

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

To: Resource Based Relative Value Scale (RBRVS) Users: **Memo #: 09-40**
Anesthesiologists **Issued: June 30, 2009**
Advanced Registered Nurse Practitioners (ARNPs)
Blood Banks **For information contact:**
Emergency Physicians 1-800-562-3022, option 2, or go to:
Family Planning Clinics <http://hrsa.dshs.wa.gov/contact/prucontact.asp>
Federally Qualified Health Centers
Health Departments
Laboratories
Managed Care Organizations
Nurse Anesthetists
Ophthalmologists
Physicians
Physician Clinics
Podiatrists
Psychiatrists
Radiologists
Registered Nurse First Assistants

Supersedes: # Memo 08-45

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

Subject: Physician-Related Services: Vendor Rate Decrease for Adult and Children E&M and Laboratory Services; Fee Schedule and Policy Updates; and New Timelines for Resubmitting, Modifying, or Adjusting Initial Claims

Effective for dates of service on and after July 1, 2009, the Department of Social and Health Services (DSHS) will implement:

- A vendor rate decrease for Adult and Children Evaluation and Management (E&M) Services and Clinical Laboratory Services;
- The updated Medicare Physician Fee Schedule Database (MPFSDB) Year 2009 Relative Value Units (RVUs);
- The updated Year 2009 Relative Value Guide Base Anesthesia Units (BAUs);
- The updated Medicare Clinical Laboratory Fee Schedule (MCLFS);
- The updated Medicare Average Sales Price (ASP) drug files;
- The technical changes listed in this # memo; and
- New timelines for resubmitting, modifying, or adjusting initial claims.

Maximum Allowable Fees

Effective for dates of service on and after July 1, 2009, DSHS is implementing a vendor rate reduction for Adult Evaluation & Management (E&M) codes 99201-99205 and 99211-99215; Children's E&M codes 99201-99205, 99211-99215, 99381-99385, 99391-99395, and 99460-99463; and Clinical Laboratory Services.

The rate adjustment is in accordance with the final operating budget for medical assistance payments for fiscal years 2010 and 2011, as enacted by the Legislature. This operating budget is summarized on pages 134 and 135 in the government document "Statewide Summary and Agency Detail." You may access this document online at:

http://leap.leg.wa.gov/leap/budget/detail/2009/so0911agydetailfinal_0501.pdf.

The fee schedule's maximum allowable fees have been adjusted to reflect these changes. To view the updated fee schedules, visit the DSHS/HRSA web site at:

<http://hrsa.dshs.wa.gov/RBRVS/Index.html#p>, **effective July 1, 2009**.

Bill DSHS your usual and customary charge.

Conversion Factors

Below are DSHS's July 1, 2009, Conversion Factors:

Title	Procedure Codes	July 1, 2009 Conversion Factor
Adult Primary Health Care	99201-99205, 99211-99215	22.03
Anesthesia		21.20
Children's Primary Health Care	99201-99215, 99381-99395, 99460-99463	36.48
Clinical Lab Multiplication Factor		0.76
Maternity	59000, 59025, 59400-59410, 59425-59426, 59430, 59510-59525, and 59610-58622	43.54
All other Procedure Code (except Clinical Laboratory)		22.31

Coverage Changes

DSHS has changed the following procedure codes **from covered to noncovered**:

Procedure Code	Brief Description
11200	Removal of skin tags
11201	Remove skin tags add-on
0085T	Breath test heart reject

DSHS **now covers** the following procedure codes **without Prior Authorization (PA)**:

Procedure Code	Brief Description
Q2023	Xyntha, inj

DSHS has changed the following procedure code **from noncovered to covered with PA**:

Procedure Code	Brief Description	Prior Authorization
L7510	Prosthetic device repair rep	Yes
00797	Anesth, surgery for obesity	Yes

DSHS has changed the following procedure code from covered without PA to **covered with PA**:

Procedure Code	Brief Description	Prior Authorization
L9900	O & P supply/accessory/service	Yes

DSHS has changed the following procedure codes from **covered with PA** to **covered without PA**:

