Washington Apple Health (Medicaid)

Outpatient Hospital Services Billing Guide

April 1, 2020

About this guide∗

This publication takes effect April 1, 2020, and supersedes earlier guides to this program.

The Health Care Authority (agency) is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

Services, equipment, or both, related to any of the programs listed below must be billed using their specific billing guides:

- Inpatient Hospital Services
- Physician-Related Services/Health Care Professional Services

What has changed?

Subject	Change	Reason for Change
Entire guide	General housekeeping, including typographical and hyperlink corrections	To improve usability
Surgery	Removed specific coverage information for services listed in the agency's Physician-Related Services/Health Care Professional Services Billing Guide; reorganized section	To remove redundancy between billing guides and improve clarity
	Added "hip surgery for femoroacetabular impingement syndrome" to the list of services under "Surgical and medical procedures and evaluations"	To correct an oversight

∗ This publication is a billing instruction.

|	Removed "see the covered codes in" under "Skin substitutes"	To improve clarity
Radiology	Removed specific coverage information for services listed in the agency's Physician-Related Services/Health Care Professional Services Billing Guide; reorganized section	To remove redundancy between billing guides and improve clarity
Pathology and Laboratory	Removed specific coverage information for services listed in the agency's Physician-Related Services/Health Care Professional Services Billing Guide	To remove redundancy between billing guides and improve clarity
Office and Other Outpatient Services	Removed specific coverage information for services listed in the agency's Physician-Related Services/Health Care Professional Services Billing Guide and Sleep Centers Billing Guide	To remove redundancy between billing guides and improve clarity
COVID1-19	Added hyperlink to the agency's COVID-19 information webpage	To provide a hyperlink to updated information regarding COVID-19
Centers of Excellence (COEs)	Reorganized section	To improve clarity and usability
Expedited prior authorization	Removed the EPA section	To remove information no longer relevant to this billing guide

How can I get agency provider documents?

To access provider alerts, go to the agency's provider alerts webpage.

To access provider documents, go to the agency's provider billing guides and fee schedules webpage.

Where can I download agency forms?

To download an agency provider form, go to the agency's <u>Forms & publications</u> webpage. Type the agency's form number into the **Search box** as shown below (Example: 13-835).

<div style="border:1px solid; background:#d9d9d9;">
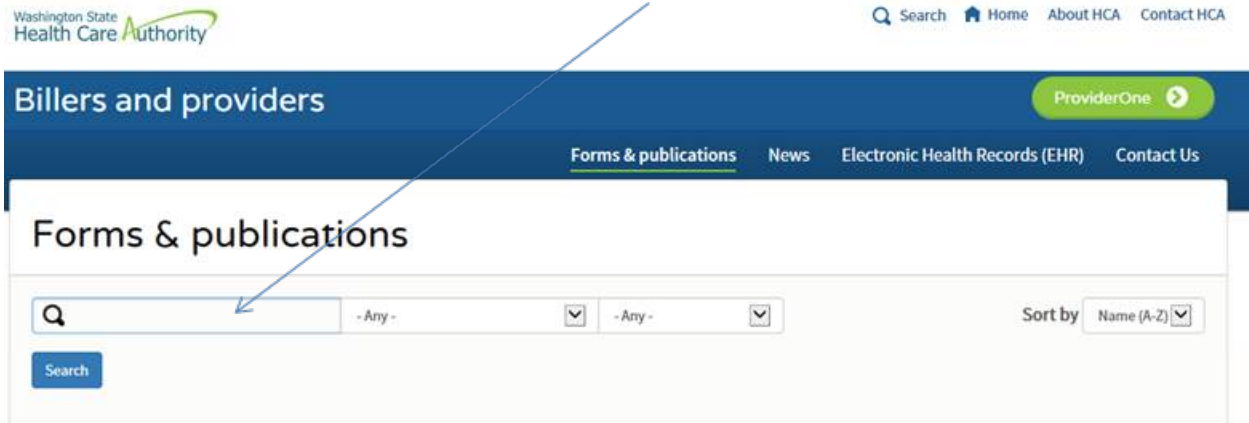
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Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

Authorization requirement – The agency's requirement that a provider present proof of medical necessity evidenced either by obtaining a prior authorization number or by using the expedited prior authorization process to create an authorization number.

Budget target adjustor – A multiplier applied to the Outpatient Prospective Payment System (OPPS) payment to ensure aggregate payments do not exceed the established budget target.
(WAC 182-550-1050)

Bundled services – Interventions integral to or related to the major procedure.
(WAC 182-550-1050)

Discount factor – The percentage applied to additional significant procedures when a claim has multiple significant procedures or when the same procedure is performed multiple times on the same day. Not all significant procedures are subject to a discount factor. (WAC 182-550-1050)

Emergency services – Health care services required by and provided to a client after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Alert: Inpatient maternity services are treated as emergency services when the agency pays a hospital for those services.

Enhanced ambulatory patient groupings (EAPG) – The payment system used by the agency to calculate reimbursement to hospitals for the facility component of outpatient services on and after October 1, 2014. This system uses 3M's EAPGs as the primary basis for payment.
(WAC 182-550-1050)

Hospital's outpatient RCC – The agency calculates a hospital's outpatient ratio of costs-to-charges (RCC) by multiplying the hospital's inpatient RCC and the OPPS outpatient adjustment factor (OAF).

International classification of diseases (ICD) – The systematic listing of diseases, injuries, conditions, and procedures as numerical or alpha numerical designations (coding). (WAC 182-550-1050)

Modifier – A two-digit alphabetic and/or numeric identifier that is added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting hospital can describe or indicate that a performed service or procedure has been altered by some specific circumstance, but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules.
(WAC 182-550-1050)

Observation services – A well-defined set of clinically appropriate services furnished while determining whether a client will require formal inpatient admission or be discharged from the hospital. Services include ongoing short-term treatment, monitoring, assessment, and reassessment. Rarely do reasonable and necessary observation services exceed forty-eight hours. The agency or its designee may determine through the retrospective utilization review process that an inpatient hospital service should have been billed as an observation service. (WAC 182-550-1050)

OPPS – See **Outpatient Prospective Payment System**. (WAC 182-550-1050)

Outpatient care – See **Outpatient hospital services**. (WAC 182-550-1050)

Outpatient hospital – A hospital authorized by the Department of Health (DOH) to provide outpatient services. (WAC 182-550-1050)

Outpatient Prospective Payment System (OPPS) – The payment system used by the agency to calculate reimbursement to hospitals for the facility component of outpatient services. This system uses enhanced ambulatory patient groups (EAPGs) as the primary basis of payment. (WAC 182-550-1050)

Outpatient Prospective Payment System (OPPS) conversion factor – See **Outpatient Prospective payment system (OPPS) rate**. (WAC 182-550-1050)

Outpatient Prospective Payment System (OPPS) rate - A hospital-specific multiplier calculated by the agency that is one of the components of the EAPG payment calculation.

