Washington Apple Health (Medicaid)

Physician-Related Services/Health Care Professional Services

June 11, 2022
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About this guide
This publication takes effective June 11, 2022, and supersedes earlier billing guides to this program. Unless otherwise specified, the program(s) in this guide is governed by the rules found in Chapter 182-531 WAC.

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

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

Refer also to HCA’s ProviderOne billing and resource guide for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?
To access providers alerts, go to HCA’s provider alerts webpage.

To access provider documents, go to HCA’s provider billing guides and fee schedules webpage.

Where can I download HCA forms?
To download an HCA form, see HCA’s Forms & Publications webpage. Type only the form number into the Search box (Example: 13-835).

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What has changed?
The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the Subject column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

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<td>Replaced the last sentence in section with billing information for office visits during the 6-week postpartum period, including the comprehensive postpartum visit usually done at 6 weeks postpartum, and information regarding the new After Pregnancy Coverage (APC) 12-month Medicaid extension for clients who have been recently pregnant.</td>
<td>APC program goes into effect on June 11, 2022. Visit HCA’s APC webpage for more information on APC coverage.</td>
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Definitions
This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC and WAC 182-531-0050 for a complete list of definitions for Washington Apple Health.

**Acquisition cost (AC)** – The cost of an item excluding shipping, handling, and any applicable taxes.

**Acute care** – Care provided for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent monitoring by a health care professional to maintain their health status.

**Add-on procedure(s)** – Secondary procedure(s) performed in addition to another procedure.

**Admitting diagnosis** – The medical condition responsible for a hospital admission.

**Assignment** – A process in which a doctor or supplier agrees to accept the Medicare program’s payment as payment in full, except for specific deductible and coinsurance amounts required of the patient.

**Base anesthesia units (BAU)** – Several anesthesia units assigned to an anesthesia procedure that includes the usual preoperative, intra-operative, and postoperative visits. This includes the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring by the anesthesiologist.

**Bone conduction hearing device** – A type of hearing aid that transmits sound vibrations through bones in the head. The inner ear translates the vibrations the same way a normal ear translates sound waves. These devices can be surgically implanted or worn on headbands. (WAC 182-547-0200)

**Bundled services** – Services integral to the major procedures that are included in the fee for the major procedure. Bundled services are not reimbursed separately.

**Calendar year** – January through December.

**Code of federal regulations (CFR)** – A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

**Global developmental delay (GDD)** - A significant delay in two or more developmental domains, including gross or fine motor, speech/language, cognitive, social/personal, and activities of daily living and is thought to predict a future diagnosis of ID. Such delays require accurate documentation by using norm-referenced and age-appropriate standardized measures of development administered by experienced developmental specialists, or documentation of profound delays based on age-appropriate developmental milestones are present. GDD is used to categorize children who are younger than 5.
HCPCS - See Healthcare Common Procedure Coding System.

Healthcare Common Procedure Coding System (HCPCS) - Standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT® codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician’s office.

Informed consent – Where an individual consents to a procedure after the provider who obtained a properly completed consent form has done all the following:

- Disclosed and discussed the client’s diagnosis
- Offered the client an opportunity to ask questions about the procedure and to request information in writing
- Given the client a copy of the consent form
- Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257
- Given the client oral information about all the following:
  - The client’s right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure
  - Alternatives to the procedure including potential risks, benefits, and consequences
  - The procedure itself, including potential risks, benefits, and consequences

Inpatient hospital admission – An admission to a hospital that is limited to medically necessary care based on an evaluation of the client using objective clinical indicators, assessment, monitoring, and therapeutic service required to best manage the client’s illness or injury, and that is documented in the client’s medical record.

Intellectual disability (ID) - A life-long disability diagnosed at or after age 5 when intelligence quotient (IQ) testing is considered valid and reliable. The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-V), defines patients with ID as having an IQ less than 70, onset during childhood, and dysfunction or impairment in more than two areas of adaptive behavior or systems of support.
Medical consultant – Physicians employed by HCA who are authorities on the medical aspects of the Medical Assistance program. As part of their responsibilities, HCA medical consultants:

- Serve as advisors in communicating to the medical community the scope, limit, and purpose of the program.
- Assist in the development of HCA medical policy, procedures, guidelines, and protocols.
- Evaluate the appropriateness and medical necessity of proposed or requested medical treatments in accordance with federal and state law, applicable regulations, HCA policy, and community standards of medical care.
- Serve as advisors to HCA staff, helping them to relate medical practice realities to activities such as claims processing, legislative requests, cost containment, and utilization management.
- Serve as liaisons between HCA and various professional provider groups, health care systems (such as HMOs), and other state agencies.
- Serve as expert medical and program policy witnesses for HCA at fair hearings.

Newborn or neonate or neonatal – A person younger than 29 days old.

Noncovered service or charge – A service or charge not reimbursed by HCA.

Professional component – The part of a procedure or service that relies on the provider’s professional skill or training, or the part of that reimbursement that recognizes the provider’s cognitive skill.

Relative value unit (RVU) – A unit that is based on the resources required to perform an individual service. RBRVS RVUs are comprised of three components – physician work, practice expense, and malpractice expense.

Resource based relative value scale (RBRVS) – A scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved.

RBRVS maximum allowable amount – The Medicare Fee Schedule relative value unit, multiplied by the statewide geographic practice cost index, times the applicable conversion factor.

Revised code of Washington (RCW) – Washington State laws.

Significant delay – Performance two standard deviations or more below the mean on age-appropriate, standardized, normal-referenced testing.

Technical component – The part of a procedure or service that relates to the equipment set-up and technician’s time, or the part of the procedure and service reimbursement that recognizes the equipment cost and technician time.

Year – The period starting 365 days before the date of service.
**Introduction**

**Acquisition cost**
Drugs with an acquisition cost (AC) indicator in the fee schedule with billed charges of $1,100.00 or greater, or supplies with billed charges of $50.00 or greater, require a manufacturer’s invoice to be paid. Attach the invoice to the claim, and if necessary, note the quantity given to the client in the Claim Note section of the claim. **DO NOT** attach an invoice to the claim for procedure codes with an AC indicator in the fee schedule for drugs with billed charges under $1,100.00, or supplies with billed charges under $50.00, unless requested by HCA.

**Note:** Bill HCA for one unit of service only when billing for drugs with an AC indicator.

**Add-on codes**
HCA will not pay for procedure codes defined in the current CPT® manual as “add-on codes” when these codes are billed alone or with an invalid primary procedure code.

**Note:** HCA has instituted claims edits requiring that “add-on” procedure codes be billed with a correct primary procedure.

**By report**
Services with a by report (BR) indicator in the fee schedule with billed charges of $1,100.00 or greater require a detailed report to be paid. Attach the report to the claim. For billed charges under $1,100.00, **DO NOT** attach a report to the claim for services with a BR indicator in the fee schedule, unless requested by HCA. HCA pays for medically necessary services on the basis of usual and customary charges or the maximum allowable fee established by HCA, whichever is lower according to WAC 182-502-0100.

**Codes for unlisted procedures**
(CPT® code XXX99)
Providers must bill using the appropriate procedure code. HCA does not pay for procedures when they are judged to be less-than-effective (i.e., an experimental procedure), as reported in peer-reviewed literature (see WAC 182-501-0165). If providers bill for a procedure using a code for an unlisted procedure, it is the provider’s responsibility to know whether the procedure is effective, safe, and evidence-based. HCA requires this for all its programs, as outlined in WAC 182-501-0050. If a provider does not verify HCA’s coverage policy before performing a procedure, HCA may not pay for the procedure.

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Conversion factors
Conversion factors are multiplied by the relative value units (RVUs) to establish the rates in HCA’s Physician-related services/health care professionals fee schedule.

Diagnosis codes
HCA requires valid and complete ICD diagnosis codes. When billing HCA, use the highest level of specificity (6th or 7th digits when applicable) or the services will be denied.

HCA does not cover the following diagnosis codes when billed as the primary diagnosis:
- V00-Y99 codes (Supplementary Classification)
- Most codes in Z00-Z99 (factors influencing health status and contact with health services)

HCA reimburses providers for only those covered procedure codes and diagnosis codes that are within their scope of practice.

Discontinued codes
HCA follows Medicare and does not allow providers a 90-day grace period to use discontinued CPT® and HCPCS codes. Use of discontinued codes to bill services provided after the date that the codes are discontinued will cause claims to be denied.

National correct coding initiative
HCA continues to follow the National Correct Coding Initiative (NCCI) policy. The Centers for Medicare and Medicaid Services (CMS) created this policy to promote national correct coding methods. NCCI assists HCA to control improper coding that may lead to inappropriate payment. HCA bases coding policies on the following:
- National and local policies and edits
- Coding guidelines developed by national professional societies
- The analysis and review of standard medical and surgical practices
- Review of current coding practices

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Procedure code selection must be consistent with the current CPT® guidelines, introduction, and instructions on how to use the CPT coding book. Providers must comply with the coding guidelines that are within each section (e.g., E/M services, radiology, etc.) of the current CPT book.

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

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

HCA may perform a post-pay review on any claim to ensure compliance with NCCI. NCCI rules are enforced by the ProviderOne payment system.

**Procedure codes**

HCA uses the following types of procedure codes within this billing guide:

- Current Procedure Terminology (CPT)
- Level II Healthcare Common Procedure Coding System (HCPCS)
- Current Dental Terminology (CDT)

Procedures performed must match the description and guidelines from the most current CPT or HCPCS manual for all HCA-covered services. Due to copyright restrictions, HCA publishes only the official short CPT descriptions. To view the full CPT description, refer to a current CPT manual.

**Social determinants of health (SDOH)**

HCA encourages health care providers and coding professionals to use ICD diagnosis SDOH Z codes to enable providers and payers to:

- Identify and understand the SDOH risks for individuals and populations.
- Identify interventions and strategies to address these risks.
- Support quality improvement initiatives.
- Monitor the SDOH status of their patient population.
- Understand the relationship between SDOH domains (e.g., food insecurity, housing instability, transportation insecurity, financial insecurity, lack of technology and devices for telehealth, etc.) and health care costs.

Centers for Medicare and Medicaid Services (CMS) guidance for health care providers and coding professionals specifies that:
• ICD Z encounter reason codes (Z55-Z65) are available to document SDOH data.
• SDOH Z codes are for use in any healthcare setting.
• SDOH Z codes must be accompanied by a corresponding procedure code to describe any procedure performed.
• SDOH Z codes cannot be the primary diagnosis.
• SDOH Z codes may be documented in the problem or diagnosis list, patient or client history, or provider notes.

CMS guidance on the use of SDOH ICD diagnosis codes can be found on CMS’s website or on the Using Z Codes infographic.

CMS encourages the use of the ICD browser tool to search for ICD codes and information on code usage. The ICD-10-CM browser tool is available on the Centers for Disease Control and Prevention’s website.
Provider Eligibility

Who may provide and bill for physician-related services?
The following health care professionals may request enrollment with HCA to provide and bill for physician-related and health care professional services provided to eligible clients:

- Advanced Registered Nurse Practitioners (ARNPs)
- Federally Qualified Health Centers (FQHCs)
- Genetic Counselors
- Health Departments
- Hospitals currently licensed by the Department of Health (DOH)
- Independent (outside) laboratories CLIA-certified to perform tests. See WAC 182-531-0800
- Licensed marriage and family therapists, only as provided in WAC 182-531-1400
- Licensed mental health counselors, only as provided in WAC 182-531-1400
- Licensed radiology facilities
- Licensed social workers, only as provided in WAC 182-531-1400 and 182-531-1600
- Medicare-certified Ambulatory Surgery Centers (ASCs)
- Medicare-certified Rural Health Clinics (RHCs)
- Naturopathic physicians (see Can naturopathic physicians provide and bill for physician-related services?)
- Providers who have a signed agreement with HCA to provide screening services to eligible persons in the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) program
- Registered Nurse First Assistants (RNFAs)
• Persons currently licensed by the State of Washington DOH to practice any of the following:
  o Dentistry
  o Medicine and osteopathy
  o Nursing
  o Optometry
  o Podiatry
  o Psychiatry
  o Psychology

Can naturopathic physicians provide and bill for physician-related services?
Yes. Effective for dates of service on and after January 1, 2014, HCA added naturopathic physicians (taxonomy 175F00000X) to the list of professionals who can provide and bill for physician-related services. HCA recognizes a naturopathic physician’s scope of practice in accordance with RCW 18.36A.040.

Licensure
Naturopathic physicians with an active Washington State license may request enrollment with HCA. If a naturopathic physician is practicing naturopathic childbirth, HCA requires the naturopathic physician to have a separate active Washington State midwifery license.

Limitations
• HCA does not pay for:
  o Nonsurgical cosmetic procedures.
  o Prescription or nonprescription botanical, herbal, or homeopathic medicine.

• Manual manipulation - HCA applies the limitations for manual manipulation (mechanotherapy). See manipulative therapy (CPT® codes 98925-98929).
• Malignancies – Treatment of a client with a malignancy must not be done independently by a naturopathic physician.
• Controlled substance prescriptions – As authorized under WAC 246-836-211, these are limited to testosterone and codeine-containing substances in Schedules III-V.
• Billing a client - A Medicaid client must not be charged for a covered over-the-counter (nonprescription) drug which is dispensed in the office. Covered over-the-counter drugs must be prescribed and the prescription filled by a pharmacy. Refer to HCA’s Prescription Drug Program Billing Guide for complete instructions.

• Injectable drugs – Physician-administered injectable drugs are subject to prior authorization requirements as described in HCA’s Professional administered drugs fee schedule.

Can substitute physicians (locum tenens) provide and bill for physician-related services?
Yes. Physicians may bill under certain circumstances for services provided on a temporary basis (i.e., locum tenens) to their patients by another physician [42 U.S.C. Chapter 7, Subchapter XIX, Sec 1396a (32)(C)].

The physician’s claim must identify the substituting physician providing the temporary services. Complete the claim as follows:

• Enter the provider NPI and taxonomy of the locum tenens physician who performed the substitute services in the Rendering (Performing) Provider section of the electronic claim.

• Any provider that will perform as a locum tenens provider that will treat a Medicaid client must be enrolled as a Washington Apple Health (Medicaid) provider for claims to be paid. For enrollment information, go to the Enroll as a provider webpage.

• Enter the billing provider information in the usual manner.

• Use modifier Q6 when billing.

Documentation in the patient’s record must show that in the case of:

• An informal reciprocal arrangement, billing for temporary services was limited to a period of 14 continuous days, with at least one day elapsing between 14-day periods.

• A locum tenens arrangement involving per diem or other fee-for-time compensation, billing for temporary services was limited to a period of 90 continuous days, with at least 30 days elapsing between 90-day periods.

Resident Physicians
A resident cannot bill HCA for services they provide to a client. If a resident physician prescribes, orders, or refers, the resident physician must be enrolled with HCA as a nonbilling provider according to WAC 182-502-0006.

If a resident is involved in any part of the patient care or treatment, the billing provider must use a GC modifier with the appropriate HCPCS or CPT® code when billing. The modifier is for tracking purposes only and does not affect payment.

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Which health care professionals does HCA not enroll?
HCA does not enroll licensed or unlicensed health care practitioners not specifically listed in WAC 182-502-0002, including but not limited to:

- Acupuncturists
- Christian Science practitioners or theological healers
- Counselors (i.e., M.A. and M.S.N.), except as provided in WAC 182-531-1400
- Herbalists
- Homeopathists
- Massage therapists as licensed by the Washington State Department of Health (DOH)
- Sanipractors
- Social workers, except those who have a master's degree in social work (MSW) and:
  - Are employed by an FQHC.
  - Who have received prior authorization from HCA to evaluate a client for bariatric surgery.
  - As provided in WAC 182-531-1400.
- Any other licensed or unlicensed practitioners not otherwise specifically provided for in WAC 182-502-0010
- Any other licensed practitioners providing services that the practitioner is not licensed or trained to provide

HCA pays practitioners listed above for physician-related and health care professional services only if those services are mandated by, and provided to, clients who are eligible for one of the following:

- The EPSDT program
- A Medicaid program for qualified Medicare beneficiaries (QMB)
- A waiver program
**Does HCA pay for out-of-state hospital admissions?**
(Does not include border hospitals)

HCA pays for emergency care at an out-of-state hospital, not including hospitals in bordering cities, only for Medicaid and CHIP clients on an eligible program. See WAC 182-501-0175 for recognized bordering cities.

HCA requires prior authorization (PA) for elective, nonemergency care and approves these services only when both of the following apply:

- The client is on an eligible program (e.g., the Categorically Needy Program).
- The service is medically necessary and is unavailable in the State of Washington.

Providers requesting elective, out-of-state care must send a completed Out-of-State Medical Services Request form, 13-787, with additional required documentation attached to HCA Medical Request Coordinator. (See HCA’s Billers, providers, and partners webpage. See also Where can I download HCA forms?)

Providers must obtain prior authorization from the appropriate Behavioral Health and Service Integration Administration (BHSIA) designee for out-of-state psychiatric hospital admissions for all Washington Apple Health (Medicaid) clients. Neither HCA nor the BHSIA designee pays for inpatient services for non-Medicaid clients if those services are provided outside of the state of Washington. An exception is clients who are qualified for the medical care services (MCS) program. For these clients, HCA and the BHSIA designee pays for inpatient psychiatric services provided in bordering cities and critical border hospitals. All claims for admissions to out-of-state hospitals are paid as voluntary legal status as the Involuntary Treatment Act applies only within the borders of Washington State.
Client Eligibility

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

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

How do I verify a client’s eligibility?

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

Verifying eligibility is a two-step process:

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

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

Step 2. **Verify service coverage under the Apple Health client’s benefit package.** To determine if the requested service is a covered benefit under the Apple Health client’s benefit package, see HCA’s Program benefit packages and scope of services webpage.
**Note:** Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- By visiting the Washington Healthplanfinder’s website at: [www.wahealthplanfinder.org](http://www.wahealthplanfinder.org)

- By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)

- By mailing an 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](http://www.wahealthplanfinder.org) or call the Customer Support Center.

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

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

All medical services covered under an HCA-contracted MCO must be obtained through the MCO’s contracted network. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

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

**Send claims to the client’s MCO for payment.** Call the client’s MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.
Note:  HCA continues to pay for the following through fee-for-service (FFS):

- Professional fees for dental procedures using CDT® codes
- Professional fees using CPT® codes only when the provider’s taxonomy starts with 12

See the Dental-Related Services Billing Guide or the Physician-Related Services/Health Care Professional Services Billing Guide, or both, for how to bill professional fees.

Managed care enrollment
Most Apple Health (Medicaid) clients are enrolled in HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may still start their first month of MC eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination. Providers must check eligibility to determine enrollment for the month of service.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care.

Checking eligibility
- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder’s Get Help Enrolling webpage.
- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO’s requirements and be compliant with the MCO’s policies.
Clients’ options to change plans
Clients have a variety of options to change their plan:

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

- **Available to all Apple Health clients:**
  - Visit the ProviderOne Client Portal website:
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.
  - Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic “Enroll/Change Health Plans.”

For online information, direct clients to HCA’s Apple Health Managed Care webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services
Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the fee-for-service (FFS) Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an HCA-contracted managed care plan are automatically enrolled in a BHSO, except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS Medicaid program will reimburse providers for the covered services. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.
Integrated managed care (IMC)
Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

For full details on integrated managed care, see HCA’s Apple Health Managed Care webpage and scroll down to “Changes to Apple Health managed care.”

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

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

These clients are identified in ProviderOne as “Coordinated Care Healthy Options Foster Care.”

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

Fee-for-service Apple Health Foster Care
Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA’s Mental Health Services Billing Guide, under How do providers identify the correct payer?
**American Indian/Alaska Native (AI/AN) Clients**

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) American Indian/Alaska Native webpage.

**What if a client has third-party liability (TPL)?**

If the client has third-party liability (TPL) coverage (excluding Medicare), prior authorization must be obtained before providing any service requiring prior authorization. For more information on TPL, refer to HCA’s ProviderOne Billing and Resource Guide.
**Coverage - General**

**What is covered?**

HCA covers health care services, equipment, and supplies listed in this guide, according to HCA rules and subject to the limitations and requirements in this guide, when they are:

- Within the scope of an eligible client’s medical assistance program. Refer to WAC 182-501 0060 and 182-501 0065.
- Medically necessary as defined in WAC 182-500 0070.

HCA evaluates a request for a service that is in a covered category under the provisions of WAC 182-501 0165.

HCA evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions as described in WAC 182-501 0169.

HCA covers the following physician-related services and health care professional services, subject to the conditions listed in this billing guide:

- Allergen immunotherapy services
- Anesthesia services
- Cosmetic, reconstructive, or plastic surgery, and related services and supplies to correct physiological defects from birth, illness, or physical trauma, or for mastectomy reconstruction for post cancer treatment
- Dialysis and end stage renal disease services (see HCA’s Kidney Center Services Billing Guide)
- Early and periodic screening, diagnosis, and treatment (EPSDT) services (see HCA’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Billing Guide)
- Emergency physician services
- ENT (ear, nose, and throat) related services
- Foot care and podiatry services
- Habilitative services (see Habilitative services)
- Hospital inpatient services (see HCA’s Inpatient Hospital Services Billing Guide)
- Obstetric care, delivery, and newborn care services (see Obstetric Care and Delivery)
- Office visits
- Osteopathic treatment services
- Pathology and laboratory services

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Physiatry and other rehabilitation services
Primary care services
Psychiatric services, provided by a psychiatrist (see HCA’s Mental Health Services Billing Guide)
Psychotherapy services (see HCA’s Mental Health Services Billing Guide)
Pulmonary and respiratory services
Radiology services
Reproductive health services (see HCA’s Family Planning Billing Guide)
Surgical services
Vision-related services (see also HCA’s Vision Hardware for Clients 20 Years of Age and Younger Billing Guide)
Other outpatient physician services

HCA covers physical examinations for medical assistance clients only when the physical examination is one or more of the following:

- A screening exam covered by the EPSDT program
- An annual exam for clients of the Developmental Disabilities Administration
- A screening pap smear performed according to nationally recognized clinical guidelines
- Mammogram performed according to nationally recognized clinical guidelines
- Prostate exam performed according to nationally recognized clinical guidelines

By providing covered services to a client eligible for a medical assistance program, a provider who has signed an agreement with HCA accepts HCA’s rules and fees as outlined in the agreement, which includes federal and state law and regulations, billing guides, and HCA issuances.

**Does HCA cover nonemergency services provided out-of-state?**

*(WAC 182-501-0182)*

HCA covers nonemergency services provided out-of-state with prior authorization as described in WAC 182-501-0182. A designated bordering city is considered the same as an in-state city for the purposes of health care coverage (see WAC 182-501-0175).
What services are noncovered?
(WAC 182-501-0070)

General information
Procedures that are noncovered are noted with (NC) in the Nonfacility Setting (NFS) and Facility Setting (FS) columns in the fee schedule.

HCA reviews requests for noncovered health care services according to WAC 182-501-0160 as an exception to rule (ETR). To request a noncovered service using the ETR process, send a completed typed General Authorization form (HCA13-835) and a Fax/Written Request Basic Information form, 13-756, to HCA. (See HCA’s Billers, providers, and partners webpage. See also Where can I download HCA forms?)

Refer to HCA’s ProviderOne Billing and Resource Guide for information regarding noncovered services and billing an HCA client who is on a fee-for-service program.

The following are examples of administrative costs and/or services not covered separately by HCA:

- Missed or canceled appointments
- Mileage
- Take-home drugs
- Educational supplies or services
- Copying expenses, reports, client charts, insurance forms
- Service charges/delinquent payment fees
- Telephoning for prescription refills
- Other areas as specified in this fee schedule
- After-hours charges for services during regularly scheduled work hours

Noncovered physician-related and health care professional services
(WAC 182-531-0150)

HCA does not cover the following:

- Acupuncture, massage, or massage therapy
- Any service specifically excluded by statute
- Care, testing, or treatment of infertility, frigidity, or impotency. This includes procedures for donor ovum, sperm, womb, and reversal of vasectomy or tubal ligation
- Cosmetic treatment or surgery, except for medically necessary reconstructive surgery to correct defects attributable to trauma, birth defect, or illness

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• Experimental or investigational services, procedures, treatments, devices, drugs, or application of associated services, except when the individual factors of an individual client’s condition justify a determination of medical necessity under WAC 182-501 0165

• Hair transplantation

• Marital counseling or sex therapy

• More costly services when HCA determines that less costly, equally effective services are available

• Vision-related services as follows:
  o Services for cosmetic purposes only
  o Group vision screening for eyeglasses
  o Refractive surgery of any type that changes the eye’s refractive error (refractive surgery is intended to reduce or eliminate the need for eyeglass or contact lens correction, and does not include intraocular lens implantation following cataract surgery)

• Payment for body parts, including organs, tissues, bones, and blood, except as allowed in this guide

• Physician-supplied medication, except those drugs administered by the physician in the physician’s office

• Physical examinations, routine checkups, and other preventive services, except as provided in this guide

• Foot care to treat chronic acquired conditions of the foot such as, but not limited to:
  o Treatment of mycotic disease tinea pedis
  o Removal of warts, corns, or calluses
  o Trimming of nails and other regular hygiene care
  o Treatment of flat feet
  o Treatment of high arches (cavus foot)
  o Onychomycosis
  o Bunions and tailor’s bunion (hallux valgus)
  o Hallux malleus
  o Equinus deformity of foot, acquired
  o Cavovarus deformity, acquired
  o Adult acquired flatfoot (metatarsus adductus or pes planus
  o Hallux limitus
• Except as provided in this guide, weight reduction and control services, procedures, treatments, devices, drugs, products, gym memberships, equipment for the purpose of weight reduction, or the application of associated services

• Nonmedical equipment

• Nonemergency admissions and associated services to out-of-state hospitals or noncontracted hospitals in contract areas

• Vaccines recommended or required for the sole purpose of international travel. This does not include routine vaccines administered according to current Centers for Disease Control (CDC) advisory committee on immunization practices (ACIP) immunization schedule for adults and children in the United States.

**Note:** HCA covers excluded services listed in this section if those services are mandated under and provided to a client who is eligible for one of the following:

- The EPSDT program

- A Medicaid program for qualified Medicare beneficiaries (QMBs)

- A waiver program
Medical Policy Updates

Policy updates effective 4/1/2021
• Based upon review of evidence provided by the Health Technology Clinical Committee (HTCC), HCA does not consider stem cell therapy for musculoskeletal conditions to be medically necessary.
• Based upon review of evidence provided by the HTCC, HCA considers cognitive behavioral therapy to be medically necessary for treatment of subjective tinnitus. See Tinnitus for more details.

Policy updates effective 9/1/2020
• Based upon review of evidence provided by the HTCC, HCA does not consider bronchial thermoplasty for asthma to be medically necessary. See Bronchial thermoplasty for asthma.
• Based upon review of evidence provided by the HTCC, HCA does not consider autologous blood/platelet-rich plasma injections to be medically necessary. See Autologous blood/platelet-rich plasma injections.
Billable Services Provided by Resident Physicians

**Billable services provided by resident physicians**
HCA follows Medicare’s rules for teaching physicians and residents. HCA also allows a teaching physician to work with a resident physician providing services outside of the sponsoring teaching facility (such as private practice).

The teaching physician-to-resident ratio is 1:1.

The resident must have completed a minimum of six months in a Graduate Medical Education (GME) approved residency program and be assigned to a physician outside the sponsoring teaching facility. The teaching physician can schedule a regular client load and allow the resident-in-training to examine patients independently under the teaching physician’s supervision.

The teaching physician is personally responsible for the care of each client and must be always on-site. The teaching physician can bill for routine or low-level services provided by the resident physician after the teaching physician reviews and countersigns the resident physician’s note, assuring that the resident has written a note appropriate to the service provided.

**Billing requirements for teaching physicians**
The primary physician must be identified on all claims as the teaching physician.

- Use the *GC modifier* when billing for a service performed in part by a resident physician under the direction of a teaching physician.
- Use the *GE modifier* if the teaching physician is not physically present.

**General documentation guidelines**
The teaching physician and the resident physician must document physician services in the patient’s medical record. The documentation must be dated and contain a legible signature or identity completed using one of these methods:

- Dictated and transcribed
- Typed
- Hand-written
- Computer-generated
Billing codes
The following codes are considered routine or low level under the primary care exception:

- 99381
- 99382
- 99383
- 99384
- 99385 (for ages 18-20 only)
- 99391
- 99392
- 99393
- 99394
- 99395 (for ages 18-20 only)
- 99202
- 99203
- 99211
- 99212
- 99213

Claims must comply with requirements in the General documentation guidelines and “Documentation guidelines for evaluation and management services” found on the Medicare learning network® webpage.

Medical students
A medical student is a person who is not an intern or resident and who is not in an approved Graduate Medical Education (GME) program. The medical student must be in one of the following programs: Liaison Committee on Medical Education (LCME), AOA Commission on Osteopathic College Accreditation (COCA), or Association of Accredited Naturopathic Medical Colleges (AANMC).

HCA allows medical students to review systems and past person, family, and social information when done as a part of an Evaluation and Management (E/M) service. The teaching physician or resident must be physically present during all portions of the E/M service.

The teaching physician must personally perform the physical exam and medical decision-making activities of the billed E/M service. Medical students can document their own findings and findings of the teaching physician. The teaching physician can review and verify a student’s review without redoing or re-documenting it.
Evaluation and Management

Evaluation and management documentation and billing
The evaluation and management (E/M) service is based on key components listed in the CPT® manual. For E/M CPT® codes 99202-99205 and 99211-99215 providers must determine the appropriate level of service based on the level of medical decision-making or total time for E/M services performed on the date of the encounter per 2021 coding guidelines. For all other E/M services providers must use either the 1995 or 1997 "Documentation guidelines for evaluation and management services" to determine the appropriate level of service. See the Medicare learning network® webpage.

Once the licensed practitioner chooses the appropriate guidelines, the licensed practitioner must use the same guidelines for the entire visit. Chart notes must contain documentation that justifies the level of service billed.

Documentation must:
- Be legible to be considered valid.
- Support the level of service billed.
- Support medical necessity for the service billed.
- Be authenticated by provider performing service with date and time.

A provider must follow the CPT coding guidelines and their documentation must support the E/M level billed. While some of the text of CPT has been repeated in this billing guide, providers should refer to the CPT book for the complete descriptors for E/M services and instructions for selecting a level of service.

Advance directives/physician orders for life-sustaining treatment
HCA covers for counseling and care planning services for end-of-life treatment when conducted by a licensed health care provider.

End of life service should be evidence-based and use tested guidelines and protocols. This service may include assisting the client or the client’s authorized representative to understand and complete advance directives, or physician orders, or both, for life-sustaining treatment (POLST) form.
HCA pays separately for this counseling and planning in addition to the appropriate E/M code. Bill for this service using one of the following procedure codes, as appropriate:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Short Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>S0257</td>
<td>End of life counseling</td>
</tr>
<tr>
<td>CPT® 99497</td>
<td>Advncd care plan 30 min</td>
</tr>
<tr>
<td>CPT® 99498</td>
<td>Advncd care plan addl 30 min</td>
</tr>
</tbody>
</table>

This service may include:
- Assessing client readiness.
- Educating the client on their health status.
- Helping the client choose a suitable surrogate and involving the designated surrogate in the conversation if appropriate.
- Discussing and clarifying values (e.g., “If you were in X situation, what would be most important to you?”).
- Documenting the advance care plan with an advance directive and POLST if appropriate.

The Washington State Medical Association (WSMA) coordinates the Washington POLST Task Force with the Washington State Department of Health. The WSMA offers up-to-date POLST forms, frequently asked questions, and provides resources to providers and patients about the legality of and operational uses of POLST.

For further information, see the National POLST website and the Washington State Medical Association’s website.

**Telephone services**

HCA pays for telephone services when used by a physician to report and bill for episodes of care initiated by an established patient (i.e., someone who has received a face-to-face service from you or another physician of the same specialty in your group in the past three years) or by the patient’s guardian. Report and bill for telephone services using the following CPT® codes:

- **CPT® code 99441** - Telephone evaluation and management (E/M) service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion.
- **CPT® code 99442** - Same as CPT® code 99441 except call includes 11–20 minutes of medical discussion.

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• CPT® code 99443 - Same as CPT® code 99441 except call includes 21–30 minutes of medical discussion.

Additional information when billing with these codes for telephone services:

• Telephone services that are billed with CPT® codes 99441, 99442 or 99443 must be personally performed by the physician.

• If the telephone service relates to and takes place within the postoperative period of a procedure provided by the physician, the service is considered part of the procedure and should not be billed separately.

• Do not bill for telephone services when the same services are billed as care plan oversight or anticoagulation management (CPT® codes 99339-99340, 99374-99380 or 99363-99364).

• When a telephone service refers to an E/M service performed and billed by the physician within the previous seven days, it is not separately billable, regardless of whether it is the result of patient-initiated or physician-requested follow-up.

• Do not bill this service if the service results in the patient being seen within 24 hours or the next available appointment.

**Partnership Access Line**
The Partnership Access Line (PAL) is a telephone-based child mental health consultation system for Washington State. PAL employs child psychiatrists, child psychologists, and social workers affiliated with Seattle Children’s Hospital to deliver its consultation services.

The PAL team is available to any primary care provider throughout Washington State. Washington’s primary care providers are encouraged to call the PAL toll free number 866-599-7257 as often as they would like. PAL provides rapid consultation responses during business hours (Monday-Friday, 8:00 a.m. to 5:00 p.m.) for any type of child mental health issue that arises with any child.

**Office and other outpatient services**

**Office or other outpatient visit limits**
HCA allows one office or other outpatient visit per noninstitutionalized client, per day for an individual provider (except for call-backs to the emergency room). Refer to WAC 182-531-0500. Certain procedures are included in the office call and cannot be billed separately.

**Example:** HCA does not pay separately for ventilation management (CPT® codes 94002-94004, 94660, and 94662) when billed in addition to an Evaluation and Management (E/M) service, even if the E/M service is billed with modifier 25.
New patient visits
HCA pays one new patient visit, per client, per provider or group practice in a three-year period.

**Note:** A new patient is one who has not received any professional services from the physician (or qualified health care professional) or another physician (or qualified health care professional) of the exact same subspecialty who belongs to the same group practice, within the past three years.

An established patient has received professional services from the physician (or qualified health care professional) or another physician (or qualified health care professional) in the same group and the same specialty within the prior three years.

Established patient visits
(CPT® code 99211)
When billing HCA for CPT® code 99211, at a minimum, the client’s record must be noted with the reason for the visit and the outcome of the visit. The note must be signed and dated (with title) by the qualified health care professional who provided the service.

Nursing facility services
HCA allows two physician visits per month for a client residing in a nursing facility or an intermediate care facility. Nursing facility discharges (CPT® codes 99315 and 99316) are not included in the two-visit limitation. HCA pays for one nursing facility discharge per client, per stay.

**Note:** The two physician visits per month limit does not apply to pulmonologists or their designee that are seeing clients who are ventilator and/or tracheostomy dependent and residing in the respiratory care unit of a designated ventilator weaning nursing facility. For these clients, the physician visit limit is five per month.
Pre-operative visit before a client receives a dental service under anesthesia

HCA allows one pre-operative evaluation and management (E/M) visit by the primary care physician, per client, to provide medical clearance before the client receives the dental service under anesthesia. Bill using the appropriate dental diagnosis codes as the primary diagnosis along with the appropriate pre-op diagnosis codes as the secondary diagnosis.

Submit claims to the appropriate medical insurer (fee-for-service or the managed care organization).

Physical examination - clients of the DSHS’ Developmental Disabilities Administration

HCA allows one physical examination per client, per 12 months for clients of DSHS’ Developmental Disabilities Administration (DDA) as identified in ProviderOne. Use HCPCS code T1023 with modifier HI and ICD diagnosis code Z13.40, Z13.41, Z13.42, Z13.49, or Z13.89 to bill for an annual examination.

Office visit related to acamprosate, naltrexone, buprenorphine/naloxone

HCA will cover medication for opioid use disorder products for the treatment of substance use disorders as an office-based therapy. The pharmacy will continue to require prior authorization for some medications. For coverage details, see the Apple Health (Medicaid) drug coverage criteria webpage.

HCA pays for office visits related to acamprosate (Campral®), naltrexone (ReVia®), naltrexone (Vivitrol®) or buprenorphine.

**Buprenorphine/naloxone (Suboxone®):** HCA pays for office visits related to buprenorphine/naloxone (Suboxone®). Clients enrolled in an HCA-contracted managed care organization (MCO) must contact their MCO for information regarding their coverage.

Acamprosate and oral naltrexone when prescribed for medication for opioid use disorder are covered without prior authorization.

**Coverage for naltrexone injections**

HCA will cover naltrexone (Vivitrol®) injections for clients who have a diagnosis of moderate to severe opioid or alcohol use disorder. See the Apple Health (Medicaid) drug coverage criteria webpage.
Aged, Blind, or Disabled (ABD) Evaluation Services
Effective for claims with dates of service on and after November 1, 2015, providers must be enrolled with ProviderOne to claim and receive payment for ABD Evaluation Services. See the Department of Social and Health Services’ (DSHS) Medical evaluation and diagnostic procedures webpage.

Medical evidence reimbursements are solely for the cost of obtaining medical evidence of an impairment that limits work activity, and for the purposes of an ABD disability determination. See the DSHS Medical evidence requirements and reimbursements webpage.

For information regarding reimbursement for psychological evaluations and testing, see the DSHS Community Services Division (CSD) Mental incapacity evaluation services webpage.

Behavior change intervention - tobacco/nicotine cessation
Tobacco/nicotine cessation, which can include free counseling, nicotine replacement therapy (NRT), and prescription drugs, represents a major advancement in public health for Washington State. Below is a brief overview of the way the benefit works and the services available for clients in HCA fee-for-service program. Clients enrolled in an HCA-contracted managed care organization (MCO) must contact their MCO for information regarding the tobacco/nicotine cessation benefit.

Services available
The following services are available:

- Referral to the toll-free Washington State Quitline for telephone counseling and follow-up support calls for clients age 13 and older. When a client is receiving counseling from the Washington State Quitline, the Washington State Quitline may recommend a tobacco/nicotine cessation prescription for the client.

- Nicotine replacement products and prescription drugs to promote tobacco/nicotine cessation with a prescription, prescribed by a provider with prescriptive authority, when submitted to a pharmacy.
Washington State Quitline

800-QUIT-NOW (1-800-784-8669) English
855-DEJELO-YA (1-855-335-3569) Spanish
1-877-777-6534 TTY Line & Video Relay
www.quitline.com English and Spanish
Text “Ready” to 200-400 English

Client eligibility
- All Washington Apple Health (Medicaid) clients are eligible for tobacco/nicotine cessation services through the Washington State Quitline.
- Clients eligible for the Alien Emergency Medical (AEM) program or enrolled in the Family Planning Only – Pregnancy Related program or Family Planning Only program (formerly referred to as TAKE CHARGE) are eligible for some of the above-mentioned services; however, these clients are not eligible for prescription drugs and tobacco/nicotine cessation services provided by their primary care provider. The Washington State Department of Health (DOH) provides tobacco/nicotine cessation services for clients enrolled in the Family Planning Only-Pregnancy-Related program (formally referred to as TAKE CHARGE) as well as uninsured/underinsured Washington residents.

Payment for a tobacco/nicotine cessation referral
HCA will pay a provider for a tobacco/nicotine cessation referral (T1016) when all the following are met:
- The client is eligible.
- The referral is billed with an appropriate ICD diagnosis.
This service may be provided in combination with another service or evaluation management office visit within the provider’s scope of practice.

Tobacco/nicotine cessation referral for an evaluation for a tobacco/nicotine cessation prescription
HCA pays the prescriber for a tobacco/nicotine cessation referral (T1016) for an evaluation for a tobacco/nicotine cessation prescription when all the following are met:
- The client is eligible.
- The referral is billed with the appropriate ICD diagnosis codes.

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• An evaluation is done for a tobacco/nicotine cessation prescription, with or without the client present.
• The referral is not billed in combination with an evaluation and management office visit.

Additional information:
• Call HCA toll-free at 800-562-3022.
• Visit Tobacco Use and Dependence Treatment

Tobacco/nicotine cessation for pregnant clients
HCA pays for face-to-face counseling for tobacco/nicotine cessation for pregnant clients. Tobacco/nicotine cessation counseling complements the use of prescription and nonprescription tobacco/nicotine cessation products. These products are also covered by Medicaid.

Pregnant clients can receive provider-prescribed nicotine replacement therapy directly from a pharmacy. Prescription medications for tobacco/nicotine cessation may be obtained without going through the Washington State Quitline.

Face-to-face visit requirements for pregnant clients
Providers must document the client’s pregnancy status and estimated date of confinement in the medical record. Additionally, the provider must establish and document the client’s motivation to quit tobacco/nicotine use and provide an appropriate intervention based on client’s readiness to change.

Provider types for providing face-to-face tobacco/nicotine cessation counseling for pregnant clients
Office-based practitioners (physicians, advanced registered nurse practitioners (ARNPs), physician-assistants-certified (PA-Cs), and naturopathic physicians), psychologists, pharmacists, certified nurse-midwives (CNM), and licensed midwives (LM).

Benefit limitations for providing face-to-face tobacco/nicotine cessation counseling for pregnant clients
A cessation counseling attempt occurs when a qualified physician or other Medicaid-recognized practitioner determines that a beneficiary meets the eligibility requirements and initiates treatment with a cessation counseling attempt.

Face-to-face cessation counseling attempts are defined and limited as follows:
• HCA allows two tobacco/nicotine cessation counseling attempts every 12 months.
• An attempt is defined as up to four tobacco/nicotine cessation counseling sessions.

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• HCA covers one face-to-face tobacco/nicotine cessation counseling session per client, per day.

This limit applies to the client regardless of the number of providers a client may see for tobacco cessation. Providers can request a limitation extension by submitting a request to HCA.

**Documentation requirements**

Keep patient record information on file for each Medicaid patient for whom a tobacco/nicotine cessation counseling claim is made. Medical record documentation must include standard information along with sufficient patient history to adequately demonstrate that Medicaid coverage conditions were met. The provider must keep written documentation in the client’s file for each face-to-face tobacco/nicotine cessation counseling session for pregnant clients. Documentation must include the client’s EDC.

Diagnosis codes should reflect that the client is pregnant and has a tobacco/nicotine use disorder.

**Billing codes**

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>99407</td>
<td>Behav chng smoking &gt; 10 min (for pregnant clients only)</td>
<td>See Benefit limitations for providing face-to-face tobacco/nicotine cessation counseling for pregnant clients.</td>
</tr>
</tbody>
</table>

**Substance use disorder treatment**

HCA reimburses for buprenorphine/naloxone when administered or dispensed in an opioid treatment program (OTP). The OTP must be Department of Health (DOH)-certified and have a current certification on file with HCA. Before billing for this service, the OTP must submit a copy of their DOH certification and their NPI number to HCA. Mail or fax certification to:

Provider Enrollment  
PO Box 45562  
Olympia, WA 98504-5562  
Fax: 360-725-2144

Clients enrolled in an HCA-contracted managed care organization (MCO) must contact their MCO for information regarding their coverage.
### How to bill for combination therapy

Providers must bill according to the actual tablet strength dispensed and not the dose given. For example, if dispensing a 10mg dose as a 1-2mg tablet and 1-8mg tablet, bill one unit of J0572 and 1 unit of J0574. You would not use J0575. For a 16mg dose, you would bill 2 units of J0574. The J0575 should only be used when dispensing a tablet strength greater than 10mg.

HCA reimburses the following codes. For rates, see the Physician-related/professional services or Professional administered drugs fee schedules.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Short Description</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0572</td>
<td>Buprenorphine/naloxone</td>
<td>Oral, less than or equal to 3 mg buprenorphine</td>
</tr>
<tr>
<td>J0573</td>
<td>Buprenorphine/naloxone</td>
<td>Oral, greater than 3 mg, but less than or equal to 3.1 to 6 mg</td>
</tr>
<tr>
<td>J0574</td>
<td>Buprenorphine/naloxone</td>
<td>Oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine</td>
</tr>
<tr>
<td>J0575</td>
<td>Buprenorphine/naloxone</td>
<td>Oral, greater than 10 mg buprenorphine</td>
</tr>
</tbody>
</table>

**Note:** HCA considers film to be included as orally administered buprenorphine/naloxone.
How to bill for monotherapy

All monotherapy must be given only as a witnessed dose. HCA does not reimburse for carry medication for monotherapy. Use the following code:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Short Description</th>
<th>Limitation Restricted to ICD Dx and/or Dosing</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0571</td>
<td>Buprenorphine</td>
<td>Oral, 1 mg, or J0592 Injection, buprenorphine hydrochloride, 0.1 mg</td>
</tr>
</tbody>
</table>

**Note:** HCA considers film to be included as orally administered buprenorphine.

How do I bill for take-home naloxone?

Retroactive to dates of service on and after January 1, 2022, hospital emergency departments (EDs), opioid treatment programs, and certified or licensed behavioral health agencies (BHAs) may be reimbursed for prepackaged opioid overdose reversal medication, naloxone, distributed to clients at risk of an opioid overdose. For billing requirements, see HCA’s Prescription Drug Program Billing Guide.

Collaborative care model guidelines

Collaborative care

The following are Washington State Health Care Authority guidelines for practicing a Collaborative Care Model (CoCM).

Collaborative care is a specific type of integrated care developed at the University of Washington where medical providers and behavioral health providers work together to address behavioral health conditions, including mental health conditions and substance use disorders. When behavioral health problems are not effectively treated, this can impair self-care and adherence to treatments, and as a result are associated with poor health outcomes and increased mortality.

Psychiatric collaborative care model

The Collaborative Care Model (CoCM) is a model of behavioral health integration that enhances “usual” primary care by adding two key services: care management support for clients receiving behavioral health treatment, and regular psychiatric or board-certified addiction medicine consultation with the primary care team, particularly regarding clients whose conditions are not improving.

Collaborative care is provided monthly for an episode of care that ends when targeted treatment goals are met or there is failure to attain targeted treatment.
goals, culminating in referral to behavioral health specialty care, or there is a break in episode (no collaborative care services for six consecutive months).

Eligible behavioral health conditions include, but are not limited to, substance use disorders, including opioid use disorder, anxiety, attention deficit hyperactivity disorder (ADHD), and depression that are being treated by the billing provider and, in the clinical judgment of the provider, warrant enrollment in CoCM services.

There are five core principles to CoCM developed in 2011 in consultation with a group of national experts in integrated behavioral health care with support from The John A. Hartford Foundation, The Robert Wood Johnson Foundation, HCA for Healthcare Research and Quality, and the California HealthCare Foundation.

**Core principles**

**Patient-centered team care**

Primary care and behavioral health providers collaborate with shared care plans that incorporate patient goals. The ability to get both physical and behavioral health care at a familiar location is comfortable to patients and reduces duplicate assessments. Increased patient engagement oftentimes results in a better health care experience and improved patient outcomes.

The treating medical provider leads the care. The treating medical provider prescribes all medications, including those recommended by the psychiatric consultant. The team structure in CoCM includes the following team members. These team members are required to be part of the care to be reimbursed for CoCM.

- **Treating (Billing) Medical Provider:** A physician and/or non-physician practitioner (MD, ARNP, ND, DO); typically, primary care, but may be of another specialty (e.g., cardiology, oncology). This provider leads the care and prescribes all medications, including those recommended by the psychiatric consultant.

- **Behavioral Health Care Manager:** A designated licensed professional with formal education or specialized training in behavioral health (including social work, nursing, or psychology), working under the oversight and direction of the treating medical provider.

- **Psychiatric Consultant:** A medical professional trained in psychiatry and qualified to prescribe the full range of psychotropic medications. This may be a board-certified addiction medicine provider or an addiction psychiatrist when the client has a substance use disorder.

- **Beneficiary:** The beneficiary is the patient who is a member of the care team.
The following visual was developed by the University of Washington to demonstrate the team structure and support that surrounds the client through CoCM:

**Measurement-based treatment to target**

A client’s treatment plan must clearly articulate personal goals and target clinical outcomes that are routinely measured by using a validated clinical rating scale like the PHQ-9 depression scale. Treatment adjustments are made for clients not improving as expected under their current treatment plan. Treatment adjustments are made until clients achieve treatment goals or care is discontinued due to referral or clients not participating.

**Population-based care**

The data-driven workflow to support CoCM requires the care team to use a registry to track clients on a CoCM caseload and monitor individual client’s clinical outcomes over time. A registry can be used in conjunction with the practice’s electronic health records (EHR) if not built into it. The Advancing Integrated Mental Health Solutions (AIMS) Center offers registry tools for use in conjunction with an EHR. Additional information is located in the AIMS Center’s implementation guide: [Identify a behavioral health patient tracking system](#).

**Evidence-based treatment**

Clients are offered evidence-based treatments to help meet treatment goals. These include medications and brief psychotherapy interventions such as behavioral activation, problem solving treatment, and motivational interviewing.

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**Accountable care**

Providers are accountable for the treatment of all clients referred to the program, including quality of care and clinical outcomes for the clients managed under CoCM.

**Additional Information**

The University of Washington has additional information on the implementation of CoCM and has a variety of tools to learn more about CoCM and assess a provider’s readiness to implement CoCM.

**What to do next**

Review the guidelines and requirements for reimbursement for CoCM and assess practice readiness through the AIMS tools. If a practice can meet the requirements, complete HCA’s Attestation for Collaborative Care Model form (HCA 13-0017) and send completed form to:

Provider Enrollment  
PO Box 45562  
Olympia, WA 98504-5562  
Or fax to 360-725-2144, Attn: Provider Enrollment  
Or email mailto:providerenrollment@hca.wa.gov

See Where can I download HCA forms? The treating (billing) medical provider submits the attestation.

Once the attestation is received and reviewed, an indicator will be placed in the Medicaid billing system, ProviderOne, allowing reimbursement for fee-for-service and notification will be provided to all HCA-contracted managed care organizations. Provider Enrollment will contact the provider if there are any issues with their attestation form.

If at any time a practice no longer meets the core principles and specific function requirements to practice CoCM, notify HCA by calling Provider Enrollment at 360-725-2144. Providers are subject to post pay review to ensure the CoCM model requirements are being met. If the CoCM requirements were not met at the time of billing, recoupment of payment may occur.

**Note:** If a practice bills under one base location NPI and has several servicing locations, each servicing location must submit an attestation to provide and be reimbursed for CoCM service.

For general instructions on billing, see the ProviderOne Billing and Resource Guide. For reimbursement rates see the Physician-related/professional health care services fee schedule.
Psychiatric Collaborative Care Model (CoCM) Codes

Purpose
The following matrix is a tool to describe the requirements for selected codes. Licensed health care professionals use these codes to bill only for those services that are within their scope of licensure as defined by the Department of Health. Psychiatric CoCM typically is provided by a primary care team consisting of a treating medical provider and a care manager who work in collaboration with a psychiatric consultant, such as a psychiatrist or a psychiatric ARNP. See Collaborative care model guidelines. Care is directed by the primary care team and includes structured care management with regular assessments of clinical status using validated tools and modification of treatment as appropriate. Payments are based on services provided by all team members. CoCM practices must meet model requirements as defined by CMS and submit an attestation to HCA to be eligible for reimbursement. Additional information and introductory resources around training for practice staff are available from the AIMS Center (Advancing Integrated Mental Health Solutions).
CPT® code 99492—Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

With the following required elements:
- Outreach to and engagement in treatment of a client directed by the treating physician or other qualified health care professional
- Initial assessment of the client, including administration of validated rating scales, with the development of an individualized treatment plan
- Review by the psychiatric consultant with modifications of the plan if recommended
- Entering client in a registry and tracking client follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies

Documentation: The provider must:
- Use a registry to track the client’s clinical outcomes.
- Use a validated clinical rating scale.
- Ensure the registry is used in conjunction with the practice’s electronic health records (EHR).
- Include a plan of care.
- Identify outcome goals of the treatments.

Billing: First 70 minutes in the first calendar month of behavioral health care manager activities in consultation with a psychiatric consultant and directed by the treating physician or other qualified health care professional.

Provider Type: Billable by medical provider with collaborative care indicator (e.g., ARNP, DO, MD, ND)

Place of Service: No limitations on the place of service. Exception: Federally Qualified Health Centers (FQHC’s) and Rural Health Clinics (RHC’s) bill for CoCM using a specific code—see code G0512 for details.

Limitations:
- CPT® code 99492 is used only for initial month of an episode of care
- An episode of care starts the first calendar month of behavioral health care manager activities
- A new episode of care must be initiated after 6-month lapse in services
- If less than a 6-month lapse in service and new episode of care is to be initiated, EPA is required.
HCPCS code G2214 - Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional

With the following required elements:
- Outreach to and engagement in treatment of a client directed by the treating physician or other qualified health care professional
- Initial assessment of the client, including administration of validated rating scales, with the development of an individualized treatment plan
- Review by the psychiatric consultant with modifications of the plan if recommended
- Entering client in a registry and tracking client follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies

Documentation: The provider must:
- Use a registry to track the client’s clinical outcomes.
- Use a validated clinical rating scale.
- Ensure the registry is used in conjunction with the practice’s electronic health records (EHR).
- Include a plan of care.
- Identify outcome goals of the treatments.

Billing: First 30 minutes in the first calendar month of behavioral health care manager activities, or the first 30 minutes in the subsequent calendar months, in consultation with a psychiatric consultant and directed by the treating physician or other qualified health care professional.

Provider Type: Billable by medical provider with collaborative care indicator (e.g., ARNP, DO, MD, ND)

Place of Service: No limitations on the place of service. Exception: Federally Qualified Health Centers (FQHC’s) and Rural Health Clinics (RHC’s) bill for CoCM using a specific code—see HCPCS code G0512 for details.

Limitations:
- An episode of care starts the first calendar month of behavioral health care manager activities
- A new episode of care must be initiated after 6-month lapse in services
- If less than a 6-month lapse in service and new episode of care is to be initiated, EPA is required.
<table>
<thead>
<tr>
<th><strong>CPT® code 99493</strong></th>
<th><strong>Documentation:</strong> Documentation must include:</th>
</tr>
</thead>
</table>
| Subsequent psychiatric collaborative care management, first 60 minutes in the subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional. With the following required elements: | • Clients progress towards goals  
• Updated results of the validated clinical rating scales being utilized  
• Modifications to treatment as appropriate |
| • Tracking client follow-up and progress using the registry, with appropriate documentation | **Billing:** First 60 minutes in the subsequent calendar months following the initial calendar month of behavioral health care manager activities in consultation with a psychiatric consultant and directed by the treating physician or other qualified health care professional. |
| • Participation in weekly caseload consultation with the psychiatric consultant | **Provider Type:** Billable by medical provider with collaborative care indicator (e.g., ARNP, DO, MD, ND) |
| • Ongoing collaboration with and coordination of the patient’s mental health care with the treating physician or other qualified health care professional and any other treating mental health providers | **Place of Service:** No limitations on the place of service. Exception: Federally Qualified Health Centers (FQHC’s) and Rural Health Clinics (RHC’s) bill for CoCM using a specific code—see code G0512 for details. |
| • Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant | **Limitations:**  
• Bill once per month  
• Billed for subsequent calendar months following the initiation of an episode of CoCM services  
• May bill 5 months of subsequent care for each episode of care initiated without PA or EPA (see Additional billing information)  
• Requires EPA to continue the episode after 6th month (see Additional billing information)  
• Clients must have a minimum of one face-to-face visit every three months with the directing treating physician or other qualified health care professional  
• Requires PA after 12 months (see Additional billing information)  
• A new episode of care must be initiated after 6-month lapse in services and include an initial assessment and a treatment plan  
• EPA is required if less than a 6-month lapse in service and new episode of care is to be initiated (see Additional billing information). |
| • Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies |  
• Monitoring of client outcomes using validated rating scales and relapse prevention planning with clients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.  
• Clients must have one face-to-face visit at least every three months. |
<table>
<thead>
<tr>
<th><strong>CPT® code 99494</strong> – Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Documentation:</strong> Documentation must include:</td>
</tr>
<tr>
<td>- Client’s progress towards goals</td>
</tr>
<tr>
<td>- Updated results of the validated clinical rating scales being used</td>
</tr>
<tr>
<td>- Modifications to treatment as appropriate</td>
</tr>
<tr>
<td><strong>Billing:</strong> Additional 30-minute units of behavioral health care manager activities in consultation with a psychiatric consultant and directed by the treating physician or other qualified health care professional.</td>
</tr>
<tr>
<td><strong>Provider Type:</strong> Billable by medical provider with collaborative care indicator (e.g., ARNP, DO, MD, ND)</td>
</tr>
<tr>
<td><strong>Place of Service:</strong> No limitations on the place of service. Exception: Federally Qualified Health Centers (FQHC’s) and Rural Health Clinics (RHC’s) bill for CoCM using a specific code—see code G0512 for details.</td>
</tr>
<tr>
<td><strong>Limitations:</strong></td>
</tr>
<tr>
<td>- Use for additional 30 minutes of behavioral health care manager activities</td>
</tr>
<tr>
<td>- CPT® code 99494 to be used with CPT® code 99492 or CPT® code 99493</td>
</tr>
</tbody>
</table>
FQHC & RHC
G0512- Psychiatric Collaborative Care

Model services:
- Minimum of 60 minutes per calendar month
- Service elements provided by CoCM team for CoCM services must include:
  - Outreach and engagement of clients
  - Initial assessment, including administration of validated scales and resulting in a treatment plan
  - A minimum of one face-to-face visit every three months with the directing treating physician or other qualified health care professional
  - Entering clients into a registry for tracking client follow-up and progress
  - Participation in weekly caseload review with psychiatric consultant and modifications to treatment, if recommended
  - Provision of brief interventions using evidence-based treatments such as behavioral activation, problem-solving treatment, and other focused treatment activities
  - Tracking client follow-up and progress using validated rating scales
  - Ongoing collaboration and coordination with treating FQHC and RHC providers
  - Relapse prevention planning and preparation for discharge from active treatment

Documentation:
The provider must:
- Use a registry to track the client’s clinical outcomes
- Use a validated clinical rating scale
- Ensure the registry is used in conjunction with the practice’s EHR
- Include a plan of care
- Identify outcome goals of the treatments

Billing:
- A minimum of 60 minutes in any month of behavioral health care manager activities in consultation with a psychiatric consultant and directed by the treating physician or other qualified health care professional.

Provider Type:
- Billable by medical provider in a FQHC or RHC with collaborative care indicator (e.g., ARNP, DO/MD/ND)

Place of Service:
- Federally Qualified Health Centers (FQHC’s) and Rural Health Clinics (RHC’s)

Limitations:
- This code does not qualify for an encounter
- Once per month
- May bill 5 months of subsequent care for each episode of care initiated without PA or EPA
- EPA is required to continue the episode after 6th month
- PA is required after 12 months following initiation of episode
- A new episode of care must be initiated after 6-month lapse in services and include an initial assessment and development of a treatment plan
- If less than a 6-month lapse in service and new episode of care is to be initiated, EPA is required.

Additional billing information
Use expedited prior authorization (EPA) in the following circumstances:
- For additional services beyond the initial 6 months of CoCM services, an EPA is required. See EPA #870001428.
- For starting a new episode of care 99492 or G0512 with less than a 6-month lapse in services, an EPA is required. See EPA #870001427.
- If the client does not meet the EPA criteria, prior authorization (PA) is required.

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Use prior authorization (PA) in the following circumstance:

- After 12 months of CoCM services, PA is required.

**Note:** A psychiatric consultant working in the CoCM model may also provide traditional services directly to the client in the same month but may not bill for the same time using multiple codes. The time spent on these activities for services reported separately may not be included in the services reported using time applied to 99492, 99493, 99494 and G0512.