Procedure Code	Brief Description
A9507	Supply radiopharmaceutical diagnostic imaging agent, indium in 111 capromab pendetide, pr dose
A9542	Indium in-111 ibritumomab tiuxetan, diag, per study dose, up to 5 millicuries,
A9543	Yttrium y-90 ibritumomab tiuxetan, therapeutic, pr. Tmt dose, up to 40 millicuries
A9544	Iodine I-131 tositumomab, diag, pr study dose
A9545	Iodine I-131 tositumomab, therapeutic, pr. Treatment dose
A9698	Non-radioactive contrst imaging material, not otherwise class. pr study
15170	Acell graft trunk/arms/legs
15171	Acell graft truck/arm/leg add-on
15175	Acell graft, f/n/hf/g
15176	Acell graft, f/n/hf/g add-on
19297	Place radiother balloon cath brst inters radioele app folwing part mastectomy, inc. ig, concur w/part mast
19298	Plcmnt radiotherapy brach therapy cath brst for intersit applic, incl image guidance
20982	Abalation, bone tumors,radiofreq, percut, Inc. computed tomographic guidance
21045	Exc. Malig. Tumor mandible-radical resec
33880	Endovascular repair descnd thoracic aort w/coverage lt subclav artery
33881	Endovascular repair descnd thoracic aort w/o coverage lt. subclav artery
33883	Placement prox exten prosth descnd thorac aort initial extension
33884	Placement prox exten prosth descnd thorac aort ea add. extension
33889	Open subclav carotid artery transposition in conjunct endovas rep descnd thor aort
42160	Destruction of lesion palate or uvula thermal, cryo or chemical

Procedure Code	Brief Description
55706	Biopsies, prostate, needle, transperineal, stereotactic templ, guided saturation sampling, inc image guide
66930	Extraction lens, intracapsular
69310	Reconstruction external auditory canal
69320	Rebuild outer ear canal
76510	Ophthalmic ultrasound, dx; b-scan/quantitative a-scan performed during same patient encounter
88380	Microdissection ie sample preparation of microscopically identified target

The following procedure codes require Expedited Prior Authorization (EPA) and/or PA. If the client does not meet EPA criteria, PA is required. Refer to Section I of the Physician-Related Services Billing Instructions for EPA criteria.

Procedure Code	Brief Description
L8615	Headset/headpiece for use with cochlear implant device, replacement
L8616	Microphone for use with cochlear implant device, replacement
L8617	Transmitting coil for use with cochlear implant device, replacement
L8618	Transmitter cable for use with cochlear implant device, replacement
L8621	Zinc air battery for use with cochlear implant device, replacement, ea.
L8622	Alkaline battery for use with cochlear implant device, any size, replacement, ea
L8623	Lithium ion battery for use with cochlear implant device speech processor, repl. ea
L8624	Lithium ion battery for use with cochlear implant device speech processor, repl. ea

Injectable Drug Updates

DSHS updates the maximum allowable fees for injectable drugs on a quarterly basis. Current and past fee schedules are posted on the DSHS/HRSA website at <http://hrsa.dshs.wa.gov/RBRVS/index.html>.

All fees have been updated at 106% of the Average Sales Price (ASP) as defined by Medicare. If a Medicare fee is unavailable for a particular drug, DSHS prices the drug at 84% of the Average Wholesale Price (AWP).

Change in Billing Timelines [Refer to WAC 388-502-0150]

Resubmitting, Modifying, or Adjusting Initial Claims

Effective for claims with dates of service or admission on and after July 1, 2009:

- Within 24 months of the date the service was provided to the client, a provider may resubmit, modify, or adjust an initial claim, **other than a prescription drug claim or a claim for major trauma services.**
- After 24 months from the date the service was provided to the client, DSHS does not accept any claim for resubmission, modification, or adjustment. **This 24-month period does not apply to overpayments that a provider must refund to DSHS by a negotiable financial instrument, such as a bank check.**

Note: The billing timelines for prescription drug claims and trauma claims are not changing. For your reference, the following are the billing timelines for these claims.