Outpatient RCC – See **Hospital's outpatient RCC**.

Pass-throughs – Certain drugs, devices, and biologicals, as identified by centers for Medicare and Medicaid Studies (CMS), for which providers are entitled to additional separate payment until the drugs, devices, or biologicals are paid per the OPPS fee schedule.

Principal diagnosis – The condition chiefly responsible for the admission of the patient to the hospital. (WAC 182-550-1050)

Policy adjustor – A payment factor that increases the reimbursement of EAPGs for clients age 17 and younger.

Revenue code – A nationally assigned coding system for billing inpatient and outpatient hospital services, home health services, and hospice services. (WAC 182-550-1050)

Significant procedure – A procedure, therapy, or service provided to a client that constitutes one of the primary reasons for the visit to the health care professional, and represents a substantial portion of the resources associated with the visit.

About the Program

What is the purpose of the outpatient hospital services program?

The purpose of the outpatient hospital services program is to provide outpatient services, emergency outpatient surgical care, and other emergency care administered to eligible clients and performed on an outpatient basis in a hospital.

How does medical necessity apply to outpatient hospital services?
(WAC 182-500-0070)

The agency pays only for covered services and items that are medically necessary.

What about outpatient hospital services provided within one calendar day of paid inpatient admission?
(WAC 182-550-6000 (3)(c))

Providers must bill the following outpatient hospital services on the inpatient hospital claim when provided within one calendar day of a client's inpatient hospital stay.

- Preadmission
- Emergency room
- Observation services related to an inpatient hospital stay

Client Eligibility

Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the agency's Apple Health managed care page for further details.

> **It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.**

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health.** For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's ProviderOne Billing and Resource Guide.

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's Program Benefit Packages and Scope of Services webpage.

> **Note:** Patients who are not Apple Health clients may submit an application for health care coverage in one of the following ways:
>
> 1.   By visiting the Washington Healthplanfinder's website at:
>   www.wahealthplanfinder.org
>
> 2.   By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
>
> 3.   By mailing the application to:
>   Washington Healthplanfinder
>   PO Box 946
>   Olympia, WA 98507
>
> In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

Are clients enrolled in an agency-contracted managed care organization (MCO) eligible?

Yes. Most Medicaid-eligible clients are enrolled in one of the agency's contracted MCOs. For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an agency-contracted MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for payment of:

- Covered services
- Services referred by a provider participating with the plan to an outside provider
- Dental surgical procedures

> **Note:**   A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

> **Note:** To prevent billing denials, check the client's eligibility **prior** to scheduling services and at the **time of the service**, and make sure proper authorization or referral is obtained from the agency-contracted MCO, if appropriate. Providers must receive authorization from the client's MCO primary care provider before providing services, **except for emergency services**. See the agency's [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility.

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in fee-for-service (FFS) while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for. However, some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's [Get Help Enrolling](#) page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Apple Health – Changes for January 1, 2020

Effective January 1, 2020, the Health Care Authority (agency) completed the move to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

IMC is implemented in the last three regions of the state:

- **Great Rivers** (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties)
- **Salish** (Clallam, Jefferson, and Kitsap counties)
- **Thurston-Mason** (Mason and Thurston counties)

These last three regions have plan changes, with only Amerigroup, Molina, and United Healthcare remaining. There are changes to the plans available in these last three regions. The only plans that will be in these regions are Amerigroup, Molina, and United. If clients are currently enrolled in one of these three health plans, their health plan will not change.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:
  Go to Washington HealthPlanFinder website.

- **Available to all Apple Health clients:**

  ✓ Visit the ProviderOne Client Portal website.

  ✓ Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

  ✓ Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

For online information, direct clients to the agency's Apple Health Managed Care webpage.

Clients who are not enrolled in an agency-contracted managed care plan for physical health services

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each IMC plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Clients who are not enrolled in an agency-contracted managed care plan are automatically enrolled in a BHSO, with the exception of American Indian/Alaska Native clients. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care (IMC)

Clients qualified for managed care enrollment and living in IMC regions will receive all physical health services, mental health services, and substance use disorder treatment through their agency-contracted MCO.

> **American Indian/Alaska Native (AI/AN)** clients have two options for Apple Health coverage:
>
> - Apple Health Managed Care
> - Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])
>
> If a client does not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's American Indian/Alaska Native webpage.
>
> For more information about the services available under the FFS program, see the agency's Mental Health Services Billing Guide and the Substance Use Disorder Billing Guide.

For full details on integrated managed care, see the agency's Apple Health managed care webpage and scroll down to "Changes to Apple Health managed care."

Integrated managed care regions

Clients residing in integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency's Apple Health managed care webpage.

Region	Counties	Effective Date
Great Rivers	Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum	January 1, 2020
Salish	Clallam, Jefferson, Kitsap	January 1, 2020
Thurston-Mason	Thurston, Mason	January 1, 2020
North Sound	Island, San Juan, Skagit, Snohomish, and Whatcom	July 1, 2019
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman	January 1, 2019
King	King	January 1, 2019
Pierce	Pierce	January 1, 2019
Spokane	Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties	January 1, 2019
North Central	Grant, Chelan, Douglas, and Okanogan	January 1, 2018 January 1, 2019 (Okanogan)
Southwest	Clark, Skamania, and Klickitat	April 2016 January 1, 2019 (Klickitat)

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

> These clients are identified in ProviderOne as
> **"Coordinated Care Healthy Options Foster Care."**

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact the agency's Foster Care Medical Team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see the agency's [Mental Health Services Billing Guide](#), under *How do providers identify the correct payer*?

Admissions

What are the criteria for an outpatient short stay?

The agency applies level-of-care and intensity-of-service criteria to determine if a hospital visit should be considered an inpatient stay or an outpatient stay. The agency determines if the level-of-care and intensity-of-service criteria are met.

A visit that does not meet level-of-care and intensity-of-service criteria as an inpatient claim will not be treated as or paid as an inpatient claim, even if the patient has been admitted as an inpatient. The agency may treat such a claim as an outpatient short stay, but only if level-of-care and intensity-of-service criteria as an outpatient claim are met.

A visit that does not meet level-of-care and intensity-of-service criteria as an outpatient claim will not be treated as or paid as an outpatient claim.