**Comprehensive assessment and care planning for persons living with cognitive impairment (CPT® code 99483)**

HCA considers the comprehensive assessment and care planning for persons living with cognitive impairment to be medically necessary with the following limitations:

- Face-to-face visits via an in-person or audio-visual encounter are allowed, but HCA does not allow telephonic and email encounters.
- Clients must have a cognitive impairment as defined by one of the following ICD diagnosis codes: G300, G301, G309, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, G31.01, G31.09, G31.85, G31.83, and G31.84.
- Services must be billed by physicians, physician assistants, nurse practitioners, clinical nurse specialists, or certified nurse midwives.
- Services must include an independent historian—most often the client’s caregiver.
- The comprehensive clinical visit must result in a written plan of care.
- Components of the visit include an independent historian; multidimensional assessment that includes cognition, functions, and safety; evaluation of neuropsychiatric and behavior symptoms; review and reconciliation of medications; and an assessment of the needs of the client’s caregiver.
- Service is billable as a 50-minute visit, once every 180 days.
The following CPT® codes may be billed with CPT® code 99483 on the same day of service. When processing these CPT® codes, HCA follows the coding rules as published by Medicare:

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99358</td>
<td>Prolong service w/o contact</td>
</tr>
<tr>
<td>99359</td>
<td>Prolong serv w/o contact add</td>
</tr>
<tr>
<td>99487</td>
<td>Cplx chrnc care 1st 60 min</td>
</tr>
<tr>
<td>99489</td>
<td>Cplx chrnc care ea addl 30</td>
</tr>
<tr>
<td>99490</td>
<td>Chrnc care mgmt staff 1st 20</td>
</tr>
</tbody>
</table>

Health and behavior codes

HCA covers health and behavior codes when provided by a physician or licensed behavioral health provider. Providers use health and behavior codes when the primary diagnosis is medical, and the provider is addressing the behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. The focus of the assessment is not mental health but on the biopsychosocial factors important to physical health problems and treatments.

Use modifier HE to indicate the service is not part of a substance use disorder (SUD) or maternity support service (MSS). If these health and behavior codes are billed with a mental health diagnosis and the HE modifier, HCA will deny the claim.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96156</td>
<td>Hlth bhv assmt/reassessment</td>
</tr>
<tr>
<td>96158</td>
<td>Hlth bhv ivntj indiv 1st 30</td>
</tr>
<tr>
<td>96159</td>
<td>Hlth bhv ivntj indiv ea addl</td>
</tr>
<tr>
<td>96164</td>
<td>Hlth bhv ivntj grp 1st 30</td>
</tr>
<tr>
<td>96165</td>
<td>Hlth bhv ivntj grp ea addl</td>
</tr>
<tr>
<td>96167</td>
<td>Hlth bhv ivntj fam 1st 30</td>
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<tr>
<td>96168</td>
<td>Hlth bhv ivntj fam ea addl</td>
</tr>
<tr>
<td>CPT® Code</td>
<td>Short Description</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>96170</td>
<td>Hlth bhv ivntj fam wo pt 1st</td>
</tr>
<tr>
<td>96171</td>
<td>Hlth bhv ivntj fam w/o pt ea</td>
</tr>
</tbody>
</table>

For additional information on code descriptions and billing for health and behavior codes, visit the Behavioral health and recovery webpage.

**Children's primary health care**  
(CPT® codes 99202-99215)

HCA pays a higher payment rate for primary health care performed in the office setting (CPT® codes 99202-99215) for children age 20 and younger. These are the only services that are paid at the higher rate.

If a child is younger than 60 days of age and has not been issued an individual ProviderOne Client ID, use the birthing parent’s ProviderOne Client ID, and put "SCI=B" in the claim notes field. Put the child’s name, gender, and birth date in the client information fields. If the birthing parent is enrolled in an HCA-approved managed care organization (MCO), newborns will be enrolled in the same MCO as their birthing parent.

**Pediatric primary care rate increase**

A primary care provider rate increase is available for vaccine administration and certain pediatric care services for clients age 18 and younger.

Physician and non-physician practitioners are eligible for the increase.

See the Pediatric primary care rate increase website for more information. To view the Enhanced pediatric fee schedule, see HCA’s Provider billing guides and fees schedules webpage. Scroll down to and select “Physician-related/professional services.”

**Note:** Providers serving clients covered by an HCA-contracted managed care organization (MCO) should contact the individual MCO for rate information.
Consultations—TB treatment services

Performed by professional providers – office visits only
The E/M codes 99202-99215 are for office visits only and must be billed for professional providers such as physicians (or nursing staff under a physician’s supervision), Advanced Registered Nurse Practitioners (ARNPs), and Physician Assistants (PAs).

Performed by professional providers – in client’s home
See Home services.

Performed by nonprofessional providers – office visits and in client’s home
Health departments billing for TB treatment services provided by nonprofessional providers in either the client’s home or in the office must bill using HCPCS code T1020 (personal care services). Do not bill the initial visit with a modifier. Follow-up visits must be billed using T1020 with modifier TS (follow-up services modifier). Use the appropriate ICD diagnosis code. Health departments may use a recorded video submitted by the client in place of the in-home visit or office visit. HCPCS code G2010 may be billed when this modality is used, and the requirements of the code are met. HCPCS code G2010 is not Federally Qualified Health Center (FQHC) encounter-eligible.

Critical care
(CPT® codes 99291-99292)

Note: For neonatal or pediatric critical care services, see Neonatal intensive care unit (NICU)/Pediatric intensive care unit (PICU).

Critical care is the direct delivery and constant attention by a provider(s) for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient’s condition.

Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s); to treat single or multiple vital organ system failure; and/or to prevent further life-threatening deterioration of the patient’s condition.
Providing medical care to a critically ill, injured, or postoperative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility. Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes.

Billing for critical care
When billing for critical care, providers must bill using CPT® codes 99291-99292:

- For the provider’s attendance during the transport of critically ill or critically injured clients age 25 months or older to or from a facility or hospital.
- To report critical care services provided in an outpatient setting (e.g., emergency department or office), for neonates and pediatric clients up through 71 months.
- To report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured client, even if the time spent by the physician on that date is not continuous. For any given period spent providing critical care services, physicians must devote their full attention to the client and cannot provide services to any other patient during the same period.

**Note:** Surgery, stand-by, or lengthy consultation on a stable client does not qualify as critical care.

Where is critical care performed?
Critical care is usually performed in a critical care area of a hospital, such as a(n):

- Coronary care unit.
- Intensive care unit.
- Respiratory care unit.
- Emergency care facility.

What is covered?
HCA covers:

- A maximum of three hours of critical care per client, per day.
- Critical care provided by the attending physician who assume(s) responsibility for the care of a client during a life-threatening episode.
- Critical care services provided by more than one physician if the services involve multiple organ systems (unrelated diagnosis). However, in the emergency room, payment for critical care services is limited to one physician.
The following services (with their corresponding CPT® codes) are included in critical care. Do not bill these separately:

- Vascular access procedures (CPT® codes 36000, 36410, 36415, 36591, and 36600)
- Gastric intubation (CPT® codes 43752 and 43753)
- Chest X-rays (CPT® codes 71010, 71015, and 71020)
- Temporary transcutaneous pacing (CPT® codes 92953)
- The interpretation of cardiac output measurements (CPT® codes 93561-93562)
- Ventilator management (CPT® codes 94002-94004, 94660, and 94662)
- Pulse oximetry (CPT® codes 94760 and 94762)
- Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data) (CPT® code 99090)

**Note:** CPT® code 43752 may be billed separately when it is the only procedure code billed.

**Domiciliary, rest home, or custodial care services**

CPT® codes 99304-99318 are not appropriate E/M codes for use in place of service 13 (Assisted Living) or 14 (Group Home). Providers must use CPT® codes 99324-99328 or 99334-99337 for E/M services provided to clients in these settings.

**Emergency department services**

**Emergency physician-related services**

(CPT® codes 99281-99285)

- For services performed by the physician assigned to, or on call to, the emergency department, bill HCA using CPT® codes 99281-99285.

**Note:** For multiple emergency room (ER) visits on the same day with related diagnoses, the time(s) of the additional visit(s) must be noted in the Claim Note section of the electronic claim.

- HCA does not pay emergency room physicians for hospital admissions (e.g., CPT® codes 99221-99223) or after-hours services (e.g., CPT® codes 99050 and 99053).
- Physicians who perform emergency room services **must not** bill modifier 54 when billing HCA for surgical procedures.
Physicians who provide only the follow-up services for minor procedures performed in emergency departments must bill the appropriate level of office visit code without modifier 55.

HCA follows Medicare's policy to not pay emergency room providers for the following procedure codes: CPT® codes 96360-96361 or 96365-96368.

**Habilitative services**

Habilitative services are those medically necessary services provided to help a client partially or fully attain or maintain developmental age-appropriate skills that were not fully acquired due to a congenital, genetic, or early-acquired health condition. Such services are required to maximize clients' ability to function in their environment.

For those clients in the expanded population and covered by the Alternative Benefit Plan (ABP) only, HCA covers prosthetic and orthotic (P&O) devices and supplies, medical equipment and supplies, and outpatient therapy (physical, occupational, and speech) to treat one of the qualifying conditions listed in HCA’s Habilitative Services Billing Guide, under Client Eligibility.

**Billing for habilitative services**

Habilitative services must be billed using one of the qualifying diagnosis codes listed in HCA’s Habilitative Services Billing Guide in the primary diagnosis field on the claim.

Neurodevelopmental Centers, Outpatient Hospital Services, Physician-Related Services/Health Care Professional Services (includes Audiology), Home Health Services, and Outpatient Rehabilitation providers who provide physical therapy, occupational therapy, or speech language pathology to treat a condition that qualifies for habilitative services, for a client enrolled in ABP, must bill for these therapies according to HCA’s Habilitative Services Billing Guide.

Services and equipment related to any of the following programs must be billed using their specific billing guide:

- Medical Equipment and Supplies
- Prosthetic/Orthotic Devices and Supplies
- Complex Rehabilitation Technology

All other program requirements are applicable to a habilitative service and should be followed unless otherwise directed (e.g., prior authorization).
Home services

Home evaluation and management
HCA pays for home evaluation and management (CPT® codes 99341-99350) only when services are provided in place of service 12 (home).

TB treatment services – performed by professional providers – in client’s home
When billing for TB treatment services provided by professional providers in the client’s home, Health Departments may also bill CPT® codes 99341 and 99347. For TB treatment services performed by nonprofessional providers in client’s home, see Consultations—TB treatment services, then scroll down to Performed by nonprofessional providers—office visits and in client’s home.

Hospital inpatient and observation care services
(CPT® codes 99217-99239)
Inpatient admissions must meet intensity of service/severity of illness criteria for an acute inpatient level of care. Admission status changes must be noted in the client’s chart.

Admission status
Admission status is a client’s level of care at the time of admission. Some examples of typical types of admission status are inpatient, outpatient observation, medical observation, outpatient surgery or short-stay surgery, or outpatient (e.g., emergency room).

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

A change in admission status is required when a client's symptoms/condition or treatment, or both, does not meet medical necessity criteria for the level of care the client is initially admitted to. The documentation in the client's medical record must support the admission status and the services billed.

HCA does not pay for:

- Services that do not meet the medical necessity of the admission status ordered.
- Services that are not documented in the hospital medical record.
- Services greater than what is ordered by the physician or practitioner responsible for the client’s hospital care.

Inpatient to outpatient observation

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

- The attending physician/practitioner or the hospital’s utilization review staff, or both, determine that an inpatient client’s symptoms/condition and treatment do not meet medical necessity criteria for an acute inpatient level of care and do meet medical necessity criteria for an observation level of care.
- The admission status change is made prior to, or on the next business day following, discharge.
- The admission status change is documented in the client’s medical record by the attending physician or practitioner. If the admission status change is made following discharge, the document must:
  - Be dated with the date of the change.
  - Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Outpatient observation to inpatient

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

- The attending physician/practitioner or the hospital’s utilization review staff, or both, determine that an outpatient observation client’s symptoms/condition and treatment meet medical necessity criteria for an acute inpatient level of care.
- The admission status change is made prior to, or on the next business day following, discharge.
• The admission status change is documented in the client’s medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:
  o Be dated with the date of the change.
  o Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Inpatient or outpatient observation to outpatient

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

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

• The admission status change is made prior to, or on the next business day following, discharge.

• The admission status change is documented in the client’s medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:
  o Be dated with the date of the change.
  o Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Outpatient surgery/procedure to outpatient observation or inpatient

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

• The attending physician/practitioner or the hospital’s utilization review staff, or both, determine that the client’s symptoms/condition or treatment, or both, require an extended recovery time beyond the normal recovery time for the surgery/procedure and medical necessity for outpatient observation or inpatient level of care is met.

• The admission status change is made prior to, or on the next business day following, discharge.

• The admission status change is documented in the client’s medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:
  o Be dated with the date of the change.
  o Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).
Note: During post-payment retrospective utilization review, HCA may determine the chronic care management is not supported by documentation in the medical record. HCA may consider payment made in this circumstance an overpayment and payment may be recouped or adjusted.

Payment
HCA pays for:

- One inpatient hospital call per client, per day for the same or related diagnoses. HCA does not pay separately for the hospital call if it is included in the global surgery payment. (See Other surgical policies for information on global surgery policy.)

- Professional inpatient services (CPT® codes 99221-99223) during the global surgery follow-up period only if they are performed on an emergency basis and are unrelated to the original surgery. Use modifier 24 to indicate that the service is unrelated to the original surgery.

Note: HCA pays providers for CPT® codes 99221-99223 for scheduled hospital admissions during the follow-up period only when billed with a modifier 24.

HCA does not pay for:

- A hospital admission (CPT® codes 99221-99223) and a planned surgery billed in combination. The hospital admission is included in the global fee for the surgery.

- Inpatient or observation care services (including admission and discharge services (CPT® codes 99234-99236) for stays of less than 8 hours on the same calendar date.

Other guidelines

- When a hospital admission (CPT® codes 99221-99223) and an emergency surgery is billed in combination, HCA will pay when there is a decision to do surgery, the provider has not seen the client for this condition, and modifier 57 is used. This only applies to surgical procedures with a 90-day global period.

- When a client is admitted for observation care for less than 8 hours and is discharged on the same calendar date, providers must bill using CPT® codes 99218-99220. HCA does not pay providers separately for discharge services.

- When a client is admitted for observation care and is discharged on a different calendar date, providers must bill using CPT® codes 99218-99220 and observation discharge CPT® code 99217.

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When a client qualifies for an inpatient hospital admission and is discharged on a different calendar date, providers must bill using CPT® codes 99221-99233 and hospital discharge day management CPT® code 99238 or 99239.

When a client qualifies for an inpatient hospital admission and is discharged on the same calendar date, providers must bill using CPT® codes 99234-99236. HCA does not pay providers separately for hospital discharge day management services.

Providers must satisfy the documentation requirements for both admission to and discharge from, inpatient or observation care to bill CPT® codes 99234-99236. The length of time for observation care or treatment status must also be documented.

When clients are fee-for-service (FFS) when admitted to a hospital and then enroll in an HCA managed care organization (MCO) during the hospital stay, the entire stay for physician services is paid FFS until the client is discharged. Enter the initial hospitalization date in the appropriate field for the claim billing format. For billing details, see the ProviderOne Billing and Resource Guide.

Inpatient neonatal and pediatric critical care

Neonatal intensive care unit (NICU)/Pediatric intensive care unit (PICU)
(CPT® codes 99468-99480)

NICU/PICU care includes management, monitoring, and treatment of the neonate/infant including respiratory, pharmacological control of the circulatory system, enteral and parenteral nutrition, metabolic and hematological maintenance, parent/family counseling, case management services, and personal direct supervision of the health care team’s activities.

HCA covers:

- One NICU/PICU service per client, per day.
- Intensive observation, frequent interventions, and other intensive services for neonates. Use CPT® code 99477 for initial hospital care, per day, when a neonate requires intensive observation, frequent interventions, and other intensive services. Providers may report CPT® codes 99460 and 99477 when two distinct services are provided on the same day but must use modifier 25 with CPT® code 99460. Bill CPT® code 99460 with modifier 25 when a normal newborn is seen after an uneventful delivery and then later the infant develops complications and is transferred to an intensive setting for observation, frequent interventions, and other intensive services.

- NICU/PICU services when directing the care of a neonate/infant in a NICU/PICU. These codes represent care beginning with the date of admission to the NICU/PICU.

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Note: Once the infant is no longer considered critically ill, hospital care CPT® codes 99231-99233 or 99478-99480 must be used.

- Newborn resuscitation (CPT® codes 99464 and 99465) in addition to NICU/PICU services.
- The provider’s attendance during the transport of critically ill or critically injured pediatric clients 24 months of age or younger to or from a facility or hospital (CPT® code 99466 or 99467).
- CPT® codes 99291-99292 for critical care services provided in an outpatient setting when the client is 24 months of age or younger.

The following services and the subsequent intensive, noncritical services (with their corresponding CPT® codes) are included in neonatal or pediatric critical care. Do not bill these separately. Providers must follow the national CCI edits as this list is not exhaustive:

- Bladder catheterization (CPT® codes 51701-51702)
- Central (CPT® code 36555) or peripheral vessel catheterization (CPT® code 36000)
- Continuous positive airway pressure (CPAP) (CPT® code 94660)
- Endotracheal intubation (CPT® code 31500)
- Initiation and management of mechanical ventilation (CPT® codes 94002-94004)
- Invasive or noninvasive electronic monitoring of vital signs, bedside pulmonary function testing (CPT® code 94375), and/or monitoring or interpretation of blood gases or oxygen saturation (CPT® codes 94760-94762)
- Lumbar puncture (CPT® code 62270)
- Oral or nasogastric tube placement (CPT® code 43752)
- Other arterial catheters (CPT® codes 36140 and 36620)
- Umbilical arterial catheterization (CPT® code 36660)
- Umbilical venous catheterization (CPT® code 36510)
- Suprapubic bladder aspiration (CPT® code 51100)
- Surfactant administration, intravascular fluid administration (CPT® codes 96360, 96361, 90780, and 90781)
- Transfusion of blood components (CPT® codes 36430 and 36440)
- Vascular punctures (CPT® codes 36420 and 36600)
- Vascular access procedures (CPT® codes 36400, 36405, and 36406)
**Note:** CPT® code 43752 may be billed separately when it is the only procedure code billed.

**Intensive (noncritical) low birth weight services**  
(CPT® codes 99478-99480)

- Bill the appropriate procedure codes only once per day, per client.
- These codes represent care that begins after the admission date.

**Perinatal conditions**
HCA covers professional services related to conditions originating in the perinatal period if all the following are met:

- HCA considers the services to be medically necessary and would otherwise be covered by HCA.
- Professional services are provided in an inpatient hospital (place of service 21).
- ICD diagnosis codes are listed as the primary diagnosis.
- An admission date is included on the claim.
- There are 28 or fewer days between the patient’s date of birth and the admission date listed on the claim.

For clients who transfer between facilities for services not otherwise available, or to a higher level of care, the original date of admission must be used on the claim to represent a continuous episode of care. For clients greater than 28 days of age, the appropriate ICD diagnosis codes may be listed as the secondary rather than the primary diagnosis.

**Mental health**
For coverage and billing information for mental health services for children and adults, including evidence-based medicine, evidence-based practice, research-based practice, and evidence-based health care (collectively “EBM”), see HCA’s Mental Health Services Billing Guide.

**Note:** The reimbursement rate may differ depending on the provider’s education level. See the Mental health services and the Physician-related/professional services fee schedules for details.
**Depression screening—structured depression screening**

HCA covers one structured depression screening each year for clients age 12 and older. When billing HCA, use CPT® code 96127 or 96160. If more frequent screening is needed, providers can submit a limitation extension (LE) request to HCA. See Limitation extension (LE).

**Depression screening—caregiver/birthing parent depression screening**

- Caregiver/Birthing parent depression screening is required at well-child checkups for caregivers/birthing parents of infants up to age six months. Use CPT® code 96161 with EPA #870001424 for fee-for-service (FFS) with the infant’s ProviderOne ID number.

- Caregiver/birthing parents depression screening completed by the caregiver’s provider during the six months postpartum and billed under the caregiver’s Provider One ID number. Use CPT® code 96160 with EPA #870001424.

For further information, see the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Billing Guide and the Mental Health Services Billing Guide.

**Newborn care**

(CPT 99460, 99461)

To assist providers in billing CPT® codes with "newborn" in the description, HCA defines a newborn as 28 days old or younger.

Newborn diagnosis codes are to be used as the primary diagnosis during the newborn 28-day period. After 28 days and throughout the life of the patient, a newborn code may be used as an additional diagnosis if the condition is still present.

**HCA covers:**

- One newborn evaluation per newborn when they are not discharged on the same day using either CPT® code 99460 for hospital or birthing center or CPT® code 99461 for home births.

- Subsequent hospital care (other than initial evaluation or discharge) using CPT® code 99462.

- One newborn evaluation and discharge per newborn performed in the hospital or birthing center on the same day using CPT® code 99463.
Billing for infants not yet assigned a ProviderOne client ID

Use the birthing parent’s ProviderOne Client ID for a newborn if the infant has not yet been issued a ProviderOne Client ID. Enter indicator SCI=B in the Comments section of the claim to indicate that the birthing parent’s ProviderOne Client ID is being used for the infant. Put the child’s name, gender, and birthdate in the client information fields. When using a birthing parent’s ProviderOne Client ID for twins, triplets, etc., use the following claim indicators to identify the infant being treated: SCI=BA for twin A, SCI=BB for twin B, and SCI=BC for a third infant in the case of triplets, using a separate claim for each. **Note:** For a birthing parent enrolled in an HCA managed care organization (MCO), the MCO is responsible for providing medical coverage for the newborn(s).

For more information on billing for newborns and for newborns who will be placed in foster care, see the Inpatient Hospital Services Billing Guide.

Physician/Professional services

Does HCA pay for newborn screening tests?

**Yes.** The initial screening is typically billed through the hospital.

For newborns born at a birthing center or at home, the midwife or physician collects the blood for the newborn screening and sends it to the Washington State Department of Health (DOH). The midwife or physician may bill for the blood collection using the appropriate CPT® code. DOH bills HCA for the newborn screening tests using HCPCS code S3620. HCA reimburses only DOH for this service.

For subsequent screenings done in an outpatient setting, the provider may bill for blood collection using the appropriate CPT® code.

The newborn screening panel includes tests for treatable disorders as determined by DOH. For the most current list of tests included in the screening panel, visit DOH’s webpage.

Newborn screening panels are covered in accordance with DOH recommendations. For most infants, newborn screening requires two tests on two different dates of service. For some infants, a third newborn screen is recommended. Refer to the DOH Newborn Screening Program Health Care Provider Manual for guidance on the timing and frequency of newborn screening tests.
**Physician care plan oversight**  
*(CPT® codes 99375, 99378, and 99380)*

**HCA covers:**
- Physician care plan oversight services once per client, per month.
  - A plan of care must be established by the home health agency, hospice, or nursing facility.
  - The provider must perform 30 or more minutes of oversight services for the client each calendar month.

**HCA does not cover:**
- Physician care plan oversight services of less than 30 minutes per calendar month (CPT® codes 99374, 99377, and 99379).
- Physician care plan oversight services provided by more than one provider during the global surgery payment period unless the care plan oversight is unrelated to the surgery.

**Physician supervision of a patient requiring complex and multidisciplinary care modalities**

HCA covers CPT® codes 99339 and 99340 with prior authorization. For supervision services that are less than 30 minutes, use CPT® code 99339; and for services exceeding 30 minutes, use CPT® code 99340. There is a unit limit of one unit of CPT® code 99339 or one unit of CPT® code 99340 per calendar month. Claims are subject to post-payment review. Clear documentation of care plan oversight is required by HCA, including:

- Time allocation.
- Care plans.
- Review of diagnostic reports and laboratory studies.
- Treatment-related communications with other health care professionals and caregivers.
- Adjustment of medical therapy.
<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>99339</td>
<td>Domicil/r-home care supervis</td>
<td>Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) and/or key caregiver(s) involved in patient’s care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes</td>
</tr>
<tr>
<td>99340</td>
<td>Domicil/r-home care supervis</td>
<td>Within a calendar month; 30 minutes or more</td>
</tr>
</tbody>
</table>

**Preventative medicine services**

**HIV/AIDS counseling/testing (CPT® code 99401)**

HCA covers two sessions of risk factor reduction counseling (CPT® code 99401) counseling per client, each time tested (i.e., one pre- and one post-HIV/AIDS counseling/testing session). Use ICD diagnosis code Z71.7 when billing CPT® code 99401 for HIV/AIDS counseling.

HCA does not pay for HIV/AIDS counseling when billed with an E/M service unless the client is being seen on the same day for a medical problem and the E/M service is billed with a separately identifiable diagnosis code and with modifier 25.

Prolonged services
(CPT® codes 99354-99357)

Prolonged services with direct patient contact
HCA covers prolonged services:

- Up to three hours per client, per diagnosis, per day.
- Only when the provider performs one of the services listed below for the client on the same day:

<table>
<thead>
<tr>
<th>Prolonged HCPCS Code</th>
<th>Other CPT® Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>G2212</td>
<td>99205, 99215</td>
</tr>
</tbody>
</table>

- For the following codes, the time counted toward payment for prolonged E/M services includes direct face-to-face contact between the provider and the client for CPT® codes 99354-99355, or time at bedside on the floor for CPT® codes 99356-99357, even if the time spent was not continuous:

<table>
<thead>
<tr>
<th>Prolonged CPT® Code</th>
<th>Other CPT® Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99354</td>
<td>90837, 90847, 99241-99245, 99324-99337, 99341-99350</td>
</tr>
<tr>
<td>99355</td>
<td>99354 and one of the E/M codes required for 99354</td>
</tr>
<tr>
<td>99356</td>
<td>90837, 90847, 99218-99220, 99221-99233, 99224-99226, 99231-99233, 99234-99236, 99251-99255, 99304-99310</td>
</tr>
<tr>
<td>99357</td>
<td>99356 and one of the E/M codes required for 99356</td>
</tr>
</tbody>
</table>

**Note:** Both the prolonged services CPT® code and any of the “Other CPT® Code(s)” listed above must be billed on the same claim.
Physician standby services
(CPT® code 99360)

HCA covers physician standby services when those services are requested by another physician and involve prolonged physician attendance without direct (face-to-face) client contact.

**Note:** The standby physician cannot provide care or services to other clients during the standby period.

**Limitations**
- Standby services of less than 30 minutes are not covered.
- After the first 30 minutes, subsequent periods of standby services are covered only when a full 30 minutes of standby is provided for each unit billed.

**HCA does not cover physician standby services when:**
- The provider performs a surgery that is subject to the global surgery policy.
- Billed in addition to any other procedure code, except for CPT® codes 99460 and 99465.
- When the service results in an admission to a neonatal intensive care unit (CPT® code 99468) on the same day.

**Telemedicine**

**What is telemedicine?**
Telemedicine is when health care practitioners use HIPAA-compliant, interactive, real-time audio and video telecommunications (including web-based applications) or store and forward technology to deliver covered services that are within their scope of practice to a client at a site other than the site where the provider is located.

If the service is provided through store and forward technology, there must be an associated office visit between the client and the referring health care provider.

Using telemedicine when it is medically necessary enables the health care practitioner and the client to interact in real-time communication as if they were having a face-to-face session. Telemedicine allows HCA clients, particularly those in medically underserved areas of the state, improved access to essential health care services that may not otherwise be available without traveling long distances.
HCA does not cover the following services as telemedicine:
- Email, audio only telephone, and facsimile transmissions
- Installation or maintenance of any telecommunication devices or systems
- Purchase, rental, or repair of telemedicine equipment

Who is eligible for telemedicine?
Fee-for-service clients are eligible for medically necessary covered health care services delivered via telemedicine. The referring provider is responsible for determining and documenting that telemedicine is medically necessary. As a condition of payment, the client must be present and participating in the telemedicine visit. Clients under the Family Planning Only – Pregnancy Related program, Family Planning Only program (formerly referred to as TAKE CHARGE), First Steps, and School-Based Health Care Services programs are eligible for telemedicine through fee-for-service.

When does HCA cover telemedicine?
HCA covers telemedicine when it is used to substitute for an in-person face-to-face, hands-on encounter for only those services specifically listed in this telemedicine section. MCO’s cover the delivery of care via telemedicine. Follow the MCO’s policy and billing requirements.

Telemedicine and COVID-19
Refer to the Health Care Authority’s Provider Billing Guides and Fee Schedules webpage, under Telehealth, for current telemedicine policy.

What are the documentation requirements?
The documentation requirements are the same as those listed in Evaluation and management documentation and billing, in addition to the following:
- Specification of the telehealth modality that was used (e.g., visit was conducted via HIPAA-compliant real-time audio/visual)
- Verification that telemedicine was clinically appropriate for this service
- Whether any assistive technologies were used
- The location of the client
- The names and credentials (MD, ARNP, RN, PA, CNA, etc.) of all provider personnel involved in the telemedicine visit
- Consent for care via the modality that was used
Originating site (location of client)

What is an originating site?
An originating site is the physical location of the eligible HCA client at the time the professional service is provided by a physician or practitioner through telemedicine. Approved originating sites are:

- Clinics
- Community mental health/chemical dependency settings
- Dental offices
- Federally qualified health centers (FQHC)
- Homes or any location determined appropriate by the individual receiving service
- Hospitals (inpatient and outpatient)
- Neurodevelopmental centers
- Physician or other health professional’s offices
- Renal dialysis centers, except an independent renal dialysis center
- Rural health clinics (RHC)
- Schools
- Skilled nursing facilities

Is the originating site paid for telemedicine?
Yes. The originating site is paid an originating site facility fee per completed transmission for telemedicine services. HCA does not pay the originating site facility fee to the client in any setting.

How does the originating site bill HCA for the originating site facility fee?

- **Hospital outpatient:** When the originating site is a hospital outpatient agency, payment for the originating site facility fee will be paid according to the maximum allowable fee schedule. To receive payment for the originating site facility fee, outpatient hospital providers must bill revenue code 0780 on the same line as HCPCS code Q3014.

- **Hospital inpatient, skilled nursing facility, home, or location determined appropriate by the individual receiving service:** There is no payment to the originating site for the originating site facility fee in these settings.

- **Critical access hospitals:** When the originating site is a critical access hospital outpatient agency, payment is separate from the cost-based payment methodology. To receive payment for the originating site facility fee, critical access hospitals must bill revenue code 0780 on the same line as HCPCS code Q3014.

- **FQHCs and RHCs:** When the originating site is an FQHC or RHC, bill for the originating site facility fee using HCPCS code Q3014. This is not considered an FQHC or RHC service and is not paid as an encounter.
- **Physicians' or other health professional offices:** When the originating site is a physician’s office, bill for the originating site facility fee using HCPCS code Q3014.

- **Other settings:** When the originating site is an approved telemedicine site, bill for the originating site facility fee using HCPCS Q3014.

If a provider from the originating site performs a separately identifiable service for the client on the same day as telemedicine, documentation for both services must be clearly and separately identified in the client’s medical record.

**Distant site (location of consultant)**

**What is a distant site?**

A distant site is the physical location of the health care professional providing the health care service to an eligible HCA client through telemedicine.

**What services are covered using telemedicine?**

HCA reimburses medically necessary covered services through telemedicine when the service is provided by a Washington Apple Health provider and is within their scope of practice.

**How does the distant site bill HCA for the services delivered through telemedicine?**

The payment amount for the professional service provided through telemedicine by the provider at the distant site is equal to the current fee schedule amount for the service provided. Submit claims for telemedicine services using the appropriate CPT or HCPCS code for the professional service.

Use place of service (POS) 02 to indicate that a billed service was furnished as a telemedicine service from a distant site.

**Effective for dates of service on and after April 4, 2022,** providers must use the following coding guidance when billing with place of service (POS) 02 or 10. Providers whose systems are ready to bill using new POS 10 before April 4, 2022, may begin to do so effective with dates of service on and after January 1, 2022:

<table>
<thead>
<tr>
<th>Place of service (POS)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>The location where health services and health related services are provided or received through telecommunication technology. Patient is not located in their home when receiving health services or health-related services through telecommunication technology.</td>
</tr>
</tbody>
</table>
### Place of service (POS) Description

| 10 | The location where health services and health-related services are provided or received through telecommunication technology. Patient is in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health-related services through telecommunication technology. |

When billing for POS 02:
- Add modifier 95 if the distant site is designated as a nonfacility.
- Nonfacility providers must add modifier 95 to the claim to receive the nonfacility payment.

HCA discontinued the use of the GT modifier for claims submitted for professional services (services billed on a CMS-1500 claim form, when submitting paper claims). Distant site practitioners billing for telemedicine services under the Critical Access Hospital (CAH) optional payment method must use the GT modifier. See HCA’s [ProviderOne Billing and Resource Guide](#) for more information on submitting claims to HCA. See HCA’s [Inpatient Hospital Services Billing Guide](#) for more information on billing for services under the CAH optional payment method.

Follow CMS guidance for modifiers if Medicare is the primary insurance.

### Store and Forward

Store and Forward is the transmission of medical information to be reviewed later by a physician or practitioner at a distant site. A client’s medical information may include, but is not limited to, video clips, still images, x-rays, laboratory results, audio clips, and text. The physician or practitioner at the distant site reviews the case without the client present.

HCA pays for Store and Forward for teledermatology.

HCA pays for Store and Forward when all the following conditions are met:
- It is associated with an office visit between the eligible client and the referring health care provider. The associated visit can be done in person or via asynchronous telemedicine and include one or more of the following types of information: video clips, still images, x-rays, MRIs, electrocardiograms and electroencephalograms, laboratory results, audio clips, and text. The visit results in a documented care plan that is communicated back to the referring provider.
- The transmission of protected health information is HIPPA compliant.
- Written informed consent is obtained from the client that store and forward technology will be used and who the consulting provider is.

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If the consultation results in a face-to-face visit in person or via telemedicine with the specialist within 60 days of the Store and Forward consult, HCA does not pay for the store and forward consultation.

Teledermatology does not include single-mode consultations by telephone calls, images transmitted via facsimile machines, or electronic mail.

Teledermatology services provided via store and forward telecommunications system must be billed with modifier GQ.

Only the portion(s) rendered from the distant site are billed with modifier GQ. The sending provider bills as usual with the E/M and no modifier. The use of modifier GQ does not alter reimbursement for the CPT or HCPCS code billed.

**Note:** The originating site for Store and Forward is not eligible to receive an originating site fee.

The POS 02 must be used to indicate the location where health services are provided through store and forward technology. The POS 02 code does not apply to the originating site.

**Claims will be denied if a bill is submitted for Store and Forward services with POS code 02 but without the GQ modifier.**

HCA may perform a post-pay review on any claim to ensure the above conditions were met.

The following codes are covered for teledermatology:

<table>
<thead>
<tr>
<th>E/M Service CPT® Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241-99243</td>
<td>Office consultation, new or established patient</td>
</tr>
<tr>
<td>99251-99253</td>
<td>Initial inpatient consultation</td>
</tr>
<tr>
<td>99211-99214</td>
<td>Office or other outpatient visit</td>
</tr>
<tr>
<td>99231-99233</td>
<td>Subsequent hospital care</td>
</tr>
</tbody>
</table>

**Note:** Teledermatology requires expedited prior authorization (EPA). See EPA #870001419.
Anesthesia

General anesthesia

- HCA requires providers to use anesthesia CPT® codes 00100-01999 to bill for anesthesia services paid with base and time units. Do not use the surgical procedure code with an anesthesia modifier to bill for the anesthesia procedure.

- HCA pays for CPT® code 01922 for noninvasive imaging or radiation therapy when either of the following applies:
  - The client is 17 years of age or younger.
  - There are client-specific reasons why the procedure cannot be performed without anesthesia services. Documentation must be kept in the client’s medical record.

- HCA pays providers for covered anesthesia services performed by one of the following:
  - Anesthesiologist
  - Certified registered nurse anesthetist (CRNA)
  - Other providers who have a contract with HCA to provide anesthesia services (See also Oral surgery)

- For each client, the anesthesia provider must do all the following:
  - Perform a pre-anesthetic examination and evaluation
  - Prescribe the anesthesia plan
  - Personally, participate in the most demanding aspects of the anesthesia plan, including, induction and emergence
  - Ensure that any procedures in the anesthesia plan that he or she does not perform are done 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 postanesthesia care

- The anesthesia provider may direct no more than four anesthesia services concurrently. The anesthesia provider may not perform any other services while directing these services, other than attending to medical emergencies and other limited services as allowed by Medicare policy.

- The anesthesia provider must document in the client’s medical record that the medical direction requirements were met. Providers do not need to submit documentation with each claim to substantiate these requirements.
- Anesthesia time begins when the anesthesia provider starts to physically prepare the client for the induction of anesthesia in the operating room area or its equivalent. When there is a break in continuous anesthesia care, blocks of time may be summed if there is continuous monitoring of the client within the blocks of time. An example of this includes, but is not limited to, the time a client spends in an anesthesia induction room or under the care of an operating room nurse during a surgical procedure. Anesthesia time ends when the anesthesia provider or surgeon is no longer in constant attendance (i.e., when the client can be safely placed under postoperative supervision).

- Do not bill CPT® codes 01953 or 01996 with an anesthesia modifier or with the time in the "units" field. HCA has assigned flat fees for these codes.

- HCA does not adopt any ASA RVG codes that are not included in the CPT book. Bill all anesthesia codes according to the descriptions published in the current CPT book. When there are differences in code descriptions between the CPT book and the ASA RVG, HCA follows CPT® code descriptions.

- HCA does not pay providers for anesthesia services when these services are billed using the CPT surgery, radiology, and/or medicine codes with anesthesia modifiers. Continue to use the appropriate anesthesia modifier with anesthesia CPT® codes.

**Exception:** Anesthesia providers may bill CPT pain management/other services procedure codes that are not paid with base and time units. These services are paid as a procedure using RBRVS methodology. Do not bill time in the unit field or use anesthesia modifiers.

- When billing for sterilization, details regarding anesthesia are in the Sterilization Supplemental Billing Guide.

- When multiple surgical procedures are performed during the same period of anesthesia, bill the surgical procedure with the greatest base value, along with the total time in whole minutes.

- When more than one anesthesia provider is present, HCA pays each provider 50% of the allowed amount. HCA limits payment in this circumstance to 100% of the total allowed payment for the service.

- Providers must report the number of actual anesthesia minutes (calculated to the next whole minute) in the appropriate field on the claim. HCA calculates the base units.

**Note:** When billing for Medicare crossovers, remember that Medicare pays per the base units and HCA pays per minute of anesthesia. When billing a Medicare crossover on a Direct Data Entry (DDE) claim, bill HCA using minutes in the unit field. When billing a Medicare crossover on a HIPAA 837P transaction, bill units the same as if billing Medicare.
Regional anesthesia

- Bill HCA the appropriate procedure code (e.g., epidural CPT® code 62326) with no time units and no anesthesia modifier. HCA determines payment by using the procedure’s maximum allowable fee, not anesthesia base and time units.
- Local nerve block CPT® code 64450 (other than digital and metacarpal) for subregional anatomic areas (such as the hand, wrist, ankle, foot, and vagina) is included in the global surgical package and is not paid separately.

Moderate sedation

Moderate sedation is a drug induced depression of consciousness performed while the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Moderate sedation does not include minimal sedation, deep sedation, or monitored anesthesia care.

Providers must report the appropriate CPT or HCPCS code that describes the moderate sedation services provided. Moderate sedation services are provided in combination with and in support of a procedural service, consistent with CPT guidance.

Moderate sedation is covered when medically necessary.

Other

- Patient acuity does not affect payment levels. Qualifying circumstances (CPT® codes 99100, 99116, 99135, and 99140) are considered bundled and are not paid separately.
- HCA follows Medicare’s policy of not paying surgeons for anesthesia services. Claims for anesthesia services with modifier 47 will be denied. Under Medicare’s payment policy, separate payment for local, regional, or digital block or general anesthesia administered by the surgeon is not allowed. These services are considered included in the RBRVS payments for the procedure.
- When billing for anesthesia services using CPT unlisted anesthesia code 01999, providers must attach documentation (operative report) to their claim indicating what surgical procedure was performed that required the anesthesia, to receive payment. HCA will determine payment amount after review of the documentation.

Teaching anesthesiologists

HCA pays teaching anesthesiologists for supervision of anesthesiology residents as follows:

- When supervising one resident only, the teaching anesthesiologist must bill HCA the appropriate anesthesia procedure code with modifier AA. Payment to the teaching anesthesiologist will be 100% of the allowed amount.
• When supervising two or more residents concurrently, the teaching anesthesiologist must bill HCA the appropriate anesthesia procedure codes with modifier QK. Payment to the teaching anesthesiologist will be 50% of the allowed amount for each case supervised.

Physician fee schedule payment for services of teaching physicians
General rule: If a resident physician participates in providing a service in a teaching setting, physician fee schedule payment is made only if a teaching physician is present during the key portion of any service or procedure for which payment is sought.

• Surgical, high-risk, or other complex procedures: The teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure.
  o Surgery: The teaching physician’s presence is not required during opening and closing of the surgical field.
  o Procedures performed through an endoscope: The teaching physician must be present during the entire viewing.

• Evaluation and management services: The teaching physician must be present during the portion of the service that determines the level of service billed. (However, in the case of evaluation and management services furnished in hospital outpatient departments and certain other ambulatory settings, the requirements of 42 C.F.R. §415.174 apply.)

Anesthesia for dental
General anesthesia is allowed when provided by an anesthesiology provider in a hospital for dental admissions. To bill for dental anesthesia provided in a hospital, providers must use CPT® anesthesia code 00170 with the appropriate anesthesia modifier.

See HCA’s Dental-Related Services Billing Guide for information on billing for office-based anesthesia for dental procedures.

**Note:** Bill HCA directly for dental anesthesia for all clients, including those enrolled in an HCA-contracted managed care organization.

Anesthesia for labor and delivery
• HCA pays a maximum of 6 hours (360 minutes) of anesthesia for labor and delivery time (CPT® codes 01960, 01961, 01967 and 01968) per delivery, including multiple births and/or cesarean section delivery.
Exception: The following obstetrical anesthesia codes are not subject to the 6-hour (360 minute) limitation: CPT® codes 01962-01966 or 01969.

- When billing more than one time-limited anesthesia code, the total time may not exceed 6 hours (360 minutes).
- Bill the applicable CPT anesthesia code with applicable modifier and time. To determine time for obstetric epidural anesthesia during normal labor and delivery and C-sections, time begins with insertion and ends with removal for a maximum of 6 hours per delivery.
- CPT® codes 01968 and 01969 are anesthesia add-on codes to be used for cesarean delivery and cesarean hysterectomy following anesthesia given for a planned vaginal delivery. An additional base of 3 is allowed for CPT® code 01968 and an additional base of 5 is allowed for CPT® code 01969, in conjunction with the base of 5 for CPT® code 01967. The time involved with each portion of the procedure should be reported with the appropriate CPT code.

For example: When a physician starts a planned vaginal delivery (CPT® code 01967) and it results in a cesarean delivery (CPT® code 01968), both procedures may be billed. However, if both an anesthesiologist and a certified registered nurse assistant (CRNA) are involved, each provider bills only for those services he/she performed. The sum of the payments for each procedure will not exceed HCA’s maximum allowable fee.

- Anesthesia time for sterilization is added to the time for the delivery when the two procedures are performed during the same operative session. If the sterilization and delivery are performed during different operative sessions, the time is calculated separately.

Anesthesia for radiological procedures
General anesthesia is allowed for radiological procedures for children and/or noncooperative clients when the medically necessary procedure cannot be performed unless the client is anesthetized.

Providers must use the anesthesia CPT® code 01922 when providing general anesthesia for noninvasive imaging or radiation therapy. Do not bill the radiological procedure code (e.g., CPT® code 71010) with an anesthesia modifier to bill for the anesthesia procedure. When using CPT® code 01922 for noninvasive imaging or radiation therapy, one of the following must be met:

- The client must be 17 years of age or younger.
- A statement of the client-specific reasons why the procedure cannot be performed without anesthesia services must be kept in the client’s medical record and made available to HCA on request.

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Anesthesia payment calculation for services paid with base and time units

- HCA’s current anesthesia conversion factor is $21.20.
- Anesthesia time is paid using one minute per unit.
- Total anesthesia payment is calculated by adding the base value for the anesthesia procedure with the actual time. Bill time in total minutes only, rounded to the next whole minute. Do not bill the procedure’s base units.

The following table illustrates how to calculate the anesthesia payment:

<table>
<thead>
<tr>
<th>Payment Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Multiply base units by 15.</td>
</tr>
<tr>
<td>B. Add total minutes to value from step A.</td>
</tr>
<tr>
<td>C. Divide anesthesia conversion factor by 15, to obtain the rate per minute.</td>
</tr>
<tr>
<td>D. Multiply total from Step B by the rate per minute in Step C.</td>
</tr>
</tbody>
</table>

Anesthesia conversion factor is based on 15-minute time units.
**Surgery**

HCA requires prior authorization for selected surgical procedures. Providers must check the Physician-related services fee schedule for those surgical services that require either prior authorization (PA) or expedited prior authorization (EPA).

**Tobacco/nicotine cessation**

Nicotine use is a strong contraindication to spine surgeries. Patients undergoing cervical fusions and repeat fusions for radiculopathy are required to abstain from nicotine for four weeks before surgery. HCA covers tobacco/nicotine cessation which can include free counseling and prescription drugs. See Behavior change intervention - tobacco/nicotine cessation.

**Pain management services**

- Pain management services and selected surgical services that are commonly performed by anesthesiologists and CRNAs are not paid with anesthesia base and time units. These services are paid using HCA’s assigned maximum allowable fee for the procedure code.

- When billing for pain management and other services that are payable using HCA’s assigned maximum allowable fee, do not use anesthesia modifiers. HCA denies claims for these services billed with an anesthesia modifier.

- Two postoperative procedures for pain management are allowed during the same inpatient stay. Only one (1) unit may be billed per procedure. Do NOT bill time.
Pain management procedure codes
The listings shown below are not guaranteed to be all-inclusive and are provided for convenience purposes only. The CPT® codes listed in the following table with an asterisk (*) are limited to two (2) during the postoperative period while the client is admitted to the hospital. Do not bill modifier S9, XE, XS, XP, or XU with any of the following CPT® codes.

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>11981*</td>
<td>62272</td>
<td>62361*</td>
<td>64417*</td>
<td>64484*</td>
<td>64595*</td>
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<td>11982*</td>
<td>62273*</td>
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<td>64418*</td>
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<td>64605*</td>
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<td>63650*</td>
<td>64421*</td>
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<td>64425*</td>
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<td>64448*</td>
<td>64565*</td>
<td>64681*</td>
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<td>61790*</td>
<td>62351*</td>
<td>64413*</td>
<td>64479*</td>
<td>64581*</td>
<td>64809*</td>
</tr>
<tr>
<td>62264*</td>
<td>62355*</td>
<td>64415*</td>
<td>64480*</td>
<td>64585*</td>
<td>64818*</td>
</tr>
<tr>
<td>62270</td>
<td>62360*</td>
<td>64416*</td>
<td>64483*</td>
<td>64590*</td>
<td></td>
</tr>
</tbody>
</table>

Other Services

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>36400</td>
<td>36566</td>
<td>36589</td>
<td>36660</td>
<td>76000</td>
<td>77003</td>
</tr>
<tr>
<td>36420</td>
<td>36568</td>
<td>36600</td>
<td>62263</td>
<td>76496</td>
<td>93503</td>
</tr>
<tr>
<td>36425</td>
<td>36580</td>
<td>36620</td>
<td>62287</td>
<td>77001</td>
<td>95970</td>
</tr>
<tr>
<td>36555</td>
<td>36584</td>
<td>36625</td>
<td>63600</td>
<td>77002</td>
<td>95990</td>
</tr>
</tbody>
</table>

These CPT® codes are paid as a procedure using HCA’s maximum allowable fee, not with base units and time.
**Interoperative or postoperative pain management**
HCA covers interoperative and postoperative pain control using a spinal injection or infusion (CPT® codes 62320, 62321, 62322, 62323, 62324, 62325, and 62327). Expedited prior authorization (EPA) is required. See EPA #870001351. If the client does not meet the EPA criteria, prior authorization (PA) is required (see Prior authorization). Authorization requests must be submitted to HCA, not Comagine Health.

**Peripheral nerve ablation**
Based on review of the evidence provided by the Health Technology Clinical Committee (HTCC), HCA does not consider peripheral nerve ablation, using any technique, to treat limb pain including for knee, hip, foot, or shoulder due to osteoarthritis or other conditions, to be medically necessary.

**Registered Nurse First Assistants**
Registered Nurse First Assistants (RNFA) are allowed to assistant at surgeries within their scope of practice. Use modifier AS to bill HCA for these services.

New RNFA providers must meet all the following criteria:
- Licensed in Washington State as a Registered Nurse in good standing
- Work under the direct supervision of the performing surgeon
- Hold current certification as a certified nurse operating room (CNOR)

Submit all the following documentation to HCA along with the Core Provider Agreement:
- Proof of current certification as a CNOR from the Certification Board Perioperative Nursing
- Proof of successful completion of an RNFA program that meets the Association of Perioperative Registered Nurses (AORN) standards for RN first assistant education programs. (See Perioperative Standards and Recommended Practices, Denver, CO: AORN)
- Proof of allied health personnel privileges in the hospital where the surgeries are performed
- Proof of liability insurance
Billing/Payment

Bilateral procedures
- If a procedure is done bilaterally and is identified by its terminology as bilateral (e.g., CPT® codes 27395 or 52290), do not bill the procedure with modifier 50.
- If a procedure is done bilaterally and is not identified by its terminology as a bilateral procedure, bill the procedure using modifier 50 on one line only or include modifier LT or RT on the separate lines when the surgical procedure is performed on both sides.
- Use modifiers LT and RT to indicate left and right for unilateral procedures.

Bundled services
The following procedure codes are bundled within the payment for the surgical procedure during the global period. Do not bill these codes separately unless one of the conditions on the following page exists:

E/M Services

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211-99223</td>
<td>Office visits, initial hospital observation care, and initial hospital inpatient care</td>
</tr>
<tr>
<td>99231-99239</td>
<td>Subsequent hospital care, observation or inpatient care services, and hospital discharge services</td>
</tr>
<tr>
<td>99241-99245</td>
<td>Office consultations</td>
</tr>
<tr>
<td>99291-99292</td>
<td>Critical care services</td>
</tr>
<tr>
<td>99307-99310</td>
<td>Subsequent nursing facility care</td>
</tr>
<tr>
<td>99324-99337</td>
<td>Domiciliary, rest home, or custodial care services</td>
</tr>
<tr>
<td>99347-99350</td>
<td>Home services</td>
</tr>
</tbody>
</table>
Ophthalmological Services

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92012-92014</td>
<td>General ophthalmological services</td>
</tr>
</tbody>
</table>

The E/M codes may be allowed if there is a separately identifiable reason for the additional E/M service unrelated to the surgery. In these cases, the E/M code must be billed with one of the following modifiers:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>Unrelated E/M service by the same physician during a postoperative period (reason for the E/M service must be unrelated to the procedure)</td>
</tr>
<tr>
<td>25</td>
<td>Significant, separately identifiable E/M service by the same physician on the same day of a procedure (reason for the E/M service must be unrelated to the procedure)</td>
</tr>
<tr>
<td>57</td>
<td>Decision for surgery (only applies to surgeries with a 90-day global period)</td>
</tr>
<tr>
<td>79</td>
<td>Unrelated procedure or service by the same physician during the postoperative period</td>
</tr>
</tbody>
</table>

- Professional inpatient services (CPT® codes 99221-99223) are payable only during the global follow-up period if they are performed on an emergency basis (i.e., they are not payable for scheduled hospital admissions).
- Bundled procedure codes are not payable during the global surgery payment period.

A provider (other than the surgeon) who provides all postoperative care (including all inpatient postoperative care) before discharge, must bill subsequent hospital care codes (CPT® codes 99231-99233) for the inpatient hospital care, and the surgical code with modifier 55 for the post-discharge care. The surgeon must bill the surgery code with modifier 54.

- Providers who perform only the follow-up services for minor procedures performed in emergency agencies must bill the appropriate level E/M code. These services are not included in the global surgical payment.
- The provider who performs the emergency room service must bill for the surgical procedure without using modifier 54.
- Preoperative and postoperative critical care services provided during a global period for a seriously ill or injured client are not considered related to a surgical procedure and are paid separately when all the following apply:
  - The client is critically ill or injured and requires the constant attendance of the provider.

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The critical care is unrelated to the specific anatomic injury or general surgical procedure performed.
The client is potentially unstable or has conditions that could pose a significant threat to life or risk of prolonged impairment.

Bill the appropriate critical care codes with either modifier 24 or 25.

- HCA allows separate payment for:
  - The initial evaluation to determine need for surgery.
  - Preoperative visits that occur two or more days before the surgery. Use the specific medical diagnosis for the client. Do not use Z01.89.
  - Postoperative visits for problems unrelated to the surgery.
  - Postoperative visits for services that are not included in the normal course of treatment for the surgery.
  - Services of other providers, except when more than one provider furnishes services that are included in a global package (see modifiers 54 and 55).

Global surgery payment
Global surgery payment includes all the following services:
- The surgical procedure
- For major surgeries (90-day global period), preoperative visits (all sites of service) that occur the day before or the day of the surgery
- For minor surgeries (less than 90-day global period), preoperative visits (all sites of service) that occur on the day of surgery
- Services by the primary surgeon (all sites of service) during the postoperative period
- Postoperative dressing changes, including all the following:
  - Local incision 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, nasogastric and rectal tubes
  - Change and removal of tracheostomy tubes
- Additional medical or surgical services required because of complications that do not require additional operating room procedures

Note: Casting materials are not part of the global surgery policy and are paid separately.
Global surgery payment period

- The global surgery payment period applies to any provider who participates in the surgical procedure. These providers include:
  - The surgeon.
  - The assistant surgeon (modifiers 80, 81, or 82).
  - Two surgeons (modifier 62).
  - Team surgeons (modifier 66).
  - Anesthesiologists and CRNAs.
  - Physician assistant, nurse practitioner, or clinical nurse specialist for assistant at surgery (modifier AS).

Multiple surgeries

When multiple surgeries are performed on the same client, during the same operative session, HCA pays providers:

- 100% of HCA’s maximum allowable fee for the most expensive procedure; plus,
- 50% of HCA’s maximum allowable fee for each additional procedure.

To expedite payment of claims, bill all surgeries performed during the same operative session on the same claim. This includes secondary claims with payment by a primary commercial insurance and Medicare crossover claims.

If a partial payment is made on a claim with multiple surgeries, providers must adjust the paid claim. Refer to the ProviderOne Billing and Resource Guide, Key Step 6 under “Submit Fee for Service Claims to Medical Assistance” which addresses adjusting paid claims. Providers must adjust claims electronically.

Note: For second operative session performed on the same date of service (e.g., return to the operating room for a staged procedure), bill the second operative session on a separate claim. Add in the claim comments, "Operative reports attached" and submit claim to HCA with operative reports.

Other surgical policies

- Use modifiers 80, 81, and 82 to bill for an assistant surgeon. An assistant at major surgery is paid at 20% of the surgical procedure’s maximum allowable fee. The multiple surgery rules apply for surgery assistants.
- Supporting documentation is required to establish the medical necessity of two surgeons for the procedure.
- Use modifier AS for an assistant at surgery for PA-Cs, ARNPs, or Clinical Nurse Specialists – do not use modifier 80. An assistant at major surgery is paid at 20% of the surgical procedure’s maximum allowable fee.
• To expedite payment of claims, bill for the assistant surgeon on a different claim.

• A properly completed consent form must be attached to all claims for sterilization and hysterectomy procedures. For sterilizations, see the Sterilization Supplemental Billing Guide. For hysterectomies, see Hysterectomies in this guide.)

• Microsurgery Add on CPT® Code 69990
CPT indicates that CPT® code 69990 is not appropriate when using magnifying loupes or other corrected vision devices. Also, CPT® code 69990 is not payable with procedures where use of the operative microscope is an inclusive component of the procedure (i.e., the procedure description specifies that microsurgical techniques are used).

HCA follows CCI guidelines regarding the use of the operating microscope. Do not bill CPT® code 69990 in addition to procedures where the use of the operating microscope is an inclusive component.

• Salpingostomies (CPT® codes 58673 and 58770) are payable only for a tubal pregnancy (ICD diagnosis code O00.1).

• Modifier 53 must be used when billing for incomplete colonoscopies (CPT® code 45378 or HCPCS codes G0105 or G0121). Do not bill incomplete colonoscopies as sigmoidoscopies. Modifier 53 indicates that the physician elected to terminate a surgical procedure. Use of modifier 53 is allowed for all surgical procedures. Modifier 53 is a payment modifier when used with CPT® code 45378 or HCPCS codes G0105 or G0121. It is informational only for all other surgical procedures.

• HCA requires EPA for reduction mammoplasties (CPT® code 19318) and for mastectomy for gynecomastia for men (CPT® code 19300). See Expedited prior authorization (EPA) for more information.

Breast removal and breast reconstruction
• HCA pays for the following procedure codes which include breast removal and breast reconstruction for clients who have one of the conditions below. HCA pays for one breast reconstruction; if further surgery is necessary, prior authorization is required. If a client does not have one of the following conditions, the service requires prior authorization (PA):
  o Breast cancer or a history of breast cancer
  o Tested positive for BRCA 1, BRCA 2, or other definitive genetic test for cancer
  o Burns, open wound injuries, or congenital anomalies of the breast.

• HCA allows ICD diagnosis Z42.1 and Z15.01 as primary diagnosis for surgical consultation.

• HCA allows ICD diagnosis Z85.3 as a primary diagnosis for breast reconstruction.
• Removal of failed breast implants with the appropriate ICD diagnosis code T85.41XA or T85.42XA requires PA. HCA will pay to remove implants (CPT® codes 19328 and 19330) but will not replace them if they were placed for cosmetic reasons.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>11920</td>
<td>Correct skin color defects 6.0 cm (use V10.3) (Tattoo)</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>11921</td>
<td>Correct skin color 6.1-20.0 cm</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>11960</td>
<td>Insertion tissue expander(s)</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>11970</td>
<td>Replace tissue expander</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>11971</td>
<td>Remove tissue expander(s)</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>19301</td>
<td>Partial mastectomy</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>19302</td>
<td>P-mastectomy w/In removal</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>19303</td>
<td>Mast simple complete</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>19316</td>
<td>Suspension of breast</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>19340</td>
<td>Immediate breast prosthesis</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>19342</td>
<td>Delayed breast prosthesis</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>19350</td>
<td>Breast reconstruction</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>19357</td>
<td>Breast reconstruction</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>19361</td>
<td>Breast reconstruct w/lat flap</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>19364</td>
<td>Breast reconstruction</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>19367</td>
<td>Breast reconstruction</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>19368</td>
<td>Breast reconstruction</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>19369</td>
<td>Breast reconstruction</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>19370</td>
<td>Surgery of breast capsule</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>19371</td>
<td>Removal of breast capsule</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>CPT® Code</td>
<td>Short Description</td>
<td>Limitations</td>
</tr>
<tr>
<td>-----------</td>
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<td>--------------------------------------------------</td>
</tr>
<tr>
<td>19380</td>
<td>Revise breast reconstruction</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>S2066</td>
<td>Breast GAP flap reconst</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
<tr>
<td>S2067</td>
<td>Breast &quot;stacked&quot; DIEP/GAP</td>
<td>Limited to the appropriate ICD dx codes</td>
</tr>
</tbody>
</table>

**Panniculectomy**

Panniculectomy requires prior authorization (PA). Photographs and supporting clinical documentation must be submitted with PA requests. See Prior authorization (PA).

All the following must be present for panniculectomy:
- The pannus hangs at or below the level of the symphysis pubis.
- The pannus causes a chronic and persistent skin condition (e.g., intertriginous dermatitis, panniculitis, cellulitis, or skin ulcerations) that is refractory to at least three months of medical treatment and associated with at least one episode of cellulitis requiring systemic antibiotics. In addition to good hygiene practices, all the following treatments (unless contraindicated) have been tried and failed: topical antifungals, topical or systemic corticosteroids, and local or systemic antibiotics.
- The pannus causes a functional deficit because of a severe physical deformity or disfigurement.
- The surgery is expected to restore or improve the functional deficit.
- The pannus is interfering with daily living.