Prescription Drug Claims

- DSHS allows providers to resubmit, modify, or adjust any prescription drug claim with a timely internal control number (ICN) within 15 months of the date the service was provided to the client. After 15 months, DSHS does not accept any prescription drug claim for resubmission, modification or adjustment.
- The 15-month period described above does not apply to overpayments that a prescription drug provider must refund to DSHS. After 15 months, a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

Major Trauma Claims

- DSHS allows a provider of trauma care services to resubmit, modify, or adjust, within 365 calendar days of the date of service, any trauma claim that meets the criteria specified in WAC 388-531-2000 (for physician claims) or WAC 388-550-5450 (for hospital claims) for the purpose of receiving payment from the trauma care fund (TCF).
 - ✓ No increased payment from the TCF is allowed for an otherwise qualifying trauma claim that is resubmitted after 365 calendar days from the date of service.
 - ✓ Resubmission of or any adjustments to a trauma claim for purposes other than receiving TCF payments are subject to WAC 388-502-0150.
- The 365-day period described above does not apply to overpayments from the TCF that a trauma care provider must refund to DSHS. A provider must refund an overpayment for a trauma claim that received payment from TCF using a method specified by DSHS.

Note: If a provider fails to bill a claim according to these requirements and DSHS denies payment of the claim, the provider or any provider's agent cannot bill the client or the client's estate. The client is not responsible for payment.

Note: DSHS still requires providers to bill within 365 days in order to establish initial timeliness standards when any of the following apply:

- The date the provider furnishes the service to the eligible client;
- The date a final fair hearing decision is entered that impacts the particular claim;
- The date a court orders DSHS to cover the services;
- The date DSHS certifies a client eligible under delayed certification criteria; or
- The date a DSHS managed plan or Basic Health Plus client's premium has been recouped by DSHS.

Important Information for Prescribers of Durable Medical Equipment and Supplies, Nondurable Medical Supplies and Equipment, Oral Enteral Nutrition, and Prescription Drugs

The State Legislature has directed DSHS to reduce its expenditures in order to help balance the budget. This means that certain services DSHS has provided in the past no longer will be available, or will only be available in a reduced amount. **These reductions will take effect starting July 1, 2009.**

The services that are affected by this necessary reduction are listed in the table on the following page. Because these changes affect all Medicaid clients, there is no right for an evidentiary hearing to challenge these reductions, and therefore there will be no continuation of the affected services after July 1, 2009. However, providers may request an exception to rule¹ for requesting coverage for a noncovered service or request a limitation extension² for more than the allowed amount by contacting DSHS and providing the necessary information for the program to make a decision in your client's individual case.

¹ **Exception to Rule:** The prior authorization process used by DSHS to consider the appropriateness of a noncovered item when that service is specifically needed for that client because their clinical needs are so different than the rest of the population. You may download the HRSA Exception to Rule Request form, DSHS 13-864, at: <http://www1.dshs.wa.gov/msa/forms/eforms.html>.

² **Limitation Extension:** The prior authorization process used to consider when it is medically necessary to allow more of a product for a specific client because their healthcare needs are not being met by the amount allowed in the base benefit for that service. You may download the HRSA Limitation Extension Request form, DSHS 13-866, at: <http://www1.dshs.wa.gov/msa/forms/eforms.html>.

2009-2011 Benefit Changes

<p>For Adults Effective July 1, 2009</p>	<p>Enteral Nutrition</p> <ul style="list-style-type: none"> • DSHS will no longer pay for oral nutrition. • DSHS will continue to pay for enteral nutrition for tube feedings only.
<p>For Adults Effective August 1, 2009</p>	<p>Durable Medical Equipment and Supplies/Nondurable Medical Supplies and Equipment</p> <ul style="list-style-type: none"> • DSHS considers bathroom or shower items, stockings, and auto blood pressure cuffs as noncovered with an Exception to Rule (ETR) option per WAC 388-501-0160. • DSHS limits diabetic supplies, with a Limitation Extension (LE) option, to: <ul style="list-style-type: none"> ✓ Lancets and test strips 100, per client, per month if the client is on insulin; and ✓ Lancets and test strips 100, per client, every 3 months if the client is not on insulin. • DSHS limits incontinent supplies to 200 per client, per month with an LE option; • DSHS limits nonsterile gloves to 200 per client, per month with an LE option; • DSHS limits sterile gloves to 30 per client, per month with an LE option. <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Note: You may download the HRSA Exception to Rule Request form, DSHS 13-864, or the HRSA Limitation Extension Request form, DSHS 13-866, at: http://www1.dshs.wa.gov/msa/forms/eforms.html.</p> </div>