What is admission status?

Admission status is determined by the admitting physician or practitioner. Continuous monitoring, such as telemetry, can be provided in an observation or inpatient status. Consider overall severity of illness and intensity of service in determining admission status rather than any single or specific intervention. Specialty inpatient areas (including ICU or CCU) can be used to provide observation services. Level of care, not physical location of the bed, dictates admission status.

Some examples of typical types of admission status are:

- Inpatient
- Outpatient observation
- Medical observation
- Outpatient surgery or short stay surgery
- Outpatient (e.g., emergency room)

When to change admission status

A change in admission status is required when a client's symptoms/condition and treatment does not meet medical necessity criteria for the level of care the client is initially admitted under. The documentation in the client's medical record must support the admission status and the services billed. The agency does not pay for any of the following:

- Services not meeting the medical necessity of the admission status ordered

- Services not documented in the hospital medical record

- Services greater than what is ordered by the physician or practitioner responsible for the client's hospital care

Changing status from inpatient to outpatient observation

The attending physician or practitioner may make an admission status change from **inpatient** to outpatient observation when:

- The attending physician/practitioner or the hospital's utilization review staff, or both, determine that an inpatient client's symptoms/condition and treatment do not meet medical necessity criteria for an acute inpatient level of care and do meet medical necessity criteria for an observation level of care.

- The admission status change is made before, or on the next business day following, discharge.

- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the document must:

    ✓ Be dated with the date of the change.

    ✓ Contain the reason the change was not made before discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Changing status from outpatient observation to inpatient

The attending physician or practitioner may make an admission status change from **outpatient observation** to inpatient when:

- The attending physician/practitioner or the hospital's utilization review staff, or both, determine that an outpatient observation client's symptoms/condition and treatment meet medical necessity criteria for an acute inpatient level of care.

- The admission status change is made before, or on the next business day following, discharge.

- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:

    ✓ Be dated with the date of the change.

    ✓ Contain the reason the change was not made before discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Changing status from inpatient or outpatient observation to outpatient

The attending physician or practitioner may make an admission status change from **inpatient or outpatient observation** to outpatient when:

- The attending physician/practitioner or the hospital's utilization review staff, or both, determine that an outpatient observation or inpatient client's symptoms/condition and treatment **do not** meet medical necessity criteria for observation or acute inpatient level of care.

- The admission status change is made before, or on the next business day following, discharge.

- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:

    ✓ Be dated with the date of the change.

    ✓ Contain the reason the change was not made before discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Changing status from outpatient surgery/procedure to outpatient observation or inpatient

The attending physician or practitioner may make an admission status change from **outpatient surgery/procedure** to outpatient observation or inpatient when:

- The attending physician/practitioner or the hospital's utilization review staff, or both, determine that the client's symptoms/condition or treatment, or both, require an extended recovery time beyond the normal recovery time for the surgery/procedure and medical necessity for outpatient observation or inpatient level of care is met.
- The admission status change is made before, or on the next business day following, discharge.

- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:

  - ✓ Be dated with the date of the change.

  - ✓ Contain the reason the change was not made before discharge (e.g., due to the discharge occurring on the weekend or a holiday).

> **Note:** During post-payment retrospective utilization review, the agency may determine the admission status ordered is not supported by documentation in the medical record. The agency may consider payment made in this circumstance an overpayment and payment may be recouped or adjusted.

Surgery

Surgical and medical procedures and evaluations

For more information about the agency's surgical and medical procedures and evaluations, and for information regarding the following specific procedures and evaluations, see the Physician-Related Services/Health Care Professional Services Billing Guide:

- Carotid artery stenting
- Cervical spinal fusion arthrodesis
- Drug eluting or bare metal cardiac stents
- Facet neurotomy, cervical and lumbar
- Hip resurfacing
- Hip surgery for femoroacetabular impingement syndrome
- Implantable ventricular assist devices
- Percutaneous kyphoplasty, vertebroplasty and sacroplasty
- Sacroiliac Joint Fusion
- Sterilization and hysterectomy (also see the agency's Sterilization Supplemental Billing Guide)
- Transgender Surgery

Cochlear implants and bone conduction hearing devices

See the Physician-Related Services/Health Care Professional Services Billing Guide and the Hearing Hardware Billing Guide.

Replacement parts or repairs for cochlear implants and bone conduction hearing devices

See the agency's Hearing Hardware Billing Guide.

Corneal tissue

The agency pays for corneal tissue processing (HCPCS procedure code V2785) by acquisition cost (AC). To receive payment, providers must:

- Bill the amount paid to the eye bank for the processed eye tissue.
- Attach invoice to claim.

The agency will update the [Outpatient Prospective Payment System (OPPS) and Outpatient Hospitals Fee Schedule](#) to reflect this change.

Robotic assisted surgery (RAS)

Robotic assisted surgery (RAS) may be considered medically necessary. However, the agency does not pay separately for HCPCS code S2900 and reimburses only for the underlying procedure.

When billing for the underlying procedure, the agency requests billing providers to include RAS on the claim in order to track utilization and outcome. The agency will monitor RAS through retrospective auditing of billing and the review of operative reports.

Skin substitutes

The agency pays for skin substitutes. See the agency's [Outpatient Hospital Fee Schedule](#).

Vagus nerve stimulator

See the agency's Physician-Related Services/Health Care Professional Services Billing Guide.

The agency's payment for vagus nerve stimulator devices is by acquisition cost (AC). Vagus nerve stimulators require prior authorization (PA) (see Prior Authorization).

To receive payment, providers must:

- Bill for a new device or complete replacement using all three of the following CPT codes:

Procedure code	Short description
CPT: 64568	*Inc for vagus n elect impl*
CPT: C1767	*Generator, neuro non-recharg*
CPT: C1778	*Lead, Neurostimulator*

- Bill for battery replacement using both of the following CPT codes:

Procedure code	Short description
CPT: 61885	*Insrt/redo neurostim 1 array*
CPT: C1767	*Generator, neuro non-recharg*

- Bill for electrode replacement using both of the following CPT codes:

Procedure code	Short description
CPT: 64569	*Revise/repl vagus n eltrd*
CPT: C1778	*Lead, Neurostimulator*

Note: To be considered for payment, the invoice for the devices must be attached to the claim.

CPT® codes and descriptions only are copyright 2019 American Medical Association.

