

## Re-issued 7/1/2011

### HEALTH CARE AUTHORITY Olympia, Washington

**To:** All Hospitals  
Managed Care Organizations

**# Memo: 11-30**  
**Re-Issued: July 1, 2011**

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Health Care Authority

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<http://hrsa.dshs.wa.gov/contact/default.aspx>

**Subject: Hospitals: Program, Coverage and Fee Schedule Updates**

**Effective for dates of service on and after July 1, 2011**, the Health Care Authority (the Agency) will update the *Inpatient Hospital Services Billing Instructions* with the following:

- Clarification of the medical inpatient detoxification (MID) process to request approval of administrative days;
- Implementation of a new requirement to include present on admission indicators on all inpatient claims;
- High outlier qualification criteria.

**Retroactive to date of services on and after January 1, 2011**, the Agency changed condition codes used to identify trauma claims.

**Effective for dates of service on and after July 1, 2011**, the Agency will:

- Implement updates to outpatient prior authorization and coverage requirements;
- The Revenue Code Grid with updated revenue codes;
- Revise the *Outpatient Hospitals and Outpatient Prospective Payment System (OPPS) Fee Schedule* with the updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2011 Relative Value Units (RVUs), Current Procedural Terminology (CPT®) codes, and Healthcare Common Procedure Coding System (HCPCS) codes;
- Implement the updated coverage limits for vaccines;
- Replace the Agency Observation Policy with CMS Extended Assessment and Management composite payment method; and
- Clarify the billing policy for situations when more than one outpatient visit occurs on the same day

## Billing Instruction Changes

Effective for dates of service on and after July 1, 2011, the Agency made the following miscellaneous changes to the *Inpatient Hospital Services Billing Instructions*:

Effective Date/Reason for Change	Section/ Page No.	Subject	Change
July 1, 2011  Clarification and update Billing Instructions	B.7	Diagnosis Related Group (DRG) payment method	Changes to the last two bullets under the heading “ <b>High Outlier Claim Qualification Criteria</b> ” and the last two bullets under the heading “ <b>High outlier Claim Qualification Criteria for Neonatal and Pediatric DRG Classifications (Per Diem)</b> ”.
	B.8	Diagnosis Related Group (DRG) payment method	Changes to the three bullets under the heading “ <b>Calculating High Outlier Payment - Diagnosis Related Group (DRG) Payment Method</b> ” and the bottom sentence in the blue note box adding January 31, 2011, and 85% for claims with admission dates on or after February 1, 2011.
	B.12	Diagnosis Related Group (DRG) payment method	Under the heading “ <b>High Outlier Qualification Criteria</b> ” changes to the last two bullets.
	B.12	Diagnosis Related Group (DRG) payment method	Under the heading “ <b>High Outlier Claim Qualification Criteria for Neonatal and Pediatric DRG Classifications</b> ” changes to the dates in the third bullet and add sentence to the last bullet.
	B.13	Diagnosis Related Group (DRG) payment method	Under the heading “ <b>Calculating High Outlier Payment (Per Diem)</b> ” change the dates in the last first two bullets.
	C.4	Trauma Condition Codes	Replace codes in the table in the column titles “ <b>Condition Code</b> ”
	D.7	Medical Inpatient Detoxification (MID)	Clarify information about getting paid for MID services under the heading “ <b>Medical Inpatient Detoxification (MID) Services</b> ”

	D.8	Medical Inpatient Detoxification (MID)	Update information about detoxification programs getting paid by Medicaid Under the heading “ <b>What Condition Code/Authorization Number is Used When Billing for MID?</b> ”
	D.9	Medical Inpatient Detoxification (MID)	Clarify how to request an extension when MID exceeds length of stay limitation under the heading “ <b>How Do I Bill the Agency for MID Services that Exceed the Three or Five Day Limitation?</b> ”
	G.7 and G.8	Present On Admission	Clarify information to include on “Paper Claim”, “Direct Data Entry Claim”, and an “Electronic Claim”.