**Pre-/intra-/postoperative payment splits**

Pre-, intra-, and postoperative payment splits are made when modifiers 54, 55, 56, and 78 are used.

HCA has adopted Medicare’s payment splits. If Medicare has not assigned a payment split to a procedure, HCA uses a payment split of 10%/80%/10% if modifiers 54, 55, 56, and 78 are used. For current information and updates on Medicare payment splits, see the Medicare physician fee schedule (MPFS).
Auditory system

Tympanostomies
Based upon review of evidence provided by the Health Technology Clinical Committee (HTCC), HCA considers tympanostomy tubes for children age 16 and younger to be medically necessary. Expedited prior authorization (EPA) is required. See EPA #870001382. If the client does not meet the EPA criteria, prior authorization (PA) is required (see Prior authorization).

Cochlear implant services (clients age 20 and younger)
Unilateral (CPT® code 69930) and bilateral (CPT® code 69930 with modifier 50) cochlear implantation require EPA (see EPA #870000423 for unilateral and EPA #870001365 for bilateral). If a client does not meet the EPA criteria, PA is required.

HCA covers replacement parts for cochlear devices through HCA’s Hearing Hardware Program only. HCA pays only those vendors with a current core provider agreement that supply replacement parts for cochlear implants and bone conduction hearing devices.

Note: HCA does not pay for new cochlear implantation for clients age 21 and older. HCA considers requests for removal or repair of previously implanted cochlear implants for clients age 21 and older when medically necessary. Prior authorization is required.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>69930</td>
<td>Implant cochlear device</td>
<td>No corresponding removal codes specific to cochlear devices</td>
</tr>
<tr>
<td>69715</td>
<td>Temple bne implnt w/stimulat</td>
<td></td>
</tr>
</tbody>
</table>

Bone conduction hearing devices for clients age 20 and younger
Insertion or initial placement of bone conduction hearing devices (CPT® codes 69714-69718; HCPCS L8693) requires prior authorization (PA) (refer to Prior authorization). For billing the initial placement of soft headband bone conduction hearing devices, use the appropriate E/M procedure code and the appropriate hardware HCPCS code. See HCA’s Hearing hardware fee schedule.

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**Note:** This information relates only to those clients NOT enrolled in an HCA-contracted managed care organization (MCO). For clients enrolled in an HCA-contracted MCO, refer to the coverage guidelines in the enrollee’s plan.

The procedure can be performed in an inpatient hospital setting or outpatient hospital setting.

HCA covers replacement parts or repair for bone conduction hearing devices through HCA’s Hearing Hardware Program only. HCA pays only those vendors that supply replacement parts for cochlear implants and bone conduction hearing devices who have a current Core Provider Agreement.

**Note:** HCA does not pay for a new bone conduction hearing device for clients age 21 and older. HCA considers requests for removal or repair of previously implanted bone conduction hearing devices for clients age 21 and older when medically necessary. PA is required.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>69710</td>
<td>Implant/replace hearing aid</td>
<td>Replacement procedure includes removal of the old device</td>
</tr>
<tr>
<td>69711</td>
<td>Remove/repair hearing aid</td>
<td></td>
</tr>
<tr>
<td>69714</td>
<td>Implant temple bone w/stimul</td>
<td></td>
</tr>
<tr>
<td>69715</td>
<td>Temple bne implnt w/stimulat</td>
<td></td>
</tr>
<tr>
<td>69717</td>
<td>Temple bone implant revision</td>
<td></td>
</tr>
<tr>
<td>69718</td>
<td>Revise temple bone implant</td>
<td></td>
</tr>
</tbody>
</table>

**Bariatric surgeries**

(WAC 182-550-2301)

Bariatric surgery requires prior authorization (PA) and must be performed in a facility that is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).
Clients enrolled in an HCA-contracted managed care organization (MCO) may be eligible for bariatric surgery. Clients enrolled in an HCA-contracted MCO must contact their MCO for information regarding the bariatric surgery benefit.

Clients age 21 through 59
HCA covers medically necessary bariatric surgery for clients 21 through 59 years of age in an approved hospital with a bariatric surgery program in accordance with WAC 182-531-1600. Prior authorization is required. To begin the authorization process, providers must fax HCA a completed Bariatric Surgery Request form 13-785. (See HCA’s Billers, providers, and partners webpage. See also Where can I download HCA forms?)

Clients age 18 through 20
HCA covers medically necessary bariatric surgery for clients age 18 through 20 years:
- For the laparoscopic gastric band procedure (CPT® code 43770).
- When prior authorized.
- When performed in an approved hospital with a bariatric surgery program.
- In accordance with WAC 182-531-1600.

Bariatric case management fee
HCA may authorize up to 34 units of a bariatric case management fee as part of the Stage II bariatric surgery approval. One unit of HCPCS code G9012 = 15 minutes of service. Prior authorization is required.

This fee is given to the primary care provider or bariatric surgeon performing the services required for Bariatric Surgery Stage II. This includes overseeing weight loss and coordinating and tracking all the necessary referrals, which consist of a psychological evaluation, nutritional counseling, and required medical consultations as requested by HCA.

Clients enrolled in an HCA-contracted managed care organization (MCO) must contact their MCO for information regarding coverage of bariatric case management.
Cardiovascular system

Carotid artery stenting
HCA pays for extracranial carotid artery stenting:

- When performed in an HCA-accredited facility as determined by CMS. For a list of accredited facilities, see CMS’s webpage for Carotid artery stenting facilities.
- For patients who are at high surgical risk for carotid endarterectomy (CEA) and who also have one of the following:
  - Symptomatic carotid artery stenosis >50%
  - Asymptomatic carotid artery stenosis ≥80%

Patients at high surgical risk for CEA are defined as having significant comorbidities or anatomic risk factors (i.e., recurrent stenosis and/or previous radical neck dissection), or both, and would be poor candidates for CEA. Significant comorbid conditions include, but are not limited to the following:

- Congestive heart failure (CHF) class III/IV
- Left ventricular ejection fraction (LVEF) < 30%
- Unstable angina
- Contralateral carotid occlusion
- Recent myocardial infarction (MI)
- Previous CEA with recurrent stenosis
- Prior radiation treatment to the neck
- Other conditions that were used to determine patients at high risk for CEA in the prior carotid artery stenting trials and studies, such as ARCHER, CABERNET, SAPPHIRE, BEACH, and MAVERIC II

HCA does not pay for carotid artery stenting of intracranial arteries.

Implantable ventricular assist devices
Left ventricular assist devices (LVAD), right ventricular assist devices (RVAD), Bi-ventricular assist devices (BiVAD)

HCA may consider implantable ventricular assist devices with FDA approval to be medically necessary in the following situations:

- For use as a bridge to transplantation when both of the following requirements are met:
  - The client is currently listed as a heart transplantation candidate or under evaluation to determine eligibility for heart transplantation.
  - The client is not expected to live until a donor heart is available.
• For use in the post-cardiotomy setting in clients who are unable to be weaned off cardiopulmonary bypass.
• For use as a destination therapy when the following requirements are met:
  o The client is at end-stage heart failure.
  o There is documented ineligibility for human heart transplantation.
  o The client has either of the following:
    o New York Heart Association (NYHA) class III or IV* for at least 28 days and received at least 14 days support with an intraaortic balloon pump or is dependent on intravenous inotropic agents, with two failed weaning attempts
    o NYHA class IV* heart failure for at least 60 days.

*NYHA Class III = marked limitation of physical activity; less than ordinary activity leads to symptoms
NYHA Class IV= inability to carry on any activity without symptoms; symptoms may be present at rest

**Note:** Destination therapy must be done at a CMS-approved VAD destination therapy facility.

**Implantable ventricular assist devices battery replacement and accessories**
• Battery replacement- 6 months
• Accessories- 1 year

**Percutaneous ventricular assist devices (pVAD)**
HCA considers an FDA-approved percutaneous left ventricular assist device (pVAD) medically necessary for the following indications:
• Providing short-term circulatory support in cardiogenic shock
• As an adjunct to percutaneous coronary intervention (PCI) in the following high-risk patients:
  o Clients undergoing unprotected left main or last-remaining-conduit PCI with ejection fraction less than 35%
  o Clients with three vessel disease end diastolic ejection fraction less than 30%
**Pediatric VAD (age 0-18 years)**

HCA considers FDA-approved pediatric VADs medically necessary when both of the following criteria are met:

- The child has documented end-stage left ventricular failure.
- An age- and size-appropriate VAD will be used until a donor heart can be obtained.

**Varicose vein treatment**

Based upon review of evidence provided by the HTCC, HCA considers treatment for varicose veins medically necessary when the following criteria are present:

- Demonstrated reflux in the affected vein
- Minimum of three months of symptoms of pain or swelling sufficient to interfere with instrumental activities of daily living or presence of complications (e.g., ulceration, bleeding, or recurrent thrombophlebitis)
- For tributary varicose veins, the previous two conditions must apply and must have a diameter larger than 3 mm.

Treatments included in this policy are:

- Endovenous Laser Ablation
- Radiofrequency Ablation
- Sclerotherapy
- Phlebectomy

Varicose vein treatment requires a medical necessity review by Comagine Health. Contraindications for treatment for varicose vein include:

- Pregnancy
- Active infection
- Peripheral arterial disease
- Deep vein thrombosis
Digestive system

Diagnostic upper endoscopy for GERD
Diagnostic upper endoscopy for adults with gastroesophageal reflux disease (GERD) may be considered medically necessary with one of the following conditions:

- Failure of an adequate trial of medical treatment to improve or resolve symptoms
- Presence of the following alarm symptoms:
  - Persistent dysphagia or odynophagia
  - Persistent vomiting of unknown etiology
  - Evaluation of epigastric mass
  - Confirmation and specific histological diagnosis of radiologically demonstrated lesions
  - Evaluation for chronic blood loss and iron deficiency anemia when an upper gastrointestinal source is suspected or when colonoscopy results are negative
  - Progressive unintentional weight loss

This policy does not apply to therapeutic endoscopy (e.g., removal of foreign body) or for clients with known esophageal or gastric varices or neoplasms, inflammatory bowel disease, familial adenomatous polyposis syndrome, biopsy confirmed Barrett’s esophagus, biopsy confirmed esophageal or gastric ulcers, history of upper gastrointestinal stricture.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>43200</td>
<td>Esophagus endoscopy</td>
</tr>
<tr>
<td>43202</td>
<td>Esophagus endoscopy biopsy</td>
</tr>
<tr>
<td>43234</td>
<td>Upper gi endoscopy exam</td>
</tr>
<tr>
<td>43235</td>
<td>Uprr gi endoscopy diagnosis</td>
</tr>
<tr>
<td>43239</td>
<td>Upper gi endoscopy biopsy</td>
</tr>
</tbody>
</table>
**Closure of enterostomy**
Mobilization of splenic flexure (CPT® code 44139) is not paid when billed with enterostomy procedures (CPT® codes 44625 and 44626). CPT® code 44139 must be used only in conjunction with partial colectomy (CPT® codes 44140-44147).

**Fecal microbiota transplantation**
Based upon review of evidence provided by the Health Technology Clinical Committee (HTCC), HCA considers fecal microbiota transplantation (FMT) to be medically necessary for patients with c. difficile infection who have undergone a failed course of appropriate antibiotic therapy.

HCA does not consider fecal microbiota transplantation medically necessary for treatment of inflammatory bowel disease.

HCA may perform a post-pay review on any claim to ensure the treatment met coverage conditions.

**FDA position update:**
The FDA announced that it would exercise enforcement discretion regarding FMT. As long as the treating physician obtains adequate informed consent from the patient or the patient’s legally authorized representative for the procedure, the FDA will not require submission of an Investigational New Drug Application (IND). Informed consent should include, at a minimum, a statement that the use of FMT products to treat c. difficile is investigational and include a discussion of its potential risks. The FMT product is not obtained from a stool bank. The FDA will exercise this discretion on an interim basis while HCA develops appropriate policies for the study and use of FMT products under IND.

**Drug eluting or bare metal cardiac stents**
HCA pays for drug eluting stents or bare metal cardiac stents when the technology criteria are met. This procedure requires EPA. See expedited prior authorization (EPA) criteria for EPA #870000422.

**Cardiovascular**

**Angioscopy**
HCA pays for one unit of angioscopy (CPT® code 35400), per session.
Apheresis
Therapeutic apheresis (CPT® codes 36511-36516) includes payment for all medical management services provided to the client on the date of service. HCA pays for only one unit of either CPT® code per client, per day, per provider. Separate payment is not allowed for the following procedures on the same date that therapeutic apheresis services are provided, unless a significant and separately identifiable condition exists which is reflected by the diagnosis code and billed with modifier 25:

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Office/outpatient visit est</td>
</tr>
<tr>
<td>99212</td>
<td>Office/outpatient visit est</td>
</tr>
<tr>
<td>99213</td>
<td>Office/outpatient visit est</td>
</tr>
<tr>
<td>99214</td>
<td>Office/outpatient visit est</td>
</tr>
<tr>
<td>99215</td>
<td>Office/outpatient visit est</td>
</tr>
<tr>
<td>99231</td>
<td>Subsequent hospital care</td>
</tr>
<tr>
<td>99232</td>
<td>Subsequent hospital care</td>
</tr>
<tr>
<td>99233</td>
<td>Subsequent hospital care</td>
</tr>
</tbody>
</table>

Do not bill apheresis management when billing for critical care time (CPT® codes 99291-99292).

Extracorporeal membrane oxygenation therapy (ECMO)
Based upon review of evidence provided by the Health Technology Clinical Committee (HTCC), HCA considers extracorporeal membrane oxygenation therapy (ECMO) to be medically necessary when used for clients:

- With severe life-threatening, but potentially reversible, acute respiratory or cardiac dysfunction unresponsive to conventional management.
- Who need a bridging therapy for pulmonary failure and who are on a pulmonary transplant list.
- Who need a bridging therapy for cardiac failure and who are eligible for a ventricular assist device or cardiac transplantation.
Note: All procedures must be provided at a facility participating in the Extracorporeal Life Support Organization (ELSO) case registry. To bill for ECMO services, the facility must have, available on request, documentation demonstrating current ELSO registration.

Transcatheter aortic valve replacement (TAVR)
Transcatheter aortic valve (TAVR) is considered medically necessary only for the treatment of severe symptomatic aortic valve stenosis when all the following occur:

- Prior authorization (PA) must be obtained for the procedure.
- The NPI for each team surgeon must be provided for payment.
- The heart team and hospital must be participating in a prospective, national, audited registry approved by CMS.
- Conditions of the CMS Medicare national coverage determinations must be met.

Note: HCA does not pay for TAVR for indications not approved by the FDA, unless treatment is being provided in the context of a clinical trial and PA has been obtained.

Percutaneous pulmonary valve implantation (PPVI)
HCA will cover PPVI with prior authorization (PA) for adult patients and children. To obtain PA, the client:

- Must have right ventricular outflow tract (RVOT) dysfunction following prior RVOT repair.
- Must have conduits equal to or larger than 16 millimeters (mm) and equal to or smaller than 22 mm.
- Cannot undergo, or would like to delay, pulmonary valve replacement through open heart surgery.
- Must have one of the following dx codes:
  - I37.x* – Nonrheumatic pulmonary valve disorders
  - I37.0 – Nonrheumatic pulmonary valve stenosis
  - I37.1 – Nonrheumatic pulmonary valve insufficiency
  - I37.2 – Nonrheumatic pulmonary valve stenosis with insufficiency
  - I37.8 – Other nonrheumatic pulmonary valve disorders
  - I37.9 – Nonrheumatic pulmonary valve disorder, unspecified
  - Q21.3 –Tetralogy of Fallot

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Genital/Reproductive system

Hysterectomies
Prior authorization for hysterectomies is required regardless of the client’s age. Some hysterectomy procedures will require a medical necessity review by Comagine Health to establish medical necessity. However, HCA will use expedited prior authorization (EPA) criteria, instead of a medical necessity review, for one of the following clinical situations:

- Cancer
- Trauma

For more information, including the EPA numbers and specific criteria, refer to Expedited prior authorization (EPA).

- Hysterectomies are paid only for medical reasons unrelated to sterilization. A sterilization consent form is not required when a hysterectomy is performed.

- Federal regulations prohibit payment for hysterectomy procedures until a properly completed Hysterectomy Consent and Patient Information Form, HCA 13-365, is received. See Where can I download HCA forms? To comply with this requirement, surgeons, anesthesiologists, and assistant surgeons must obtain a copy of a completed HCA-approved consent form to attach to their claim.

- ALL hysterectomy procedures require a properly completed HCA-approved Hysterectomy Consent and Patient Information Form, 13-365, regardless of the client’s age or the ICD diagnosis. The form must be completed and signed by all parties prior to the procedure. See Where can I download HCA forms?

- Submit the claim and completed HCA-approved consent form (see HCA’s Billers, providers, and partners webpage).

Download the Hysterectomy Consent and Patient Information Form, 13-365. See Where can I download HCA forms?

Sterilizations
Information on sterilization, instructions on how to complete the sterilization consent form and how to become an approved hysteroscopic sterilization provider are available in HCA’s Sterilization Supplemental Billing Guide.

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**Circumcisions**  
(CPT® codes 54150, 54160, and 54161)

Circumcisions are covered when billed with one of the following diagnoses:

- Phimosis (ICD diagnosis code N47.3 - N47.8)
- Balanoposthitis (ICD diagnosis code N47.0 – N47.8, N48.1)
- Balanitis Xerotica (ICD diagnosis code N48.0)

**Note:** HCA covers circumcisions (CPT® codes 54150, 54160, and 54161) only with medical ICD diagnosis codes Phimosis, Balanoposthitis, or Balanitis Xerotica.

**Integumentary system**

**Clarification of coverage policy for miscellaneous procedures**

Limitations on coverage for certain miscellaneous procedures are listed below:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Short Description</th>
<th>PA?</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>11980</td>
<td>Implant hormone pellet(s)</td>
<td>Y</td>
<td>N/A</td>
</tr>
<tr>
<td>S0189</td>
<td>Testosterone pellet 75 mg</td>
<td>Y</td>
<td>N/A</td>
</tr>
<tr>
<td>S0139</td>
<td>Minoxidil, 10 mg</td>
<td>N</td>
<td>I10 (essential hypertension)</td>
</tr>
</tbody>
</table>

**Musculoskeletal system**

**Artificial disc replacement**

Based on review of the evidence provided by HTCC, HCA considers Cervical Disc Replacement when the technology criteria are met to be medically necessary. These procedures require a medical necessity review by Comagine Health.

HCA does not consider lumbar disc replacement to be medically necessary.

**Bone growth stimulators**

HCA pays for bone growth stimulators (CPT® codes 20974, 20975, and 20979) when the technology criteria are met. These procedures require prior authorization (PA) to establish medical necessity.
Bone morphogenetic protein 2 for lumbar fusion
HCA requires that the following criteria be met for the use of bone morphogenetic protein -2 (rhBMP-2):

- Clients are age 18 and older.
- It is used only in the lumbar spine.
- Either of the following:
  - It is used in primary anterior open or minimally invasive fusion at one level between L4 and S1.
  - Revision of lumbar fusion when autologous bone or bone marrow harvest is not technically feasible or is not expected to result in fusion for clients who are diabetic, smokers or have osteoporosis.
- Lumbar fusion is not covered for clients with a diagnosis of degenerative disc disease.

HCA requires a medical necessity review by Comagine Health for associated spinal fusion procedures. Include in the request for authorization:

- The anticipated use of BMP -2
- Either of the following:
  - The CPT® code 20930.
  - Diagnosis code 3E0U0GB, insertion of recombinant bone morphogenetic protein.

Bone morphogenetic protein 7 for lumbar fusion
HCA will not pay for bone morphogenetic protein – 7 (rhBMP-7) as supporting clinical evidence has not been established.

Cervical spinal fusion arthrodesis
HCA pays for cervical spinal fusion for degenerative disc disease with limitations.

For clients 20 age and younger, HCA does not require prior authorization for these services. For clients age 21 and older, HCA requires a medical necessity review by Comagine Health.

Limitations of Coverage
Cervical spinal fusion is covered when all the following conditions are met:

- Patients have signs and symptoms of radiculopathy
- There is advanced imaging evidence of corresponding nerve root compression
- Conservative (non-operative) care has failed
Cervical surgery for radiculopathy and myelopathy

HCA may cover cervical surgery for neck pain when there is subjective, objective and imaging evidence of radiculopathy or myelopathy. For clients age 20 and younger, HCA does not require prior authorization for the surgeries listed below. For clients age 21 and older the surgeries listed below require a medical necessity review by Comagine Health.

- ACDF anterior cervical discectomy with fusion
- TDA total disc arthroplasty
- Laminotomy
- Laminectomy with or without a fusion
- Laminoplasty
- Foraminotomy
- Corpectomy
- Repeat surgeries

*For nicotine users: Abstinence from nicotine for at least four weeks before surgery as shown by two negative urine cotinine tests is highly recommended for all fusions and repeat fusions done for radiculopathy. This does not apply to progressive myelopathy or motor radiculopathy. Tobacco/nicotine cessation services are a covered benefit. See Behavior change intervention - tobacco/nicotine cessation.

Endoscopy procedures

Endoscopy procedures are paid as follows:

- When multiple endoscopies from the same endoscopy group are performed on the same day, the procedure with the highest maximum allowable fee is paid the full amount. The second, third, etc., are paid at the maximum allowable amount minus the base endoscopy procedure’s allowed amount.
- When multiple endoscopies from different endoscopy groups are billed, the multiple surgery rules detailed above apply.
- When payment for other procedures within an endoscopy group is less than the endoscopy base code, no payment is made.
- HCA does not pay for an E/M visit on the same day as the diagnostic or surgical endoscopy procedure unless there is a separately identifiable service unrelated to the endoscopy procedure. If it is appropriate to bill the E/M code, use modifier 25.

Epiphyseal

Epiphyseal surgical procedures (CPT® codes 25450, 25455, 27185, 27475, 27477-27485, 27742, and 27730-27740) are allowed only for clients age 17 and younger.
**Extracorporeal shock wave therapy**
Based upon review of evidence provided by HTCC, HCA does not consider extracorporeal shock wave therapy for musculoskeletal conditions to be medically necessary.

**Hip resurfacing**
HCA does not consider hip resurfacing to be medically necessary.

**Hip surgery for femoroacetabular impingement syndrome**
Based upon review of evidence provided by HTCC, HCA does not consider hip surgery to be medically necessary for treatment of femoroacetabular impingement syndrome.

**Knee arthroscopy for osteoarthritis**
HCA does not recognize lavage, debridement and/or shaving of the knee (CPT® code 29877) as medically necessary when these are the only procedure(s) performed during the arthroscopy. HCA does not reimburse for CPT® code 29877 under these circumstances. HCA will pay for arthroscopies done for other diagnostic and therapeutic purposes. This requires a medical necessity review by Comagine Health.

**Microprocessor-controlled lower limb prostheses**
See HCA’s Prosthetic and Orthotic (P&O) Devices Billing Guide.

**Osteochondral allograft and autograft transplantation**
HCA does not recognize osteochondral allograft or autograft transplantation for joints other than the knee as medically necessary. Osteochondral allograft or autograft transplantation in the knee joint may be considered medically necessary.

Osteochondral allograft or autograft transplantation is considered medically necessary under all the following conditions:

- The client is younger than 50 years of age.
- There is no presence of malignancy, degenerative arthritis, or inflammatory arthritis in the joint.
- There is a single focal full-thickness articular cartilage defect that measures less than 3 cm in diameter and 1 cm in bone depth on the weight bearing portion of the medial or lateral femoral condyle.

The following codes are covered and require a medical necessity review by Comagine Health for clients age 21 and older:

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<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>29866</td>
<td>Autgrft implnt knee w/scope</td>
<td></td>
</tr>
<tr>
<td>29867</td>
<td>Allgrft implnt knee w/scope</td>
<td></td>
</tr>
<tr>
<td>29868</td>
<td>Meniscal trnspl knee w/scpe</td>
<td></td>
</tr>
</tbody>
</table>

**Osteotomy reconstruction**

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>21198</td>
<td>Reconstr lwr jaw segment</td>
<td>Does not require PA when billed with the appropriate ICD diagnoses</td>
</tr>
</tbody>
</table>

**Kyphoplasty, vertebroplasty, and sacroplasty**

Based on review of the evidence provided by the HTCC, HCA does not consider kyphoplasty, vertebroplasty, and sacroplasty to be medically necessary for relief of pain and improvement of function for spinal fractures.

**Sacroiliac joint fusion**

Based upon review of evidence provided by the HTCC, HCA does not consider minimally invasive and open sacroiliac joint fusion procedures to be medically necessary for clients age 21 and older with chronic sacroiliac joint pain related to degenerative sacroiliitis or sacroiliac joint disruption, or both. This decision does not apply to any of the following:

- Low back pain of other etiology
- Sacroiliac joint pain related to recent major trauma or fracture
- Infection
- Cancer
- Sacroiliitis associated with inflammatory arthropathies

For these issues, see the fee schedule for coverage.

**Robotic assisted surgery**

Although robotic assisted surgery (RAS) may be considered medically necessary, HCA does not pay separately for HCPCS code S2900 and reimburses only for the underlying procedure.
When billing for the underlying procedure, HCA requests billing providers to include RAS on the claim to track utilization and outcome. HCA will monitor RAS through retrospective auditing of billing and the review of operative reports.

**Nervous system**

**Discography**
The following procedures require prior authorization from HCA for clients age 21 and older. Prior authorization is not required for clients age 20 and younger.

Discography for clients with chronic low back pain and uncomplicated lumbar degenerative disc disease is considered not medically necessary. Conditions which may be considered for authorization by HCA include:

- Radiculopathy.
- Functional neurologic deficits (motor weakness or EMG findings of radiculopathy).
- Spondylolisthesis (Grade 1).
- Isthmic spondylolysis.
- Primary neurogenic claudication associated with stenosis.
- Fracture, tumor, infection, inflammatory disease.
- Degenerative disease associated with significant deformity.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>62290</td>
<td>Inject for spine disk x-ray</td>
</tr>
<tr>
<td>62291</td>
<td>Inject for spine disk x-ray</td>
</tr>
<tr>
<td>72285</td>
<td>Discography cerv/thor spine</td>
</tr>
<tr>
<td>72295</td>
<td>X-ray of lower spine disk</td>
</tr>
</tbody>
</table>
Facet neurotomy, cervical and lumbar
Facet neurotomy requires a medical necessity review by Comagine Health. HCA has instructed Comagine Health to use Washington State’s Labor & Industries (L&I) Medical Treatment Guidelines (MTG) to establish medical necessity with the following exceptions:

A trial of conservative treatment modalities has been tried and failed for a minimum of three months, instead of six months, including all the following:

- Medications: NSAIDS, muscle relaxants, corticosteroids, antidepressants, anticonvulsants, or opiates
- Activity modification
- Physical therapy

Lumbar radiculopathy
Based on review of the evidence provided by HTCC, HCA considers surgery for lumbar radiculopathy or sciatica to be medically necessary for disectomy or microdiscectomy with or without endoscopy (lumbar laminectomy, laminotomy, discectomy, foraminotomy) with all the following conditions:

- For clients age 21 and older with lumbar radiculopathy with subjective and objective neurologic findings that are corroborated with an advanced imaging test (i.e., Computed Tomography (CT) scan, Magnetic Resonance Imaging (MRI), or myelogram)
- There is a failure to improve with a minimum of 6 weeks of nonsurgical care, unless progressive motor weakness is present

HCA does not consider minimally invasive procedures that do not include laminectomy, laminotomy, or foraminotomy, including but not limited to the following, to be medically necessary:

- Energy ablation techniques
- Automated Percutaneous Lumbar Discectomy (APLD)
- Percutaneous laser
- Nucleoplasty

Implantable infusion pumps or implantable drug delivery systems
HCA pays for CPT® codes 62350, 62351, 62360, and 62361 when medically necessary and only for the indications below:

- Cancer pain
- Spasticity
Note: Implantable drug delivery systems (Infusion Pump or implantable drug delivery system) are not considered medically necessary for treatment of chronic pain not related to cancer.

Spinal cord stimulation for chronic neuropathic pain
Based upon review of evidence provided by HTCC, HCA does not consider spinal cord stimulation for chronic neuropathic pain to be medically necessary. For the revision, removal, or update of existing stimulator or electrode array/equipment, submit a prior authorization request to HCA.

Spinal injections for diagnostic or therapeutic purposes (outpatient)
HCA requires medical necessity reviews for spinal injection procedures, including diagnostic selective nerve root block through Comagine Health, which uses an established online questionnaire. (See Comagine Health in this guide for additional information.)

Diagnostic selective nerve root block
HCA requires a medical necessity review for the diagnostic selective nerve root block through Comagine Health.

Sacroiliac joint injections
For this procedure, the following policy applies:
- The patient has chronic sacroiliac joint pain.
- There must be a failure of at least 6 weeks of conservative therapy.
- These injections must be done with fluoroscopic or CT guidance

Restrictions:
- There must be no more than 1 injection without medical record documentation of at least 30% improvement in function and pain, when compared to the baseline documented before the injections started.
- Requests for more than 2 injections require clinical review.

Therapeutic/diagnostic epidural injections in the cervical, thoracic, or lumbar spine
Therapeutic/diagnostic epidural injections in the cervical, thoracic, or lumbar spine are considered medically necessary for the treatment of chronic pain when the following criteria are met:
- Radicular pain (such as, back pain radiating below the knee, with or without positive straight leg raise) with at least 6 weeks of failed conservative therapy
- Radiculopathy (such as motor weakness, sensory low or reflex changes) with at least 2 weeks of failed conservative therapy
• The medical record with objective documentation of patient’s baseline level of function and pain
• An injection that is given with anesthetic agent and/or steroid agent
• An injection that is transforaminal, translaminar or interlaminar
• Use of fluoroscopic, CT or ultrasound guidance

Restrictions:
• Prior authorization is required for the first injection, which will cover the second injection, if indicated. Additional authorization is required for the third injection.
• No more than 2 injections (2 dates of service) may be given without medical record documentation of a 30% improvement in function and pain when compared to the baseline documented before the injections started. Function and pain must be measured and documented on a validated instrument.
• There is a maximum of 3 injections within 6 months, and no more than 3 injections per a 12-month period.
• There should be no more than 2 vertebral levels and only one side injected (right or left) per date of service.
• The MRI/CT scan is not a prerequisite for authorization of an epidural injection.

Electrical nerve stimulation (ENS) device
Refer to HCA’s Medical Equipment and Supplies Billing Guide.

Vagus nerve stimulation (VNS)
Based on review of evidence provided by the HTCC, HCA considers vagal nerve stimulation (VNS) for epilepsy to be medically necessary for adults and children (age 4 and older) when all the following conditions are met:
• Seizure disorder is refractory to medical treatment, defined as adequate trials of at least three appropriate but different anti-epileptic medications.
• Surgical treatment is not recommended or has failed.
See EPA #870001554.
HCA does not consider VNS for treatment of depression or transcutaneous VNS to be medically necessary.
Skin substitutes
HCA considers skin substitutes to be medically necessary for wound treatment under the following conditions:

- For the treatment of partial and full-thickness diabetic foot ulcers of greater than 4 weeks duration that have not adequately responded to standard ulcer therapy (including adequate off-loading and debridement) and that extend through the dermis but without tendon, muscle, or bone exposure. Standard wound therapy is defined to include all the following:
  - Assessment of vascular status with treatment as indicated
  - Nutritional optimization
  - Optimal blood glucose control
  - Adequate debridement
  - Moist dressing
  - Off-loading
  - Treatment of infection
  - Tobacco/nicotine cessation intervention when applicable.
- For the treatment of chronic, non-infected, partial and full-thickness venous stasis ulcers that have failed standard ulcer therapy of greater than 4 weeks using regular dressing changes and therapeutic compression
- For the treatment of burns, including partial-thickness and full-thickness burns
- For the treatment of wounds related to dystrophic epidermolysis bullosa when standard wound therapy has failed
- For use in breast reconstruction surgery as a part of breast cancer treatment

Limitations
- HCA covers a maximum of 10 applications per year.
- HCA does not cover reapplication if the initial treatment episode is not successful.
Sleep apnea

Surgical treatment for sleep apnea
HCA requires prior authorization for the following surgical treatment for obstructive sleep apnea (OSA) or upper airway resistance syndrome (UARS) when billed with diagnosis code G47.33 (obstructive sleep apnea) or G47.30 (unspecified sleep apnea):

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21199</td>
<td>Reconstr lwr jaw w/advance</td>
</tr>
<tr>
<td>21685</td>
<td>Hyoid myotomy &amp; suspension</td>
</tr>
<tr>
<td>42120</td>
<td>Remove palate/lesion</td>
</tr>
<tr>
<td>42140</td>
<td>Excision of uvula</td>
</tr>
<tr>
<td>42145</td>
<td>Repair palate pharynx/uvula</td>
</tr>
<tr>
<td>42160</td>
<td>Treatment mouth roof lesion</td>
</tr>
<tr>
<td>42299</td>
<td>Palate/uvula surgery</td>
</tr>
</tbody>
</table>

See also Sleep medicine testing.

Urinary systems

Collagen implants
HCA pays for CPT® code 51715 and HCPCS codes L8603, L8604 and/or L8606 only when the appropriate diagnosis code N36.42 or N36.43 (Intrinsic sphincter deficiency) is used. See Urinary tract implants for limitations.

Indwelling catheter
- Separate payment is allowed for insertion of a temporary, indwelling catheter when it is used to treat a temporary obstruction and is performed in a physician's office.
- Bill for the insertion of the indwelling catheter using CPT® code 51702 or 51703.
• HCA pays providers for insertion of an indwelling catheter only when performed in an office setting.

• Insertion of an indwelling catheter is bundled when performed on the same day as a major surgery.

• Insertion of an indwelling catheter is bundled when performed during the postoperative period of a major surgery.

**Urinary tract implants**  
(CPT® code 51715)

Before inserting a urinary tract implant, the provider must:

• Have urology training in the use of a cystoscope and must have completed a urinary tract implant training program for the type of implant used.

• Document that the client has shown no incontinence improvement through other therapies for at least 12 months prior to collagen therapy.

• Administer and evaluate a skin test for collagen sensitivity (CPT® code 95028) over a four-week period prior to collagen therapy. A negative sensitivity must be documented in the client’s record.

Refer to urinary tract implants covered by HCA. All services provided and implant codes must be billed on the same claim.

**Urological procedures with sterilizations in the description**

These procedures may cause the claim to stop in HCA’s payment system and trigger a manual review because of HCA’s effort to remain in compliance with federal sterilization consent form requirements. If the surgery is not being done for the purpose of sterilization, or the sterilizing portion of the procedure is not being performed, a sterilization consent form is not required. However, one of the following must be noted in the Claim Note section of the claim:

• Not sterilized

• Not done primarily for the purpose of sterilization
Radiology Services

Radiology services – general limits

- HCA does not pay radiologists for after-hours service codes.
- Claims must have the referring provider’s national provider identifier (NPI) in the appropriate field on the claim.
- The following services are not usually considered medically necessary and may be subject to post-pay review:
  - X-rays for soft tissue diagnosis
  - Bilateral X-rays for a unilateral condition
  - X-rays in excess of two views

**Note:** HCA does not pay for radiology services with diagnosis code Z01.89. Providers must bill the appropriate medical ICD diagnosis code.

Radiology modifiers for bilateral procedures

- Bill the procedure on two separate lines using modifier 50 on one line only. In addition, include modifier LT or RT on the separate lines when the radiological procedure is performed on both sides.
- Do not use modifier 50, LT, or RT if the procedure is defined as bilateral.

Breast, mammography

Mammograms

HCA has adopted the National Cancer Institute (NCI) recommendations regarding screening mammograms. For clients age 40 and over, one annual screening mammogram is allowed per calendar year. Screening mammograms, with or without tomosynthesis, for clients age 39 and younger require prior authorization.

HCA covers digital breast tomosynthesis when performed with a screening mammography for clients age 40 through 74 who are candidates for screening mammography. One annual screening is allowed per calendar year. See HCA’s Physician-related/professional services fee schedule for specific code details.

Diagnostic mammograms are a covered service when they are medically necessary. Digital breast tomosynthesis is covered when medically necessary and performed with diagnostic mammography.
Diagnostic radiology (diagnostic imaging)

Multiple procedure payment reduction (MPPR)
HCA applies the multiple payment model outlined by the Centers for Medicare and Medicaid Services (CMS) for multiple diagnostic radiology procedures. See MLN Matters® Number: MM6993.

The MPPR applies to the technical component (TC) of certain diagnostic imaging procedures when billed for the same client, on the same day and session, by the same billing provider.

The MPPR applies to:

- TC only services.
- TC portion of global services for the procedures with multiple surgery value of ‘4’ in the Medicare Physicians Fee Schedule Database.

The MPPR does not apply to:

- The professional component (PC).
- The PC portion of global services.

HCA’s payment is as follows:

- A full payment for the highest priced TC radiology code on the claim
- A 50% reduction applied to each subsequent TC radiology code on the same claim

Which procedures require a medical necessity review by Comagine Health?
HCA requires prior authorization for selected procedures

HCA and Comagine Health have contracted to provide web-based submittal for utilization review services to establish the medical necessity of selected procedures. Comagine Health conducts the review of the request to establish medical necessity but does not issue authorizations. Comagine Health forwards its recommendations to HCA for final authorization determination. See Medical necessity review by Comagine Health for additional information.
### Computed Tomography (CT)

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<td>Head/neck</td>
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- Multiple CT scans are allowed only if done at different times of the day or if modifiers LT or RT are attached.

### Magnetic Resonance Imaging (MRI)

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</table>

*Required for outpatient hospital claims

**Reminder for outpatient hospitals:** When requesting a medical necessity review by Comagine Health for a breast MRI, use the 7xxxx CPT® code. However, when billing Medicaid, use the “C” HCPCS code.

The advanced imaging services listed above do NOT require prior authorization when billed with either of the following place of service (POS):

- (POS) 21 (Inpatient Hospital)
- (POS) 23 (Emergency Room)
When billing for a professional component performed in a POS other than POS 21 or 23 such as a radiologist’s office, but the image was performed on a client who was in the ER or an inpatient setting, use modifier 26 and enter “ER ordered service,” or “client inpatient,” or “client referred from ER,” or “professional read only for image not done by our facility,” or “professional services only for pre-authorized service” in the Claim Note section of the electronic claim.

A radiologist who performed a professional interpretation, referred to as a “read-only,” on an outpatient advanced image must be added to HCA’s authorization record to receive payment.

- Contact HCA at 800-562-3022, ext. 52018, to add the reading radiologist’s NPI to the record.

- OR -

- Submit a written request for an NPI add/update as follows:
  - Go to Document submission cover sheets.
  - Scroll down to PA (Prior Authorization) Pend Forms.
  - When the form appears on the screen, insert the Authorization Reference number (ProviderOne authorization number) in the space provided and press enter to generate the barcode on the form.

**Note:** Professionals who do “read-only” when another facility ordered and performed the advanced imaging, **but did not obtain prior authorization**, must add: “Professional read only for image not done by our facility” in the comments field of the claim.

**Breast MRI**

Based upon review of evidence provided by the HTCC, HCA considers breast MRI to be medically necessary for screening for breast cancer. There must be a minimum of 11 months between screenings in clients at high risk of breast cancer. Clients at high risk are defined as individuals who have one of the following:

- A personal history or strong family history of breast cancer.
- A genetic mutation of BRCA 1, BRCA2, TP53, or PTEN genes (Li-Fraumeni syndrome and Cowden and Bannayan-Riley-Ruvalcaba syndromes).
- GAIL model lifetime cancer risk of 20% or higher.
- A history of radiation treatment to the chest between ages 10 and 30, such as for Hodgkin’s disease.
**Computed tomography angiography (CTA)**

CPT® code 75574 is restricted to place of service 19, 21, 22, 23.

HCA pays for CTA when:

- Using computed tomography machines with 64-slice or better capability
  - AND -
  - The following medical necessity criteria are met:
    - Patients have low to intermediate risk of coronary artery disease
    - Investigation of acute chest pain is conducted in an emergency department or hospital setting

HCA will not pay for CTA when:

- Using a CT scanner that uses lower than 64-slice technology
  - OR -
  - The procedure is not medically necessary as follows:
    - Patients are asymptomatic or at high risk of coronary artery disease.
    - Investigation of coronary artery disease is conducted outside of the emergency department or hospital setting.

**Contrast material**

Contrast material is not paid separately, except in the case of low-osmolar contrast media (LOCM) used in intrathecal, intravenous, and intra-arterial injections for clients with one or more of the following conditions:

- A history of previous adverse reaction to contrast material, except for a sensation of heat, flushing, or a single episode of nausea or vomiting
- A history of asthma or allergy
- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension
- Generalized severe debilitation
- Sickle cell disease

To bill for LOCM, use the appropriate HCPCS codes: Q9951, Q9965, Q9966 or Q9967. The brand name of the LOCM and the dosage must be documented in the client’s record.
Consultation on X-ray examination
When billing a consultation, the consulting physician must bill the specific X-ray code with modifier 26 (professional component).

For example: The primary physician would bill with the global chest X-ray (CPT® code 71020), or the professional component (CPT® code 71020-26), and the consulting physician would bill only for the professional component of the chest X-ray (e.g., CPT® code 71020-26).

Coronary artery calcium scoring
Based upon review of evidence provided by HTCC, HCA does not consider coronary artery calcium scoring to be medically necessary.

Imaging for rhinosinusitis
Based upon review of the evidence provided by HTCC, HCA considers imaging of the sinus with computed tomography (CT) for rhinosinusitis to be medically necessary when one of the following is true:

- The client is experiencing the following “red flags:"
  - Swelling of orbit
  - Altered mental status
  - Neurological findings
  - Signs of meningeal irritation
  - Severe headache
  - Signs of intracranial complication, including, but not limited to:
    - Meningitis
    - Intracerebral abscess
    - Cavernous sinus thrombosis
  - Involvement of nearby structures, including, but not limited to periorbital cellulitis
- Two of the following persistent symptom for more than 12 weeks AND medical therapy has failed:
  - Facial pain-pressure-fullness
  - Mucopurulent drainage
  - Nasal obstruction (congestion)
  - Decreased sense of smell
- Needed for surgical planning.
HCA considers magnetic resonance imaging (MRI) of the sinus to be medically necessary when the criteria in this section are met AND the client is younger than age 21 or is pregnant.

**Note:** Expedited prior authorization is required.
- Use EPA number 870001422 or 870001553 for MRI of the sinus.
- Use EPA number 870001423 for CT imaging of the sinus.

HCA considers repeat scanning (CT or MRI) to be medically necessary for “red flags” or surgical planning only.

**Magnetic resonance imaging (MRI)**
Check the [Physician’s related services fee schedule](#) for authorization requirements for MRIs.

**Upright/Positional MRI**
Based upon review of [evidence provided by the HTCC](#), HCA does not consider upright and positional MRI to be medically necessary.

**Portable X-rays**
- Portable X-ray services furnished in a client’s home or nursing facility and payable by HCA are limited to the following:
  - Skeletal films involving extremities, pelvis, vertebral column, or skull
  - Chest or abdominal films that do not involve the use of contrast media
  - Diagnostic mammograms
• Bill for transportation of X-ray equipment as follows:
  o R0070 - If there is only one patient, bill one unit.
  o R0075 - If there are multiple patients, **bill one unit** per individual client’s claim with one of the following modifiers, as appropriate. **Bill using a separate claim for each Medicaid client seen.** HCA pays the fee for procedure code R0075 divided by the number of clients, as outlined by the modifiers in the following table:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Short Description</th>
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<tbody>
<tr>
<td>R0070</td>
<td>Transport portable x-ray</td>
</tr>
<tr>
<td>R0075-UN</td>
<td>Transport port x-ray multipl-2 clients seen</td>
</tr>
<tr>
<td>R0075-UP</td>
<td>Transport port x-ray multipl-3 clients seen</td>
</tr>
<tr>
<td>R0075-UQ</td>
<td>Transport port x-ray multipl-4 clients seen</td>
</tr>
<tr>
<td>R0075-UR</td>
<td>Transport port x-ray multipl-5 clients seen</td>
</tr>
<tr>
<td>R0075-US</td>
<td>Transport port x-ray multipl-6 or more clients seen</td>
</tr>
</tbody>
</table>

**Note:** The fee for HCPCS code R0075 is divided among the clients served, as outlined by the modifiers indicated above. If no modifiers are used for HCPCS code R0075, the code will be denied. Do not bill HCPCS code R0070 in combination with HCPCS code R0075.

**Ultrasound screening for abdominal aortic aneurysm (CPT 76706)**

HCA covers ultrasound screening for abdominal aortic aneurysm only when both of the following apply:

• Billed with diagnosis code Z13.6 (special screening for other and unspecified cardiovascular conditions)

• A client meets at least one of the following conditions:
  o Has a family history of an abdominal aortic aneurysm
  o Was assigned male at birth, is between 65 and 75 years old, and has smoked at least 100 cigarettes in lifetime
Virtual colonoscopy or computed tomographic colonography
HCA does not recognize computed tomographic colonography for routine colorectal cancer screening as medically necessary.

<table>
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<tr>
<th>CPT® Code</th>
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<tr>
<td>74261</td>
<td>Ct colonography dx</td>
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<tr>
<td>74262</td>
<td>Ct colonography dx w/dye</td>
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<tr>
<td>74263</td>
<td>Ct colonography screening</td>
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</tbody>
</table>

Screening and monitoring tests for osteopenia/osteoporosis
HCA covers bone mineral density testing and repeat testing with dual x-ray absorptiometry (DXA) with limitations. These tests require expedited prior authorization. See EPA #87001363 and EPA #870001364 for criteria. If the EPA criteria are not met, prior authorization is required.

Note: Serial monitoring is not covered once treatment for osteoporosis has begun.

Functional neuroimaging for primary degenerative dementia or mild cognitive impairment
Based upon review of the evidence provided by the HTCC, HCA does not consider functional neuroimaging for primary degenerative dementia or mild cognitive impairment to be medically necessary. The following imaging technologies included in this policy are:

- Fludeoxyglucose (FDG) Positron Emission Tomography (PET)
- (11)C-dihydrotetrabenazine (C-DTBZ) PET
- Single Photon Emission Computed Tomography (SPECT)
- Functional Magnetic Resonance Imaging (fMRI)
Diagnostic Ultrasound

Obstetrical ultrasounds
Routine ultrasounds for average risk pregnant clients are considered medically necessary with limitations. HCA considers two ultrasounds per average risk singleton pregnancy as medically necessary. HCA pays for:

- One routine ultrasound in the first trimester (less than 13 weeks gestational age) for the purpose of:
  - Identifying fetal aneuploidy
  - Anomaly
  - Dating confirmation
- One routine ultrasound for the purpose of anatomy screening between 16- and 22-weeks gestation.

HCA does not pay for:

- Ultrasounds when provided solely for the determination of gender.
- Third trimester ultrasounds unless a specific indication has developed, or the pregnancy is considered high-risk.

The above conditions and limitations do not apply to multiple gestation pregnancies and/or fetus with aneuploidy or known anomaly.

Note: Additional ultrasounds are subject to postpayment review.

Nuclear medicine
HCA requires prior authorization for selected procedures.

Which procedures require a medical necessity review from HCA?
(CPT® code 78459)
HCA requires prior authorization for myocardial PET imaging for metabolic evaluation.
Which procedures require a medical necessity review by Comagine Health?

HCA and Comagine Health have contracted to provide web-based submittal for utilization review services to establish the medical necessity of selected procedures. Comagine Health conducts the review of the request to establish medical necessity but does not issue authorizations. Comagine Health forwards its recommendations to HCA for final authorization determination. See Medical necessity review by Comagine Health for additional information.

- **Cardiac Imaging (SPECT)**

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- **PET scans**

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<td>Limited Area</td>
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<td>Skull base to mid thigh</td>
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<td>Full Body</td>
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- **PET-CT scans**

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<td>Limited Area (Chest, head, neck)</td>
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<td>Skull base to mid thigh</td>
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<tr>
<td>Whole body</td>
<td>78816</td>
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Advanced imaging services do NOT require PA when billed with either of the following place of service (POS):

- (POS) 21 (Inpatient Hospital)
- (POS) 23 (Emergency Room)

CPT® codes and descriptions only are copyright 2021 American Medical Association.
When billing for a professional component performed in a POS other than POS 21 or 23 such as a radiologist’s office, but the image was performed on a client who was in the ER or an inpatient setting, enter “ER Ordered Service” or “client inpatient” in the Claim Note section of the electronic claim.

A radiologist who performed a professional interpretation, referred to as a “read-only”, on an outpatient advanced image must be added to HCA’s authorization record to receive payment. Contact HCA at 800-562-3022, ext. 52018, to add the reading radiologist’s NPI to the record.

**Note:** Professionals who do read-only when another facility ordered and performed the advanced imaging, but did not obtain prior authorization, must add: “Professional read only for image not done by our facility” in the claim note of the claim.

### Radiopharmaceutical diagnostic imaging agents
- When performing nuclear medicine procedures, HCA allows separate payment for radiopharmaceutical diagnostic imaging agents. To see if a procedure code is covered, see the [Physician-related services fee schedule](#).
- HCA allows the following CPT® codes for radiopharmaceutical therapy without PA: CPT® codes 79101, 79445, and 79005.

### Positron emission tomography (PET) scans for lymphoma
- Based upon review of evidence provided by the Health Technology Clinical Committee (HTCC), HCA in most cases considers positron emission tomography (PET) scans (i.e., PET with computed tomography or PET/computed tomography) for lymphoma to be medically necessary under the following conditions:
  - **Initial staging scan.** Covered followed by up to three (3) scans per active occurrence of lymphoma.
    - When used to assess a response to chemotherapy, scans should not be done any sooner than 3 weeks after completion of any chemotherapy cycle, except for advanced stage Hodgkin’s lymphoma, after four (4) cycles of ABVD chemotherapy.
    - When used to assess response to radiation therapy, scans should not be done any sooner than 8 weeks after completion of radiation or combined chemotherapy and radiation therapy.
  - **Relapse.** Covered when relapse is suspected in the presence of clinical symptoms or other imaging finding suggestive of recurrence.

HCA does not consider PET scans to be medically necessary when done for surveillance.
Nuclear medicine - billing
When billing HCA for nuclear medicine, the multiple surgery rules are applied when the coding combinations listed below are billed:

- For the same client, on the same day, by the same physician or by more than one physician of the same specialty in the same group practice
- With other codes that are subject to the multiple surgery rules, not just when billed in the combinations specified below:
  - CPT® code 78306 (bone imaging; whole body) and CPT® code 78320 (bone imaging; SPECT)
  - CPT® code 78802 (radionuclide localization of tumor; whole body), CPT® code 78803 (tumor localization; SPECT), and CPT® code 78804 (radiopharmaceutic localization of tumor requiring 2 or more days)
  - CPT® code 78806 (radionuclide localization of abscess; whole body) and 78807 (radionuclide localization of abscess; SPECT)

Radiation oncology

Intensity modulated radiation therapy (IMRT)
IMRT is considered medically necessary:

- To spare adjacent critical structures to prevent toxicities within client’s expected life span
  - See EPA #870001374.
  - To meet EPA criteria, any cancer that would require radiation to focus on the head/neck/chest/abdomen/pelvic area meets the EPA criteria. Clinical documentation is required that states which critical structure is spared. For example: “Critical structure spared is bladder.” IMRT is considered medically necessary when there is a concern about damage to surrounding critical structures with the use of external beam or 3D conformal radiation therapy.
- For undergoing treatment in the context of evidence collection/submission of outcome data - Prior authorization required
Proton beam therapy
Based upon review of evidence provided by the Health Technology Clinical Committee (HTCC), HCA considers proton beam therapy to be medically necessary for:

- Clients age 20 and younger without conditions
- Clients age 21 and older for the treatment of the following primary cancers:
  - Esophageal
  - Head/neck
  - Skull-based
  - Hepatocellular carcinoma
  - Brain/spinal
  - Ocular
  - Other primary cancers where all other treatment options are contraindicated after review by a multidisciplinary tumor board.

For clients age 21 and older, HCA does not consider proton beam therapy to be medically necessary for all other conditions.

Stereotactic radiation surgery
Stereotactic Radiation Surgery (SRS) for Central Nervous System (CNS) primary and metastatic tumors require prior authorization.

HCA pays for SRS for adults and children when both of the following criteria are met:

- Patient functional status score (i.e., Karnofsky score) is greater than or equal to 50
- Evaluation includes multidisciplinary team analysis (e.g., tumor board), including surgical input

Stereotactic body radiation therapy
Stereotactic Body Radiation Therapy (SBRT) is covered for adults and children for the following conditions only:

- For cancers of spine/paraspinal structures
- For inoperable non-small cell lung cancer, stage 1

Evaluation includes multidisciplinary team analysis (e.g., tumor board), including surgical input.

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Tumor treating fields
Based upon review of evidence provided by the Health Technology Clinical Committee (HTCC), HCA in most cases does not consider tumor treating fields to be medically necessary for treatment of newly diagnosed glioblastoma multiforme, recurrent glioblastoma multiforme, and for treatment of other cancers.
Pathology and Laboratory

Certifications

Independent laboratories - certification
Independent laboratories must be certified according to Title XVII of the Social Security Act (Medicare) to receive payment from Medicaid. HCA pays laboratories for Medicare-approved tests only.

Reference labs and facilities - CLIA certification
All reference (outside) labs and facilities performing laboratory testing must have a Clinical Laboratory Improvement Amendment (CLIA) certificate and identification number on file with HCA to receive payment from HCA.

To obtain a CLIA certificate and number, or to resolve questions concerning a CLIA certification, call (206) 361-2805 or write to:

DOH - Office of Laboratory Quality Assurance
1610 NE 150th Street
Shoreline, WA 98155
(206) 361-2805 (phone); (206) 361-2813 (fax)

Anatomic pathology

Pap smears
For professional services related to Pap smears, refer to Cancer screens.

• Use CPT® codes 88147-88154, 88164-88167, and HCPCS P3000-P3001 for conventional Pap smears.
• HCA pays for thin layer preparation CPT® codes 88142-88143 and 88174-88175. HCA does not pay providers for HCPCS codes G0123-G0124 and G0141-G0148. HCA pays for thin layer Pap smears at Medicare’s payment levels. Thin layer preparation and conventional preparation CPT® codes cannot be billed in combination.
• Use CPT® code 88141 in conjunction with one of the following codes: 88142-88143, 88164-88167, or 88174-88175.
• Use the appropriate medical diagnosis if a condition is found.
• HCA pays providers for cervical cancer screening according to nationally recognized clinical guidelines in conjunction with an office visit focused on family planning.
• For clients on the Family Planning Only – Pregnancy Related program or the Family Planning Only program (formerly referred to as TAKE CHARGE), see the Family Planning Billing Guide.

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Screening exams

Cancer screens
(HCPCS codes G0101, G0102, G0103-G0105, G0121-G0122, and CPT® codes 71271, 82270, and 81519)

HCA covers the following cancer screenings:
- Cervical or vaginal
- Colonoscopies
- Colorectal
- Lung (low dose CT)
- Oncology genomic testing (breast)
- Pelvic/breast exams
- Prostate
- PSA testing
- Screening sigmoidoscopies

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<thead>
<tr>
<th>CPT® or HCPCS Code</th>
<th>Short Description</th>
<th>Limitations</th>
</tr>
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<tr>
<td>G0101</td>
<td>CA screen; pelvic and clinical breast examination</td>
<td>Clients assigned female at birth only. As indicated by nationally recognized clinical guidelines. This is an examination code. Do not use this code for laboratory tests like Pap smears or HPV testing. Bill in the same way as other exam codes. This may be billed in conjunction with an E/M code.</td>
</tr>
<tr>
<td>G0103</td>
<td>PSA screening</td>
<td>Once every 12 months when ordered for clients age 50 and older</td>
</tr>
<tr>
<td>G0104</td>
<td>CA screen; flexi sigmoidoscope</td>
<td>Clients age 45 and older who are not at high risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Once every 48 months</td>
</tr>
<tr>
<td>G0105*</td>
<td>Colorectal scrn; hi risk ind</td>
<td>Clients at high risk for colorectal cancer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>One every 24 months</td>
</tr>
</tbody>
</table>

CPT® codes and descriptions only are copyright 2021 American Medical Association.
<table>
<thead>
<tr>
<th>CPT® or HCPCS Code</th>
<th>Short Description</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>71271</td>
<td>Ct thorax lung cancer scr c-</td>
<td>Requires EPA (see EPA #870001362). If the client does not meet EPA criteria, PA is required (see Prior authorization). HCA allows ICD diagnosis code Z87.891 as a primary diagnosis.</td>
</tr>
<tr>
<td>82270</td>
<td>Occult blood, feces</td>
<td>N/A</td>
</tr>
<tr>
<td>81519</td>
<td>Genomic testing (breast)</td>
<td>Requires EPA (see EPA #87001386 and EPA #870001420)</td>
</tr>
<tr>
<td>G0121*</td>
<td>Colon CA scbrn; not high risk ind</td>
<td>Clients age 45 and older Once every 10 years</td>
</tr>
<tr>
<td>G0122</td>
<td>Colon CA scrn; barium enema</td>
<td>Clients age 45 and older Once every 5 years</td>
</tr>
</tbody>
</table>

*Note: Per Medicare guidelines, HCA’s payment is reduced when billed with modifier 53 (discontinued procedure).

Disease organ panels--automated multi-channel tests
HCA pays for CPT lab panel codes 80047, 80048, 80050, 80051, 80053, 80061, 80069, and 80076. The individual automated multi-channel tests are:

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>82040</td>
<td>Assay of serum albumin</td>
</tr>
<tr>
<td>82247</td>
<td>Bilirubin total</td>
</tr>
<tr>
<td>82248</td>
<td>Bilirubin direct</td>
</tr>
<tr>
<td>82310</td>
<td>Assay of calcium</td>
</tr>
<tr>
<td>82330</td>
<td>Assay of calcium</td>
</tr>
<tr>
<td>82374</td>
<td>Assay blood carbon dioxide</td>
</tr>
<tr>
<td>82435</td>
<td>Assay of blood chloride</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>82465</td>
<td>Assay bld/serum cholesterol</td>
</tr>
<tr>
<td>82565</td>
<td>Assay of creatinine</td>
</tr>
<tr>
<td>82947</td>
<td>Assay glucose blood quant</td>
</tr>
<tr>
<td>82977</td>
<td>Assay of ggt</td>
</tr>
<tr>
<td>83615</td>
<td>Lactate (ld) (ldh) enzyme</td>
</tr>
<tr>
<td>84075</td>
<td>Assay alkaline phosphatase</td>
</tr>
<tr>
<td>84100</td>
<td>Assay of phosphorus</td>
</tr>
<tr>
<td>84132</td>
<td>Assay of serum potassium</td>
</tr>
<tr>
<td>84155</td>
<td>Assay of protein serum</td>
</tr>
<tr>
<td>84295</td>
<td>Assay of serum sodium</td>
</tr>
<tr>
<td>84450</td>
<td>Transferase (ast) (sgot)</td>
</tr>
<tr>
<td>84460</td>
<td>Alanine amino (alt) (sgpt)</td>
</tr>
<tr>
<td>84478</td>
<td>Assay of triglycerides</td>
</tr>
<tr>
<td>84520</td>
<td>Assay of urea nitrogen</td>
</tr>
<tr>
<td>84550</td>
<td>Assay of blood/uric acid</td>
</tr>
<tr>
<td>85004</td>
<td>Automated diff wbc count</td>
</tr>
<tr>
<td>85007</td>
<td>BI smear w/diff wbc count</td>
</tr>
<tr>
<td>85009</td>
<td>Manual diff wbc count b-coat</td>
</tr>
<tr>
<td>85027</td>
<td>Complete cbc automated</td>
</tr>
</tbody>
</table>

- Providers may bill a combination of panels and individual tests not included in the panel. Duplicate tests will be denied. Providers may not bill for the tests in the panel separately per the National Correct Coding Initiative (NCCI).
- Each test and/or panel must be billed on a separate line.
- All automated/nonautomated tests **must be billed on the same claim when performed for a client by the same provider** on the same day.

