

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

To: Optometrists
Opticians
Managed Care Organizations

Memo #: 09-47
Issued: June 30, 2009

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

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

**Supersedes # Memorandum:
08-52**

**Subject: Vision Care: Fee Schedule Updates and New Timelines for Resubmitting,
Modifying, or Adjusting Claims**

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

- Update the Vision Care Services Fee Schedule with the Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2009 Relative Value Units (RVUs); and
- Change the time frame in which providers may resubmit, modify, or adjust initial claims submitted to DSHS for payment.

Reminder: Bill using the appropriate code descriptions as published in the Current Procedural Terminology (CPT®) book and/or the Healthcare Common Procedure Coding System (HCPCS) book.

Maximum Allowable Fees

Effective for dates of service on and after July 1, 2009, DSHS will update the Vision Care Services Fee Schedule with MPFSDB Year 2009 RVUs. DSHS will adjust the maximum allowable fees to reflect the new rates.

Visit the DSHS/HRSA website at <http://hrsa.dshs.wa.gov/RBRVS/Index.html#v> to view the new fee schedule effective July 1, 2009.

Bill DSHS your usual and customary charge.

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

Resubmitting, Modifying, or Adjusting Initial Claims

Effective for claims with a date of service or admission on or 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 the provisions of 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 the 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.

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.