



## **Offender Healthcare Providers**

### **Billing Instructions**

***For Offsite Professional Providers, Facilities and Hospitals***

[www.http://www.doc.wa.gov/business/healthcareproviders/default.asp](http://www.doc.wa.gov/business/healthcareproviders/default.asp)

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**Log of Updates/Corrections made to Offender Healthcare Providers Billing Instructions as of 01/01/11.**

Note: All updates/corrections are made in the text of the billing instructions posted on the Offender Health Care Provider's website, so it is always up to date. This log shows all changes made to the 1/1/11 version.

<b>Section Revised</b>	<b>Nature of Revision</b>	<b>Initial</b>	<b>Date</b>
Section 3.4.1 Services provided onsite at the prison	Directs onsite services to be billed with place of service "09" and added NPI numbers for Washington State Prison	PC	4/28/11
Section 3.2 RBRVS Pricing	Removed annual GPCI figures from billing Instructions, see Professional Provider Fee Schedule for these figures	PC	4/28/11
Section 3.4 Site of Service Payment Differentials	Updated Prison (Code 09) place of service differential	PC	4/28/11
Section 5.1 Drugs and Biologicals Pricing Method	Updated percentages of Medicare fees	PC	1/10/11
Section 8.1 Example of CMS-1500	Added CMS-1500 form	PC	1/10/11
Section 9.5 Examples of UB-04	Added UB-04 form	PC	1/10/11

## Contents

<b>SECTION 1 BILLING INSTRUCTIONS: GENERAL RULES.....</b>	<b>7</b>
<b>1.1 Claim Submission Procedures .....</b>	<b>7</b>
1.1.1. Paper Claim Submission .....	7
1.1.2. Electronic Claim Submission .....	7
<b>1.2 Timely Submission of Claims.....</b>	<b>7</b>
<b>1.3 Audit and Right of Recovery Policy .....</b>	<b>7</b>
<b>1.4 Offenders' Rights to Confidentiality.....</b>	<b>7</b>
<b>1.5 Payment Methods .....</b>	<b>8</b>
1.5.1. Warrant .....	8
1.5.2. Electronic Funds Transfer (EFT) .....	8
<b>SECTION 2 FACILITY REIMBURSEMENT .....</b>	<b>9</b>
<b>2.1 General Information .....</b>	<b>9</b>
<b>2.2 Non-Covered Revenue Codes .....</b>	<b>9</b>
<b>2.3 Inpatient Reimbursement.....</b>	<b>9</b>
2.3.1. Definitions .....	10
2.3.2. Service Prior to Admission.....	10
2.3.3. Cost Outliers .....	10
2.3.4. Transfers: Contracted Hospital Paid under AP-DRG Methodology .....	12
2.3.5. Readmissions: Inpatient Claims.....	12
2.3.6. AP-DRG Grouping of Claims.....	12
<b>2.4 Outpatient Reimbursement.....</b>	<b>12</b>
2.4.1. Repetitive Services .....	12
2.4.2. Outpatient Observation Billing Policy.....	12
<b>2.5 Ambulatory Surgery Center .....</b>	<b>13</b>
2.5.1. General Information .....	13
2.5.2. Billing Information .....	13
2.5.3. Packaged Services and Supplies .....	13
2.5.4. ASC Services and Supplies that May be Paid Separately .....	14
2.5.5. Other Services Provided by ASCs that May be Paid Separately .....	14
2.5.6. Multiple Surgery Rules.....	14
2.5.7. Payment Rules for Terminated Procedures.....	15
2.5.8. Request for Pre-Authorization.....	15

<b>SECTION 3</b>	<b>PROFESSIONAL SERVICES.....</b>	<b>17</b>
<b>3.1</b>	<b>General Information .....</b>	<b>17</b>
<b>3.2</b>	<b>RBRVS Pricing .....</b>	<b>17</b>
<b>3.3</b>	<b>Services not paid by RBRVS .....</b>	<b>18</b>
3.3.1.	By Report .....	18
3.3.2.	Bundled Supplies and Services .....	18
3.3.3.	Code Accepted for Tracking Purposes Only.....	18
<b>3.4</b>	<b>Site of Service Payment Differentials .....</b>	<b>19</b>
3.4.1.	Facility Setting Relative Value Units (RVU) .....	20
3.4.2.	Non-Facility Setting Relative Value Units (RVU) .....	20
3.4.3.	Services Provided in a Prison Correctional Facility .....	21
<b>3.5</b>	<b>Global Surgery Rules.....</b>	<b>21</b>
3.5.1.	Services Included in the Global Surgical Package .....	21
3.5.2.	Global Day Periods.....	21
<b>3.6</b>	<b>Therapies Provided in Hospitals or Skilled Nursing Facilities.....</b>	<b>22</b>
<b>3.7</b>	<b>Surgical Assistants .....</b>	<b>22</b>
<b>3.8</b>	<b>Documentation Requirements for Unlisted Procedures.....</b>	<b>23</b>
<b>3.9</b>	<b>Modifiers That May Affect Payment .....</b>	<b>24</b>
3.9.1.	Requirements for Submission of Supporting Documentation for Modifiers.....	24
3.9.2.	Modifiers for Evaluation and Management (E&M) Services .....	25
<b>3.10</b>	<b>Modifiers for Surgical Procedures .....</b>	<b>26</b>
<b>3.11</b>	<b>Radiology Services .....</b>	<b>29</b>
3.11.1.	Modifiers Required for Professional and Technical Components for Radiology Services .....	29
<b>3.12</b>	<b>Laboratory Services.....</b>	<b>30</b>
3.12.1.	Payment for Laboratory Services.....	30
3.12.2.	Clinical Laboratory Pricing .....	30
3.12.3.	Organ-and Disease-Oriented Lab Panels .....	31
3.12.4.	Automated Multichannel Chemistries .....	31
3.12.5.	Modifiers Required for Professional and Technical Components for Laboratory Services .....	32
<b>SECTION 4</b>	<b>ANESTHESIA SERVICES.....</b>	<b>33</b>
<b>4.1</b>	<b>Anesthesia Payment System Overview .....</b>	<b>33</b>
<b>4.2</b>	<b>Anesthesia Procedure Codes .....</b>	<b>33</b>
<b>4.3</b>	<b>Anesthesia Modifiers.....</b>	<b>33</b>
4.3.1.	Medical direction of anesthesia modifiers (QK and QY).....	34
4.3.2.	Monitored anesthesia care service .....	34
4.3.3.	Teaching anesthesia services.....	34

<b>4.4</b>	<b>Anesthesia Time Units and Maximum Allowance Calculation.....</b>	<b>34</b>
<b>4.5</b>	<b>Add-on Anesthesia Procedure Codes .....</b>	<b>35</b>
4.5.1.	Burn Excisions or Debridement .....	35
4.5.2.	Obstetric .....	36
4.5.3.	Anesthesia Payment Limitations for Obstetric Deliveries .....	36
<b>4.6</b>	<b>Pain Management and Other Services Paid Under the RBRVS Methodology .....</b>	<b>36</b>
<b>4.7</b>	<b>Anesthesia Services Performed by the Surgeon (CPT® Modifier 47) Payment Policy.....</b>	<b>36</b>

**SECTION 5 DRUGS AND BIOLOGICALS.....37**

<b>5.1</b>	<b>Pricing Methods.....</b>	<b>37</b>
<b>5.2</b>	<b>Invoice Pricing .....</b>	<b>37</b>
<p>It is never DOC's intent to reimburse less than the cost of a drug. If DOC's allowed amount is less than a provider's cost, the provider may submit a request for reconsideration along with an invoice showing the drug purchase price and DOC may reprocess the claim at invoice cost. ....</p>		
<b>5.3</b>	<b>Billing Guidelines .....</b>	<b>37</b>
<b>5.4</b>	<b>Unspecified Drug Codes .....</b>	<b>37</b>
<b>5.5</b>	<b>Drug Administration Payment Policies.....</b>	<b>38</b>
<b>5.6</b>	<b>"Initial" Service Codes .....</b>	<b>38</b>
<b>5.7</b>	<b>Concurrent Infusion .....</b>	<b>38</b>
<b>5.8</b>	<b>Services Not Separately Payable with Drug Administration .....</b>	<b>38</b>
<b>5.9</b>	<b>Coding and Reimbursement for Chemotherapy Administration .....</b>	<b>38</b>
5.9.1.	Coding and Reimbursement for Chemotherapy Agents.....	38

**SECTION 6 OTHER OFFENDER COVERAGE.....39**

<b>6.1</b>	<b>Medicaid (WA State Department of Social and Health Services).....</b>	<b>39</b>
<b>6.2</b>	<b>WA State Department of Labor and Industries (L&amp;I).....</b>	<b>39</b>
<b>6.3</b>	<b>Other Coverage .....</b>	<b>39</b>

**SECTION 7 PROCESS FOR RESUBMISSION OR ADJUSTMENT OF CLAIMS.....40**

<b>7.1</b>	<b>Requesting Adjustment of Previously Processed Claim.....</b>	<b>40</b>
<b>7.2</b>	<b>Submitting a Corrected Claim .....</b>	<b>40</b>

<b>SECTION 8</b>	<b>COMPLETING THE CMS-1500 CLAIM FORM .....</b>	<b>41</b>
8.1	Example of CMS-1500.....	46
<b>SECTION 9</b>	<b>COMPLETING THE UB-04 CLAIM FORM .....</b>	<b>47</b>
9.1	Coding Information.....	48
9.2	Type of Bill.....	49
9.3	Line Item Dates of Service .....	49
9.4	Service Units.....	49
9.5	Example of UB-04 .....	50

## **Section 1 Billing Instructions: General Rules**

### **1.1 Claim Submission Procedures**

Incomplete claims will cause delay or denial of claims payment. DOC will deny services submitted with invalid procedure, diagnosis, or place of service codes.

#### **1.1.1. Paper Claim Submission**

Professional providers must use the 8/05 revision of the CMS-1500 claim form. Hospitals and most facilities bill with the UB-04 form.