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**Fetal fibronectin**
The semiquantitative measurement of fetal fibronectin may be considered as medically necessary with all the following conditions:

- Singleton or multiple gestation pregnancies
- Intact amniotic membranes
- Cervical dilation <3 cm
- Signs or symptoms suggestive of preterm labor (such as, regular uterine contractions, cramping, abdominal pain, change in vaginal discharge, vaginal bleeding, pelvic pressure, or malaise)
- Sampling that is performed between 24 weeks 0 days and 34 weeks 6 days of gestation
- Results available in less than 4 hours, for the test results to impact immediate care decisions for the pregnant client

HCA does not consider the use of fetal fibronectin assays to be medically necessary for the following indications:

- No symptoms of preterm birth (there is no clinical evidence that treating pregnant clients with no labor symptoms or high risk for premature delivery benefits pregnant client or baby)
- Routine screening or determination of risk of preterm delivery in asymptomatic pregnant clients
- Outpatient tests and the pregnant client awaits test results at home
- Monitoring of asymptomatic pregnant clients at high-risk for preterm labor (PTL)
- Pregnant clients not requiring induction due to likelihood of delivery within 24 to 48 hours
- Ruptured membranes or advanced cervical dilation (3 cm or more)
- Imminent birth

For all other indications, there is insufficient evidence to permit conclusions on efficacy and net health outcomes.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>82731</td>
<td>Fetal fibronectin, cervicovaginal secretions, semi-quantitative</td>
</tr>
</tbody>
</table>
Examples of ICD diagnoses codes that support medical necessity are:

<table>
<thead>
<tr>
<th>ICD Diagnosis Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N88.3</td>
<td>Incompetence of cervix</td>
</tr>
<tr>
<td>O34.32, O34.33</td>
<td>Cervical incompetence during pregnancy, childbirth, and the puerperium</td>
</tr>
<tr>
<td>O36.8190</td>
<td>Decreased fetal movement</td>
</tr>
<tr>
<td>O09.40, O09.529</td>
<td>Other indications for care or intervention related to labor and delivery</td>
</tr>
<tr>
<td>R10.9</td>
<td>Abdominal pain</td>
</tr>
</tbody>
</table>

Noninvasive prenatal diagnosis of fetal aneuploidy using cell-free fetal nucleic acids in birthing parent blood (NIPT)

HCA pays for noninvasive prenatal diagnosis of fetal aneuploidy using cell-free fetal nucleic acids in birthing parent blood (NIPT) (CPT® code 81507 and 81420) when it is medically necessary. Expedited prior authorization (EPA) is required. See EPA #870001344.

Vitamin D screening and testing (CPT® code 82306, 82652)

Routine Vitamin D screening for the general population (CPT® codes 82306, 82652) is not considered medically necessary.

Vitamin D testing (25-hydroxy vitamin D, calcidiol, CPT® code 82306) may be considered medically necessary for the following conditions:

- Chronic kidney disease stage 3 or greater
- End stage renal disease
- Evaluation of hypo- or hypercalcemia
- Hypocalcemia and hypomagnesemia of newborn
- Hypophosphatemia
- Hypoparathyroidism
- Intestinal malabsorption including:
  - Blind loop syndrome
  - Celiac disease
  - Pancreatic Steatorrhea

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- Secondary hyperparathyroidism
- Hypervitaminosis D
- Osteomalacia
- Osteopenia
- Rickets
- In the setting of other laboratory or imaging indicators of vitamin D deficiency for:
  - Calculus of kidney or ureter
  - Chronic liver disease in the absence of alcohol dependency
  - Protein-calorie malnutrition

Vitamin D testing (25-dihydroxy vitamin D, calcitriol, CPT 82652) may be considered medically necessary as a second-tier test for the following conditions:
- Disorders of calcium metabolism
- Familial hypophosphatemia
- Fanconi syndrome
- Hypoparathyroidism or hyperparathyroidism
- Vitamin D resistant rickets
- Tumor induced Osteomalacia
- Sarcoidosis

**Lead toxicity screening**
Lead toxicity screening is mandatory at age 12 months and 24 months for all children, including children enrolled in an HCA-contracted managed care organization, regardless of lead exposure risk.

Additionally, all children between age 36 months and 72 months must receive a lead toxicity screening if they have not been tested previously.

**Drug Testing for Substance Use Disorder**
HCA pays for drug screens when both of the following apply:
- The screen is medically necessary and ordered by a physician as part of a medical evaluation.
- The drug or alcohol screen is required to assess suitability for medical tests or treatment being provided by the physician.

**Note:** HCA covers 12 breathalyzer tests (CPT 82075) per client, per year, without authorization when medically necessary.
Drug screening for medication for opioid use disorder

Urine and blood drug assay tests are covered for Washington Apple Health clients receiving medication for opioid use disorder for substance use disorders under the following conditions. Other biological testing is noncovered.

**Note:** HCA requires prior authorization for the use of presumptive or confirmatory testing panels that test substances or drug groups not listed below. Clinical documentation supporting the rationale for the particular tests being ordered is required.

**For presumptive testing, use the following codes:**
- CPT® codes 80305, 80306, and 80307 (Only one of the three presumptive codes may be billed per client per day.)
- Up to 24 presumptive tests will be reimbursed per client, per year

**For definitive drug testing, use the following G codes:**
- G0480, G0481, G0482 and G0483 (Only one of the four definitive G codes may be billed per client per day.)
- Up to 16 definitive tests (follow-up tests to presumptive tests) will be reimbursed per client, per year

If additional tests are needed, providers can submit a limitation extension request to HCA See **Limitation extension (LE).**

For definitive testing, the unit used to determine the appropriate definitive G code to bill is “drug class.” Each drug class may only be used once per day in determining the appropriate definitive G code to bill. Drug classes are listed in the CPT Manual. The CPT Manual may be consulted for examples of individual drugs within each class. Codes G0481, G0482 and G0483 are reimbursed at the same rate.

**The following testing codes are no longer covered:**
- G0431, G0434
- HCPCS codes G6030 through G6058
- 80309 – 80377

For substance use disorder, HCA will not reimburse for serial quantitative testing to monitor levels of drug metabolites.
(Monitoring for patients who are on chronic opioid therapy for the treatment of chronic noncancer pain should follow the Agency Medical Director’s Group 2015 Interagency guideline on prescribing opioids for pain, Appendix D).

(These guidelines do not pertain to urine drug testing required for employment, emergency department evaluation or those related to criminal justice requirements).

For monitoring patients receiving medication for opioid use disorder, drug assay tests are considered medically necessary in the following instances:

Screening, presumptive, or in office testing with point of care immunoassays (IA) is considered medically necessary to:

- Confirm the use of prescribed substances
- Identify the presence of illicit or non-prescribed substances
- Prior to starting a patient on medication for opioid use disorder for a substance use disorder

Confirmatory or definitive testing with gas chromatography–mass spectrometry (GCMS) or liquid chromatography-tandem mass spectrometry (LCMS) is considered medically necessary to interpret the findings on presumptive testing when there is a discrepancy between patient report, the test and what is being prescribed:

For example:

- To confirm the presence of an unexpected or non-prescribed drug identified by an IA
- To confirm that a prescribed drug or its metabolite not present on the IA are in fact being taken

In addition, confirmatory testing should only be ordered and performed on a patient/drug specific basis. Clinical documentation must support why a particular drug or class was tested for and document a follow up plan based on the test results.

Serial quantitative monitoring of drugs or drug metabolite levels is not considered medically necessary.

Periodic reviews of ordering patterns will be performed to look for and contact practices that appear to be outliers compared to their peers.

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

A provider must be categorized as a High Complexity MTS/CLIA by the Office of Washington Laboratory Assurance or be accredited as High Complexity MTS/CLIA by COLA/College of American Pathologists Joint Commission if confirmatory testing is performed at the site of practice.

Enter the following information on the claim forms: “Certified bupren provider” in the Claim Note section of the electronic claim.

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

For treatment of chronic noncancer pain, HCA has adopted the Agency Medical Directors’ Group (AMDG) drug screening guidelines outlined in the AMDGs’ interagency guidelines. For more information, go online to Interagency guidelines on opioid dosing for chronic non-cancer pain.

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Recommended Urine Drug Testing Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk by Opiate Risk Tool (ORT)</td>
<td>Periodic (e.g., up to one time per year)</td>
</tr>
<tr>
<td>Moderate Risk by ORT</td>
<td>Regular (e.g., up to two times per year)</td>
</tr>
<tr>
<td>High Risk by ORT or opioid doses &gt;120 MED/d</td>
<td>Frequent (e.g., up to three times per year)</td>
</tr>
<tr>
<td>Aberrant Behavior (lost prescriptions, multiple requests for early refill, opioids from multiple providers, unauthorized dose escalation, apparent intoxication)</td>
<td>At the time of visit (address aberrant behavior in person, not by telephone)</td>
</tr>
</tbody>
</table>

HCA does not pay for either of the following:

- Routine drug screening panels
- Monitoring for program compliance in either a residential or outpatient drug or alcohol treatment program
**Note:** Labs must offer single drug testing. Drug screening must be medically indicated and the reason for the specific drug screening must be documented in the client record. Lab slips must be signed by the prescribing provider.

When monitoring a client for drug/alcohol use, refer the client to a Department of Health-licensed or -certified provider. See the facility search webpage. Clients served by these programs may receive drug/alcohol screening according to an established treatment plan determined by their treating provider.

**Buprenorphine when used for pain control**

HCA pays for drug screens when both of the following apply:

- They are medically necessary and ordered by a physician as part of a medical evaluation.
- The drug and/or alcohol screens are required to assess suitability for medical tests or treatment being provided by the physician.

See HCA’s [Physician-related fee schedule](#) for covered drug screening codes.

**Enhanced reimbursement rate for medication for opioid use disorder**

HCA pays an enhanced reimbursement using the Medicare rate when medication for opioid use disorder is part of the visit for selected evaluation and management (E/M) codes.

The purpose of this enhanced reimbursement is to encourage providers to obtain and use a Drug Addiction Treatment Act of 2000 Waiver ([DATA 2000 Waiver](#)) to increase patient access to evidence-based treatment using medications for opioid use disorder.

To receive this enhancement, providers must:

- Have a DATA 2000 Waiver.
- Currently use the waiver to prescribe medication for opioid use disorder to clients with opioid use disorder.
- Bill for treating a client with a qualifying diagnosis for opioid use disorder.
- Provide opioid-related counseling during the visit.
- Bill with EPA #870001537.

HCA pays one enhanced reimbursement per client per day. HCA does not pay the enhanced reimbursement if the client receives services for opioid use disorder through an opioid treatment program facility licensed by the Department of Health.
Providers are subject to post-pay review to ensure the EPA criteria for the rate enhancement are met. If the requirements are not met at the time of service, recoupment of payment may occur.

To view the medication for opioid use disorder fee schedule, see HCA’s Provider billing guides and fee schedules webpage.

**Immunology**

**HIV testing**
HCA pays providers for HIV testing as recommended in the [CDC guidelines](#).

**Targeted TB testing with interferon-gamma release assays**
Targeted TB testing with interferon-gamma release assays may be considered medically necessary for clients age 5 and older for one of the following conditions:

- History of positive tuberculin skin test or previous treatment for TB disease
- History of vaccination with BCG (Bacille Calmette-Guerin)
- Recent immigrants (within 5 years) from countries that have a high prevalence of tuberculosis
- Residents and employees of high-risk congregate settings (e.g., homeless shelters, correctional facilities, substance abuse treatment facilities, etc.)
- Clients with an abnormal chest X-ray (CXR) consistent with old or active TB
- Clients undergoing evaluation or receiving TNF alpha antagonist treatment for rheumatoid arthritis, psoriatic arthritis, or inflammatory bowel disease
- Exposure less than 2 years before the evaluation AND client agrees to remain compliant with treatment for latent tuberculosis infection if found to have a positive test

The tuberculin skin test is the preferred method of testing for children under the age of 5.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>86480</td>
<td>Tb test cell immun measure</td>
</tr>
<tr>
<td>86481</td>
<td>Tb ag response t-cell susp</td>
</tr>
</tbody>
</table>

Providers must follow HCA’s expedited prior authorization (EPA) process to receive payment for targeted TB testing. See EPA #870001325 in EPA Criteria Coding List.
Molecular Pathology Tests
Genetic testing may be considered as medically necessary to establish a molecular diagnosis of an inheritable disease when all the following are met:

- The client displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic) based on family history, an analysis of genetic relationships and medical history in the family.
- Diagnostic results from physical examination, pedigree analysis, and conventional testing are inconclusive.
- The clinical utility of the test is documented in the authorization request, including how the test results will guide decisions concerning disease treatment, management, or prevention; AND these treatment decisions could not otherwise be made in the absence of the genetic test results.
- Clients receive pre- and post-test genetic counseling from a qualified professional when testing is performed to diagnose or predict susceptibility for inherited diseases.

Genetic testing is considered not medically necessary if any of the above criteria are not met. Refer to the fee schedule for HCA coverage of Tier 1 and Tier 2 molecular pathology procedures.

Genomic microarray
Genomic microarray is considered medically necessary under the conditions outlined below.

HCA requires prior authorization (PA) when using CPT® codes 81228 and 81229 for genomic microarray to diagnose genetic abnormalities in children for any one of the following:

- Significant dysmorphic features or congenital anomalies
- Global developmental delay or clinical diagnosis of intellectual disability
- Clinical diagnosis of autism spectrum disorder

AND all the following:

- Targeted genetic testing, if indicated, is negative
- Clinical presentation is not specific to a well-delineated genetic syndrome
- The results of testing could impact the clinical management
Note: HCA uses the following definitions:

- For clients younger than age 5, **Global developmental delay (GDD)**. See Definitions.
- For clients age 5 and older, **Intellectual disability (ID)**. See Definitions.

### Companion diagnostic tests

HCA considers companion diagnostic and certain pharmacogenetic tests to be medically necessary and may require prior authorization.

Based upon the review of evidence provided by HTCC, HCA does not consider pharmacogenetic testing for patients treated with oral anticoagulants to be medically necessary.

Based upon the review of evidence provided by HTCC, HCA does not consider pharmaceutical testing to be medically necessary (with CPT® codes 81225, 81226, 81227, and 81291) when the primary diagnosis is one of the following:

- Depression
- Mood disorders
- Psychosis
- Anxiety
- Attention deficit hyperactivity disorder (ADHD)
- Substance use disorder

### Organ and disease-oriented panels

#### Automated multi-channel tests - payment

For individual automated multi-channel tests, providers are paid based on the total number of individual automated multi-channel tests performed for the same client, on the same day, by the same laboratory.

- When all the tests in a panel are not performed, each test must be billed as a separate line item on the claim.
- When there are additional automated multi-channel tests not included in a panel, each additional test must be billed as a separate line item on the claim.
- Bill any other individual tests as a separate line item on the claim.
Payment calculation for individual automated laboratory tests is based on the total number of automated multichannel tests performed per day, per patient. Payment for each test is based on Medicare’s fees multiplied by HCA’s fiscal year laboratory conversion factor.

**For example:**

If five individual automated tests are billed, the payment is equal to the internal code’s maximum allowable fee.

If five individual automated tests and a panel are billed, HCA pays providers separately for the panel at the panel’s maximum allowable. Payment for the individual automated tests, less any duplicates, is equal to the internal code’s maximum allowable fee.

If one automated multi-channel test is billed, payment is at the individual procedure code or internal code’s maximum allowable fee, whichever is lower. The same applies if the same automated multi-channel test is performed with modifier 91.

**Disease organ panel - nonautomated multi-channel**

Organ and disease panels (CPT® codes 80055 and 80074) do not include automated multi-channel tests. If all individual tests in the panel are not performed, payment is the individual procedure code maximum allowable fee or billed charge, whichever is lower.

The nonautomated multi-channel tests are:

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>83718</td>
<td>Assay of lipoprotein</td>
</tr>
<tr>
<td>84443</td>
<td>Assay thyroid stim hormone</td>
</tr>
<tr>
<td>85025</td>
<td>Automated hemogram</td>
</tr>
<tr>
<td>85651</td>
<td>Rbc sed rate, nonautomated</td>
</tr>
<tr>
<td>86255</td>
<td>Fluorescent antibody, screen</td>
</tr>
<tr>
<td>86430</td>
<td>Rheumatoid factor test</td>
</tr>
<tr>
<td>86592</td>
<td>Blood serology, qualitative</td>
</tr>
<tr>
<td>86644</td>
<td>CMV antibody</td>
</tr>
<tr>
<td>86694</td>
<td>Herpes simplex test</td>
</tr>
<tr>
<td>86705</td>
<td>Hep b core antibody, test</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>86709</td>
<td>Hep a antibody, igm</td>
</tr>
<tr>
<td>86762</td>
<td>Rubella antibody</td>
</tr>
<tr>
<td>86777</td>
<td>Toxoplasma antibody</td>
</tr>
<tr>
<td>86803</td>
<td>Hep c ab test, confirm</td>
</tr>
<tr>
<td>86850</td>
<td>RBC antibody screen</td>
</tr>
<tr>
<td>86900</td>
<td>Blood typing, ABO</td>
</tr>
<tr>
<td>86901</td>
<td>Blood typing, Rh(D)</td>
</tr>
<tr>
<td>87340</td>
<td>Hepatitis b surface ag, eia</td>
</tr>
</tbody>
</table>

**Gene expression**

Based upon review of the evidence provided by HTCC, HCA considers gene expression profile testing to be medically necessary for breast or prostate cancer when the criteria in the following EPAs are met: #870001386, #870001420, #870001545, #870001546, #870001547, #870001548, #870001549, #870001550, and #870001551. HCA considers only the listed tests as medically necessary.

HCA does not consider gene expression profile testing for multiple myeloma or colon cancer to be medically necessary.

**Breast and ovarian genetic testing**

HCA requires prior authorization (PA) for all breast and ovarian cancer genetic testing. Effective for dates of service on and after October 1, 2019, if the client meets expedited prior authorization (EPA) criteria, providers may use EPA #870001603. If the client does not meet the EPA criteria, providers must follow the full PA process (see Prior Authorization (PA)).

**Billing**

**Billing for laboratory services that exceed the lines allowed**

- Electronic submitters are allowed 50 lines per claim. **Use additional claim forms if the services exceed the lines allowed.** Enter the statement “Additional services” in the Claim Note section when billing electronically. Total each claim separately.
• If HCA pays a claim with one or more automated/nonautomated lab tests, providers must bill any additional automated/nonautomated lab tests for the same date of service as an adjusted claim. Refer to Key Step 6 of the “Submit Fee for Service Claims to Medical Assistance” in the ProviderOne Billing and Resource Guide which addresses adjusting paid claims. Currently, providers may adjust claims electronically in ProviderOne. Make sure the claim is adjusted with the paid automated/nonautomated lab tests using the comment “additional services.”

Clinical laboratory codes
Some clinical laboratory codes have both a professional component and a technical component. If performing only the technical component, bill with modifier TC. If performing only the professional component bill with modifier 26. Laboratories performing both the professional and the technical components must bill the code without a modifier. See Laboratory physician interpretation procedure codes with both a technical and professional component.

Coding and payment policies
• Pathology and laboratory services must be provided either by a pathologist or by technologists who are under the supervision of a physician.

• HCA expects independent laboratories to bill hospitals for the technical component of anatomic pathology services furnished to hospital inpatients and outpatients. To prevent duplicate payment, HCA will not pay independent laboratories if they bill Medicaid for these services.

• An independent laboratory and/or hospital laboratory must bill using its NPI for any services performed in its facility.

• Physicians must bill using their NPI for laboratory services provided by their technicians under their supervision.

• HCA reimburses blood draw fees with the following limits:
  o For separate and distinct times
  o Up to two separate blood draw fees for CPT® codes 36415 or 36591 per day
  o Up to three separate blood draw fees for CPT® code 36416 per day

• HCA pays for one catheterization for collection of a urine specimen (HCPCS code P9612) per day.

• Complete blood count (CPT® code 85025) includes the following CPT® codes: 85004, 85007, 85008, 85009, 85013, 85014, 85018, 85027, 85032, 85041, 85048, 85049, and G0306. Complete blood count (CPT® code 85027) includes the following CPT® codes: 85004, 85008, 85013, 85014, 85018, 85032, 85041, 85048, 85049, and G0307.

• CPT® codes 81001-81003 and 81015 are not allowed in combination with urinalysis procedure 81000.
CPT® codes 86812-86822 are limited to a maximum of 15 tests total for human leukocyte antigens (HLA) typing per client, per lifetime. Prior authorization is required for more than 15 tests.

Do not bill with modifier 26 if the description in CPT indicates professional services only.

Payment for lab tests includes handling, packaging, and mailing fee. Separate payment is not allowed.

Laboratories must obtain PA from the ordering physician, or HCA-approved genetic counselor to be paid for certain genetic testing requiring PA. All genetic testing must be billed with the appropriate genetic testing modifier.

CPT® code 83037 [hemoglobin glycosylated (A1C)] does not require PA when performed in a physician’s office; however, it can be billed only once every three months.

Note: Laboratory claims must include the provider’s national provider identifier (NPI) and an appropriate medical diagnosis code and PA if applicable. The ordering provider must give the appropriate medical diagnosis code, prior authorization number, and modifier, if applicable, to the performing laboratory at the time the tests are ordered. HCA does not pay a laboratory for procedures billed using ICD diagnosis codes Z00.00, Z01.812, or Z01.89 as a primary diagnosis. For lab services use the appropriate diagnosis for the service(s) provided.

CPT® code 87999 can be used for billing the monogram Trofile test for AIDS patients when physicians are prescribing the drug Selzentry®. HCA pays By Report for CPT® code 87999.

For outpatient hospital laboratory services such as therapeutic blood levels and electrocardiograms and related professional services that are denied by managed care because the services were ordered or referred by a BHO, providers must do both of the following:

- Put “Referred by the BHO” in the Claim Note section of the claim.
- Include the managed care denial with their claim when billing HCA.
Laboratory physician interpretation procedure codes

The following CPT® codes are clinical laboratory procedure codes for which separate payment for interpretations by laboratory physicians may be made. The actual performance of the tests is paid for under the Physician-related/professional services fee schedule. Modifier TC must not be used with these procedure codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense, and malpractice expense.

- 81200-81479
- 83020
- 84165
- 84166
- 84181
- 84182
- 85390
- 85576
- 86255
- 86256
- 86320
- 86325
- 86327
- 86334
- 86335
- 87164
- 87207
- 88371
- 88372
- 89060

Laboratory codes requiring modifier and PA clarification

Laboratory claims must include an appropriate medical diagnosis code, modifier, and PA, if applicable. The ordering provider must give the appropriate medical diagnosis code, modifier, and PA number, if applicable, to the performing laboratory at the time the tests are ordered. HCA does not pay for laboratory procedures billed using the appropriate ICD diagnosis codes Z00.00, Z01.812, or Z01.89. For lab services, use the appropriate diagnosis for the service(s) that was provided.
Laboratory modifiers

Modifier QP

Modifier QP indicates documentation is on file showing that the laboratory test(s) was ordered individually or ordered as a CPT-recognized panel. HCA recognizes this modifier as informational only. This modifier is not appropriate to use for billing repeat tests or to indicate the test was not done as a panel.

Modifier 90

Reference (Outside) Laboratory:

- When a laboratory sends a specimen to a reference (outside) laboratory, the referring laboratory may bill for the reference laboratory (pass-through billing) by adding modifier 90 to the laboratory procedure code. The reference laboratory NPI must be entered in the Referring Provider Information section on the claim.

- When laboratory procedures are performed by a lab other than the referring lab, the procedure must be identified by adding modifier 90 to the procedure code. The reference lab NPI must be entered in the Rendering (Performing) Provider section on the electronic professional claim. The reference lab must be CLIA-certified.

Modifier 91

Repeat Clinical Laboratory Diagnostic Test

When it is necessary to repeat the same laboratory test on the same day for the same client to obtain subsequent (multiple) test results, use modifier 91. Otherwise, the claim will be denied as a duplicate.

Do not use this modifier when tests are rerun:

- To confirm initial results.
- Due to testing problems with specimens or equipment.
- For any reason when a normal, one-time, reportable result is all that is required.
- When there are standard procedure codes available that describe the series of results (e.g., glucose tolerance test, evocative/suppression testing, etc.).

Laboratory services referred by CMHC or DBHR-contracted providers

When a community mental health center (CMHC) or DBHR-contracted providers refer clients enrolled in an HCA managed care plan for laboratory services, the laboratory must bill HCA directly. All the following conditions apply:

- The laboratory service is medically necessary.
- The laboratory service is directly related to the client's mental health or alcohol and substance abuse.

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The laboratory service is referred by a CMHC or DBHR-contracted provider who has a core provider agreement with HCA.

The laboratory must bill with a mental health, substance abuse, or alcohol abuse diagnosis.

To bill for laboratory services, laboratories must put the CMHC or DBHR-contracted referring provider National Provider Identifier (NPI) number in the “Referring Provider Information” section of the claim. CMHC and DBHR-contracted services are excluded from HCA’s managed care contracts.

**STAT laboratory charges**

When the laboratory tests listed on the following page are performed on a STAT basis, the provider may bill HCPCS code S3600 (STAT laboratory request).

- Payment is limited to one STAT charge per episode (not once per test).
- Tests must be ordered STAT and payment is limited to only those that are needed to manage the client in a true emergency.
- The laboratory report must contain the name of the provider who requested the STAT.
- The medical record must reflect the medical necessity and urgency of the service.

**Note:** "STAT" must be clearly indicated by the provider and must be documented in the laboratory report and the client’s record. Tests generated from the emergency room do not automatically justify a STAT order. Use HCPCS code S3600 with the procedure codes on the following page.

The STAT charge is paid only with the following tests:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0306</td>
<td>CBC/diffwbc w/o platelet</td>
</tr>
<tr>
<td>G0307</td>
<td>CBC without platelet</td>
</tr>
<tr>
<td>80047</td>
<td>Metabolic panel ionized ca</td>
</tr>
<tr>
<td>80048</td>
<td>Metabolic panel total ca</td>
</tr>
<tr>
<td>80051</td>
<td>Electrolyte panel</td>
</tr>
<tr>
<td>80069</td>
<td>Renal function panel</td>
</tr>
<tr>
<td>80076</td>
<td>Hepatic function panel</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Short Description</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>80156</td>
<td>Assay, carbamazepine total</td>
</tr>
<tr>
<td>80162</td>
<td>Assay of digoxin</td>
</tr>
<tr>
<td>80170</td>
<td>Assay of gentamicin</td>
</tr>
<tr>
<td>80164</td>
<td>Assay dipropylacetic acid</td>
</tr>
<tr>
<td>80178</td>
<td>Assay of lithium</td>
</tr>
<tr>
<td>80184</td>
<td>Assay of phenobarbital</td>
</tr>
<tr>
<td>80185</td>
<td>Assay of phenytoin total</td>
</tr>
<tr>
<td>80188</td>
<td>Assay primidone</td>
</tr>
<tr>
<td>80192</td>
<td>Assay of procainamide</td>
</tr>
<tr>
<td>80194</td>
<td>Assay of quinidine</td>
</tr>
<tr>
<td>80197</td>
<td>Assay of tacrolimus</td>
</tr>
<tr>
<td>80198</td>
<td>Assay of theophylline</td>
</tr>
<tr>
<td>81000</td>
<td>Urinalysis nonauto w/scope</td>
</tr>
<tr>
<td>81001</td>
<td>Urinalysis auto w/scope</td>
</tr>
<tr>
<td>81002</td>
<td>Urinalysis nonauto w/o scope</td>
</tr>
<tr>
<td>81003</td>
<td>Urinalysis auto w/o scope</td>
</tr>
<tr>
<td>81005</td>
<td>Urinalysis</td>
</tr>
<tr>
<td>82009</td>
<td>Test for acetone/ketones</td>
</tr>
<tr>
<td>82040</td>
<td>Assay of serum albumin</td>
</tr>
<tr>
<td>82055</td>
<td>Assay of ethanol</td>
</tr>
<tr>
<td>82150</td>
<td>Assay of amylase</td>
</tr>
<tr>
<td>82247</td>
<td>Bilirubin total</td>
</tr>
<tr>
<td>82248</td>
<td>Bilirubin direct</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>82310</td>
<td>Assay of calcium</td>
</tr>
<tr>
<td>82330</td>
<td>Assay of calcium</td>
</tr>
<tr>
<td>82374</td>
<td>Assay blood carbon dioxide</td>
</tr>
<tr>
<td>82435</td>
<td>Assay of blood chloride</td>
</tr>
<tr>
<td>82550</td>
<td>Assay of ck (cpk)</td>
</tr>
<tr>
<td>82565</td>
<td>Assay of creatinine</td>
</tr>
<tr>
<td>82803</td>
<td>Blood gases any combination</td>
</tr>
<tr>
<td>82945</td>
<td>Glucose other fluid</td>
</tr>
<tr>
<td>82947</td>
<td>Assay glucose blood quant</td>
</tr>
<tr>
<td>83615</td>
<td>Lactate (LD) (LDH) enzyme</td>
</tr>
<tr>
<td>83633</td>
<td>Test urine for lactose</td>
</tr>
<tr>
<td>83664</td>
<td>Lamellar bdy fetal lung</td>
</tr>
<tr>
<td>83735</td>
<td>Assay of magnesium</td>
</tr>
<tr>
<td>83874</td>
<td>Assay of myoglobin</td>
</tr>
<tr>
<td>83880</td>
<td>Assay of natriuretic peptide</td>
</tr>
<tr>
<td>84100</td>
<td>Assay of phosphorus</td>
</tr>
<tr>
<td>84132</td>
<td>Assay of serum potassium</td>
</tr>
<tr>
<td>84155</td>
<td>Assay of protein serum</td>
</tr>
<tr>
<td>84157</td>
<td>Assay of protein other</td>
</tr>
<tr>
<td>84295</td>
<td>Assay of serum sodium</td>
</tr>
<tr>
<td>84302</td>
<td>Assay of sweat sodium</td>
</tr>
<tr>
<td>84450</td>
<td>Transferase (AST)(SGOT)</td>
</tr>
<tr>
<td>84484</td>
<td>Assay of troponin quant</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>84512</td>
<td>Assay of troponin qual</td>
</tr>
<tr>
<td>84520</td>
<td>Assay of urea nitrogen</td>
</tr>
<tr>
<td>84550</td>
<td>Assay of blood/uric acid</td>
</tr>
<tr>
<td>84702</td>
<td>Chorionic gonadotropin test</td>
</tr>
<tr>
<td>84704</td>
<td>Hcg free betachain test</td>
</tr>
<tr>
<td>85004</td>
<td>Automated diff wbc count</td>
</tr>
<tr>
<td>85007</td>
<td>BI smear w/diff wbc count</td>
</tr>
<tr>
<td>85025</td>
<td>Complete cbc w/auto diff wbc</td>
</tr>
<tr>
<td>85027</td>
<td>Complete cbc automated</td>
</tr>
<tr>
<td>85032</td>
<td>Manual cell count each</td>
</tr>
<tr>
<td>85046</td>
<td>Reticyte/hgb concentrate</td>
</tr>
<tr>
<td>85049</td>
<td>Automated platelet count</td>
</tr>
<tr>
<td>85378</td>
<td>Fibrin degrade semiquant</td>
</tr>
<tr>
<td>85380</td>
<td>Fibrin degradj d-dimer</td>
</tr>
<tr>
<td>85384</td>
<td>Fibrinogen activity</td>
</tr>
<tr>
<td>85396</td>
<td>Clotting assay whole blood</td>
</tr>
<tr>
<td>85610</td>
<td>Prothrombin time</td>
</tr>
<tr>
<td>85730</td>
<td>Thromboplastin time partial</td>
</tr>
<tr>
<td>86308</td>
<td>Heterophile antibody screen</td>
</tr>
<tr>
<td>86367</td>
<td>Stem cells total count</td>
</tr>
<tr>
<td>86403</td>
<td>Particle agglut antbdy scrn</td>
</tr>
<tr>
<td>86880</td>
<td>Coombs test</td>
</tr>
<tr>
<td>86900</td>
<td>Blood typing ABO</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Short Description</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>86901</td>
<td>Blood typing rh (d)</td>
</tr>
<tr>
<td>86920</td>
<td>Compatibility test spin</td>
</tr>
<tr>
<td>86921</td>
<td>Compatibility test incubate</td>
</tr>
<tr>
<td>86922</td>
<td>Compatibility test antiglob</td>
</tr>
<tr>
<td>86923</td>
<td>Compatibility test electric</td>
</tr>
<tr>
<td>86971</td>
<td>Rbc pretx incubatj w/enzymes</td>
</tr>
<tr>
<td>87205</td>
<td>Smear gram stain</td>
</tr>
<tr>
<td>87210</td>
<td>Smear wet mount saline/ink</td>
</tr>
<tr>
<td>87281</td>
<td>Pneumocystis carinii ag if</td>
</tr>
<tr>
<td>87327</td>
<td>Cryptococcus neoform ag eia</td>
</tr>
<tr>
<td>87400</td>
<td>Influenza a/b ag eia</td>
</tr>
<tr>
<td>89051</td>
<td>Body fluid cell count</td>
</tr>
<tr>
<td>86367</td>
<td>Stem cells total count</td>
</tr>
<tr>
<td>86923</td>
<td>Compatibility test electric</td>
</tr>
<tr>
<td>88720</td>
<td>Bilirubin total transcut</td>
</tr>
<tr>
<td>88740</td>
<td>Transcutaneous carboxyhb</td>
</tr>
<tr>
<td>88741</td>
<td>Transcutaneous methb</td>
</tr>
</tbody>
</table>
Allergen and clinical immunology

Allergen immunotherapy
Subcutaneous allergen immunotherapy may be medically necessary for the following conditions in children and adults:

- Allergic rhinitis, conjunctivitis, or allergic asthma
- History of systemic reaction to Hymenoptera

And the client:

- Has symptoms of allergic rhinitis and/or asthma after natural exposure to the allergen
  OR
- Has life-threatening allergy to insect stings
  AND
- Has a skin test and/or serologic evidence of IgE-medicated antibody to the allergen
  AND
- Must have tried/failed attempt at allergen avoidance and pharmacologic therapy, or the client has unacceptable side effects with pharmacologic therapy

And:

- The prescribing physician must be a board-certified allergist
  AND
- Immunotherapy injections must be administered in a setting that permits the prompt recognition and management of adverse reactions, particularly anaphylaxis
  AND
- If clinical improvement is not apparent after 12 months of maintenance therapy, immunotherapy should be discontinued

HCA will pay for 50 units (CPT® 95165) per client, per year. HCA allows 30 unit to be billed per date of service.

Prior authorization is required for amounts greater than 50 units per client, per year.

Payment for antigen/antigen preparation (CPT® codes 95145-95149, 95165, and 95170) is per dose.
<table>
<thead>
<tr>
<th>Service Provided</th>
<th>What should I bill?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection and antigen/antigen preparation for allergen immunotherapy</td>
<td>One injection (CPT® code 95115 or 95117); and</td>
</tr>
<tr>
<td></td>
<td>One antigen/antigen preparation (CPT® codes 95145-95149, 95165 or 95170).</td>
</tr>
<tr>
<td>Antigen/antigen preparation for stinging/biting insects</td>
<td>CPT® codes 95145-95149 and 95170</td>
</tr>
<tr>
<td>All other antigen/antigen preparation services (e.g., dust, pollens)</td>
<td>CPT® code 95144 for single dose vials; or CPT® code 95165 for multiple dose vials.</td>
</tr>
<tr>
<td>Allergist prepared the extract to be injected by another physician</td>
<td>CPT® code 95144</td>
</tr>
<tr>
<td>Allergists who billed the complete services (CPT® codes 95120-95134) and used</td>
<td>One antigen/antigen preparation (CPT® codes 95145-95149, 95165, and 95170); and</td>
</tr>
<tr>
<td>treatment boards</td>
<td>One injection (CPT® code 95115 or 95117).</td>
</tr>
<tr>
<td>Physician injects one dose of a multiple dose vial</td>
<td>Bill for the total number of doses in the vial and an injection code</td>
</tr>
<tr>
<td>Physician or another physician injects the remaining doses at subsequent times</td>
<td>Bill only the injection service</td>
</tr>
</tbody>
</table>

For an allergist billing both an injection and either CPT® code 95144 or 95165, payment is the injection fee plus the fee of CPT® code 95165, regardless of whether CPT® code 95144 or 95165 is billed. The allergist may bill an Evaluation and Management (E/M) procedure code for conditions not related to allergen immunotherapy.

**Audiology**

HCA may pay for audiology program services for conditions that are the result of medically recognized diseases and defects.

**Who is eligible to provide audiology services?**

Audiologists who are appropriately licensed or registered to provide audiology services within their state of residence to HCA clients.

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What type of equipment must be used?
Audiologists must use annually calibrated electronic equipment, according to RCW 18.35.020.

- For caloric vestibular testing (CPT® code 92537), bill one unit per irrigation. If necessary, providers may bill up to four units for each ear.
- For sinusoidal vertical axis rotational testing (CPT® code 92546), bill 1 unit per velocity/per direction. If necessary, providers may bill up to 3 units for each direction.

Unilateral (CPT® code 69930) and bilateral (CPT® code 69930 with modifier 50) cochlear implantation require EPA. See Auditory system.

HCA considers requests for removal or repair of previously implanted bone conduction hearing devices and cochlear devices for clients age 21 and older only when medically necessary. Prior authorization from HCA is required.

Audiology coverage
See the Physician-Related Services Fee Schedule for covered services.

Audiology billing

The outpatient rehabilitation benefit limits do not apply to therapy services provided and billed by audiologists. Audiologists (and physicians) must use AF modifier when billing.

Bronchial thermoplasty for asthma
Based upon review of evidence provided by the HTCC, HCA does not consider bronchial thermoplasty for asthma to be medically necessary.

Cardiovascular

Catheter ablation for supraventricular tachyarrhythmias
(CPT® codes 93653, 93655, 93656, 93657)
Based upon review of evidence provided by the HTCC, HCA considers ablation medically necessary for adults with the following conditions:

- Reentrant tachycardias (e.g., Wolff-Parkinson-White Syndrome, Atrioventricular reentrant tachycardia, Atrioventricular nodal reentrant tachycardia
- Symptomatic atrial flutter
- Symptomatic atrial fibrillation in patients for whom drug therapy is either not tolerated, or ineffective.

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HCA does not consider catheter ablation for adults medically necessary for other nonreentrant supraventricular tachycardias.

**Heart catheterizations**
When a physician performs cardiac catheterization in a setting where the physician does not own the equipment (e.g., a hospital or ASC), HCA pays providers for the appropriate **procedure code with modifier 26 (professional component) only**.

Use cardiac catheterization and angiography to report services individually. It is not appropriate to bill with modifier 51 (multiple procedures) with any of these codes. See HCA’s **Physician-related/professional fee schedule** for covered codes and status indicators.

**Outpatient cardiac rehabilitation**
HCA covers outpatient cardiac rehabilitation in a hospital outpatient agency for eligible clients who:

- Are referred by a physician.
- Have coronary artery disease (CAD).
- Do not have specific contraindications to exercise training.
- Have:
  - A recent documented history of acute myocardial infarction (MI) within the preceding 12 months.
  - Had coronary angioplasty (coronary artery bypass grafting [CABG]).
  - Percutaneous transluminal coronary angioplasty [PTCA]).
  - Stable angina.

Bill physician services with CPT® code 93797 or 93798 or HCPCS G0422 or G0423 (per session) with one of the following diagnoses:

- Acute myocardial infarction
- Angina pectoris
- Aortocoronary bypass status
- Percutaneous transluminal coronary angioplasty status

**Note:** Cardiac rehabilitation does not require PA, and it is only approved for the above diagnoses.
The outpatient cardiac rehabilitation program hospital facility must have all the following:

- A physician always on the premises, and each client is under a physician’s care
- Cardiopulmonary emergency equipment and therapeutic life-saving equipment available for immediate use
- An area set aside for the program’s exclusive use while it is in session
- Personnel who are:
  - Trained to conduct the program safely and effectively.
  - Qualified in both basic and advanced life-support techniques and exercise therapy for coronary disease.
  - Under the direct supervision of a physician
- Non physician personnel that are employees of the hospital
- Stress testing:
  - To evaluate a patient’s suitability to participate in the program
  - To evaluate chest pain
  - To develop exercise prescriptions
  - For pre- and postoperative evaluation of coronary artery bypass clients
- Psychological testing or counseling provided if either of the following are true. The client:
  - Exhibits symptoms such as excessive fear or anxiety associated with cardiac disease
  - Has a diagnosed mental, psychoneurotic, or personality disorder

HCA covers up to 24 sessions (usually 3 sessions a week for 4-6 weeks) of cardiac rehabilitation sessions (phase II) per event. HCA covers continued participation in cardiac rehabilitation programs beyond 24 sessions only on a case-by-case basis with prior authorization. Phase II of cardiac rehabilitation is the initial outpatient cardiac rehabilitation program. The goal of phase II is to lower the risk of future heart problems.
Central nervous system assessments/tests

Coverage for developmental screening for delays and surveillance and screening for autism
All children: As a part of routine well child exams for clients age 9 months, 18 months, and 30 months, HCA pays for one developmental screening for primary care providers when performed by a physician, ARNP, or PA. For further information about well child exams, see HCA’s Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Billing Guide.

To support timely access to a formal diagnostic evaluation and referral for applied behavioral analysis (ABA) treatment or other medically necessary services, HCA pays for one autism screening for all children at age 18 months, and a second screening before 36 months, when performed by a physician, ARNP, or PA.

See HCA’s Applied Behavior Analysis (ABA) Program Billing Guide for additional information.

*If additional units are necessary, providers must request prior authorization from HCA.

Chemotherapy

Chemotherapy services
Bill the appropriate chemotherapy administration CPT® code for each drug administered.

HCA’s chemotherapy administration policy is as follows:

- Providers may bill chemotherapy administration (CPT® codes 96411 or 96417) and bill one administration for each drug given. The administration and drug must be billed on the same claim.

- HCA pays for only one initial drug administration code (CPT® code 96409 or 96413) per encounter unless one of the following applies:
  - Protocol requires the use of two separate IV sites.
  - The client comes back for a separately identifiable service on the same day (in this case, bill the second initial service code with modifier -59).

- HCA does not pay for Evaluation and Management (E/M) CPT® code 99211 on the same date of service as the following drug administration codes: 96401-96549. If billed in combination with one of these drug administration codes, HCA will deny the E/M code 99211. However, providers may bill other E/M codes on the same date of service using modifier 25 to indicate that a significant and separately identifiable E/M service was provided. If modifier 25 is not used, HCA will deny the E/M code.
• **Items and services not separately payable with drug administration:**

Some items and services are included in the payment for the drug administration service, and HCA does not pay separately for them. These services include, but are not limited to the following:

- The use of local anesthesia
- IV start
- Access to indwelling IV (a subcutaneous catheter or port)
- A flush at conclusion of an infusion
- Standard tubing
- Syringes and supplies

• **Infusion vs. push:**

An intravenous or intra-arterial push is defined as either of the following:

- An injection in which the health care professional who administers the substance or drug is continuously present to administer the injection and observe the patient.
- An infusion of 15 minutes or less.

**Note:** Drug, infusion, and injection codes must be billed on the same claim.

**Irrigation of venous access pump**

CPT® code 96523 may be billed as a stand-alone procedure. However, if billed by the same provider/clinic on the same day as an office visit, modifier 25 must be used to report a separately identifiable medical service. If modifier 25 is not used, HCA will deny the E/M code.
Dermatology

Treatment of vitiligo with phototherapy
HCA covers phototherapy treatment for vitiligo with prior authorization (PA). Refer to the Physician-related services fee schedule for services that require PA.

Dialysis-end-stage renal disease (ESRD)

Inpatient visits for hemodialysis or outpatient non-ESRD dialysis services
(CPT® codes 90935 and 90937)

<table>
<thead>
<tr>
<th>CPT® Codes Billed</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 90935 and 90937   | Bill these codes for the hemodialysis procedure with all E/M services related to the client’s renal disease on the day of the hemodialysis procedure. Bill these codes for the following clients:  
  • Clients in an inpatient setting with ESRD  
  • Clients receiving hemodialysis in an outpatient or inpatient setting who do not have ESRD  
  Bill using ICD diagnosis code N18.6 or the appropriate diagnosis code (N17.2–N19, E74.8) for clients requiring dialysis but who do not have ESRD. |
| 90935             | Bill using CPT® code 90935 if only one evaluation is required related to the hemodialysis procedure. |
| 90937             | Bill using CPT® code 90937 if a re-evaluation(s) is required during a hemodialysis procedure on the same day. |
Inpatient visits for dialysis procedures other than hemodialysis
(e.g., peritoneal dialysis, hemofiltration, or continuous renal replacement therapies)
(CPT® codes 90945 and 90947)

<table>
<thead>
<tr>
<th>CPT® Codes Billed</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>90945 and 90947</td>
<td>Bill these codes for E/M services related to the client’s renal disease on the day of the procedure that includes peritoneal dialysis, hemofiltration, or continuous renal replacement. Bill using ICD diagnosis code N18.6 or the appropriate diagnosis code (N17.2-N19, E74.8) for clients requiring dialysis but who do not have ESRD.</td>
</tr>
<tr>
<td>90945</td>
<td>Bill using CPT® code 90945 if only one evaluation is required related to the procedure.</td>
</tr>
<tr>
<td>90947</td>
<td>Bill using CPT® code 90947 if a re-evaluation(s) is required during a procedure on the same day.</td>
</tr>
</tbody>
</table>

If a separately identifiable service is performed on the same day as a dialysis service, any of the following E/M procedures codes may be billed with modifier 25:

- 99202-99205 Office or Other Outpatient Visit: New Patient
- 99211-99215 Office or Other Outpatient Visit: Established Patient
- 99221-99223 Initial Hospital Care: New or Established Patient
- 99238-99239 Hospital Discharge Day Management Services
- 99241-99245 Office or Other Outpatient Consultations: New or Established Patient
- 99291-99292 Critical Care Services

**Endocrinology**

**Professional or diagnostic continuous glucose monitoring**
HCA pays for the in-home use of professional, diagnostic, short-term continuous glucose monitoring (CGM) for a minimum of a 72-hour monitoring period with Expedited prior authorization (EPA). See EPA # 870001312 for coverage criteria.

For personal, long-term CGM supplies, see HCA’s Home Infusion Therapy/Parenteral Nutrition Program Billing Guide for policy.

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Note: CPT® code 95251 is covered without EPA/PA; limit of one per month.

Genetic testing

Whole exome sequencing
HCA considers whole exome sequencing (WES) to be medically necessary for the evaluation of unexplained congenital or neurodevelopmental disorders in a phenotypically affected individual when ALL the following criteria are met:

- A board-certified or board-eligible medical geneticist, or an advanced practice nurse in genetics (APGN) credentialed by either the Genetic Nursing Credentialing Commission (GNCC) or the American Nurses Credentialing Center (ANCC), who is not employed by a commercial genetic testing laboratory, has evaluated the patient and family history, and recommends or orders, or both, the test.

- A genetic etiology is considered the most likely explanation for the phenotype, based on EITHER of the following:
  - Multiple abnormalities affecting unrelated organ systems (e.g., multiple congenital anomalies)
  - TWO of the following criteria are met:
    - Significant abnormality affecting at a minimum a single organ system
    - Profound global developmental delay or intellectual disability (see Definitions)
    - Family history strongly suggestive of a genetic etiology, including consanguinity
    - Period of unexplained developmental regression (unrelated to autism or epilepsy)
    - Biochemical findings suggestive of an inborn error of metabolism where targeted testing is not available

- Other circumstances (e.g., environmental exposures, injury, infection, etc.) do not reasonably explain the constellation of symptoms

- Clinical presentation does not fit a well-described syndrome for which single-gene or targeted panel testing (e.g., comparative genomic hybridization [CGH]/chromosomal microarray analysis [CMA]) is available

- The differential diagnosis list or phenotype warrant testing, or both, of multiple genes and ONE of the following:
  - WES is more efficient and economical than the separate single-gene tests or panels that would be recommended based on the differential diagnosis (e.g., genetic conditions that demonstrate a high degree of genetic heterogeneity)
- WES results may preclude the need for multiple invasive procedures or screening that would be recommended in the absence of testing (e.g., muscle biopsy)
- A standard clinical work-up has been conducted and did not lead to a diagnosis.
- Results will impact clinical decision-making for the individual being tested.
- Pre- and post-test counseling is performed by an American Board of Medical Genetics-certified or American Board of Genetic Counseling-certified genetic counselor.

HCA does not consider WES to be medically necessary for any the following:
- Uncomplicated autism spectrum disorder, developmental delay, or mild to moderate global developmental delay
- Other circumstances (e.g., environmental exposures, injury, infection, etc.) that reasonably explain the constellation of symptoms
- Carrier testing for "at risk" relatives
- Prenatal or pre-implantation testing

**Hydration, therapeutic, prophylactic, diagnostic injections, infusions**

**Hydration therapy with chemotherapy**
Intravenous (IV) infusion of saline (CPT® codes 96360–96361) is not paid separately when administered at the same time as chemotherapy infusion (CPT® codes 96413–96417). If hydration is provided as a secondary or subsequent service after a different initial service (CPT® codes 96360, 96365, 96374, 96409, 96413), and it is administered through the same IV access, report with CPT® code 96361 for the first hour and again for each additional hour.

**Note:** The CPT® codes 96365–96368 are for administration of therapeutic, prophylactic, or diagnostic IV infusion or injection (other than hydration).
Therapeutic or diagnostic injections/infusions
(CPT® codes 96360-96379)

- If no other service is performed on the same day, a subcutaneous or intramuscular injection code (CPT® code 96372) may be billed in addition to an injectable drug code.
- HCA does not pay separately for intravenous infusion (CPT® codes 96372-96379) if they are provided in conjunction with IV infusion therapy services (CPT® codes 96360-96361 or 96365-96368).
- HCA pays for only one initial intravenous infusion code (CPT® codes 96360, 96365, or 96374) per encounter unless either of the following are true:
  - Protocol requires the use of two separate IV sites.
  - The client comes back for a separately identifiable service on the same day. In this case, bill the second initial service code with modifier 59, XE, XS, XP, or XU.
- HCA does not pay for CPT® code 99211 on the same date of service as drug administration. If billed in combination, HCA denies the E/M CPT® code 99211.

Note: Other E/M codes may be billed on the same date of service using modifier 25 to indicate that a significant and separately identifiable service was provided. If modifier 25 is not used, HCA will deny the E/M code.

Concurrent infusion
HCA pays for concurrent infusion (CPT® code +96368) only once per day.

Immune globulins, serum, or recombinant products

Hepatitis B
(CPT® code 90371)
Reimbursement is based on the number of 1.0 ml syringes used. Bill each 1.0 ml syringe used as 1 unit.
**Immune globulins**

Bill HCA for immune globulins using the HCPCS procedure codes listed below. HCA does not reimburse for the CPT® codes listed in the Noncovered CPT® code column below.

<table>
<thead>
<tr>
<th>Noncovered CPT® Code</th>
<th>Covered HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>90281</td>
<td>J1460-J1560</td>
</tr>
<tr>
<td>90283</td>
<td>J1566</td>
</tr>
<tr>
<td>90284</td>
<td>J1562</td>
</tr>
<tr>
<td>90291</td>
<td>J0850</td>
</tr>
<tr>
<td>90384</td>
<td>J2790</td>
</tr>
<tr>
<td>90385</td>
<td>J2790</td>
</tr>
<tr>
<td>90386</td>
<td>J2792</td>
</tr>
<tr>
<td>90389</td>
<td>J1670</td>
</tr>
<tr>
<td></td>
<td>J1568, J1569, J1572, J1561</td>
</tr>
</tbody>
</table>

**Rabies immune globulin (Rlg)**

(CPT® codes 90375-90376)

Medicaid pays for Rlg when medically necessary as part of a post-exposure treatment protocol. Use the appropriate administration code in addition to the product CPT® code.

**Note:** Rabies post-exposure treatment may require Rlg and rabies vaccine (90675-90676).
Medical genetics and genetic counseling services

Genetic counseling and genetic testing
HCA covers genetic counseling for all fee-for-service adults and children when performed by a physician.

- To bill for prenatal genetic counseling, use ICD diagnosis code Z31.5 and the appropriate E/M code
- To bill for genetic counseling other than prenatal, use ICD diagnosis code Z71.83 and the appropriate E/M code.

HCA covers genetic counseling (CPT 96040) when performed by a health care professional appropriately credentialed by the Department of Health (DOH).

Certain genetic testing procedure codes need PA. Providers must obtain PA if required for certain genetic tests and must give both the PA number and the appropriate genetic testing modifier to the laboratory or when the laboratory bills so they can bill correctly. Providers must check the Physician-related services fee schedule for services that require either PA or EPA.

For procedure codes that require PA, use the General Information for Authorization form, 13-835 and Fax/Written Request Basic Information form, 13-756. See Where can I download HCA forms?

Prenatal genetic counseling
(Chapter 246-680 and 246-825 WAC)
Genetic counselors who meet the requirements in chapter 246-825 WAC are eligible to enroll with HCA to provide and receive payment for providing prenatal genetic counseling services. Genetic counselors must be approved by the Department of Health (DOH) Screening and Genetics Unit and be supervised by a practicing licensed physician.

Note: Clients enrolled in an HCA-contracted managed care organization (MCO) are covered under the fee-for-service benefit. Provider must bill HCA directly for prenatal genetic counseling provided to MCO clients. Prior authorization is not required.

Coverage
HCA covers:
- Face-to-face encounters only, including telemedicine. Telephonic and email encounters are not covered.
- One initial prenatal genetic counseling encounter. This encounter must be billed in 30-minute increments and cannot exceed 90 minutes.

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• Two follow-up prenatal genetic counseling encounters per pregnancy. The encounters must occur no later than 11 months after conception. These encounters must be billed in 30-minute increments and cannot exceed 90 minutes.

Prenatal procedures other than genetic counseling, such as laboratory or diagnostic testing, must be requested directly through the client’s primary care provider (PCP) or PCCM.

**Fee Schedule**

See HCA’s [Prenatal diagnosis counseling](#) fee schedule.

**Billing for prenatal genetic counseling**

Providers must follow the billing requirements listed in HCA’s [ProviderOne Billing and Resource Guide](#). The guide explains how to complete the claim. If you provide this service via telemedicine, see [Telemedicine](#) for information on billing telemedicine claims.

**Note:** 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.

Enter the following information in the listed fields on the claim:

<table>
<thead>
<tr>
<th>Name</th>
<th>Enter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place of Service</td>
<td>The appropriate place-of-service code, which must be either:</td>
</tr>
<tr>
<td></td>
<td>11 (office),</td>
</tr>
<tr>
<td></td>
<td>21 (inpatient hospital), or</td>
</tr>
<tr>
<td></td>
<td>22 (outpatient hospital)</td>
</tr>
<tr>
<td>Rendering (Performing) Provider Taxonomy Code</td>
<td>The taxonomy for prenatal genetic counseling: 170300000X</td>
</tr>
<tr>
<td>Rending (Performing) Provide NPI</td>
<td>The genetic counselor’s NPI number</td>
</tr>
<tr>
<td>Billing Provider NPI</td>
<td>The approved HCA billing NPI</td>
</tr>
<tr>
<td>Billing Provider Taxonomy Code</td>
<td>The approved HCA billing taxonomy code, which cannot be 170300000X</td>
</tr>
</tbody>
</table>
Note: CPT® code 96040 must be billed using taxonomy 170300000X for both the initial visit and the two follow-up visits. To bill for genetic counseling, use an ICD diagnosis code for genetic counseling and the appropriate E/M code. 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).

Applying to HCA to become a genetic counseling provider

To apply to provide services, a genetic counselor must:

- Be a licensed genetic counselor with the state of Washington. The Genetic Counselor License Application Packet is on the Department of Health’s website. For assistance, contact Nirupama Shridhar.
- Enroll on HCA’s website as a provider for Washington Apple Health (Medicaid). Include a copy of their Washington State genetic counselor professional license with their application.

Miscellaneous

After-hours

After-hours office codes are payable in addition to other services only when the provider’s office is not regularly open during the time the service is provided. An after-hours procedure billed for a client treated in a 24-hour facility (e.g., emergency room) is payable only in situations where a provider who is not already on-call is called to the facility to treat a client. These codes are not payable when billed by emergency room physicians, anesthesiologists/anesthetists, radiologists, laboratory clinical staff, or other providers who are scheduled to be on call at the time of service. The client’s file must document the medical necessity and urgency of the service. Only one code for after-hours services will be paid per patient, per day, and a second day may not be billed for a single episode of care that carries over from one calendar day.

For example: If a clinic closes at 5pm and takes a break for dinner, and then opens back up from 6 pm-10 pm, these services are not eligible for after-hours service codes.

Note: This policy does not include radiologists, pathologists, emergency room physicians, or anesthesiologists. HCA does not pay these providers for after-hour service codes.
# Neurology and neuromuscular procedures

## Needle electromyography (EMGs)
HCA has adopted Medicare-established limits for billing needle EMGs (CPT® codes 95860 – 95870) as follows:

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>95860</td>
<td>Muscle test one limb</td>
<td>Extremity muscles innervated by three nerves, or four spinal levels must be evaluated with a minimum of five muscles studied.</td>
</tr>
<tr>
<td>95861</td>
<td>Muscle test 2 limbs</td>
<td>Extremity muscles innervated by three nerves, or four spinal levels must be evaluated with a minimum of five muscles studied.</td>
</tr>
<tr>
<td>95863</td>
<td>Muscle test 3 limbs</td>
<td>Extremity muscles innervated by three nerves, or four spinal levels must be evaluated with a minimum of five muscles studied.</td>
</tr>
<tr>
<td>95864</td>
<td>Muscle test 4 limbs</td>
<td>Extremity muscles innervated by three nerves, or four spinal levels must be evaluated with a minimum of five muscles studied.</td>
</tr>
<tr>
<td>95865</td>
<td>Muscle test larynx</td>
<td>Limited to one unit per day</td>
</tr>
<tr>
<td>95866</td>
<td>Muscle test hemidiaphragm</td>
<td>Limited to one unit per day</td>
</tr>
<tr>
<td>95869</td>
<td>Muscle test thor paraspinal</td>
<td>Limited to one unit per day For this to pay with extremity codes 95860-95864, test must be for T3-T11 areas only; T1 or T2 alone are not separately payable.</td>
</tr>
</tbody>
</table>
### Muscle test nonparaspinal

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>95870</td>
<td>Muscle test nonparaspinal</td>
<td>Limited to one unit per extremity, and one unit for cervical or lumbar paraspinal muscle, regardless of number of levels tested (maximum of 5 units). Not payable with extremity codes (CPT® codes 95860-95864).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>95885</td>
<td>Musc tst done w/ nerv tst lim</td>
<td>3 units</td>
</tr>
<tr>
<td>95886</td>
<td>Musc test done w/n test comp</td>
<td>3 units</td>
</tr>
<tr>
<td>95887</td>
<td>Musc tst done w/n tst nonext</td>
<td>1 unit</td>
</tr>
</tbody>
</table>

### Nerve conduction study (NCS)

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>95907</td>
<td>Motor&amp;sens 1-2 nrv cndj tst</td>
<td>1-2 studies</td>
</tr>
<tr>
<td>95908</td>
<td>Motor&amp;sens 3-4 nrv cndj tst</td>
<td>3-4 studies</td>
</tr>
<tr>
<td>95909</td>
<td>Motor&amp;sens 5-6 nrv cndj tst</td>
<td>5-6 studies</td>
</tr>
<tr>
<td>95910</td>
<td>Motor&amp;sens 7-8 nrv cndj tst</td>
<td>7-8 studies</td>
</tr>
<tr>
<td>95911</td>
<td>Motor&amp;sens 9-10 nrv cndj tst</td>
<td>9-10 studies</td>
</tr>
<tr>
<td>95912</td>
<td>Motor&amp;sens 11-12 nrv cndj tst</td>
<td>11-12 studies</td>
</tr>
<tr>
<td>95913</td>
<td>Motor&amp;sens 13 or more nrv cndj tst</td>
<td>13 or more</td>
</tr>
</tbody>
</table>
Sleep medicine testing (sleep apnea)
See the Sleep Centers Billing Guide.