## Medical Inpatient Detoxification

The Agency no longer requires providers to bill for a denial, prior to requesting medical inpatient detoxification (MID) extensions.

If the hospital’s “utilization review department” has already determined that an extension days should be paid at the administrative day rate, indicate that the request is for “Detox Extension admin days” in the “description of service being requested” field, of the:

- General Information for Authorization form, DSHS 13-835\*; and
- Fax/Written Request Basic Information form, DSHS 13-75\*6.

\*Forms submitted to the Agency must be typed.

The Agency requires providers to use both of the above forms when requesting authorization.

**Reminder:** Basic detoxification services must be provided in a Division of Behavioral Health and Recovery (DBHR) approved facility.

**Note:** Please see the Agency’s *ProviderOne Billing and Resource Guide* at: [http://hrsa.dshs.wa.gov/download/ProviderOne\\_Billing\\_and\\_Resource\\_Guide.html](http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html) for more information on requesting authorization.

## Present on Admission Indicators

### New Requirement

**Effective for dates of service on and after July 1, 2011**, the Agency requires present on admission (POA) indicators on all inpatient claims. The Agency will review all inpatient claims for hospital acquired conditions (HAC) consistent with Medicare policy and will not receive additional payment related to treatment of the HAC. For more information (See [WAC 388-550-1650](#))

### How To Indicate a POA on a Paper Claim

On the UB-04 Claim Form, the POA indicator is the 8th digit of the field locator 67, principal diagnosis, and the 8th digit of each of the secondary diagnosis fields, field locator 67 A-Q.

In other words, report the applicable POA indicator (Y, N, U, or W) for the principal and any secondary diagnoses, and include this as the 8th digit; leave this field blank if the diagnosis is exempt from POA reporting.

### How To Indicate a POA on a Direct Data Entry Claim

When submitting a claim using Direct Data Entry (DDE), submit the POA indicator in Billing Note.

**Example:** POA for this example should be coded as **POAYNUW1YZ**.

<b>POA</b>	“POA” is always required first, followed by a single indicator for every diagnosis.
<b>Y</b>	The principle diagnosis is always the first indicator after “POA”. In this example POA is present on admission.
<b>N</b>	The first secondary was not present on admission, designated by “N”.
<b>U</b>	It was unknown if this secondary diagnosis was present on admission. For HAC purposes treated as “N”.
<b>W</b>	It was clinically undetermined if this diagnosis was present on admission. For HAC purposes treated as “Y”.
<b>1</b>	The fourth secondary diagnosis was exempt from POA reporting, designated by “1”.
<b>Y</b>	Fifth diagnosis was present on admission.
<b>Z</b>	The letter “Z” is used to indicate the end of the data element.

## How To Indicate a POA on an Electronic Claim

Using the 837i, submit the POA indicator in segment K3 in the 2300 loop, data element K301.

**Example:** POA for this example should be coded as **POAYNUW1YZ**.

<b>POA</b>	“POA” is always required first, followed by a single indicator for every diagnosis.
<b>Y</b>	The principle diagnosis is always the first indicator after “POA”. In this example POA is present on admission.
<b>N</b>	The first secondary was not present on admission, designated by “N”.
<b>U</b>	It was unknown if this secondary diagnosis was present on admission. For HAC purposes treated as “N”.
<b>W</b>	It was clinically undetermined if this diagnosis was present on admission. For HAC purposes treated as “Y”.
<b>1</b>	The fourth secondary diagnosis was exempt from POA reporting, designated by “1”.
<b>Y</b>	Fifth diagnosis was present on admission.
<b>Z</b>	The letter “Z” is used to indicate the end of the data element.

## High Outlier Qualification Criteria

The Agency has updated the *Inpatient Hospital Services Billing Instructions* to reflect the February 1, 2011, change in high outlier qualification criteria for initial claim allowed amounts.

## Trauma Condition Code Change

**Retroactive to dates of service on and after January 1, 2011**, the Agency has adopted the CMS definitions for condition codes MP, MT, MV, MW, MX, MY, and MZ and will no longer use these condition codes to identify trauma claims. See Memo [11-48 Trauma Supplemental Payments: Recoupment of Physician Overpayments in the SFY2010 Trauma Care Liquidation, and Change in Hospital Trauma Condition Codes](#).