#### **Mail paper claims to:**

Department of Corrections  
Medical Disbursement Unit  
PO Box 41107  
Olympia, WA 98504-1107

#### **1.1.2. Electronic Claim Submission**

The Department does not currently have the capability to accept electronic claim submission.

### **1.2 Timely Submission of Claims**

You should submit claims for covered services within 60 days of the date of service or discharge, but not more than 365 days. DOC will not process claims submitted more than 365 days after the date of service or discharge.

### **1.3 Audit and Right of Recovery Policy**

As stated in the Medical General Terms and Conditions between DOC and the provider, DOC has the right to audit, inspect, and duplicate records maintained on offenders by contracted healthcare providers.

Please notify DOC of any overpayments or underpayments promptly. DOC has the right to seek prompt refund from you for any duplicate, excess, or otherwise erroneous payments, or to deduct the amount overpaid from future payments and take other actions, as is stated in the Medical General Terms and Conditions between DOC and the provider.

You are reminded that under chapter 74.09 RCW, payment by DSHS Medicaid is considered payment in full. If you have received payment from DOC for any Medicaid covered services prior to DSHS payment, DOC must be reimbursed for its payment. You may not seek or accept payment from offenders for any billed amount in excess of the payment.

### **1.4 Offenders' Rights to Confidentiality**

You must keep audit, billing, payment, medical, and other offender-related information for DOC offenders confidential, except as stated in the contract between DOC and the

provider, or unless required by law. All providers must to be compliant with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. You can find information about compliance requirement at <http://www.hipaa.org/>

## **1.5 Payment Methods**

### **1.5.1. Warrant**

Providers will receive a Warrant from the Office of Financial Management. The Warrant identifies the sum of your payment for the batch in which it was processed. At this time DOC is unable to provide line item detail of the amount paid for each claim.

### **1.5.2. Electronic Funds Transfer (EFT)**

Electronic Funds Transfer (EFT) is a free service available to registered State wide vendors. Through this service, DOC deposits payments for claims directly into your organization's bank account instead of mailing a check. You'll receive payment more quickly with EFT.

## Section 2 Facility Reimbursement

### 2.1 General Information

Payment rates are specified in the contract between the hospital and DOC. For inpatient hospital claims, DOC's payment is based on the offender's admission date. This includes determination of covered services, and provider status (for example, contracted or non-contracted). If the contracted provider status ends while an offender is hospitalized, payment is based on the contractual arrangement in effect at time of admission.

### 2.2 Non-Covered Revenue Codes

Charges for the following services should be listed as non-covered (Form locator 48), and are generally not considered for payment.

Revenue Code	Description
180–189	Leave of Absence
220	Special Charges- requires submittal of additional information identifying and justifying the charges
256	Experimental Drugs
257	Pharmacy—Non-Prescription
399	Other Blood Storage and Processing
540–549	Ambulance
624	Medical/Surgical Supplies FDA Investigational Devices
670	Outpatient Special Residence Charges
723	Labor Room/Delivery Newborn Circumcision
810–812, 819	Acquisition of Body Components
941	Recreational Therapy
942	Education/Training - DOC provides benefits for Medicare-approved diabetes education programs and follows Medicare protocol and criteria
949	Other Rx Svcs/Weight Loss
960–989	Professional Fees-are generally not covered when billed on a UB-04 form. Bill these services with the appropriate CPT®/HCPCS level II code on a CMS-1500 form or electronic equivalent. We will consider professional services separately if submitted on a CMS-1500 form; covered charges will be paid using the DOC Professional Provider Fee Schedule
990–999	Offender Convenience Items

### 2.3 Inpatient Reimbursement

DOC bases its reimbursement for inpatient hospital payment on the All-Patient Diagnosis Related Group (AP-DRG) system. The applicable AP-DRG relative weight is multiplied by the hospital-specific contracted conversion factor.

The AP-DRG payment amount includes all pre-admission, diagnostic, appliance, pharmaceutical, operative, treatment, and room and board charges for the offender, beginning one calendar day before the date of admission and extending through date of discharge.

Please note that the Department follows Medicare guidelines regarding the determination of inpatient and outpatient admission status. The Department reserves the right to audit all claims to make a final determination of admission status.”

### 2.3.1. Definitions

- **AP-DRG Relative Weight:** AP-DRGs are weighted, and measure related types of diagnosis treated to the costs incurred by the hospital. The current weight table is available on our [website](#).
- **Conversion Factor:** The conversion factor is a dollar amount, specific to each hospital.
- **Exceptions** to AP-DRG pricing may apply to certain categories of cases. Please refer to your individual provider contract for detailed information.
- **Inpatient Stay** We define an inpatient stay as an enrollee’s admittance to a hospital that incurs room and board services for an expected duration of 24 hours or longer.

### 2.3.2. Service Prior to Admission

AP-DRG per-case facilities can consider all services provided within one calendar day prior to admission as part of the admission and covered by AP-DRG reimbursement. This includes, but is not limited to radiology, pathology, and emergency room services.

Any charges for services on the calendar day before admission must be submitted on the inpatient UB-04 bill and not billed separately as an outpatient service. The Statement Covers Period (Form locator 06 on the UB-04) must reflect the admission date (from) and discharge date (through).

### 2.3.3. Cost Outliers

Outlier claims are those claims with unusually high or low costs.

#### Definitions:

- **Inlier Amount:** The allowed charge for the specific AP-DRG which the claim is grouped to
- **Estimated Percentage of Charges (EPOC):** Defined in the payment addendum of the hospital contract
- **Allowed Charges:** Billed charges minus any charges for non-covered revenue codes identified in Section 2.2 of this billing manual
- **Threshold:** The dollar amount or percentage of inlier amount (whichever is greater) specified in the payment addendum of the hospital contract.
-

### 2.3.3.1 High Cost Outliers

DOC's high cost outlier payment methodology applies to cases where the costs exceed a specific outlier threshold, as defined in the payment section of your individual hospital contract.

**High cost outlier calculation:** Cost=Covered Charges x EPOC

	<b>Explanation</b>	<b>Amount</b>
1	Claim's charges	\$172,419.16
2	Multiplied by hospital's EPOC	x 65%
3	Adjusted charges (line 1 x line 2 )	\$112,072.45
4	Inlier Amount	\$27,872.89
5	Factor for cost outlier threshold #1	x 2.0
6	Cost outlier threshold #1 (line 4 x line 5)	\$55,745.78
7	Fixed cost outlier threshold	\$30,000
8	Final cost outlier threshold (greater of line 6 or line 7)	\$55,745.78
9	Cost outlier add-on (line 3 – line 8)	\$56,326.67

To determine a high-cost outlier case, the cost outlier add on (adjusted charges minus final cost outlier threshold) must be greater than \$0. See example below.

Payment for the case equals the inlier amount plus the cost outlier add-on (line 4 plus line 9)

		\$27,872.89
	+	\$56,326.67
		<hr/>
		\$84,199.56

### 2.3.3.2 Low Charge Outliers

DOC's low charge outlier payment methodology applies to cases where the allowed charges are less than the low charge outlier threshold for the AP-DRG on the DOC weight table. In these situations, reimbursement is calculated by multiplying the allowable billed charges by the estimated percentage of charges (EPOC).

For claims paid on an AP-DRG or per diem basis, we will deny all late claims and notify the hospital that the case was paid in full under the AP-DRG or per diem payment system.

If the original claim was submitted incorrectly or needs to be adjusted, submit a corrected claim with "7" as the third digit in Field 4, Type of Bill (xx7), and we will process it accordingly.

### **2.3.4. Transfers: Contracted Hospital Paid under AP-DRG Methodology**

Reimbursement for patient transfers to another hospital will be calculated using the hospital's contracted percentage (EPOC) multiplied by allowed charges.

These cases are commonly referred to as transfer-out cases, and are defined on the UB-04 by any of the following codes entered in Form locator 17 (Offender Discharge Status):

- 02 (Transfer to an acute care hospital)
- 05 (to another type of institution for inpatient care)
- 62 (Inpatient Rehab Facilities)
- 63 (Medicare Certified Long-Term Care Hospital)

*Exceptions: Please refer to your individual provider contract agreements for any exceptions*

### **2.3.5. Readmissions: Inpatient Claims**

DOC may review inpatient readmission for the same or a similar condition that occurs within 30 days of a previous discharge on a retrospective basis.

### **2.3.6. AP-DRG Grouping of Claims**

DOC assigns the inpatient claim to an All-Patient Diagnosis Related Group (AP-DRG) during claims processing. The grouping and pricing methodology is based on offender discharge date. The rates and the weights in effect for the discharge period will apply.

## **2.4 Outpatient Reimbursement**

Please refer to your facility contract for outpatient reimbursement. If you have any questions, you may contact the contract liaison via our [website](#).

Please note that the Department follows Medicare guidelines regarding the determination of inpatient and outpatient admission status. The Department reserves the right to audit all claims to make a final determination of admission status.”

### **2.4.1. Repetitive Services**

Follow Medicare billing guidelines for repetitive services.

### **2.4.2. Outpatient Observation Billing Policy**

Hospitals billing for observation must follow Medicare billing policy. DOC follows Medicare coverage criteria when determining whether observation services are eligible for separate APC reimbursement. DOC calculates observation services eligible for separate reimbursement using a single unit.

## 2.5 Ambulatory Surgery Center

### 2.5.1. General Information

The Department of Corrections (DOC) Ambulatory Surgery Center Fee Schedule contains the maximum allowances for services provided in ambulatory surgery centers (ASC). All DOC coverage rules regarding the medical necessity of a given procedure for a given patient are applicable to ASC services in the same manner as all other covered services.

DOC follows Medicare payment policies and billing requirements for ASCs.

The list of procedures covered in an ASC includes the majority of procedures covered in an outpatient hospital setting. The ASC payment rates are based on the ambulatory payment classifications (APCs) used to group procedures under the Outpatient Prospective Payment System (OPPS).