Ophthalmology – vision care services

Eye examinations and refraction services
HCA covers, without prior authorization (PA), eye examinations and refraction and fitting services with the following limitations:

- Once every 24 months for asymptomatic clients age 21 or older
- Once every 12 months for asymptomatic clients age 20 or younger
- Once every 12 months, regardless of age, for asymptomatic clients of the Developmental Disabilities Administration (DDA)

Vision hardware fitting fees billable to the client’s MCO

What has changed?
Retroactive to dates of service on and after July 1, 2021, providers must bill the following CPT® codes directly to the client’s MCO (see Managed care enrollment for more information on MCO coverage):

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92071</td>
<td>Contact lens fitting for tx</td>
</tr>
<tr>
<td>92072</td>
<td>Fit contact lens for managmnt</td>
</tr>
<tr>
<td>92310</td>
<td>Contact lens fitting</td>
</tr>
<tr>
<td>92311</td>
<td>Contact lens fitting</td>
</tr>
<tr>
<td>92312</td>
<td>Contact lens fitting</td>
</tr>
<tr>
<td>92313</td>
<td>Contact lens fitting</td>
</tr>
<tr>
<td>92340</td>
<td>Fit spectacles monofocal</td>
</tr>
<tr>
<td>92341</td>
<td>Fit spectacles bifocal</td>
</tr>
<tr>
<td>92342</td>
<td>Fit spectacles multifocal</td>
</tr>
<tr>
<td>92352</td>
<td>Fit aphakia spectcl monofocl</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92353</td>
<td>Fit aphakia spectcl multifoc</td>
</tr>
<tr>
<td>92354</td>
<td>Fit spectacles single system</td>
</tr>
<tr>
<td>92355</td>
<td>Fit spectacles compound lens</td>
</tr>
</tbody>
</table>

**What has not changed?**

When billing for the following CPT® codes for prescriptions and repairs, providers must continue to bill HCA through fee-for-service—not through the client’s MCO:

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92314</td>
<td>Prescription of contact lens</td>
</tr>
<tr>
<td>92315</td>
<td>Rx contact lens aphakia 1 eye</td>
</tr>
<tr>
<td>92316</td>
<td>Rx contact lens aphakia 2 eye</td>
</tr>
<tr>
<td>92317</td>
<td>Rx comeoscleral contact lens</td>
</tr>
<tr>
<td>92370</td>
<td>Repair &amp; adjust spectacles</td>
</tr>
<tr>
<td>92371</td>
<td>Repair &amp; adjust spectacles</td>
</tr>
</tbody>
</table>

**Coverage for additional examinations and refraction services**

HCA covers additional examinations and refraction services outside the limitation described in eye examinations and refraction services when:

- The provider is diagnosing or treating the client for a medical condition that has symptoms of vision problems or disease. Supporting medical documentation must be submitted with the claim.
- The client is on medication that affects vision. Supporting medical documentation must be submitted with the claim.

**OR**
• The service is necessary due to lost or broken eyeglasses/contacts. In this case:
  o No type of authorization is required for clients age 20 or younger or for clients of the Developmental Disabilities Administration (DDA), regardless of age. Authorization is not required for two or less replacement glasses. More than two pairs of glasses in a 12-month period requires Prior Authorization (PA).
  o Providers must follow HCA’s expedited prior authorization (EPA) process to receive payment for clients age 21 or older. See EPA #870000610 in Expedited Criteria Coding List. Providers must also document the following in the client’s file:
      ▪ The eyeglasses or contacts are lost or broken
      ▪ The last examination was at least 18 months ago

**Visual field exams**
HCA covers visual field exams for the diagnosis and treatment of abnormal signs, symptoms, or injuries. Providers must document all the following in the client’s record:
• The extent of the testing
• Why the testing was reasonable and necessary for the client
• The medical basis for the frequency of testing

**Vision therapy**
HCA covers orthoptics and vision therapy which involves a range of treatment modalities including the following:
• Lenses
• Prisms
• Filters
• Occlusion or patching
• Orthoptic/pleoptic training which is used for eye movement and fixation training

**Note:** HCA requires PA for eye exercises/vision training/orthoptics/pleoptics. HCA requires expedited prior authorization (EPA) for orthoptics/pleoptic training (CPT® code 97110, 97112, or 97530) when there is a secondary diagnosis of traumatic brain injury (TBI). See EPA #870001371, #870001372, and #870001373.
**Corneal topography**

HCA considers corneal topography to be medically necessary for the following diagnoses:

- Central corneal ulcer
- Corneal dystrophy, bullous keratopathy, and complications of transplanted cornea
- Diagnosing and monitoring disease progression in keratoconus or Terrien’s marginal degeneration
- Difficult fitting of contact lens
- Post-traumatic corneal scarring
- Pre- and post-penetrating keratoplasty and post kerato-refractive surgery for irregular astigmatism
- Pterygium or pseudo pterygium

HCA allows up to two tests per client, per calendar year. If the client meets the medical necessity criteria, bill using EPA #870001609. Otherwise, PA is required. You must document clinical rationale for each test in the medical record (e.g., change in condition). If needed more frequently or for a different diagnosis than what is listed above, PA is required.

**Ocular prosthetics**

HCA covers ocular prosthetics when provided by any of the following:

- An ophthalmologist
- An ocularist
- An optometrist who specializes in prosthetics

See HCA’s *Prosthetic and Orthotic Devices Billing Guide* for more information on coverage for ocular prosthetics.

**Eye surgery**

**Cataract surgery**

HCA covers cataract surgery, without PA, when either of the following clinical criteria are met:

- Correctable visual acuity in the affected eye is at 20/50 or worse, as measured on the Snellen test chart
- One or more of the following conditions exist:
  - Dislocated or subluxated lens
  - Intraocular foreign body
  - Ocular trauma

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Phacogenic glaucoma
Phacogenic uveitis
Phacoanaphylactic endophthalmitis
Increased ocular pressure in a person who is blind and is experiencing ocular pain

HCA does not cover the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Short Description</th>
<th>Policy/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1840</td>
<td>Telescopic intraocular lens</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Corneal cross-linking surgery (CPT® code 0402T)**

HCA considers corneal cross-linking surgery to be medically necessary when all the following are met. Prior authorization is required:

- Corneal thickness at thinnest point is at minimum 350 microns
- Documented progression of keratoconus as evidenced by one or more of the following:
  - Increase of 1 diopter or more in the steepest keratometry measurement in the last 12 months (if the client is < 26 years old, interval can be 3 months)
  - Increase of 1 diopter or more in astigmatism in the last 12 months
  - Myopic shift of 0.5 diopter on subjective manifest refraction

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Short Description</th>
<th>Policy/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>0402T</td>
<td>Colgn cross-link crn med sep</td>
<td>Covered</td>
</tr>
</tbody>
</table>

HCA requires the following from providers:

- The servicing provider must be classified as board eligible or board-certified with the American Board of Ophthalmology.
- Providers must submit a completed Corneal Cross-Linking Prior Authorization Form (HCA 13-0087) with the request.
- Providers must submit in full any supporting clinical documentation.
Strabismus surgery
HCA considers strabismus surgery to be medically necessary when the following is met:

<table>
<thead>
<tr>
<th>Clients</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 17 or younger</td>
<td>The provider clearly documents the need in the client's record. HCA does not require authorization.</td>
</tr>
<tr>
<td>Age 18 or older</td>
<td>The provider should use expedited prior authorization (EPA) #870000631 when the clinical criteria is met. If the client does not meet the clinical criteria, the provider must request prior authorization (PA). Follow the PA process.</td>
</tr>
</tbody>
</table>

Blepharoplasty or blepharoptosis surgery
HCA covers blepharoplasty or blepharoptosis surgery when all the clinical criteria are met. To receive payment, providers must follow HCA’s EPA process. See Expedited prior authorization (EPA). The following clinical criteria must be met:

- The client’s excess upper eyelid skin is blocking the superior visual field.
- The blocked vision is within 10 degrees of central fixation using a central visual field test.

Implantable miniature telescope
The implantable miniature telescope, CPT® code 66999, is used in clients with untreated, end stage, age related macular degeneration. It is a visual aid for clients with low vision, and like the other adult low vision aids, is considered vision hardware. Like all vision hardware, this is not included in the clients’ benefit package for clients age 21 and older.

Vision coverage table
Due to its licensing agreement with the American Medical Association, HCA publishes only the official CPT procedure code short descriptions. To view the long description, refer to a current CPT book.

Note: The maximum allowable fee for vision coverage services can be found in the Physician-Related/Professional Services Fee Schedule.
## Contact Lens Services

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Modifier</th>
<th>Short Description</th>
<th>PA</th>
<th>Policy/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>92071</td>
<td></td>
<td>Contact lens fitting for tx</td>
<td>No</td>
<td>Ages 21-99 2 fittings every 24 months.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ages 0-20 1 fittings every 12 months for asymptomatic clients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Part of July 1, 2021, update(^2)</td>
</tr>
<tr>
<td>92072</td>
<td></td>
<td>Fit contact lens for managmnt</td>
<td>No</td>
<td>Ages 21-99 2 fittings every 24 months.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ages 0-20 2 fittings every 12 months limited to the appropriate diagnosis code.</td>
</tr>
<tr>
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## Spectacle Fitting fees, monofocal

<table>
<thead>
<tr>
<th>CPT® Code</th>
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<th>Policy/Comments</th>
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<tr>
<td>92340</td>
<td></td>
<td>Fit spectacles monofocal</td>
<td>No</td>
<td>Part of July 1, 2021, update(^3)</td>
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<tr>
<td>92352</td>
<td></td>
<td>Fit aphakia spectcl monofocl</td>
<td>No</td>
<td>Part of July 1, 2021, update(^3)</td>
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</table>

## Spectacle Fitting fees, bifocal

<table>
<thead>
<tr>
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<th>Policy/Comments</th>
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<tr>
<td>92341</td>
<td></td>
<td>Fit spectacles bifocal</td>
<td>No</td>
<td>Part of July 1, 2021, update(^3)</td>
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</tbody>
</table>

\(^2\) See Vision hardware fitting fees billable to the client’s MCO for more information.  
\(^3\) See Vision hardware fitting fees billable to the client’s MCO for more information.  

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## Spectacle Fitting fees, multifocal

<table>
<thead>
<tr>
<th>CPT® Code</th>
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<th>Short Description</th>
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<th>Policy/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>92342</td>
<td></td>
<td>Fit spectacles multifocal</td>
<td>No</td>
<td>Part of July 1, 2021, update³</td>
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<tr>
<td>92353</td>
<td></td>
<td>Fit aphakia spectcl multifoc</td>
<td>No</td>
<td>Part of July 1, 2021, update³</td>
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</tbody>
</table>

**Note:** Fitting fees are **not** currently covered by Medicare and may be billed directly to HCA without attaching a Medicare denial.

## Other

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Modifier</th>
<th>Short Description</th>
<th>PA</th>
<th>Policy/Comments</th>
</tr>
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<tbody>
<tr>
<td>92354</td>
<td></td>
<td>Fit spectacles single system</td>
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<td>92355</td>
<td></td>
<td>Fit spectacles compound lens</td>
<td>Yes</td>
<td>Part of July 1, 2021, update⁴</td>
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<tr>
<td>92370</td>
<td></td>
<td>Repair &amp; adjust spectacles</td>
<td>No</td>
<td>Applies only to clients age 20 and younger.</td>
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<tr>
<td>92371</td>
<td></td>
<td>Repair &amp; adjust spectacles</td>
<td>No</td>
<td>Applies only to clients age 20 and younger.</td>
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<tr>
<td>92499</td>
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<td>Eye service or procedure</td>
<td>Yes</td>
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⁴ See Vision hardware fitting fees billable to the client’s MCO for more information.
### General Ophthalmological Services

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<tr>
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<th>Policy/Comments</th>
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<td>Eye exam new patient</td>
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<td>92004</td>
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<td>Eye exam new patient</td>
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<td>92012</td>
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<td>Eye exam establish patient</td>
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<tr>
<td>92014</td>
<td></td>
<td>Eye exam &amp; tx estab pt 1&gt;/vst</td>
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### Special Ophthalmological Services

<table>
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<th>Policy/Comments</th>
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<tbody>
<tr>
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<td>Determine refractive state</td>
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<td>92018</td>
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<td>New eye exam &amp; treatment</td>
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<tr>
<td>92019</td>
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<td>Eye exam &amp; treatment</td>
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<tr>
<td>92020</td>
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<td>Special eye evaluation</td>
<td>No</td>
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<tr>
<td>92025</td>
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<td>Corneal topography</td>
<td>Yes</td>
<td>EPA required. Limited to 2 per calendar year. EPA #870001609</td>
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<tr>
<td>92025</td>
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<td>Corneal topography</td>
<td>Yes</td>
<td>EPA required. Limited to 2 per calendar year. EPA #870001609</td>
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<table>
<thead>
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<th>PA</th>
<th>Policy/Comments</th>
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<td>EPA required. Limited to 2 per calendar year. EPA #870001609</td>
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<td>Special eye evaluation</td>
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<td>92060</td>
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<td>Special eye evaluation</td>
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<td>Special eye evaluation</td>
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<tr>
<td>92065</td>
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<td>Orthoptic/pleoptic training</td>
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<tr>
<td>92065</td>
<td>TC</td>
<td>Orthoptic/pleoptic training</td>
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<td>Visual field examination(s)</td>
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<td>92100</td>
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<td>Serial tonometry exam(s)</td>
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<td>Cmptr ophth img optic nerve</td>
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<td>Limited to 1 per calendar year</td>
</tr>
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<td>92133</td>
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<td>No</td>
<td>Limited to 1 per calendar year</td>
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<tr>
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<td></td>
<td>Cmptr ophth img optic nerve</td>
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<td>Limited to 1 per calendar year</td>
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<tr>
<td>92134</td>
<td></td>
<td>Cptr ophth dx img post segmt</td>
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<td>First 2 procedures per calendar year do not require PA when medically necessary.</td>
</tr>
<tr>
<td>92134</td>
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<td>Cptr ophth dx img post segmt</td>
<td>Yes</td>
<td>EPA required if additional procedures are medically necessary. Limited to 12 per calendar year. EPA #870000051.</td>
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<td>92136</td>
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<td>Ophthalmic biometry</td>
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<td>92136</td>
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<tr>
<td>92140</td>
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<td>Glaucoma provocative tests</td>
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## Ophthalmoscopy

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<th>Procedure Code</th>
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<th>Short Description</th>
<th>PA</th>
<th>Policy/Comments</th>
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<tbody>
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<td>92230</td>
<td></td>
<td>Eye exam with photos</td>
<td>No</td>
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<td>92235</td>
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<td>Eye exam with photos</td>
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<td>Icg angiography</td>
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<td>92260</td>
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<td>Ophthalmoscopy/Dynamometry</td>
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<td>V2630</td>
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## Other Specialized Services

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<th>PA</th>
<th>Policy/Comments</th>
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<td>92265</td>
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<td>Eye muscle evaluation</td>
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<table>
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<th>Policy/Comments</th>
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<td>Eye muscle evaluation</td>
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### Contact Lens Services

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<tr>
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<td>Contact lens fitting</td>
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<td>92317</td>
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</tbody>
</table>

[^5]: See Vision hardware fitting fees billable to the client’s MCO for more information.

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**Note: Ocular Prosthesis** - See the Outpatient Hospital Services Billing Guide and the Outpatient Prospective Payment System (OPPS) fee schedule on HCA’s Hospital reimbursement webpage for more information on coverage for ocular prosthetics.

**Manipulative therapy**  
(CPT® codes 98925-98929)

**HCA covers:**

- Ten (10) manipulative therapy treatments per client, per calendar year.
- Manipulative therapy services only when provided by either an osteopathic physician licensed under chapter 18.71 RCW or a naturopathic physician licensed under chapter 18.36A RCW.
- Manipulative therapy services by body regions. Body regions are defined as:
  - abdomen and viscera
  - pelvic
  - cervical
  - rib cage
  - head
  - sacral
  - lower extremities
  - thoracic
  - lumbar
  - upper extremities
- One manipulative therapy CPT® code in the range 98925-98929 per client, per day. Bill using the CPT® code that describes the number of body regions involved. For example, if three body regions are manipulated, bill one unit of CPT® code 98926.
- An E/M service (billed with modifier 25) in addition to the manipulative therapy service, under one of the following circumstances:
  - When a provider diagnoses the condition requiring manipulative therapy and provides the therapy during the same visit
  - When the existing condition fails to respond to manipulative therapy or significantly changes, requiring E/M services beyond those considered included in the manipulation codes
  - When the provider treats the client for a condition unrelated to the manipulative therapy during the same encounter

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Justification for the E/M and manipulative therapy services must be documented and kept in the client’s record for review.

**Note:** HCA does not cover physical therapy services performed by osteopathic physicians or naturopathic physicians unless they are also physiatrists.

### Other services and procedures

**Hyperbaric oxygen therapy**
(CPT® code 99183 and HCPCS G0277)

Hyperbaric oxygen therapy may be considered medically necessary for treatment of the following conditions in the inpatient or outpatient hospital setting:

- Decompression sickness
- Acute carbon monoxide poisoning
- Acute cyanide poisoning
- Acute gas or air embolism
- Gas gangrene (clostridial myositis and myonecrosis)
- Progressive necrotizing soft tissue infections
- Acute traumatic ischemia secondary to crush injuries
  - For prevention of loss of function or for limb salvage
  - Used in combination with standard medical and surgical management
- Late radiation tissue injury
- Prevention of osteoradionecrosis following tooth extraction in a previously radiated field
- Refractory osteomyelitis
  - Unresponsive to standard medical and surgical management
- Compromised flaps and skin grafts
  - For prevention of loss of function or for limb salvage
- Non-healing diabetic wounds of the lower extremities
  - Patient has type 1 or type 2 diabetes and has a lower extremity wound that is due to diabetes
  - Patient has a wound classified as Wagner grade 3 or higher
  - Patient has failed an adequate course of standard wound therapy
The following are considered not medically necessary:

- Thermal burns
- Acute and chronic sensorineural hearing loss
- Cluster and migraine headaches
- Multiple sclerosis
- Cerebral palsy
- Traumatic and chronic brain injury
- Arterial, venous or pressure ulcers

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99183</td>
<td>Hyperbaric oxygen therapy</td>
</tr>
<tr>
<td>G0277</td>
<td>Hyperbaric oxygen</td>
</tr>
</tbody>
</table>

Hyperbaric oxygen therapy requires EPA. See Expedited Prior Authorization Criteria Coding List, EPA #870000425. If the client does not meet the EPA criteria, prior authorization (PA) is required (see Prior authorization (PA)). When requesting PA, provide the number of sessions being requested and the amount of time requested per session. For example: If the client is receiving a 90-minute session of hyperbaric oxygen therapy, the provider would request 1 unit of 99183 and 3 units of G0277.

**Neuropsychological testing**
For Neuropsychological testing, see HCA’s Mental Health Services Billing Guide.

**Stem cell therapy for musculoskeletal conditions**
Based upon review of evidence provided by the Health Technology Clinical Committee (HTCC), HCA does not consider stem cell therapy for musculoskeletal conditions to be medically necessary.
Testosterone testing
(CPT® codes 84402, 84403, and 84410)

HCA covers medically necessary testosterone testing for any eligible client. See the following table for cases in which prior authorization is required:

<table>
<thead>
<tr>
<th>Client</th>
<th>Prior authorization required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assigned female at birth, any age</td>
<td>No</td>
</tr>
<tr>
<td>Assigned male at birth, age 18 and younger</td>
<td>No</td>
</tr>
<tr>
<td>Assigned male at birth, age 19 and older</td>
<td>Yes. When the client meets the coverage criteria, you may use EPA #870001368.</td>
</tr>
<tr>
<td>Client of any age, being treated for gender dysphoria</td>
<td>Yes. When the client meets the coverage criteria, you may use EPA #870001368.</td>
</tr>
</tbody>
</table>

Tinnitus
Based upon review of evidence provided by the HTCC, HCA considers cognitive behavioral therapy to be medically necessary for treatment of subjective tinnitus. HCA does not consider the following treatments for tinnitus to be medically necessary:

- Sound therapies:
  - Altered auditory stimuli
  - Auditory attention training
- Repetitive transcranial magnetic stimulation
- Tinnitus-specific therapies, including but not limited to, the following:
  - Tinnitus retraining therapy (TRT)
  - Neuromonics tinnitus treatment (NTT)
  - Tinnitus activities treatment (TAT)
  - Tinnitus-masking counseling

Transient elastography
HCA pays for a transient elastography such as a FibroScan® only for determining if qualifying criteria measures are met for immune modulators and anti-viral medication treatment of chronic Hepatitis C virus (HCV) infection. Transient elastography requires EPA. See Expedited Prior Authorization Criteria Coding List, EPA #870001350.
Psychiatry

Clozaril - case management
- Physicians, psychiatrists, and ARNPs must bill for Clozaril case management using the applicable E/M code for drug monitoring.
- For Pharmacist billing, see HCA’s Prescription Drug Program Billing Guide.
- Put “Clozaril Case Management” in the claim notes field on the claim.
- HCA reimburses providers for one unit of Clozaril case management per week.
  - HCA reimburses providers for Clozaril case management when billed with the appropriate ICD diagnosis codes.
  - Routine venipuncture (CPT® code 36415) and a blood count (CBC) may be billed in combination when providing Clozaril case management.
- HCA does not pay for Clozaril case management when billed on the same day as any other psychiatric-related procedures.

For additional information, see HCA’s Mental Health Services Billing Guide.

Pulmonary

Extracorporeal membrane oxygenation therapy (ECMO)
See extracorporeal membrane oxygenation therapy (ECMO). ECMO is for both cardiovascular and pulmonary services.

Ventilator management
Evaluation and Management (E/M) services are not allowed in combination with CPT® codes 94002-94004, 94660, and 94662 for ventilator management on the same day, by the same provider/clinic. However, E/M services may be billed for on the same date of service using modifier 25 to indicate that a significant and separately identifiable service was provided. If modifier 25 is not used, HCA will deny the E/M code.
**Special services**

**Group clinical visits for clients with diabetes or asthma**

**Overview of the program**

The intent of the Diabetes and Asthma Group Clinical Visits program is to provide clinical services and educational counseling to HCA clients who have been diagnosed with diabetes or asthma. These visits are limited to groups of two or more clients and are payable only to physicians or advanced registered nurse practitioners (ARNPs). However, participation from other professional staff, including physician assistants, physical therapists, nurses, and nutritionists, is encouraged.

**Program requirements**

- Prior to a group clinical visit, the provider must perform an assessment of individual client medical information and document the proposed treatment plan for each client.
- The group clinical visit must be led by a physician or ARNP but may include other staff as well.
- The group clinical visit must last at least one hour and include:
  - A group discussion on clinical issues to promote long-term disease control and self-management. This discussion should include at least one of the following topics:
    - Prevention of exacerbation or complications
    - Proper use of medications and other therapeutic techniques (spacers, peak flow meter use; glucose measurement, foot care, eye exams, etc.)
    - Living with a chronic illness
  - A question-and-answer period
  - The collection of prevention-based care data needed to monitor chronic illness (e.g., weight and blood pressure)
  - Short (approximately 5-10 minutes per client) one-on-one visits to gather needed data and establish an individual management plan with the client
- The following must be documented in the medical record:
  - Individual management plan, including self-management capacity
  - Data collected, including physical exam and lab findings
  - Patient participation
  - Beginning and ending time of the visit
Billing and reimbursement

Providers must use the following CPT® code when billing for diabetes or asthma group counseling visits, subject to the limitations in the table below. Providers must bill visits in increments of one-hour units (one hour = one unit). Multiple units may be billed on the same day.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Restricted to Diagnoses</th>
<th>Visit Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>99078</td>
<td>Diabetes and asthma</td>
<td>Limited to four (4) one-hour units per calendar year, per client, per condition</td>
</tr>
</tbody>
</table>

Note: HCA only pays for the time that a client spends in the group clinical visit.

Other limitations

HCA does not reimburse a diabetes or asthma group clinical visit in conjunction with an office visit or other outpatient evaluation and management (E/M) codes for the same client, same provider, and same condition on the same day.

A diabetes group clinical visit may be billed on the same day as a Department of Health (DOH) -approved diabetes education core module if the times documented in the medical record indicate two separate sessions.

Therapies (physical, occupational, and speech therapy)

Physicians, Podiatrists, Advanced Registered Nurse Practitioners (ARNP), Physician Assistants Certified (PA-C), and Wound Care Center Specialty Physicians - Billing

The outpatient rehabilitation benefit limits do not apply to therapy services provided and billed by physicians, podiatrists, ARNPs, PA-Cs, and wound care center specialty physicians.

Modifier required when billing

Physicians, podiatrists, ARNPs, and PA-Cs, and wound care center specialty physicians must use the following modifier when billing for PT/OT/ST services:

<table>
<thead>
<tr>
<th>Modality</th>
<th>Modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT/OT/ST</td>
<td>AF</td>
</tr>
</tbody>
</table>

Note: For additional information, see HCA’s Outpatient Rehabilitation Billing Guide.
Treatment of chronic migraines and chronic tension-type headaches

HCA requires prior authorization for OnabotulinumtoxinA (Botox) injections through a medical necessity review by Comagine Health.

For treatment of chronic migraine (as defined by the International Headache Society), HCA covers OnabotulinumtoxinA when the following criteria are met:

- The client has not responded to at least three prior pharmacological prophylaxis therapies from two different classes of drugs.
- The condition is appropriately managed for medication overuse.

OnabotulinumtoxinA injections must be discontinued when the condition has shown inadequate response to treatment (defined as less than a 50% reduction in headache days per month after two treatment cycles).

A maximum of five treatment cycles is allowed in a 12-month period. HCA evaluates requests for additional treatment cycles on a case-by-case basis.

Treatment of chronic migraine or chronic tension-type headache with acupuncture, massage, trigger point injections, transcranial magnetic stimulation, or manipulation/manual therapy is not a covered benefit.

Vaccines/toxoids (immunizations)

HCA covers vaccines administered according to the current Centers for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP) immunization schedule for adults and children in the United States, including make-up schedules. There is detailed guidance on vaccines at the CDC website. Refer to the Professional administered drugs fee schedule for the list of covered vaccines by CPT® code.

HCA covers only those vaccines listed on the CDC immunization schedule for adults and children in the United States. HCA does not cover vaccines recommended or required for the sole purpose of international travel (such as yellow fever, typhoid, Japanese encephalitis, etc.).

Note: In the case of rabies vaccines, HCA does not cover pre-exposure immunization for rabies. Medicaid pays for the rabies vaccine when medically necessary as part of the post-exposure treatment protocol.

Clients from birth through age 18

DOH supplies free vaccines for children 0-18 years only. For clients 18 years of age and younger, see HCA's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Billing Guide.
Clients age 19 and older

HCA covers vaccines recommended by the CDC. HCA covers vaccines needed throughout the client’s lifetime based on age, health conditions, or other factors.

Routine adult immunizations include an annual flu shot as well as tetanus (Td or Tdap) shots at intervals determined by healthcare professionals.

Health care providers should regularly review client immunization histories and offer any vaccine indicated for their adult clients. HCA covers these vaccines as necessary.

Clients with a Family Planning Only benefit are eligible only for human papillomavirus (HPV) vaccine administered according to the current Centers for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP) immunization schedule for adults and children in the United States.

How to bill HCA for adult immunizations

- The claim must include the CPT® code for each vaccine product given.
- Include the appropriate vaccine administration CPT® codes on the same claim form:
  - 90471 if only one vaccine is injected
  - 90472 for each additional vaccine injected at the visit
  - 90473 if one vaccine is administered via the oral or intranasal route
  - 90474 for each additional vaccine administered by the oral or intranasal route
- HCA reimburses providers for the vaccine product using HCA’s maximum allowable fee schedule.

If an immunization is the only service provided, bill only for the vaccine and for the administration of the vaccine.

Billing with an E/M code

Do not bill an E/M code unless a significant and separately identifiable condition exists and is reflected by the diagnosis.

When a significant and separately identifiable condition exists, bill the appropriate E/M code with modifier 25. If the E/M code is billed without modifier 25 on the same date of service as a vaccine administration, HCA will deny the E/M code. **Exception:** The E/M code 99211 may not be billed with a vaccine or the vaccine administration code.
Obstetric Care and Delivery

Policies and resources regarding pregnancy care

- For information regarding family planning services, including immediate postpartum long-acting reversible contraceptive (LARC) insertion, see the Family Planning Billing Guide.

- For information regarding support services covered during and post pregnancy see the Maternity Support Services/Infant Case Management Billing Guide. Maternity Support Services/Infant Case Management (MSS/ICM) are services provided through the First Steps program. Services are designed to help pregnant clients and their newborns gain access to medical, social, educational, and other services. Services are provided in the home or clinic throughout pregnancy and up to the infant’s first birthday.

- For information regarding childbirth education see the Childbirth Education Billing Guide.

- To bill for anesthesia during delivery, see Anesthesia for labor and delivery.

- For deliveries in a birthing center, see HCA’s Planned Home Births and Births in Birthing Centers Billing Guide.

- For deliveries in a home birth setting, see HCA’s Planned Home Births and Births in Birthing Centers Billing Guide.

- For information on treating substance use in pregnancy:
  - See the Chemical-Using Pregnant (CUP) Women Program Billing Guide for detoxification services.
  - See Drug screening for medication for opioid use disorder regarding drug screening.

Confirmation of pregnancy
If a client presents with signs or symptoms of pregnancy and the purpose of the client’s visit is to confirm the pregnancy and:

- The obstetrical (OB) record is not initiated, bill this visit using the appropriate level E/M code. Bill using the diagnosis code(s) for the signs and/or symptoms the client is having [e.g., suppressed menstruation (ICD diagnosis code N92.5 or N93.8)]. Do not bill using the pregnancy diagnosis codes (e.g., Z33.1, Z34.00, Z34.80, or Z34.90).

- The OB record is initiated at this visit the visit is considered part of the global OB package and must not be billed separately. The pregnancy diagnosis codes (e.g., Z33.1, Z34.00, Z34.80, or Z34.90) are used when billing the global OB package. (See below)
If some other source has confirmed the pregnancy and the provider wants to do his/her own confirmation, bill this visit using the appropriate level E/M code if the OB record is not initiated. If the OB record is initiated at this visit, the visit is considered part of the global OB package and must not be billed separately.

**Diagnostic testing to confirm pregnancy and gestational age:**
- See the Physician-related/professional services fee schedule and clinical laboratory codes for coverage of urine and blood testing for confirmation of pregnancy.
- See obstetrical ultrasounds in this guide.

**Problem visits during pregnancy**
If a client is seen for reasons other than routine antepartum or postpartum care, providers must bill using the appropriate Evaluation and Management (E/M) procedure code with a medical diagnosis code as the primary diagnosis. Claims with diagnosis codes Z33.1, Z34.00, Z34.80, or Z34.90 will be denied if listed as the principal diagnosis.

For those clients who have non-pregnancy-related issues and diagnosis(es), the provider should use the appropriate E/M code with the modifier GB.

**HIV/AIDS counseling/testing**
See HIV/AIDS counseling/testing for coverage policy.

**Exceptions for pregnancy:** HCA pays for counseling visits when billed with an E/M service on the same day when either of the following is true:

- The client is being seen for a medical problem and modifier 25 is billed.
- The client is being seen for an antepartum visit and modifier TH is used.

HCA does not pay for a counseling visit if the client is being seen only to confirm pregnancy and an office visit is billed, because the counseling is considered part of the office visit.

HCA covers HIV testing (86701-86703) for pregnant clients when billed with the following appropriate diagnosis codes: Z33.1, Z34.00, Z34.80, Z34.90 or Z36.

**Tobacco/nicotine cessation for pregnant clients**
See tobacco/nicotine cessation coverage and billing policies and resources.
Early pregnancy loss and abortion services

- Pregnancy services include the assessment, management, treatment of pregnancy loss, and voluntary terminations. This includes spontaneous, incomplete, missed, induced, and elective abortions.

- Providers must bill using the appropriate diagnosis codes for the type of abortion – elective, induced, spontaneous, incomplete, or missed. An elective termination of pregnancy requires the ICD diagnosis code Z33.2.

- Office visits, laboratory tests, and diagnostic tests performed for the purpose of confirming pregnancy, gestational age, and successful treatment are covered.

- Rho(D) immune globulin must be billed using the appropriate HCPCS codes when it is given. See Physician-related/professional services fee schedule and Professionally administered drug fee schedule.

- Clients enrolled in an HCA managed care organization (MCO) may self-refer outside the MCO for induced abortions.

- Clients on the Family Planning Only – Pregnancy Related program or Family Planning Only program are not covered for pregnancy care including induced abortions. They must apply for pregnancy medical coverage.

- Medical abortions:
  - HCA pays a bundled rate (HCPCS S0199) for medical abortions administered in an office or outpatient clinic setting.
    - HCPCS S0199 includes services rendered over an 18-day period, including office visits, ultrasounds, laboratory studies, and education/counseling. Day 1 of the 18-day period is the day medical abortion mediations are provided, administered, or prescribed to the client.
    - Providers may bill HCPCS S0199 after the follow-up appointment or 18 days after the first visit, whichever comes first.
    - Reimbursement for HCPCS S0199 is limited to once every 5 weeks.
    - Bill HCPCS S0199 on professional (J) claims only.
    - Providers must bill for medical abortions using HCPCS S0199 unless there is a complication.
CPT® codes incorporated into the HCPCS S0199 rate include: 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 76815, 76817, 76830, 85018, 86901, 36416, 36410, 36415, 99000, 99001, and 84702.

The medical abortion provider must not bill these codes separately to either FFS or the client’s MCO during the 18-day service period for HCPCS S0199.

**Note:** HCPCS S0199 does not include abortion medications, which must be billed on different lines. Rho(D) immune globulin is not included in the bundled rate and must be billed on a different line when administered.

**Note:** Do not use HCPCS S0199 when the client undergoes surgical abortion during the 18-day service period due to complications or incomplete medical abortion. Instead, bill separately for each individual service provided.

- When a client does not present for a follow-up visit, use modifier TS when billing HCPCS S0199. The provider payment for HCPCS S0199 is unchanged when modifier TS is used.
- HCA covers the following medications used according to nationally accepted guidelines issued by the Food and Drug Administration (FDA) and the American College of Obstetricians and Gynecologists (ACOG):
  - Methotrexate sodium, 50 mg (HCPCS J9260)
  - Mifepristone, oral, 200 mcg (HCPCS S0190)
  - Misoprostol, oral, 200 mcg (HCPCS S0191)
- **Telemedicine**
  - When telemedicine is used to provide HCPCS S0199 bundled services, HCA does not pay any additional originating facility fees.

  **Example:** Client receives ultrasound(s), laboratory studies, and medication at Clinic A (originating site) and uses a telemedicine platform to meet with the medical abortion provider, who is at Clinic B (distant site). The provider may not bill for HCPCS Q3014 (originating facility fee). See Telemedicine for more information.
• Medical abortion services provided via telemedicine to a client who does not receive ultrasound(s) and laboratory studies from the medical abortion provider are not eligible for the HCPCS S0199 bundled payment.

**Example:** the client is at home and uses a telemedicine platform to meet with the provider for medical abortion education and counseling. The client then picks up the abortion medications at the clinic. The provider may only bill the appropriate evaluation and management (E/M) code, along with codes for the medications dispensed.

**Note:** Do not bill HCA for medical abortion services until all care is completed.

• **Surgical abortions:**
  - HCA pays for surgical abortions that occur in an ambulatory surgical center (ASC), hospital, or HCA-approved and -contracted non-hospital-based center (abortion center).
  - ASCs and hospitals must bill for surgical services according to their billing guides. See the **Ambulatory Surgery Centers Billing Guide**, the **Inpatient Hospital Services Billing Guide**, and the **Outpatient Hospital Services Billing Guide**.
  - Abortion centers:
    - Abortion centers must be approved by and contracted with HCA to bill for facility fee payments for a surgical abortion. To become an approved abortion center, send a request to womenshealth@hca.wa.gov.
    - Abortion centers are reimbursed facility fees only for surgical abortions. Abortion centers are not paid a facility fee for medical abortions not requiring surgical intervention.
    - The HCA-contracted abortion center facility fee payment includes the following:
      - All room charges
      - Equipment and supplies
      - All drugs and medications related to the procedure, including but not limited to, anti-anxiety, antibiotics, pain medications, miscellaneous drugs (HCPCS code J3490), and anesthesia medication
      - All injections and blood draws associated with the procedure
  - HCA-contracted abortion center facility fee does not include professional services, laboratory charges, ultrasound and other X-rays, and Rho(D) immune globulin which may be billed separately.
• Payment is limited to one HCA-contracted abortion center facility fee per client, per abortion. The facility fee is not payable per visit, even though a particular procedure or case may take several days or visits to complete.

Global (total) obstetrical (OB) care
Global OB care (CPT® codes 59400, 59510, 59610, or 59618) includes all the following:

• Routine antepartum care in any trimester
• Delivery
• Postpartum care

If the provider furnishes all the client’s antepartum care, performs the delivery, and provides the postpartum care, the provider **must bill** using one of the global OB procedure codes.

Use HCPCS code 0500F along with the appropriate diagnosis code6 on the first prenatal visit. HCA is tracking the date a client begins receiving obstetrical care (date the OB record is initiated). Note this date by entering HCPCS code 0500F with the appropriate ICD diagnosis codes Z33.1, Z34.00, Z34.80, or Z34.90 on the claim.

**Note:** When billing global Obstetrical Services, the place of service code must correspond with the place where the child was born (for example: 25).

When more than one provider in the same clinic (same group NPI) sees the same client for global obstetrical care, HCA pays only one provider for the global (total) obstetrical care.

Providers who are in the same clinic who **do not** have the same group NPI **must not** bill HCA the global (total) obstetrical care procedure codes. In this case, the OB services must be unbundled and the antepartum, delivery, or postpartum care must be billed separately.

**Note:** **Do not** bill HCA for obstetrical services until all care is completed.

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6 HCA collects this code for quality measurement, tracking, and care coordination. Other payers use the code in the same way.

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Unbundling obstetrical care

In the situations described below, providers may not be able to bill HCA for global OB care as HCA may have paid another provider for some of the client’s OB care, or a provider may have been paid by another insurance carrier for some of the client’s OB care. In these cases, it may be necessary to unbundle the OB services and bill the antepartum, delivery, and postpartum care separately.

When a client transfers to a practice late in the pregnancy

- If the client has had antepartum care elsewhere, the subsequent provider must not bill the global OB package. Bill the antepartum care, delivery, and postpartum care separately. The provider that had been providing the antepartum care bills for the services that he/she performed. Therefore, if the subsequent provider bills the global OB package, that provider is billing for some antepartum care that another provider has claimed.

- OR –

- If the client did not receive any antepartum care prior to coming to the provider’s office, bill the global OB package.

In this case, the provider may actually perform all the components of the global OB package in a short time. HCA does not require this provider to perform a specific number of antepartum visits to bill for the global OB package.

If a client transfers to another provider (not associated with the providers practice), moves out of the area prior to delivery, or loses the pregnancy...

When provider A has seen the client for part of the antepartum care and has transferred the client to provider B for care, and provider B is billing separately for the antepartum care being delivered, provider B enters “transfer of care” in the Claim Note section of the electronic claim. Provider B bills only those services actually provided to these clients.

If a client changes insurance during pregnancy...

Sometimes, a client is fee-for-service at the beginning of pregnancy and enrolled in an HCA managed care organization (MCO for the remainder of the pregnancy. HCA is responsible for paying only those services provided to the client while the client is on fee-for-service. The MCO pays for services provided after the client is enrolled with the plan.

HCA encourages early prenatal care and is actively enrolling new clients into managed care. If a client is on fee-for-service and is not yet enrolled in an MCO plan at the beginning of the client’s pregnancy, consider billing the first visit as a secondary confirmation of pregnancy using ICD diagnosis code N92.5 or N93.8 with the appropriate level of office visit as described under the Confirmation of Pregnancy section.
When a client changes from one plan to another, bill those services that were provided while the client was enrolled with the original plan to the original carrier, and those services that were provided under the new coverage to the new plan. The provider must unbundle the services and bill the antepartum, delivery, and postpartum care separately. For clients who move in and out of managed care and fee for service, use TH and CG modifiers to unbundle the codes.

**Antepartum care**

Per CPT guidelines, HCA considers routine antepartum care for a normal, uncomplicated pregnancy to consist of:

- Monthly visits up to 28 weeks gestation.
- Biweekly visits to 36 weeks gestation.
- Weekly visits until delivery.

Antepartum care includes:

- Initial and subsequent history.
- Physical examination.
- Recording of weight and blood pressure.
- Recording of fetal heart tones.
- Routine chemical urinalysis.
- Pregnancy counseling, such as risk factor assessment and referrals.

Necessary prenatal monitoring, diagnostic, and laboratory tests may be billed in addition to antepartum care, **except for the following tests** (CPT® codes 81000, 81001, 81002, 81003, and 81007).

**Coding for antepartum care only**

If it is necessary to unbundle the OB package and bill separately for antepartum care, bill as follows:

- If the client had a total of one to three antepartum visits, bill the appropriate level of **E/M service with modifier TH** for each visit, with the date of service the visit occurred and the appropriate diagnosis.

- If the client had a total of four to six antepartum visits, bill using **CPT® code 59425** with a "1" in the units box. Bill HCA using the date of the last antepartum visit in the to and from fields.

- If the client had a total of seven or more visits, bill using **CPT® code 59426** with a "1" in the units box. Bill HCA using the date of the last antepartum visit in the to and from fields.

Do not bill antepartum care only codes in addition to other procedure codes that include antepartum care (i.e., global OB codes).

**Do not bill** using CPT E/M codes for the first three visits, then CPT® code 59425 for visits four through six, and then CPT® code 59426 for visits seven and on.

CPT® codes and descriptions only are copyright 2021 American Medical Association.
These CPT® codes are used to bill only the total number of times the client was seen for all antepartum care during the client’s pregnancy and may not be billed in combination with each other during the entire pregnancy period.

**Note:** Do not bill HCA until all antepartum services are complete. Hospital care for pregnant clients can be billed concurrently.

### Coding for deliveries without antepartum care

If it is necessary to unbundle the OB package and bill for the delivery only, bill HCA using one of the following CPT® codes:

- 59409 (vaginal delivery only)
- 59514 (cesarean delivery only)
- 59612 [vaginal delivery only, after previous cesarean delivery (VBAC)]
- 59620 [cesarean delivery only, after attempted vaginal delivery after previous cesarean delivery (attempted VBAC)]

If a provider does not furnish antepartum care, but performs the delivery and provides postpartum care, bill HCA using one of the following CPT® codes:

- 59410 (vaginal delivery, including postpartum care)
- 59515 (cesarean delivery, including postpartum care)
- 59614 (VBAC, including postpartum care)
- 59622 (attempted VBAC, including postpartum care)
Coding for postpartum care only

If it is necessary to unbundle the OB package and bill for postpartum care only, bill HCA using CPT® code 59430 (postpartum care only).

If a provider furnishes all the antepartum and postpartum care, but does not perform the delivery, bill HCA for the antepartum care using the antepartum care only codes, along with CPT® code 59430 (postpartum care only).

Do not bill CPT® code 59430 (postpartum care only) in addition to any procedure codes that include postpartum care. (i.e., global OB codes)

Note: For billing purposes, postpartum care includes routine office visits for the 6-week period after the delivery. The codes for obstetric care (global payment or unbundled) apply only to the period up to and including the comprehensive postpartum visit, usually done at 6 weeks postpartum. Services provided after the 6-week postpartum visit are eligible for separate reimbursement. After Pregnancy Coverage (APC) is a 12-month Medicaid extension for clients who have been recently pregnant. Visit HCA’s APC webpage for more information on APC coverage.

Additional monitoring for high-risk conditions

When providing additional monitoring for high-risk conditions more than the CPT guidelines for normal antepartum visits, bill using E/M codes 99211-99215 with modifier UA. The office visits may be billed in addition to the global fee only after exceeding the CPT guidelines for normal antepartum care. Providers must bill with a primary diagnosis that identifies that the high-risk condition is pregnancy related.

A condition that is classifiable as high-risk alone does not entitle the provider to additional payment. Per CPT guidelines, it must be medically necessary to see the client more often than what is considered routine antepartum care to qualify for additional payments. The additional payments are intended to cover additional costs incurred by the provider because of more frequent visits.
For example: Client A is scheduled to see a provider for the client’s antepartum visits on January 4, February 5, March 3, and April 7. The client attends the January and February visits, as scheduled. However, during the scheduled February visit, the provider discovers the client’s blood pressure is slightly high and wants the client to come in on February 12 to be checked again. At the February 12 visit, the provider discovers the client’s blood pressure is still slightly high and asks to see the client again on February 18. The February 12 and February 18 visits are outside of the client’s regularly scheduled antepartum visits and outside of the CPT guidelines for routine antepartum care since the client is being seen more often than once per month. The February 12 and February 18 visits may be billed separately from the global antepartum visits using the appropriate E/M codes with modifier UA, and the diagnosis must represent the medical necessity for billing additional visits. A normal pregnancy diagnosis (i.e., Z33.1, Z34.00, Z34.80, or Z34.90) will be denied outside of the global antepartum care. It is not necessary to wait until all services included in the routine antepartum care are performed to bill the extra visits if the extra visits are outside of the regularly scheduled visits.

Assessment and treatment of high-risk conditions:
Preterm labor and birth:
- HCA does not pay separately for CerviLenz. It is considered bundled into the practice expense.
- See fetal fibronectin in this guide.
- See Alpha hydroxyprogesterone (17P) and Makena® in this guide.

Diagnostic and monitoring tests:
- See obstetrical ultrasounds in this guide.

Consultations
If another provider refers a client during her pregnancy for a consultation, bill HCA using consultation CPT® codes 99241-99245. If an inpatient consultation is necessary, bill using CPT® codes 99251 – 99255 or for a follow-up bill using CPT® codes 99231-99233. The referring physician’s name and NPI must be listed in the Referring Physician field on the claim.

If the consultation results in the decision to perform surgery (i.e., a cesarean section), HCA pays the consulting physician for the consultation as follows:
- If the consulting physician does not perform the cesarean section, bill HCA the appropriate consultation code.
• If the consulting physician performs the cesarean section and does the consultation two or more days prior to the date of surgery, bill HCA the appropriate consultation code with modifier 57 (e.g., 99241-57).

HCA does not pay the consulting physician if the following applies:

• If the consulting physician performs the cesarean section and does the consultation the day before or the day of the cesarean section, the consultation is bundled within payment for the surgery. Do not bill HCA for the consultation in this situation.

Bill HCA for consultations using an appropriate ICD diagnosis code. The medical necessity (i.e., sign, symptom, or condition) must be demonstrated. HCA does not pay providers for a consultation with a normal pregnancy diagnosis code (e.g., Z33.1, Z34.00, Z34.80, or Z34.90).

HCA pays consulting OB/GYN providers for an external cephalic version (CPT® code 59412) and a consultation when performed on the same day.

**Elective deliveries**

HCA does not reimburse for early elective deliveries. An early elective delivery is defined in WAC 182-500-0030 as any nonmedically necessary induction or cesarean section before 39 weeks gestation.

An early elective delivery is considered medically necessary if the birthing parent or fetus has a diagnosis listed in the Joint Commission’s current table of Conditions possibly justifying elective delivery prior to 39 weeks gestation (WAC 182-533-0400). If the client meets the medical necessity criteria, bill using EPA #870001375. This EPA also needs to be used for clients who deliver naturally prior to 39 weeks.

If the early elective delivery does not meet medical necessity criteria, HCA will pay only for the antepartum and postpartum professional services. When billing, these services must be unbundled. HCA will not pay for the delivery services.

For all deliveries for a client equal to or over 39 weeks gestation, bill using EPA #870001378. This applies to both elective and natural deliveries for clients equal to or over 39 weeks gestation.

**Labor management**

Providers may bill for labor management only when a provider outside of the first provider’s group practice performs the delivery. If a provider or clinic where a group NPI is used performed all the client’s antepartum care, admitted the client to the hospital during labor, delivered the baby, and performed the postpartum care, do not bill HCA for the hospital admission or for labor management. These services are included in the global OB package.

If, however, a provider performed all the client’s antepartum care and admitted the client to the hospital during labor, but another provider (outside of the first provider’s group practice) takes over delivery, the global OB package must be unbundled, and the providers must bill separately for antepartum care, the hospital admission, and the time spent managing the client’s labor. The client CPT® codes and descriptions only are copyright 2021 American Medical Association.
must be in active labor and admitted to a hospital when the referral to the delivering provider is made.

To bill for labor management in the situation described above, bill HCA for one of the hospital admission CPT® codes 99221-99223 with modifier TH.

In addition to the hospital admission, HCA pays providers for up to three hours of labor management using prolonged services CPT® codes 99356-99357 with modifier TH.

Payment for prolonged services is limited to three hours per client, per pregnancy, regardless of the number of calendar days a client is in labor, or the number of providers who provide labor management.

Labor management may not be billed by the delivering provider, or by any provider within the delivering provider’s group practice even if the group practice does not have a group NPI.

**Note:**

- HCA pays for prolonged services CPT® codes for labor management only when the provider performs the hospital admission and labor management services on the same day.
- The hospital admission code and prolonged services code(s) must be billed on the same claim with the same dates of services.

**High-risk deliveries**

Delivery includes management of uncomplicated labor and vaginal delivery (with or without episiotomy, with or without forceps) or cesarean section. If a complication occurs during delivery resulting in an unusually complicated, high-risk delivery, HCA pays providers an additional add-on fee. Bill the high-risk add-on fee by adding modifier TG to the delivery code (e.g., 59400 TG or 59409 TG).

The ICD diagnosis code must clearly demonstrate the medical necessity for the high-risk delivery add-on (e.g., a diagnosis of fetal distress). A normal delivery diagnosis is not paid an additional high-risk add-on fee, even if the birthing parent had a high-risk condition during the antepartum period.
For example: For cesarean delivery, the primary diagnosis is the condition that was responsible for the client's admission. If a particular condition resulted in the admission and the cesarean procedure, list that condition's ICD diagnosis code first on the claim.

Bill only ONE line of service (e.g., 59400 TG) to receive payment for BOTH the delivery and the high-risk add-on. DO NOT bill the delivery code (e.g., 59400) on one line of the claim and the high-risk add-on (e.g., 59400 TG) on a second line of the claim.

A physician who provides stand-by attendance for high-risk delivery can bill CPT® code 99360 and resuscitation CPT® code 99465, when appropriate.

**Note:** HCA does not pay an assistant surgeon, RNFA, or co-surgeon for a high-risk delivery add-on. Payment is limited to one per client, per pregnancy (even in the case of multiple births).

**Additional delivery payment policies and limitations**

- HCA pays a multiple vaginal delivery (for twins, triplets, etc.) at 100% for the first baby. When billing for the second or third baby, bill using the delivery-only code (CPT® code 59409 or 59612) for each additional baby. Payment for each additional baby will be 50% of the delivery-only code's maximum allowance. Bill each baby's delivery on a separate line.

- HCA pays for multiple births by cesarean delivery at 100% for the first baby. No additional payment will be made for additional babies.

- Physician assistants-certified (PA-C) must bill for assisting during a C-section on their own claim using modifier 80, 81, or 82 to the delivery-only code (e.g., 59514-80). The claim must be billed using the PA-C's NPI.

- Physician assistants (PA) must bill for an assist by adding modifier 80, 81, or 82 to the delivery-only code (e.g., 59514-80).

- RNFAs assisting at C-sections may only bill using CPT® code 59514 or 59620 with modifier 80.

- Use of an intrauterine balloon to treat postpartum hemorrhage is reimbursable by billing CPT® code 58999 with modifier U3 and EPA #870001614.

---

7 HCA follows the American College of Obstetricians and Gynecologists (ACOG) guidelines on diagnosis when billing a high-risk delivery.

CPT® codes and descriptions only are copyright 2021 American Medical Association.
Global (total) obstetrical (OB) care
The following tables summarize billing HCA for pregnancy-related services.

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT® Code/Modifier</th>
<th>Short Description</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirmation of pregnancy</td>
<td>99202-99215</td>
<td>Office visits</td>
<td>Code the sign or symptom (e.g., suppressed menstruation)</td>
</tr>
<tr>
<td>Global OB care</td>
<td>59400</td>
<td>Obstetrical care</td>
<td>Includes all antepartum, delivery, and postpartum care; bill after all services are complete; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed with the appropriate delivery-only code.</td>
</tr>
<tr>
<td>Global OB care</td>
<td>59510</td>
<td>Cesarean delivery</td>
<td>Includes all antepartum, delivery, and postpartum care; bill after all services are complete; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed with the appropriate delivery-only code.</td>
</tr>
<tr>
<td>Global OB care</td>
<td>59610</td>
<td>Vbac delivery</td>
<td>Includes all antepartum, delivery, and postpartum care; bill after all services are complete; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed with the appropriate delivery-only code.</td>
</tr>
<tr>
<td>Global OB care</td>
<td>59618</td>
<td>Attempted vbac delivery</td>
<td>Includes all antepartum, delivery, and postpartum care; bill after all services are complete; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed with the appropriate delivery-only code.</td>
</tr>
</tbody>
</table>

CPT® codes and descriptions only are copyright 2021 American Medical Association.
### Antepartum care only

Note: Bill only one of these codes to represent the total number of times the client was seen for antepartum care.

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT® Code/ Modifier</th>
<th>Short Description</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antepartum</td>
<td>99202-99215 TH</td>
<td>Offices visits, antepartum care 1-3 visits only, with OB service modifier</td>
<td>Limited to 3 units when used for routine antepartum care. Modifier TH must be billed.</td>
</tr>
<tr>
<td>Antepartum</td>
<td>59425</td>
<td>Antepartum care only</td>
<td>Limited to one unit per client, per pregnancy, per provider</td>
</tr>
<tr>
<td>Antepartum</td>
<td>59426</td>
<td>Antepartum care only</td>
<td>Limited to one unit per client, per pregnancy, per provider</td>
</tr>
</tbody>
</table>

### Deliveries

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT® Code/ Modifier</th>
<th>Short Description</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery only</td>
<td>59409</td>
<td>Obstetrical care</td>
<td>Must not be billed with any other codes that include deliveries; assist at c-section must be billed with delivery-only code with modifier 80.</td>
</tr>
<tr>
<td>Delivery only</td>
<td>59514</td>
<td>Cesarean delivery only</td>
<td>Must not be billed with any other codes that include deliveries; assist at c-section must be billed with delivery-only code with modifier 80.</td>
</tr>
<tr>
<td>Delivery only</td>
<td>59612</td>
<td>Vbac delivery only</td>
<td>Must not be billed with any other codes that include deliveries; assist at c-section must be billed with delivery-only code with modifier 80.</td>
</tr>
<tr>
<td>Service</td>
<td>CPT® Code/ Modifier</td>
<td>Short Description</td>
<td>Limitations</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------</td>
<td>-------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Delivery only</td>
<td>59620</td>
<td>Attempted VBAC delivery only</td>
<td>Must not be billed with any other codes that include deliveries; assist at c-section must be billed with delivery-only code with modifier 80.</td>
</tr>
<tr>
<td>Delivery with postpartum care</td>
<td>59410</td>
<td>Obstetrical care</td>
<td>Must not be billed with any other codes that include deliveries; must not be billed with postpartum only code; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed using the appropriate delivery-only code.</td>
</tr>
<tr>
<td>Delivery with postpartum care</td>
<td>59515</td>
<td>Cesarean delivery</td>
<td>Must not be billed with any other codes that include deliveries; must not be billed with postpartum only code; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed using the appropriate delivery-only code.</td>
</tr>
<tr>
<td>Delivery with postpartum care</td>
<td>59614</td>
<td>Vbac care after delivery</td>
<td>Must not be billed with any other codes that include deliveries; must not be billed with postpartum only code; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed using the appropriate delivery-only code.</td>
</tr>
</tbody>
</table>
### Delivery with postpartum care

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT® Code/ Modifier</th>
<th>Short Description</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attempted vbac after care</td>
<td>59622</td>
<td>Attempted vbac after care</td>
<td>Must not be billed with any other codes that include deliveries; must not be billed with postpartum only code; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed using the appropriate delivery-only code.</td>
</tr>
</tbody>
</table>

### Postpartum care only

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT® Code/ Modifier</th>
<th>Short Description</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care after delivery</td>
<td>59430</td>
<td>Care after delivery</td>
<td>Must not be billed with any other codes that include postpartum care; limited to one per client, per pregnancy.</td>
</tr>
</tbody>
</table>

### Additional monitoring for high-risk conditions

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT® Code/ Modifier</th>
<th>Short Description</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office/outpatient visit est</td>
<td>99211-99215 UA</td>
<td>Office/outpatient visit est</td>
<td>Must not be billed with a normal pregnancy diagnosis (Z33.1, Z34.00, Z34.80, or Z34.90); diagnosis must detail need for additional visits; must be billed with modifier UA.</td>
</tr>
</tbody>
</table>

### Labor management

**Note**: Labor management may only be billed when another provider takes over and delivers the infant.
<table>
<thead>
<tr>
<th>Service</th>
<th>CPT® Code/ Modifier</th>
<th>Short Description</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor management</td>
<td>99221-99223 TH</td>
<td>Initial hospital care</td>
<td>Prolonged services are limited to 3 hours per client, per pregnancy; must be billed with modifier TH; <strong>must not be billed by delivering provider.</strong> Admit code with modifier TH and the prolonged services code(s) <strong>must be billed on the same claim.</strong></td>
</tr>
<tr>
<td></td>
<td>+99356 TH Limited to 1 unit</td>
<td>Prolonged service inpatient</td>
<td>Prolonged services are limited to 3 hours per client, per pregnancy; must be billed with modifier TH; <strong>must not be billed by delivering provider.</strong> Admit code with modifier TH and the prolonged services code(s) <strong>must be billed on the same claim.</strong></td>
</tr>
<tr>
<td></td>
<td>+99357 TH Limited to 4 units</td>
<td>Prolonged service inpatient</td>
<td>Prolonged services are limited to 3 hours per client, per pregnancy; must be billed with modifier TH; <strong>must not be billed by delivering provider.</strong> Admit code with modifier TH and the prolonged services code(s) <strong>must be billed on the same claim.</strong></td>
</tr>
</tbody>
</table>
## High-risk deliveries

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT® Code/Modifier</th>
<th>Short Description</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-risk delivery</td>
<td>Add modifier TG</td>
<td>Complex/high level of care</td>
<td>Diagnosis must demonstrate medical necessity; not paid with normal delivery diagnosis; limited to one per client, per pregnancy. Bill only <strong>ONE</strong> line of service (e.g., 59400 TG) for <strong>BOTH</strong> the delivery and high-risk add-on.</td>
</tr>
<tr>
<td>[Not covered for assistant surgeons, co-surgeons, or RNFA]</td>
<td>to the delivery code (e.g., 59400 TG)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Billing with modifiers for obstetric care

Nonsupervision, not part of global, medical diagnosis is always primary.

