

Health and Recovery Services Administration (HRSA)



Blood Bank Services Billing Instructions

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About this publication

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Important Contacts

A provider may use HRSA's toll-free lines for questions regarding HRSA's programs. However HRSA's response is based solely on the information provided to the representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern HRSA's programs. [WAC 388-502-0020(2)]

How do I obtain information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Contact Provider Enrollment:
<http://maa.dshs.wa.gov/provrel/> or
866.545.0544 (toll free)

Where do I send my claims?

Electronic Claims:
Providers who would like to access the *free* WAMedWeb application can enroll now by contacting ACS EDI Gateway via telephone at 800.833.2051 (toll free) or visit <https://wamedweb.acs-inc.com/wa/general/home.do>

Hardcopy Claims:
Division of Program Support
PO Box 9247
Olympia WA 98507-9247

How Do I Request Billing Instructions? Check out our website:

<http://hrsa.dshs.wa.gov>
or write/call:

Provider Relations
PO Box 45562
Olympia WA 98504-5562
800.562.3022

Where Do I Call If I Have Questions Regarding...

Payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations
800.562.3022

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits
800.562.6136

Electronic Billing?

360.753.0318
or write to:
Electronic Billing
PO Box 45564
Olympia, WA 98504-5564

Definitions & Abbreviations

This section defines terms and abbreviations (includes acronyms) used in these billing instructions.

Blood Bank - A health care facility that draws blood from voluntary donors, and tests, processes, stores, and distributes human blood and blood components.

Categorically Needy Program (CNP) – Federally-matched Medicaid program(s) that provide the broadest scope of medical coverage. Person may be eligible for CNP only or may also be eligible for cash benefits under the SSI (Supplemental Security Income) or TANF (Temporary Assistance for Needy Families) programs. CNP includes full scope of coverage for pregnant women and children.

Client – An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) – A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement – A basic contract that the Health and Recovery Services Administration (HRSA) holds with medical providers serving HRSA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Department or DSHS – The Washington State Department of Social and Health Services. [WAC 388-500-0005]

Explanation of Benefits (EOB) – A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Fraud - An attempt to obtain benefits or payments in a greater amount than that to which a provider is entitled by means of:

- (a) A willful false statement;
- (b) Willful misrepresentation, or by concealment of any material facts; or
- (c) A fraudulent scheme or device, including, but not limited to:
 - (i) Billing for services, drugs, supplies, or equipment that were unfurnished, of lower quality, or a substitution or misrepresentation of items billed; or
 - (ii) Repeated billing for purportedly covered items, which were not in fact covered.

Health and Recovery Services

Administration (HRSA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Internal Control Number (ICN) - A 17-digit number used to identify a claim. This number appears on the Remittance and Status Report near the client's name.

Managed Care – A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary services. Managed care involves having clients enrolled:

- With, or assigned to, a primary care provider;
- With, or assigned to, a plan; or
- With an independent provider, who is responsible for arranging or delivering all contracted medical care. [WAC 388-538-001].

Maximum Allowable – The maximum dollar amount HRSA will reimburse a provider for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to persons eligible for:

- Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or
- Medically needy program as defined in WAC 388-503-0320 and 388-500-0005.

Medical Identification (ID) card – The document that identifies a client's eligibility for a medical program. This card was formerly known as the medical assistance identification (MAID) card or medical coupon.

Medically Necessary – A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section “course of treatment” may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- a) “Part A” covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- b) “Part B” is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor’s services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Patient Identification Code (PIC) – An alphanumeric code that is assigned by HRSA to each client consisting of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Program Support, Division of (DPS) – The division within the Health and Recovery Services Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

Provider or Provider of Service – An institution, agency, or person:

- Who has a signed agreement (Core Provider Agreement) with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Remittance and Status Report (RA) – A report produced by the claims processing system in the Division of Program Support, Health and Recovery Services Administration that provides detailed information concerning submitted claims and other financial transactions.

Stat Charges – Stat charges are payable when sudden unexpected event occurs which requires immediate action and is needed to manage the patient in a true emergency situation. Limited to one STAT charge per episode; not once per test.