<p style="text-align: center;">For Children Effective August 1, 2009</p>	<p>Durable Medical Equipment</p> <ul style="list-style-type: none"> • DSHS limits diabetic supplies, with a Limitation Extension (LE) option, to: <ul style="list-style-type: none"> ✓ Lancets and test strips 100 per client, per month if the client is on insulin; and ✓ Lancets and test strips 100 per client, every 3 months if the client is not on insulin. • DSHS limits incontinent supplies to 200 per client, per month with an LE option; • DSHS limits nonsterile gloves to 200 per client, per month with an LE option; • DSHS limits sterile gloves to 30 per client, per month with an LE option. <div style="border: 1px solid black; background-color: #e0f0ff; padding: 5px; margin-top: 10px;"> <p>Note: You may download the HRSA Limitation Extension Request form, DSHS 13-866, at: http://www1.dshs.wa.gov/msa/forms/eforms.html.</p> </div>
<p style="text-align: center;">For All Clients Effective September 1, 2009</p>	<p>Prescription Drug Program</p> <ul style="list-style-type: none"> • DSHS will cover only a limited list of over-the-counter (OTC) products. The list can be found at on the DSHS/HRSA website at http://hrsa.dshs.wa.gov/pharmacy/ • DSHS will cover only the following generic products for the treatment of symptoms associated with cough and cold: <ul style="list-style-type: none"> ✓ Guaifenesin 100mg/5ml liquid/syrup* ✓ Dextromethorphan 15mg/5ml liquid/syrup* ✓ Dextromethorphan-guaifenesin 10-100 mg/5 ml syrup* (including sugar –free formulations) ✓ Pseudoephedrine 30mg tablet* ✓ Pseudoephedrine 60mg tablet* ✓ Saline Nasal Spray 0.65% * <p>*generic products only</p>

Changes to Billing Instructions

DSHS made the following changes to the Physician-Related Services Billing Instructions. You may view/download the updated billing instructions on the DSHS/HRSA website at:

http://hrsa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/Physician-Related_Services.html

Section Changed	Description of Change
A	<ul style="list-style-type: none">• On page A.3, added a section describing who can provide and bill for physician-related healthcare services.• On page A.4, corrected a publication error under the “Noncovered Practitioners” heading.• On page A.6, updated the “Conversion Factors” section.
B	Removed outdated section on page B.11 titled “Change to Current Smoking Cessation Benefit for Pregnant Women Only.”
C	On page C.21 under the “Clarification of Coverage Policy for Certain Injectable Drugs” heading, added the words, “allowed once every 67 days” in the “Limitation Restricted to ICD-9-CM column for procedure code J1055.

Section Changed	Description of Change
E	<ul style="list-style-type: none"> • On page E.9, added a sentence stating: “Psychiatrists can also bill the procedures listed on page E.3 which are not subject to the 20-hour visit limitation.” • On pages E.12 and E.13, added clarifying language and a table (on E.13) explaining services that psychiatric ARNPs can bill for. • On page E.22, added code G0202 to the list of allowed mammograms. • On page E.27, added 4 cancer screens to the list of covered cancer screens and added the brief descriptions for the procedure codes in the table. • On page E.29: <ul style="list-style-type: none"> ✓ Added the following to the first bullet on the page: <ul style="list-style-type: none"> ✓ The provider is certified and approved to prescribe Buprenorphine-Suboxone (see # Memo 03-58 MAA). The provider must have a CLIA waiver. Enter the following information on the CMS-1500 Claim Form: <ul style="list-style-type: none"> ➤ ICD-9-CM diagnosis codes 304.01-304.02; ➤ CPT code 80101 QW; and ➤ “Certified bupren provider” in field 19. ✓ Added the following under the second bullet: “When clients need to be monitored for drug/alcohol use, please refer them to a DASA-approved program for evaluation/treatment.” • On page E.35, added procedure codes J7186 and Q2023 to the table of blood bank services.

