Washington State Health Care Authority

Washington Apple Health (Medicaid)

Physician-Related Services/Health Care Professional Services

April 1, 2025

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, check the most recent version of the guide. If the broken link is in the most recent guide, notify us at askmedicaid@hca.wa.gov.

About this guide[1]

This publication takes effective **April 1, 2025,** 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.

Confidentiality toolkit for providers

The Washington State Confidentiality Toolkit for Providers is a resource for providers required to comply with health care privacy laws.

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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[1] This publication is a billing instruction.

Copyright disclosure

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.

Subject	Change	Reason for Change
Entire guide	Grammar/punctuation changes	To improve clarity and usability
Integrated Apple Health Foster Care (AHFC)	Corrected acronym for Coordinated Care (CCW). Also added Unaccompanied Refugee Minors (URM) program to the list of clients under the AHFC program	Housekeeping and to update the list of clients under the AHFC program
Radiology modifiers for bilateral procedures	Removed this sentence from the first bullet: "In addition, include modifier LT or RT on the separate lines when the radiological procedure is performed on both sides."	To improve clarity
Screening and monitoring tests for osteopenia/ osteoporosis	Under Medical necessity criteria for initial bone mineral density testing with dual x-ray absorptiometry (DXA), added a third bullet regarding other conditions known to be associated with low bone mass to the list of criteria any individual must have	To better align this policy with the HTCC decision
Radiopharmaceutical: Diagnostic imaging agents	Reformatted and revised section	To clarify HCA's policy. This is not a policy change.

Subject	Change	Reason for Change
COVID-19 molecular and antigen testing	Removed policy that ended on March 31, 2025	To align with evidence-based practices. HCA pre-released the April 1, 2025, effective policy on January 1, 2025.
Drug Testing for Substance Use Disorder	• Rewrote the entire section • Changed 16 definitive test limitation to 12 definitive tests • Added that HCA now reimburses HCPCS codes G0480, G0481, G0482, and G0483, at the same rate • Moved information regarding treatment of chronic noncancer pain under a new heading named *Drug screening for chronic noncancer pain*	• To clarify HCA's policy and improve usability • Coverage policy change • Reimbursement policy change • To improve clarity and usability
Targeted TB testing with interferon-gamma release assays	Replaced medical necessity criteria and deleted fee-for-service (FFS) billing instructions and documentation requirements sections, including reference to EPA# 870001325	To align with evidence-based practice for TB testing. EPA is no longer allowed for this service.
What documentation is required to continue as a qualified COE for hemophilia treatment?	In the intro to the bulleted list, changed "every two years" to "annually"	To align with WAC 182-531-1625. This is not a change in policy.
Radiopharmaceutical: Therapeutic	Added the section using information previously located in the *Radiopharmaceutical diagnostic imaging agents* section	To add clarity and usability. This is not a policy change.

Subject	Change	Reason for Change
Miscellaneous prosthetics and orthotics	Deleted HCPCS code L8010 from table	CMS discontinued this HCPCS code.
Some forms available to submit PA requests	Removed *Application for Chest Wall Oscillator, 13-841* from list	Reference to this form was moved to HCA's *Respiratory Care Billing Guide*
EPA# 870001381	Removed EPA number	HCA discontinued this EPA number.

Table of Contents

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.

Actual acquisition cost (AC) – See WAC 182-530-1050.

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.

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. **For example:** If a service is allowed once per client, per **calendar year**, and it was provided on June 30, 2022, then the service would not be allowed for that client again until January 1, 2023.

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.

Health Technology Clinical Committee (HTCC) – See RCW 70.14.090.

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.

HTCC - See Health Technology Clinical Committee.

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.

Medically necessary – See WAC 182-500-0070.

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.

Provider – See WAC 182-500-0085.

Qualifying clinical trial – A phase I, phase II, phase III, or phase IV clinical trial that is approved, conducted, or supported by one or more of the following: the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, or a qualified research study that meets the criteria for NIH Center Support Grant eligibility.

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.

Routine costs - Items and services delivered to the client that are consistent with and typically covered by the plan or coverage for a client who is not enrolled in a clinical trial, including items or services provided to prevent, diagnose, monitor, or treat complications resulting from participation in the trial, to the extent that it would otherwise be covered.

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. **For example**: If a service is allowed once per client, per **year**, and it was provided on June 30, 2022, then the service would not be allowed for that client again until June 30, 2023.

