

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington**

To: Outpatient Hospitals
Managed Care Organizations

Memo #: 10-14
Issued: March 11, 2010

From: Douglas Porter, Assistant Secretary
Health and Recovery Services
Administration (DSHS)

For information, contact:
1-800-562-3022, option 2, or go to:
<http://hrsa.dshs.wa.gov/contact/prucontact.asp>

Subject: Outpatient Hospital Services: Medical Policy Updates, Authorization Requirement Changes, Coverage Changes, and Revenue Code Updates

Effective for dates of service on and after April 1, 2010, the Department of Social and Health Services (the Department) notifies providers of:

- Medical Policy Updates;
- Authorization Requirement Changes;
- Coverage Changes;
- Observation Billing Clarification; and
- Revenue Code Table Updates.

This memo also reminds providers of the requirement to complete ProviderOne registration.

Overview

All policies previously published remain the same unless specifically identified as changed in this memo.

Fee Schedule

The Department has updated the Department/HRSA Outpatient Prospective Payment System (OPPS) and Outpatient Hospital Fee Schedule. To view these changes go to the Department/HRSA website online at: <http://hrsa.dshs.wa.gov/RBRVS/#O>

Bill DSHS the usual and customary charge.

Medical Policy Updates

In accordance with WAC 388-501-0055, the Department has reviewed the recommendations of the health technology assessment clinical committee (HTACC) (RCW 70.14.080 through 70.14.140) and has made the decision to adopt recommendations for the following technologies:

- Knee Arthroscopy
- Transcutaneous Electrical Nerve Stimulation (TENS) device
- Drug Eluting Stents
- Bone Growth Stimulators
- Computed Tomography Angiography (CTA) and
- Implantable Infusion Pumps

For additional details and medical necessity criteria, go online at:
<http://www.hta.hca.wa.gov/assessments.html>

Knee Arthroscopy

Knee Arthroscopy for Osteoarthritis

The Department does not recognize lavage, debridement and/or shaving of the knee (CPT 29877) as medically necessary when these are the only procedure(s) performed during the arthroscopy. Under the above circumstances CPT Code 29877 is not reimbursable. The Department will pay for arthroscopies done for other diagnostic and therapeutic purposes.

Transcutaneous Electrical Nerve Stimulation (TENS) device

Effective for dates of service on and after February 1, 2010, the Department does not cover TENS devices, related supplies and services for independent home-use.

The Department no longer covers the following procedure code

Procedure Code	Brief Description
64550	Apply neurostimulator

Drug Eluting Stents

The Department will pay for drug eluting stents when the medical necessity criteria and the following expedited prior authorization (EPA) criteria are met.

Expedited Prior Authorization (EPA) Criteria

Placement of Drug Eluting Stent and Device

CPT codes: 92980, 92981, C1874, C1875, G0290 and G0291

Bill with EPA #870000422 if criteria are met.

The Department pays for drug eluting stents when:

- Medically necessary; and
- One or more of the following criteria are met:
 - ✓ Stent diameter of 3 mm or less;
 - ✓ Length of stent(s) of longer than 15 mm placed within a single vessel;
 - ✓ Stents are placed to treat in-stent restenosis;
 - ✓ For patients with diabetes mellitus; or
 - ✓ For treatment of left main coronary disease.

See Section I of the Department/HRSA [Physician-Related Services Billing Instructions](#) for information on how to use EPA.

Bone Growth Stimulators

The Department will pay for bone growth stimulators when medical necessity criteria are met and prior authorization (PA) is required.

Computed Tomography Angiography (CTA)

The Department will pay for CTA when the medical necessity criteria are met and PA is required. CPT code 75574 is restricted to POS 21, 22, 23.

Implantable Infusion Pumps or Implantable Drug Delivery Systems (IDDS)

The Department will pay for CPT codes: 62318, 62319, 62350, 62351, 62360, and 62361 when medically necessary and only for the indications below:

- Cancer pain;
- Spasticity.

