

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAID PURCHASING ADMINISTRATION
Olympia, Washington**

To: Advanced Registered Nurse Practitioners
Approved Trauma Facilities
Certified Registered Nurse Anesthetists
Emergency Room Physicians
Managed Care Organizations
Participating Trauma Physicians
Trauma Services Coordinators

#Memo: 10-62
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From: Doug Porter, Administrator and Medicaid Director, Health Care Authority/Medicaid Purchasing Administration

For information, contact:
1-800-562-3022 or go to:
<http://hrsa.dshs.wa.gov/contact/default.aspx>

Subject: Trauma Supplemental Payments: Early Liquidation of the Department's SFY2010 Trauma Care Appropriation and Reminder About Use of Trauma Condition Codes

Effective December 1, 2010, the Department of Social and Health Services (the Department) will liquidate its Trauma Care Fund (TCF) appropriation for state fiscal year (SFY) 2010. As of that date the Department will stop making enhanced or supplemental payments to providers for qualified trauma care services provided to medical assistance clients in SFY2010 (July 1, 2009-June 30, 2010).

The Department will continue to make enhanced or supplemental payments for qualified trauma care services provided in SFY2011.

What Does the Medicaid Purchasing Administration (MPA) Plan to Do?

Effective December 1, 2010, the Department will liquidate its TCF appropriation for SFY2010. The early liquidation will maximize the amount of federal match the Department receives for the statewide trauma system. This liquidation normally would have been done in the summer of 2011.

Note: Trauma claims for SFY2010 that are not in paid status by November 30, 2010, will not qualify for TCF payments.

The Department will continue to make TCF payments for trauma care services provided on and after July 1, 2010.

Why is it Necessary to Liquidate the Department's SFY2010 Trauma Care Fund Appropriation Early?

The Department is taking this action to:

- Leverage the higher federal match (62.94%) available under the American Recovery and Reinvestment Act (ARRA); and
- Implement the 2010-2011 Trauma Spending Plan recommended by the Governor's Emergency Medical Services and Trauma Care Steering Committee (EMS&TCSC).

What Must Trauma Care Providers Do to Benefit from the Early TCF Liquidation for SFY2010?

The Department requires trauma care providers to submit their qualified trauma claims **electronically**.

- Claims for trauma care services provided in SFY2010 (July 1, 2009-June 30, 2010) must be submitted no later than **November 19, 2010**.
- SFY2010 trauma claims must be in **paid** status by November 30, 2010, to qualify for liquidation payments from the TCF.
- SFY2010 trauma claims that are not in paid status by November 30, 2010, will not receive TCF payments.

Why Must Claims Be Submitted Electronically?

The Department is experiencing delays of 90 days or more in processing paper claims. Paper claims submitted after July 2010 most likely will not be in paid status by November 30, 2010. Claims not in paid status by this date will not qualify for inclusion in the TCF payout calculations.

If a provider is unsure whether a submitted paper claim will be processed in time to be eligible for the TCF supplemental payment, the Department recommends that the provider submit an electronic claim.

To learn more about electronic billing, go to "How to Bill Successfully in ProviderOne" online at: <https://www2.gotomeeting.com/register/399418274>

Other recorded webinars are located online at:
<http://hrsa.dshs.wa.gov/ProviderOne/Provider%20Training.htm>

To learn more about ProviderOne, visit the new Provider Relations website at:
<http://www.dshs.wa.gov/provider/index.shtml>.

Make sure you get the latest information by signing up for our email distribution lists at:
<https://fortress.wa.gov/dshs/hrsalistsrvsignup/>

What Will Happen After November 30, 2010, If a Provider Submits a New Trauma Claim for SFY2010, or Adjusts a Prior Trauma Claim for SFY2010?

A trauma claim for SFY2010 that is paid after November 30, 2010, will be paid as follows:

- An **original** claim for professional services will be paid at the regular fee schedule rate, even with the trauma modifier (“ST”) present on the claim.
- A claim for professional services that is being **adjusted** will be paid at the regular fee schedule rate, even when the original claim was paid at the enhanced rate for trauma care. For professional services, the TCF payment is made at the time a claim is adjudicated. Claims adjudicated after November 30, 2010, will not receive enhanced payments. (Adjustments mean “void and replace.”)
- An **original** hospital claim will be paid under the applicable hospital payment method. This claim will not receive a supplemental TCF payment. (Supplemental TCF payments to hospitals are made after the fact, not concurrent with claim adjudication.)
- The payment amount for a hospital trauma claim being **adjusted** may or may not change, depending on the reason for the adjustment.
 - ✓ If the reason for adjustment is solely to add a trauma condition code (the claim was not identified as a trauma claim when originally submitted), the payment amount will not change. The claim is not included in the calculation of the TCF liquidation payment.
 - ✓ If a paid claim is being adjusted for reasons not related to trauma, the actual payment amount may or may not change. For TCF purposes, if the claim was previously submitted with a valid trauma condition code and was paid on or before November 30, 2010, the claim is included in the TCF liquidation payment calculation. Liquidation payments for SFY2010 will be calculated based on paid claims data as of November 30, 2010.

REMINDER: Hospitals Must Use Condition Codes to Identify Qualified Trauma Cases!

In 2007, the Department replaced occurrence codes with **condition codes** for identifying hospital claims eligible for supplemental payments from the TCF.

Note: Please remember to put the appropriate condition code on a claim that meets criteria published in WAC 388-550-5450. Occurrence codes are not recognized trauma claim identifiers in ProviderOne.

The valid condition codes when billing for trauma claims are as follows:

Condition Code	Description
MP	Indicates a pediatric client (through age 14 only) with an Injury Severity Score (ISS) in the range of 9-12
MT	Indicates a transferred client with an ISS that is less than 13 for adults or less than 9 for pediatric clients
MV	Indicates an ISS in the range of 13 to 15
MW	Indicates an ISS in the range of 16 to 24
MX	Indicates an ISS in the range of 25 to 34
MY	Indicates an ISS in the range of 35 to 44
MZ	Indicates an ISS of 45 or greater

Note: The “MT” condition code should be used only by a Level I, Level II, or Level III *receiving* hospital. A Level II or Level III transferring hospital must use the appropriate condition code indicating the Injury Severity Score of the qualifying trauma case. See WAC 388-550-5450(4)(c)(ii).

How Can I Get the Department/MPA Provider Documents?

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