## Updated Billing Instructions

The Agency will be updating the *Inpatient Hospital Services Billing Instructions* with the information in this memo. You may download these updated billing instructions at: [http://hrsa.dshs.wa.gov/download/Billing\\_Instructions/Inpatient\\_Hospital/Inpatient\\_Hospital\\_BI.pdf](http://hrsa.dshs.wa.gov/download/Billing_Instructions/Inpatient_Hospital/Inpatient_Hospital_BI.pdf).

## Revenue Code Grid Updates

For dates of service on and after July 1, 2011, the Agency will update the revenue code grid as follows:

Revenue Code	“IP”	“OP”	OP procedure code required	Notes
0274**	N-Y	N-Y	REQ	When billed in combination with covered orthotic procedure code.

\*\*Orthotics may only be billed by either the DME vendor or the hospital, not both.

To view the Revenue Code Grid, visit the Agency’s website at:  
<http://hrsa.dshs.wa.gov/HospitalPymt/Outpatient/Index.htm>.

## Outpatient Authorization

Effective for dates of service on and after July 1, 2011, the Agency either *requires* authorization, or has limits on coverage for the following procedures codes when billed on a hospital claim (UB-04) as follows:

Type of Prior Authorization Required	Procedure Code	Brief Description
PA	A9543	Y90 ibritumomab, rx
PA	J1745*	Infliximab injection

## Added/Updated Procedure Codes

Effective for dates of service on and after July 1, 2011, the Agency will update the *Outpatient Hospital and OPSS Fee Schedule* for procedures performed in an outpatient hospital setting. Procedures with a value in the Alternate Payment Method column may be paid using that method if an Ambulatory Payment Classification (APC) payment is not applicable. Where no method is listed, the Ratio of Cost-to-Charges (RCC) method may be used if APC payment is not applicable.

Auth	Procedure Code	Short Description	Coverage Indicator	Maximum Units	Alternate Payment Method
	L0140**	Cervical semi-rigid adjustab	1	1	Max Fee
	L0150**	Cerv semi-rig adj molded chn	1	1	Max Fee
	L0172**	Cerv col thermplas foam 2 pi	1	1	Max Fee
	L0458**	TLSO 2Mod symphis-xipho pre	1	1	Max Fee
	L0625**	LO flexibl L1-below L5 pre	1	1	Max Fee
	L1832**	KO adj jnt pos rigid support	1	1	Max Fee
	L1834**	Ko w/0 joint rigid molded to	1	1	Max Fee
	L1836**	Rigid KO wo joints	1	1	Max Fee
	L1930**	Afo plastic	1	1	Max Fee
	L2112**	Afo tibial fracture soft	1	1	Max Fee
	L2116**	Afo tibial fracture rigid	1	1	Max Fee
	L3660**	Abduct restrainer canvas&web	1	1	Max Fee
	L3670**	Acromio/clavicular canvas&we	1	1	Max Fee
	L3808**	WHFO, rigid w/o joints	1	1	Max Fee
	L3913**	HFO w/o joints CF	1	1	Max Fee
	L3925**	FO pip/dip with joint/spring	1	1	Max Fee
	L3927**	FO pip/dip w/o joint/spring	1	1	Max Fee
	L3929**	HFO nontorsion joint, prefab	1	1	Max Fee
	L3933**	FO w/o joints CF	1	1	Max Fee
	L3982**	Upper ext fx orthosis	1	1	Max Fee

Auth	Procedure Code	Short Description	Coverage Indicator	Maximum Units	Alternate Payment Method
		rad/ul			
	L4350**	Ankle control orthosi prefab	1	1	Max Fee
L***	Q2035	Afluria vacc, 3 yrs & >, im	1	1	Max Fee
L***	Q2036	Flulaval vacc, 3 yrs & >, im	1	1	Max Fee
L***	Q2037	Fluvirin vacc, 3 yrs & >, im	1	1	Max Fee
L***	Q2038	Fluzone vacc, 3 yrs & >, im	1	1	Max Fee
	Q2039	NOS flu vacc, 3 yrs & >, im	1	1	
	Q2041	Wilate injection	1	UR	
	Q2043	Silleucel-T Auto CD54+	1	UR	

\*Use DSHS form 13-897 to request authorization at <http://dshs.wa.gov/msa/forms/eforms.html>.