Note: Implantable drug delivery systems (Infusion Pump or IDDS) are not considered medically necessary for treatment of chronic pain not related to cancer.

Authorization Requirement Changes

For dates of service on and after April 1, 2010, the Department will require prior authorization for the following codes:

Procedure Code	Brief Description	Authorization Required
C1874	Stent, coated/cov w/del sys	EPA
C1875	Stent, coated/cov w/o del sy	EPA
G0290	Drug-eluting stents, single	EPA
G0291	Drug-eluting stents,each add	EPA
J0718	Certolizumab pegol inj	PA*

*Please use the Department form, DSHS 13-885 when requesting prior authorization.

You may view/download DSHS forms on the Department/HRSA web site at <http://www.dshs.wa.gov/msa/forms/eforms.html>.

Coverage Changes

For dates of service on and after April 1, 2010, the Department *will* cover the following procedure codes with prior authorization:

Prior Authorization	Procedure Code	Short Description	Coverage Indicator	Maximum Units
PA	20979	Us bone stimulation	1	1
PA	75572	Ct hrt w/3d image	1	1
PA	75573	Ct hrt w/3d image, congen	1	1
PA	75574	Ct angio hrt w/3d image	1	1
PA	Q0138	Ferumoxytol, non-esrd	1	UR
PA	Q0139	Ferumoxytol, esrd use	1	UR

Legend

- A = Covered, ambulatory payment classification (APC)-paid hospitals (OPPS) only.
- B = Covered, non-OPPS and critical access hospitals (CAH) only.
- L = Use of this procedure code may have certain limitations or restrictions (e.g., ages, authorization requirements, diagnosis, or facilities). Please see program specific publications for details prior to providing this service.
- 1 = Covered, all hospitals paid in accordance with each hospital's specific payment methodology.
- PA = Prior Authorization.
- UR = Under Review
- BR = By Report

Revenue Code Table Update

Effective for dates of service on and after April 1, 2010, the Department *will* update the Outpatient Revenue Code Table as follows:

REV CODE	DESCRIPTION	OP	OP PROC CODE REQ
039X	Administration, Processing, and Storage for Blood and Blood Components		
0	General Classification	R	REQ
1	Administration (e.g., transfusions)	R	REQ

You may view the Outpatient Revenue Code Table on the Department/HRSA website at:
<http://hrsa.dshs.wa.gov/HospitalPymt/Outpatient/>

Observation Billing Clarification

The Department pays Outpatient Prospective Payment System (OPPS) hospitals separately for observation when the stay is medically necessary for 8 or more hours. For stays less than 8 hours, the Department may pay for the direct admit if applicable.

The Department pays Critical Access Hospitals for observation services using the Outpatient Department Weighted Cost to Charges payment method when the service is allowed.

G0378 (observation) should be billed in accordance with Current Procedural Terminology (CPT), units = hours of service provided.

Bill all observation services claimed with CPT G0378 on one line. The line must have the date of service that was written on the observation order and include all hours for the incident of care.

Changes to Billing Instructions

The Department has updated Section A of the Department/HRSA *Outpatient Hospital Billing Instructions* with this new information.

ProviderOne Registration

To continue to receive payment, providers must complete ProviderOne registration to prepare for ProviderOne implementation. Specific instructions and resources are available at <http://hrsa.dshs.wa.gov/providerone/providers.htm>.

How Do I Conduct Business Electronically With DSHS?

You may conduct business electronically with DSHS by accessing the WAMedWeb at <http://wamedweb.acs-inc.com>.

How Can I Get DSHS/HRSA Provider Documents?

To download and print DSHS/HRSA provider numbered memos and billing instructions, go to the DSHS/HRSA website at <http://hrsa.dshs.wa.gov> (click the *Billing Instructions and Numbered Memorandum* link).