

Washington State Health Care Authority

Medicaid Provider Guide

Outpatient Hospital Services
(Chapter 182-550 WAC)

January 1, 2014



Washington State
Health Care Authority

A Billing Instruction

About this guide

This publication, by the Health Care Authority (agency), supersedes all previous *Outpatient Hospital Services Medicaid Provider Guides* published by the agency.

Note: The underlined words and phrases are links in this guide. Some are internal, taking you to a different place within the document, and some are external to the guide, leading you to information on other websites.

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

- [Inpatient Hospital Services](#)
- [Physician-Related Services/Health Care Professional Services](#)

What has changed?

Reason for Change	Effective Date	Subject	Change
PN 13-100	January 1, 2014	How does the agency pay for vaccines provided in outpatient hospitals?	Payment for Herpes Zoster (Shingles) vaccine provided in outpatient hospitals.
		Billing for medications contained in single and multi-dose vials.	Updates and instructions to bill for drugs contained in single dose and multi-dose vials

Additional resources

To download and print agency provider notices and Medicaid provider guides, see the agency's [Provider Publications](#). For additional resources, see the agency's list of [Resources Available](#).

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Definitions

This list defines terms and abbreviations, including acronyms, used in this provider guide. See the agency's [Medical Assistance Glossary](#) for a more complete list of definitions.

Ambulatory payment classification (APC)

- A grouping that categorizes outpatient visits according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed.

(WAC [182-550-7050](#))

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

Budget target adjustor - The agency-established component of the APC payment calculation applied to all payable Ambulatory Payment Classifications (APCs) to allow the agency to reach and not exceed the established budget target.

(WAC [182-550-7050](#))

Bundled services – Interventions that are integral to the major procedure and are not paid separately. (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 [182-550-7050](#))

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

Alert: Inpatient maternity services are treated as emergency services when the agency pays a hospital for those services. (WAC [182-550-1050](#))

Hospital's outpatient RCC Rate - The agency calculates a hospital's outpatient RCC rate by multiplying the hospital's inpatient RCC rate and the OPPI outpatient adjustment factor (OAF).

ICD-9-CM - International classification of diseases, 9th revision, clinical modification edition - The systematic listing that transforms verbal descriptions of diseases, injuries, conditions and procedures into numerical or alpha numerical designations (coding). (WAC [182-550-1050](#))

Modifier - A two-digit alphabetic and/or numeric identifier that is added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting hospital can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules. (WAC [182-550-7050](#))

National payment rate (NPR) - A rate for a given procedure code, published by the Centers for Medicare and Medicaid Studies (CMS), that does not include a state or location specific adjustment. (WAC [182-550-7050](#))

Nationwide rate - See National payment rate (NPR). (WAC [182-550-7050](#))

Observation services – Health care services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by hospital staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient. (WAC [182-550-1050](#))

OPPS – See **Outpatient Prospective Payment System**. (WAC [182-550-1050](#))

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

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

Outpatient Code Editor (OCE) - Software program that the agency uses for classifying

and editing claims in ambulatory payment classification (APC) based OPPTS. (WAC [182-550-7050](#))

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 ambulatory payment classifications (APCs) as the primary basis of payment. (WAC [182-550-1050](#))

Outpatient prospective payment system (OPPS) conversion factor – See outpatient prospective payment system (OPPS) rate. (WAC [182-550-7050](#))

Outpatient prospective payment system (OPPS) rate - A hospital-specific multiplier assigned by the agency that is one of the components of the APC payment calculation. (WAC [182-550-7050](#))

Outpatient RCC Rate – See Hospital's Outpatient RCC Rate.

Pass-throughs - Certain drugs, devices, and biologicals, as identified by centers for Medicare and Medicaid Studies (CMS), for which providers are entitled to additional separate payment until the drugs, devices, or biologicals are assigned their own ambulatory payment classification (APC). (WAC [182-550-7050](#))

Plan of treatment or plan of care - The written plan of care for a patient which includes, but is not limited to, the physician's order for treatment and visits by the disciplines involved, the certification period,

medications, and rationale indicating need for services. (WAC [182-550-1050](#))

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

Principal procedure - A procedure performed for definitive treatment, rather than diagnostic or exploratory purposes, or because it was necessary due to a complication. (WAC [182-550-1050](#))

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

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

SI - See status indicator. (WAC [182-550-7050](#))

Significant procedure - A procedure, therapy, or service provided to a client that constitutes the primary reason for the visit to the health care professional. (WAC [182-550-7050](#))

Status indicator (SI) – A code assigned to each medical procedure or service by the agency that contributes to the selection of a payment method. (WAC [182-550-7050](#))

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

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

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:

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

The agency's Outpatient Prospective Payment System (OPPS) uses an APC-based reimbursement method as its primary reimbursement method. The agency has modeled its OPPS after the Centers for Medicare and Medicaid Services (CMS) Prospective Payment System for Hospital Outpatient Agency Services to pay certain hospitals for covered outpatient services provided to medical assistance clients.