Introduction

Actual acquisition cost

Drugs with an actual acquisition cost (AAC) 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 AAC 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 AAC 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.

Conversion factors

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

Diagnosis codes

HCA requires valid and complete ICD diagnosis codes. When billing HCA, use the highest level of specificity (6th or 7th digit 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:

- The American Medical Association's (AMA) Current Procedural Terminology (CPT) manual
- 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

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) Z codes

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 under Washington state law to practice any of the following:
  - Dentistry
  - Medicine and osteopathy
  - Nursing
  - Optometry
  - Podiatry
  - Psychiatry
  - Psychology

Can naturopathic physicians provide and bill for physician-related services?

Yes. 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:
  - Nonsurgical cosmetic procedures.
  - 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 reciprocal billing or fee-for-time compensation (formerly known as locum tenens) arrangements be billed for physician-related services?

Yes. HCA follows Medicare's rules for reciprocal billing and fee-for-time compensation arrangements (formerly known as locum tenens arrangements) found in **CMS Pub 100-04, Changes to the Payment Policies for Reciprocal Billing Arrangements and Fee-for-Time Compensation Arrangements (formerly referred to as Locum Tenens Arrangements)**. To be paid for services provided to Apple Health (Medicaid) clients, all providers must be enrolled as Apple Health (Medicaid) providers. For enrollment information, go to the **Enroll as a provider webpage**.

The billing provider must use one of the following modifiers when billing for reciprocal billing or fee-for-time compensation arrangements:

Modifier	Description
Q5	Service furnished under a reciprocal billing arrangement by a substitute physician
Q6	Service furnished under a fee-for-time compensation arrangement by a substitute physician

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.

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 the practitioners listed above for physician-related and health care professional services only if those services are provided to clients who are eligible for one of the following programs and the service is mandated under the program:

- 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 pay 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:

- **Online**: Go to Washington Healthplanfinder - select the "Apply Now" button. For patients age 65 and older or on Medicare, go to Washington Connections select the "Apply Now" button.
- **Mobile app:** Download the WAPlanfinder app – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 1-855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, Forms & Publications webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Support (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the Health Benefit Exchange Navigator.

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

Yes. Most Apple Health clients are enrolled in one of HCA's contracted managed care organizations (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

Apple Health clients are enrolled in an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may start their first month of eligibility in the fee-for-service (FFS) program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination. **Exception:** Apple Health Expansion clients are enrolled in managed care and will not start their first month of eligibility in the FFS program. For more information, visit Apple Health Expansion. 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. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to **HCA's Apply for or renew coverage webpage**.

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

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 Apple Health clients do not meet the qualifications for managed care enrollment. These clients are eligible for physical health services under the fee-for-service (FFS) program.

In this situation, each managed care plan will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in integrated managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an integrated 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 program will reimburse providers for the covered services. 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

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).

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's (CCW) Apple Health Core Connections Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 18 who are in foster care (out of home placement) or in the Unaccompanied Refugee Minors (URM) program
- 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 Adoption Support (FCAS) team at 1-800-562-3022, Ext. 15480.

Apple Health Expansion

Individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs and who receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contract health plan. For more information, visit Apple Health Expansion.

See also **Apple Health expansion enrollees age 19 and 20** in this guide for coverage outside of HCA's contracted health plans.

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) Well-Child Program 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 HCA's **Pregnancy-Related Services Billing Guide**)
- Office visits
- Osteopathic treatment services
- Pathology and laboratory services
- 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
- A mammogram performed according to nationally recognized clinical guidelines
- A 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 a core provider 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).

Coverage of routine costs associated with qualifying clinical trials

General information

In 2020, Congress passed the Clinical Treatment Act, with the intent of expanding clinical trial access to Medicaid beneficiaries. The Consolidated Appropriations Act of 2021 amended section 1905 of the Social Security Act to state that routine costs associated with qualified clinical trials must be covered for Medicaid beneficiaries.

How does this differ from current practice for Apple Health?

Fee-for-service

There is no change in payment for routine costs related to clinical trials for fee-for-service (FFS) clients, as these costs have traditionally been covered under the Medicaid State Plan, the CHIP State Plan, a waiver, or a demonstration project before the January 1, 2022, Act took effect.

Managed care organizations

Managed care organizations (MCOs) may have differed in their coverage of routine costs related to clinical trials, depending on the MCO. However, MCOs are now required to follow the coverage policy for routine costs associated with clinical trials as mandated in the new Act.