Radiology

Radiology guidelines and procedures

For specific information regarding the following radiology procedures, see the agency's
[Physician-Related Services/Health Care Professional Services Billing Guide](#):

- Functional neuroimaging for primary degenerative dementia or mild cognitive impairment

- Mammograms

- Osteopenia/osteoporosis screening and monitoring tests

- Proton beam radiation therapy

- Stereotactic body radiation therapy

- Stereotactic radiation surgery

Pathology and Laboratory

Breast and/or ovarian genetic testing

See the agency's [Physician-Related Services/Health Care Professional Services Billing Guide](#).

Gene expression profile testing

See the agency's [Physician-Related Services/Health Care Professional Services Billing Guide.](#)

Pathology and laboratory guidelines

The agency bundles laboratory services as ancillary services under EAPG. See the agency's [Physician-Related Services/Health Care Professional Services Billing Guide](#) for additional information.

Pharmacogenetic testing guidelines

See the agency's [Physician-Related Services/Health Care Professional Services Billing Guide](#) for additional information.

Shingles vaccine when administered in outpatient hospitals

The agency pays for the administration of the Herpes Zoster (shingles) vaccine (CPT® codes 90471 and 90736) provided in outpatient hospitals and administered according to the guidelines in the agency's [Physician-Related Services/Health Care Professional Services Billing Guide](#).

Testosterone testing

See the agency's [Physician-Related Services/Health Care Professional Services Billing Guide](#).

Mental Health

When does an MCO pay for an outpatient hospital visit for a client with a psychiatric principal diagnosis?

A provider may bill the client's assigned managed care organization (MCO) for an emergency room (ER) visit provided to an MCO client when all of the following criteria are met:

- The client is seen in the ER.

- The ER visit results in a transfer to a different hospital for an integrated managed care (IMC)-authorized admission.

- The client's principle diagnosis is in the psychiatric range.

All other ER visits should be billed to the client's MCO.

> **Note**: The agency now covers voluntary behavioral health admissions for nonMedicaid-eligible persons through the Behavioral Health Administrative Services Organization (BH-ASO). For additional information on voluntary treatment, see the agency's Mental Health Billing Guide.

Office and Other Outpatient Services

When billing for the following services, follow the individual program guidelines as described in the program-specific billing guides.

COVID-19

For updated information regarding COVID-19, visit the agency's COVID-19 information webpage.

Diabetes Education

In order for a client to participate in the diabetes education program, a licensed primary health care provider must refer the client to a program for diabetes education. Hospitals must be approved by the Washington State Department of Health (DOH) as a diabetes education provider.

For diabetes education services provided in a hospital outpatient setting, the provider must:

- Bill using revenue code 0942.
- Provide a minimum of 30 minutes of education/management per session.

> **Note:** Services provided in an outpatient hospital department or hospital-based clinic must be billed on an institutional claim. Services provided in a non-hospital based clinic or a physician's office must be billed on a professional claim.

> **Note:** The agency requires authorized hospital outpatient diabetes education programs to bill with revenue code 0942. Claims submitted using HCPCS codes G0108 and G0109 will be denied.

See the agency's Diabetes Education Billing Guide for more information.

Drugs professionally administered

See the Physician-Related Services/Health Care Professional Services Fee Schedule.

Hyaluronic acid/viscosupplementation

See the [Physician-Related Services/Health Care Professional Services Billing Guide](#).

Rabies immune globulin (RIG)

See the agency's [Physician-Related Services/Health Care Professional Services Billing Guide](#).

National drug code format

All providers are required to use the 11-digit National Drug Code (NDC) when billing the agency for professionally administered drugs.

- **National Drug Code (NDC)** – The 11-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging. The 11-digit NDC is composed of a 5-4-2 grouping. The first 5 digits comprise the labeler code assigned to the manufacturer by the Food and Drug Administration (FDA). The second grouping of 4 digits is assigned by the manufacturer to describe the ingredients, dose form, and strength. The last grouping of 2 digits describes the package size. (WAC 182-530-1050)

- The NDC **must** contain 11-digits in order to be recognized as a valid NDC. It is not uncommon for the label attached to a drug's vial to be missing leading zeros.

Herpes Zoster (Shingles) vaccine

See the agency's [Physician-Related Services/Health Care Professional Services Billing Guide](#).

Spinraza™

The agency requires prior authorization for Spinraza™. Providers must bill for Spinraza™ on a UB-04 claim form, listing the units used on each line of the claim. Bill using the actual acquisition cost and include the invoice with the claim.

Drug screening

Drug screening for medication assisted treatment (MAT) and substance use disorders (SUD)

See the agency's Physician-Related Services/Health Care Professional Services Billing Guide.

Additional information when prescribing (Suboxone®)

The provider must have FDA approval to prescribe buprenorphine/naloxone (Suboxone®) for opioid use disorders (OUD).

The provider must have a CLIA waiver if confirmatory testing is performed at the site of practice.

Enter the following information on the claim forms:

- "Certified bupren provider" in the *Claim Note* section of the electronic claim
- ICD diagnosis codes F11.20 – F11.288 in the *Claim Note* section of the electronic claim

More information regarding CLIA certification can be found on the U.S. Food and Drug Administration website.

Fecal microbiota transplantation

See the agency's Physician-Related Services/Health Care Professional Services Billing Guide.

Foot care services

See the agency's Physician-Related Services/Health Care Professional Services Billing Guide.

Imaging for rhinosinusitis

See the agency's Physician-Related Services/Health Care Professional Services Billing Guide.

Radiopharmaceutical diagnostic imaging agents

See the agency's Physician-Related Services/Health Care Professional Services Billing Guide.

Kidney centers

Certified kidney centers:

- Are exempt from the Outpatient Prospective Payment System (OPPS) reimbursement methodology.

- Must bill using their NPI and kidney center taxonomy code.

- For information about kidney centers and billing, see the agency's Kidney Center Services Billing Guide.

Medical genetics and genetic counseling services

See the agency's Physician-Related Services/Health Care Professional Services Billing Guide.

Medical nutrition therapy

The agency pays outpatient hospitals for medical nutrition therapy according to the agency's Medical Nutrition Therapy Billing Guide.

Neurodevelopmental providers
(WAC 182-545-900)

The agency pays certified neurodevelopmental centers according to the agency's Neurodevelopmental Centers Billing Guide. A hospital must bill for neurodevelopmental services provided to outpatient clients using appropriate billing codes listed in agency billing guides. The agency does not pay outpatient hospitals a facility fee for these services.

Do not bill more than one bill for a single client for the same services (same revenue code, procedure code, and medical provider).

Occupational therapy, physical therapy, or speech/audiology services

The agency pays for outpatient rehabilitation (which includes occupational therapy, physical therapy, and speech/audiology) provided to eligible clients as an outpatient hospital service according to WAC 182-545-200 and 182-550-6000.