Note: For a complete description of the CMS OPPS, including the assignment of status indicators (SIs), see 42 CFR, Chapter IV, Part 419, et al. The Code of Federal Regulations (CFR) is available from the [CFR website](#) and the Government Printing Office, Seattle office. The document is also available for public inspection at the Washington state library (a copy of the document may be obtained upon request, subject to any pertinent charge).

Note: Only critical access hospitals are exempt from OPPS.
(WAC [182-550-7100](#))

How does the agency make the payment method determination?

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

- The APC method is used to pay for covered services for which CMS has established an APC weight or a national payment rate.
- The fee schedule (including Maximum Fee, By Report, Acquisition Cost, Injection Fee Schedule, and ASC methods) is used to pay for covered services for which there is no established APC weight or nationwide payment rate and for services exempted from APC payment.
- The hospital's outpatient RCC rate, as described in WAC 182-550-4500, is used to pay for the covered services for which neither a nationwide payment rate nor a fee has been established.

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

(WAC [182-550-7600](#))

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

$$\text{APC payment} = \text{APC national payment rate} \times \text{the hospital OPPS rate} \times \text{Discount factor (if applicable)} \times \text{Units of service (if applicable)} \times \text{Budget target adjustor}$$

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

The agency pays hospitals for claims that involve clients who have third-party liability (TPL) insurance the lesser of either one of the following:

- Billed amount minus the third-party payment amount
- Allowed amount minus the third-party payment amount

What are packaged (bundled) services?

Some ancillary (subordinate or secondary) services are packaged (bundled) for payment with a primary service. The agency makes no separate payment for ancillary services. In establishing weights and payments rates, CMS and agency included payments for ancillary services in the payments for associated primary services.

The services packaged on a claim will depend on:

- The revenue code used with a given procedure.
- The status indicator assigned to given procedure.
- The status indicator assigned to other procedures on the same claim.
- Which combinations of procedure codes appear on the same claim.

The agency packaging practices generally follow those of CMS, which are complex but well described in federal rule. For a detailed history, see Federal Register, Title [42 CFR](#) Parts 410, 416, and 419.

Note: Payment to a provider may be denied or recouped if the agency determines that an ancillary procedure should have been bundled with a procedure that was not covered.

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 HCPCS code S2900 and reimburses only for the underlying procedure.

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

When does the agency require a By Report for certain procedures?

The agency may require a special report for certain services provided to agency clients. These services are identified in the fee schedule by the listing **BR** (By Report). This special report must include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary for the procedure or service. You may also be required to provide additional information.

How does medical necessity apply to outpatient hospital services?

The agency pays only for covered services and items that are medically necessary.
(WAC [182-500-0070](#))

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

The following outpatient hospital services must be billed on the inpatient hospital claim when provided within one calendar day of a client's inpatient hospital stay paid by the DRG method: preadmission, emergency room, and observation services related to an inpatient hospital stay.
(see WAC [182-550-6000](#) (3)(c))

What is 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 as an outpatient stay. The agency determines if the level of care and intensity of service criteria are met.

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

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

The agency pays observation services procedure codes (HCPCS codes G0378 and G0379) with the **maximum allowable fee payment method**. There are no changes in other policies related to observation services.

What is the criteria for outpatient observation services?

The agency covers and pays for observation services under the CMS rules for Extended Assessment and Management composites APC 8002 and APC 8003. Details of the policy are described in the [Medicare Claims Processing Manual: Chapter 4](#). Composite APC policies, including Extended Assessment and Management, are described in §10.2.1. Observation services are described in detail in §290 of Chapter 4.