What are considered routine costs?

The following are considered routine costs:

- Any item or service that would otherwise be covered outside the course of participation in the Medicaid State Plan, the CHIP State Plan, a waiver, or a demonstration project under section 1115 of the Social Security Act
- Any item or service provided to a client enrolled in a clinical trial that is provided to prevent, diagnose, monitor, or treat complications resulting from the participation in the clinical trial
- Any item or service provided to a client enrolled in a clinical trial that is required solely for the provision of the investigational drug, item, device, or service

What costs are not considered routine costs?

Routine costs do not include ANY of the following:

- The investigational item or service itself
- Items and services for the purpose of determining eligibility for the study that are not related to medically necessary clinical care
- Items and services customarily provided by the research sponsors free-of-charge for any enrollee in the trial and items provided by the research sponsors free-of-charge for any person enrolled in the trial
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the client. Examples include, but are not limited to, laboratory tests and imaging studies done at a frequency dictated by the study protocol and not consistent with signs and symptoms and other standards of care for that diagnosis or treatment type.
- Items and services not covered under the clients benefit service package, not allowed per Washington Administrative Code (WAC), or not covered in the Medicaid State Plan.

What is considered a "qualified clinical trial"?

According to **CMS guidance**, a qualified clinical trial is all the following:

- A Phase I, Phase II, Phase III, or Phase IV clinical trial (see **Glossary of common site terms** for a definition of each phase.)
- A trial being conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition
- A clinical trial that meets the following requirements (see *Qualifying clinical trial* in **SMD #21-005**.):
    - A study or investigation that is approved, conducted, or supported (including by funding through in-kind contributions) by one or more of the following:
        - The National Institutes of Health (NIH)
        - The Centers for Disease Control and Prevention (CDC)
        - The Agency for Health Care Research and Quality (AHRQ)
        - The Centers for Medicare & Medicaid Services (CMS)
        - A cooperative group or center of any of the previously listed entities or the Department of Defense or the Department of Veterans Affairs

    - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants[2]
  - A clinical trial, approved or funded by any of the following entities, that has been reviewed and approved through a system of peer review that the secretary of the Department of Health and Human Services determines comparable to the system of peer review of studies and investigations used by the NIH, and that assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review:
    - The Department of Energy
    - The Department of Veterans Affairs
    - The Department of Defense
  - A clinical trial that is one conducted pursuant to an investigational new drug exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act
  - A clinical trial that is a drug trial exempt from being required to have one of the exemptions in the previous bullet

Attestation form process

- Participation itself in a clinical trial is not subject to prior authorization. However, the principal investigator (or their delegated authority if they have a documented process) and the administering provider must attest that the clinical trial meets the definition of a qualified clinical trial and is the appropriate clinical trial for the client's condition.
- HCA requires the CMS attestation form, per CMS, before the start of ALL clinical trials.
- Providers may use the attestation form found on **CMS's website** or HCA's Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial (HCA 13-0103) found on **HCA's Forms & Publications webpage**.
- It is the provider's responsibility to submit the attestation form at the start of the clinical trial. Providers must keep this form on file as part of the medical record for clinical trial participants for compliance purposes.
- The researcher or the client's provider must manage the procurement of the forms. Apple Health is not responsible for providing forms.

[2] While section 210 of the Consolidated Appropriations Act references a qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants, NIH has clarified that no such guidelines exist.

How do I submit completed forms?

When submitting completed forms:

- Fax attestation forms for fee-for-service clients to (866) 668-1214 or submit them via the Provider One portal.
- For managed care clients, contact the client's plan for their attestation form process.

> **Note**: HCA does not require an attestation form for clients enrolled in a clinical trial before July 1, 2022. Retroactively submit forms for clients enrolled after July 1, 2022, as outlined above.

Prior authorization

- Participation in the clinical trial itself does not require prior authorization (PA) but does require the attestation form to be on file in the agency or MCO system.
- All utilization management rules and coverage policies that apply to routine care for clients not in clinical trials also apply to routine patient care for clients in clinical trials. See Prior authorization.
- PA requests for routine services or items are processed according to HCA's PA process. If the routine item or service is needed urgently, indicate this on the first page of the PA request.
- To ensure that HCA can process these in a timely manner, note the following:
  - Providers must indicate on the first page of the request that it is related to a clinical trial.
  - Providers must include all required documentation with the request. HCA rejects incomplete requests, which delays processing.
  - Providers do not need to send the attestation form with each request. However, if there is no attestation form on file, HCA will reject the request, which will delay processing.