\*\*Orthotics may only be billed by either the DME vendor or the hospital, not both.

\*\*\*Only reimbursed for clients 19 years of age and older.

1	= Covered for all hospitals paid in accordance with each hospital's specific methodology.
*L	= The use of this procedure code may have certain limitations or restrictions (e.g., ages, authorization requirements, diagnosis, or facilities). Please see the program specific publications for details prior to providing this service.
PA	= Prior Authorization.
EPA	= Expedited Prior Authorization

## Immunization Coverage

Effective for dates of service on or after July 1, 2011, the Agency limits coverage of vaccines. The Agency does not cover vaccines in an “outpatient setting” that are available from the Department of Health through the Washington State Childhood Vaccine Program. Vaccine coverage may be limited to clients 19 years of age or older.

Vaccine administration fees are covered for all age groups when the vaccine is administered in a hospital setting. Vaccine payments for adults are packaged with the payment for the vaccine administration code when SI = N.

## Vaccine Administration

Auth	SI	Procedure Code	Short Description	Coverage Indicator	Maximum Units	Alternate Payment Method
	S	90472	Immunization admin each add	1	3	Max Fee

## Influenza Vaccines

Auth	SI	Procedure Code	Short Description	Coverage Indicator	Maximum Units	Alternate Payment Method
L/CVP	L	90655	Flu vaccine no preserv 6-35m	0	NC	
L/CVP	L	90656	Flu vaccine no preserv 3 & >	0	NC	
L/CVP	L	90657	Flu vaccine 3 yrs im	0	NC	
L/CVP	E	90658	Flu vaccine 3 yrs & > im	0	NC	
L/CVP	L	90660	Flu vaccine nasal	0	NC	
L	L	Q2035	Afluria vacc, 3 yrs & >, im	1	1	Max Fee
L	L	Q2036	Flulaval vacc, 3 yrs & >, im	1	1	Max Fee
L	L	Q2037	Fluvirin vacc, 3 yrs & >, im	1	1	Max Fee
L	L	Q2038	Fluzone vacc, 3 yrs & >, im	1	1	Max Fee
L	L	Q2039	NOS flu vacc, 3 yrs & >, im	0	NC	

## Other Vaccines

Auth	SI	Procedure Code	Short Description	Coverage Indicator	Maximum Units	Alternate Payment Method
L	N	90632	Hep a vaccine adult im	1	1	IFS
L/CVP	N	90633	Hep a vacc ped/adol 2 dose	0	0	
L	N	90636	Hep a/hep b vacc adult im	1	1	IFS
L	N	90645	Hib vaccine hboc im	1	1	IFS
L/CVP	N	90647	Hib vaccine prp-omp im	1	1	IFS
L/CVP	N	90648	Hib vaccine prp-t im	1	1	IFS
L/CVP	M	90649	Hpv vaccine 4 valent im	0	NC	
L/CVP	M	90650	Hpv vaccine 2 valent im	0	NC	
L/CVP	L	90670	Pneumococcal vacc 13 val im	1	1	IFS
L/CVP	K	90680	Rotavirus vacc 3 dose oral	0	NC	
L/CVP	K	90681	Rotavirus vacc 2 dose oral	0	NC	
L/CVP	N	90696	Dtap-ipv vacc 4-6 yr im	0	NC	
L/CVP	N	90698	Dtap-hib-ip vaccine im	0	NC	
	L	90669	Pneumococcal vacc 7 val im	0	NC	
L/CVP	N	90700	Dtap vaccine < 7 yrs im	0	NC	
L/CVP	N	90702	Dt vaccine < 7 im	0	NC	
L/CVP	N	90707	Mmr vaccine sc	1	1	IFS
L/CVP	N	90710	Mmr vaccine sc	0	NC	
L/CVP	N	90713	Poliovirus ipv sc/im	1	1	IFS
L/CVP	N	90714	Td vaccine no prsrv >= 7 im	1	1	IFS
L/CVP	N	90715	Tdap vaccine >7 im	1	1	IFS
L/CVP	M	90716	Chicken pox vaccine sc	0	NC	
L/CVP	N	90718	Td vaccine > 7 im	1	1	IFS
L/CVP	E	90723	Dtap-hep b-ipv vaccine im	0	NC	
L/CVP	L	90732	Pneumococcal vaccine	1	1	IFS
L/CVP EPA	K	90734	Meningococcal vaccine im	1	1	IFS
L/CVP	F	90743	Hep b vacc adol 2 dose im	0	NC	
L/CVP	F	90744	Hepb vacc ped/adol 3 dose im	0	NC	
L	F	90746	Hep b vaccine adult im	1	1	IFS
L/CVP	F	90747	Hepb vacc ill pat 4 dose im	1	1	IFS
L/CVP	E	90748	Hep b/hib vaccine im	0	0	