When services for adults in the outpatient hospital setting are provided by physical therapists, occupational therapists, or speech therapists, benefit limits are per client, per calendar year regardless of setting (example: home health, free-standing clinic or outpatient hospital).

See the agency's Outpatient Rehabilitation Billing Guide for information about these therapies, and limitations for 19-20 year olds with Medical Care Services (MCS) or Alcohol and Drug Addiction Treatment Act (ADATSA) coverage.

A hospital must bill outpatient hospital occupational therapy, physical therapy, or speech/audiology using appropriate billing codes listed in the agency's billing guides. The agency does not pay outpatient hospitals a facility fee for such services.

> **Note: The maximum number of visits allowed is based on appropriate medical justification.** The agency does not allow duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure(s). If the client requires more than one therapist in the residence on the same day, the agency requires the therapist to document the therapeutic benefit of having more than one therapist for specialized therapy on the same day.

Sleep medicine testing (sleep apnea)
(**WAC 182-531-1500**)

See the agency's Sleep Centers Billing Guide.

Telemedicine

See the agency's Physician-Related Services/Health Care Professional Services Billing Guide and Fee Schedule.

Treatment of chronic migraine and chronic tension-type headache

See the agency's [Physician-Related Services/Health Care Professional Services Billing Guide](#).

Varicose vein treatment

See the agency's [Physician-Related Services/Health Care Professional Services Billing Guide](#).

Vision care services

See the agency's [Physician-Related Services/Health Care Professional Services Billing Guide](#).

Centers of Excellence (COEs)

Where can I find agency-approved COEs?

See the agency's approved centers of excellences (COEs) for sleep centers and organ transplants:

- [COEs for sleep study centers](#)
- [COEs for organ transplants](#)

What services must be performed in agency-approved COEs?

The following services must be performed in agency-approved centers of excellence (COEs). See the agency's [Physician-Related Services/Health Care Professional Services Billing Guide](#) for more information:

- Bariatric surgeries
- Hemophilia treatment
- Organ transplants
- Sleep studies

Medical Necessity Review by Comagine Health

What is a medical necessity review by Comagine Health?

The agency contracts with Comagine Health to provide web-based access for reviewing for medical necessity and surgical procedures for the following:

- Outpatient advanced imaging services
- Select surgical procedures
- Spinal injections, including diagnostic selective nerve root blocks
- Carpal tunnel release
- Major joints
- Spinal, including facet injections
- Thoracic outlet release
- Upper and lower extremities
- Facet neurotomy, cervical and lumbar

Comagine Health conducts the review of the request to establish medical necessity, but **does not** issue authorizations. Comagine Health forwards its recommendations to the agency for final authorization determination. The procedure codes that require review by Comagine Health can be found in the agency's [Physician-Related/Professional Health Care Services fee schedule](#).

For more information about the requirements for submitting medical necessity reviews for authorization, see *Medical Necessity Review by Comagine Health* in the agency's [Physician-Related Services/Health Care Professional Services Billing Guide](#)

> **Note:** This process through Comagine Health is for Washington Apple Health (Medicaid) clients enrolled in fee-for-service **only**. Authorization requests for managed care clients will **not** be authorized.

> **Note:** To prevent billing denials, check the client's eligibility **before** scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained. Providers must receive authorization from the client's primary care provider before providing services, **except for emergency services**. See the agency's [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility.

What imaging procedures require medical necessity review by Comagine Health?

The agency and Comagine Health have contracted to provide web-based submittal for utilization review services to establish the medical necessity of selected procedures. Comagine Health conducts the review of the request to establish medical necessity, but **does not** issue authorizations. Comagine Health forwards its recommendations to the agency for final authorization determination. For additional information see *Medical Necessity Review by Comagine Health* in the agency's Physician-Related Services/Health Care Professional Services Billing Guide.

Authorization

([WAC 182-531-0200](#))

Authorization is the agency's approval for covered services, equipment, or supplies before the services are provided to clients, as a precondition for provider reimbursement. **Prior authorization (PA), expedited prior authorization (EPA), and limitation extensions (LE) are forms of authorization.**

Prior authorization (PA)

What is PA?

PA is the process the agency uses to authorize a service **before it is provided** to a client. The PA process applies to covered services and is subject to client eligibility and program limitations. Bariatric surgery is an example of a covered service that requires PA. PA does not guarantee payment.

For psychiatric inpatient authorizations, see the agency's current [Inpatient Hospital Billing Guide](#).

> **Note:** In addition to receiving PA, the client must be on an eligible program. For example, a client on the Family Planning Only program would not be eligible for bariatric surgery.

For examples on how to complete a PA request, see the agency's [Billers, providers, and partners](#) webpage.

> **Note:** The agency reviews requests for payment for noncovered health care services according to [WAC 182-501-0160](#) as an exception to rule (ETR).

How does the agency determine PA?

For information on how the agency determines PA, see the [Physician-Related Services/Health Care Professional Services Billing Guide](#).

Services requiring PA
(**WAC 182-531-0200 (4)-(6)**)

See the agency's Physician-Related Services/Health Care Professional Services Billing Guide.

Documentation requirements for PA or LE

Authorization Documentation	
How do I obtain PA or an LE?	**Submit by direct data entry into ProviderOne** See the agency's prior authorization webpage for details. **-OR-** **Submit request in writing or by fax** along with the following documentation: • A completed, TYPED *General Information for Authorization* form. This request form MUST be the initial page of the request. • A completed *Fax/Written Request Basic Information* form, if there is not a form specific to the service being requested, and all the documentation is listed on this form with any other medical justification. To obtain a copy, see Where can I download agency forms? **Fax the request to:** (866) 668-1214.