FFS billing instructions

Claims for services and items for FFS clients enrolled in a clinical trial must be submitted with one of the following modifiers:

- **Q0: Investigational clinical service/item provided in an approved clinical research study**. HCA does not reimburse for services and items submitted with the Q0 modifier.
- **Q1: Routine clinical service/item provided in an approved clinical research study**. HCA reimburses for services and items submitted with the Q1 modifier, subject to medical necessity and established PA criteria.

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

HCA does not cover the following:

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

For a complete list of noncovered services, see WAC 182-501-0070 and 182-531-0150.

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

Billable Services Provided by Teaching and Resident Physicians

HCA follows Medicare's rules for teaching physicians and residents found in the current version of the Centers for Medicare and Medicaid Service's (CMS's) Guidelines for Teaching Physicians, Interns & Residents Medical Learning Network booklet.

What are the billing requirements for teaching physicians?

Providers must identify the primary physician 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.

What are the general documentation guidelines?

The teaching physician and the resident physician must document the services rendered in the client'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

After providing the service, providers must include in the client's medical record documentation of either of the following:

- The teaching physician's physical presence during the provision of services
- The teaching physician's virtual presence if present via audio-video real-time technology, including telehealth services, during the provision of services. The client's medical record must indicate the specific part of the service performed while the teaching physician was present via audio/video real-time technology.

Does HCA allow the primary care exception (PCE)?

Yes. The PCE enables a teaching physician to work with a resident physician providing services outside of the sponsoring teaching facility (such as a private practice) as follows:

- The teaching physician-to-resident ratio must be 1:1.
- Under the PCE, the teaching physician must use only medical decision making (MDM) to select the E/M visit level.
- 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 may 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.
- Teaching physicians may direct, manage, and review care furnished by residents through audio/video real-time communications technology for the following CPT® codes only:
    - 99202
    - 99203
    - 99211
    - 99212
    - 99213

    For all other procedure codes, the teaching physician must always be on-site.
- The teaching physician must review the care provided; this includes the client's medical history and diagnosis review, physical examination finding, and treatment plan. The teaching physician must countersign the resident physician's documentation, assuring the resident has documented the services appropriately.

Which CPT® codes may be billed?

HCA considers the following CPT® codes 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

Note: Claims must comply with requirements found in the General documentation guidelines and in *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 the 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 current coding guidelines. 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

Service procedure codes

CPT® codes: 99497 and 99498

HCPCS code: S0257

Medical necessity criteria

HCA considers counseling and discussing advanced directives or portable orders for life-sustaining treatment (POLST) to be medically necessary when provided by a qualified health care profession (QHP). Providers must follow standard coding practices when billing and follow applicable agency rules. Refer to the current CPT® book for complete code descriptions, definitions, and guidelines

Fee-for-Service (FFS) billing instructions

HCA provides separate reimbursement for these care planning services for end-of-life treatment in addition to the appropriate E/M code.

General billing information

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.

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 allows 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 allows 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 covers 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 covers 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

Providers must be enrolled with ProviderOne to claim and receive payment for ABD Evaluation Services. 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 Department of Social and Health Service's (DSHS's) Medical evidence requirements and reimbursements webpage.