Third Party – Any entity that is, or may be, liable to pay all or part of the medical cost of care of a medical program client. [WAC 388-500-0005]

Title XIX – The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Usual and Customary Fee - The rate that may be billed to the department for a certain service or equipment.

This rate *may not exceed*:

- 1) The usual and customary charge that you bill the general public for the same services; or
- 2) If the general public is not served, the rate for the same services normally offered to other contractors.

Washington Administrative Code (WAC)
Codified rules of the State of Washington.

Blood Bank Services

What services do blood banks offer?

Blood banks collect, process, store and supply blood and blood products to facilities that provide blood transfusions. The processing of blood includes all laboratory work required to prepare the product for use. Blood banks also provide blood transfusions if the client is in their facility and provide anti-hemophilic factor to hemophilic clients.

Who is eligible?

All Medicaid clients are eligible for Blood Bank Services.

Are managed care clients eligible?

Blood bank services are covered under managed care. Clients covered under managed care will have a Health Maintenance Organization (HMO) indicator in the HMO column on their Medical ID Card. The managed care plan/provider must arrange or provide all services for a managed care client. The plan's 800 telephone number is located on the Medical ID Card.

Coverage

What Is Covered?

- DSHS will pay for whole blood or blood derivatives only when they are **not available** to the patient from other sources.

Limitations:

- ✓ For clients who are covered by Medicare and Medicaid, DSHS will pay up to the first three pints of blood or plasma in any spell of illness.
 - ✓ DSHS will not pay for blood or blood derivatives that are donated.
- DSHS will pay for the service charges necessary in handling and processing blood, plasma, or blood derivatives.

Limitations:

- ✓ If the patient is hospitalized, all charges must be included in the hospital's charges.
 - ✓ After-hours charges, "stat" charges, and weekend charges are not reimbursable.
- Administration of blood or blood derivatives on an outpatient basis in a hospital may be added to the total billing for outpatient service.

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Coverage
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Blood Bank Services Coverage Table

Procedure Code	Code Status Indicator	Modifier	Brief Description	EPA/PA	Policy/Comments
Radiology and Laboratory Services					
36415			Drawing blood		
36416			Capillary blood draw		
36430			Blood transfusion service		
36450			Exchange transfusion service		
36511			Apheresis wbc		
36512			Apheresis rbc		
36516			Apheresis, selective		
36522			Photopheresis		
36593			Declot vascular device		
38205			Harvest allogenic stem cells		
38206			Harvest auto stem cells		
38207			Cryopreserve stem cells		
38208			Thaw preserved stem cells		
38209			Wash harvest stem cells		
38210			T-cell depletion of harvest		
38211			Tumor cell deplete of harvest		
38212			Rbc depletion of harvest		
38213			Platelet deplete of harvest		
38214			Volume deplete of harvest		
38215			Harvest stem cell concentrate		
78120			Red cell mass, single		
78120		26	Red cell mass, single		
78120		TC	Red cell mass, single		
78121			Red cell mass, multiple		
78121		26	Red cell mass, multiple		
78121		TC	Red cell mass, multiple		
82143			Amniotic fluid scan		
82247			Bilirubin, total		
82248			Bilirubin, direct		
82668			Assay of erythropoietin		
82784			Assay, iga/igd/igg/igm each		Description Change
82803			Blood gases: pH, pO2 & pCO2		
83020			Hemoglobin eletrophoresis		