The standard ASC payment for covered surgical procedures is calculated by multiplying the DOC ASC conversion factor by the APC payment weight for each separately payable procedure.

Conversion Factor	Coverage Description
\$62.83	most surgical procedures
\$96.47	pain management and gastrointestinal procedures (see the fee schedule for a list of specific CPT and HCPCS codes paid using this conversion factor)

### 2.5.2. Billing Information

Ambulatory Surgery Centers should bill the same procedure code(s) reported by the surgeon. ASCs can submit paper claims and use either a CMS 1500 or UB-04 claim form for payment consideration. The ASC charges must be billed with place of service code "24." The modifier "TC" must be used unless the code has no professional component.

*Note: The "SG" modifier is no longer required by Medicare, however DOC will continue to accept it on the claim.*

### 2.5.3. Packaged Services and Supplies

ASC services for which payment is included in the ASC allowed amount for a covered procedure include, but are not limited to the following:

- Administrative, record keeping and housekeeping items and services
- Anesthesia supplies/materials
- Blood, blood plasma, and platelets
- Drugs and biologicals for which separate payment is not allowed under the outpatient prospective payment system (OPPS).
- Implanted DME and related accessories and supplies not on pass-through status
- Implanted prosthetic devices not on pass-through status, including intraocular lenses (IOLS) inserted during or subsequent to cataract surgery.

- Nursing, technician and related services
- Radiology services for which separate payment is not allowed under the OPPS and other diagnostic or therapeutic services or items integral to the surgical procedure (including routine pre-op lab services)
- Surgical dressings, surgical trays, supplies, splints, screws, casts, post-op shoes
- Use of ASC facilities (including operating/recovery rooms and patient preparation areas)

#### **2.5.4. ASC Services and Supplies that May be Paid Separately**

DOC will pay separately for certain covered ancillary services that are provided integral to covered surgical procedures in ASCs including the following:

- Brachytherapy sources
- Certain implantable items that have pass through status under OPPS
- Certain radiology services for which separate payment is allowed under the OPPS
- Corneal tissue procurement (HCPCS code V2785)
- Drugs and biologicals that are separately paid under the OPPS
- New Technology Intraocular Lens (NTIOLS)

#### **2.5.5. Other Services Provided by ASCs that May be Paid Separately**

- Ambulance services
- Artificial limbs
- Durable medical equipment for use in the patient's home
- Leg, arm, back and neck braces
- Professional services, including; physician services, surgeon, assistant surgeon, anesthesiologist and nurse anesthetist
- Pre/post-operative professional services (E/M codes subject to global surgery rules)
- Services furnished by an independent laboratory

#### **2.5.6. Multiple Surgery Rules**

In general, the following procedure for multiple surgery rules applies. In some cases due to automated claims adjudication and additional logic built into the processing system, these rules may be overridden and procedures that might otherwise result in reduced payment may not have the reduction for multiple surgeries taken. Please contact DOC Customer Service if you have any questions regarding how the claim was processed for multiple surgeries as outlined below.

##### **2.5.6.1**      *Payment Rule for Multiple Procedures (modifier 51)*

If multiple procedures are performed on the same patient at the same operative session or on the same day, the total maximum allowance is equal to the sum of the following:

- 100% of the DOC ASC Fee Schedule allowed amount for the highest fee-schedule-valued procedure.
- 50% of the DOC ASC Fee Schedule allowed amount for any other ASC covered surgical procedure(s)

#### 2.5.6.2 *Payment Rule for Bilateral Procedures (modifier 50)*

When a bilateral procedure is performed, the DOC allowed charge is based on 150% of the DOC ASC Fee Schedule amount. Providers must bill using the single procedure code with the modifier.

### **2.5.7. Payment Rules for Terminated Procedures**

DOC will not pay claims for an ASC procedure that is terminated either for non-medical or medical reasons before expending substantial resources. For example, DOC would not pay a claim for a scheduled surgery that was cancelled or postponed because the patient on intake complained of a cold or flu.

#### 2.5.7.1 *Termination of a Procedure After Anesthesia (Modifier 74)*

An ASC may be paid when a medical complication arises causing the covered procedure to be terminated after inducement of an anesthetic agent. Resources of the facility are consumed in essentially the same manner and to the same extent as they would have been had the surgery been completed. In these circumstances, modifier 74 (representing a discontinued procedure after administration of anesthesia) must be present with the procedure code.

#### 2.5.7.2 *Termination of a Procedure Before Anesthesia (Modifier 73)*

An ASC may be paid when a surgical procedure is terminated due to the onset of medical complications after the patient has been prepared for surgery and taken to the operating room but before anesthesia has been induced. Modifier 73 must be present with the procedure code. The DOC ASC Fee Schedule amount is generally reduced by 50% for payment of covered procedures in these situations.

*Note: Supporting documentation may be requested on a periodic basis by DOC when modifiers 73 or 74 are used.*

### **2.5.8. Request for Pre-Authorization**

Pre-Authorization is not required for ASCs. In the unlikely event that the cost of a procedure (procedure plus implant) is estimated to exceed the DOC allowed amount ASCs may request a preauthorization. Preauthorization must be obtained prior to delivery of services to be considered for additional payment. Please see our [website](#) for the appropriate fax number for Pre-Authorization. Fax your request and include the following information:

- Diagnosis code
- Provider/facility name, phone number, fax number
- Reason for requesting the pre-auth including supporting documentation
- Specific procedure being requested with CPT or HCPCS code
- Estimated cost of any implants (must submit invoice at the time of claim submission)
- DOC offender number

## Section 3 Professional Services

### 3.1 General Information

The Department of Corrections (DOC) Professional Provider Fee Schedule contains the maximum allowances for professional services. The maximum allowances in this document do not reflect the payment differentials that apply to certain provider types.

DOC's primary fee schedule updates occur annually in July. The July fee schedule includes updates to the Resource Based Relative Value Scale (RBRVS) relative value units (RVUs), and statewide Geographic Practice Cost Indices (GPCIs). It also includes fee updates for codes not priced by the RBRVS method.

The DOC RVU schedule uses Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes. Code descriptions are not included in the DOC RVU schedule due to the AMA copyright on the CPT® code descriptions. For billing purposes, use the most current CPT® and HCPCS level II coding references, which include complete code descriptions.

### 3.2 RBRVS Pricing

The majority of the DOC fee schedule is based on the RBRVS reimbursement methodology.

The RBRVS maximum allowances are calculated by multiplying DOC's conversion factor by geographically adjusted relative value units (RVUs).

**Please refer to your contract with DOC for your conversion factor.**

The RVUs for most services are based on the Centers for Medicare & Medicaid Services (CMS) relative value units (RVUs). The CMS RVUs are available on the CMS Web site at [www.cms.hhs.gov](http://www.cms.hhs.gov).

The RVUs are geographically adjusted using the current statewide Geographic Practice Cost Indices (GPCIs). The statewide GPCIs are a blend of the CMS Seattle/King County GPCIs and the CMS Rest of Washington GPCIs.

The GPCI'd RVU totals are calculated by the following formula:

<p style="text-align: center;"><b>GPCI'd RVU =</b> (work RVU x work GPCI) + (practice expense RVU x practice expense GPCI) + (malpractice RVU x malpractice GPCI)</p> <p>**Note that the result is rounded to 2 decimal places.</p>
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The RBRVS maximum allowances are determined by the following formula:  
**DOC Maximum Allowable Fee = Contracted conversion factor x GPCI'd RVUs**

### **3.3 Services not paid by RBRVS**

Professional services not reimbursed using the RBRVS methodology include, but are not limited to:

- Laboratory Services (Section 3.12)
- Anesthesia Services (Section 4)
- Drug's and Biological (Section 5)
- Durable Medical Equipment
- Prosthetics and Orthotics

#### **3.3.1. By Report**

Codes without payment methodology's explained in this document are subject to review to determine payment. When billing with "By Report" codes you must submit with the claim, supporting documentation to include by not limited to, chart notes, the manufactures invoice and/or any other pertinent information supporting the submitted charges.

#### **3.3.2. Bundled Supplies and Services**

DOC does not pay separately for supplies and services that are considered "bundled"—included as an integral part of another service.

The DOC Fee Schedule and Payment Systems (FSPS) show which supplies and services are considered bundled.

DOC does not pay separately for surgical dressings when applied by a provider during the course of a procedure or an office visit.

DOC does not pay for CPT® code 99070 (miscellaneous supplies provided by the physician). Providers must bill specific HCPCS level II codes for supplies, prosthetics, and durable medical equipment.

#### **3.3.3. Code Accepted for Tracking Purposes Only**

CPT® Category II Codes (codes ending with the letter "F") are tracking codes intended for performance measurement. Use of these codes is optional and is not required for correct coding although the Category II codes will be accepted and processed, these codes are not eligible for payment by DOC.

Visit [www.ama-assn.org](http://www.ama-assn.org) for the most current list of CPT® Category II codes.

### 3.4 Site of Service Payment Differentials

For many procedure codes, DOC professional provider reimbursement differs based on where the procedure is performed. This site of service payment differential for professional claims is based on the CMS dual practice expense RVUs and accompanying policy.

Higher reimbursement is made for services provided in “nonfacility” sites of service, such as a physician office. Services provided in “facility” sites of service, such as hospital or ambulatory surgery center, receive a lower professional reimbursement because additional separate reimbursement is made to the facility.

The applicable CMS 2-digit place of service code must be included on all professional claims submitted to DOC for payment consideration. The codes are specified in the table below.