Section Changed	Description of Change
F	<ul style="list-style-type: none"> • On page F.1, added the following language to the first bullet under the heading, “Chemotherapy Services”: “and bill one administration for each drug given. They must be billed on the same claim.” Also added a note clarifying that providers must bill drug, infusion, and injection codes all on the same claim. • On page F.7, added the following language to the 2nd checkmark under the 5th bullet: “Use the specific medical diagnosis for the client. Do not use V72.83-V72.85. • On page F.10, added CPT code 11920 to table. • On page F.15, removed the “Graft” section. • On page F.28, made various housekeeping and clarity changes.
G	<ul style="list-style-type: none"> • On page G.10, updated the “Cochlear Implant Services” section. • On page G.11, added a bullet to the “Osseointegrated Implants” section. • On page G.17, updated the last paragraph in the “Out-of-State Hospital Admissions” section.
H	<ul style="list-style-type: none"> • On page H.13, added two clarifying paragraphs under the “Unbundling Obstetrical Care” section. • On page H.20, removed section on Smoking Cessation. Added clarifying language to the “HIV/AIDS Counseling/Testing” section. • On page H.26, added clarifying language in the 3rd bullet under the “Who completes the Sterilization Consent Form?” section. • On page H.34, added “(non hospital-based)” to the last paragraph under the section “Abortion Services (Drug Induced).”

Section Changed	Description of Change
I	<ul style="list-style-type: none"> • On page I.6, under “Cochlear Implants,” replaced the note box with: <div data-bbox="440 394 1268 474" style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>Note: Replacement parts (HCPCS codes L8619, L7510, and L9900) require PA.</p> </div> • On page I.8, added the following under the “Hyperbaric Oxygen Therapy” section: “(C1300 is billed for the outpatient facility charge.)” • On pages I.12 and I.13, added clarifying coverage information under the section titled: “DSHS-Approved Centers of Excellence (COE).” • On page I.14, removed “(PSC-T only)” after “Dorenbacher Children’s Hospital/Portland NW Marrow Transplant Program” in the “Approved Transplant Hospitals” column in the table. • On pages I.16 and I.17, made name changes to the DSHS-Approved Sleep Centers list, removed “Forks Community Hospital” from the list, and added “Skagit Valley Hospital Sleep Center” to the list. • On page I.19, removed the “DSHS-Approved Inpatient Pain Program” section. Also added clarifying language to the “DSHS-Approved Bariatric Hospitals and Their Associated Clinics” section.
K	<ul style="list-style-type: none"> • On page K.3, added procedure codes A4461 and A4463 to table. • On page K.5, added procedure code L7510 to table. Added PA to procedure codes L8691 and L9900. • On pages K.9 and K.10, changed any indication of DSHS pricing drugs at 86% of AWP to 84% of AWP.
L	<p>On page L.5, added the following new modifiers:</p> <ul style="list-style-type: none"> • PA—Surgery-wrong body part • PB—Surgery-wrong patient • PC—Wrong surgery on patient • PI—Tumor initial treatment strategy • PS—PET tumor subsq tx strategy
M	<ul style="list-style-type: none"> • On page M.1, replaced sections on time limits, PCPM clients, third-party liability, etc., with a section titled: “What Are the General Billing Requirements?” • Combined Section N with Section M.
N	<p>Combined Section N with Section M.</p>

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>.

Later in 2009, DSHS will replace its current Medicaid Management Information System with a new payment processing system named ProviderOne. When fully operational, ProviderOne will pay about 100,000 providers who serve the one million people qualifying for DSHS services each year. Please visit <http://hrsa.dshs.wa.gov/ProviderOne> for more information.

How Can I Get DSHS/HRSA Provider Documents?

To obtain 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). These documents may be downloaded and printed.