Forms Available to Submit Authorization Requests
• *Botulinum Toxin Provider Questionnaire* • *Application for Chest Wall Oscillator* • *Bariatric Surgery Request* form • *Fax/Written Request Basic Information* form • *Oral Enteral Nutrition Worksheet* • *Out of State Medical Services Request* form

Forms Available to Submit Authorization Requests for Medication
• Acetaminophen Injection, J0131, use *Basic Information* form, 13-756 • Alglucosidase alfa (lumizyme) 10 mg, J0221, use *Basic Information* form, 13-756 • Belimumab injection, J0490, use *Basic Information* form, 13-756 • *Botulinum Toxin Provider Questionnaire*, use form 13-003 • Cimzia (Certolizumab pegol Inj.), J0717, use *CIMZIA J0717 Request* form, 13-885 • Ceftaroline fosamil injection, J0712, use *Fax/Written Request Basic Information* form, 13-756 • Exondys 51 (eteplirsen), use form 13-0012 • Infliximab (Remicade) Injection, J1745, use form 13-897 • Ipilimumab injection, J9228, use *Fax/Written Request Basic Information* form, 13-756 • IV Iron, use form 13-0013

- Mannitol for inhaler, J7665, use *Fax/Written Request Basic Information* form, 13-756
- Oncotype DX, 81519, use form 13-908
- Opdivo (nivolumab), J9299, use form 13-0010
- Pegloticase injection, J2507, use *Fax/Written Request Basic Information* form, 13-756
- Perjeta (pertuzumab), J9306, use form 13-916
- Photofrin (Porfimer Sodium Inj.) 75mg, J9600, use *Fax/Written Request Basic Information* form, 13-756
- Prolia (Denosumab Inj.), J0897, use *Fax/Written Request Basic Information* form, 13-756
- Stelara (Ustekinumab Inj.) J3357, use form 13-898
- Tysabri (Natalizumab Inj.) J2323, use *TYSABRI J2323 Request* form, 13-832
- Xolair (Omalizumab), J2357, use form 13-852a

How do I request PA?

When a procedure's EPA criteria has not been met or the covered procedure requires PA, providers must request prior authorization from the agency. Procedures that require PA are listed in the fee schedule. The agency does not retrospectively authorize any health care services that require PA after they have been provided except when a client has delayed certification of eligibility.

Online submission by direct data entry into ProviderOne

Providers may submit a prior authorization request by direct data entry into ProviderOne or by submitting the request in writing (see the agency's prior authorization webpage for details).

Written or fax request

Providers who choose to submit a written or fax PA request must provide all of the following with the request:

- The *General Information for Authorization* form. This form must be page one of the mailed/faxed request and must be typed. See Where can I download agency forms?

- The program form. This form must be attached to the request.

- Charts and justification to support the PA request.

Submit written or fax PA requests (with forms and documentation) to:

- **By Fax:** (866) 668-1214

- **By Mail:**
  Authorization Services Office
  PO Box 45535
  Olympia, WA 98504-5535

For a list of forms and where to send them, see Documentation requirements for PA or LE. Be sure to complete all information requested. The agency returns incomplete requests to the provider.

Submission of photos and X-rays for medical and DME requests

For submitting photos and X-rays for medical and DME requests, use the FastLook™ and FastAttach™ services provided by Vyne Medical.

Register with Vyne Medical through www.vynemedical.com/.

Contact Vyne Medical at 865-293-4111 with any questions.

When this option is chosen, fax the request to the agency and indicate the MEA# in the NEA field (box 18) on the *PA Request* form. **There is an associated cost, which will be explained by the MEA services.**

> **Note:** See the agency's ProviderOne Billing and Resource Guide for more information on requesting authorization.

Limitation extension (LE)

What is an LE?

LE is an authorization of services beyond the designated benefit limit allowed in Washington Administration Code (WAC) and agency billing guides.

How do I request an LE?

For information on how to request an LE, see Documentation requirements for PA or LE and the agency's Physician-Related Services/Health Care Professional Services Billing Guide.

Outpatient prospective payment system (OPPS)

How does the agency pay for outpatient hospital services?

The agency pays for outpatient hospital services using several payment methods including, but not limited to, the following:

- Enhanced ambulatory patient group (EAPG)
- Maximum allowable fee schedule
- Ratio of costs-to-charges (RCC)

The agency's outpatient Prospective payment system (OPPS) uses an EAPG-based reimbursement method as its primary reimbursement method. The agency uses the EAPG software provided by 3M™ Health Information Systems to group OPPS claims based on services performed and resource intensity.

> **Note:** Only hospitals paid by the agency using the Critical Access Hospital payment methodology are exempt from OPPS. See WAC 182-550-7000.

How does the agency determine the payment method for OPPS?

The agency's payment method for OPPS is generally determined by the procedure and revenue codes on the claim line(s). The agency pays OPPS hospitals using the following methods in the following order:

- The EAPG method is used to pay for covered services for which 3M™ Health Information Systems has established an EAPG weight.

- The fee schedule is used to pay for covered services for which there is no established EAPG weight and for services exempted from EAPG payment.

- The hospital's outpatient RCC, as described in WAC 182-550-4500, is used to pay for the covered services for which the agency has not established a maximum allowable fee.

What is the OPPS payment calculation?
(WAC 182-550-7600)

The agency calculates the EAPG payment as follows:

EAPG payment =
EAPG relative weight x
Hospital-specific conversion factor x
Discount factor (if applicable) x
Policy adjustor (if applicable)

The total OPPS claim payment is the sum of the EAPG payments plus the sum of the allowed amounts for each non-EAPG service.

If a client's third-party liability insurance has made a payment on a service, the agency subtracts any such payments made from the Medicaid allowed amount.

OPPS payment enhancements

The agency has established policy adjustors for the following services effective July 1, 2014:

Adjustment	Service	Adjustor
Pediatric	EAPG services for clients under age 18 years	1.35
Chemotherapy and Combined Chemotherapy/Pharmacotherapy	Services grouped as chemotherapy drugs or combined chemotherapy and pharmacotherapy drugs	1.1

When billing for chemotherapy and/or pharmacotherapy drugs, the agency may allow for billing more than one service line for the same date of service, revenue code, CPT/HCPCS code, and NDC.

Billing

All claims must be submitted electronically to the agency, except under limited circumstances. For more information, see the agency's ProviderOne Billing and Resource Guide webpage and scroll down to *Paperless billing at HCA*.
For providers approved to bill paper claims, visit the same webpage and scroll down to *Paper Claim Billing Resource.*

What are the general billing requirements?

Providers must follow the agency's ProviderOne Billing and Resource Guide. These billing requirements include, but are not limited to, all of the following:

- What time limits exist for submitting and resubmitting claims and adjustments
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
- How to bill for clients eligible for both Medicare and Medicaid
- How to handle third-party liability claims
- What standards to use for record keeping

What additional outpatient hospital billing requirements are there?

National correct coding initiative (NCCI)

Providers are required to bill according to National Correct Coding Initiative (NCCI) standards. NCCI standards are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT®) manual, current standards of medical and surgical coding practices, input from specialty societies, and analysis of current coding practices. The Centers for Medicare and Medicaid Services (CMS) maintains NCCI policy.

Information on NCCI can be found online.

The agency payment systems require consistent input to operate correctly. Providers are required to comply with these standards for the agency to make accurate and timely payment.