Code	Facility or Non-Facility	Place of Service Description
01	Non-Facility	Pharmacy
03	Non-Facility	School
04	Non-Facility	Homeless Shelter
05	Facility	Indian Health Service Free-Standing Facility
06	Facility	Indian Health Service Provider-Based Facility
07	Facility	Tribal 638 Free-Standing Facility
08	Facility	Tribal 638 Provider-Based Facility
09	Facility	Prison Correctional Facility
11	Non-Facility	Office
12	Non-Facility	Home
13	Non-Facility	Assisted Living Facility
14	Non-Facility	Group Home
15	Non-Facility	Mobile Unit
20	Non-Facility	Urgent Care Facility
21	Facility	Inpatient Hospital
22	Facility	Outpatient Hospital
23	Facility	Emergency Room—Hospital
24	Facility	<b>Ambulatory Surgical Center (ASC)</b> An ASC facility must be licensed by the state(s) in which it operates, unless that state does not require licensure. In addition, the facility must be Medicare-certified or be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or have accreditation as an ASC by another national accrediting organization recognized by DOC.
25	Non-Facility	Birth Center
26	Facility	Military Treatment Facility
31	Facility	Skilled Nursing Facility
32	Non-Facility	Nursing Facility
33	Non-Facility	Custodial Care Facility

Code	Facility or Non-Facility	Place of Service Description
34	Facility	Hospice
41	Facility	Ambulance (Land)
42	Facility	Ambulance (Air or Water)
49	Non-Facility	Independent Clinic
50	Non-Facility	Federally Qualified Health Center
51	Facility	Inpatient Psychiatric Facility
52	Facility	Psychiatric Facility Partial Hospitalization
53	Facility	Community Mental Health Center
54	Non-Facility	Intermediate Care Facility/Mentally Retarded
55	Non-Facility	Residential Substance Abuse Treatment Facility
56	Facility	Psychiatric Residential Treatment Center
57	Non-Facility	Non-Residential Substance Abuse Treatment Facility
60	Non-Facility	Mass Immunization Center
61	Facility	Comprehensive Inpatient Rehabilitation Facility
62	Non-Facility	Comprehensive Outpatient Rehabilitation Facility
65	Non-Facility	End Stage Renal Disease Treatment Facility
71	Non-Facility	State or Local Public Health Clinic
72	Non-Facility	Rural Health Clinic
81	Non-Facility	Independent Laboratory
99	Non-Facility	Other Place of Service

#### **3.4.1. Facility Setting Relative Value Units (RVU)**

When professional services are performed in a facility setting, DOC payment is based on “facility setting RVU.” These payments do not include reimbursement for facility overhead and resource costs. The facility bills DOC separately for associated facility charges.

#### **3.4.2. Non-Facility Setting Relative Value Units (RVU)**

When professional services are performed in a non-facility setting, DOC payment is based on “non-facility setting RVU.” These payments apply when the professional provider who performs the service is responsible for overhead expenses and resource costs such as labor, medical supplies and equipment. When the non-facility RVU applies, DOC does not pay facility charges separately.

### 3.4.3. Services Provided in a Prison Correctional Facility

When professional services are performed at a Washington State prison, DOC payment is based on “facility setting RVU.” Please bill the department using place of service code “09” and designate the NPI number for the prison as found in the table below:

Facility	NPI
Airway Heights Correction Center	1902197882
Cedar Creek Correction Center	1750672572
Clallam Bay Correction Center	1902197387
Coyote Ridge Correction Center	1629369095
Larch Correction Center	1538450911
Mission Creek Correction Center for Women	1689965063
Monroe Correctional Complex	1588955306
Olympic Correction Center	1194016576
Stafford Creek Correction Center	1427349802
Washington Correction Center	1447541834
Washington Correction Center for Women	1114218591
Washington State Penitentiary	1164713558

## 3.5 Global Surgery Rules

DOC follows Medicare’s global surgery rules. Under these rules, DOC pays a single fee for all services provided by the surgeon before, during, and after a surgical procedure. All care by the surgeon during the postoperative period is included in the global surgery payment.

### 3.5.1. Services Included in the Global Surgical Package

The global surgery definition includes:

- The operation
- Preoperative visits, in or out of the hospital, beginning on the day before surgery
- Services by the primary surgeon, in or out of the hospital, during a standard postoperative period as described above
- Dressing changes; local incisional care and removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral IV lines, and nasogastric and rectal tubes; and change and removal of tracheostomy tubes
- All additional medical or surgical services required because of complications that do not require additional trips to the operating room

### 3.5.2. Global Day Periods

The global day periods include:

- 90-day postoperative periods for major procedures
- 10-day postoperative periods for minor surgeries and endoscopies
- 45-day postoperative periods for maternity procedures
- XXX for procedures where the global concept does not apply
- ZZZ for procedures where the global period is included in the global period of another procedure

### **3.6 Therapies Provided in Hospitals or Skilled Nursing Facilities**

DOC does not pay the performing provider of the following therapies separately when services are provided in a hospital or skilled nursing facility:

- Physical therapy
- Massage therapy
- Occupational therapy
- Speech therapy

The facility must submit a consolidated bill for all therapies provided, consistent with Medicare's consolidated billing requirements.

### **3.7 Surgical Assistants**

DOC covers services provided by a surgeon, assistant surgeon\*, licensed physician assistant\*, certified registered nurse first assistant\*, and anesthesia provider in performing medically necessary surgery for a covered condition.

\*DOC follows Medicare's rules about assistants at surgery

### 3.8 Documentation Requirements for Unlisted Procedures

When billing with unlisted CPT® and/or HCPCS level II codes, you must submit supporting documentation with the claim. Unlisted codes do not refer to a specific procedure and generally end with “99” or “9” in the last digits of the CPT® code. Supporting documentation is defined as follows in the chart below.

Type of Unlisted Service	Unlisted CPT® Codes Within This Range	Type of Supporting Documentation
Surgical procedures	15999 to 69979	Operative report
Radiology	76496 to 79999	Clinic or office notes, X-ray report, and/or written description on or attached to the claim
Laboratory	80299 to 89240	Laboratory or pathology report and/or written description on or attached to the claim
Medicine	90399 to 99199 and 99600	Written description on or attached to the claim
Evaluation and management	99429 and 99499	Daily office notes and/or written description on or attached to the claim
Drugs and biologicals (administered by the professional provider)	J3490 – J9999 Note: Codes J8499 and J8999 for oral drugs are generally not covered.	Name, manufacturer, strength, dosage, and quantity of the drug. If there is a specific drug code available, it must be used instead of an unclassified or unspecified drug code.

You can identify unlisted HCPCS level II codes by the terms used to describe them:

- Unlisted
- Not otherwise classified (NOC)
- Unspecified
- Unclassified
- Other
- Miscellaneous

Use the appropriate unlisted procedure code, and include a written description of the item or service with the claim.

### 3.9 Modifiers That May Affect Payment

You must use a valid CPT® or HCPCS level II modifier when a modifier is needed to clarify a service. The modifiers in the following table may affect how DOC pays a claim. While other valid CPT® and HCPCS level II modifiers may be used for informational purposes, they do not affect payment.

Modifier	Description
22	Unusual services
24	Unrelated evaluation and management (E&M) services by the same physician during a postoperative period
25	Significant, separately identifiable E&M service by the same physician on the same day of a procedure or other service
26	Professional component
50	Bilateral procedure
51	Multiple procedures
54	Surgical care only
55	Postoperative management only
56	Preoperative management only
57	Decision for surgery
58	Staged or related procedure or service by same physician during the postoperative period
59	Distinct procedural service
62	Two surgeons
66	Surgical team
78	Return to O.R. for related procedure during postoperative period
80	Assistant surgeon
81	Minimum assistant surgeon
82	Assistant surgeon (when qualified resident surgeon not available)
99	Multiple modifiers which may affect payment
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
TC	Technical component

These modifiers are explained in more detail under the appropriate service headings on the following pages.

#### 3.9.1. Requirements for Submission of Supporting Documentation for Modifiers

Modifier 22 is the only modifier that requires an operative report or other supporting documentation to accompany the incoming claim.

DOC reviews claims with modifiers 22, 51, 62, and 66 before paying the claim.

- When using modifier 22, you must submit an operative report and/or other supporting documentation with the claim.
- When using modifier 51 and reporting more than five procedures, you must submit supporting documentation with the claim. If reporting fewer than five

procedures, you do not need to submit supporting documentation with the claim, but we may request it during our review.

- When using modifiers 62 and 66, you do not need to submit an operative report or supporting documentation with the claim, but we may request it during our review.
- When using other modifiers, you need to submit supporting documentation only if requested to do so by DOC.

### 3.9.2. Modifiers for Evaluation and Management (E&M) Services

DOC does not pay separately for most E&M services provided during the global surgery period indicated on the DOC fee schedule. DOC follows the same global surgery rules as the Centers for Medicare and Medicaid Services (CMS), with a few exceptions.

Description of Modifier	
24	Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure or Other Service
57	Decision for Surgery

Some E&M services during the global surgery period will be paid separately when the appropriate modifier is used (see the table). You may be asked to send supporting documentation when these modifiers are used

### 3.10 Modifiers for Surgical Procedures

DOC follows Medicare's pricing rules for the CPT® surgical modifiers listed below.