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

Collaborative care model guidelines

Collaborative care

The following are HCA's 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

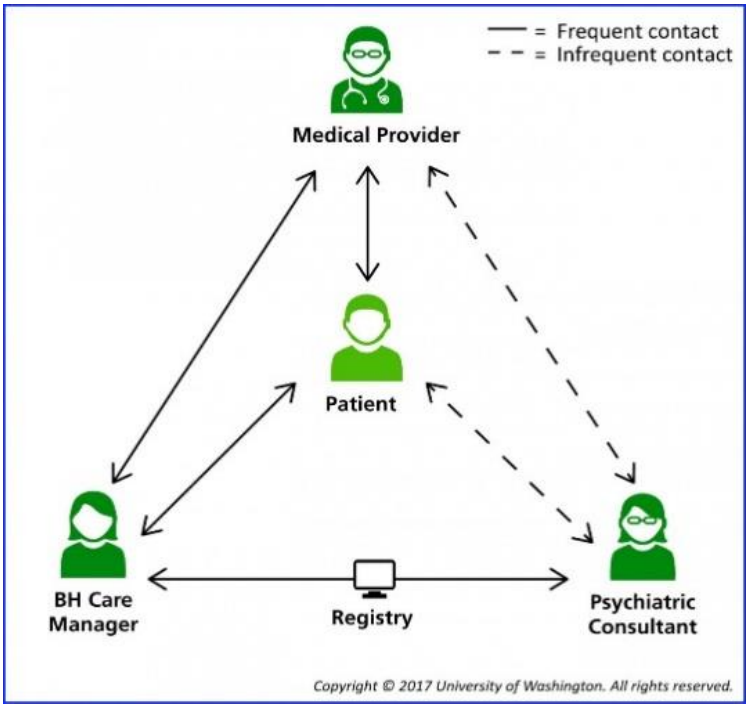
Primary care and behavioral health providers collaborate with shared care plans that incorporate patient goals. The ability to get both physical and behavioral health care at a familiar location is comfortable to patients and reduces duplicate assessments. Increased patient engagement oftentimes results 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 (Servicing) 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. **Note:** The servicing provider could be the billing provider if the servicing provider also does the billing.
- **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.

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 services/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 the 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 a 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 a 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.**

CPT® code 99493

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:

- Tracking client follow-up and progress using the registry, with appropriate documentation
- Participation in weekly caseload consultation with the psychiatric consultant
- 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

- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant
- 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.

Documentation: Documentation must include all the following:

- Clients progress towards goals
- Updated results of the validated clinical rating scales being utilized
- Modifications to treatment as appropriate

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.

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:

- 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 a 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).

CPT® code 99494

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

Documentation: Documentation must include all the following:

- Client's progress towards goals
- Updated results of the validated clinical rating scales being used
- Modifications to treatment as appropriate

Billing: 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.

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:

- Use for additional 30 minutes of behavioral health care manager activities.
- CPT® code 99494 to be used with CPT® code 99492 or CPT® code 99493.

HCPCS code G0512

FQHC & RHC - Psychiatric Collaborative Care Model services: Minimum of 60 minutes per calendar month

With the following required elements:

Service elements provided by CoCM team for CoCM services must include all the following:

- 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 HER.
- 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 a 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.

Use **PA** after 12 months of CoCM services.

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

Service procedure codes

CPT® code 99483

Medical necessity criteria

HCA considers comprehensive assessment and care planning for persons living with cognitive impairment to be medically necessary. 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, G31.83, G31.84, and G31.85. Providers must follow standard coding practices when billing and follow applicable agency rules.

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal infections (PANDAS) and Pediatric acute-onset neuropsychiatric syndrome (PANS)

Medical necessity criteria

Diagnosis and treatment of PANS/PANDAS requires a multidisciplinary team. (See PANS/PANDAS clinician resources.) Before starting intravenous immunoglobulin therapy, follow published clinical guidelines to diagnose and treat PANS/PANDAS. (See Clinical Approach to the Diagnosis of Autoimmune Encephalitis in the Pediatric Patient.)

HCA considers up to three monthly intravenous immunoglobulin therapies to be medically necessary when all the following are met:

- A trial of two or more separate categories of less-intensive treatment was not effective, not tolerated, or did not result in sustained improvement in symptoms (as measured by a validated instrument with lack of clinical improvement). (See PANDAS AND PANS: Clinical, Neuropsychologic, and Biological Characterization of a Monocentric Series of Patients and Proposal for a Diagnostic Protocol.) Categories of treatment consist of a limited course of any of the following:
  - Nonsteroidal anti-inflammatory drugs (NSAIDs)
  - Corticosteroids
  - Selective serotonin reuptake inhibitors (SSRIs)
  - Behavioral therapy
  - Short-course antibiotic therapy)

  These treatments may be done concurrently. (See *Table 2: Treatments Proposed for PANDAS AND PANS* in the Health Evidence Review Commission's (HERC's) Coverage Guidance for PANDAS/PANS, dated May 19, 2022.)
- Received a consultation with and recommendation from a pediatric subspecialist (e.g., pediatric neurologist, pediatric psychiatrist, neurodevelopmental pediatrician, pediatric rheumatologist, or pediatric allergist/immunologist) as well as the recommendation of the patient's primary care provider (e.g., family physician, pediatrician, pediatric nurse practitioner, or naturopath). The subspecialist consultation may be a teleconsultation. For adolescents, an adult subspecialist consult may replace a pediatric subspecialist consult.