<table>
<thead>
<tr>
<th>Modifiers</th>
<th>GB</th>
<th>CG</th>
<th>TH</th>
<th>UA</th>
</tr>
</thead>
<tbody>
<tr>
<td>All these modifiers must be used with E/M only</td>
<td><strong>Nonsupervision</strong>, Not part of global. Is a high risk medical condition or condition unrelated to the pregnancy, which is always primary reason for the visit. Do not use a supervision diagnosis code.</td>
<td>Supervision when client is <strong>in</strong> and <strong>out</strong> of managed care</td>
<td>Supervision of the client when the provider treats client for less than four visits and unbundles care</td>
<td>Supervision with additional visits beyond global (for high-risk pregnancy)</td>
</tr>
</tbody>
</table>

Multiple providers for OB care X

Providers seeing client for medical reasons other than current pregnancy X
<table>
<thead>
<tr>
<th>Modifiers</th>
<th>GB</th>
<th>CG</th>
<th>TH</th>
<th>UA</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk pregnancy and all prenatal OB care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client moves to/from managed care and FFS</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Perinatologist visit for preexisting condition and client is now pregnant (visit is outside of OB care/outside of OB bundle)</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Antepartum care and/or postpartum care if only 1-3 visits</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Medical Supplies and Equipment

General payment policies

- HCA pays providers for certain medical supplies and equipment (MSE) dispensed from their offices when these items are considered prosthetics and are used for a client's permanent condition (see Supplies included in an office call (bundled supplies)).

- Most MSE used to treat a client's temporary or acute condition are considered incidental to a provider's professional services and are bundled in the office visit payment (see Supplies included in an office call (bundled supplies)). HCA pays providers separately for only those MSE listed (see Supplies included in an office call (bundled supplies)).

- HCA does not pay providers separately for surgical trays, as these are bundled within the appropriate surgical procedure. The fees for these procedures include the cost of the surgical trays.

- Procedure codes for MSE that do not have a maximum allowable fee and cost less than $50.00 are paid at acquisition cost. A manufacturer's invoice must be maintained in the client's records for MSE under $50.00 and made available to HCA upon request. **DO NOT send in an invoice with a claim** for MSE under $50.00 unless requested by HCA.

- Procedure codes for MSE that do not have a maximum allowable fee and cost $50.00 or more are paid at acquisition cost. **A copy of the manufacturer’s invoice must be attached** to the claim for MSE costing $50.00 or more.

**Note**: Refer to HCA’s Billers and providers webpage for information on prior authorization.

Supplies included in an office call (bundled supplies)

Items with an asterisk (*) in the following list are considered prosthetics when used for a client's permanent condition. HCA pays providers for these supplies when they are provided in the office for permanent conditions only. They are not considered prosthetics if the condition is acute or temporary. Providers must indicate “prosthetic for permanent condition” in the Claim Note section of the electronic claim.

**For example**, if a patient has an indwelling Foley catheter for permanent incontinence and a problem develops for which the physician is required to replace the catheter, it is considered a prosthetic and is paid separately. The Foley catheter used to obtain a urine specimen, used after surgery, or used to treat an acute obstruction is not paid separately because it is treating a temporary problem.
<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99070</td>
<td>Special supplies phys/qhp</td>
</tr>
<tr>
<td>A4206</td>
<td>1 CC sterile syringe&amp;needle</td>
</tr>
<tr>
<td>A4207</td>
<td>2 CC sterile syringe&amp;needle</td>
</tr>
<tr>
<td>A4208</td>
<td>3 CC sterile syringe&amp;needle</td>
</tr>
<tr>
<td>A4209</td>
<td>5+ CC sterile syringe&amp;needle</td>
</tr>
<tr>
<td>A4211</td>
<td>Supp for self-adm injections</td>
</tr>
<tr>
<td>A4212</td>
<td>Non coring needle or stylet</td>
</tr>
<tr>
<td>A4213</td>
<td>20+ CC syringe only</td>
</tr>
<tr>
<td>A4215</td>
<td>Sterile needle</td>
</tr>
<tr>
<td>A4220</td>
<td>Infusion pump refill kit</td>
</tr>
<tr>
<td>A4244</td>
<td>Alcohol or peroxide, per pint</td>
</tr>
<tr>
<td>A4245</td>
<td>Alcohol wipes per box</td>
</tr>
<tr>
<td>A4246</td>
<td>Betadine/phisohex solution</td>
</tr>
<tr>
<td>A4247</td>
<td>Betadine/iodine swabs/wipes</td>
</tr>
<tr>
<td>A4252</td>
<td>Blood ketone test or strip</td>
</tr>
<tr>
<td>A4253</td>
<td>Blood glucose/reagent strips</td>
</tr>
<tr>
<td>A4256</td>
<td>Calibrator solution/chips</td>
</tr>
<tr>
<td>A4258</td>
<td>Lancet device each</td>
</tr>
<tr>
<td>A4259</td>
<td>Lancets per box</td>
</tr>
<tr>
<td>A4262</td>
<td>Temporary tear duct plug</td>
</tr>
<tr>
<td>A4263</td>
<td>Permanent tear duct plug</td>
</tr>
<tr>
<td>A4265</td>
<td>Paraffin</td>
</tr>
<tr>
<td>A4270</td>
<td>Disposable endoscope sheath</td>
</tr>
<tr>
<td>HCPCS Code</td>
<td>Short Description</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>A4300</td>
<td>Cath impl vasc access portal</td>
</tr>
<tr>
<td>A4301</td>
<td>Implantable access syst perc</td>
</tr>
<tr>
<td>A4305</td>
<td>Drug delivery system &gt;=50 ML</td>
</tr>
<tr>
<td>A4306</td>
<td>Drug delivery system &lt;=50 ml</td>
</tr>
<tr>
<td>A4310</td>
<td>Insert tray w/o bag/cath</td>
</tr>
<tr>
<td>A4311</td>
<td>Catheter w/o bag 2-way latex</td>
</tr>
<tr>
<td>A4312</td>
<td>Cath w/o bag 2-way silicone</td>
</tr>
<tr>
<td>A4313</td>
<td>Catheter w/bag 3-way</td>
</tr>
<tr>
<td>A4314</td>
<td>Cath w/ drainage 2-way latex</td>
</tr>
<tr>
<td>A4315</td>
<td>Cath w/ drainage 2-way silcne</td>
</tr>
<tr>
<td>A4316</td>
<td>Cath w/ drainage 3-way</td>
</tr>
<tr>
<td>A4320</td>
<td>Irrigation tray</td>
</tr>
<tr>
<td>A4330</td>
<td>Stool collection pouch</td>
</tr>
<tr>
<td>A4335*</td>
<td>Incontinence supply</td>
</tr>
<tr>
<td>A4338*</td>
<td>Indwelling catheter latex</td>
</tr>
<tr>
<td>A4340*</td>
<td>Indwelling catheter special</td>
</tr>
<tr>
<td>A4344*</td>
<td>Cath indw foley 2 way silcn</td>
</tr>
<tr>
<td>A4346*</td>
<td>Cath indw foley 3 way</td>
</tr>
<tr>
<td>A4351</td>
<td>Straight tip urine catheter</td>
</tr>
<tr>
<td>A4352</td>
<td>Coude tip urinary catheter</td>
</tr>
<tr>
<td>A4353</td>
<td>Intermittent urinary cath</td>
</tr>
<tr>
<td>A4354</td>
<td>Cath insertion tray w/bag</td>
</tr>
<tr>
<td>A4355</td>
<td>Bladder irrigation tubing</td>
</tr>
<tr>
<td>HCPCS Code</td>
<td>Short Description</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>A4356*</td>
<td>Ext ureth clmp or compr dvc</td>
</tr>
<tr>
<td>A4357*</td>
<td>Bedside drainage bag</td>
</tr>
<tr>
<td>A4358*</td>
<td>Urinary leg or abdomen bag</td>
</tr>
<tr>
<td>A4361*</td>
<td>Ostomy face plate</td>
</tr>
<tr>
<td>A4362*</td>
<td>Solid skin barrier</td>
</tr>
<tr>
<td>A4364*</td>
<td>Adhesive, liquid or equal</td>
</tr>
<tr>
<td>A4367*</td>
<td>Ostomy belt</td>
</tr>
<tr>
<td>A4368*</td>
<td>Ostomy filter</td>
</tr>
<tr>
<td>A4397</td>
<td>Irrigation supply sleeve</td>
</tr>
<tr>
<td>A4398*</td>
<td>Ostomy irrigation bag</td>
</tr>
<tr>
<td>A4399*</td>
<td>Ostomy irrig cone/cath w brs</td>
</tr>
<tr>
<td>A4400*</td>
<td>Ostomy irrigation set</td>
</tr>
<tr>
<td>A4402</td>
<td>Lubricant per ounce</td>
</tr>
<tr>
<td>A4404*</td>
<td>Ostomy ring each</td>
</tr>
<tr>
<td>A4421*</td>
<td>Ostomy supply misc</td>
</tr>
<tr>
<td>A4455</td>
<td>Adhesive remover per ounce</td>
</tr>
<tr>
<td>A4461</td>
<td>Surgicl dress hold non-reuse</td>
</tr>
<tr>
<td>A4463</td>
<td>Surgical dress holder reuse</td>
</tr>
<tr>
<td>A4465</td>
<td>Non-elastic extremity binder</td>
</tr>
<tr>
<td>A4470</td>
<td>Gravlee jet washer</td>
</tr>
<tr>
<td>A4480</td>
<td>Vabra aspirator</td>
</tr>
<tr>
<td>A4550</td>
<td>Surgical tray</td>
</tr>
<tr>
<td>A4556</td>
<td>Electrodes, pair</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4557</td>
<td>Lead wires, pair</td>
</tr>
<tr>
<td>A4558</td>
<td>Conductive paste or gel</td>
</tr>
<tr>
<td>A4649</td>
<td>Surgical supply</td>
</tr>
<tr>
<td>A5051*</td>
<td>Pouch clsd w barr attached</td>
</tr>
<tr>
<td>A5052*</td>
<td>Clsd ostomy pouch w/o barr</td>
</tr>
<tr>
<td>A5053*</td>
<td>Clsd ostomy pouch faceplate</td>
</tr>
<tr>
<td>A5054*</td>
<td>Clsd ostomy pouch w/flange</td>
</tr>
<tr>
<td>A5055*</td>
<td>Stoma cap</td>
</tr>
<tr>
<td>A5061*</td>
<td>Pouch drainable w barrier at</td>
</tr>
<tr>
<td>A5062*</td>
<td>Drnble ostomy pouch w/o barr</td>
</tr>
<tr>
<td>A5063*</td>
<td>Drain ostomy pouch w/flange</td>
</tr>
<tr>
<td>A5071*</td>
<td>Urinary pouch w/barrier</td>
</tr>
<tr>
<td>A5072*</td>
<td>Urinary pouch w/o barrier</td>
</tr>
<tr>
<td>A5073*</td>
<td>Urinary pouch on barr w/flng</td>
</tr>
<tr>
<td>A5081*</td>
<td>Continent stoma plug</td>
</tr>
<tr>
<td>A5082*</td>
<td>Continent stoma catheter</td>
</tr>
<tr>
<td>A5083*</td>
<td>Stoma absorptive cover</td>
</tr>
<tr>
<td>A5093*</td>
<td>Ostomy accessory convex inse</td>
</tr>
<tr>
<td>A5102*</td>
<td>Bedside drain btl w/wo tube</td>
</tr>
<tr>
<td>A5105*</td>
<td>Urinary suspensory</td>
</tr>
<tr>
<td>A5112*</td>
<td>Urinary leg bag</td>
</tr>
<tr>
<td>A5113*</td>
<td>Latex leg strap</td>
</tr>
<tr>
<td>A5114*</td>
<td>Foam/fabric leg strap</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A5120</td>
<td>Skin barrier, wipe or swab</td>
</tr>
<tr>
<td>A5121*</td>
<td>Solid skin barrier 6x6</td>
</tr>
<tr>
<td>A5122*</td>
<td>Solid skin barrier 8x8</td>
</tr>
<tr>
<td>A5126*</td>
<td>Disk/foam pad +or- adhesive</td>
</tr>
<tr>
<td>A5131*</td>
<td>Appliance cleaner</td>
</tr>
<tr>
<td>A6021</td>
<td>Collagen dressing &lt;=16 sq in</td>
</tr>
<tr>
<td>A6022</td>
<td>Collagen dressing &gt;16&lt;=48 sq in</td>
</tr>
<tr>
<td>A6023</td>
<td>Collagen dressing &gt;48 sq in</td>
</tr>
<tr>
<td>A6024</td>
<td>Collagen dsg wound filler</td>
</tr>
<tr>
<td>A6025</td>
<td>Silicone gel sheet, each</td>
</tr>
<tr>
<td>A6154</td>
<td>Wound pouch, each</td>
</tr>
<tr>
<td>A6231</td>
<td>Hydrogel dsg &lt;=16 sq in</td>
</tr>
<tr>
<td>A6232</td>
<td>Hydrogel dsg &gt;16&lt;=48 sq in</td>
</tr>
<tr>
<td>A6233</td>
<td>Hydrogel dressing &gt;48 sq in</td>
</tr>
<tr>
<td>A6413</td>
<td>Adhesive bandage, first-aid</td>
</tr>
</tbody>
</table>
**Alcohol and Substance Misuse Counseling**

HCA covers alcohol and substance misuse counseling through screening, brief interventions, and referral to treatment (SBIRT) services when provided by, or under the supervision of, a certified physician or other certified licensed health care professional within the scope of their practice.

SBIRT is a comprehensive, evidenced-based public health practice designed to identify people who are at risk for or have some level of substance use disorder which can lead to illness, injury, or other long-term morbidity or mortality. SBIRT services are provided in a wide variety of medical and community health care settings such as primary care centers, hospital emergency rooms, and trauma centers (see list of SBIRT places of service under Who is eligible to become a certified SBIRT provider?).

**What is included in SBIRT?**

**Screening.** With just a few questions on a questionnaire or in an interview, practitioners can identify patients who have alcohol or other drug (substance) use problems and determine how severe those problems already are. Three of the most widely used screening tools are the Alcohol Use Disorders Identification Test (AUDIT), the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) and the Drug Abuse Screening Test (DAST).

**Brief intervention.** If screening results indicate at risk behavior, individuals receive brief interventions. The intervention educates them about their substance use, alerts them to possible consequences and motivates them to change their behavior.

**Referral to treatment.** Individuals whose screening indicates a severe problem or dependence should be referred to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder (SUD).

**What is covered?**

SBIRT services are covered for determining risk factors that are related to alcohol and other drug use disorders, providing interventions to enhance patient motivation to change, and making appropriate referrals as needed.

SBIRT screening may occur during an E/M exam, or the client may complete the questionnaire and give it to the provider during the E/M exam. The screening form may be scored by a trained staff member who is supervised by a certified SBIRT provider. If the screening is positive, scoring time may be factored into the time requirement of the SBIRT CPT® code. The provider is then able to provide the brief intervention. An SBIRT CPT® code may be billed in addition to the E/M code.

Brief interventions are limited to four sessions per patient, per provider, per calendar year. Providers may submit a limitation extension (LE) request to HCA for more sessions. Include with the LE request any information that describes the medical necessity of the extra sessions.

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### CPT® Codes

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>99408</td>
<td>Audit/dast 15-30 min</td>
<td>For structured screening and brief intervention</td>
</tr>
<tr>
<td>99409</td>
<td>Audit/dast over 30 min</td>
<td>For structured screening and brief intervention</td>
</tr>
</tbody>
</table>

**SBIRT services will be covered by HCA when all the following are met:**

- The billing provider and servicing provider have submitted their SBIRT certification to HCA.
- The billing provider has an appropriate taxonomy to bill for SBIRT.
- The diagnosis code is Z71.41 or Z71.51.
- The treatment or brief intervention does not exceed the limit of four (4) encounters per client, per provider, per year.

**Who is eligible to become a certified SBIRT provider?**

The following categories of licensed or certified health care professionals are eligible to become certified to provide or supervise staff that provides SBIRT services.

- Advanced registered nurse practitioners, in accordance with chapter 18.79 RCW and chapter 246-840 WAC
- Chemical dependency professionals, in accordance with chapter 18.205 RCW and chapter 246-811 WAC
- Licensed practical nurse, in accordance with chapter 18.79 RCW and chapter 246-840 WAC
- Mental health counselor, in accordance with chapter 18.225 RCW and chapter 246-809 WAC
- Marriage and family therapist, in accordance with chapter 18.225 RCW and chapter 246-809 WAC
- Independent and advanced social worker, in accordance with chapter 18.225 RCW and chapter 246-809 WAC
- Physician, any specialty, in accordance with chapter 18.71 RCW and chapter 246-919 WAC
- Physician assistant, in accordance with chapter 18.71A RCW and chapter 246-918 WAC
- Psychologist, in accordance with chapter 18.83 RCW and chapter 246-924 WAC

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• Registered nurse, in accordance with chapter 18.79 RCW and chapter 246-840 WAC
• Dentist, in accordance with chapter 18.260 RCW and chapter 246-817 WAC
• Dental hygienists, in accordance with chapter 18.29 RCW and chapter 246-815 WAC

What are the requirements to be a certified SBIRT provider?
SBIRT services must be provided by or under the supervision of a certified physician or other certified licensed health care professional. SBIRT services may be provided by a certified health care professional under supervision of and as recommended by a certified physician or licensed health care professional within the scope of their practice.

Required training
All licensed health care professionals must be trained to provide or supervise individuals providing SBIRT services. Licensed health care professionals must complete SBIRT training approved by HCA. This requirement is waived if a provider has an addiction specialist certification. The provider must submit proof of this certification to HCA by mail or fax.

Training is available through a variety of entities. Distance learning is industry-recognized education obtained through sources such as internet course work, satellite downlink resources, or online courses. HCA-approved training is available through the following:
• Substance Abuse and Mental Health Services Administration (SAMHSA)
• An education program that includes SBIRT training that the practitioner has completed, and the provider has documentation showing the training was included

All health care professionals must document successful training of an approved course of training to bill for services. This documentation will be used to identify the health care professional through his/her National Provider Identifier (NPI) number for billing services.

Providers who are already enrolled and have completed the training must update their provider profile in ProviderOne with the training certificate or other proof of completion.

Mail or fax certificate to:
Provider Enrollment
PO Box 45562, Olympia, WA 98504-5562
Fax: 360-725-2144

Health care professionals who are not enrolled with HCA, but who are licensed and have completed the training, may enroll as a Washington Apple Health (Medicaid) provider to offer this service.

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Who can bill for SBIRT services?
The following is a list of providers who can bill for SBIRT services when properly certified:

- Advanced registered nurse practitioners
- Mental health counselors
- Marriage and family therapists
- Independent and advanced social workers
- Physicians (any specialty)
- Psychologists
- Dentists
- Dental hygienists
## Alcohol and Substance Abuse Treatment Services

### Medical services for clients in residential chemical dependency treatment
HCA will pay medical professionals (within their scope of practice) for the following services when the practitioner provides services at a Residential Chemical Dependency Treatment Center (place of service 55).

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT® Code</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>E/M Services</td>
<td>99202-99205; 99211-99215</td>
<td></td>
</tr>
<tr>
<td>Basic Laboratory Services</td>
<td>81000; 81002; 81025; 82948</td>
<td>Lab specimens processed in the provider’s office must be billed in POS 11. Lab specimens processed in a laboratory should be billed in POS 81.</td>
</tr>
<tr>
<td>Venipuncture</td>
<td>36415</td>
<td></td>
</tr>
</tbody>
</table>

Clients requiring additional nonemergency medical services such as wound care must go to the provider’s office or another medical setting.

### Withdrawal management services
HCA considers withdrawal management services to be medically necessary for clients receiving alcohol or drug withdrawal services in an acute care hospital when the following conditions are met:

- The stay meets the intensity of service and severity of illness standards necessary to qualify for an inpatient hospital stay.
- The care is provided in a medical unit.
- The client is not participating in HCA’s Chemical-Using Pregnant (CUP) Women program.
- Inpatient psychiatric care is not medically necessary.
- The person meets medical necessity criteria for hospital withdrawal management services.
**Note:** The hospital’s NPI must be included in the Claim Note section when billing electronically; otherwise, the claim will be denied.

When the medically necessary conditions are met, bill using the following information:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Short Description</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0009&lt;sup&gt;8&lt;/sup&gt;</td>
<td></td>
<td>Alcohol and/or drug services</td>
<td>Limited to one per hospitalization. Restricted to the appropriate ICD diagnosis codes.</td>
</tr>
<tr>
<td>H0009&lt;sup&gt;9&lt;/sup&gt;</td>
<td>TS</td>
<td>Alcohol and/or drug services</td>
<td>Limited to one per hospitalization. Restricted to the appropriate ICD diagnosis codes.</td>
</tr>
</tbody>
</table>

See HCA’s [Inpatient Hospital Services Billing Guide](http://www.inpatient-billing-guide.com) and [Substance Use Disorder Program Billing Guide](http://www.substance-use-disorder-program-billing-guide.com) for more information.

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<sup>8</sup> Bill for the initial admission.

<sup>9</sup> Bill for any follow-up days using follow-up service modifier.

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Blood, blood products, and related services

Whole blood and components (red cells, plasma, platelets, cryoprecipitate) are used in the treatment of a wide variety of conditions.

Blood products are therapeutic substances derived from human blood or plasma and produced by a manufacturing process. Blood products are also used to treat a wide variety of conditions. Examples of blood products are plasma derivatives such as:

- Albumin
- Coagulation factors
- Immunoglobulins

Payment for blood and blood products

- HCA does not pay for blood or blood products that are donated.
- HCA pays for the covered service charges necessary in handling and processing blood and blood products.
- For managed care clients, hemophilia products are reimbursed through fee-for-service. Contact HCA-contracted managed care organization for case management and service coordination.

Autologous blood/platelet-rich plasma injections

Based upon review of evidence provided by the HTCC, HCA does not consider autologous blood/platelet-rich plasma injections to be medically necessary.

Fee schedule

To view the fee schedules, see HCA's:

- Physician-related/professional health care services fee schedule
- Professional administered drugs fee schedule
Centers of Excellence

**Note:** When private insurance or Medicare has paid as primary insurance and the provider is billing HCA as secondary insurance, HCA does not require PA or that the transplant, or sleep study be done in a Center of Excellence or HCA-approved hospital.

**List of approved Centers of Excellence (COEs)**
See HCA’s approved COEs for sleep centers, and transplants.

**Services which must be performed in a COE**

**Hemophilia treatment COEs**
*(For administration in the home only)*
To be paid by HCA for hemophilia and von Willebrand-related products for administration to Apple Health clients in the home, the products must be provided through an approved hemophilia treatment Center of Excellence (COE). Center of Excellence is defined in **WAC 182-531-0050**.

**Note:** HCA does not require the use of an approved hemophilia treatment COE to obtain hemophilia and von Willebrand-related products when one of the following applies:

- HCA is not the primary payer
- The client receives the product in an outpatient hospital or clinic setting for nonroutine or urgent care needs
- The product is provided by a hemophilia treatment center (HTC) for nonroutine pediatric care and other urgent care needs

A hemophilia treatment COE uses a comprehensive care model to provide care for persons with bleeding disorders. The comprehensive care model includes specialized prevention, diagnostic, and treatment programs designed to provide family-centered education, state-of-the-art treatment, research, and support services for individuals and families living with bleeding disorders.
Qualified Centers of Excellence (COE) for Hemophilia Treatment are:

- Washington Center for Bleeding Disorders – Seattle
- Hemophilia Center at Oregon Health Science University (OHSU) – Portland

For managed care clients, hemophilia products are reimbursed through fee-for-service. Contact HCA-contracted managed care organization for case management and service coordination.

What criteria must be met to qualify as a COE for hemophilia treatment?
To qualify as a COE, a hemophilia treatment center must meet all the following:

- Have a Core Provider Agreement with HCA
- Be a federally approved HTC as defined in WAC 182-531-0050
- Meet or exceed all Medical and Scientific Advisory Council (MASAC) standards of care and delivery of services
- Participate in the public health service 340b provider drug discount program and be listed in the Medicaid exclusion files maintained by the federal Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA)
- Submit a written request to HCA to be a qualified hemophilia treatment COE and include proof of the following:
  - U.S. Center for Disease Control (CDC) and prevention surveillance site identification number
  - Listing in the Hemophilia Treatment Center (HTC) directory
- Submit requests to:
  Hemophilia Treatment COE
  Health Care Authority–Health Care Services
  PO Box 45506
  Olympia WA 98504-5506
- Receive written approval including conditions of payment and billing procedures from HCA
What documentation is required to continue as a qualified COE for hemophilia treatment?
The HTC must annually submit to HCA:

- Copies of grant documents and reports submitted to the Maternal and Child Health Bureau/Human Resources and Services Administration/Department of Health and Human Services or to their designated subcontractors.
- Proof of continued federal funding by the National Hemophilia Program and listing with the Regional Hemophilia Network and the CDC.

Are managed care clients required to receive their hemophilia or von Willebrand-related products from a qualified COE?
Clients enrolled in a managed care plan must contact their plans for information.

### Hemophilia Treatment Coverage Table

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Short Description</th>
</tr>
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<tbody>
<tr>
<td>J7170</td>
<td>emicizumab-kxwh inj - Hemlibra</td>
</tr>
<tr>
<td>J7175</td>
<td>Coagadex (Coagulation Factor X (Human) for Inj.)</td>
</tr>
<tr>
<td>J7179</td>
<td>Vonvendi (Von Willebrand Factor (Recomb) for Inj.)</td>
</tr>
<tr>
<td>J7180</td>
<td>Factor xiii anti-hem factor</td>
</tr>
<tr>
<td>J7181</td>
<td>Factor xiii recomb a-subunit</td>
</tr>
<tr>
<td>J7182</td>
<td>Factor viii recomb novoeight</td>
</tr>
<tr>
<td>J7183</td>
<td>Wilate injection</td>
</tr>
<tr>
<td>J7185</td>
<td>Xyntha inj</td>
</tr>
<tr>
<td>J7186</td>
<td>Antihemophilic viii/vwf comp</td>
</tr>
<tr>
<td>J7187</td>
<td>Humate-P, inj</td>
</tr>
<tr>
<td>J7188</td>
<td>Factor viii anti-hemophilic factor, recomb, (obizur)</td>
</tr>
<tr>
<td>J7189</td>
<td>Factor viia - Novoseven</td>
</tr>
<tr>
<td>J7190</td>
<td>Factor viii- Hemofil M</td>
</tr>
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</table>

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<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7192</td>
<td>Factor viii recombinant NOS</td>
</tr>
<tr>
<td>J7193</td>
<td>Factor IX non-recombinant</td>
</tr>
<tr>
<td>J7194</td>
<td>Factor IX complex</td>
</tr>
<tr>
<td>J7195</td>
<td>Factor IX recombinant</td>
</tr>
<tr>
<td>J7198</td>
<td>Anti-inhibitor – FEIBA</td>
</tr>
<tr>
<td>J7199</td>
<td>Hemophilia clotting factor, not otherwise classified</td>
</tr>
<tr>
<td>J7200</td>
<td>Factor IX recombinant rixubis</td>
</tr>
<tr>
<td>J7201</td>
<td>Factor IX fc fusion recombinant</td>
</tr>
<tr>
<td>J7202</td>
<td>Idelvioni (Coagulation Factor IX (RECOMB) (RIX-FP) For Inj.)</td>
</tr>
<tr>
<td>J7204</td>
<td>Factor VIII, antihemophilic factor (recombinant), (esperoct), glycopegylated-exei</td>
</tr>
<tr>
<td>J7205</td>
<td>Factor VIII fc fusion recombinant – Eloctate</td>
</tr>
<tr>
<td>J7207</td>
<td>Adynovate (Antihemophilic Factor Recomb Pegylated for Inj.)</td>
</tr>
<tr>
<td>J7208</td>
<td>Injection, factor VIII, (antihemophilic factor, recombinant), pegylated-aucl, (jivi)</td>
</tr>
<tr>
<td>J7209</td>
<td>Factor VIII nuwiq recombinant 1iu</td>
</tr>
<tr>
<td>J7210</td>
<td>Factor VIII, anti-hemophilic, recombinant (afstyla)</td>
</tr>
<tr>
<td>J7211</td>
<td>Injection, factor VIII, (antihemophilic factor, recombinant), (kovaltry)</td>
</tr>
<tr>
<td>J7212</td>
<td>Factor VIA (antihemophilic factor, recombinant)-jncw (sevenfact)</td>
</tr>
</tbody>
</table>
Sleep studies
Becoming an HCA-approved sleep center

To become an HCA-approved COE, a sleep center must send the following documentation to the Health Care Authority, Provider Enrollment, PO Box 45510, Olympia, WA 98504-5510:

- A completed Core Provider Agreement
- Copies of the following:
  - The sleep center’s current accreditation certificate by AASM
  - Either of the following certifications for at least one physician on staff:
    - Current certification in sleep medicine by the American Board of Sleep Medicine (ABSM)
    - Current subspecialty certification in sleep medicine by a member of the American Board of Medical Specialties (ABMS)
  - The certification of an RPSGT who is employed by the sleep center

**Note:** Sleep centers must request reaccreditation from AASM in time to avoid expiration of COE status with HCA.

At least one physician on staff at the sleep center must be board certified in sleep medicine. If the only physician on staff who is board certified in sleep medicine resigns, the sleep center must ensure another physician on staff at the sleep center obtains board certification or another board-certified physician is hired. The sleep center must then send provider enrollment a copy of the physician’s board certification.

If a certified medical director leaves a COE, the COE status does not transfer with the medical director to another sleep center.

The COE must maintain a record of the physician’s order for the sleep study.

For further information, see sleep medicine testing.

Transplants
(WAC 182-550-1900)

Who is eligible for transplants?

HCA pays for medically necessary transplant procedures only for eligible HCA clients who are not otherwise subject to a managed care organization (MCO) plan.

Who is not eligible for transplants?

Clients eligible under the Alien Emergency Medical (AEM) program are not eligible for transplant coverage.
Which transplant procedures are covered?
HCA covers the following transplant procedures when the transplant procedures are performed in a hospital designated by HCA as a Center of Excellence for transplant procedures and meet that hospital’s criteria for establishing appropriateness and the medical necessity of the procedures:

- Solid organs involving the heart, kidney, liver, lung, heart-lung, pancreas, kidney-pancreas, and small bowel
  HCA pays for a solid organ transplant procedure only once per a client’s lifetime, except in cases of organ rejection by the client’s immune system during the original hospital stay.
- Nonsolid organs include bone marrow and peripheral stem cell transplants

Does HCA pay for skin grafts and corneal transplants?
HCA pays for skin grafts and corneal transplants to any qualified hospital when medically necessary.

Does HCA pay for organ procedure fees and donor searches?
HCA pays for organ procurement fees and donor searches. For donor searches, CPT® codes 86812-86822 are limited to a maximum of 15 tests total for human leukocyte antigens (HLA) typing per client, per lifetime. HCA requires PA for more than 15 tests.

To bill for donor services:
- Use the client’s ProviderOne Client ID.
- Use the appropriate Z52 series diagnosis code as the principal diagnosis code.
- Include donor operative notes with claim.

For example: If billing a radiological exam on a potential donor for a kidney transplant, bill Z52.4 for the kidney donor and use Z00.5 or Z00.8 as a secondary diagnosis-examination of a potential donor. Refer to WAC 182-531-1750, 182-550-1900, 182-550-2100, and 182-550-2200.

Note: Use of Z00.5 or Z00.8 as a principal diagnosis will cause the line to be denied.
Does HCA pay for experimental transplant procedures?

HCA does not pay for experimental transplant procedures. In addition, HCA considers as experimental those services including, but not limited to, the following:

- Transplants of three or more different organs during the same hospital stay.
- Solid organ and bone marrow transplants from animals to humans.
- Transplant procedures used in treating certain medical conditions for which use of the procedure has not been generally accepted by the medical community or for which its efficacy has not been documented in peer-reviewed medical publications.
Drugs Professionally Administered

(WAC 182-530-2000)

HCA covers outpatient drugs, including over-the-counter drugs listed on HCA’s Covered over-the-counter product list, as defined in WAC 182-530-1050, subject to the limitations and requirements in this section, when:

- The drug is approved by the Food and Drug Administration (FDA).
- The drug is for a medically accepted indication as defined in WAC 182-530-1050.
- The drug is not excluded from coverage (see WAC 182-530-2000 Covered – Outpatient drugs, devices, and drug related supplies).
- The manufacturer has a signed drug rebate agreement with the federal Department of Health and Human Services (DHHS). Exceptions to the drug rebate requirement are described in WAC 182-530-7500 which describes the drug rebate program.

For more information, see HCA’s Prescription Drug Program Billing Guide.

**Note:** HCA requires prior authorization (PA) for all drugs new to market until reviewed and evaluated by HCA’s clinical team according to WAC 182-530-3100. This applies to all products billed under miscellaneous codes or product specific procedure codes. View the list of Drugs billed under miscellaneous HCPCS codes for drugs that require authorization.

HCA’s fees for injectable drug codes are the maximum allowances used to pay covered drugs and biologicals administered in a provider’s office only.

**Invoice requirements**

A copy of the manufacturer’s invoice showing the actual acquisition cost of the drug relevant to the date of service must be attached to the claim for drug reimbursed by report (BR) or when billing for compounded drugs. If needed, HCA will request any other necessary documentation after receipt of the claim.

A copy of any manufacturer’s invoices for all drugs (regardless of billed charges) must be maintained in the client’s record and made available to HCA upon request.
Drug pricing
HCA follows Medicare’s drug pricing methodology of 106% of the Average Sales Price (ASP). HCA updates the rates each time Medicare’s rate is updated, up to once per quarter. If a Medicare fee is unavailable for a particular drug, HCA prices the drug at the Point-of-Sale (POS) Actual Acquisition Cost (AAC). Unlike Medicare, HCA effective dates are based on dates of service, not the date the claim is received.

National drug code format
When billing HCA, providers must use the 11-digit National Drug Code (NDC) from a rebate-eligible manufacturer for the drug administered in the provider’s office.

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

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

For example: The label may list the NDC as 123456789 when, in fact, the correct NDC is 01234056789. Make sure that the NDC is listed as an 11-digit number, inserting any leading zeros missing from the 5-4-2 groupings, as necessary. **HCA will deny claims for drugs billed without a valid 11-digit NDC.**

Electronic Claim Billing Requirements
Providers must continue to identify the drug given by reporting the drug’s CPT or HCPCS code in the **Procedure Code field and the corresponding 11-digit NDC in the National Drug Code field.** In addition, the units reported in the **Units field** must continue to correspond to the description of the CPT or HCPCS code.

If the 11-digit NDC is missing, incomplete, or invalid, the claim line for the drug or supply will be denied.
Physicians billing for compound drugs
To bill for compounding of drugs, enter J3490 as the procedure code. Enter the NDC for the main ingredient in the compound on the line level. Put compound in the notes field. Attach an invoice showing all the products with NDCs and quantities used in the compound. Claims are manually priced per the invoice.

Drugs requiring prior authorization
Drugs requiring prior authorization are noted in the fee schedule with a PA next to them. For information on how to request prior authorization, refer to Prior authorization.

HCA requires prior authorization for all new drugs to market until reviewed and evaluated by HCA’s clinical team according to WAC 182-530-3100. This applies to all products billed under miscellaneous codes or product specific procedure codes.

View the list of Drugs billed under miscellaneous HCPCS codes for drugs that require authorization.

Contraceptives
See the Family Planning Billing Guide for information on coverage for contraceptives dispensed, injected, or inserted in an office/clinic setting, and additional instructions on billing.

Injectable drugs - limitations
Limitations on coverage for certain injectable drugs are listed below, all other diagnoses are noncovered without prior authorization:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Short Description</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0637</td>
<td>Caspofungin acetate</td>
<td>B37.81, B44.9, B48.4, B44.2, B44.7, B44.1, B44.0, B44.89</td>
</tr>
<tr>
<td>J0725</td>
<td>Chorionic gonadotropin/1000u</td>
<td>Q53.01, Q53.02, Q53.10, Q53.11, Q53.12, Q53.20, Q53.21, Q53.22, Q53.9, R01.0</td>
</tr>
<tr>
<td>J1212</td>
<td>Dimethyl sulfoxide 50% 50 ML</td>
<td>N30.10, N30.11, N30.20, N30.21</td>
</tr>
<tr>
<td>J1595</td>
<td>Injection glatiramer acetate</td>
<td>340 G35 (multiple sclerosis)</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Short Description</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1640</td>
<td>Hemin, 1 mg</td>
<td>Limited to office or outpatient hospital, assigned female at birth only, 2 vials daily, 8 days per month total. Prior authorization is required for additional days/vials.</td>
</tr>
<tr>
<td>J1756</td>
<td>Iron sucrose injection</td>
<td>N18.1 – N18.9 (chronic kidney disease)</td>
</tr>
<tr>
<td>J2323</td>
<td>Natalizumab injection</td>
<td>Multiple sclerosis G35 Crohn's disease Requires PA. Use TYSABRI J2323 Request form 13-832. See Where can I download HCA forms?</td>
</tr>
<tr>
<td>J2325</td>
<td>Nesiritide</td>
<td>No diagnosis restriction Restricted use only to cardiologists</td>
</tr>
<tr>
<td>J2501</td>
<td>Paricalcitol</td>
<td>N18.6 (End stage renal disease)</td>
</tr>
<tr>
<td>J2916</td>
<td>Na ferric gluconate complex</td>
<td>N18.6 (End stage renal disease)</td>
</tr>
<tr>
<td>J3398</td>
<td>(Luxturna) (Voretigeme neparvovec-rzyl)</td>
<td>May only be provided by a Washington Apple Health-enrolled provider who is certified by the drug manufacturer to administer the product</td>
</tr>
<tr>
<td>J3465</td>
<td>Injection, voriconazole</td>
<td>B44.9, B48.4, B44.2, B44.7, B44.1, B44.0, B44.89</td>
</tr>
<tr>
<td>J9041</td>
<td>Bortezomib injection</td>
<td>C83.10 – C83.19, C90.00, C90.01</td>
</tr>
</tbody>
</table>
## Billing for Injectable Drugs and Biologicals

When billing for injectable drugs and biologicals, providers must use the description of the procedure code to determine the units and include the correct number of units on the claim to be paid the appropriate amount. For drugs priced at acquisition cost, providers must do one of the following:

- Include a copy of the manufacturer’s invoice for each line item in which billed charges exceed $1,100.00
- Retain a copy of the manufacturer’s invoice in the client’s record for each line item in which billed charges are equal to or less than $1,100.00

**Do not bill using unclassified or unspecified drug codes unless there is no specific code for the drug being administered.** The National Drug Code (NDC) and dosage given to the client must be included with the unclassified or unspecified drug code for coverage and payment consideration.

**HCPCS codes J8499 and J8999 for oral prescription drugs are not covered.**

Injectable drugs can be injected subcutaneously, intramuscularly, or intravenously. Indicate that the injectable drugs came from the provider’s office supply. The name, strength, and dosage of the drug must be documented and kept in the client’s record.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Short Description</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>J3490</td>
<td>(Yescarta) Axicabtagene ciloleucel suspension for IV infusion</td>
<td>May only be provided by a Washington Apple Health enrolled provider who is certified by the drug manufacturer to administer the product</td>
</tr>
<tr>
<td>Q2042</td>
<td>(Kymriah) Tisageneleucel suspension for IV infusion</td>
<td>May only be provided by a Washington Apple Health enrolled provider who is certified by the drug manufacturer to administer the product</td>
</tr>
<tr>
<td>Q3027</td>
<td>Inj beta interferon im 1 mcg</td>
<td>G35 (multiple sclerosis)</td>
</tr>
<tr>
<td>Q3028</td>
<td>Inj beta interferon sq 1 mcg</td>
<td>G35 (multiple sclerosis)</td>
</tr>
</tbody>
</table>
Chemotherapy drugs  
(J9000-J9999)
The following payment guidelines apply to chemotherapy drugs (HCPCS codes J9000-J9999):

- HCA’s maximum allowable fee per unit is based on the HCPCS description of the chemotherapy drug.
- HCA follows Medicare’s drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, HCA continues to price the drug at the actual acquisition cost.
- Preparation of the chemotherapy drug is included in the payment for the administration of the drug.
- Bill number of units used based on the description of the drug code. For example, if 250 mg of Cisplatin (J9062) is given to the client, the correct number of units is five (5).

**Note:** See Unlisted drugs for information on when it is necessary to bill HCA for a chemotherapy drug using an unlisted drug code.

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

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

HCA pays for justified waste when billed with the JW modifier, for Medicare crossover bills only.

For HCA requirements for splitting single dose vials, see Billing for single dose vials (SDV) in the Prescription Drug Program Billing Guide.
Billing for multiple dose vials

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

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

Billing for oral anti-emetic drugs when part of a chemotherapy regimen

To bill HCA for oral anti-emetic drugs (HCPCS codes Q0162-Q0181), the drug must be:

- Part of a chemotherapy regimen.
- Administered or prescribed for use immediately before, during, or within 48 hours after administration of the chemotherapy drug.
- Billed using the appropriate ICD cancer diagnoses.
- Submitted on the same claim with one of the chemotherapy drug codes (HCPCS codes J8530-J9999).

Rounding of units

The following guidelines should be used to round the dosage given to the client to the appropriate number of units for billing purposes:

1. **Single-Dose Vials:**

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

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

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

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

**Unlisted drugs**
(HCPCS J3490, J3590, and J9999)

When it is necessary to bill HCA for a drug using an unlisted drug code, providers must report the National Drug Code (NDC) of the drug administered to the client. HCA uses the NDC when unlisted drug codes are billed to appropriately price the claim. To be reimbursed:

- Claims **must** include:
  - The dosage (amount) of the drug administered to the client.
  - The 11-digit NDC of the office-administered drug.
  - One unit of service.
- The drug must be approved by the Food and Drug Administration (FDA).
- The drug must be for a medically accepted indication as defined in WAC 182-530-1050 (see WAC 182-530-2000 Covered – Outpatient drugs, devices, and drug related supplies).
- The drug must not be excluded from coverage.
- For claims billed using an electronic professional claim, list the required information in the Claim Note section of the claim.

See **Vaccines/toxoids (immunizations)** for more detailed information on NDC billing.

**Note:** If there is an assigned HCPCS code for the administered drug, providers **must bill** HCA using the appropriate HCPCS code. **Do not** bill using an unlisted drug code for a drug that has an assigned HCPCS code. HCA will recoup payment for drugs paid using an unlisted drug code if an assigned HCPCS code exists for the administered drug.
The list of all injectable drug codes and maximum allowable fees are listed in the Professional administered drugs fee schedule.

**Botulinum toxin injections (Botox)**

HCA requires prior authorization for all Botox injections regardless of the diagnosis.

**Prior authorization for Botox for treatment of chronic migraines and chronic tension-type headaches** must be submitted to Comagine Health for a medical necessity review. For more information, see [How do I submit a request to Comagine Health?](#).

**Prior authorization for other Botox treatments:**

Must be submitted to HCA. Submission of an authorization request must be typed and submitted on the *General Information for Authorization* (13-835) form along with a completed *Botulinum Toxin Provider Questionnaire* (13-003) form. See [Where can I download HCA forms?](#).

**Collagenase injections**  
(HCPCS code J0775, CPT® codes 20527 and 26341)

HCA requires prior authorization for HCPCS code J0775, CPT® codes 20527 and 26341.

**Hyaluronic acid/viscosupplementation**

HCA covers hyaluronic acid/viscosupplementation for the treatment of pain associated with osteoarthritis of the knee (OA), as follows:

- Restricted to clients who have a documented medical contraindication to other forms of non-surgical care including all the following: NSAIDS, corticosteroid injections and physical therapy/exercise
- Performed by an orthopedic surgeon, rheumatologist, or physiatrist only
- Limited to two courses per year with at least four months between courses
- Documented evidence of clinical benefit in terms of pain and function from the prior course of treatment is required for subsequent treatment courses

Bill for the injectable drug after all injections are completed.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7320</td>
<td>Gen Visc 850 inj per dose</td>
<td>Five injections (1 week apart) covers a full course of treatment per knee. Maximum of two courses of treatment per year, per knee, at least four months apart</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>HCPCs Code</th>
<th>Short Description</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7321</td>
<td>Hyalgan/supartz inj per dose</td>
<td>Five injections (1 week apart) covers a full course of treatment per knee. Maximum of two courses of treatment per year, per knee, at least four months apart</td>
</tr>
<tr>
<td>J7322</td>
<td>Hymovis inj per dose</td>
<td>Two injections (1 week apart) covers a full course of treatment per knee. Maximum of two courses of treatment per year, per knee, at least four months apart</td>
</tr>
<tr>
<td>J7323</td>
<td>Euflexxa inj per dose</td>
<td>Three to four injections (1 week apart) covers a full course of treatment per knee. Maximum of two courses of treatment per year, per knee, at least four months apart</td>
</tr>
<tr>
<td>J7324</td>
<td>Orthovisc inj per dose</td>
<td>Three to four injections (1 week apart) covers a full course of treatment per knee. Maximum of two courses of treatment per year, per knee, at least four months apart</td>
</tr>
<tr>
<td>J7325</td>
<td>Synvisc inj per dose</td>
<td>One unit equals one mg. Full course of treatment is 3 injections per knee, one week apart. Limited to 2 courses of treatment per knee, per year, at least four months apart. Maximum of 48 units per knee, per course of treatment.</td>
</tr>
<tr>
<td>J7326</td>
<td>Gel-One inj per dose</td>
<td>Maximum of 2 injections per year, per knee at least 4 months apart</td>
</tr>
<tr>
<td>J7327</td>
<td>Monovisc inj per dose</td>
<td>One injection is the full course of treatment. Maximum of two courses of treatment per year, per knee, at least four months apart.</td>
</tr>
<tr>
<td>J7328</td>
<td>GelSyn-3 inj per dose</td>
<td>Three injections (1 week apart) covers a full course of treatment per knee. Maximum of two courses of treatment per year, per knee, at least four months apart.</td>
</tr>
</tbody>
</table>
Note: HCA requires PA for any off-label use of these products. Failure to obtain PA will result in denied payment or recoupment.

- Hyaluronic acid/viscosupplementation injections are covered only with the following ICD diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M17.0, M17.9, M17.10, M17.11, M17.12, M13.861, M13.862, M13.869</td>
<td>Osteoarthritis, localized, primary lower leg.</td>
</tr>
<tr>
<td>M17.9, M13.861, M13.862, M13.869</td>
<td>Osteoarthritis, localized, not specified whether primary or secondary, lower leg.</td>
</tr>
<tr>
<td>M13.861, M13.862, M13.869</td>
<td>Osteoarthritis, unspecified whether generalized or localized, lower leg.</td>
</tr>
</tbody>
</table>

- The injectable drugs must be billed after all injections are completed.
- Bill CPT injection code 20610 or 20611 each time an injection is given, up to a maximum of 5 per knee, per course of treatment.
- Bill both the injection CPT® code and HCPCS drug code on the same claim.

**Alpha Hydroxyprogesterone (17P)**

HCA will cover the use of Alpha Hydroxyprogesterone (17P) as one strategy to reduce the incidence of premature births. The American College of Obstetricians and Gynecologists (ACOG) has indicated that 17P may be of benefit to pregnant clients with:

- A singleton gestation.
- A history of prior spontaneous preterm delivery (between 20 weeks gestation and 36 weeks, 6 days gestation) which was either:
  - Due to preterm labor.
  - A spontaneous delivery due to unknown etiology.

HCA will reimburse administering providers (except for hospitals) without prior authorization for 17P, and its administration as follows:

- 17P must be purchased by the provider from a sterile compounding pharmacy
- The compound is individually produced on a client-by-client basis
- One dose per week is covered during week 16 through week 36 of pregnancy

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How to bill for Alpha Hydroxyprogesterone (17P)
When billing for 17P (HCPCS code J3490), enter the following information on the claim:
- The NDC for the main ingredient in the compound on the line level
- The word Compound in the Notes field

Attach to the claim the invoice from the pharmacy showing all the products with NDCs and quantities used in the compound.

Makena®
Makena® (HCPCS code J1726) is the commercially marketed form of 17P. Makena® is covered for clients age 10 and older who have a history of pre-term labor and receive pregnancy supervision. Makena® can be dispensed and billed by a retail pharmacy for administration by a physician, or Makena® can be billed by the physician’s office.

Prolia/Xgeva
HCA covers denosumab injection (Prolia® and Xgeva®) as follows:
- Prior authorization is required
- Providers bill HCA using HCPCS code J0897

When submitting the General Information for Authorization (13-835) form to request PA, field 15 must contain the brand name (Prolia® or Xgeva®) of the requested product. See Where can I download HCA forms? HCA will reject requests for J0897 without this information. Providers must complete all other required fields.

Spinraza™
See Outpatient Hospital Services Billing Guide for information.

Synagis®

What are the requirements for administration and authorization of Synagis®?
(CPT® code 90378)
HCA requires providers to follow the guidelines and standards as published in The Official Journal of the American Academy of Pediatrics, Updated guidance for Palivizumab Prophylaxis among infants and young children at increased risk of hospitalization for respiratory syncytial virus infection for clients considered for Synagis® prophylaxis during the RSV season.
Note: This information relates only to those clients NOT enrolled in an HCA-contracted managed care organization (MCO). For clients enrolled in an HCA-contracted MCO, refer to the coverage guidelines in the enrollee’s plan.

Respiratory syncytial virus (RSV) Season
HCA has established the RSV season as December through April. HCA monitors RSV incidence as reported by laboratories throughout the state and may change the dates based on the data collected. Unless otherwise notified by HCA, these dates are firm.

Criteria for the administration of Synagis® to HCA clients
HCA requires that the following guidelines and standards of care be applied to clients considered for Synagis® prophylaxis during the RSV season. HCA established these guidelines and standards as published in The Official Journal of the American Academy of Pediatrics, “Updated guidance for Palivizumab Prophylaxis among infants and young children at increased risk of hospitalization for respiratory syncytial virus infection.”

Are there other considerations when administering Synagis®?
Administer the first dose of Synagis® 48 to 72 hours before discharge or promptly after discharge to infants who qualify for prophylaxis during the RSV season.

If an infant or child who is receiving Synagis® immunoprophylaxis experiences a breakthrough RSV infection, continue administering monthly prophylaxis for the maximum allowed doses as above.

Note: HCA does not authorize Synagis® for children with cystic fibrosis.

What are the authorization and billing procedures for Synagis®?
Direct questions or concerns regarding billing and authorization of Synagis® to HCA at (800) 562-3022. Fax prior authorization requests on completed HCA prior authorization form(s) to (866) 668-1214. See Where can I download HCA forms?

Bill HCA for Synagis® using the following guidelines:
- Synagis® may be dispensed and billed by a retail pharmacy for administration by a physician or may be billed by the physician’s office.
- Pharmacies bill through standard pharmacy Point-of-Sale electronic claim submission using the appropriate National Drug Code for the product dispensed.
- Physician’s offices billing directly for Synagis® must bill on a professional claim using CPT® code 90378.
- To bill for the administration of Synagis® use CPT® code 90471 or 90472 if:
  - Dispensed through the pharmacy POS.
  - Administered through the physician’s office.

**What are the criteria for coverage or authorization of Synagis®?**

**Note:** Criteria for coverage or authorization vary depending on the patient’s age.

- **Children younger than 1 year of age**
  HCA requires providers to use and accurately apply the criteria for the administration of Synagis® to HCA clients. Billing for Synagis® outside of the guidelines mentioned in the *Official journal of the American Academy of Pediatrics* will be considered an overpayment and will be subject to recoupment.

  HCA will continue to cover Synagis® for clients younger than 1 year of age without authorization, if utilization is appropriate. In this case, physicians and pharmacies are not required to submit paperwork or obtain pre-approval for the administration of Synagis®.

- **Children age 1 and 2**
  Prior authorization is required to administer Synagis® to HCA clients age 1 and 2. Request authorization by faxing the Request for Synagis® (13-771) form. See *Where can I download HCA forms?*

- **Children age 3 and older**
  HCA does not pay for administering Synagis® to clients age 3 and older.

**What are the authorization procedures for Synagis®?**

- **Pharmacy billers**
  - Pharmacies must submit a request for authorization using HCA’s Pharmacy Information Authorization (13-835A) form as the cover sheet. This form must be **typed**. See *Where can I download HCA forms?*
  - Fax the form to HCA at: (866) 668-1214. If authorized, HCA may approve the 100mg strength, the 50mg strength, or both. However, pharmacies must use National Drug Code (NDC) 60574-4113-01 in box #21 on CPT® codes and descriptions only are copyright 2021 American Medical Association.
Pharmacy Information Authorization form (13-835A). After HCA reviews your request, you will receive notification by fax of strengths, quantities, and NDC(s) approved. See Where can I download HCA forms?

- The Request for Synagis (13-771) form must accompany a typed Pharmacy Information Authorization form (13-835A) as supporting documentation. See Where can I download HCA forms?
- Pharmacies billing for Synagis® through standard pharmacy Point-of-Sale electronic claim submission must use the appropriate National Drug Code for the product dispensed.

**Physician office billers**

- Physician offices must submit a request for authorization using HCA’s General Information for Authorization form (13-835) as the cover sheet. This form must be typed. See Where can I download HCA forms?
- HCA’s Request for Synagis® form (13-771) must be submitted as supporting documentation in addition to the General Information for Authorization form (13-835). See Where can I download HCA forms?
- Physician offices billing HCA directly for Synagis® must bill on a professional claim using CPT® code 90378. After HCA reviews your request, you will receive notification by fax of the total milligrams and NDC(s) approved.

**Requesting an increase in Synagis® dose**

The quantity of Synagis® authorized for administration is dependent upon the weight of the client at the time of administration. If you obtained authorization for a quantity of Synagis® that no longer covers the client’s need due to weight gain:

- Complete the appropriate ProviderOne Cover Sheet by entering the initial authorization number.
  - Pharmacy billers use the Pharmacy PA Supporting Docs sheet.
  - Physician office billers use PA (Prior Authorization) Pend Forms sheet.
- Complete the Request for Additional MG’s of Synagis® Due to Client Weight Increase (HCA 13-770) form and submit along with the ProviderOne Cover Sheet. See Where can I download HCA forms?

HCA will update the authorization to reflect an appropriate quantity and return a fax to the requestor confirming the increased dosage. See the Updated guidance for Palivizumab Prophylaxis among infants and young children at increased risk of hospitalization for respiratory syncytial virus infection.

**Evaluation of authorization requests for Synagis®**

HCA physicians will evaluate requests for authorization to determine whether the client falls within 2014 AAP guidelines for the administration of Synagis®. HCA will fax an approval or denial to the requestor.
Allow at least five business days for HCA to process the authorization request. You may verify the status of a pending authorization by using the ProviderOne PA Inquire feature.

**Verteporfin injection**  
(HCPCS code J3396)
Verteporfin injections are limited to ICD diagnosis codes H35.30 and H35.32.

**Vivitrol**  
(HCPCS J2315)
HCA does not require prior authorization for Vivitrol.

**How do providers who participate in the 340B drug pricing program bill for drugs and dispensing fees?**  
(WAC 182-530-7900)
- All provider NPI(s) used for billing 340B drugs to Washington Apple Health managed care or fee for service programs must be accurately reported on the federal Office of Pharmacy Affairs Medicaid Exclusion File (MEF).
- All drugs billed under the 340B participating NPI(s) must be purchased under the 340B program.
- Only the qualified participating Public Health Services-covered entity (CE) may bill 340B drugs to Washington Apple Health managed care or fee for service programs.
- Providers must bill HCA the 340B actual acquisition cost (AAC) for all drugs purchased under the 340B drug discount program—unless billing an outpatient prospective payment system (OPPS) or ambulatory surgery center (ASC) claim paid under a grouper methodology.

**Drugs administered to managed care clients but reimbursed through fee-for-service**
For clients enrolled in an HCA-contracted managed care organization (MCO), HCA reimburses providers through fee-for-service for professionally administered drugs listed on the Drugs Administered to Managed Care Clients but Reimbursed Fee-for-Service table on HCA’s website.
Foot Care Services

This section addresses care of the lower extremities (foot and ankle) referred to as foot care and applies to clients age 21 and older.

Note: Care of the lower extremity is defined as foot and ankle care.

Are foot care services covered?
HCA covers foot care services for clients age 21 and older as listed in this section when those services are provided by any of the following health care providers and billed to HCA using procedure codes and diagnosis codes that are within their scope of practice:

- Physicians and surgeons or physician's assistants-certified (PA C)
- Osteopathic physicians and surgeons, or physician's assistant-certified (PA C)
- Podiatric physicians and surgeons
- Advanced registered nurse practitioners (ARNP)

HCA covers evaluation and management visits to assess and diagnose conditions of the lower extremities. Once diagnosis is made, HCA covers treatment if the criteria in WAC 182-531-1300 (4)(a) are met.

What foot care services are not covered?
HCA does not cover:

- Treatment of or follow-up office visits for chronic acquired conditions of the lower extremities. HCA pays for prescriptions using the criteria found in the Prescription Drug Program Billing Guide.

- The following foot care services, unless the client meets criteria and conditions outlined in WAC 182-531-1300:
  - Routine foot care, such as but not limited to:
    - Cutting or removing warts, corns, and calluses
    - Treatment of tinea pedis
    - Trimming, cutting, clipping, or debriding of nails
  - Nonroutine foot care, such as, but not limited to treatment of:
    - Adult acquired flatfoot (metatarsus adductus or pes planus)
    - Bunions and tailor's bunion (hallux valgus)
    - Cavovarus deformity, acquired
    - Equinus deformity of foot, acquired
• Flat feet
• High arches (cavus foot)
• Hallux malleus
• Hallux limitus
• Onychomycosis

• Any other service performed in the absence of localized illness, injury, or symptoms involving the foot.

**Note:** Providers may request an exception to rule (ETR) for treatment of those conditions not described in this section. See WAC 182-501-0160 Exception to rule – Request for a noncovered health care service.

**What foot care services does HCA pay for?**

HCA considers treatment of the lower extremities to be medically necessary only when there is an acute condition, an exacerbation of a chronic condition, or presence of a systemic condition such as metabolic, neurologic, or peripheral vascular disease and evidence that the treatment will prevent, cure or alleviate a condition in the client that causes pain resulting in inability to perform activities of daily living, acute disability, or threatens to cause the loss of life or limb, unless otherwise specified.

HCA pays for:

**Section 1**

• Treatment of the following conditions:
  o Acute inflammatory processes such as, but not limited to, tendonitis
  o Circulatory compromise such as, but not limited to:
    ➢ Lymphedema
    ➢ Raynaud’s disease
    ➢ Thromboangiitis obliterans
    ➢ Phlebitis
  o Injuries, fractures, sprains, and dislocations
  o Gout
  o Lacerations, ulcerations, wounds, blisters
  o Neuropathies (e.g., reflex sympathetic dystrophy secondary to diabetes and charcot arthropathy
  o Osteomyelitis
  o Postoperative complications

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Warts, corns, or calluses in the presence of an acute condition such as infection and pain effecting the client’s ability to ambulate as a result of the warts, corns, or calluses and meets the medical necessity criteria found under the heading What foot care services does HCA pay for?

Tendonitis

Soft tissue conditions, such as, but not limited to:
- Rashes.
- Infections (fungal, bacterial).
- Gangrene.
- Cellulitis of lower extremities.
- Soft tissue tumors.
- Neuroma.

Nail bed infections (paronychia).

Treatment of tarsal tunnel syndrome.

Section 2
- Treatment of diabetic foot ulcers with skin substitutes. See HCA’s Outpatient prospective payment system (OPPS) fee schedule for more information.

Section 3
-Trimming and/or debridement of nails to treat, as applicable, conditions found under Section 1 above.

Note: HCA pays for one treatment in a 60-day period. HCA covers additional treatments in this period if documented in the client's medical record as being medically necessary.

Section 4
- A surgical procedure to treat one of the conditions found under Section 1 above performed on the lower extremities and performed by a qualified provider.

Section 5
- Impression casting to treat one of the conditions found under Section 1 above. HCA includes 90-day follow-up care in the reimbursement.

Section 6
- Custom fitted or custom molded, or both, orthotic devices to treat one of the conditions found under Section 1 above.
**Note:** HCA’s fee for the orthotic device includes reimbursement for a biomechanical evaluation (an evaluation of the foot that includes various measurements and manipulations necessary for the fitting of an orthotic device).

HCA includes an evaluation and management (E/M) fee reimbursement in addition to an orthotic fee reimbursement if the E/M services are justified and well documented in the client’s medical record.