<b>Surgical Modifiers</b>	
<b>50</b>	<p><b>Bilateral Procedure</b></p> <p>The bilateral modifier identifies cases where a procedure typically performed on one side of the body is, in fact, performed on both sides of the body. For surgical procedures typically performed on one side of the body that are, in a specific case, performed bilaterally, the maximum allowance is 150% of the global surgery fee schedule amount for the procedure. Providers must bill using the single procedure code with modifier 50.</p> <p>When multiple bilateral procedures are performed, the bilateral surgery adjustment is applied to each bilateral procedure, and then the multiple procedure adjustment is applied. For example, if two procedures are performed bilaterally, the maximum allowance for the highest valued procedure would be 150% of the global surgery fee schedule amount for the procedure and the maximum allowance for the second bilateral procedure would be 75% of the global surgery fee schedule amount for the procedure (50% of 150%).</p>
<b>51</b>	<p><b>Multiple Procedures</b></p> <p><b>Multiple Surgeries:</b> If multiple procedures are performed on the same offender at the same operative session or on the same day, the total maximum allowance is equal to the sum of the following: 100% of the global fee schedule amount for the highest fee-schedule-valued procedure and 50% of the global fee schedule amount for the second through fifth procedures. Surgical procedures in excess of five require submission of supporting documentation and individual review to determine payment amount.</p> <p><b>Multiple Endoscopies:</b> Related endoscopic procedures performed on the same day are subject to the multiple endoscopy rules. The maximum allowance for the procedure with the highest fee schedule value is the full fee schedule amount. The maximum allowance for the second procedure is the full fee schedule amount minus the fee schedule amount for its base diagnostic endoscopy procedure. Unrelated endoscopic procedures performed on the same day are subject to the regular multiple surgery rules instead of the multiple endoscopy rule, since the codes are not in the same procedure family. The maximum allowance for the procedure with the highest fee schedule value is the full fee schedule amount, and the second procedure is allowed at 50% of the fee schedule amount.</p> <p>If multiple related endoscopies (for example, upper and lower gastrointestinal endoscopies) are performed on the same day, the special multiple endoscopy rules are applied separately within each group, and the multiple surgery rules are applied between groups.</p> <p>Please note: Providers should not discount their billed charges for multiple procedures. The appropriate discount as indicated above is applied to the maximum allowances by DOC.</p>
<b>Surgical Modifiers</b>	
<b>54, 55 &amp; 56 Providers Furnishing Less than the Global Surgical Package</b>	

<p>These modifiers are designed to ensure that the sum of all maximum allowances for all practitioners who furnished parts of the services included in a global surgery fee schedule allowance do not exceed the total amount that would have been allowed to a single practitioner. The payment policy pays each provider directly for the portion of the global surgery services furnished to the enrollee. DOC follows Medicare's pre-, post-, and intraoperative percentages as published in the Medicare Physician Fee Schedule Data Base. For split-care, there must be an agreement for the transfer of care between the surgeon and provider who will provide pre- and/or postoperative care. Postoperative care is paid according to the number of days each provider is responsible for the offender's care and must be agreed upon by each provider so each provider bills the correct number of days. The three modifiers used are:</p>	
<b>54</b>	<p><b>Surgical Care Only</b> This modifier is used when the surgeon performs only the preoperative and intraoperative care. Payment is limited to the amount allotted to the preoperative and intraoperative services</p>
<b>55</b>	<p><b>Postoperative Management Only</b> This modifier must be used when a provider other than the operating surgeon assumes responsibility for the postoperative care of the offender. When submitting charges, the same CPT® code that the surgeon used must be billed with modifier 55. The postoperative care is paid at a percentage of the physician's fee schedule. The receiving provider cannot bill for any part of the service included in the global period until he/she provides at least one service. The receiving provider must bill postoperative care as one DOC sum</p>
<b>56</b>	<p><b>Preoperative Management Only</b> This modifier is used by a provider who performs the preoperative care and evaluation and who is not the operating surgeon. Payment is limited to the amount allotted to the preoperative services.</p>
<b>58</b>	<p><b>Staged or Related Procedure or Service by Same Physician During the Postoperative Period</b> This modifier is used when a surgical procedure is performed during the postoperative period of another surgical procedure because the subsequent procedure: a) was planned at the time of the original procedure; b) was more extensive than the original procedure; or c) was for therapy following a diagnostic surgical procedure</p>
<b>59</b>	<p><b>Distinct Procedural Service</b> This modifier represents procedure(s) or service(s) not ordinarily performed or encountered on the same day by the same provider, but that are appropriate under certain circumstances (for example, different site or organ system, or separate excision or lesion). Supporting documentation may be requested for review.</p>
<b>62</b>	<p><b>Co-Surgeons</b> This modifier is used when surgical procedures requiring the skills of two surgeons (each with a different specialty) are performed. The maximum allowance for each surgeon is 62.5% of the global surgical fee schedule amount. No payment is made for an assistant-at-surgery in these cases</p>
<b>Surgical Modifiers</b>	
<b>66</b>	<b>Team Surgery</b>

	This modifier is used when highly complex procedures are carried out by a surgical team, which may include the concomitant services of several physicians, often of different specialties; other highly skilled, specially trained personnel; and various types of complex equipment. Procedures with this modifier are reviewed and priced on an individual basis. Supporting documentation may be requested for review
<b>76</b>	<b>Repeat Procedure by Same Physician</b> This modifier is used to indicate that a procedure or service was repeated subsequent to the original procedure or service
<b>77</b>	<b>Repeat Procedure by Another Physician</b> This modifier is used to indicate that a procedure or service performed by another physician had to be repeated.
<b>78</b>	<b>Return to O.R. for Related Surgery During Postoperative Period</b> Use of this modifier allows separate payment for procedures associated with complications from surgery. The maximum allowance is limited to the amount allotted for intraoperative services only.
<b>80, 81, 82, &amp; AS Assistant-at-Surgery</b>	
<p>Four modifiers may be used to identify procedures where a second provider assists another in the procedure. They are:</p> <p>80 – Assistant Surgeon  81 – Minimum Assistant Surgeon  82 – Assistant Surgeon (when qualified resident surgeon is not available)  AS – Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery. Note: “AS” is the appropriate modifier for Certified Registered Nurse First Assistant claims.</p> <p>The maximum allowance for procedures with these modifiers is the lesser of the following:</p> <ul style="list-style-type: none"> <li>• Actual charge.</li> <li>• Twenty (20) percent of the global surgery fee schedule amount for the procedure.</li> </ul> <p>Multiple surgery rules apply to subsequent multiple procedures.</p> <p>Provider payment differentials described in Section 3.7 of this manual apply to maximum allowances for services reported with modifier AS</p>	
<b>Other Related Modifiers</b>	
<b>22</b>	<b>Unusual Services</b> This modifier is used when the services were significantly greater than what is usually described by the given procedure code. Claims with this modifier are individually reviewed prior to payment. An operative report and/or other supporting documentation must be submitted with the claim for review
<b>24</b>	<b>Unrelated Evaluation and Management (E&amp;M) Services by the Same Physician During a Postoperative Period</b> This modifier is used when an evaluation and management service unrelated to the

	surgical procedure (and thus separately payable) was performed during the postoperative period. Supporting documentation may be requested for review
<b>Other Related Modifiers</b>	
<b>25</b>	<b>Significant, Separately Identifiable Evaluation and Management (E&amp;M) Service by the Same Physician on the Same Day of a Procedure or Other Service</b> This modifier is used to indicate that, on the day of a procedure or other service, a significant, separately identifiable, related or unrelated E&M service was required due to the offender's condition. Supporting documentation may be requested for review
<b>99</b>	<b>Multiple Modifiers</b> Under certain circumstances, two or more modifiers may be necessary to completely delineate a service. For procedures where more than two modifiers which affect payment apply, modifier "99" must be added to the base procedure and other applicable modifiers listed as part of the service description. Claims with this modifier are individually reviewed prior to payment. Supporting documentation may be requested for review

### 3.11 Radiology Services

Services covered by DOC under this benefit include X-rays and other imaging tests, studies, and examinations intended to establish a diagnosis or monitor the progress and outcome of therapy.

Diagnostic testing must be appropriate to the diagnosis or symptoms reported by the ordering provider and must be medically necessary. The ordering provider must be an authorized provider.

#### 3.11.1. Modifiers Required for Professional and Technical Components for Radiology Services

DOC will pay for professional and technical components of radiology procedures according to Medicare payment rules. Providers must use the following modifiers, as appropriate, when billing radiology services.

Description of Modifier	
26	<b>Professional Component</b> This modifier is used to bill for the professional component of a procedure which can be split into professional and technical components.
TC	<b>Technical Component</b> This modifier is used to bill for the technical component of a procedure which can be split into professional and technical components

Some providers may use modifiers 26 and/or TC to separately report the professional and/or technical components of a service when the global service was provided. In these instances, DOC's combined payment for the separate components will not exceed the fee schedule amount for the global procedure.

If another provider (for example, a facility) performs the technical component of a service, the provider performing only the professional component must report his/her service using the 26 modifier to signify that he/she performed only the professional component of the service.

The reverse is true in instances where another provider performs the professional component; in this case, the provider performing only the technical component must report the service using the TC modifier to signify that only the technical component of the service was performed.

### **3.12 Laboratory Services**

Services covered by DOC under this benefit include diagnostic laboratory tests, studies, and examinations intended to establish a diagnosis or monitor the progress and outcome of therapy.

Diagnostic testing must be appropriate to the diagnosis or symptoms reported by the ordering physician and must be medically necessary. The ordering physician must be an authorized provider. If the clinician refers lab tests to an authorized outside vendor for processing, the diagnosis/es must accompany the referral.

#### **3.12.1. Payment for Laboratory Services**

The following laboratory services are reimbursed based on the relative value units established in the Medicare Physician Fee Schedule Data Base (MPFSDB):

- Clinical pathology consultations
- Bone marrow services
- Physician blood bank services
- Cytopathology services
- Surgical pathology services

Codes not contained on the MPFSDB are reimbursed at 100% of the Medicare Clinical Lab Fee schedule amount

#### **3.12.2. Clinical Laboratory Pricing**

Codes not contained on the MPFSDB are reimbursed at 100% of the Medicare Clinical Lab Fee schedule amount and can be found on the DOC Professional Provider Fee Schedule in the allowed amount column.

### 3.12.3. Organ-and Disease-Oriented Lab Panels

Please refer to a current CPT® reference for complete descriptions of the component tests within each laboratory panel code.

The DOC allowed amount will be the same whether the service is billed using the individual test codes or the lab panel code. When component tests of a lab panel are billed separately, DOC bundles the individual codes to the appropriate lab panel code for payment, and the reimbursement is distributed among the separately billed codes.

Automated Multichannel Lab Test Codes		
82040	82565	84295
82247	82947	84450
82248	82977	84460
82310	83615	84478
82330	84075	84520
82374	84100	84550
82435	84132	
82465	84155	
82550	82565	

### 3.12.4. Automated Multichannel Chemistries

Providers will bill the organ and disease oriented panel CPT® code(s) if all component tests within the panel code are performed.