Some key elements of the CMS policy are:

Composite APC	Composite APC Description	Criteria for Composite Payment
8002	Level I Extended Assessment and Management Composite	1) Eight or more units of Healthcare Common Procedure Coding System (HCPCS) code G0378 are billed either: <ul style="list-style-type: none"> a) On the same day as HCPCS code G0379.¹ b) On the same day or the day after CPT code 99205 or 99215. 2) There is no service with SI=T on the claim on the same date of service or one day earlier than HCPCS code G0378.
8003	Level II Extended Assessment and Management Composite	1) Eight or more units of HCPCS code G0378 ² are billed on the same date of service or the date of service after CPT code 99284, 99285, or 99291. 2) There is no service with SI=T on the claim on the same date of service or 1 day earlier than HCPCS code G0378.

- Observation hours (HCPCS code G0378) are always packaged.
- Composite payment may be made for HCPCS code G0379 or CPT code 99205, 99215, 99284, 99285, or 99291 if criteria are met.
- All observation hours must be claimed on a single line of HCPCS code G0378, with a from service date corresponding to the date of the observation order, and units equal to the number of hours of active observation provided.
- Direct admission for hospital observation care (HCPCS code G0379) must always be claimed in conjunction with at least one unit of HCPCS code G0378.
- Direct admission units should reflect the number of direct admissions, not the number of observation hours.
- Observation services must be reasonable and medically necessary to be covered. Only in rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

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

² For additional reporting requirements for observation services reported with HCPCS code G0378, see §290.5.1 of Chapter 4.

The agency:

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

What is admission status?

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

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

When to change admission status

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

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

Changing from inpatient admission status

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

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

Changing from outpatient admission status

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

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

Change from inpatient or outpatient observation to outpatient admission status

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

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

How is a change from outpatient surgery/procedure to outpatient observation or inpatient admission status made?

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

- The attending physician/practitioner and/or the hospital's utilization review staff determines that the client's symptoms/condition and/or treatment require an extended recovery time beyond the normal recovery time for the surgery/procedure and medical necessity for outpatient observation or inpatient level of care is met.
- The admission status change is made prior to, or on the next business day following, discharge.
- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:
 - ✓ Be dated with the date of the change.

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

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

What if the client dies prior to inpatient admission?

If the client dies prior to inpatient admission, the agency applies the CMS **Ancillary Outpatient Services When Patient Expires** composite APC payment method.

If the hospital reports one or more procedure(s) with Status Indicator (SI) = C (see the outpatient fee schedule), and the client dies prior to inpatient admission or transfer to another hospital, the provider must report both of the following:

- Patient Status 20
- Modifier **CA** (on only one SI = C procedure)

The agency may make a single payment at the APC 0375 rate on claims for the day that services were provided.

Authorization

What are the general authorization requirements?

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

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

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

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

What is write or fax PA?

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

Forms available to providers to request PA include:

- *Fax/Written Request Basic* form, HCA [13-756](#).
- *Out of State Medical Services Request* form, HCA [13-787](#) (for elective, non-emergency out-of-state medical services).

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

Mail or fax the completed forms to 866-668-1214.

How does the agency process PA requests?

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

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

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

The denial letter includes:

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

Note: See the agency's [ProviderOne Billing and Resource Guide](#) for more information on requesting authorization.

Does the agency require PA for new drugs?

The agency requires PA for all drugs new to market until reviewed by the agency's Drug Evaluation Matrix Committee, according to WAC [182-530-3100](#). This applies to all products billed under miscellaneous CPT codes or product specific CPT codes.

Visit the agency's [DRUGS BILLED UNDER MISCELLANEOUS CODES](#) for a list of drugs that require authorization. See the [Outpatient Prospective Payment System \(OPPS\) and Outpatient Hospital Fee Schedule](#) to see the coverage status for drugs billed with product-specific CPT codes.

Specialty Services

(WAC [182-531-1500](#))

What are the requirements for providing sleep studies?

Sleep studies include polysomnography (PSG) and multiple sleep latency testing (MSLT). The agency covers attended, full-channel, PSG and MSLT when:

- Ordered by the client's physician.
- Performed in an agency-designated center of excellence (COE) that is an independent diagnostic testing facility, sleep laboratory, or outpatient hospital.
- Results are used to:
 - ✓ Establish a diagnosis of narcolepsy or sleep apnea.
 - ✓ Evaluate a client's response to therapy, such as continuous positive airway pressure (CPAP).

Facility requirements

To be paid for providing sleep studies to eligible clients, the facility must:

- Be a sleep study COE.
- Be currently accredited by the American Academy of Sleep Medicine (AASM) and continuously meet the accreditation standards of AASM.
- Have at least one physician on staff who is board certified in sleep medicine.
- Have at least one registered polysomnographic technologist (RPSGT) in the sleep laboratory when studies are being performed.