---

**What foot care services does HCA not pay for?**

HCA does not pay:

- For the following radiology services:
  - Bilateral X-rays for a unilateral condition
  - X-rays in excess of three views
  - X-rays that are ordered before the client is examined

- Podiatric physicians or surgeons for X-rays for any part of the body other than the foot or ankle.

**May I bill the client for foot care services which HCA does not pay for?**

A waiver is required when clients choose to pay for a foot care service for which HCA does not pay. Requesting an ETR is optional for the client. See WAC 182-502-0160, Billing the Client for details.

**How do I bill for foot care services?**

HCA will pay for treatment of an acute condition only when the condition is the primary reason for the service. This must be documented in the client’s record. When billing, the diagnosis code for the acute condition must be on the service line for the foot care service being billed.

If the description of the orthotic code indicates the code is for a single orthotic or impression casting of one foot, either modifier RT or LT must be included on the claim. Providers must use an appropriate procedure code with the word “pair” in the description when billing for fabrications, casting, or impressions of both feet.

HCA pays for an Evaluation and Management (E/M) code and an orthotic on the same day if the E/M service performed has a separately identifiable diagnosis and the provider bills using modifier 25 to indicate a significant and separately identifiable condition exists and is reflected by the diagnosis.
If Medicare does not cover orthotics and casting, providers may bill HCA directly for those services without submitting a Medicare denial, unless the client's eligibility check indicates QMB - Medicare only, in which case the orthotics and casting is not covered by HCA. If Medicare does cover the service, bill Medicare first.
Home Health and Hospice

Physician signature requirement for home health services
To comply with federal regulations, home health services must be cosigned by a physician, if ordered by a nonphysician provider. If the physician is cosigning the order (that was written by a nonphysician practitioner) for home health services, the physician may bill HCA using CPT® code 99446. All other information regarding home health services may be found in HCA’s Home Health Services (Acute Care Services) Billing Guide.

Physicians providing service to hospice clients
HCA pays providers who are attending physicians and not employed by the hospice agency:
- For direct physician care services provided to a hospice client
- When the provided services are not related to the terminal illness
- When the client's provider, including the hospice provider, coordinates the health care provided

Concurrent care for children who are on hospice (WAC 182-551-1860)
In response to the Patient Protection and Affordable Care Act, clients age 20 and younger who are on hospice service are also allowed to have access to curative services.

Note: The legal authority for these clients' hospice palliative services is Section 2302 of the Patient Protection and Affordable Care Act of 2010 and Section 1814(a)(7) of the Social Security Act; and for client's curative services is Title XIX Medicaid and Title XXI Children's Health Insurance Program (CHIP) for treatment of the terminal condition.

Major Trauma Services

Increased payments for major trauma care
The legislature established the Trauma Care Fund (TCF) in 1997 to help offset the cost of operating and maintaining a statewide trauma care system. The Department of Health (DOH) and the Health Care Authority (HCA) receive funding from the TCF to help support provider groups involved in the state's trauma care system.

HCA uses its TCF funding to draw federal matching funds. HCA makes supplemental payments to designated trauma centers and pays enhanced rates to physicians/clinical providers for trauma cases that meet specified criteria.

The enhanced rates are available for trauma care services provided to a fee-for-service Medical Assistance client with an Injury Severity Score (ISS) of:

- 13 or greater for adults.
- 9 or greater for pediatric patients (age 14 and younger).
- Less than (a) or (b) for a trauma patient received in transfer by a Level I, II, or III trauma center.

Beginning with dates of service on and after July 1, 2012, physicians/clinical providers also receive enhanced rates for qualified trauma care services provided to managed care enrollees who meet trauma program eligibility criteria.

Client eligibility groups included in TCF payments to physicians
Claims for trauma care services provided to the following client groups are eligible for enhanced rates:

- Medicaid (Title XIX)
- CHIP (Title XXI)
- Medical Care Services (Aged, Blind, and Disabled (ABD))
- Apple Health for Kids (Children's Health)
Client eligibility groups excluded from TCF payments to physicians
Claims for trauma care services provided to the following client groups are not eligible for enhanced rates:

- Refugee Assistance
- Alien Emergency Medical
- Family Planning Only – Pregnancy Related/Family Planning Only (formerly referred to as TAKE CHARGE)

Services excluded from TCF payments to physicians
Claims for the following services are not eligible for enhanced rates:

- Laboratory and pathology services
- Technical Component (TC)-only radiology services
- Services unrelated to a client’s traumatic injury (e.g., treatment for chronic diseases)
- Services provided after discharge from the initial hospital stay, except for inpatient rehabilitation services and/or planned follow-up surgery related to the traumatic injury and provided within six months of the date of the traumatic injury

TCF payments to physicians

Enhanced rates for trauma care
To receive payments from the TCF, a physician or other clinician must:

- Be on the designated trauma services response team of any Department of Health (DOH)-designated or DOH-recognized trauma service center.
- Submit all information to the TCF that HCA requires to monitor the trauma program.

HCA makes a TCF payment to a physician or clinician:

- When the provider submits an eligible trauma claim with the appropriate trauma indicator within the time frames specified by HCA.
- On a per-claim basis.
Each qualifying trauma service or procedure on the provider’s claim is paid at HCA’s current fee-for-service rate, multiplied by the appropriate payment enhancement percentage at a rate of 2 ¾ times HCA’s current fee-for-service rate for qualified trauma services, or other payment enhancement percentage HCA deems appropriate. Laboratory and pathology services and procedures are not eligible for payments from the TCF and are paid at HCA’s current fee-for-service rate.

For an eligible trauma service, payment is currently calculated as follows:

\[
\text{Trauma care payment} = \text{Base rate} \times 275\%
\]

**Criteria for TCF payments to physicians**

Physicians and clinical providers receive TCF payments from HCA:

**Section 1**

- For qualified trauma care services. Qualified trauma care services are those that meet the ISS specified in Section 3 below. Qualified trauma care services also include inpatient rehabilitation and surgical services provided to Medical Assistance clients within six months of the date of the qualifying injury when the following conditions are met:
  - The follow-up surgical procedures are directly related to the qualifying traumatic injury.
  - The follow-up surgical procedures were planned during the initial acute episode of care (inpatient stay).
  - The plan for the follow-up surgical procedure(s) is clearly documented in the medical record of the client’s initial hospitalization for the traumatic injury.

**Section 2**

- For hospital-based services only, except as specified in Section 4.

**Section 3**

- Only for trauma cases that meet the ISS of:
  - Thirteen or greater for an adult trauma patient (a client age 15 or older).
  - Nine or greater for a pediatric trauma patient (a client younger than age 15).
  - Less than 13 for adults or 9 for pediatric patients for a trauma case received in transfer by a Level I, II, or III trauma service center.

**Section 4**

- On a claim-specific basis. Services must have been provided in a designated trauma service center, except that qualified follow-up surgical care within six months of the initial traumatic injury, as described in Section 1 above, may be provided in other approved care settings, such as Medicare-certified ambulatory surgery centers.
Section 5

- At a rate determined by HCA. The enhanced rates are subject to the following limitations:
  - Laboratory and pathology charges are not eligible for enhanced payments from the TCF. Laboratory and pathology services are paid at the lesser of HCA’s current FFS rate or the billed amount.
  - Technical component only (TC) charges for radiology services are not eligible for enhanced rates when billed by physicians. (These are facility charges.)
  - The rate enhancement percentage is subject to periodic adjustments to ensure that total payments from the TCF for the state fiscal year will not exceed the legislative appropriation for that fiscal year. HCA has the authority to take whatever actions are needed to ensure it stays within its TCF appropriation.

TCF payments to providers in transferred trauma cases

When a trauma case is transferred from one hospital to another, HCA makes TCF payments to providers as follows:

- If the transferred case meets or exceeds the appropriate ISS threshold (ISS of 13 or greater for adults, and 9 or greater for pediatric clients), both transferring and receiving hospitals and physicians/clinicians who furnished qualified trauma care services are eligible for increased payments from the TCF. The transfer must be to a higher-level designated trauma service center, and the transferring hospital must be at least a level 3 hospital. Transfers from a higher level to a lower-level designated trauma service center are not eligible for the increased payments.

- If the transferred case is below the ISS threshold, only the receiving hospital and the physicians/clinicians at the receiving facility who furnished qualified trauma care services are eligible for increased payments from the TCF. The transferring hospital and clinical team are paid the regular rates for the services they provided to the transferred client with an ISS below the applicable threshold.

Billing for trauma care services

To bill for qualified trauma care services, physicians and clinical providers must add the trauma modifier ST to the appropriate procedure code line. Enter the required ST modifier into the modifier field of the claim to receive the enhanced payment.

**Note:** The ProviderOne system can accommodate up to 4 modifiers on a line if multiple modifiers are necessary.
Claims for trauma care services provided to a managed care enrollee must be submitted to the client’s managed care plan. Claims for trauma care services provided to a fee-for-service client must be submitted to HCA. The payment for a trauma care service provided to a managed care enrollee will be the same amount for the same service provided to a fee-for-service client.

**Adjusting trauma claims**
HCA considers a provider’s request to adjust a claim for the purpose of receiving TCF payment (e.g., adding the ST modifier to a previously billed service, or adding a new procedure with the ST modifier to the claim) only when the adjustment request is received **within 1 year** from the date of service on the initial claim. See WAC 182-502-0150(11).

A claim which included a trauma service may be submitted for adjustment beyond 365 calendar days when the reason for the adjustment request is other than TCF payment (e.g., adding lab procedures, correcting units of service).

**Note:** HCA takes back the original payment when processing an adjustment request. Electronic claims get a Julian date stamp on the date received, including weekends and holidays. When a trauma care service that was billed timely and received the enhanced rate and is included in a claim submitted for adjustment after 365 days, HCA will pay the provider the regular rate for the service when the adjustment is processed and recoup the original enhanced payment.

All claims and claim adjustments are subject to federal and state audit and review requirements.

**Injury severity score (ISS)**

**Note:** The current ISS qualifying score is 13 or greater for adults, and 9 or greater for pediatric clients (through age 14 only).

The ISS is a summary severity score for anatomic injuries.
- It is based upon the Abbreviated Injury Scale (AIS) severity scores for six body regions:
  - Head and neck
  - Face
  - Chest
  - Abdominal and pelvic contents
  - Extremities and pelvic girdle

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• External

- The ISS values range from 1 to 75. Generally, a higher ISS indicates more serious injuries.

**Additional Information**

For information on the **statewide trauma system**, designated trauma services, trauma service designation, trauma registry, or trauma care fund (TCF), see the Department of Health’s [Trauma System](#) webpage.

For information on a specific **trauma claim**, contact:

Health Care Authority
Customer Service Center
800-562-3022

**Physician/clinical provider list**

Below is a list of providers eligible to receive enhanced rates for providing major trauma care services to Medical Assistance clients:

- Advanced Registered Nurse Practitioner
- Anesthesiologist
- Cardiologist
- Certified Registered Nurse Anesthetist
- Critical Care Physician
- Emergency Physician
- Family/General Practice Physician
- Gastroenterologist
- General Surgeon
- Gynecologist
- Hand Surgeon
- Hematologist
- Infectious Disease Specialist
- Internal Medicine
- Nephrologist
- Neurologist
- Neurosurgeon
- Obstetrician
- Ophthalmologist
- Oral/Maxillofacial Surgeon
- Orthopedic Surgeon

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- Pediatric Surgeon
- Pediatrician
- Physiatrist
- Physician Assistant
- Plastic Surgeon (not cosmetic surgery)
- Pulmonologist
- Radiologist
- Thoracic Surgeon
- Urologist
- Vascular Surgeon

**Note:** Many procedures are not included in the enhanced payment program for major trauma services.

The services of some specialists listed above are eligible for enhanced rates only when provided in the context of major trauma care (e.g., stabilization services by a General Practitioner prior to client’s transfer to a trauma care facility; C-Section performed by obstetrician on pregnant accident victim when fetus is in danger).
Oral Health

Access to Baby and Child Dentistry (ABCD)/MouthMatters program (WAC 182-535-1245)

What is the purpose of the ABCD/MouthMatters program?
The ABCD/MouthMatters program does the following:

- Works to increase access to dental services for Washington Apple Health (Medicaid) -eligible clients through age five and clients of the Developmental Disabilities Administration (DDA) through age 12
- Trains and certifies dental providers to care for young children
- Provides outreach to families, connects them to ABCD dental providers, and supports families that need help to make and keep dental appointments.

The MouthMatters program trains, certifies, and provides technical support to medical teams delivering oral health services to young children and referring to ABCD dental providers. Medical providers are crucial to early intervention, as they typically see young children eight to eleven times before age three. Medical providers can deliver preventive oral health services and identify dental disease early as part of whole-person care.

The ABCD/MouthMatters program’s goal is to ensure that early access to dental care and positive dental experiences in childhood lead to lifelong, good oral health practices. This is done in part by identifying and removing obstacles to early preventive dental care.

**Note:** Certified medical providers are eligible to bill the managed care organizations (MCO) for preventative dental services.

For more information on becoming a certified MouthMatters provider, contact the Arcora Foundation by email or at 206-473-9542.

For more information on the ABCD/MouthMatters program and billing information, visit Access to Baby & Child Dentistry.
Topical fluoride treatment
HCA covers fluoride varnish per client, per provider or clinic as follows:

<table>
<thead>
<tr>
<th>Clients who are....</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 6 and younger</td>
<td>Three times within a 12-month period with a minimum of 110 days between applications</td>
</tr>
<tr>
<td>Age 7 through 18 or residing in ALFs or nursing facilities</td>
<td>Two times within a 12-month period with a minimum of 170 days between applications</td>
</tr>
<tr>
<td>Age 19 through 20</td>
<td>Once within a 12-month period</td>
</tr>
</tbody>
</table>

**Note:** Participating primary care medical providers do not need to be ABCD-certified to be paid for administering fluoride varnish. Appropriately trained medical assistants are allowed to apply topical fluoride.

Oral health services coverage table for medical providers

<table>
<thead>
<tr>
<th>Payment</th>
<th>CPT® Code</th>
<th>Short Description</th>
<th>Modifier needed</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99188</td>
<td>App topical fluoride varnish</td>
<td>DA</td>
<td>Limited to 3 times within a 12-month period with a minimum of 110 days between applications. Continue to use CPT® code 99188 with modifier DA for ABCD-enrolled clients with an MCO.</td>
</tr>
</tbody>
</table>

**Note:** Follow CPT® coding guidelines when billing two E/M services on the same day by the same provider.
**Oral surgery**

Services performed by a physician or dentist specializing in oral maxillofacial surgery  
*(WAC 182-535-1094)*

**Provider requirements**
- An appropriate consent form, if required, signed, and dated by the client or the client’s legal representative must be in the client’s record.
- An anesthesiologist providing oral health care under this section must have a current provider’s permit on file with HCA.
- A health care provider providing oral or parenteral conscious sedation, or general anesthesia, must meet all the following:
  - The provider’s professional organization guidelines
  - The Department of Health (DOH) requirements in chapter 246 817 WAC
  - Any applicable DOH medical, dental, and nursing anesthesia regulations
- HCA-enrolled dental providers who are not specialized to perform oral and maxillofacial surgery must use only the current dental terminology (CDT) codes to bill claims for services that are listed in the Oral surgery coverage table. (See WAC 182-535 1070 (3)). See HCA’s Dental-Related Services Billing Guide.

**Note:** If it is anticipated that the client will require orthognathic surgery as part of orthodontic treatment, see HCA’s Orthodontic Services Billing Guide.

**Oral surgery coverage table**
HCA covers the following services:

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>PA?</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10060</td>
<td>N</td>
<td>Drainage of skin abscess</td>
</tr>
<tr>
<td>10120</td>
<td>N</td>
<td>Remove foreign body</td>
</tr>
<tr>
<td>10140</td>
<td>N</td>
<td>Drainage of hematoma/fluid</td>
</tr>
<tr>
<td>11000</td>
<td>N</td>
<td>Debride infected skin</td>
</tr>
<tr>
<td>11012</td>
<td>N</td>
<td>Deb skin bone at fx site</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>PA?</th>
<th>Short Description</th>
</tr>
</thead>
</table>
| 11042     | N   | Deb subq tissue 20 sq cm/|<  
| 11044     | N   | Deb bone 20 sq cm/|<  
| 11440     | N   | Exc face-mm b9+marg 0.5 < cm  
| 11441     | N   | Exc face-mm b9+marg 0.6-1 cm  
| 11442     | N   | Exc face-mm b9+marg 1.1-2 cm  
| 11443     | N   | Exc face-mm b9+marg 2.1-3 cm  
| 11444     | N   | Exc face-mm b9+marg 3.1-4 cm  
| 11446     | N   | Exc face-mm b9+marg > 4 cm  
| 11640     | N   | Exc face-mm malig+marg 0.5 <  
| 11641     | N   | Exc face-mm malig+marg 0.6-1  
| 11642     | N   | Exc face-mm malig+marg 1.1-2  
| 11643     | N   | Exc face-mm malig+marg 2.1-3  
| 11644     | N   | Exc face-mm malig+marg 3.1-4  
| 11646     | N   | Exc face-mm mlg+marg > 4 cm  
| 12001     | N   | Repair superficial wound(s)  
| 12002     | N   | Repair superficial wound(s)  
| 12004     | N   | Repair superficial wound(s)  
| 12005     | N   | Repair superficial wound(s)  
| 12011     | N   | Repair superficial wound(s)  
| 12013     | N   | Repair superficial wound(s)  
| 12014     | N   | Repair superficial wound(s)  
| 12015     | N   | Repair superficial wound(s)  
| 12016     | N   | Repair superficial wound(s)  

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<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>PA?</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12031</td>
<td>N</td>
<td>Intmd wnd repair s/tr/ext</td>
</tr>
<tr>
<td>12032</td>
<td>N</td>
<td>Intmd wnd repair s/tr/ext</td>
</tr>
<tr>
<td>12034</td>
<td>N</td>
<td>Intmd wnd repair s/tr/ext</td>
</tr>
<tr>
<td>12035</td>
<td>N</td>
<td>Intmd wnd repair s/tr/ext</td>
</tr>
<tr>
<td>12036</td>
<td>N</td>
<td>Intmd wnd repair s/tr/ext</td>
</tr>
<tr>
<td>12051</td>
<td>N</td>
<td>Intmd wnd repair face/mm</td>
</tr>
<tr>
<td>12052</td>
<td>N</td>
<td>Intmd wnd repair face/mm</td>
</tr>
<tr>
<td>12053</td>
<td>N</td>
<td>Intmd wnd repair face/mm</td>
</tr>
<tr>
<td>12054</td>
<td>N</td>
<td>Intmd wnd repair face/mm</td>
</tr>
<tr>
<td>12055</td>
<td>N</td>
<td>Intmd wnd repair face/mm</td>
</tr>
<tr>
<td>12056</td>
<td>N</td>
<td>Intmd rpr face/mm 20.1-30.0</td>
</tr>
<tr>
<td>13121</td>
<td>N</td>
<td>Cmplx rpr s/a/l 2.6-7.5 cm</td>
</tr>
<tr>
<td>13122</td>
<td>N</td>
<td>Cmplx rpr s/a/l addl 5 cm/&gt;</td>
</tr>
<tr>
<td>13131</td>
<td>N</td>
<td>Repair of wound or lesion</td>
</tr>
<tr>
<td>13132</td>
<td>N</td>
<td>Repair of wound or lesion</td>
</tr>
<tr>
<td>13133</td>
<td>N</td>
<td>Repair wound/lesion add-on</td>
</tr>
<tr>
<td>13151</td>
<td>N</td>
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<td>42280</td>
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<td>Preparation, palate mold</td>
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<td>42281</td>
<td>N</td>
<td>Insertion, palate prosthesis</td>
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<td>42330</td>
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<td>Removal of salivary stone</td>
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<td>64795</td>
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<td>64864</td>
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<td>Repair facial nerve</td>
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<td>64910</td>
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<td>Nerve repair w/allograft</td>
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<td>70300</td>
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<td>X-ray exam of teeth</td>
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*Billing evaluation and management (E/M) codes

Dentists specializing in oral surgery must use CPT® codes and follow CPT rules when billing for evaluation and management of clients. When billing for these services, the following must be true:

- Services must be billed on an 837P HIPAA compliant claim.
- Services must be billed using one of the CPT® codes above and modifiers must be used if appropriate.
# Prosthetic/Orthotics

## Prosthetic and orthotics for podiatry and orthopedic surgeons

The following codes are payable only to podiatrists and orthopedic surgeons:

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<th>HCPCS Code</th>
<th>Short Description</th>
<th>Policy Comments</th>
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<tr>
<td>A5500</td>
<td>Diab shoe for density insert</td>
<td>Limit 1 per client, per year</td>
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<tr>
<td>A5501</td>
<td>Diabetic custom molded shoe</td>
<td>Limit 1 per client, per year</td>
</tr>
<tr>
<td>A5503</td>
<td>Diabetic shoe w/roller/rocker</td>
<td>Limit 1 per client, per year</td>
</tr>
<tr>
<td>A5504</td>
<td>Diabetic shoe with wedge</td>
<td>Limit 1 per client, per year</td>
</tr>
<tr>
<td>A5505</td>
<td>Diab shoe w/metatarsal bar</td>
<td>Limit 1 per client, per year</td>
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<tr>
<td>A5506</td>
<td>Diabetic shoe w/offset heal</td>
<td>Limit 1 per client, per year</td>
</tr>
<tr>
<td>A5507</td>
<td>Modification diabetic shoe</td>
<td>Requires PA</td>
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<tr>
<td>A5512</td>
<td>Multi den insert direct form</td>
<td>Limit 1 per client, per year</td>
</tr>
<tr>
<td>A5513</td>
<td>Multi den insert custom mold</td>
<td>Limit 1 per client, per year</td>
</tr>
<tr>
<td>L1902</td>
<td>Afo ankle gauntlet</td>
<td></td>
</tr>
<tr>
<td>L1906</td>
<td>Afo multiligamentus ankle su</td>
<td></td>
</tr>
<tr>
<td>L3000</td>
<td>Ft insert ucb berkeley shell</td>
<td>EPA required</td>
</tr>
<tr>
<td>L3030</td>
<td>Foot arch support remov prem</td>
<td>EPA required</td>
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<tr>
<td>L3140</td>
<td>Abduction rotation bar shoe</td>
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<td>L3150</td>
<td>Abduct rotation bar w/o show</td>
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<td>L3170</td>
<td>Foot plastic heel stabilizer</td>
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<tr>
<td>L3215</td>
<td>Orthopedic ftwear ladies oxf</td>
<td>EPA required. Noncovered for clients age 21 and older.</td>
</tr>
<tr>
<td>L3219</td>
<td>Orthopedic mens shoes oxford</td>
<td>EPA required. Noncovered for clients age 21 and older.</td>
</tr>
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<td>HCPCS Code</td>
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<td>Policy Comments</td>
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</tr>
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<td>L3310</td>
<td>Shoe lift elev heel/sole neo</td>
<td>Limit 1 per client, per year</td>
</tr>
<tr>
<td>L3320</td>
<td>Shoe lift elev heel/sole cor</td>
<td>Limit 1 per client, per year</td>
</tr>
<tr>
<td>L3334</td>
<td>Shoe lifts elevation heel /i</td>
<td>Limit 1 per client, per year</td>
</tr>
<tr>
<td>L3340</td>
<td>Shoe wedge sach</td>
<td>PA required</td>
</tr>
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<td>L3350</td>
<td>Shoe heel wedge</td>
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<td>L3360</td>
<td>Shoe sole wedge outside sole</td>
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<td>L3400</td>
<td>Shoe metatarsal bar wedge ro</td>
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<tr>
<td>L3410</td>
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<td>Full sole/heel wedge between</td>
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<td>Shoe heel count plast reinfor</td>
<td>Limit 1 per client, per year</td>
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<td>L4350</td>
<td>Ankle control orthosi prefab</td>
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<tr>
<td>L4360</td>
<td>Pneumatic walking boot prefab</td>
<td>Fractures only; PA required</td>
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<tr>
<td>L4386</td>
<td>Non-pneum walk boot prefab</td>
<td>PA required</td>
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</table>

(For authorization requirements, follow the Prosthetic and Orthotic Devices Billing Guide.)
Supplies paid separately when dispensed from provider’s office/clinic

Casting materials
Bill the appropriate HCPCS code (Q4001-Q4051) for fiberglass and plaster casting materials limited to one unit per limb per day. Do not bill for the use of a cast room. Use of a cast room is considered part of a provider’s practice expense.

Inhalation solutions
Refer to the Professional administered drugs fee schedule for those specific codes for inhalation solutions that are paid separately.

Metered dose inhalers and accessories

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<td>Hand-hled PEFR meter</td>
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<td>A4627</td>
<td>Spacer bag/reservoir</td>
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Miscellaneous prosthetics and orthotics

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<td>L0120</td>
<td>Cerv flexible non-adjustable</td>
</tr>
<tr>
<td>L0220</td>
<td>Thor rib belt custom fabrica</td>
</tr>
<tr>
<td>L1810</td>
<td>Ko elastic with joints</td>
</tr>
<tr>
<td>L1820</td>
<td>Ko elas w/ condyle pads &amp; jo</td>
</tr>
<tr>
<td>L1830</td>
<td>Ko immobilizer canvas longit</td>
</tr>
<tr>
<td>L3650</td>
<td>Shlder fig 8 abduct restrain</td>
</tr>
<tr>
<td>L3807</td>
<td>WHFO, no joint, prefabricated</td>
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<tr>
<td>L3908</td>
<td>Wrist cock-up non-molded</td>
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<tr>
<td>L8000</td>
<td>Mastectomy bra</td>
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<td>L8010</td>
<td>Mastectomy sleeve</td>
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<td>L8600</td>
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For additional information and authorization requirements, see HCA’s [Prosthetic and Orthotic Devices Billing Guide](#).

### Miscellaneous supplies

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<td>A4562</td>
<td>Pessary, nonrubber, any type</td>
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<tr>
<td>A4565</td>
<td>Slings</td>
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<tr>
<td>A4570</td>
<td>Splint</td>
</tr>
<tr>
<td>L8695</td>
<td>External recharge sys extern. <em>(Requires PA)</em></td>
</tr>
</tbody>
</table>

### Urinary tract implants

See important policy limitations in [Urinary systems](#).

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L8603</td>
<td>Collagen imp urinary 2.5 ml</td>
</tr>
<tr>
<td>L8604</td>
<td>Dextranomer/hyaluronic acid</td>
</tr>
<tr>
<td>L8606</td>
<td>Synthetic implnt urinary 1ml</td>
</tr>
</tbody>
</table>

**Note:** L8603, L8604 and/or L8606 must be billed on the facility claim only if the implantation procedure is performed in place of service 21 and 22.
Transhealth Program

For resources that may be helpful for providing healthcare services to members of the transgender community, go to the Transgender Health Services Program webpage.

Gender-affirming interventions and treatment

In addition to all the other services addressed in this billing guide, HCA-covered medical services for gender-affirming treatment include, but are not limited to:

- Pre-surgical and post-surgical hormone therapy
- Puberty suppression therapy
- Behavioral health services
- Surgical and ancillary services including:
  - Anesthesiology
  - Labs
  - Pathology
  - Radiology
  - Hospitalization
  - Physician services
  - Hospitalizations and physician services related to postoperative complications of procedures performed for gender-affirming surgery.

**Note:** A health care provider with experience prescribing or delivering, or both, gender affirming treatment must review and confirm the appropriateness of any adverse benefit determination.
Payment for gender-affirming interventions and treatment

- Payment for hormone and behavioral health services to treat gender dysphoria is the responsibility of the client’s MCO.

- Payment for gender-affirming treatment (other than behavioral health and hormone therapy), including electrolysis and post-operative complications, if required, to treatment gender dysphoria are the responsibility of the Medicaid fee-for-service program. These services require prior authorization (PA). See Required documentation for prior authorization (PA)?

  - HCA pays for consultations related to gender-affirming treatment and associated electrolysis or laser hair removal required for gender reassignment surgery (GRS). These consultations are paid for by HCA through fee-for-service. To ensure payment, bill HCA directly for this consultative visit using an expedited prior authorization (EPA) number. See EPA #870001400 for details.

Note: When billing Medicaid fee-for-service for complications related to GRS, providers must add “SCI=TC” in the Comments filed on the claim.

Surgical services

Surgical services to treat gender dysphoria are covered for clients who have a primary diagnosis of gender dysphoria (ICD codes F64.0, F64.1, F64.2 and F64.9). Prior authorization is required. Under this program:

- HCA authorizes and pays for only medically necessary services.

- Providers of surgical services must be enrolled with HCA.

- HCA may cover transportation services to and from medical appointments.

- Any out-of-state care, including a pre-surgical consultation, must be prior authorized as an out-of-state service.

- HCA does not pay for procedures and surgeries related to reversal of gender-affirming surgery.

Required documentation for prior authorization (PA)

HCA requires PA for all surgical services to treat gender dysphoria. Surgical services include the initial surgery, modifications to a previous surgery, or complications from a previous surgery. The only exception to the PA requirement is mastectomy for gender dysphoria, which is processed through expedited prior authorization (EPA). If the client does not meet the EPA criteria for mastectomy, then PA is required. EPA cannot be used for a revision or repair of previous mastectomy; PA is required.
The provider must include the required documentation with the PA request, as detailed on the following pages. The documentation must be signed and dated by the provider and in letter format, except for the surgeon’s history and physical and surgical plan.

**Breast augmentation**
For breast augmentation, submit:

- One comprehensive psychosocial evaluation completed within the past 18 months from a qualified and licensed behavioral health provider.
- A letter written within the past 18 months from the provider managing the client’s hormone therapy.
- The client’s history and physical and surgical plan completed within the past 12 months from the surgeon who will perform the surgery.

**Note:** It is a general requirement for the client to be on hormone therapy and live in a gender role that is congruent with their gender identity for a minimum of 12 months preceding breast augmentation.

**Mastectomy**
If the client meets the EPA criteria required for a mastectomy, use EPA #870001615 (EPA) for clients age 17 and older. Otherwise, prior authorization is required. The following clinical criteria and documentation must be kept in the client’s medical record and made available to HCA upon request:

- One comprehensive psychosocial evaluation completed within 18 months preceding surgery from a qualified and licensed behavioral health provider that:
  - Independently confirms the diagnosis of gender dysphoria as defined by the *Diagnostic Statistical Manual of Mental Disorders*.
  - Documents that the client has been evaluated for any coexisting behavioral health conditions and if any are present, the conditions are adequately managed.
- A letter of medical necessity within the past 18 months supporting the request for mastectomy from the primary care provider
- The client’s history and physical and surgical plan completed within the past 12 months from the surgeon who will perform the surgery
For clients age 17 and younger, each comprehensive psychosocial evaluation must be performed by a licensed and qualified behavioral health provider who specializes in adolescent transgender care and meets the qualifications outlined in WAC 182-531-1400.

**Note:** It is not a requirement for the client to be on hormone therapy and live in a gender role congruent with their gender identity preceding mastectomy.

### Hysterectomy and orchiectomy:
For hysterectomy and orchiectomy, submit:

- One comprehensive psychosocial evaluation completed within the past 18 months from a qualified and licensed behavioral health provider.
- A letter written within the past 18 months from the provider managing the client’s hormone therapy.
- The client’s history and physical, as well as the surgical plan completed within the past 12 months from the surgeon who will perform the surgery.
- For hysterectomy, a completed *Hysterectomy Consent* form, HCA 13-365.

**Note:** It is a general requirement for the client to be on hormone therapy for a minimum of 12 months preceding hysterectomy or orchiectomy. However, it is not a requirement for the client to live in a gender role congruent with the client’s gender identity for a minimum of 12 months preceding hysterectomy or orchiectomy.

### Full-bottom surgery
For full-bottom surgery, submit:

- Two separate psychosocial evaluation completed within the past 18 months, from two separate qualified and licensed behavioral health providers.
- A letter written within the past 18 months from the provider managing the client’s hormone therapy.
- The client’s history and physical and the surgical plan completed within the past 12 months by the surgeon who will perform the surgery.

### Genital or donor skin site hair removal
If the client meets EPA criteria for genital or donor skin site hair removal in preparation for bottom surgery, use EPA #870001616 for clients age 18 and older. Otherwise, prior authorization is required. The following documentation must be kept in the client’s medical record and made available to HCA upon request:

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• A letter of medical necessity from the treating surgeon. The letter must include the size and location of the area to be treated and expected date of the planned genital surgery; or

• A letter of medical necessity from the provider who will perform the hair removal. The letter must include the surgical consult for bottom surgery that addresses the need for hair removal before gender-affirming surgery.

**Facial or body hair removal**
For facial or body hair removal, submit:

• A letter written within the past 18 months from the provider managing the client’s hormone therapy.

• A letter of medical necessity from the dermatologist or primary care provider, completed within the past 18 months. The letter must include:
  o A description of the medical condition and attempted treatments that prevent the client from shaving or using other hair removal techniques (not including electrolysis or laser). Examples include:
    ▪ Documented folliculitis
    ▪ Documented sensitivity to hair removal techniques
    ▪ Thick male pattern hair growth prohibiting adequate hair removal
  o Photos of requested area to be treated from approximately two feet (include method of hair removal used in the following photo series for documentation):
    ▪ Before hair removal (minimum of 8 hours of hair growth; include length of time from last hair removal)
    ▪ Immediately after hair removal

• Letter of medical necessity from the provider who will perform the hair removal that includes the size and location of the area to be treated and the number of expected units needed to complete treatment.
Facial feminization
For facial feminization surgery, submit:

• One comprehensive psychosocial evaluation completed within the past 18 months from a qualified and licensed behavioral health provider.

• A letter written within the past 18 months from the provider managing the client’s hormone therapy.

• The client’s history and physical, and the surgical plan completed within the past 12 months by the surgeon who will perform the surgery.

• Photos of the client’s face (including the neck, if requesting laryngoplasty, or tracheal shave, or both) from approximately two feet away, to include views from the front, sides, and with the client looking up and looking down.

Other gender-affirming treatment
For other gender-affirming treatments, submit:

• One comprehensive psychosocial evaluation completed within the past 18 months from a qualified and licensed behavioral health care provider.

• A letter written within the past 18 months from the provider managing the client’s hormone therapy.

• For surgery, the client’s history and physical and the surgical plan completed within the past 12 months by the surgeon who will perform the surgery.

• For other gender-affirming treatment, a letter from provider requesting the prior authorization that includes treatment requested and medical necessity for the requested treatment.

Requirements for provider documentation
The provider must include the following documentation with the prior authorization request. The documentation must be signed and dated by the provider and in letter format, except for the surgeon’s history and physical and surgical plan.

Psychosocial evaluations. Each comprehensive psychosocial evaluation must:

• Be completed within the past 18 months.

• Be in letter form, and must:
  
  o Independently confirm the diagnosis of gender dysphoria as defined by the Diagnostic Statistical Manual of Mental Disorders.
  
  o Document that the client has been evaluated for any coexisting behavioral health conditions and if any are present, the conditions are adequately managed.
Document that the client has:

- Lived in a gender role congruent with their gender identity for a minimum of 12 months preceding surgery; or
- Been unable to live in their gender identity due to personal safety concerns.

**Note:** It is **not** a requirement for the client to live in a gender role congruent with the client’s gender identity for a minimum of 12 months preceding mastectomy, hysterectomy, or orchiectomy.

**Primary care provider’s documentation.** A letter of support from the primary care provider or provider managing the hormonal therapy must be completed within the past 18 months and include:

- A medical necessity for surgery and confirmation that the client is adherent with current gender dysphoria treatment; and either:
  - Documentation of hormone use for a minimum of 12 continuous months immediately preceding the request for surgery, except for mastectomy or reduction mammoplasty; or
  - A medical contraindication to hormone therapy.

**Surgeon’s documentation.** A clinical note from the surgeon performing the procedure must be completed within the past 12 months preceding surgery and include the:

- Medical history and physical examination
- Medical necessity for surgery
- Surgical plan
- For hysterectomies, a completed *Hysterectomy Consent* form, HCA 13-365.
- For breast augmentation, documentation of Tanner stage and consistent hormone therapy for 12 continuous months prior to the surgery

**Requirements for qualified and licensed behavioral health providers**

Licensed behavioral health providers who perform psychosocial evaluations must meet the definition of WAC 182-531-1400(5). The following providers are eligible to perform these evaluations under Chapter 182-502 WAC:

- Psychiatrists
- Psychologists
- Psychiatric advanced registered nurse practitioners (ARNP)
- Psychiatric mental health nurse practitioners- board certified (PMHNP-BC)
- Licensed mental health counselors (LMHC)
Licensed independent clinical social workers (LICSW)
Licensed advanced social workers (LASW)
Licensed marriage and family therapists (LMFT)

In addition, qualified and licensed mental health care providers must:

- Be competent in using the *Diagnostic Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) and the *International Classification of Diseases* for diagnostic purposes.
- Be able to recognize and diagnose coexisting mental health conditions and to distinguish these from gender dysphoria.
- Have completed supervised training in psychotherapy or counseling.
- Be knowledgeable of gender-nonconforming identities and expressions and the assessment and treatment of gender dysphoria.
- Have completed continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

**Prior authorization (PA) for clients age 17 and younger**

Clients age 17 and younger must submit the same required documentation for prior authorization (PA) with their request, except that:

- Each comprehensive psychosocial evaluation must be performed by a behavioral health provider who specializes in adolescent transgender care and meets the qualifications outlined in WAC 182-531-1400.
- For bottom surgery, HCA requires two separate comprehensive psychosocial evaluations from two behavioral health providers, one of whom must specialize in adolescent transgender care and meet the qualifications outlined in WAC 182-531-1400.

**Note for EPSDT:** If gender dysphoria treatment is requested or prescribed for clients age 20 and younger under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, HCA evaluates it as a covered service under the EPSDT program’s requirement that the service is medically necessary, safe, effective, and not experimental.
Expedited prior authorization (EPA)
HCA allows a provider to use the EPA process for the following medically necessary procedures:

Genital or donor skin graft site hair removal
For clients age 18 and older: For genital or donor skin graft site hair removal in preparation for gender-affirming surgery, use EPA # 870001616. A maximum of 156 units per year is allowed. After two years, PA is required.

Criteria:
- Primary diagnosis code of: F64.0, F64.1, F64.2, or F64.9
- CPT® codes 17380 (electrolysis) and 64999 (nerve block) are only allowed if associated with a primary diagnosis code of F64.0, F64.1, F64.2, or F64.9, and CPT® code 64999 can only be billed in conjunction with CPT® code 17380.
- The client must be age 18 or older to use EPA.
- For clients age 17 and younger, a PA request must be requested.

Documentation requirements:
See Genital or donor skin site hair removal for PA.

Mastectomy or reduction mammoplasty
For clients age 17 and older: For bilateral mastectomy or reduction mammoplasty with or without chest reconstruction, use EPA #870001615. There is a lifetime limit of one for CPT® codes 19303 and 19318. For example, if the client undergoes reduction mammoplasty and is billed using CPT® code 19318, the client is not eligible for services billed using either CPT® code 19318 or CPT® code 19303 at a later time. EPA cannot be used to revise or repair a previous mastectomy or reduction mammoplasty; PA is required.

Criteria:
- Primary diagnosis code of; F64.0, F64.1, F64.2, or F64.9
- CPT® codes 19303 (mastectomy), 19318 (breast reduction), 19350 (nipple/areola reconstruction), 15877 (suction lipectomy-trunk), 15860 (test vascular flow in flap or graft)
- CPT® codes 19350, 15877, and 15860 are only allowed if associated with either CPT® code 19303 or CPT® code 19318 AND a primary diagnosis code of F64.0, F64.1, F64.2, or F64.9
- The client must be age 17 or older to use EPA.

Documentation requirements:
See Mastectomy section.
**Recoupment.** HCA may recoup any payment made to a provider for services to treat gender dysphoria if the provider does not follow the EPA process outlined in WAC 182-501-0163 or if the provider does not maintain the required documentation.
Medical Necessity Review by Comagine Health

What is a medical necessity review by Comagine Health?
HCA contracts with Comagine Health to provide web-based access for reviewing medical necessity for:

- Outpatient advanced imaging services
- Select surgical procedures
- Outpatient advanced imaging
- Spinal injections, including diagnostic selective nerve root blocks
- Botox injections (OnabotulinumtoxinA) for the treatment of chronic migraines and chronic tension-type headaches

Comagine Health conducts the review of the request to establish medical necessity but does not issue authorizations. Comagine Health forwards its recommendations to HCA for final authorization determination. The procedure codes that require review by Comagine Health can be found in HCA’s Physician-related/professional health care services fee schedule.

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

Who can request a review?
Only the performing provider or facility (site of service) can request the medical necessity review by Comagine Health. If initiating the request for authorization, the physician must include the name and billing NPI of the facility where the procedure will be performed. If a facility is requesting the authorization, the request must include the name and billing NPI of the physician performing the procedure.

Note: Billing entities such as clearinghouses do not request authorization through Comagine Health or HCA.
How do I register with Comagine Health?
To submit requests to Comagine Health, providers must:

- Register as a provider through http://www.comagine.org/.
- Register as a Washington State Medicaid provider.
- Be familiar with the criteria that will be applied to requests.

Comagine Health offers on-line training and a printable WA Medicaid Training Manuals.

Note: A username and password is needed for Washington State Medicaid even if a provider is already a registered provider with Washington State Labor and Industries.

Is authorization required for all Washington Apple Health (Medicaid) clients?
No. Authorization through Comagine Health is required only for Washington Apple Health clients who are currently eligible and enrolled in fee-for-service as the primary insurance and Emergency Related Services Only (ERSO) noncitizen program/Alien Medical Program (AMP) clients.

DO NOT submit a request for a client who has:

- Medicaid Managed Care.
- Another insurance as primary (Third Party Liability or TPL).
- Medicare as the primary insurance.
- No current eligibility.
- Unmet spenddown.
- Detoxification only coverage.

If one of the above applies, HCA will reject the request for authorization regardless of Comagine Health's medical necessity determination.
For ERSO/AMP clients in the cancer or end stage renal disease (ESRD) program (WAC 182-507-0120), submit all imaging and surgical requests to Comagine Health.

When Medicare is the primary payer and denies a service that is an HCA-covered service with a prior authorization requirement, HCA waives the “prior” requirement in this circumstance. Submit a request for authorization. Attach the Explanation of Benefits (EOB) to the request for services denied by Medicare.

Reminder: Check client eligibility before submitting a request! An HCA Washington Apple Health (Medicaid) eligibility ID card does not guarantee that a client is currently eligible. To save time, confirm eligibility through ProviderOne before submitting an authorization request. To learn more about confirming client eligibility in ProviderOne, go to the ProviderOne Billing and Resource Guide.

How do I submit a request to Comagine Health?
Requests may be submitted electronically, by fax, or via telephone. Instructions for submitting a medical necessity review request, including how to use OneHealthPort, are available at Comagine Health.

Fax or Telephone Option through Comagine Health
Fax and telephone requests are available only to providers who do not have access to a computer.

Requests initiated by telephone or fax will require supporting documentation to be faxed per the instructions found at Comagine Health. Once supporting documentation is received, Comagine Health will open a case in their system by:

- Entering the information.
- Responding to the provider with a Comagine Health reference number.

Once all necessary clinical information is received (either electronically or via fax), Comagine Health staff will:

- Conduct the medical necessity review.
- Forward a recommendation to HCA.

Comagine Health will process telephone and fax requests during normal business hours. Faxed requests can be sent at any time and Comagine Health will process them the following business day. Comagine Health provides the following toll-free numbers:

- Washington Apple Health (Medicaid) (phone) 888-213-7513
- Washington Apple Health (Medicaid) (fax) 888-213-7516

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What is the Comagine Health reference number for?

Upon successful submission of a request through iEXCHANGE® or when a request has been faxed to Comagine Health, a provider will receive a 9-digit Comagine Health reference number starting with the prefix 913 (e.g., 913-xxx-xxx). The Comagine Health reference number provides verification that Comagine Health reviewed the request.

A Comagine Health reference number is NOT a billable authorization number.

Providers must not bill for or perform a procedure(s) until a written approval and an HCA-issued ProviderOne authorization number is received. HCA approves or denies authorization requests based on recommendations from Comagine Health.

For questions regarding the status of an authorization, need to update an authorization, or have general questions regarding an authorization, contact HCA at 1-800-562-3022, ext. 52018.

Note: HCA has 15 calendar days from the time Comagine Health receives a request for authorization to provide a written determination.

When does HCA consider retroactive authorizations?

HCA considers retroactive authorization when one of the following applies:

- The client’s eligibility is verifiably approved after the date of service, but retroactive to a date(s) that includes the date that the procedure was performed.
- The primary payer does not pay for the service and payment from Medicaid is being identified as the primary payer.

Note: Retroactive authorizations must be submitted to Comagine Health within 5 business days for procedures or advanced imaging performed as urgent or emergency procedures on the same day.

When requesting retroactive authorization for a required procedure, providers must check authorization requirements for the date of service that the procedure was performed.
What are the authorization requirements for advanced imaging?
For advanced imaging, providers must complete the appropriate questionnaire form. Questionnaires for radiology services are available online from Comagine Health and can be printed out for provider convenience.

Some radiology codes continue to require prior authorization (PA) from HCA, but not from Comagine Health. See the Physician-related/professional services fee schedule.

**Note:** The PA requirement is for diagnostics provided as urgent and scheduled. HCA allows 5 business days to complete authorization for urgent or ordered-the-same-day procedures when the authorization cannot be completed before the procedure is performed. This authorization requirement does not apply to diagnostics done in association with an emergency room visit, an inpatient hospital setting, or when another payer, including Medicare, is the primary payer.

How does HCA’s hierarchy of evidence protocol apply?
The criteria in the online Comagine Health questionnaires represent “B” level of evidence under WAC 182-501-0165. In other words, this represents the clinical/treatment guideline* HCA has adopted to establish medical necessity and make authorization decisions for these advanced imaging procedures. “B” level evidence shows the requested service or equipment has some proven benefit supported by:

- Multiple Type II or III evidence or combinations of Type II, III or IV evidence with generally consistent findings of effectiveness and safety (A "B" rating cannot be based on Type IV evidence alone).
- Singular Type II, III, or IV evidence in combination with HCA-recognized:
  - Clinical guidelines*.
  - Treatment pathways*.
  - Other guidelines that use the hierarchy of evidence in establishing the rationale for existing standards.

If the criteria in the questionnaire are not met, the request will be denied.

**Note:** In most circumstances, HCA’s program uses the same criteria and questionnaires as Labor and Industries for MRIs and CT scans.
What are the authorization requirements for surgical procedures?
Requests initiated electronically will require supporting documentation to be included with the electronic submission or faxed per the instructions found at Comagine Health.

Surgical services require HCA authorization regardless of place of service or when performed as:

- Urgent.
- An emergency.
- A scheduled surgery.

If the client is age 20 and younger, prior authorization for the surgical procedure may not be required. See HCA’s Physician-related/professional services fee schedule to determine if a procedure is exempt by client’s age.

Surgical modifiers
Co-Surgeons, Assistants, Team Surgeries, and other surgical modifiers

When requesting an authorization for any surgical procedure requiring a medical necessity review by Comagine Health, indicate if the authorization request also includes an assistant surgeon, a co-surgeon, or a surgical team. For further information, see the Centers for Medicare and Medicaid’s (CMS) Global surgery booklet or CMS’s Claims processing manual for physicians/nonphysician practitioners.

When submitting an authorization request for a surgical service that requires additional surgeons, include the following on the request:

- The appropriate modifier(s)
- If available, each surgeon’s billing NPI
- Clinical justification for an assistant surgeon, co-surgeon, or surgical team

Enter the information above in the Communication box when the case is either of the following:

- Loaded through Comagine Health iEXCHANGE®
- Submitted by fax, on the Request for Surgical Authorization form

How does HCA’s hierarchy of evidence protocol apply?
Hierarchy of Evidence (WAC 182-501-0165)

HCA recognizes the criteria described as “B” level of evidence. If the request meets medical necessity criteria, the request will be approved.
What criteria will Comagine Health use to establish medical necessity?

HCA has instructed Comagine Health to use the following surgical procedure criteria to establish medical necessity:

- Health Technology Clinical Committee (HTCC) determinations reviewed and implemented by Washington Apple Health
- Labor and Industries (LNI)
- InterQual criteria

If there is an applicable HTCC decision, HCA uses the decision during the medical necessity review. If there are no HTCC criteria available, applicable criteria from Washington State’s Labor & Industries (L&I) Medical treatment guidelines (MTG) will be applied. If L&I does not have available criteria, InterQual criteria will be applied.

Is there a provider appeals process for Comagine Health?

Yes. If HCA denies authorization because of a recommendation from Comagine Health, Comagine Health offers providers an appeal process. Request an appeal as follows:

- Prepare a written request for appeal to Comagine Health indicating the Comagine Health reference number (starting with 913…) for which the appeal is requested.
- Fax the request for appeal along with any appropriate clinical notes, laboratory, and imaging reports to be considered with the appeal to Comagine Health at 888-213-7516.

Note: If the clinical information that is submitted is NEW (information obtained after the denial was issued), a new review will be initiated by Comagine Health and a new reference number will be assigned. An appeal will be conducted if the information submitted was available at the time of the initial review but not submitted.

Upon receipt of a request for appeal, Comagine Health staff will review the documentation to determine if the appeal meets the medical necessity criteria. If it is determined that the appeal request does not meet the medical necessity criteria, the case will be referred to a physician to make a final determination.

More information about Comagine Health’s provider appeal process is available online at Comagine Health (Washington State Medicaid).

If Comagine Health ultimately recommends the authorization be denied and Washington Apple Health (Medicaid) agrees, the client has the right to appeal to the Administrative Hearings Office.

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Authorization

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

Prior authorization (PA)

What is prior authorization (PA)?

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

For psychiatric inpatient authorizations, see HCA’s Inpatient Hospital Services Billing Guide or Mental Health Services Billing Guide.

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

For examples on how to complete a PA request, see HCA’s Billers, providers, and partners webpage.

Note: HCA reviews requests for payment for noncovered health care services according to WAC 182-501-0160 as an exception to rule (ETR).

How does HCA determine PA?

HCA reviews PA requests in accordance with WAC 182-501-0165. HCA uses evidence-based medicine to evaluate each request. HCA considers and evaluates all available clinical information and credible evidence relevant to the client’s condition. At the time of the request, the provider responsible for the client’s diagnosis or treatment must submit credible evidence specifically related to the client’s condition. Within 15 days of receiving the request from the client’s provider, HCA reviews all evidence submitted and will either:

- Approve the request.
- Deny the request if the requested service is not medically necessary.
- Request the provider to submit additional justifying information within 30 days. When the additional information is received, HCA will approve or deny the request within 5 business days of the receipt of the additional information.
If the additional information is not received within 30 days, HCA will deny the requested service.

When HCA denies all or part of a request for a covered service or equipment, HCA sends the client and the provider written notice within 10 business days of the date the information is received that:

- Includes a statement of the action HCA intends to take.
- Includes the specific factual basis for the intended action.
- Includes references to the specific WAC provision upon which the denial is based.
- Is in sufficient detail to enable the recipient to learn why HCA’s action was taken.
- Is in sufficient detail to determine what additional or different information might be provided to challenge HCA’s determination.
- Includes the client’s administrative hearing rights.
- Includes an explanation of the circumstances under which the denied service is continued or reinstated if a hearing is requested.
- Includes example(s) of lesser cost alternatives that permit the affected party to prepare an appropriate response.

**Services requiring PA**

HCA requires PA for the following:

- Abdominoplasty
- Bariatric surgery
- Eating disorders (diagnosis and treatment for clients age 21 and older)
- Elective surgical procedures (HCA may require a second opinion and/or consultation before authorizing)
- Hysterectomies and other surgeries of the uterus – see fee schedule for codes requiring PA (this policy applies to all ages)
  
  When requesting surgery, also indicate if the request is for assistant or co-surgeon. For further information, see the Centers for Medicare and Medicaid’s (CMS) [Global surgery booklet](#) or CMS’s [Claims processing manual for physicians/nonphysician practitioners](#).

- Inpatient hospital stays for acute physical medicine and rehabilitation (PM&R).
- Mometasone sinus implant
- Oncotype DX
- Osseointegrated/bone conduction hearing devices (for clients age 20 and younger)
- Osteopathic manipulative therapy (more than HCA’s published limits)

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• Molecular pathology tests as specified on HCA’s Physician-related services/health care professional services fee schedule

• Panniculectomy

• Removal or repair of a previously implanted bone conduction hearing device or cochlear device for clients age 21 older when medically necessary

• Hematopoietic progenitor cell boost (CPT® code 38243)

• Vagus nerve stimulator insertion

  For coverage, vagus nerve stimulator insertion must be performed in an inpatient or outpatient hospital facility and for reimbursement, providers must attach the invoice to the claim.

• Intensity Modulated Radiation Therapy (IMRT)
  o When requesting IMRT, providers must submit an initial request for treatment planning (CPT® code 77301) to HCA. Once a treatment plan is established, the number of treatment units needed must be submitted to the existing prior authorization number using the process below. HCA expedites requests for treatment planning.
  o To submit additional information to the request for IMRT, use the following instructions:
    ▪ Use HCA’s ProviderOne PA pend forms submission cover sheet.
    ▪ Type the 9-digit Reference Number from your letter into the "Authorization Reference #" field and hit Enter (this will expand the barcode shown).
    ▪ Click on the "Print Cover Sheet" button; choose “Yes” if you’re asked whether you want to allow the document to print.
    ▪ Fax the barcode sheet as the FIRST page, (no coversheet) then the supporting documents to 1-866-668-1214 and the documents will be added to this authorization.
  o Submit a new treatment request only when one of the following:
    ▪ 6 months has elapsed since the last request
    ▪ The treatment plan has changed.

• The following surgical procedure codes require medical necessity review by Comagine Health:

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Short Description</th>
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<tbody>
<tr>
<td>22899</td>
<td>Spine surgery procedure</td>
</tr>
<tr>
<td>23929</td>
<td>Shoulder surgery procedure</td>
</tr>
<tr>
<td>24999</td>
<td>Upper arm/elbow surgery</td>
</tr>
</tbody>
</table>

CPT® codes and descriptions only are copyright 2021 American Medical Association.
When requesting PA for surgical services where co-surgeons, a surgical team, or a surgical assistant are needed, include all the following:

- The General Information for Authorization form, 13-835. See Where can I download HCA forms?
- One PA request per client
- One Basic Information form, 13-756 for each surgeon. See Where can I download HCA forms?
- All appropriate modifier(s)
- Indicate in box 30 this is for co-surgeon, surgical team, or surgical assistant
- Each surgeon’s billing NPI on the appropriate forms

**Documentation requirements for PA or LE**

**PA documentation**

**How do I obtain PA or an LE?**

For all requests for PA or LEs, the following documentation is required:

- A completed, TYPED General Information for Authorization form, 13-835. This request form MUST be the initial page when of the request.
- A completed Fax/Written Request Basic Information form, 13-756, if there is not a form specific to the service being requested, and all the documentation is listed on this form with any other medical justification.

Fax the request to: (866) 668-1214.

See HCA’s Billers, provider, and partners webpage.

See Where can I download HCA forms?
Forms available to submit PA requests
- *Application for Chest Wall Oscillator, 13-841*
- *Bariatric Surgery Request form, 13-785*
- *Fax/Written Request Basic Information form, 13-756*
- *Insomnia Referral Worksheet, 13-850*
- *Oral Enteral Nutrition Worksheet, 13-743*
- *Out of State Medical Services Request form, 13-787*

Forms available to submit PA requests for medication

<table>
<thead>
<tr>
<th>Drug name (brand)</th>
<th>HCPCS code(s)</th>
<th>Form number</th>
</tr>
</thead>
<tbody>
<tr>
<td>acetaminophen injection</td>
<td>J0131</td>
<td>13-756</td>
</tr>
<tr>
<td>alglucosidase alfa (Lumizyme) IV inj</td>
<td>J0221</td>
<td>13-756</td>
</tr>
<tr>
<td>belimumab (Benlysta) IV inj</td>
<td>J0490</td>
<td>13-756</td>
</tr>
<tr>
<td>botulinum toxin inj</td>
<td>J0585*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>J0586</td>
<td>13-003</td>
</tr>
<tr>
<td></td>
<td>J0587</td>
<td></td>
</tr>
<tr>
<td></td>
<td>J0588</td>
<td></td>
</tr>
<tr>
<td>burosomab-twza (Crysvita) inj</td>
<td>J0584</td>
<td>13-0064</td>
</tr>
<tr>
<td>ceftaroline fosamil (Teflaro) IV inj</td>
<td>J0712</td>
<td>13-756</td>
</tr>
<tr>
<td>certolizumab pegol (Cimzia) inj</td>
<td>J0717</td>
<td>13-885</td>
</tr>
<tr>
<td>denosumab (Prolia) inj</td>
<td>J0897</td>
<td>13-756</td>
</tr>
<tr>
<td>elapegademase-lvlr (Revcovi) IM inj</td>
<td>J35990</td>
<td>13-0062</td>
</tr>
<tr>
<td>eteplirsen (Exondys 51) IV inj</td>
<td>J1428</td>
<td>13-0012</td>
</tr>
<tr>
<td>infliximab (Remicade) IV inj.</td>
<td>J1745</td>
<td>13-897</td>
</tr>
<tr>
<td>ipilimumab (Yervoy) IV inj.</td>
<td>J9228</td>
<td>13-756</td>
</tr>
<tr>
<td>Drug name (brand)</td>
<td>HCPCS code(s)</td>
<td>Form number</td>
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<td>-------------------</td>
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</tr>
<tr>
<td>IV iron</td>
<td>J1756, J2916, Q0138, Q0139, J1439</td>
<td>13-0013</td>
</tr>
<tr>
<td>lutetium lu 177 dotatate (Lutathera) IV inj</td>
<td>A9513</td>
<td>13-0060</td>
</tr>
<tr>
<td>mannitol for inhaler</td>
<td>J7665</td>
<td>13-756</td>
</tr>
<tr>
<td>mepolizumab (Nucala) inj</td>
<td>J2182</td>
<td>13-0011</td>
</tr>
<tr>
<td>natalizumab (Tysabri) IV inj</td>
<td>J2323</td>
<td>13-832</td>
</tr>
<tr>
<td>nivolumab (Opdivo) IV inj</td>
<td>J9299</td>
<td>13-0010</td>
</tr>
<tr>
<td>omalizumab (Xolair) inj</td>
<td>J2357</td>
<td>13-852a</td>
</tr>
<tr>
<td>pegloticase (Krystexxa) inj</td>
<td>J2507</td>
<td>13-756</td>
</tr>
<tr>
<td>pertuzumab (Perjeta) IV inj</td>
<td>J9306</td>
<td>13-916</td>
</tr>
<tr>
<td>porfimer sodium (Photofrin) inj</td>
<td>J9600</td>
<td>13-756</td>
</tr>
<tr>
<td>ustekinumab (Stelara) inj</td>
<td>J3357</td>
<td>13-898</td>
</tr>
<tr>
<td>voretigene neparvovec-rzyl (Luxturna) susp</td>
<td>J3398</td>
<td>13-0059</td>
</tr>
</tbody>
</table>

*J0585 - For treatment of chronic migraines and chronic tension-type headaches, see Botulinum toxin injections (Botox) for prior authorization submission information.

See Where can I download HCA forms?

**Requesting prior authorization (PA)**
When a procedure’s EPA criteria has not been met or the covered procedure requires PA, providers must request prior authorization from HCA. Procedures that require PA are listed in the fee schedule. HCA does not retrospectively authorize any health care services that require PA after they have been provided except when a client has delayed certification of eligibility.
Online direct data entry into ProviderOne

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

Written or fax

If providers chose to submit a written or fax PA request, the following must be provided:

- The General Information for Authorization form, HCA 13-835. See Where can I download HCA forms? This form must be page one of the mailed/faxed request and must be typed.
- The program form. This form must be attached to the request.
- Charts and justification to support the request for authorization.

