

Washington State Health Care Authority

Medicaid Provider Guide

Prenatal Genetic Counseling
[Refer to Chapter 246-680 WAC]

March 8, 2013



Washington State
Health Care Authority

A Billing Instruction

About this guide

This guide, by Health Care Authority (Medicaid agency), supersedes all previous *Prenatal Genetic Counseling Medicaid Provider Guide* (billing instructions) published by the Department of Social and Health Services (DSHS).

What has changed?

Reason for Change	Effective Date	Page No.	Subject	Change
Clarification for more accurate enrollment and billing (PN 13-12)	03-08-13	Page 4	Provider requirements	Clarified the process for provider enrollment and billing.
		Page 7	Billing	Made a change to correct billing the taxonomy.
		Various	Various	Made housekeeping changes to clarify and streamline information, and update cross-references.

How can I get agency provider documents?

To download and print agency provider notices and Medicaid provider guides, go to the agency's [Provider Publications](#) website.

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Alert! The page numbers in this table of contents are now “clickable”—simply hover over on a page number and click to go directly to the page. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks on the left side of the document. (If you don’t immediately see the bookmarks, right click on the document and select Navigation Pane Buttons. Click on the bookmark icon on the left of the document.) 

Resources Available

Note: This section contains important resource information relevant to prenatal genetic counseling. For more Medicaid resource information, see the Medicaid agency's [Resources Available](#) web page.

Topic	Contact Information
Who do I contact for information regarding Genetic Counseling?	Debra Lochner Doyle, MS, LCGC Department of Health Screening and Genetics Unit 1-253-395-6742
Regional genetic clinics	See Washington's Genetic Clinics' website through the Department of Health
Regulations related to genetic services	See the website on Laws and Regulations for genetics through the Department of Health
Genetic services	See the Genetic Services website through the Department of Health

Definitions

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Medicaid agency's [online Medical Assistance Glossary](#) for a more complete list of definitions.

American Board of Genetic Counseling (ABGC) - A national organization that certifies genetic counselors. Prior to 1993, the certification of genetic counselors was conducted by the American Board of Medical Genetics (ABMG).

Authorization Number - A nine-digit number, assigned by the Medicaid agency that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pending, or denied.

Authorization Requirement - To obtain authorization for some services and equipment, you must provide proof of medical necessity. Each request must include a complete, detailed description of the diagnosis and/or any disabling conditions, justifying the need for the equipment or the level of service being requested.

Certified Genetic Counselor - A genetic counselor who has successfully passed *either* the American Board of Medical Genetics (ABMG) general genetic examination as well as the subspecialty examination of genetic counseling (if prior to 1993), *or* the American Board of Genetic Counseling examination. A genetic counselor with Active Candidate Status has successfully completed an ABGC accredited training program and has been accepted to

take the next available ABGC certification examination. See [Provider Requirements](#).

Emergency Medical Condition - The sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Genetic Counselor - An individual who:

- Holds a post-baccalaureate degree; and
- Is qualified as a counselor and coordinator of services and resources in the care of persons with genetically caused and predisposed disorders.

Health care providers - Persons licensed or certified by the state of Washington under Title 18 RCW to provide prenatal care or to practice medicine. [WAC 246-680-010]

Laboratory - A private or public person, provider, or organization performing prenatal tests for congenital and heritable disorders.

Provider - A prenatal genetic counseling service agency with at least one board certified or board eligible genetic counselor on staff who is supervised by a practicing licensed physician.

About the Program

What is the purpose of the prenatal genetic counseling program?

The prenatal genetic counseling program was established to ensure that all Health Care Authority's (Medicaid agency's) clients have access to high quality, comprehensive prenatal genetic counseling services. Rapid advances in the field of genetics may outpace many obstetrical providers' abilities to stay current in standards of genetics practice and/or understand the complex ramifications associated with genetic testing.

Genetic counselors are nationally certified and licensed health care professionals in the field of genetics and can ensure that clients receive informed consent, particularly regarding reproductive issues. Funds in the DOH Division of Community & Family Health Screening and Genetics Unit budget are used as the required state match for this Medicaid program for prenatal genetic counseling services. These services are available to all women/couples during their pregnancy and up to 90 days post-partum.

Client Eligibility

How can I verify a patient's eligibility?

All pregnant clients are eligible for prenatal genetic counseling during pregnancy and through the end of the month containing the 90th day after the pregnancy ends.

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

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

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

Step 2. Verify service coverage under the Washington Apple Health client's benefit package. To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's [Health Care Coverage—Program Benefit Packages and Scope of Service Categories](#) web page.

Note: Patients who are not Washington Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to:
Washington Healthplanfinder
PO Box 946
Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

Are clients eligible when enrolled in agency-contracted managed care?

[Refer to WACs [182-538-060](#), [-063](#), and [-095](#)]

Yes! Clients are eligible when enrolled in Medicaid agency-contracted managed care.

- Fee for service (FFS) and Healthy Options (HO) clients may self-refer or be referred by any provider.
- Primary Care Case Management (PCCM) clients may self-refer.

Provider Requirements

Who is eligible for payment to provide prenatal genetic counseling?

[Refer to [Chapter 246-680 WAC](#) and [Chapter 246-825 WAC](#)]

Only a prenatal genetic counseling service (provider) is eligible for payment from the Medicaid agency to provide prenatal genetic counseling. The genetic counselors must be approved by the DOH Screening and Genetics Unit, and is supervised by a practicing licensed physician.