Clients 21 years of age and older

For clients 21 years of age and older, the agency covers:

- Full-night, in-laboratory PSG for either:
 - ✓ Confirmation of obstructive sleep apnea (OSA) in an individual with signs or symptoms consistent with OSA (e.g., loud snoring, awakening with gasping or choking, excessive daytime sleepiness, observed cessation of breathing during sleep, etc.).
 - ✓ Titration of positive airway pressure therapy when initial PSG confirms the diagnosis of OSA, and positive airway pressure is ordered.
- Split-night, in-laboratory PSG in which the initial diagnostic portion of the PSG is followed by positive airway pressure titration when the PSG meets either of the following criteria:
 - ✓ The apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) is greater than or equal to fifteen events per hour with a minimum of thirty events.
 - ✓ The AHI or RDI is greater than or equal to five and less than or equal to fourteen events per hour with a minimum of ten events with documentation of either of the following:
 - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia
 - Hypertension, ischemic heart disease, or history of stroke

Clients 20 years of age and younger

For clients 21 years of age and younger, the agency considers any of the following indications as medically necessary criteria for a sleep study:

- OSA suspected based on clinical assessment
- Obesity, Trisomy 21, craniofacial abnormalities, neuromuscular disorders, sickle cell disease, or mucopolysaccharidosis (MPS), prior to adenotonsillectomy in a child
- Residual symptoms of OSA following mild preoperative OSA
- Residual symptoms of OSA in a child with preoperative evidence of moderate to severe OSA, obesity, craniofacial anomalies that obstruct the upper airway, or neurologic disorder following adenotonsillectomy
- Titration of positive airway pressure in a child with OSA
- Suspected congenital central alveolar hypoventilation syndrome or sleep-related hypoventilation due to neuromuscular disorder or chest wall deformities
- Primary apnea of infancy
- Evidence of a sleep-related breathing disorder in an infant who has experienced an apparent life threatening event
- Child being considered for adenotonsillectomy to treat OSA
- Clinical suspicion of an accompanying sleep-related breathing disorder in a child with chronic asthma, cystic fibrosis, pulmonary hypertension, bronchopulmonary dysplasia, or chest wall abnormality

Noncovered sleep studies

The agency does not cover sleep studies:

- When the sleep study is an unattended home study.
- When documentation for a repeat study does not indicate medical necessity (e.g., no new clinical documentation indicating the need for a repeat study).
- For the following indications, except when an underlying physiology exists (e.g., loud snoring, awakening with gasping or choking, excessive daytime sleepiness, observed cessation of breathing during sleep, etc.):
 - ✓ Chronic insomnia
 - ✓ Snoring

Becoming an agency-approved sleep center

To become an agency-approved COE, a sleep center must send all of the following documentation to the Health Care Authority, c/o Provider Enrollment, P.O. Box 45510, Olympia, WA 98504-5510:

- A completed Core Provider Agreement
- Copies of the following:
 - ✓ The sleep center's current accreditation certificate by AASM
 - ✓ Either of the following certifications for at least one physician on staff:
 - Current certification in sleep medicine by the American Board of Sleep Medicine (ABSM)
 - Current subspecialty certification in sleep medicine by a member of the American Board of Medical Specialties (ABMS)
 - ✓ The certification of an RPSGT who is employed by the sleep center

Note: Sleep centers must request reaccreditation from AASM in time to avoid expiration of COE status with the agency.

At least one physician on staff at the sleep center must be board certified in sleep medicine. If the only physician on staff who is board certified in sleep medicine resigns, the sleep center must

ensure another physician on staff at the sleep center obtains board certification or another board-certified physician is hired. The sleep center must then send provider enrollment a copy of the physician's board certification.

If a certified medical director leaves a COE, the COE status does not transfer with the medical director to another sleep center.

Note: The COE must maintain a record of the physician's order for the sleep study.

Billing requirements

- Use CPT codes 95782, 95783, 95805, and 95807-95811 for sleep study services.
- Enter the approved agency sleep center’s NPI where the sleep study/polysomnogram or multiple sleep latency testing was performed. (See previous page for appropriate location of agency-approved sleep center.) Enter the COE NPI in box 32 on the CMS-1500 claim form. When billing electronically, note the COE NPI in the **Comments** section.
- Sleep studies are limited to rule out obstructive sleep apnea or narcolepsy.