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

- **By Fax**: (866) 668-1214
- **By Mail**: Authorization Services Office, PO Box 45535, Olympia, WA 98504-5535

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

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

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

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

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

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

---

**Note**: See HCA’s ProviderOne Billing and Resource Guide for more information on requesting authorization.
**Limitation extension (LE)**

**What is a limitation extension (LE)?**
A limitation extension (LE) is an authorization of services beyond the designated benefit limit allowed in Washington Administration Code (WAC) and HCA billing guides.

**Note:** A request for an LE must be appropriate to the client’s eligibility and/or program limitations. Not all eligibility groups cover all services.

**How do I request an LE authorization?**
Some LE authorizations are obtained by using the EPA process. Refer to the EPA criteria list for criteria. If the EPA process is not applicable, an LE must be requested in writing and receive HCA approval prior to providing the service.

The written request must state all the following:
- The name and ProviderOne Client ID of the client
- The provider’s name, ProviderOne Client ID, and fax number
- Additional service(s) requested
- The primary diagnosis code and CPT® code
- Client-specific clinical justification for additional services

**Expedited prior authorization (EPA)**

**What is expedited prior authorization (EPA)?**
Expedited prior authorization (EPA) is designed to eliminate the need for written authorization. HCA establishes authorization criteria and identifies the criteria with specific codes, enabling providers to create an EPA number using those codes.

To bill HCA for diagnostic conditions, procedures and services that meet the EPA criteria on the following pages, the provider must use the 9-digit EPA number. The first five or six digits of the EPA number must be 87000 or 870000. The last 3 or 4 digits must be the EPA number assigned to the diagnostic condition, procedure, or service that meets the EPA criteria (see EPA criteria list for numbers). Enter the EPA number on the billing form in the authorization number field, or in the Authorization or Comments section when billing electronically.
Example: The 9-digit authorization number for a client with the following criteria would be 870000421:

- Client is age 11 through 55
- Client is in one of the at-risk groups because the client meets one of the following:
  - Has terminal complement component deficiencies
  - Has anatomic or functional asplenia
  - Is a microbiologist who is routinely exposed to isolates of Neisseria meningitis
  - Is a freshman entering college who will live in a dormitory

HCA denies claims submitted without a required EPA number.

HCA denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.

The billing provider must document in the client’s file how the EPA criteria were met and make this information available to HCA on request. If HCA determines the documentation does not support the criteria being met, the claim will be denied.

Note: HCA requires written/fax PA when there is no option to create an EPA number.

EPA documentation guidelines

The provider must verify medical necessity for the EPA number submitted. The client’s medical record documentation must support the medical necessity and be available upon HCA’s request. If HCA determines the documentation does not support the EPA criteria requirements, the claim will be denied.

Note: For enteral nutrition EPA requirements, refer to the Prior Authorization section in HCA’s Enteral Nutrition Billing Guide.

EPA criteria list

A complete EPA number is 9 digits. The first five or six digits of the EPA number must be 87000 or 870000. The last 3 or 4 digits must be the EPA number assigned to the diagnostic condition, procedure, or service that meets the EPA criteria. If the client does not meet the EPA criteria, prior authorization (PA) is required (see Prior authorization).
<table>
<thead>
<tr>
<th>EPA Number</th>
<th>Service Name</th>
<th>CPT/HCPCS/Dx</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| 87000051   | Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral, retina. | **CPT® Code:** 92134 | Limit to 12 per calendar year. The client must meet both of the following criteria:  
- The client is undergoing active treatment (intraocular injections, laser or incisional surgery) for conditions such as cystoid macular edema (CME); choroidal neovascular membrane (CNVM) from any source (active macular degeneration (AMD) in particular); diabetic retinopathy or macular edema; retinal vascular occlusions; epiretinal membrane; vitromacular traction; macular holes; unstable glaucoma; multiple sclerosis with visual symptoms; optic neuritis; optic disc drusen; optic atrophy; eye toxicity or side-effects related to medication use; papilledema or pseudopapilledema  
- There is documentation in the client’s record describing the medical circumstance and explaining the need for more frequent services. |
| 870000241  | Reduction Mammoplasties/Mastectomy for Gynecomastia | **CPT® codes:** 19318, 19300  
**Dx codes:** N62, N64.9, or L13.9 | A client assigned female at birth with a diagnosis for **hypertrophy of the breast** with:  
- Photographs in client’s chart  
- Documented medical necessity including:  
  - Back, neck, and/or shoulder pain for a minimum of 1 year, directly attributable to macromastia  
  - Conservative treatment not effective  
- Abnormally large breasts in relation to body size with shoulder grooves  
- Within 20% of ideal body weight, and  
- Verification of minimum removal of 500 grams of tissue from each breast |
<table>
<thead>
<tr>
<th>EPA Number</th>
<th>Service Name</th>
<th>CPT/HCPCS/ Dx</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| 870000242  | Reduction Mammoplasties/Mastectomy for Gynecomastia | **CPT® codes:** 19318, 19300  
**Dx codes:** N62, N64.9, or L13.9 | A client assigned male at birth with a diagnosis for *gynecomastia* with:  
• Pictures in clients’ chart  
• Persistent tenderness and pain  
• If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than 1 year |
| 870000421  | Meningococcal Vaccine                             | **CPT® code:** 90734 (Conjugate Vaccine – Menactra®) | Client is age 19 through 55 and is in one of the at-risk groups because the client meets one of the following:  
• Not routinely recommended for ages 19-21, but may be administered as catch-up vaccination for those who have not received a dose after their 16th birthday  
• Has persistent complement deficiencies  
• Has anatomic or functional asplenia  
• Are at risk during a community outbreak attributable to a vaccine serogroup  
• Infected with human immunodeficiency virus (HIV) if another indication for vaccination exists  
• Is a microbiologist who is routinely exposed to isolates of N. meningitidis  
• Is a freshman entering college who will live in a dormitory |
<table>
<thead>
<tr>
<th>EPA Number</th>
<th>Service Name</th>
<th>CPT/HCPCS/Dx</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| 870000422  | Placement of Cardiac Drug Eluting or Bare Metal Stent and Device | **HCPCS codes:** C1874, C1875, C9601, C9602, C9603, C9604, C9605, C9606, C9607, and C9608 (Institutional only) **Bare Metal –** 92928, 92929 | Either drug eluting or bare metal cardiac stents are **covered** when cardiac stents are indicated for treatment when medically necessary. For patients being treated for stable angina, cardiac stents are a **covered benefit with the following conditions:**  
  - Angina refractory to optimal medical therapy  
  - Objective evidence of myocardial ischemia |
870000423  |  Unilateral cochlear implant for clients age 20 and younger  |  CPT® code: 69930  

HCA pays for cochlear implantation only when the products come from a vendor with a Core Provider Agreement with HCA, there are no other contraindications to surgery, and one of the following must be true:

- **Unilateral cochlear implantation** for clients age 18 through 20 with post-lingual hearing loss and clients (12 months-17 years old) with prelingual hearing loss when all the following are true:
  
  o The client has a diagnosis of profound to severe bilateral, sensorineural hearing loss

  o The client has stimulable auditory nerves but has limited benefit from appropriately fitted hearing aids (e.g., fail to meet age-appropriate auditory milestones in the best-aided condition for young children, or score of less than ten or equal to 40% correct in the best-aided condition on recorded open-set sentence recognition tests

  o The client has the cognitive ability to use auditory clues

  o The client is willing to undergo an extensive rehabilitation program

  o There is an accessible cochlear lumen that is structurally suitable for cochlear implantation

  o The client does not have lesions in the auditory nerve and/or acoustic areas of the central nervous system

**Note:** See EPA #870001365 for criteria for bilateral cochlear implantation. See HCA’s Hearing Hardware Billing Guide for replacement parts for cochlear implants.
<table>
<thead>
<tr>
<th>EPA Number</th>
<th>Service Name</th>
<th>CPT/HCPCS/Dx</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>870000425</td>
<td>Hyperbaric Oxygen Therapy</td>
<td>CPT® code: 99183</td>
<td>All the following must be true:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HCPCS code: G0277</td>
<td>• Patient has type 1 or type 2 diabetes and has a lower extremity wound that is due to diabetes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Institutional only)</td>
<td>• Patient has a wound classified as Wagner grade 3 or higher</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Hyperbaric oxygen therapy is being done in combination with conventional diabetic wound care</td>
</tr>
<tr>
<td>870000610</td>
<td>Visual Exam/Refraction</td>
<td>CPT® codes: 92014-92015</td>
<td><strong>Eye Exam/Refraction - Due to loss or breakage:</strong> For adults within 2 years of last exam when no medical indication exists, and both of the following are documented in the client’s record:</td>
</tr>
<tr>
<td></td>
<td>(Optometrists/Ophthalmologists only)</td>
<td></td>
<td>• Glasses are broken or lost or contacts that are lost or damaged</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Last exam was at least 18 months ago</td>
</tr>
<tr>
<td></td>
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<td></td>
<td><strong>Note:</strong> EPA # is not required when billing for children or clients with developmental disabilities.</td>
</tr>
<tr>
<td>870000630</td>
<td>Blepharoplasties</td>
<td>CPT® codes: 15822, 15823, and 67901, 67902, 67903, 67904, 67906, 67908</td>
<td>Blepharoplasty for noncosmetic reasons when both of the following are true:</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• The excess upper eyelid skin impairs the vision by blocking the superior visual field</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• On a central visual field test, the vision is blocked to within 10 degrees of central fixation</td>
</tr>
<tr>
<td>EPA Number</td>
<td>Service Name</td>
<td>CPT/HCPCS/Dx</td>
<td>Criteria</td>
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</tr>
</tbody>
</table>
| 87000631   | Strabismus Surgery               | **CPT® codes:** 67311, 67312, 67314, 37316, 67318, 67320, 67331, 67332, 67334, 67335, 67340 | Strabismus surgery for clients 18 years of age and older when both of the following are true:  
- The client has a strabismus-related double vision (diplopia) and  
- It is not done for cosmetic reasons  
**Dx Code:** H53.2 |
| 87001300   | Injection, Romiplostim, 10  
Microgram | **HCPCS code:** J2796 | **All the following must apply:**  
- Documented diagnosis of Idiopathic Thrombocytopenic Purpura (ITP)  
- Patient must be at least 18 years of age  
- Inadequate response (reduction in bleeding) to one of the following:  
  - Immunoglobulin treatment  
  - Corticosteroid treatment  
  - Splenectomy |
<p>| 87001302   | Hysterectomies for Cancer         | <strong>CPT® codes:</strong> 58150, 58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573 | Client must have a diagnosis of cancer requiring a hysterectomy as part of the treatment plan. |</p>
<table>
<thead>
<tr>
<th>EPA Number</th>
<th>Service Name</th>
<th>CPT/HCPCS/Dx</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>870001303</td>
<td>Hysterectomies - Complications and Trauma</td>
<td><strong>CPT® codes:</strong> 58150, 58152, 58180, 58200, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58545, 58546, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573</td>
<td>Client must have a complication related to a procedure or trauma (e.g., postprocedure complications; postpartum hemorrhaging requiring a hysterectomy; trauma requiring a hysterectomy)</td>
</tr>
</tbody>
</table>
| 870001312  | Professional or diagnostic continuous glucose monitoring (CGM) | **CPT® codes:** 95250 | **Allowed** for the in-home use of professional or diagnostic CGM for a 72-hour period. The client must:  
• Have diabetes mellitus (DM).  
• Be insulin dependent.  
The CGM must be:  
• Ordered by a provider.  
• Provided by an FDA-approved CGM device.  
**Limit:** 2 monitoring periods of 72 hours each, per client, every 12 months. |
<p>| 870001321  | Orencia (abatacept) | <strong>HCPCs code:</strong> J0129 | Treatment of rheumatoid arthritis when prescribed by a rheumatologist in patients who have tried and failed one or more DMARDs. Dose is subcutaneous injection once weekly. IV dosing is up to 1000mg dose to start, repeated at week 2 and 4, then maintenance up to 1000mg every 4 weeks. |</p>
<table>
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<th>Criteria</th>
</tr>
</thead>
</table>
| 870001325  | Targeted TB testing with interferon-gamma release assays     | **CPT® codes:** 86480, 86481 | Targeted TB testing with interferon-gamma release assays may be considered medically necessary for clients **5 years of age and older** for any of the following conditions:  
  - History of positive tuberculin skin test or previous treatment for TB disease  
  - History of vaccination with BCG (Bacille Calmette-Guerin)  
  - Recent immigrants (within 5 years) from countries that have a high prevalence of tuberculosis  
  - Residents and employees of high-risk congregate settings (e.g., homeless shelters, correctional facilities, substance abuse treatment facilities, etc.)  
  - Clients with an abnormal CXR consistent with old or active TB  
  - Clients undergoing evaluation or receiving TNF alpha antagonist treatment for rheumatoid arthritis, psoriatic arthritis, or inflammatory bowel disease  
  - Exposure less than 2 years before the evaluation  
  **AND**  
  - Client in agreement to remain in compliance with treatment for latent tuberculosis infection if found to have a positive test.  
  The tuberculin skin test is the preferred method of testing for children under the age of 5. |
| 870001342  | Alloderm                                                      | **CPT® Code:** Q4116 | All the following must be met:  
  - It is medically necessary.  
  - The client has a diagnosis of breast cancer.  
  - The servicing provider is either a general surgeon or a plastic surgeon. |
<table>
<thead>
<tr>
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<th>Service Name</th>
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</tr>
</thead>
</table>
| 870001344     | Noninvasive prenatal diagnosis of fetal aneuploidy (NIPT) | **CPT® code:** 81507 and 81420 | HCA considers NIPT for serum marker screening for fetal aneuploidy to be medically necessary in pregnant clients with high-risk singleton pregnancies, who have had genetic counseling, when one or more of the following are met:  
  - Pregnant client is age 35 years or older at the time of delivery  
  - History of a prior pregnancy with a trisomy or aneuploidy  
  - Family history of aneuploidy (first degree relatives or multiple generations affected)  
  - Positive first or second trimester standard biomarker screening test for aneuploidy, including sequential, or integrated screen, or a positive quadruple screen  
  - Parental balanced Robertsonian translocation with increased risk for fetal T13 or T21  
  - Findings indicating an increased risk of aneuploidy |
| 870001350     | Transient elastograph                             | **CPT® code:** 91200 | All the following must be met:  
  - Baseline detectable HCV RNA viral load  
  - Chronic hepatitis C virus infection and BMI < 30  
  - Both APRI (AST to platelet ratio index) and FibroSURE™ tests have been completed with one of the following results:  
    - FibroSURE™ < 0.49 and APRI > 1.5  
    - FibroSURE™ > 0.49 and APRI < 1.5 |
| 870001351     | Interoperative or postoperative pain control using a spinal injection or infusion | **CPT® codes:** 62320, 62321, 62322, 62323, 62324, 62325, and 62327 | These CPT® codes may be billed with this EPA when they are done interoperatively or postoperatively for pain control. |

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<th>Criteria</th>
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</thead>
</table>
| 870001362  | Low dose CT for lung cancer screen | **CPT® code:** 71271 | The client must meet all the following criteria:  
  - Is age 50-80  
  - Has a history of smoking 20 packs a year and either of the following:  
    - Still smokes  
    - Has quit smoking in the last 15 years |
| 870001363  | Bone mineral density testing with dual x-ray absorptiometry (DXA) - initial screening | **CPT® codes:** 77080 and 77081 | Bone mineral density testing with dual x-ray absorptiometry (DXA) is a covered benefit with the following conditions:  
  **Asymptomatic persons assigned female at birth**  
  Either of the following:  
  - 65 years of age and older  
  - 64 years of age and younger with equivalent 10-year fracture risk to individuals age 65 as calculated by FRAX (Fracture Risk Assessment) tool or other validated scoring tool  
  **Any individual**  
  Either of the following:  
  - Long term glucocorticoids (i.e., current or past exposure to glucocorticoids for more than 3 months)  
  - Androgen deprivation or other conditions known to be associated with low bone mass |
<table>
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<tr>
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</tr>
</thead>
</table>
| 870001364 | Bone mineral density testing with dual x-ray absorptiometry (DXA) - repeat test | **CPT® codes:** 77080 and 77081 | Repeat bone mineral density testing with dual x-ray absorptiometry (DXA) is a covered benefit when the client meets one of the following:  
- T-score** > -1.5, 15 years to next screening test  
- T-score -1.5 to -1.99, 5 years to next screening test  
- T-score ≤ -2.0, 1 year to next screening test  
- Use of medication associated with low bone mass or presence of a condition known to be associated with low bone mass |
| 870001365 | Bilateral cochlear implants  
See EPA #870000423 for unilateral cochlear implants | **CPT®:** 69930  
**Modifier:** 50 | The client must:  
- Be age 12 months through 20 years old  
- Have bilateral severe to profound sensorineural hearing loss.  
- Be limited or no benefit from hearing aids  
- Have cognitive ability and willingness to participate in an extensive auditory rehabilitation program  
- Have freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system  
- Have no other contraindications for surgery  
- Use device in accordance with the FDA approved labeling |
<table>
<thead>
<tr>
<th>EPA Number</th>
<th>Service Name</th>
<th>CPT/HCPCS/Dx</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| 870001368   | Testosterone testing | **CPT® code:** 84402,84403, 84410 | **Covered:**  
  - For clients assigned male at birth age 19 and older when at least one of the following conditions are met:  
    - Suspected or known primary hypogonadism  
    - Suspected or known secondary hypogonadism with organ causes such as:  
      - Pituitary disorder  
      - Suprasellar tumor  
      - Medications suspected to cause hypogonadism  
      - HIV with weight loss  
      - Osteoporosis  
    - Monitoring of testosterone therapy  
  - As part of the treatment for gender dysphoria when a client has a diagnosis of gender dysphoria and is being treated with one of the following:  
    - Hormone replacement therapy  
    - Hormone suppression therapy                                                                                                                                 |
| 870001371   | Orthoptic/pleoptic training | **CPT® code:** 97110  
**Dx:** H50.411 or H50.412 with secondary dx of TBI | Documented diagnosis of convergence insufficiency, convergence excess, or binocular dysfunction, with a secondary diagnosis of traumatic brain injury (TBI) |
| 870001372   | Orthoptic/pleoptic training | **CPT® code:** 97112  
**Dx:** H51.12 with secondary dx of TBI | Documented diagnosis of convergence insufficiency, convergence excess, or binocular dysfunction, with a secondary diagnosis of traumatic brain injury (TBI) |
<table>
<thead>
<tr>
<th>EPA Number</th>
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<th>CPT/HCPCS/Dx</th>
<th>Criteria</th>
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</thead>
<tbody>
<tr>
<td>870001373</td>
<td>Orthoptic/pleoptic training</td>
<td>CPT® code: 97530, Dx: H53.30 with secondary dx of TBI</td>
<td>Documented diagnosis of convergence insufficiency, convergence excess, or binocular dysfunction with a secondary diagnosis of traumatic brain injury (TBI)</td>
</tr>
</tbody>
</table>
| 870001374  | Intensity modulated radiation therapy (IMRT)     | CPT® code: 77301, 77338, 77370, G6015, G6016 | • Any cancer that would require radiation to focus on the head/neck/chest/abdomen/pelvic area  
• Document in the clinical notes which critical structure is being spared |
| 870001375  | Early elective delivery or natural delivery prior to 39 weeks gestation | CPT® code: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622 | Client is under 39 weeks gestation and the birthing parent or fetus has a diagnosis listed in the Joint Commission’s current table of Conditions possibly justifying elective delivery prior to 39 weeks gestation, or client delivers naturally |
| 870001378  | Elective delivery or natural delivery at or over 39 weeks gestation | CPT® code: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622 | Client is 39 weeks gestation or over 39 weeks gestation |
| 870001381  | HPV genotyping                                   | CPT® code: 87625 | For clients with cervix age 30 and older, when the following conditions are met:  
• Pap negative and HPV positive  
• Pap no EC/TZ and HPV positive |
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<tr>
<th>EPA Number</th>
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<th>CPT/HCPCS/Dx</th>
<th>Criteria</th>
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</thead>
<tbody>
<tr>
<td>870001382</td>
<td>Tympanostomy tubes</td>
<td>69433 or 69436</td>
<td>The client is age 16 or younger and is diagnosed with one of the following:</td>
</tr>
<tr>
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<td>• <strong>Acute otitis media</strong> (AOM) and the client has either of the following:</td>
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<tr>
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<td>o Complications, is immunocompromised, or is at risk for infection</td>
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<td></td>
<td>o Both of the following are true:</td>
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<td></td>
<td>• Has had 3 episodes of AOM in the last 6 months with one occurring in the last 6 months</td>
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<td>• Has the presence of effusion at the time of assessment for surgical candidacy</td>
</tr>
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<td></td>
<td>• <strong>Otitis media with effusion</strong> (OME) and the client has one of the following:</td>
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<tr>
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<td></td>
<td>o An effusion for 3 months or greater and there is documented hearing loss</td>
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<td></td>
<td>o A disproportionate risk</td>
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<td></td>
<td>• For persistent effusion based on anatomic abnormalities</td>
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<tr>
<td></td>
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<td></td>
<td>• From the effects of hearing loss, such as those with speech delay, underlying sensory-neuro hearing loss or cognitive disorders</td>
</tr>
<tr>
<td>870001400</td>
<td>Surgical consultation related to</td>
<td>Dx: F64.0,</td>
<td>All the following must be met:</td>
</tr>
<tr>
<td></td>
<td>transgender surgery</td>
<td>F64.1, F64.2 and F64.9</td>
<td>• Client has gender dysphoria diagnosis</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• Appointment is done as a consultation to discuss possible transgender related surgery including hair removal by electrolysis or laser</td>
</tr>
<tr>
<td>EPA Number</td>
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<td>CPT/HCPCS/Dx</td>
<td>Criteria</td>
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</table>
| 870001386  | Gene expression profile (breast cancer) Oncotype Dx | 81519 | Breast cancer gene expression testing is covered when all the following conditions are met:  
• Stage 1 or 2 cancer  
• Estrogen receptor positive and Human Epidermal growth factor Receptor 2 (HER2-NEU) negative  
• Lymph node negative or 1-3 lymph node(s) positive  
• The test result will help the patient and provider make decisions about chemotherapy or hormone therapy |
| 870001420  | Gene expression profile (breast cancer) Endopredict | 81599 | Breast cancer gene expression testing is covered when all the following conditions are met:  
• Stage 1 or 2 cancer  
• Estrogen receptor positive and Human Epidermal growth factor Receptor 2 (HER2-NEU) negative  
• Lymph node negative or 1-3 lymph node(s) positive  
• The test result will help the patient and provider make decisions about chemotherapy or hormone therapy |
| 870001545  | Gene expression profile (breast cancer) Prosigna | 81520 | Breast cancer gene expression testing is covered when all the following conditions are met:  
• Stage 1 or 2 cancer  
• Estrogen receptor positive and Human Epidermal growth factor Receptor 2 (HER2-NEU) negative  
• Lymph node negative or 1-3 lymph node(s) positive  
• The test result will help the patient and provider make decisions about chemotherapy or hormone therapy |
<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>870001546</td>
<td>Gene expression profile (breast cancer) MammaPrint</td>
<td>81521</td>
<td>Breast cancer gene expression testing is covered when all the following conditions are met:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Stage 1 or 2 cancer</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Estrogen receptor positive and Human Epidermal growth factor Receptor 2 (HER2-NEU) negative</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Lymph node negative or 1-3 lymph node(s) positive</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• The test result will help the patient and provider make decisions about chemotherapy or hormone therapy</td>
</tr>
<tr>
<td>870001547</td>
<td>Gene expression profile (breast cancer) Mammostrat</td>
<td>81599</td>
<td>Breast cancer gene expression testing is covered when all the following conditions are met:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Stage 1 or 2 cancer</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• The test result will help the patient make decisions about hormone therapy</td>
</tr>
<tr>
<td>870001548</td>
<td>Gene expression profile (breast cancer) Breast Cancer Index</td>
<td>81479</td>
<td>Breast cancer gene expression testing is covered when all the following conditions are met:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Stage 1 or 2 cancer</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• The test result will help the patient make decisions about hormone therapy</td>
</tr>
<tr>
<td>870001549</td>
<td>Gene expression profile (prostate cancer) Oncotype Dx prostate cancer assay</td>
<td>0047U</td>
<td>Prostate cancer gene expression is covered when the following conditions are met:</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• Low and favorable intermediate risk disease as defined by the National Comprehensive Cancer Network (NCCN)</td>
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<td>• Test result will help inform treatment decision between definitive therapy (surgery or radiation) and conservative management</td>
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<tr>
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</tbody>
</table>
| 870001550  | Gene expression profile (prostate cancer) Prolaris | 81541        | Prostate cancer gene expression is covered when the following conditions are met:  
  • Low and favorable intermediate risk disease as defined by the National Comprehensive Cancer Network (NCCN)  
  • Test result will help inform treatment decision between definitive therapy (surgery or radiation) and conservative management |
| 870001551  | Gene expression profile (prostate cancer) Decipher prostate cancer classifier assay | 81479        | Is covered if both of the following are true:  
  • The client is post radical prostatectomy.  
  • The test result will help the client decide between active surveillance and adjuvant radiotherapy. |
| 870001419  | Teledermatology | **CPT® code:** 99241-99243, 99251-99253, 99211-99214, 99231-99233. | All the following must be met:  
  • The teledermatology is associated with an office visit between the eligible client and the referring health care provider.  
  • The teledermatology is asynchronous telemedicine and the service results in a documented care plan, which is communicated back to the referring provider.  
  • The transmission of protected health information is HIPPA compliant.  
  • Written informed consent is obtained from the client that store and forward technology will be used and who the consulting provider is.  
  • GQ modifier required. |
<table>
<thead>
<tr>
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</thead>
</table>
| 870001422  | Magnetic Resonance Imaging (MRI) of the sinus for rhinosinusitis | **CPT® code:** 70540, 70542, and 70543 | Criteria for sinus MRI listed below AND client is younger than age 21 OR pregnant:  
- Red Flags; OR  
- Two of the listed persistent symptoms longer than 12 weeks AND failure of medical therapy; OR  
- Surgical planning.  
HCA does not consider repeat scanning to be medically necessary except for Red Flags or Surgical Planning. |
| 870001553  | Magnetic Resonance Imaging (MRI) orbit                 | **CPT® code:** 70540, 70542, and 70543 | Evaluation of one of the following:  
- Suspected or known infection  
- A mass or other structural abnormality |
| 870001423  | Sinus Computed Tomography (CT) for rhinosinusitis      | **CPT® code:** 70450, 70460, 70470, 70486, 70487, and 70488 | • Red Flags OR  
• Two of the listed persistent symptoms longer than 12 weeks AND failure of medical therapy; OR  
• Surgical planning.  
Repeat scanning is not covered except for Red Flags or surgical planning. |
| 870001424  | Caregiver/Birthing parent depression screening         | **CPT® code:** 96160, 96161 | • Caregiver/birthing parent depression screening is required at well-child checkups for caregivers/birthing parents of infants up to age 6 months. Use CPT® code 96161 with EPA.  
• Caregiver/birthing parent depression screening completed by the caregiver’s provider during the 6 months postpartum and billed under the caregiver’s ProviderOne ID number. Use CPT® code 96160 with EPA. |
<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>870001427</td>
<td>Initial psychiatric collaborative care management</td>
<td>CPT® code: 99492</td>
<td>To be used to initiate new episode of care when there has been less than a 6-month lapse in services:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HCPCS code: G0512, G2214</td>
<td>• Provider has identified a need for a new episode of care for an eligible condition</td>
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<td>• There has been less than 6 months since the client has received any CoCM services</td>
</tr>
<tr>
<td>870001428</td>
<td>Subsequent psychiatric collaborative care management</td>
<td>CPT® code: 99493</td>
<td>To be used to continue the episode of care after 6th month when:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HCPCS code: G0512</td>
<td>• Identified need to continue CoCM episode of care past initial 6 months</td>
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<td>• Client continues to improve as evidenced by improved score from a validated clinical rating scale</td>
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<td></td>
<td>• Targeted goals have not been met</td>
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<td></td>
<td>• Patient continues to actively participate in care</td>
</tr>
<tr>
<td>870001537</td>
<td>Enhanced medication for opioid use disorder provider rate</td>
<td>CPT® code: 99202, 99203, 99204,</td>
<td>All the following criteria must apply:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99205, 99211, 99212, 99213, 99214,</td>
<td>The client must have an opioid use disorder diagnosis code listed on the claim.</td>
</tr>
<tr>
<td></td>
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<td>99215, 99251, 99252, 99253, 99254,</td>
<td>The provider meets all the following criteria:</td>
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<td>99255</td>
<td>• Has a DATA 2000 Waiver.</td>
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<td>• Currently uses the waiver to prescribe medication for opioid use disorder to clients with opioid use disorder.</td>
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<td></td>
<td>• Bills for treating a client with a qualifying diagnosis for opioid use disorder.</td>
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<td></td>
<td>• Provides opioid-related counseling during the visit.</td>
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<td>*HCA reimburses the enhancement once per client, per day.</td>
</tr>
<tr>
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<tr>
<td>870001554</td>
<td>Vagus nerve stimulation (VNS)</td>
<td>61885, 61886, 64553, 64568,</td>
<td>For management of epileptic seizures for clients that meet all the following criteria:</td>
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<td></td>
<td>C1822</td>
<td>• Adult or child (age 4 or older)</td>
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<td>• Seizure disorder is refractory to medical treatment, defined as adequate trials of at least three appropriate but different anti-epileptic medications.</td>
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<td></td>
<td>• Surgical treatment is not recommended or has failed.</td>
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</tbody>
</table>
|            |                                      |                              | *These Outpatient Prospective Payment System (OPPS) codes are listed here for providers billing for services using institutional claims. These codes pay as they are set up in OPPS only.
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>870001603</td>
<td>BRCA Genetic Testing</td>
<td>81162, 81163, 81164, 81165, 81166, 81167, 81212, 81215, 81216, 81217</td>
<td>Client must be one of the following:</td>
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<td>• Of any age with a known pathogenic gene variant in a cancer susceptibility</td>
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<td></td>
<td>gene or with a blood relative with a known gene variant in a cancer</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>susceptibility gene</td>
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<td></td>
<td>• Diagnosed at any age with any of the following:</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>o Ovarian cancer</td>
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<td></td>
<td>o Pancreatic cancer</td>
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<td></td>
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<td>o Metastatic prostate cancer</td>
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<td>o Breast cancer or a high grade (Gleason score &gt; 7) prostate cancer</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>and of Ashkenazi Jewish ancestry</td>
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<td>• With a breast cancer diagnosis meeting any of the following:</td>
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<td>o Breast cancer diagnosed &lt; age 50</td>
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<td></td>
<td>o Triple negative breast cancer diagnosed age &lt; age 60</td>
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<td></td>
<td>o Two breast cancer primaries</td>
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<td>o Breast cancer at any age and both of the following:</td>
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<td>➢ One or more close blood relatives* with any of the following:</td>
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<td></td>
<td>▪ Breast cancer &lt; age 50</td>
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<td></td>
<td>▪ Breast cancer in person assigned male at birth</td>
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<td></td>
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<td></td>
<td>▪ Pancreatic cancer</td>
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<td></td>
<td>▪ High grade or metastatic prostate cancer</td>
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<td></td>
<td>➢ Two or more close blood relatives* with breast cancer at any age</td>
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<td>*First-, second-, and third-degree relatives</td>
</tr>
<tr>
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<tr>
<td>870001609</td>
<td>Corneal topography</td>
<td>92025</td>
<td>Limited to two tests per calendar year.</td>
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<td></td>
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<td>Client has one of the following diagnoses:</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Central corneal ulcer</td>
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<td></td>
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<td></td>
<td>• Corneal dystrophy, bullous keratopathy, and complications of transplanted cornea</td>
</tr>
<tr>
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<td></td>
<td>• Diagnosing and monitoring disease progression in keratoconus or Terrien’s marginal degeneration</td>
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<td></td>
<td>• Difficult fitting of contact lens</td>
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<td>• Post-traumatic corneal scarring</td>
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<td></td>
<td>• Pre- and post-penetrating keratoplasty and post kerato-refractive surgery for irregular astigmatism</td>
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<td></td>
<td></td>
<td></td>
<td>• Pterygium or pseudo pterygium</td>
</tr>
<tr>
<td>870001614</td>
<td>Intrauterine balloon</td>
<td><strong>CPT® code:</strong> 59899</td>
<td><strong>Dx:</strong> 072, 072.0, 072.1, 072.2, 072.3</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>To treat postpartum hemorrhage</td>
</tr>
</tbody>
</table>
Mastectomies and reduction mammoplasty

**CPT® codes**

19303, 19318, 19350, 15877, 15860

- CPT® codes 19350, 15877, and 15860 are only allowed if associated with either 19303 or 19318 AND a primary diagnosis code of F64.0, F64.1, F64.2, or F64.9
- Primary diagnosis code must be one of the following: F64.0, F64.1, F64.2, or F64.9
- The client must be age 17 or older to use EPA.
- The following clinical criteria and documentation must be kept in the client's medical record and made available to HCA upon request:
  - Documentation from the surgeon of the client's medical history and physical examination(s) performed within the twelve months before surgery that includes the medical necessity for surgery and the surgical plan.
  - A letter of support from the primary care provider signed and dated within the last 12 months that includes documentation of medical necessity for surgery and confirmation that the client is adherent with current gender dysphoria treatment.
  - One comprehensive psychosocial evaluation. The letter from the mental health provider must be signed and dated within the last 18 months and from a qualified licensed mental health professional as defined in WAC 182-531-1400 (5) who is an eligible provider under chapter 182-502:
    - Psychiatrist
    - Psychologist
    - Psychiatric advanced registered nurse practitioner (ARNP)
    - Psychiatric mental health nurse practitioner-board certified (PMHNP-BC)
<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Licensed mental health counselor (LMHC)</td>
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<td>• Licensed independent clinical social worker (LICSW)</td>
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<td>• Licensed advanced social worker (LASW)</td>
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<td>• Licensed marriage and family therapist (LMFT)</td>
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<td></td>
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<td>• The comprehensive psychosocial evaluation must:</td>
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<td>• Independently confirm the diagnosis of gender dysphoria as defined by the Diagnostic Statistical Manual of Mental Disorders.</td>
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<td>• Document that the client has been evaluated for any coexisting behavioral health conditions and if any are present, the conditions are adequately managed.</td>
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<td>• It is not a requirement that the client has been on hormone therapy and/or lived in a gender role that is congruent with the client’s gender identity for a minimum of 12 months preceding surgery for a mastectomy.</td>
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<tr>
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<td>• For clients age 17, the comprehensive psychosocial evaluation must be performed by a behavioral health provider who specializes in adolescent transgender care and meets the qualifications outlined in WAC 182-531-1400.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• This EPA can only be used once per lifetime.</td>
</tr>
</tbody>
</table>

CPT® codes and descriptions only are copyright 2021 American Medical Association.
<table>
<thead>
<tr>
<th>EPA Number</th>
<th>Service Name</th>
<th>CPT/HCPCS/Dx</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| 870001616   | Genital electrolysis or donor site hair removal and nerve block | **CPT® code:** 17380, 64999 | • CPT® codes 17380 and 64999 only with diagnosis F64.0, F64.1, F64.2, or F64.9  
• Clients must be age 18 and older for genital or donor site hair removal in preparation for gender affirming surgery.  
• Primary diagnosis code must be one of the following: F64.0, F64.1, F64.2, or F64.9.  
• CPT® code 64999 is only allowed if associated with either 17380 AND a primary diagnosis code of F64.0, F64.1, F64.2, or F64.9.  
• The client must be age 18 or older. For clients age 17 and younger, a PA request must be submitted.  
• The following documentation must be kept in the client’s medical record and made available to HCA upon request:  
  • A letter of medical necessity from the treating surgeon. The letter must include the size and location of the area to be treated and expected date of the planned genital surgery; or  
  • A letter of medical necessity from the provider who will perform the hair removal. The letter must include the surgical consult for bottom surgery that addresses the need for hair removal before gender-affirming surgery.  
• Maximum of 156 units for CPT® code 17380 per year.  
• This EPA can only be used for two years per client; additional services would require PA. |
Modifiers

CPT/HCPCS

Note: Italics indicate additional HCA language not found in CPT.

22: **Unusual Procedural Services**: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure code number. This modifier is not to be used to report procedure(s) complicated by adhesion formation, scarring, and/or alteration of normal landmarks due to late effects of prior surgery, irradiation, infection, very low weight, or trauma. For informational purposes only; no extra allowance is allowed.

23: **Unusual Anesthesia**: For informational purposes only; no extra allowance is allowed.

24: **Unrelated Evaluation and Management (E/M) by the Same Physician During a Postoperative Period**: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) **unrelated** to the original procedure. This circumstance may be reported by adding the modifier 24 to the appropriate level of E/M service. Payment for the E/M service during postoperative period is made when the reason for the E/M service is unrelated to original procedure.

25: **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure**: The physician may need to indicate that on the day a procedure or service identified by a CPT® code was performed, the client’s condition required a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. This circumstance may be reported by adding the modifier 25 to the appropriate level of E/M service. Payment for the E/M service is the billed charge or HCA’s maximum allowable, whichever is less.

26: **Professional Component**: Certain procedures are a combination of professional and technical components. When only the professional component is reported, the service is identified by adding modifier 26 to the procedure code.

TC: **Technical Component**: Certain procedures are a combination of professional and technical components. When only the technical component is reported, the service is identified by adding modifier TC to the procedure code. To receive payment, a contract with HCA is required if services are performed in a hospital setting.
32: **Mandated Services**: For informational purposes only; no extra allowance is allowed.

47: **Anesthesia by Surgeon**: Not covered by HCA.

50: **Bilateral Procedure**: Unless otherwise identified in the listing, bilateral procedures that are performed at the same operative session should be identified by adding this modifier to the appropriate five-digit code describing the first procedure.

For surgical procedures typically performed on both sides of the body, payment for the E/M service is the billed charge or HCA’s maximum allowable, whichever is less.

For surgical procedures that are typically performed on one side of the body, but performed bilaterally in a specific case, payment is 150% of the global surgery fee for the procedure.

51: **Multiple Procedures**: When multiple surgeries are performed at the same operative session, total payment is equal to the sum of the following: 100% of the highest value procedure; 50% of the global fee for each of the second through fifth procedures. More than five procedures require submission of documentation and individual review to determine the payment amount.

52: **Reduced Services**: Under certain circumstances, a service or procedure is partially reduced at the physician’s discretion. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of the modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Using this modifier does not reduce the allowance to the provider. **Note**: Modifier 52 may be used with computerized tomography procedure codes for a limited study or a follow-up study.

53: **Discontinued Procedure**: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.

Use of modifier 53 is allowed for all surgical procedures. Modifier 53 is a payment modifier when used with CPT® code 45378 and HCPCS codes G0105 and G0121 only. It is information only for all other surgical procedures.
54, 55, 56 – Providers providing less than the global surgical package should use modifiers 54, 55, & 56. These modifiers are designed to ensure that the sum of all allowances for all practitioners who furnished parts of the services included in a global surgery fee do not exceed the total amount of the payment that would have been paid to a single practitioner under the global fee for the procedure. The payment policy pays each physician directly for that portion of the global surgery services provided to the client. The breakdown is as follows:

54: **Surgical Care Only**: When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number. A specific percentage of the global surgical payment in the fee schedule is made for the surgical procedure only.

55: **Postoperative Management Only**: When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier 55 to the usual procedure number. A specific percentage of the global surgical payment in the fee schedule is made for the surgical procedure only.

56: **Preoperative Management Only**: When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by adding the modifier 56 to the usual procedure number. A specific percentage of the global surgical payment in the fee schedule is made for the surgical procedure only.

57: **Decision for Surgery**: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

58: **Staged or Related Procedure or Service by the Same Physician During the Postoperative Period**: The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding the modifier 58 to the staged or related procedure. **Note**: This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.

59: **Distinct Procedural Service**: Modifier 59 should be used only if no other more specific modifier is appropriate. Effective January 1, 2015, use modifiers XE, XS, XP, and XU in lieu of modifier 59 whenever possible. These modifiers were developed by CMS to provide greater reporting specificity in situations where modifier 59 was previously reported. The physician must indicate that a procedure or service was distinct or separate from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, separate lesion, or separate injury (or area of surgery in extensive injuries).
62: **Two Surgeons:** Under certain circumstances, the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical procedure. Under such circumstances, separate services may be identified by adding modifier 62 to the procedure code used by each surgeon for reporting his/her services. Payment for this modifier is 125% of the global surgical fee in the fee schedule. The payment is divided equally between the two surgeons. Clinical justification must be submitted with the claim. No payment is made for an assistant surgeon.

66: **Team surgery:** For informational purposes only; no extra allowance is allowed.

76: **Repeat Procedure by Same Physician:** The physician may need to indicate that a procedure or service was repeated. This may be reported by adding the modifier 76 to the repeated service.

77: **Repeat Procedure by Another Physician:** For informational purposes only; no extra allowance is allowed.

78: **Return to the Operating Room for a Related Procedure During the Postoperative Period:** The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier 78 to the related procedure. **When multiple procedures are performed, use modifier 78 on EACH detail line.** Payment for these procedures is the percentage of the global package for the intra-operative services. Assistant surgeons and anesthesiologists must use modifier 99 to indicate an additional operating room procedure.

79: **Unrelated Procedure or Service by the Same Physician During the Postoperative Period:** The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier 79.

80: **Assistant Surgeon:** Surgical assistant and/or physician assistant services must be identified by adding modifier 80 to the usual procedure code(s).

81: **Minimum Assistant Surgeon:** Minimum surgical assistant services are identified by adding the modifier 81 to the usual procedure number. Payment is 20% of the maximum allowance.

82: **Assistant Surgeon (When Qualified Resident Surgeon Not Available):** The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s). Payment is 20% of the maximum allowance.
90: **Reference (Outside) Laboratory**:

- When a laboratory sends a specimen to a reference (outside) laboratory, the referring laboratory may bill for the reference laboratory (pass-through billing) by adding modifier 90 to the laboratory procedure code. The reference laboratory NPI must be entered in the Referring Provider Information section on the claim.

- When laboratory procedures are performed by a lab other than the referring lab, the procedure must be identified by adding modifier 90 to the procedure code. The reference lab NPI must be entered in the Rendering (Performing) Provider section on the electronic professional claim. The reference lab must be CLIA-certified.

91: **Repeat Clinical Diagnostic Laboratory Test** performed on the same day to obtain subsequent report test value(s). Modifier 91 must be used when repeat tests are performed on the same day, by the same provider to obtain reportable test values with separate specimens taken at different times, only when it is necessary to obtain multiple results during treatment. When billing for a repeat test, use modifier 91 with the appropriate procedure code.

99: **Multiple Modifiers**: The ProviderOne system can read up to four modifiers on a professional transaction. Add modifier 99 only if there are more than four modifiers to be added to the claim line. If there are four or fewer modifiers on a claim line, do not add modifier 99.

AS: Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery.

CG: Policy criteria applied

FP: **Family Planning**: Used to identify family planning services. HCA requires this modifier with some procedure codes for proper payment.

GB: Claim being resubmitted for payment because it is no longer under a global payment demonstration

HA: Child/Adolescent program

LT: **Left Side**: Used to identify procedures performed on the left side of the body. HCA requires this modifier with some procedure codes for proper payment.

QP: **Documentation is on file showing that the lab test(s) was ordered individually or ordered as a CPT recognized panel other than automated profile codes**. This modifier is now used FOR INFORMATION ONLY. Internal control payment methodology for automated multi-channel test is applied. This modifier is not appropriate to use when billing for repeat tests or to indicate not as a panel.

Q6: **Physician Services**: Services furnished by a locum tenens physician. For informational purposes only; no extra allowance is allowed.
RT: **Right Side**: Used to identify procedures performed on the right side of the body. HCA requires this modifier with some procedure codes for proper payment.

SL: **State-Supplied Vaccine**: This modifier must be used with procedure codes for immunization materials obtained from the Department of Health (DOH).

ST: Related to Trauma or Injury

TC: **Technical Component**: Certain procedures are a combination of professional and technical components. When only the technical component is reported, the service is identified by adding modifier TC to the procedure code. To receive payment, a contract with HCA is required if services are performed in a hospital setting.

TG: **Complex/high level of care**.

TH: **Obstetrical treatment/services, prenatal or postpartum**: Use this modifier for unbundling obstetric care for 1-3 visits. See Billing with modifiers for obstetric care.

TJ: **Child/Adolescent Program**: To be used for enhancement payment for foster care children screening exams.

TS: **Follow-up service**: To be used with procedures and for selected Applied Behavior Analysis (ABA) services (see HCA’s Applied Behavioral Analysis (ABA) Billing Guide).

UA: **Medicaid Care Lev 10 State Def**.

UN: **Two patients served**: To be used with CPT® code R0075.

UP: **Three patients served**: To be used with CPT® code R0075.

UQ: **Four patients served**: To be used with CPT® code R0075.

UR: **Five patients served**: To be used with CPT® code R0075.

US: **Six or more patients served**: To be used with CPT® code R0075.

Use the following modifiers which were developed by CMS to provide greater reporting specificity in situations where modifier 59 was previously reported. Use these modifiers in lieu of modifier 59 whenever possible:

XE: **Separate encounter**: A service that is distinct because it occurred during a separate encounter. This modifier is used only to describe separate encounters on the same date of service.

XS: **Separate structure**: A service that is distinct because it was performed on a separate organ/structure.

XP: **Separate practitioner**: A service that is distinct because it was performed by a different practitioner.

XU: **Unusual non-overlapping service**: A service that is distinct because it does not overlap usual components of the main service.
Anesthesia

AA: Anesthesia services personally furnished by an anesthesiologist. This includes services provided by faculty anesthesiologists involving a physician-in-training (resident). Payment is 100% of the allowed amount. Modifier AA must not be billed in combination with QX.

When supervising, the physician must use one of the modifiers below. Payment for these modifiers is 50% of the allowed amount. Modifier QX must be billed by the Certified Registered Nurse Anesthetist (CRNA).

AD: Medical supervision by a physician for more than four concurrent anesthesia services.

QK: Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.

QS: Monitored anesthesia services.

To bill for monitored anesthesia care services, the following applies:

If the physician personally performs the case, modifier AA must be used, and payment is 100% of the allowed amount.

If the physician directs four or fewer concurrent cases and monitored care represents two or more of the case modifiers, modifier QK must be used, and payment is 50% of the allowed amount.

QS modifier must be used in the second modifier position in conjunction with a pricing anesthesia modifier in the first modifier position.

QX: CRNA service with medical direction by a physician should be used when under the supervision of a physician. Payment is 50% of the allowed amount. This modifier is payable in combination with Modifiers AD or QK, which is used by the supervising anesthesiologist. Modifier QX must not be billed in combination with AA.

QY: CRNA and anesthesiologist are involved in a single procedure and the physician is performing the medical direction. The physician must use modifier QY and the medically directed CRNA must use modifier QX. The anesthesiologist and CRNA each receive 50% of the allowance that would have been paid had the service been provided by the anesthesiologist or CRNA alone.

QZ: CRNA service without medical direction by a physician. Must be used when practicing independently. Payment is 100% of the allowed amount. This modifier must not be billed in combination with any other modifier.
Site-of-Service Payment Differential

How are fees established for professional services performed in facility and nonfacility settings?

Based on the Resource Based Relative Value Scale (RBRVS) methodology, HCA’s fee schedule amounts are established using three relative value unit (RVU) components: work, practice expense, and malpractice expense. HCA uses two levels of practice expense components to determine the fee schedule amounts for reimbursing professional services. This may result in two RBRVS maximum allowable fees for a procedure code. These are:

- **Facility setting maximum allowable fees (FS Fee)** - Paid when the provider performs the services in a facility setting (e.g., a hospital or ambulatory surgery center) and the cost of the resources are the responsibility of the facility.

- **Nonfacility setting maximum allowable fees (NFS Fee)** - Paid when the provider performs the service in a nonfacility setting (e.g., office or clinic) and typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the service performed.

Some services, by nature of their description, are performed only in certain settings and have only one maximum allowable fee per code. Examples of these services include:

- Evaluation and management (E/M) codes which specify the site-of-service (SOS) within the description of the procedure codes (e.g., initial hospital care)

- Major surgical procedures that are generally performed only in hospital settings

How does the SOS payment policy affect provider payments?

Providers billing professional services are paid at one of two maximum allowable fees, depending on where the service is performed.
Does HCA pay providers differently for services performed in facility and nonfacility settings?

Yes. When a provider performs a professional service in a facility setting, HCA makes two payments - one to the performing provider and another to the facility. The payment to the provider (FS Fee) includes the provider’s professional services only. A separate payment is made directly to the facility where the service took place, which includes payment for necessary resources. The FS Fee excludes the allowance for resources that are included in the payment to the facility. Paying the lower FS Fee to the performing provider when the facility is also paid eliminates duplicate payment for resources.

When a provider performs a professional service in a nonfacility setting, HCA makes only one payment to the performing provider. The payment to the provider (NFS Fee) includes the provider’s professional services and payment for necessary resources.

When are professional services paid at the facility setting maximum allowable fee?

Providers are paid at the FS Fee when HCA also makes a payment to a facility. In most cases, HCA follows Medicare’s determination for using the FS Fee. Professional services billed with the following place of service codes are paid at the FS Fee:

<table>
<thead>
<tr>
<th>FACILITY SETTING</th>
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<tbody>
<tr>
<td>Place of Service Code</td>
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<tr>
<td>06</td>
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<tr>
<td>26</td>
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<tr>
<td>31</td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>Place of Service Code</th>
<th>Place of Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td>Hospice</td>
</tr>
<tr>
<td>51</td>
<td>Inpatient Psychiatric Facility</td>
</tr>
<tr>
<td>52</td>
<td>Psychiatric Facility Partial Hospitalization</td>
</tr>
<tr>
<td>53</td>
<td>Community Mental Health Center</td>
</tr>
<tr>
<td>56</td>
<td>Psychiatric Residential Treatment Center</td>
</tr>
<tr>
<td>61</td>
<td>Comprehensive Inpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>62</td>
<td>Comprehensive Outpatient Rehabilitation Facility</td>
</tr>
</tbody>
</table>

**Note:** All claims submitted to HCA must include the appropriate Medicare two-digit place of service code. HCA will deny claims with single-digit place of service codes.

Due to Medicare’s consolidated billing requirements, HCA does not make a separate payment to providers who perform certain services in hospitals and skilled nursing facilities. The facilities are paid at the NFS Fee. Some therapies, such as physical therapy services are always paid at the NFS Fee.
When are professional services paid at the nonfacility setting maximum allowable fee?
The NFS Fee is paid when HCA does not make a separate payment to a facility, such as when services are performed in a provider’s office or a client’s home. In most cases, HCA follows Medicare’s determination for using the NFS Fee.

Professional services billed with the following place of service codes are paid at the NFS Fee:

### NONFACILITY SETTING

<table>
<thead>
<tr>
<th>Place of Service Code</th>
<th>Place of Service Description</th>
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<tbody>
<tr>
<td>04</td>
<td>Homeless Shelter</td>
</tr>
<tr>
<td>05</td>
<td>Indian Health – Free Standing</td>
</tr>
<tr>
<td>07</td>
<td>Tribal 638 – Free Standing</td>
</tr>
<tr>
<td>11</td>
<td>Office</td>
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<tr>
<td>12</td>
<td>Home</td>
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<tr>
<td>13</td>
<td>Assisted Living Facility</td>
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<tr>
<td>14</td>
<td>Group Home</td>
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<tr>
<td>15</td>
<td>Mobile Unit</td>
</tr>
<tr>
<td>20</td>
<td>Urgent Care Facility</td>
</tr>
<tr>
<td>32</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>33</td>
<td>Custodial Care Facility</td>
</tr>
<tr>
<td>49</td>
<td>Independent Clinic</td>
</tr>
<tr>
<td>50</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td>54</td>
<td>Intermediate Care Facility</td>
</tr>
<tr>
<td>55</td>
<td>Residential Substance Abuse Treatment Facility</td>
</tr>
<tr>
<td>57</td>
<td>Nonresident Substance Abuse Treatment Facility</td>
</tr>
<tr>
<td>60</td>
<td>Mass Immunization Center</td>
</tr>
<tr>
<td>Place of Service Code</td>
<td>Place of Service Description</td>
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<tr>
<td>65</td>
<td>End-Stage Renal Disease Treatment Facility</td>
</tr>
<tr>
<td>71</td>
<td>State or Local Public Health Clinic</td>
</tr>
<tr>
<td>72</td>
<td>Rural Health Clinic</td>
</tr>
<tr>
<td>81</td>
<td>Independent Laboratory</td>
</tr>
<tr>
<td>99</td>
<td>Other Place of Service</td>
</tr>
</tbody>
</table>

**Note:** All claims submitted to HCA must include the appropriate Medicare **two-digit place of service code**. HCA will deny claims with single-digit place of service codes.

**Which professional services have a SOS payment differential?**
Most of the services with an SOS payment differential are from the surgery, medicine, and E/M ranges of CPT® codes. However, some HCPCS, CPT radiology, pathology, and laboratory codes also have an SOS payment differential.
Fee Schedule Information

- Maximum allowable fees for all codes, including CPT® codes and selected HCPCS codes, are listed in the fee schedule.

- In the fee schedule, HCA identifies procedure codes that may require prior authorization. However, this list may not be all-inclusive. Prior authorization, limitations, or requirements detailed in HCA billing guides and Washington Administrative Code (WAC) remain applicable.

- HCA’s fee schedules are available for on HCA’s Professional billing guides and fee schedules webpage and the Hospital reimbursement webpage.
Billing

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

What are the general billing requirements?
Providers must follow HCA ProviderOne Billing and Resource Guide.

These billing requirements include, but are not limited to:
- Time limits for submitting and resubmitting claims and adjustments.
- What fee to bill HCA for eligible clients.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- Billing for clients eligible for both Medicare and Medicaid.
- Third-party liability.
- Record keeping requirements.

Billing for multiple services
If multiples of the same procedures are performed on the same day, providers must bill with the appropriate modifier (if applicable) and must bill all the services on the same claim to be considered for payment.

Billing for outpatient hospital services in hospital-based clinics
HCA requires clinics to bill for outpatient services in one of the following ways:
- If the Department of Health (DOH) has not designated the clinic as a hospital-based entity, the clinic must submit to HCA an electronic professional claim containing both:
  - The facility and the professional fees in the Submitted Charges field.
  - The place of service (POS) 11 (office setting) in the Place of Service field.

Medicare and Medicaid policy prohibit the hospital from billing a facility fee in this circumstance. HCA will reimburse the clinic the nonfacility setting fee. This single claim comprises the total payment for the services rendered.
• If DOH has designated the clinic as a hospital-based entity, for HCA to reimburse the clinic and the associated hospital for services provided to clients eligible for Washington Apple Health (Medicaid), the following must happen:
  o The clinic must submit to HCA a professional electronic claim containing both:
    • The professional fees in the Submitted Charges field.
    • POS 22 (outpatient setting) in the Place of Service field.
  o The hospital must submit to HCA an electronic institutional claim with the facility fees in the Total Claim Charge field.

These two billings comprise the total payment for the services rendered.

In the circumstances described above, clinics must follow instructions in this billing guide related to office setting and outpatient services.

How do I resolve issues with gender indicator when billing for transgender clients?

For gender to procedure mismatch: for transgender female with male genitalia

For a transgender client, providers must include an additional diagnosis on the claim that indicates the client is transgender (F64.0, F64.1, F64.2 and F64.9). On a professional claim, diagnosis may be in any diagnosis field on the claim. On an institutional claim, the diagnosis may be in any other diagnosis field. Use of the additional diagnosis allows the gender-specific procedures to be processed through HCA’s claims system. Without the additional diagnosis code, the claim may be denied.

Example situation:
A client self-identifies as a female but still has male specific body parts. This client then gets a routine prostate exam. This bill would deny for a male-only procedure being billed on a female client. However, if a diagnosis such as gender identity disorder was listed as the additional diagnosis, the claim would then be processed for payment.

In these circumstances, providers must bill the diagnosis (F64.0, F64.1, F64.2 and F64.9) as additional on the professional claim or as other on the institutional claim. If a claim is denied for a gender mismatch, see How does the provider notify HCA of a date of birth, date of death, or gender mismatch? On an institutional claim, the “Patient reason for visit” diagnosis may not be used.

Note: Providers should encourage transgender clients to update their gender listed on their Washington Apple Health account by contacting HCA’s Medical Eligibility Determination Services (MEDS) toll free 855-623-9357.
ProviderOne gender indicator does not match claim gender indicator
Such as when a client presents as a female, but ProviderOne has the male gender indicator in file. The provider should check the client’s gender in ProviderOne when verifying coverage. If a mismatch is found, the provider should encourage the client to update the gender field to their preferred gender. The client can do this by calling HCA’s Medical Eligibility Determination Section toll-free 1-855-623-9357.

How does the provider notify HCA of a date of birth, date of death, or gender mismatch?
If a provider finds that there is a discrepancy with a client’s date of birth, date of death, or gender, send a secured email to mmishelp@hca.wa.gov. Include the following information in the email:

- TCN #
- A comment that the client is transgender
- ProviderOne client ID
- Client’s name
- Date of birth
- Gender at birth
- Gender identified as at the time service provided
- Date of death

How does a client update their gender field?
- Clients who applied through the Healthplanfinder must call HCA’s Medical Eligibility Determination Section toll free 1-855-623-9357.
- Clients who applied through the Community Service Office (CSO) must call toll-free 1-877-501-2233 or report online at Washington Connection.

Any Washington Apple Health client can call and choose a gender. Clients should be aware other state agencies, such as the Department of Licensing, have different requirements.

How does a client update or change their name?
Before making a name change, the client should first obtain a name change with Social Security. If the client’s name does not match the client’s name in Social Security, the system will generate an error, and this could affect the client’s coverage.

- Clients who applied through the Healthplanfinder must call toll-free 1-855-623-9357.
• Clients who applied through the Community Service Office (CSO) must call toll-free 1-877-501-2233 or report online at Washington Connection.

If providers have any concerns or question regarding the policy with this benefit, contact HCA by email at transhealth@hca.wa.gov.

**How do I bill claims electronically?**
Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA’s Billers, providers, and partners webpage.

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

**Submitting professional services for Medicare crossovers**
For services paid for, and/or applied to the deductible, by Medicare:

• Medicare should forward the claim to HCA. If the claim is not received by HCA, resolve that issue prior to resubmitting the claim.

• Mark “Yes” for the question, “Is this a Medicare Crossover Claim?” in the electronic claim.

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

• Do not indicate any payment made by Medicare in the Other Payer Information section of the claim. Enter only payments made by non-Medicare, third-party payers (e.g., Blue Cross) in this section and attach the Explanation of Benefits (EOB).

**Note:** If Medicare allowed/paid on some services and denied other services, the allowed/paid services must be billed on a different claim than the denied services. **Exception:** When billing crossover claims for Indian Health Services, follow the instructions in HCA’s Tribal Health Program Billing Guide.
Requirements for the provider-generated EOMB to process a crossover claim

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

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

**Column level labels on the EOMB for the CMS-1500 claim form (version 02/12) must include all the following:**

- The client’s name
- Date of service
- Number of service units (whole number) (NOS)
- Procedure Code (PROC)
- Modifiers (MODS)
- Billed amount
- Allowed amount
- Deductible
- Amount paid by Medicare (PROV PD)
- Medicare Adjustment Reason codes and Remark codes
- Text that is font size 12
Utilization review

Utilization Review (UR) is a concurrent, prospective, and/or retrospective (including post-pay and pre-pay) formal evaluation of a client’s documented medical care to assure that the health care services provided are proper and necessary and are of good quality. The review considers the appropriateness of the place of care, level of care, and the duration, frequency, or quantity of health care services provided in relation to the condition(s) being treated.

HCA uses InterQual: Evidence-Based Clinical Criteria as a guideline in the utilization review process.

- Concurrent UR is performed during a client’s course of care.
- Prospective UR is performed prior to the provision of health care services.
- Retrospective UR is performed following the provision of health care services and includes both post-payment and pre-payment review.
- Post-payment retrospective UR is performed after health care services are provided and paid.
- Pre-payment retrospective UR is performed after health care services are provided but prior to payment.