Payment for automated multichannel laboratory tests is determined as follows:

- When all automated multichannel laboratory component tests of an organ and disease panel CPT® code are billed separately, DOC bundles the individual codes to the appropriate organ and disease oriented panel CPT® code for payment.
- All other automated multichannel laboratory tests billed are paid according to the total number of automated multichannel laboratory tests performed. The DOC fee for the total number of tests performed will be distributed among the individual codes billed so that the total allowed charge does not exceed the DOC maximum allowable fee.

Number of Automated Multichannel Lab Tests	2010 Max Fee
1-2 tests	ATP02
3 tests	ATP03
4 tests	ATP04
5 tests	ATP05
6 tests	ATP06
7 tests	ATP07
8 tests	ATP08
9 tests	ATP09
10 tests	ATP10
11 tests	ATP11
12 tests	ATP12
13-16 tests	ATP16
17-18 tests	ATP18
19 tests	ATP19
20 tests	ATP20
21 tests	ATP21
22 tests	ATP22
23+ tests	ATP23

### 3.12.5. Modifiers Required for Professional and Technical Components for Laboratory Services

DOC will pay for professional and technical components of laboratory services according to Medicare payment rules. Providers must use the following modifiers, as appropriate, when billing laboratory services:

Modifier Description	
26	Professional Component This modifier is used to bill for the professional component of a procedure which can be split into professional and technical components.
TC	Technical Component This modifier is used to bill for the technical component of a procedure which can be split into professional and technical components

Some providers may use modifiers 26 and/or TC to separately report the professional and/or technical components of a service when the global service was provided. In these instances, DOC's combined payment for the separate components will not exceed the fee schedule amount for the global procedure.

If another provider (for example, a facility) performs the technical component of a service, the provider performing the professional component must report his/her service using the 26 modifier to signify that he/she performed only the professional component of the service.

The reverse is true in instances where another provider performs the professional component; in this case, the provider performing the technical component must report the service using the TC modifier to signify that only the technical component of the service was performed.

## Section 4 Anesthesia Services

Services covered by DOC under this benefit include anesthesia services related to medically necessary surgery or pain management for a covered condition. Please see the current DOC Offender Health Plan (OHP) for specifics on coverage and benefit limits.

### 4.1 Anesthesia Payment System Overview

DOC pays for anesthesia services according to actual time units and anesthesia base units. For the majority of CPT® anesthesia codes, the anesthesia bases in the DOC payment system are the same as the anesthesia base units adopted by both Medicare and the American Society of Anesthesiologists (ASA). For the CPT® anesthesia codes where Medicare and the ASA bases are different, DOC uses Medicare's anesthesia bases, with a few exceptions.

Payment for some procedures, including pain management services, intubation, Swan-Ganz insertion and placement, and selected surgical services, is based on the DOC Professional Provider Fee Schedule amounts.

### 4.2 Anesthesia Procedure Codes

For anesthesia services paid according to base and time units, you must bill with CPT® anesthesia codes 00100 through 01999 with the applicable anesthesia modifier (see Section 4.3 below). Select the anesthesia procedure codes according to the descriptions published in current CPT®.

### 4.3 Anesthesia Modifiers

For DOC to pay, you must report the applicable anesthesia modifier from the table below with the appropriate anesthesia procedure code. DOC accepts all valid CPT®/HCPCS level II modifiers; however, the modifiers identified in the table are the only ones that affect payment for the anesthesia services

Physician Performing	
AA	Anesthesia service performed personally by anesthesiologist
Physician Directing	
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QY	Medical direction of one CRNA by an anesthesiologist
Physician Supervising	
AD	Medical supervision by a physician
CRNA Performing	
QX	CRNA service with medical direction by a physician
QZ	CRNA service without medical direction by a physician

#### **4.3.1. Medical direction of anesthesia modifiers (QK and QY).**

DOC follows Medicare's payment policy for medical direction of anesthesia services. For each offender, the physician is required to:

- Perform a pre-anesthetic examination and evaluation
- Prescribe the anesthesia plan
- Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergency
- Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in program operating instructions
- Monitor the course of anesthesia administration at frequent intervals
- Remain physically present and available for immediate diagnosis and treatment of emergencies
- Provide indicated post-anesthesia care

In addition, the physician may direct no more than four anesthesia services concurrently and may not perform any other services while directing the single or concurrent services. The physician may attend to medical emergencies and perform other limited services (as Medicare allows) and still be deemed to have medically directed anesthesia procedures. The physician must document in the offender's medical record that the medical direction requirements identified above were met.

#### **4.3.2. Monitored anesthesia care service**

Monitored anesthesia care is reimbursed in the same way as regular anesthesia care, but instead of using the QS modifier, you must bill in the following manner:

- If the physician personally performs the services, bill modifier AA
- If the physician directs four or fewer concurrent procedures and monitored care represents two or more of the procedures, bill modifier QK
- If the CRNA personally performs all of the service, bill modifier QZ
- If the CRNA is medically directed, bill modifier QX

#### **4.3.3. Teaching anesthesia services**

Modifier AA is recognized on an anesthesiologist's claim in a teaching situation (as long as DOC does not receive a separate claim for professional anesthesia services from any other provider).

### **4.4 Anesthesia Time Units and Maximum Allowance Calculation**

The anesthesia payment system is based on a per-minute reporting system. You must report the actual anesthesia minutes rounded to the next whole minute in the units field (24G) on the CMS-1500 claim form. DOC will apply the specific base units for the particular procedure code being billed.

DOC's current 15-minute conversion factor is published on our website. In the claims processing system, this is translated into an equivalent per-minute conversion factor (for example, a conversion factor of \$48.00 per 15 minutes would convert to \$3.2000 per minute). The anesthesia conversion factor is updated each year.

DOC's maximum allowance for payment of anesthesia services is determined as follows:

Step	Maximum Allowance Calculation
1	Multiply anesthesia base units by 15
2	Add total billed minutes to value from step 1
3	Multiply total from step 2 by DOC's per minute conversion factor**

Sample Calculation: Provider billed 120 minutes for a procedure code with 5 base units

Step	Maximum Allowance Calculation	Sample Calculation
1	Multiply anesthesia base units by 15	$5 \times 15 = 75$
2	Add total billed minutes to value from step 1	$75 + 120 = 195$
3	Multiply total from step 2 by DOC's per minute conversion factor**	$195 \times \$3.504 = \$683.28$

Note: If an anesthesiologist or CRNA personally performs the anesthesia service, DOC pays based on 100 percent of the maximum allowed amount. In a team care situation, where an anesthesiologist medically supervises or medically directs CRNA services, DOC payment to both the anesthesiologist and CRNA is based on 50 percent of the total maximum allowance.

Anesthesia time begins when the provider starts to physically prepare the offender for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (when the offender can be safely placed under postoperative supervision).

Following Medicare's payment policy, providers may sum up blocks of time around a break in continuous anesthesia care, as long as there is continuous monitoring of the offender within the blocks of time. This policy does not alter the fundamental principle that anesthesia time represents a continuous block of time when an offender is under the care of an anesthesiologist or CRNA. DOC does not pay for time units for the pre-anesthesia exam and evaluation, as these services are included in the base unit component.

## 4.5 Add-on Anesthesia Procedure Codes

### 4.5.1. Burn Excisions or Debridement

To receive payment from DOC, providers may report the CPT® anesthesia add-on code 01953 in addition to the primary anesthesia code 01952.

Anesthesia provided for second- and third-degree burn excision or debridement should be reported as follows:

- For the primary anesthesia code (01952), report the total anesthesia minutes in the units field (24G)

- For the add-on code (01953), use the units field (24G) to report one unit per 9 percent (or part thereof) of body surface.

#### 4.5.2. Obstetric

You may report the following CPT® add-on codes in conjunction with CPT® code 01967 (neuraxial labor analgesia/anesthesia for planned vaginal delivery) when appropriate. The anesthesia time for the primary and add-on procedures are reported and paid separately:

CPT® Code	Description
01968	Cesarean delivery following neuraxial labor analgesia/anesthesia
01969	Cesarean hysterectomy following neuraxial labor analgesia/anesthesia

#### 4.5.3. Anesthesia Payment Limitations for Obstetric Deliveries

DOC's maximum reimbursement per obstetric delivery for epidural anesthesia is equal to 360 minutes (six hours).

### 4.6 Pain Management and Other Services Paid Under the RBRVS Methodology

Some procedures commonly performed by anesthesiologists and CRNAs are reimbursed using the RBRVS maximum allowance, instead of anesthesia base and time units. These services include most pain management services, intubation, Swan-Ganz insertion and placement, as well as other selected surgical services. For DOC to pay, you must bill the applicable CPT® surgery or medicine codes (with no anesthesia modifier). See the DOC Professional Provider Fee Schedule for the maximum allowances for these services.

### 4.7 Anesthesia Services Performed by the Surgeon (CPT® Modifier 47) Payment Policy

DOC follows Medicare policy and does not pay separately for local, regional, digital block, or general anesthesia administered by the surgeon.

## **Section 5 Drugs and Biologicals**

### **5.1 Pricing Methods**

The DOC fee schedule amounts for drugs and biologicals are based on the pricing methods outlined below:

- Fee schedule amounts for most drug codes are based on 100 percent of Medicare's fees (updated quarterly).
- Fee schedule amounts for most separately payable radiopharmaceutical codes are equated to Medicare's (carrier) fees.
- Fee schedule amounts for other drugs and biologicals are 84 percent of Average Wholesale Price.

The Department updates the rates each time Medicare's rates are updated, up to once per quarter. Unlike Medicare, the Department effective dates are based on dates of service, not the date the claim is received.

### **5.2 Invoice Pricing**

It is never DOC's intent to reimburse less than the cost of a drug. If DOC's allowed amount is less than a provider's cost, the provider may submit a request for reconsideration along with an invoice showing the drug purchase price and DOC may reprocess the claim at invoice cost.

### **5.3 Billing Guidelines**

The DOC fee schedule uses Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes.

