutional fee-for-service claims using direct data entry and how to upload a HIPAA batch file.

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.

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

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

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

What does the agency require from the provider-generated 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

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