Medically Unlikely Edits (MUEs) - Part of the NCCI policy are MUEs. MUEs are the maximum unit of service per HCPC or CPT code that can be reported by a provider under most circumstances for the same patient on the same date of service. Items billed above the established number of units are automatically denied as a "Medically Unlikely Edit." Not all HCPCS or CPT codes are assigned an MUE. The agency follows the CMS MUEs for all codes.

The agency may have units of service edits that are more restrictive than MUEs.

All hospitals must bill all claims in a completely OPPS-ready format, as outlined by CMS, and:

- Use CMS acceptable procedure codes where required.
- Use appropriate modifiers.
- Use appropriate units of service.
- Ensure all services provided on a single date of service are billed on the same claim form.

Hospitals are required to bill using applicable revenue codes, CPT® codes, HCPCS codes, and modifiers. All hospitals must use these codes and the line item date of service regardless of Outpatient Prospective Payment System (OPPS) participation. For a list of all procedures and their associated fees, see the agency's Outpatient Prospective Payment System (OPPS) and Outpatient Hospitals Fee Schedule.

Outpatient short stay charges, emergency room facility charges, and labor room charges are covered in combination when time periods **do not** overlap.

Hospitals must report the line item service date, the admit hour, and the discharge hour on every outpatient claim.

Multiple visits on the same day must be unrelated in order to receive more than one payment.

Physicians' professional fees must be billed on a professional claim (see the agency's Physician-Related Services/Health Care Professional Services Billing Guide and Fee Schedule) and must be billed under the physician NPI.

Note: All services for the same episode of care or visit must be on the same claim.

How are outpatient hospital services prior to admission paid?

Related outpatient hospital services, including pre-admission, emergency room, and observation services related to an inpatient hospital stay and provided within one calendar day of a client hospital stay, must be billed on the inpatient hospital claim. See WAC 182-550-6000 (3)(c). The "from" and "to" dates on the hospital claim should cover the entire span of billed services. The admit date is the actual date of admission.

How is billing different for outpatient hospital services in hospital-based clinics?

The agency requires clinics to bill for outpatient services in one of the following ways:

- If the Department of Health (DOH) has designated the clinic as a hospital-based entity, for the agency to reimburse the clinic and the associated hospital for services provided to Washington Apple Health clients, the hospital must submit to the agency an institutional claim with the facility fees in the *Total Claim Charge* field.

- If DOH has not designated the clinic as a hospital-based entity, the clinic must submit to the agency a professional claim containing both of the following:

  - ✓ The facility and the professional fees in the *Submitted Charges* field
  - ✓ The place of service (POS) 11 (office setting) in the *Place of Service* field

Medicare and Medicaid policy prohibit the hospital from billing a facility fee in this circumstance. The agency will reimburse the clinic the nonfacility-setting fee.

In both of the above circumstances, clinics must follow the current instructions in this billing guide related to billing for outpatient services in an office setting.

What are packaged (bundled) services?

Using the EAPG system, the agency packages (bundles) some ancillary services. This simply means these services are included in the EAPG payment rate for a significant procedure or medical visit, rather than being separately reimbursed.

> **For example:** A chest X-ray may be packaged into the payment for a pneumonia visit. Although the detail of the packaged ancillary will show an allowed amount of $0, the packaging of ancillary services does not imply that there is no payment associated with the packaged ancillary. The cost of the packaged ancillaries is included in the payment amount for the significant procedure or medical visit EAPG.

The ancillary services to be packaged are selected primarily on clinical grounds, as established by the EAPG system. So, only ancillaries clinically expected to be a routine part of the specific procedure or medical visit are packaged.

> **Note:** The agency will deny ancillary services not separately reimbursable if the primary procedure is denied and there is no significant procedure or medical visit to which the ancillary service can be packaged.

Where can I find applicable procedure codes?

The agency's Outpatient Prospective Payment System (OPPS) and Outpatient Hospitals Fee Schedule is a systematic listing and coding of procedures and services provided in outpatient settings. This fee schedule is based on both CPT and Level II HCPCS books. Each procedure is identified by a five-character code to simplify reporting.

A legend outlining coverage indicators is located on the second tab of the fee schedule. The *Auth* column outlines potential limitations. See the parent program guidelines for additional information.

Professional components must be billed on a professional claim. See the agency's Physician-Related Services/Health Care Professional Services Billing Guide.

What modifiers do I bill with?

The agency follows the NCCI guidelines for the use of modifiers, and accepts only the following CPT® approved modifiers on outpatient claims:

Modifiers						
25	50	58	73	76	78	91
27	52	59	74	77	79	CA
XE	XP	XS	XU	G0		

Inappropriate use of modifiers may result in claim line denials.

> **Note:** Do not bill modifier 59 in combination with modifiers XE, XP, XS, or XU.

Modifier PO, department of a provider, and provider-based entities

Providers must bill with modifier PO for any outpatient hospital service furnished in an off-campus department of a provider, or by an off-campus provider-based entity.

For these purposes, a "campus" includes both of the following:

- The physical area immediately adjacent to the provider's buildings

- Any other area or structure that is not strictly contiguous to the main building, but is located within 250 yards of the main building

> **Note:** For a definition of "department of a provider" or "provider-based entity," see 42 CFR 413.65(a) (2).
>
> Remote locations under 42 CFR 413.65(a) (2) and satellite facilities under 42 CFR 412.22(h) are exempt from the PO modifier billing requirement.

Where can I find the revenue code grids?

The revenue code grids are located on the agency's [Hospital reimbursement](#) website.

Use only the revenue and procedure codes that appear in the revenue code grids on the website above when billing for any outpatient hospital services. Use of any other codes will result in delay or denial of your claim.

How do I bill for services provided to CHAMPUS clients?

See the agency's [ProviderOne Billing and Resource Guide](#) to get information about billing for Civilian Health and Medical Programs of the Uniformed Service (CHAMPUS) clients.

How do I bill for noncovered services?

The agency requires all services to be listed on an institutional claim, whether they are covered or noncovered, per requirements by CMS and UB-04.