When billing for drugs and biologicals, providers must:

- Follow Medicare's current coding guidelines and policies.
- Bill according to the complete code descriptions from a current CPT® or HCPCS reference.
- Include the correct number of units on the claim form.

### **5.4 Unspecified Drug Codes**

Unclassified or unspecified drug codes should be billed only when there is not a specific code for the drug being administered.

For payment consideration include the following information with any unspecified drug code:

- Drug name
- Manufacturer
- Strength

- Dosage
- Quantity

## **5.5 Drug Administration Payment Policies**

DOC fee schedule amounts for drug administration services are found in the Professional Provider Fee Schedule and are based on the RBRVS payment method.

## **5.6 "Initial" Service Codes**

The "initial" service CPTcode is the code that best describes the key or primary reason for the encounter. The "initial" service code does not necessarily represent the first service provided.

Only one "initial" drug administration code is payable per encounter unless protocol requires that two separate IV sites must be used or the patient comes back for a separately identifiable service on the same day, in which case the second "initial" service code should be reported with modifier -59.

## **5.7 Concurrent Infusion**

Concurrent infusion is payable only once per day.

## **5.8 Services Not Separately Payable with Drug Administration**

The following services are included in the payment for the drug administration service and are not separately payable:

- Use of local anesthesia.
- IV start or access to indwelling IV (a subcutaneous catheter or port).
- Flush at conclusion of an infusion.
- Standard tubing, syringes and supplies

## **5.9 Coding and Reimbursement for Chemotherapy Administration**

For payment of chemotherapy administration, DOC generally follows Medicare's coding guidelines.

### **5.9.1. Coding and Reimbursement for Chemotherapy Agents**

You must use the specific HCPCS level II "J" or "Q" code to report the drug administered. Document the name, manufacturer, strength, dosage, and quantity of the drug in the offender's medical record. These records must be available for review on request by DOC. The DOC Professional Provider Fee Schedule for Drugs and Biologicals includes the allowed amounts for the chemotherapy agents, and is available on the DOC website at <http://www.doc.wa.gov/business/healthcareproviders/default.asp>

## **Section 6 Other Offender Coverage**

### **6.1 Medicaid (WA State Department of Social and Health Services)**

The Department of Corrections (DOC) and the Department of Social and Health Services (DSHS) work together to identify DOC offenders that are eligible for DSHS services during an inpatient hospital stay. Some DOC offenders may meet the eligibility requirements for DSHS medical assistance programs authorized under Section 1905 of Title XIX of the Social Security Act and chapter 74.09 RCW. If the offender qualifies for medical assistance and you are a Medicaid contracted provider, Medicaid will pay the services in accordance with chapter 74.09 RCW.

Under chapter 74.09 RCW, payment by DSHS Medicaid is considered payment in full. If you have received payment from DOC for any Medicaid covered services prior to DSHS payment, DOC must be reimbursed for its payment. You may not seek or accept payment from offenders for any billed amount in excess of the payment.

### **6.2 WA State Department of Labor and Industries (L&I)**

Some medical claims for offenders due to on-the-job injuries or other related events may be covered by L&I. If the offender qualifies for services covered by L&I, L&I will become the payer over DOC.

### **6.3 Other Coverage**

Some medical claims for offenders may be covered by another entity. If the offender qualifies for services covered under any other entity, that entity will become the payer over DOC.

## **Section 7 Process for Resubmission or Adjustment of Claims**

### **7.1 Requesting Adjustment of Previously Processed Claim**

If you believe that DOC processed a claim incorrectly, please contact the Medical Disbursement Unit. You may find a list of unit contacts on our [website](#). If we agree, we will reprocess the claim, although we might request that you submit supporting documentation or a corrected claim.

If you think DOC processed a claim incorrectly and the department does not agree, please see our website for further resources.

### **7.2 Submitting a Corrected Claim**

You must stamp or write “corrected claim” on the resubmitted claim when submitting corrected claims by mail. Without this, we will deny the claim as a duplicate. If you need to submit a corrected claim, you must indicate on the form what was corrected and why you feel the claim should be adjusted. Include additional information necessary to justify adjustments.

Send the corrected claim, along with any additional documentation or information, to:

Department of Corrections  
Medical Disbursement  
Unit PO Box 41107  
Olympia, WA 98504-1107

Note: Providers are expected to bill accurately for services. Changing procedure or diagnostic codes or modifying records for the sole purpose of gaining additional payment from DOC, and not to correct an error, is inappropriate and may trigger an investigation.

## Section 8 Completing the CMS-1500 Claim Form

Professional service claims must be submitted on a CMS-1500 claim form. The following instructions describe how to complete each field on the form. A sample CMS-1500 form follows these instructions.

No.	Field Name	Instructions
1	Coverage Type	Check the box labeled "Other".
1a	Insured's ID Number	Enter the offender's 6 digit DOC offender identification number.
2	Offender's Name	Enter the offender's full name (last name, first name, middle initial).
3	Offender's Birth Date and Sex	Enter the offender's date of birth in MM/DD/YYYY format. For example, July 8, 1950, would be entered as 07/08/1950. Check the appropriate box: M=male; F=female
4	Offender's Name	Enter the name of the offender
5	Offender's Address	Enter the address of the facility in which the offender is incarcerated. On the first line, enter the street address; the second line is for the city and state; the third line is for the ZIP Code and phone number.
6	Offender Relationship	Check the appropriate box: Self
7	Offender's Address	Send all billing to: Department of Corrections Medical Disbursement Unit PO Box 41107 Olympia, WA 98504-1107
8	Offender Status	Check the box labeled "Other"
9	Other Offender's Name	If the offender has other insurance, enter the last name, first name, and middle initial of the other plan's policyholder if it is different from that shown in Field 2. Otherwise, enter the word "Same."
9a	Other Offender's Policy or Group Number	Enter the offender's DOC number that can be found at <a href="http://www.doc.wa.gov/offenderinfo/default.asp">http://www.doc.wa.gov/offenderinfo/default.asp</a>
9b	Other offender's Date of Birth and Sex	If the offender has other insurance, enter the policyholder's date of birth (MM/DD/YYYY format). Check the appropriate box: M=male, F=female
9c	Employer's Name or School Name	If the offender has other insurance, enter the name of the policyholder's employer or school, if applicable.
9d	Insurance Plan Name or Program Name	If the offender has other insurance, enter the other insured's plan name or program name (the offender's health maintenance organization).
10	Accident Determination	If the offender's condition is accident-related, check the appropriate box: Employment, Auto Accident, or Other
11	Insured's Policy Group	Enter the insured's policy number
11a	Insured's Date of Birth and Sex	Enter the insured's date of birth and sex, if different from offender information from item 3.
11b	Employer's Name or School Name	Enter the employer name or school name for the insured.

No.	Field Name	Instructions
11c	Insurance Plan or Program Name	Enter the plan name
11d	Other Health Benefit Plan	Check "Yes" or "No" to indicate whether there is another primary health benefit plan. For example, the offender may have other insurance through a spouse, parent, or some other person. If there is information in Fields 9 through 9d, "Yes" must be checked. If "No" is checked, then these items would be blank. If "Yes" is checked and Fields 9 through 9d are blank, claim processing will be delayed.
12	Offender's or Authorized Person's Signature	Have the offender or his/her authorized representative sign and date this block unless the signature is on file.
13	Insured's/Authorized Person's Signature	Optional (may be left blank).
14	Date of Current Illness, Injury, or Pregnancy	Enter date of onset of current illness, injury, or pregnancy.
15	Date of Same or Similar Illness	Leave blank.
16	Dates Offender Unable to Work in Current Occupation	Enter date(s) if offender is unable to work. An entry in this field could indicate employment-related insurance coverage. If this item is applicable, Field 10 (Accident Determination) may also require completion.
17	Name of Referring Provider or Other Source	If the services are the result of a referral, then enter the name of the referring physician. Note: When billing therapy services, the prescribing provider's complete name (including credentials MD, DO, DPM, DC, ND, ARNP) must be indicated in this field.
17a	Other ID	If the referring, ordering, or supervising provider does not have an NPI number, the Other ID number of the provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a (these are the same as the qualifiers used in the electronic 837 Professional 4010A1): 0B State License Number, 1B Blue Shield Provider Number, 1C Medicare Provider Number, 1D Medicaid Provider Number, 1G Provider UPIN Number, 1H CHAMPUS Identification Number, EI Employer's Identification Number, G2 Provider Commercial Number, LU Location Number, N5 Provider Plan Network Identification Number, SY Social Security Number (The social security number may not be used for Medicare.), X5 State Industrial Accident Provider Number, ZZ Provider Taxonomy
17b	NPI	Enter the NPI number of the referring, ordering, or supervising provider. If the provider does not have an NPI number, include the Other ID number in item 17a.

No.	Field Name	Instructions
18	Hospitalization Dates Related to Current Services	Optional (may be left blank).
19	Reserved for Local Use	Optional (may be left blank).
20	Outside Lab	Complete this item when billing for diagnostic tests subject to purchase limitations. Enter the purchase price under charges if the "Yes" block is checked. A "Yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "No" check indicates that no purchased tests are included on the claim. When "Yes" is checked, Field 32 must be completed.
21	Diagnosis or Nature of Illness or Injury	Enter up to four ICD-9-CM diagnosis codes in priority order (primary, secondary condition). Report the highest level of specificity.
22	Medicaid Resubmission	Leave blank.
23	Prior Authorization Number	Enter prior authorization information
24A	Dates of Service	Enter the month, day, and year for each procedure, service, or supply. If "from" and "to" dates are shown here for a series of identical services, the number must appear in Field 24g.
24B	Place of Service (POS)	Enter the 2-digit place of service code. Please see Section 7.1 for more information about place of service, including a list of codes.
24C	Emergency Indicator	Check this item to indicate that the service was provided in a hospital emergency room. (If this block is checked, then Field 24B must indicate hospital emergency room as the place of service.)
24D	Procedures, Services, or Supplies	Enter the appropriate procedure code and modifier, if applicable. DOC accepts only current CPT® and HCPCS level II procedure codes (with appropriate modifiers, where required). For each procedure, show the corresponding diagnosis pointer in Field 24E.
24E	Diagnosis Pointer	Enter the diagnosis code reference number (pointer) as shown in Field 21 (enter 1, 2, 3, or 4), to relate the date of service and the procedures performed to the appropriate diagnosis. (The ICD-9-CM diagnosis codes themselves are entered in Field 21 only. Do not enter them in 24E.)
24F	Charges	Enter the billed amount.
24G	Days or Units	Enter the number of days, units, or anesthesia minutes. When multiple services are provided, enter the actual number provided
24H	EPSDT Family Plan	Leave blank.