L/CVP – Subject to program limitations, not covered if vaccine is available free from Department of Health Child Vaccine Program. Covered only for age 19+

L – Covered for only age 19+

EPA – Expedited Prior Authorization required. See the ProviderOne Billing and Resource Guide for more information. [http://hrsa.dshs.wa.gov/download/ProviderOne\\_Billing\\_and\\_Resource\\_Guide.html](http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html)

## Observation Services

**Effective for dates of service on and after July 1, 2011**, the Agency has adopted the CMS rules for Extended Assessment and Management composites APC 8002 and APC 8003. There will be delays in the technical implementation of these changes. When the changes are completed, outpatient claims containing observation with dates of service on and after July 1, 2011 will be adjusted to reflect the CMS policy.

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.

<http://www.cms.gov/manuals/downloads/clm104c04.pdf>

Some key elements of the CMS policy are:

Composite APC	Composite APC Title	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-- <ol style="list-style-type: none"> <li>a) On the same day as HCPCS code G0379*; or</li> <li>b) On the same day or the day after CPT codes 99205 or 99215; and</li> </ol> 2) There is no service with SI=T on the claim on the same date of service or 1 day earlier than G0378
8003	Level II Extended Assessment and Management Composite	1) Eight or more units of HCPCS code G0378** are billed on the same date of service or the date of service after 99284, 99285 or 99291; and 2) There is no service with SI=T on the claim on the same date of service or 1 day earlier

- Observation hours G0378 are always packaged;
- Composite payment may be made for G0379, 99205, 99215, 99284, 99285 or 99291 if criteria are met;
- All observation hours are required to be claimed on a single line of 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 (G0379) must always be claimed in conjunction with at least one unit of 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.

The Agency will:

- Allow procedure code G0379 to be claimed with labor and delivery or other appropriate revenue codes;
- Continue to cover fetal monitoring w/report (59050) as a separate payable service;
- Require observation hours (G0378) to be claimed with revenue code 0762; and
- Continue to follow prior Agency observation rules for claims with dates of service before July 1, 2011.

### **More Than One Outpatient Visit on a Single Day**

The Agency will only reimburse for more than one visit or claim on the same day when services provided in the second incident of care are separate and unrelated to the services provided during the first incident of care.

The Agency uses condition codes (such as G0), diagnosis codes, hours of service, modifiers, and procedure codes to determine if the services provided are separate and meet the above criteria.

Absence of:

- Admit and discharge hours **may** cause claim denials; and
- Appropriate condition codes and/or modifiers **will** cause claim denials.

### **Viewing Changes to the Fee Schedule**

To view the July 1, 2011, fee schedule changes, go to the Agency website online at:  
<http://hrsa.dshs.wa.gov/RBRVS/Index.html>.

## How Can I Get the Agency Provider Documents?

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