The following is a list of approved diagnoses for sleep studies:

278.01	278.03	307.46	307.47	307.48
327.10	327.11	327.12	327.20	327.21
327.23	327.24	327.25	327.26	327.27
327.29	327.40	327.41	327.42	327.51
347.00	347.01	347.10	347.11	780.09
780.51	780.53	780.54	780.55	780.56
780.57	780.58	780.59	786.04	799.02

Note: When billing on a paper CMS-1500 claim form, note the COE NPI in field 32. When billing electronically, note the COE NPI in the **Comments** section.

What are the billing requirements for providing organ transplants?

For details about the organ transplant program and billing see the agency's current [Physician Related Services/Healthcare Professional Services Medicaid Provider Guide](#).

Where is the list of agency-approved centers of excellence (COE)?

View the agency-Approved Centers of Excellence [lists](#) for Sleep Study, Hysteroscopic Sterilization, and Transplant Centers of Excellence.

Note: For information about becoming accredited as a Center of Excellence for hysteroscopic sterilization, see the agency's current [Physician Related Services/Healthcare Professional Services Medicaid Provider Guide](#).

What are the billing requirements for providing certified outpatient diabetes education?

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

Note: The agency requires authorized diabetes education programs to bill with revenue code 0942. Use of HCPCS codes G0108 and G0109 will cause a denial of the claim.

- The agency reimburses a maximum of **6 hours, or 12 one-half hour units, of patient education/diabetes management per client, per calendar year.**
- A minimum of **30 minutes of education/management must be provided** per session.
- Diabetes education may be provided in a group or individual setting, or a combination of both, depending on the client's needs.

Note: The agency does not reimburse for diabetes education if those services are an expected part of another program provided to the client (e.g. school-based health services or adult day health services).

How does a hospital become a diabetes education provider?

- All hospitals are eligible to apply to be a diabetes education provider. The Diabetes Control Program (DCP) at the Department of Health (DOH) develops the application criteria and evaluates all applications for this program.
- For more information on becoming a certified diabetes education provider and to obtain an application, write or call:

Department of Health
Diabetes Prevention and Control Program
PO Box 47855
111 Israel Rd. SE
Tumwater, WA 98501
360-236-3695

Are there any other requirements for billing and reimbursement?

- In order to participate in the diabetes education program, a licensed primary health care provider must refer the client to a program for diabetes education.
- Hospitals must be approved by DOH as a diabetes education provider.
- The agency reimburses hospital providers for diabetes education at the hospital's current RCC rate.
- See the agency's current [Diabetes Education Medicaid Provider Guide](#) for more information.

Other Related Programs

When billing for the following services, follow the individual program guidelines as described in the program-specific [Medicaid Provider Guides](#).

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

Herpes Zoster (Shingles) vaccine
(CPT code 90471, 90736)

Yes. The agency pays for the administration of the shingles vaccine provided in outpatient hospitals and administered according to the guidelines in the agency's current [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#).

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 current [Medical Nutrition Therapy Medicaid Provider Guide](#).

How does the agency pay for physical therapy?

(WAC [182-545-200](#))

The agency pays for physical therapy provided to eligible clients as an outpatient hospital service according to WAC [182-545-200](#) and [182-550-6000](#).

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 current [Outpatient Rehabilitation Medicaid Provider Guide](#) for information on new limitations for 19-20 year olds with Medical Care Services or Alcohol and Drug Addiction Treatment Act coverage.

A hospital must bill outpatient hospital physical therapy services using appropriate billing codes listed in the agency's Medicaid 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 Medicaid 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 Medicaid agency requires the therapist to document the therapeutic benefit of having more than one therapist for specialized therapy on the same day.

How does the agency pay for occupational therapy?

(WAC [182-545-200](#))

The agency pays for occupational therapy provided as an outpatient hospital service to eligible clients according to WAC [182-545-300](#) and [182-550-6000](#).

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).

Refer to the agency's current [Outpatient Rehabilitation Medicaid Provider Guide](#) for information on new limitations for 19-20 year olds with Medical Care Services or Alcohol and Drug Addiction Treatment Act coverage.

The hospital must bill outpatient hospital occupational therapy services using appropriate billing codes listed in the agency's Medicaid 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 Medicaid 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 Medicaid agency requires the therapist to document the therapeutic benefit of having more than one therapist for specialized therapy on the same day.

How does the agency pay for speech/audiology services?