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Blood Bank Services

Procedure Code	Code Status Indicator	Modifier	Brief Description	EPA/PA	Policy/Comments
83020		26	Hemoglobin electrophoresis		
83030			Fetal hemoglobin, chemical		
83890			Molecule isolate		
83892			Molecular diagnostics		
83894			Molecular gel electrophoresis		
83896			Molecular diagnostics		
83898			Molecular nucleic amplification		
83912			Genetic examination		
83912		26	Genetic examinations		
84460			Alanine amino (ALT) (SGPT)		
85002			Bleeding time test		
85013			Hematocrit		
85014			Hematocrit		
85018			Hemoglobin		
85032			Manual cell count, each		
85049			Automated platelet count		
85130			Chromogenic substrate assay		
85210			Blood clot factor II test		
85220			Blood clot factor V test		
85230			Blood clot factor VII test		
85240			Blood clot factor VIII test		
85245			Blood clot factor VIII test		
85246			Blood clot factor VIII test		
85247			Blood clot factor VII test		
85250			Blood clot factor IX test		
85260			Blood clot factor X test		
85270			Blood clot factor XI test		
85280			Blood clot factor XII test		
85290			Blood clot factor XIII test		
85291			Blood clot factor XII test		
85292			Blood clot factor assay		
85293			Blood clot factor assay		
85300			Antithrombin III test		
85301			Antithrombin III test		
85302			Blood clot inhibitor antigen		
85303			Blood clot inhibitor test, protein C		

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Blood Bank Services

Procedure Code	Code Status Indicator	Modifier	Brief Description	EPA/PA	Policy/Comments
85305			Blood clot inhibitor assay, protein S		
85306			Blood clot inhibitor test, protein S		
85307			Assay activated protein c		
85335			Iron stain, blood cells		
85362			Fibrin degradation products		
85366			Fibrinogen test		
85370			Fibrinogen test		
85378			Fibrin degradation		
85384			Fibrinogen		
85385			Fribrinogen		
85410			Fibrinolytic antiplasminogen		
85420			Fibrinolytic plasminogen		
85421			Fibrinolytic plasminogen		
85460			Hemoglobin, fetal		
85461			Hemoglobin, fetal		
85475			Hemolysin		
85520			Heparin assay		
85576			Blood platelet aggregation		
85576		26	Blood platelet aggregation		
85597			Platelet neutralization		
85610			Prothrombin time		
85635			Reptilase test		
85660			RBC sickle cell test		
85670			Thrombin time, plasma		
85705			Thromboplastin inhibition		
85730			Thromboplastin time, partial		
85732			Thromboplastin time, partial		
85999			Unlisted hematology procedure		
86021			WBC antibody identification		
86022			Platelet antibodies		
86023			Immunoglobulin assay		
86078			Physician blood bank service		
86317			Immunoassay, infectious agent		
86329			Immunodiffusion		
86592			Blood serology, qualitative		

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Blood Bank Services

Procedure Code	Code Status Indicator	Modifier	Brief Description	EPA/PA	Policy/Comments
86593			Blood serology, quantitative		
86644			CMV antibody		
86645			CMV antibody, IgM		
86687			HTLV-I antibody		
86688			HTLV-II antibody		
86689			HTLV/HIV confirmatory test		
86701			HIV-1		
86702			HIV-2		
86703			HIV-1/HIV-2, single assay		
86704			Hep B core antibody, total		
86705			Hep B core antibody, IgM		
86706			Hep B surface antibody		
86793			Yersinia antibody		
86803			Hep C ab test		
86804			Hep C ab test, confirm		
86805			Lymphocytotoxicity assay		
86807			Cytotoxic antibody screening		
86821			Lymphocyte culture, mixed		
86849			Immunology procedure		
86850			RBC antibody screen		
86860			RBC antibody elution		
86870			RBC antibody identification		
86880			Coombs test		
86885			Coombs test		
86886			Coombs test		
86890			Autologous blood process		
86891			Autologous blood, op salvage		
86900			Blood typing, ABO		
86901			Blood typing, Rh (D)		
86903			Blood typing, antigen screen		
86904			Blood typing, patient serum		
86905			Blood typing, RBC antigens		
86906			Blood typing, Rh phenotype		
86920			Compatibility test		
86921			Compatibility test		
86922			Compatibility test		
86923			Compatibility test		
86927			Plasma, fresh frozen		
86930			Frozen blood prep		