The following are examples of **other** noncovered items for hospitals. If one of these items has a revenue code, report the appropriate code and enter the charges in the *Noncovered Line Charges* field on the electronic institutional claim. Services not identified by a revenue code should be placed under the subcategory **General Classification.**

- Bed scales (if person is ambulatory)
- Cafeteria
- Circumcision tray (routine circumcisions)
- Crisis counseling
- Crutches (rental only is covered, no instruction)
- Experimental or investigational medical services and supplies
- Father's pack (not medically necessary)
- Food supplements (except for qualified providers)
- Home health services
- Lab handling charges
- Medical photographic electronic and video records
- Non-patient room rentals
- Operating room set-up (when not utilized)
- Oxygen equipment set-up (when not utilized)
- Personal care items (e.g., slippers, toothbrush, combs)
- Portable x-ray charges (portable charge fee is included in fee for procedures)

- Psychiatric day care
- Recreational therapy
- Routine tests and procedures (e.g., admission batteries, pre-anesthesia chest x-rays, fetal monitoring, etc.) are only covered if medically necessary[*] and approved by physician.
- Standby equipment charges (for oxygen, anesthesia, and surgery when no actual service is performed)
- Take home drugs/supplies
- Telephone/telegraph/fax
- Transportation (provided during hospital stay)
- Travel time
- Whole blood (Administration of blood is covered. These charges must clearly indicate administration fees.)

How do I bill for single-dose vials?

For single-dose vials, bill for the total amount of the drug contained in the vial(s), including partial vials. Based on the unit definition for the HCPCS code, the agency pays providers for the total number of units contained in the vial.

> **For example:** If a total of 150 mg of Etoposide is required for the therapy, and two 100 mg single dose vials are used to obtain the total dosage, then the total of the two 100 mg vials is paid. In this case, the drug is billed using HCPCS code J9181 (Etoposide, 10 mg). If the agency's maximum allowable fee is $4.38 per 10 mg unit, the total allowable is $87.60 (200 mg divided by 10 = 20 units x $4.38).

For agency requirements on splitting single dose vials, see *Billing for single-dose vials (SDV)* in the agency's Prescription Drug Program Billing Guide.

How do I bill for multi-dose vials?

For multi-dose vials, bill **only** for the amount of the drug administered to the client. Based on the unit definition (rounded up to the nearest whole unit) of the HCPCS code, the agency pays providers for only the amount of drug administered to the client.

> **For example:** If a total of 750 mg of Cytarabine is required for the therapy, and is taken from a 2,000 mg multi-dose vial, then only the 750 mg administered to the client is paid. In this case, the drug is billed using HCPCS code J9110 (Cytarabine, 500 mg). If the agency's maximum allowable fee is $23.75 per 500 mg unit, the total allowable is $47.50 [750 mg divided by 500 = 2 (1.5 rounded) units x $23.75).

How do independent labs bill for pathology services?

The agency requires independent laboratories to bill hospitals for the technical component of anatomic pathology services provided to hospital inpatients and outpatients. To prevent duplicate payment, the agency will not pay independent laboratories if they bill the agency for these services.

> **Note:** Effective July 1, 2014, the agency replaced CMS policy for type of bill 141 with the EAPG payment system. See How does the agency determine the payment method for OPPS?

How does the agency pay for outpatient observation?

The agency follows the logic of the EAPG grouper for outpatient observation services.

Observation EAPG payment policy

Under the EAPG system, there are five different observation EAPGs.

EAPG 450
G0378 is present

- If there is also a Medical Visit Indicator (EAPG 491) the line receives full payment

- If G0378 is billed with less than 8 units, the line groups to EAPG 0999

- If G0378 is billed with a signification procedure, the line is packaged

- If there is also an Observation Indicator (EAPG 492) then the line will group to EAPG 500, 501, or 502

- If no Medical Visit Indicator, Observation Indicator, or no significant procedure, the line will group to EAPG 0999

EAPG 492
G0379 or an observation E/M is present

- If billed with a significant procedure, this line is packaged
- If billed with G0378, then the line will group to EAPG 500, 501, or 502
- If billed without a significant procedure or G0378, the line groups to EAPG 0999

EAPG 500
This EAPG is assigned and receives full payment if all of the following criteria are met:

- There is an Observation Indicator present
- G0378 is present
- The principal diagnosis is obstetrical

EAPG 501
This EAPG is assigned and receives full payment if both of the following criteria are met:

- There is an Observation Indicator present
- G0378 is present

EAPG 502
This EAPG is assigned and receives full payment if all of the following criteria are met:

- There is an Observation Indicator present,
- G0378 is present
- The principal diagnosis is behavioral health

Note: Observation E/M codes are noted as 99217-99220, 99224-99226, and 99234-99236. The procedure code must be covered to qualify.

EAPG 0999 cannot be grouped and lines returning this value are denied.

Observation is defined as an hourly code and has a maximum of 24 units per date of service. Units over this amount are not valid and may cause the line to deny.

How do I bill for neonates/newborns?

For services provided to a newborn who has not yet received a Services Card, bill the agency using the parent's ProviderOne Client ID in the appropriate fields on the claim. For more information on how to bill for neonates, including infants who will be placed in foster care, see the Inpatient Hospital Services Billing Guide.

When billing electronically for multiple births using the mother's ProviderOne number, enter each infant's identifying information in the *Billing Note* section of the claim. Use the following claim indicators to identify which infant is being served: SCI=BA for the first infant, SCI=BB for the second infant, and SCI=BC for the third infant, in the case of triplets. The claim may be denied if there is no identifying information for the twin/triplet.

> **Note:** Bill services for mothers on separate claims.

For information regarding family planning services, including long acting reversible contraceptives (LARC), see the Family Planning Billing Guide.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's Billers, providers, and partners webpage, under Webinars.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA Electronic Data Interchange (EDI) webpage.

> **Note:** When billing for clients, make sure to include patient status.

How do I submit institutional services on a crossover claim?

- Mark "Yes" for the question, "Is this a Medicare Crossover Claim?" in the electronic claim. (If Medicare makes a payment or allows the services, Medicaid considers it a crossover.)

- See the ProviderOne Billing and Resource Guide and the Fact Sheets webpage to get more information about submitting Medicare payment information electronically and to find out when paper backup must be attached.

- Enter the third-party (e.g. Blue Cross) supplement plan name in the *Other Insurance Information* section of the electronic claim. See the Submit an Institutional Claim with Primary Insurance other than Medicare webinar for further assistance with submitting third-party insurance information.

What does the agency require from the provider-generated Explanation of Medicare Benefits (EOMB) to process a crossover claim?

Header level information on the EOMB must include all the following:

- Medicare as the clearly identified payer
- The Medicare claim paid or process date
- The client's name (if not in the column level)
- Medicare Reason codes
- Text in font size 12 or larger

Column level labels on the EOMB for the UB-04 must include all the following:

- The client's name
- From and through dates of service
- Billed amount
- Deductible
- Co-insurance
- Amount paid by Medicare (PROV PD)
- Medicare Reason codes
- Text that is font size 12