

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

**To:** Outpatient Hospitals  
Managed Care Organizations

**Memorandum No: 09-50  
Issued: June 30, 2009**

**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: Fee Schedule, and Policy Changes, 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 & Health Services (DSHS) will:

- Update the Outpatient Hospitals and Outpatient Prospective Payment System (OPPS) Fee Schedule with the Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2009 Relative Value Units (RVUs);
- Make payment policy changes by paying all hospitals providing outpatient services, except Critical Access Hospitals, according to the Outpatient Prospective Payment System (OPPS);
- Update the value of the Budget Target Adjuster;
- Update coverage requirements;
- Identify changes to outpatient service payment;
- Update prior authorization requirements;
- Update Observation Payment Policy; and
- Change the time frame in which providers may resubmit, modify, or adjust initial claims submitted to DSHS for payment.

## **Fee Schedule Updates**

**Effective for dates of service on and after July 1, 2009**, DSHS will update the Outpatient Hospitals and Outpatient Prospective Payment System (OPPS) Fee Schedule with MPFSDB Year 2009 RVUs.

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

DSHS will adjust the maximum allowable fees to reflect the new rates.

**Effective for dates of service on and after July 1, 2009**, DSHS has incorporated the CPT and HCPCS code updates into the Outpatient Hospital and OPSS Fee Schedules.

Bill DSHS your usual and customary charge.

## Payment Policy Changes

### Outpatient Payments Made Under Outpatient Prospective Payment System (OPSS)

**Effective for dates of service on and after July 1, 2009**, DSHS will pay all hospitals providing outpatient services, except Critical Access Hospitals, according to the Outpatient Prospective Payment System (OPSS). Hospital specific OPSS Rates are available at:

<http://hrsa.dshs.wa.gov/HospitalPymt/Outpatient/RateFiles/2009OPSSRatesV8.xls>

### OPSS Budget Target Adjuster Changed

**Effective for dates of service on and after July 1, 2009**, DSHS will set the Outpatient Prospective Payment System (OPSS) Budget Target Adjuster at 0.765 in response to a legislative directive to reduce outpatient payment rates in a manner consistent with federal law.

**Note:** Due to its licensing agreement with the American Medical Association (AMA) regarding the use of CPT codes and descriptions, DSHS publishes only the official brief descriptions for all codes. Please refer to your current CPT book for full descriptions.

## Updated Coverage

### Added Procedure Codes

Effective for dates of service on and after July 1, 2009, DSHS will update the Outpatient Hospitals and Outpatient Prospective Payment System (OPPS) fee schedule to incorporate CPT and HCPCS additions including the following procedures when performed in an outpatient setting. Procedures with a value in the Maximum Allowable Fee column may be paid by DSHS using the Maximum Fee method.

Prior Authorization	Procedure Code	Short Description	Coverage Indicator	Maximum Units	Maximum Allowable Fee
L	11920	Correct Skin color defects	1	1	
L	90378	Rsv ig, im, 50mg	1	4	Yes
	Q4111	Gammagraft skin sub ,SI = K	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

### Non-Covered Procedure Codes on Hospital Claims

Effective for dates of service on and after July 1, 2009, DSHS will not cover the following procedure codes when billed on a hospital claim:

Procedure Code
0085T
11200
11201

## Outpatient Service Payment Changes

Effective for dates of service on and after July 1, 2009, DSHS will change the payment parameters applied to the following codes:

Auth	Procedure Code	Coverage Indicator	Maximum Fee
	G0378	1	Yes
	G0379	1	Yes

## Prior Authorization Changes

Effective for dates of service on and after July 1, 2009, DSHS will no longer require Prior Authorization (PA) for the following codes:

Auth	Procedure Code	Coverage Indicator	Maximum Fee
	19297	1	No
	19298	1	No
	20982	1	No
	21045	1	No
	33880	1	No
	33881	1	No
	33883	1	No
	33884	1	No
	33889	1	No
	55706	1	No
	69310	1	No
	69320	1	No
	76510	1	Yes
	88380	1	BR
	A9507	1	Yes
	A9542	1	BR
	A9543	1	BR
	A9544	1	BR
	A9545	1	BR
	A9698	1	BR

## Observation Services

Effective for dates of service on and after July 1, 2009, DSHS will pay observation services procedure codes (G0378 and G0379) with the *maximum allowable fee payment method*. There are no changes in other policies related to observation services.

## 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 trauma claims are not changing. For your reference, the following are the billing timelines for these claims.

### *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.