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Procedure Code	Code Status Indicator	Modifier	Brief Description	EPA/PA	Policy/Comments
86931			Frozen blood thaw		
86932			Frozen blood freeze/thaw		
86940			Hemolysins/agglutinins, auto		
86941			Hemolysins/agglutinins		
86945			Blood product/irradiation		
86950			Leukocyte transfusion		
86960			Volume reduction, each unit		
86965			Pooling blood platelets		
86970			RBC pretreatment		
86971			RBC pretreatment		
86972			RBC pretreatment		
86975			RBC pretreatment, serum		
86976			RBC pretreatment, serum		
86977			RBC pretreatment, serum		
86978			RBC pretreatment, serum		
86985			Split blood or products		
86999			Transfusion procedure		
87340			Hepatitis B surface ag, eia		
87390			HIV-1 ag, eia		
87391			HIV-2 ag, eia		
87449			Ag detect nos, eia, mult		
88240			Cell cryopreserve/storage		
88241			Frozen cell preparation		
Immune Globulins and Immunizations					
90281			Human Ig, IM		
90283			Human Ig, IV		
90287			Botulinum antitoxin		
90288			Botulism Ig, IV		
90291			CMV Ig, IV		
90296			Diphtheria antitoxin		
90371			Hep B Ig, IM		
90375			Rabies Ig, IM/SC		
90376			Rabies Ig, heat treated		
90378			RSV Ig, IM, 50mg		
90379	D		RSV Ig, IV		
90384			Rh Ig, full-dose, IM		
90385			Rh Ig, mini-dose, IM		
90386			Rh Ig, IV		
90389			Tetanus Ig, IM		

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Procedure Code	Code Status Indicator	Modifier	Brief Description	EPA/PA	Policy/Comments
90393			Vaccinia Ig, IM		
90396			Varicella-zoster Ig, IM		
90399			Immune globulin		
96360			Hydration IV Infusion, Init		
96361			Hydrate IV Infusion, Add-on		
96365			Ther/Proph/Diag IV Infusion, Init		
96366			Ther/Proph/Diag IV Infusion Add-on		
96367			TX/Proph/DG Add'l Seq IV infusion		
96368			Ther/Diag Concurrent Inf		
96372			Ther/Proph/Diag Injection, SC/IM		
96373			Ther/Proph/Diag Injection, IA		
96374			Ther/Proph/Diag Injection, IV Push		
99001			Specimen handling		
99090			Computer data analysis		
99195			Phlebotomy		
Processing of Blood Derivatives					
P9010			Blood (whole), each unit		
P9011			Blood (split unit), specify amount		
P9012			Cryoprecipitate, each unit		
P9016			Leukocyte poor blood, each unit		
P9017			Plasma, fresh frozen, each unit		
P9019			Platelet concentrate, each unit		
P9020			Platelet, rich plasma, each unit		
P9021			Red blood cells (RBC), packed cells, each unit		
P9022			Washed RBC, washed platelets, each unit		
P9023			Plasma, pooled multiple donor, solvent/detergent treated, frozen, each unit		

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Procedure Code	Code Status Indicator	Modifier	Brief Description	EPA/PA	Policy/Comments
P9031			Platelets, leukocytes reduced, each unit		
P9032			Platelets, irradiated, each unit		
P9033			Platelets, leukocytes reduced, irradiated, each unit		
P9034			Platelets, pheresis, each unit		
P9035			Platelets, pheresis, leukocytes reduced, each unit		
P9036			Platelets, pheresis, irradiated, each unit		
P9037			Platelets, pheresis, leukocytes reduced, irradiated, each unit		
P9038			Red blood cells, irradiated, each unit		
P9039			Red blood cells, deglycerolized, each unit		
P9040			Red blood cells, leukocytes reduced, irradiated, each unit		
P9041			Infusion, albumin (human), 5%, 50 ml		
P9043			Infusion, plasma protein fraction (human), 5%, 50 ml		
P9044			Plasma, cryoprecipitate reduced, each unit		
P9045			Infusion, albumin (human), 5%, 250 ml		
P9046			Infusion, albumin (human), 25%, 20ml		
P9047			Infusion, albumin (human). 25%, 50ml		
P9048			Infusion, plasma protein fraction (human), 5%, 250ml		
P9050			Granulocytes, phereis, each unit		
Injectable Drugs and Anti-Hemophilic Factors					
J0850			Injection, cytomegalovirus immune globulin intravenous (human), per vial		
J1460			Injection, gamma globulin, intramuscular, 1 cc		