(WAC [182-545-200](#) and [182-550-1500](#))

The agency pays for speech therapy services and 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 current [Outpatient Rehabilitation Medicaid Provider Guide](#) for information on new limitations for 19-20 year olds with Medical Care Services or Alcohol and Drug Addiction Treatment Act coverage.

A hospital must bill outpatient hospital speech therapy services and audiology using appropriate billing codes listed in the agency's Medicaid provider guides. The agency does not pay the outpatient hospital a facility fee for these services.

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

Note: For additional information for the above therapies, see the agency's current [Outpatient Rehabilitation Medicaid Provider Guide](#).

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 prior authorization record has been created either by obtaining the authorization itself or assuring the ordering physician has obtained the authorization.

See the agency's current [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#).

What are the agency's pathology/laboratory guidelines?

See the agency's current [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#).

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

See the agency's current [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#).

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

See the agency's current [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#).

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

(WAC [182-531-1700](#))

The agency expanded its prior authorization requirements to include selected surgical procedures. The medical necessity review for these procedures is conducted by the agency or Qualis Health.

What surgical procedures require medical necessity review by the agency?

To implement the prior authorization (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, refer to either of the following:

- [Physician-Related Services/Health Care Professional Services Medicaid Provider Guide](#)
- [Physician-Related/Professional and Emergent Oral 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

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 current [Physician-Related. Services/Healthcare Professional Services Medicaid Provider Guide](#).

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

The agency pays certified neurodevelopmental centers according to the agency's current [Neurodevelopmental Centers Medicaid Provider Guide](#).

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

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

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.
- Bill using bill type 072x.

Bill type 072x is reimbursed according to the agency's current [Kidney Center Services Medicaid Provider Guide](#).

Billing and Claim Forms

What are the general billing requirements?

Providers must follow the agency's [ProviderOne Billing and Resource Guide](#). These billing requirements include, but are not limited to:

- 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 practice, input from specialty societies, and analysis of current coding practices. 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 Centers for Medicare and Medicaid Services (CMS) and:

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

Hospitals are required to bill using applicable Revenue Codes, CPT® codes, HCPCS codes, and modifiers. All hospitals must use these codes and the line item date of service regardless of OPPS participation. For a list of all procedures and their associated fees, see the agency's [OPPS Fee Schedule](#) online.

Outpatient short stay, 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.

Emergency room physicians' professional fees must be billed on a CMS-1500 claim form (refer to the agency's current [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#) and [Fee Schedule](#)) and must be billed under the emergency room physician NPI.

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

The Medicaid 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 Medicaid agency to reimburse the clinic and the associated hospital for services provided to Medicaid-eligible clients, the hospital must submit to the agency a UB-04 or 837I claim form with the facility fees in form locator 47.
- If the 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 Medicaid agency will reimburse the clinic the nonfacility setting fee.

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

Where are applicable procedure codes found?

The agency's fee schedule for outpatient hospital services is a systematic listing and coding of procedures and services provided in outpatient settings. The fee schedule is based on the Physician's Current Procedural Terminology (CPT) and Level II HCPCS. Each procedure is identified by a five-character code to simplify reporting.

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

Professional components must be billed on a CMS-1500 claim form. Refer to the agency's current [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#).

View the agency's [Outpatient Fee Schedules](#) web page.

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

Inappropriate use of modifiers may result in claim line denials.

Where can I find the revenue code table?

View the agency's current [Revenue Code Table](#) web page.

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

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.**

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.

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 & supplies
- Father's Pack (not medically necessary)
- Food Supplements (except for qualified providers)
- Home Health Services
- Lab Handling Charges
- Medical Photographic Electronic & Video Records
- Nonpatient Room Rentals
- Operating Room Set-Up (when not utilized)
- Oxygen Equipment Set-Up (when not utilized)
- Personal Care Items (e.g., slippers, toothbrush, combs)
- Portable X-ray Charges (portable charge fee is included in fee for procedures)
- Psychiatric Day Care
- Recreational Therapy
- 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 billing 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 for splitting single dose vials, see *Billing for single dose vials (SDV)* in the [Physician-Related Services/Health Care Professional Services](#) Medicaid 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).

How do independent labs billing for pathology services?

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

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.

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 plan, managed care enrollment will be displayed on the client benefit inquiry screen. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their managed care plan by calling the telephone number provided to them.

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

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

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

How do I complete the UB-04 claim form?

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the [National Uniform Billing Committee](#).

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

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