No.	Field Name	Instructions
24I	ID Qual	If the provider does not have an NPI number, enter the appropriate qualifier in the shaded area. The qualifiers indicate the non-NPI number being reported. See 17a in this table for a list of qualifiers. Report the Identification Number in Fields 24I and 24J only when different from data recorded in Fields 33a and 33b.
24J	Rendering Provider ID	The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. <ul style="list-style-type: none"> <li>• If the provider has an NPI number, report the NPI number in Field 24J in the non-shaded area next to NPI from Field 24I.</li> <li>• If the provider does not have an NPI number, enter the non-NPI number in the shaded area of 24J.</li> </ul> Report the Identification Number in Items 24I and 24J only when different from data recorded in Fields 33a and 33b.
25	Federal Tax ID Number	Show the physician/supplier federal tax ID number (employer identification number) or social security number. Note: Claims must be submitted with the provider's tax ID number (TIN).
26	Offender's Account Number	Enter the offender's account number assigned by the accounting system of the physician or supplier. This optional field enhances offender identification by the physician or supplier.
27	Accept Assignment?	Leave blank.
28	Total Charge	Enter the total of the charges listed for all line items.
29	Amount Paid	Enter the amount received from a third party if another insurer has processed a claim for these services, and attach an Explanation of Benefits (EOB).
30	Balance Due	Enter the balance due (Field 28 less Field 29).
31	Signature of Physician or Supplier	The provider must sign or signature stamp each claim for services rendered, and enter the date. Only signed claims will be accepted for payment.
32	Name and Address of Facility Where Services Were Rendered	Enter the name and address of the facility where the services were rendered.
32a	NPI Number	Enter the NPI number of the service facility location.
32b	Other ID	Enter the two-digit qualifier identifying the non-NPI number followed by the ID number for the service facility location. Do not enter a space, hyphen, or other separator between the qualifier and number. See 17a in this table for a list of two-digit qualifiers.
33	Physician's/Supplier's Billing Name, Address, Etc.	Enter the billing provider's name, address, and phone number.
33a	NPI Number	Enter the NPI number of the billing provider.

No.	Field Name	Instructions
33b	Other ID	Enter the two-digit qualifier identifying the non-NPI number followed by the ID number for the billing provider. Do not enter a space, hyphen, or other separator between the qualifier and number. See 17a in this table for a list of two-digit qualifiers.

# 8.1 Example of CMS-1500

1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA
PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.		11. INSURED'S POLICY GROUP OR FECA NUMBER	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES	
1. _____ 3. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
2. _____ 4. _____		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER E. DIAGNOSIS POINTER		F. \$ CHARGES G. DAYS OF CRT H. EPSON (Family Plan) I. ID. QUAL J. RENDERING PROVIDER ID. #	
1			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For gov. claims see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$	
29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____		32. SERVICE FACILITY LOCATION INFORMATION a. _____ b. _____	
		33. BILLING PROVIDER INFO & PH # ( ) a. _____ b. _____	

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org) APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

## Section 9 Completing the UB-04 Claim Form

Hospitals must submit facility charges on the UB-04 claim form for payment consideration. See the sample form following these instructions. The descriptions in the table below show what to enter in each field. Missing or inaccurate information may result in denied or delayed processing of claims.

UB-04 Form Locator	Description
01	Billing Provider Name, Address, and Telephone Number
02	Pay-to Name and Address
03a	Offender Control Number
03b	Medical Record Number
04	Type of Bill
05	Federal Tax Identification
06	Statement Covers Period
07	Reserved for Assignment by the NUBC
08	Offender Name/Identifier
09	Offender Address
10	Offender Birth Date
11	Offender Sex
12	Admission/Start of Care Date
13	Admission Hour
14	Priority (Type) of Visit
15	Source of Admission/Point of Origin
16	Discharge Hour
17	Offender Discharge Status
18–28	Condition Codes
29	Accident State
30	Reserved for Assignment by the NUBC
31–34	Occurrence Codes and Dates
35–36	Occurrence Span Codes and Dates
37	Reserved for Assignment by the NUBC
38	Responsible Party Name and Address
39–41	Value Codes and Amounts
42	Revenue Codes
43	Revenue Description
44	HCPCS/Accommodation Rates/HIPPS Rate Codes
45	Service Date
46	Service Units
47	Total Charges
48	Non-Covered Charges
49	Reserved for Assignment by the NUBC
50	Payer Name
51	Health Plan Identification Number
52	Release of Information Certification Indicator
53	Assignment of Benefits Certification Indicator
54	Prior Payments—Payer

UB-04 Form Locator	Description
55	Estimated Amount Due—Payer
56	National Provider Identifier (NPI Number)—Billing Provider
57	Other (Billing) Provider Identifier
58	Insured's Name
59	Offender's Relationship to Insured
60	Insured's Unique Identifier
61	Insured's Group Name
62	Insured's Group Number
63	Treatment Authorization Code
64	Document Control Number (DCN)
65	Employer Name (of the Insured)
66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)
67	Principal Diagnosis Code (1-7) and Present on Admission (POA) Indicator (position 8)
67A–Q	Other Diagnosis Codes
68	Reserved for Assignment by the NUBC
69	Admitting Diagnosis Code
70a–c	Offender's Reason for Visit
71	Prospective Payment System (PPS) Code
72a–c	External Cause of Injury (ECI) Code
73	Reserved for Assignment by the NUBC
74	Principal Procedure Code and Date
74a–e	Other Procedure Codes and Dates
75	Reserved for Assignment by the NUBC
76	Attending Provider Name and Identifiers
77	Operating Physician Name and Identifiers
78–79	Other Provider (Individual) Names and Identifiers
80	Remarks Field
81	Code—Code Field

Note: Use the CMS-1500 form for billing professional services. Instructions for completing the CMS-1500 form are in Section 8

## 9.1 Coding Information

DOC recognizes UB-04 claims data elements as defined by the National Uniform Billing Committee (NUBC). Standard UB-04 revenue codes are required on all service lines of a claim.

The most appropriate (based on the date of service) versions of the ICD-9-CM diagnosis and procedure codes or CPT®/HCPCS codes are required for billing purposes. The American Medical Association (AMA) and Medicare add and revise the diagnosis and

procedure codes. The updated codes must be used for DOC claims when the codes become valid for use with Medicare claims.

DOC audits all diagnosis and procedure codes on the claim form for validity and accuracy, as applicable. DOC will deny incomplete claims and services submitted with invalid procedure or diagnosis codes.

## **9.2 Type of Bill**

Type of Bill (Form locator 4 UB-04) indicates the type of facility and bill classification (inpatient, outpatient, etc.) specific to a claim. DOC uses this required field to process claims. For appropriate Type of Bill usage, please refer to the National Uniform Billing Committee Data Specifications Manual for the UB-04.

We define late claims as those submitted by the hospital after the original claim. These claims are identified by a “5” entered in Form locator 4 (Type of Bill), 3rd digit, of the UB-04 form.

## **9.3 Line Item Dates of Service**

DOC requires line item dates of service on all hospital facility bills for each line where a CPT® or HCPCS procedure code is required. This includes claims where the “from” and “through” dates are the same. Omission of these dates will delay processing.

## **9.4 Service Units**

DOC defines a service unit as the number of times a service or procedure was performed per the CPT®, HCPCS, or Revenue Code definitions. Providers must not report multiple units on the claim form for any procedure code where it is not supported by these definitions.

## 9.5 Example of UB-04

1		2		3		4	
5		6		7		8	
9		10		11		12	
13		14		15		16	
17		18		19		20	
21		22		23		24	
25		26		27		28	
29		30		31		32	
33		34		35		36	
37		38		39		40	
41		42		43		44	
45		46		47		48	
49		50		51		52	
53		54		55		56	
57		58		59		60	
61		62		63		64	
65		66		67		68	
69		70		71		72	
73		74		75		76	
77		78		79		80	
81		82		83		84	
85		86		87		88	
89		90		91		92	
93		94		95		96	
97		98		99		100	
101		102		103		104	
105		106		107		108	
109		110		111		112	
113		114		115		116	
117		118		119		120	
121		122		123		124	
125		126		127		128	
129		130		131		132	
133		134		135		136	
137		138		139		140	
141		142		143		144	
145		146		147		148	
149		150		151		152	
153		154		155		156	
157		158		159		160	
161		162		163		164	
165		166		167		168	
169		170		171		172	
173		174		175		176	
177		178		179		180	
181		182		183		184	
185		186		187		188	
189		190		191		192	
193		194		195		196	
197		198		199		200	
201		202		203		204	
205		206		207		208	
209		210		211		212	
213		214		215		216	
217		218		219		220	
221		222		223		224	
225		226		227		228	
229		230		231		232	
233		234		235		236	
237		238		239		240	
241		242		243		244	
245		246		247		248	
249		250		251		252	
253		254		255		256	
257		258		259		260	
261		262		263		264	
265		266		267		268	
269		270		271		272	
273		274		275		276	
277		278		279		280	
281		282		283		284	
285		286		287		288	
289		290		291		292	
293		294		295		296	
297		298		299		300	
301		302		303		304	
305		306		307		308	
309		310		311		312	
313		314		315		316	
317		318		319		320	
321		322		323		324	
325		326		327		328	
329		330		331		332	
333		334		335		336	
337		338		339		340	
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