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Blood Bank Services

Procedure Code	Code Status Indicator	Modifier	Brief Description	EPA/PA	Policy/Comments
J1470			Injection, gamma globulin, intramuscular, 2 cc		
J1480			Injection, gamma globulin, intramuscular, 3 cc		
J1490			Injection, gamma globulin, intramuscular, 4 cc		
J1500			Injection, gamma globulin, intramuscular, 5 cc		
J1510			Injection, gamma globulin, intramuscular, 6 cc		
J1520			Injection, gamma globulin, intramuscular, 7 cc		
J1530			Injection, gamma globulin, intramuscular, 8 cc		
J1540			Injection, gamma globulin, intramuscular, 9 cc		
J1550			Injection, gamma globulin, intramuscular, 10 cc		
J1560			Injection, gamma globulin, intramuscular, over 10 cc		
J1561			Gamunex injection		
J1565	D		Injection, respiratory syncytial virus immune globulin, intravenous, 50 mg (Respigam only)		
J1566			Immune globulin, powder		
J1568			Octagam Injection		
J1569			Gammagard liquid injection		
J1670			Injection, tetanus immune globulin, human, up to 250 units		
J2597			Inj desmopressin acetate		
J2790			Injection, Rho D Immune globulin, human, full dose, 300 micrograms (1500 I.U.)		
J2792			Injection, Rho D immune globulin, intravenous, human solvent detergent		

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Blood Bank Services

Procedure Code	Code Status Indicator	Modifier	Brief Description	EPA/PA	Policy/Comments
J7185	N		Injection, factor VIII (antihemophilic factor, recombinant) (xyntha), per I.U.		
J7186			Injection, antihemophilic factor, VIII/Von Willebrand Factor complex (Human), per factor VIII I.U.		
J7187			Injection, Von Willebrand Factor Complex, ristocetin cofactor, per IU		
J7189			Factor VIIA, per mcg		
J7190			Factor VIII		
J7191			Factor VIII (porcine)		
J7192			Factor VIII recombinant NOS		Description changed
J7193			Factor IX non-recombinant		
J7194			Factor IX complex		
J7195			Factor IX recombinant		
J7197			Antithrombin III injection		
J7198			Anti-inhibitor		
J3490			Unclassified Drug		Claims billed with unlisted drug code J3490 must include the 11 digit National Drug Code (NDC) and the dosage of the drug given, in the <i>Comments</i> section of the claim form. In addition, billed units must equal one (1) .
Q2023	D		Injection, factor viii (antihemophilic factor, recombinant) (Xyntha), per i.u.		

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Billing

Billing for Blood Transfusions

- Health Care Financing Administration (HCFA) regulations require blood banks to bill the outpatient provider performing a blood transfusion for the blood product processing charge.
- Under Medicaid fee-for-service (FFS), the outpatient provider performing the transfusion must bill HRSA for each unit of blood. The relevant blood product procedure codes and the current maximum allowable fees are listed in the fee schedule beginning on page 9.
- The HCPCS blood codes include the collection, processing, and storage of blood. The processing includes all lab work required to prepare the product for use.
- If a blood bank also performs (staff, physician, etc) blood transfusions in its facility, bill using the P-codes on page 16.

What is the time limit for billing?

State law requires that you present your final bill to HRSA for reimbursement no later than 365 days from the date of service. (RCW 74.09.160)

- **For eligible clients:** Bill HRSA within 365 days **after** you provide a service(s). Delivery of a service or product does not guarantee payment.
- **For clients who are not eligible at the time of service, but are later found to be eligible:** Bill HRSA within 365 days from the Retroactive¹ or Delayed² certification period.

¹ **Retroactive Certification:** An applicant receives a service, then applies to HRSA for medical assistance at a later date. Upon approval of the application, the person was found to be eligible for the medical services at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill HRSA for these services.

