

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

To: Inpatient Hospital Providers

Memo #: 09-52

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<http://hrsa.dshs.wa.gov/contact/prucontact.asp>

From: Douglas Porter, Assistant Secretary
Health and Recovery Services
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Subject: Inpatient Hospital Services: Policy Updates

Effective for dates of service on and after July 1, 2009, the Department of Social and Health Services (DSHS) will implement inpatient hospital and other policy changes consistent with legislative mandates and budgetary assumptions. These changes include:

- Reducing hospital payment rates by four percent. These reductions affect Medicaid DRG, high outlier threshold and outlier adjustment factors, per diem (except psychiatric), bariatric case rate, and organ transplant payments;
- Reducing payments for cesarean sections without complications and comorbidities (i.e., paying for these services at the same all patient diagnosis related groups (AP-DRG) relative weight as vaginal births with complications);
- Reducing Diagnostic Related Group (DRG) claim payments when clients are transferred from an acute care hospital to a non-acute care setting, when the inpatient hospital stay is less than the average length of stay for the applicable AP-DRG; and
- Change the time frame in which providers may resubmit, modify, or adjust initial claims submitted to DSHS for payment.

Four percent reduction in payment rates as mandated by the legislature

DSHS will apply an inpatient adjustment factor of 96 percent to Medicaid Diagnostic Related Group (DRG) conversion factors, per diem rates (except psychiatric), bariatric case rates, outlier thresholds, outlier adjustment factors, and organ transplant payments. State program rates are not affected. Critical Access Hospital (CAH) rates are not affected.

Reduced payment for cesarean sections

For dates of admission on and after July 1, 2009, DSHS will pay DRG claims for cesarean sections without complications and comorbidities at the same AP-DRG relative weight as a vaginal birth with complicating diagnoses.

Proration of DRG claim payment when a client is transferred to a non-acute care setting and the inpatient stay is less than the average length of stay

DSHS currently prorates diagnosis related group (DRG) payments in transfer cases between acute care facilities. On and after July 1, 2009, the number of transfer cases subject to prorated DRG payments will increase. DSHS will prorate payment for a DRG claim for a client transferred from an acute care hospital to a non-acute care setting, when the transferred case's length of stay (LOS) plus one day is less than the average length of stay (ALOS) for the all patient diagnosis related group (AP-DRG) code on the claim.

In addition to transfers between acute care hospitals, proration of the DRG claim payment applies when a client is transferred from an acute care hospital to one of the following places of service:

- Skilled nursing facility;
- Intermediate care facility;
- Long term acute care facility;
- Home care under home health program;
- Hospice in a facility;
- Hospital based Medicare approved swing bed; or
- Nursing facility certified under Medicare but not Medicaid.

In these transfer cases, when the length of stay (LOS) is less than the average length of stay (ALOS), payment to the hospital is the lesser of:

- Per Diem based on diagnosis related groups (DRG) payment (DRG calculation amount divided by the DRG average length of stay) multiplied by the patient's length of stay plus 1; or
- DRG payment calculated for the applicable all patient-diagnosis related group (AP-DRG).

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.