What is the responsibility of the prenatal genetic counseling provider?

[Refer to [WAC 246-825-060](#)]

- Providers must provide prenatal genetic counseling services according to policies and guidelines provided in these billing instructions and in the Health Care Authority's Core Provider Agreement.

Note: See [Medicaid Forms](#) to find HCA 09-015, the Core Provider Agreement.

- The Medicaid agency requires prenatal genetic counselors to:
 - ✓ Be able to elicit and interpret individual and family health histories.
 - ✓ Know medical aspects of problems encountered with genetic disorders.
 - ✓ Know genetic and scientific principles to understand the limitations, significance, and interpretations of specialized laboratory and clinical procedures, and to transmit and interpret genetic information to patients and families as well as referring clinicians when applicable.
 - ✓ Be skilled in the interviewing and counseling techniques required to:
 - Elicit necessary information from the patient or family to reach appropriate conclusions about genetic risk, available options, treatment and needs.

- Anticipate areas of difficulty and conflict.
- Help the families and individuals recognize and cope with their emotional and psychological needs.
- Transmit pertinent information effectively.
- Recognize situations that require referral.
- Be knowledgeable about available health care resources to make appropriate referrals.
- Facilitate community referrals as indicated.

How does a provider become enrolled to provide services?

[Refer to [WAC 182-502-0010](#)]

- To become enrolled to provide services, a provider must:
 - ✓ Obtain a Core Provider Agreement from the Medicaid agency, or the DOH Screening and Genetics Unit.
 - ✓ Send all of the following to the DOH's Screening and Genetics Unit:
 - The completed Core Provider Agreement
 - A DOH [ABMG/ABGC certification](#) or a letter verifying the genetic counselor's eligibility to sit for the upcoming examination
 - Each qualified genetic counselor's National Provider Identification number (NPI)
 - A photocopy of the supervising physician's license

Address:

Debra Lochner Doyle, MS, LCGC
Department of Health
Screening and Genetics Unit
20425 72nd Ave. S. Suite 310
Kent, WA 98032
1-253-395-6742
Email: debra.lochnerdoyle@doh.wa.gov

- The Screening and Genetics Unit staff will send a copy of the approved Provider Agreement forms to the Medicaid agency. This will serve as a written request to the Medicaid agency for authorizing the facility and provider to bill for genetic counseling.
- After receiving the approval for acceptance as a genetic counseling provider, you may bill for services provided in accordance with Medicaid agency policies for clients (up to one year from the date of service).

Coverage

What is covered?

The Medicaid agency pays for:

- One initial prenatal genetic counseling service billable for each 30 minutes up to 90 minutes.
- Face to face encounters only. (Telephonic/email encounters are not covered.)
- Two follow-up prenatal genetic counseling encounters, billable for each 30 minutes up to 90 minutes per encounter, per pregnancy (within an 11-month period).

Note: CPT code 96040 must be billed using taxonomy 170300000X for **both** the initial visit and/or the two follow-up visits. When billing the Medicaid agency, providers must use ICD-9-CM diagnosis code V26.33 (genetic counseling) to receive payment for prenatal genetic counseling services. CPT code 96040 is a time based code and each visit is limited to no more than 3 x 96040 (i.e., no more than 90 minutes per session).

Prenatal procedures beyond genetic counseling, such as laboratory or diagnostic testing, must be requested directly through the client's Primary Care Provider (PCP) or PCCM provider.

Note: The Medicaid agency does not require prior authorization for prenatal genetic counseling services and pays providers through the FFS system.

Billing and Claim Forms

What are the general billing requirements?

Providers must follow the Medicaid agency's [ProviderOne Billing and Resource Guide](#). These billing requirements include:

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

How do providers bill services specific to this program?

- Providers must bill the Medicaid agency on the CMS-1500 Claim Form for services using:
 - ✓ The genetic counselor's NPI number as the rendering provider and the taxonomy for prenatal genetic counseling, which is 170300000X.
 - ✓ The billing NPI for the approved agency with their approved taxonomy, not 170300000X.
- Medicaid agency-approved prenatal genetic clinics are asked to submit billings within 120 days of the date of service to facilitate reconciliation of Department of Health's accounts.

Completing the CMS-1500 claim form

Note: Refer to the Medicaid agency's [ProviderOne Billing and Resource Guide](#) for general instructions on completing the CMS-1500 Claim Form.

The following CMS-1500 Claim Form instructions relate to prenatal genetic counseling:

Field No.	Name	Entry								
24B	Place of Service	<p>These are the only appropriate code(s) for the Medicaid agency:</p> <table style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="text-align: center;">Code</th> <th style="text-align: center;">To Be Used For:</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">11</td> <td style="text-align: center;">Office</td> </tr> <tr> <td style="text-align: center;">21</td> <td style="text-align: center;">Inpatient hospital</td> </tr> <tr> <td style="text-align: center;">22</td> <td style="text-align: center;">Outpatient hospital</td> </tr> </tbody> </table>	Code	To Be Used For:	11	Office	21	Inpatient hospital	22	Outpatient hospital
Code	To Be Used For:									
11	Office									
21	Inpatient hospital									
22	Outpatient hospital									

Locating the fee schedule

You can view the Medicaid agency's fee schedules online: [Prenatal Genetic Counseling Fee Schedule](#).