Washington State Health Care Authority
Medicaid

Provider Notice 13-71
This provider notice rescinds and replaces PN 13-62.

PN 13-62 had errors in the table under the heading of **Limitation Changes,** two of the CPT codes for **Correction of Bunion** were incorrectly numbered. This PN replaces CPT codes 29294 and 29296 with the correct CPT codes 28294 and 28296 and are highlighted in the table below for easy reference. PN 13-71 corrects that error.

Dear Provider,

Effective for dates of service on and after October 1, 2013, unless otherwise specified within this notice, the Medicaid Program of the Health Care Authority (agency) will update:

- The *Outpatient Prospective Payment System (OPPS) and Outpatient Hospital Fee Schedule* with the following:

  ✓ Current Procedural Terminology (CPT®) codes
  ✓ Healthcare Common Procedure Coding System (HCPCS) codes
  ✓ Implement coverage changes for some outpatient procedure codes
  ✓ Update outpatient prior authorization and coverage requirements
  ✓ Program limitation changes

- The *Outpatient Hospital Services Medicaid Provider Guide* with new billing information for providing outpatient hospital services in hospital-based clinics.

Fee Schedule Changes

Added/Changed procedure codes

The Medicaid Program of the Health Care Authority (agency) will update the Outpatient Prospective Payment System (OPPS) and Outpatient Hospital Fee Schedule for procedures performed in an outpatient hospital setting as follows:

The agency will change the following procedure codes from **noncovered to covered** through Qualis Health:

CPT Code	Brief Description	Prior Authorization
0213T	Njx paravert w/us cer/thor	CPA
0214T	Njx paravert w/us cer/thor	CPA
0215T	Njx paravert w/us cer/thor	CPA
0216T	Njx paravert w/us lumb/sac	CPA
0217T	Njx paravert w/us lumb/sac	CPA
0218T	Njx paravert w/us lumb/sac	CPA
0228T	Njx tfrml eprl w/us cer/thor	CPA
0229T	Njx tfrml eprl w/us cer/thor	CPA
0230T	Njx tfrml eprl w/us lumb/sac	CPA
0231T	Njx tfrml eprl w/us lumb/sac	CPA
27096	Inject sacroiliac joint	CPA

The agency will change the following procedure code from **covered to noncovered**:

CPT Code	Short Description
54240	Penis study

Authorization Requirement Changes

The agency will change prior authorization (PA) requirements for the following procedure codes from **covered without PA to covered with PA through Qualis Health**:

CPT Code	Short Description	Prior Authorization
64490	Inj paravert f jnt c/t 1 lev	CPA
64491	Inj paravert f jnt c/t 2 lev	CPA
64492	Inj paravert f jnt c/t 3 lev	CPA
64493	Inj paravert f jnt l/s 1 lev	CPA
64494	Inj paravert f jnt l/s 2 lev	CPA
64495	Inj paravert f jnt l/s 3 lev	CPA
62310	Inject spine c/t	CPA
62311	Inject spine l/s (cd)	CPA
62318	Inject spine w/cath c/t	CPA
62319	Inject spine w/cath l/s (cd)	CPA
64479	Inj foramen epidural c/t	CPA
64480	Inj foramen epidural add-on	CPA
64483	Inj foramen epidural l/s	CPA
64484	Inj foramen epidural add-on	CPA

Legend	
PA	Prior authorization required
CPA	Contractor prior authorization required - Current vendor is Qualis Health. For more information about Qualis prior authorization on page 234 of the *Physician-Related Services/Healthcare Professional Services Medicaid Provider*

	Guide.

Limitation Changes

The agency will change the following procedure codes to **limited coverage**. See the Physician-Related Services/Health Care Professional Services Medicaid Provider Guide for more information.

CPT Code	Short Description	Coverage Limitation
28290	Correction of bunion	L
28292	Correction of bunion	L
28293	Correction of bunion	L
28294	Correction of bunion	L
28296	Correction of bunion	L
28297	Correction of bunion	L
28298	Correction of bunion	L

New billing requirements

The agency will add the following information to the "Billing and Claim Forms" section of the Outpatient Hospital Services Medicaid Provider Guide:

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

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

- If the Department of Health (DOH) has designated the clinic as a hospital-based entity, for the Medicaid agency to reimburse the clinic and the associated hospital for services provided to Medicaid-eligible clients, the hospital must submit to the agency a UB-04 or 837I claim form with the facility fees in form locator 47.
- If the DOH has not designated the clinic as a hospital-based entity, the clinic must submit to the agency a CMS-1500 or 837P claim form containing both:
  - ✓ The facility and the professional fees in field 24F.
  - ✓ The place of service (POS) 11 (office setting) in field 24B.

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

In both of the above circumstances, clinics must follow the agency's *Outpatient Hospital Services Medicaid Provider Guide* related to billing for outpatient services in an office setting.

For more details, see the "What Has Changed" table in the agency's *Outpatient Hospital Services Medicaid Provider Guide.*

Thank you.

BC-AL
Provider Publications Team
Medicaid Program
Health Care Authority

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