² **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the Medical ID Card card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill HRSA for those services.

- **HRSA will not pay if:**
 - ✓ The service or product is not medically necessary;
 - ✓ The service or product is not covered by HRSA;
 - ✓ The client has third party coverage and the third party pays as much as, or more than, HRSA allows for the service or product; or
 - ✓ HRSA is not billed within the time limit indicated above.

What fee should I bill HRSA for eligible clients?

Bill HRSA your usual and customary fee.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical ID Card. An insurance carrier's time limit for claim submissions may be different from HRSA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as HRSA's, prior to any payment by HRSA.

You must meet HRSA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding HRSA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by HRSA, or if you have reason to believe that HRSA may make an additional payment:

- Submit a completed claim form to HRSA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the HRSA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at <http://maa.dshs.wa.gov>, or by calling the Coordination of Benefits Section at 800.562.6136.

What records does HRSA require me to keep in a client's file?

You must maintain legible, accurate, and complete charts and records in order to support and justify the services you provide. **Chart** means a summary of medical records on an individual patient. **Record** means dated reports supporting claims submitted to the Washington Health and Recovery Services Administration for medical services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service(s) provided by the practitioner must be in chronological order. For reimbursement purposes, such records must be legible; authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment, or other service to which the entry pertains; and must include, but not be limited to the following information:

1. Date(s) of service.
2. Patient's name and date of birth.
3. Name and title of person performing the service, when it is someone other than the billing practitioner.
4. Chief complaint or reason for each visit.
5. Pertinent medical history.
6. Pertinent findings on examination.
7. Quantity of medications, equipment, and/or supplies prescribed or provided.
8. Description of treatment (when applicable).
9. Recommendations for additional treatments, procedures, or consultations.
10. X-rays, tests, and results.
11. Plan of treatment/care/outcome.

Charts/records must be available to DSHS or its contractor and to the U.S. Department of Health and Human Services upon request. DSHS conducts provider audits in order to determine compliance with the various rules governing its medical programs. [Being selected for an audit does not mean that your business has been predetermined to have faulty business practices.]

Notifying clients of their rights to make their own health care decisions

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Fee Schedule

You may view HRSA's **Blood Bank Services Fee Schedule** on-line at

<http://maa.dshs.wa.gov/RBRVS/Index.html>

Completing the 1500 Claim Form

Attention! HRSA now accepts the new 1500 Claim Form.

- On November 1, 2006, HRSA began accepting the new 1500 Claim Form (version 08/05).
- As of April 1, 2007, HRSA will no longer accept the old HCFA-1500 Claim Form.

Note: HRSA encourages providers to make use of electronic billing options.
For information about electronic billing, refer to the *Important Contacts* section.

Refer to HRSA's current *General Information Booklet* for instructions on completing the 1500 claim form. You may download this booklet from HRSA's website at: <http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html> or request a paper copy from the Department of Printing (see Important Contacts section).

The following 1500 claim form instructions relate to **Blood Bank Services Billing Instructions**. Click the link above to view general 1500 Claim Form instructions.

For questions regarding claims information, call HRSA toll-free:
800.562.3022

1500 Claim Form Field Descriptions

Field No.	Name	Field Required	Entry						
9.	Other Insured's Name		Secondary insurance. If the client has insurance secondary to the insurance listed in <i>field 11</i> , enter it here. When applicable, show the last name, first name, and middle initial of the insured if it is <i>different from</i> the name shown in <i>field 4</i> . Otherwise, enter the word <i>Same</i> .						
24B.	Place of Service	Yes	The following is the only appropriate code(s) for Washington State Medicaid: <table> <thead> <tr> <th>Code Number</th> <th>To Be Used For</th> </tr> </thead> <tbody> <tr> <td>3</td> <td>Office or center</td> </tr> <tr> <td>9</td> <td>Other</td> </tr> </tbody> </table>	Code Number	To Be Used For	3	Office or center	9	Other
Code Number	To Be Used For								
3	Office or center								
9	Other								
24C.	Type of Service	Yes	Enter a 3 for all services billed.						