A re-evaluation at 3 months by both the primary care provider and pediatric subspecialist is required for continued therapy of IVIG. This evaluation must include clinical testing with a validated instrument, which must be performed pretreatment and posttreatment to demonstrate clinically meaningful improvement as indicated by the validated instrument.

If the client does not meet these criteria, prior authorization (PA) is required. HCA reviews requests for PA in accordance with WAC 182-501-0165.

Fee-for-service (FFS) billing instructions

See HCA's **Physician-related services/professional health care services fee schedule** for procedure codes, authorization requirements, and maximum allowable fees.

Documentation requirements

Providers must keep the following documentation in the client's record:

- Documentation that supports meeting the diagnostic criteria of PANDAS/PANS according to a recognized consensus group (e.g., PANDAS Physician Network, The Nordic Pediatric Immunopsychiatry Group, etc.)
- Trial of two or more less intensive treatments (See *Table 2: Treatments Proposed for PANDAS AND PANS* in the Health Evidence Review Commission's (HERC's) Coverage Guidance for PANDAS/PANS, dated May 19, 2022.)
- Consultation from pediatric subspecialist
- Recommendation from the client's primary provider
- Validated instrument measurement tool after trial of two or more less intensive treatments (pretreatment reading) (See PANDAS AND PANS: Clinical, Neuropsychologic, and Biological Characterization of a Monocentric Series of Patients and Proposal for a Diagnostic Protocol.)
- Start date of IVIG therapy
- Pretreatment and post-treatment clinical testing reading from a validated measurement tool
- Re-evaluation at 3 months by both primary care provider and pediatric subspecialist with clinical testing from a validated instrument

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 E/M and vaccine enhancement

A primary care provider rate increase is available for vaccine administration and certain pediatric care services for clients age 20 and younger.

Physician and nonphysician practitioners who do not already receive enhanced rates or supplemental payments are eligible for the increase.

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 assumes 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.

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.

Adult E/M enhancement
An adult E/M enhancement is available for vaccine administration and certain adult care services for clients age 21 and older.

Physician and nonphysician practitioners who do not already receive enhanced rates or supplemental payments are eligible for the increase.

To view the *Enhanced adult primary care fee schedule*, see HCA's **Provider billing guides and fees schedules webpage**. Scroll down 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.

Habilitative services
See HCA's **Habilitative Services Billing Guide**.

Home services

Home or residence evaluation and management

Service procedure codes

CPT® codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, and 99350

Medical necessity criteria

HCA considers home or residence evaluation and management to be medically necessary. Providers must follow standard coding practices when billing and follow applicable agency rules.

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

Initial Hospital Inpatient or Observation Care

Service Procedure Codes

CPT® codes: 99221, 99222, and 99223

Medical Necessity Criteria

HCA considers initial hospital inpatient or observation care to be medically necessary. Providers must follow standard coding practices when billing and follow applicable agency rules.

Subsequent Hospital Inpatient or Observation Care

Service Procedure Codes

CPT® codes: 99231, 99232, and 99233

Medical Necessity Criteria

HCA considers subsequent hospital inpatient or observation care to be medically necessary. Providers must follow standard coding practices when billing and follow applicable agency rules.

Hospital Inpatient or Observation Care Services – admission and discharge on the same date

Service Procedure Codes

CPT® codes: 99234, 99235, and 99236

Medical Necessity Criteria

HCA considers hospital inpatient or observation care – admission and discharge on the same date to be medically necessary. Providers must follow standard coding practices when billing and follow applicable agency rules.

Hospital Inpatient and Observation Discharge Services

Service Procedure Codes

CPT® codes 99238 and 99239

Medical Necessity Criteria

HCA considers hospital inpatient or observation services on the same date to be medically necessary. Providers must follow standard coding practices when billing and follow applicable agency rules.

> **Note:** 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.

> **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.

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 fee schedule and the Physician-related services/professional health care services fee schedule for details.

Newborn care

Service procedure codes

CPT® codes 99460, 99461, 99462, and 99463

Medical necessity criteria

HCA considers newborn care to be medically necessary when the client is younger than 29 days old.

Fee-for-service (FFS) billing instructions

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.

Use newborn diagnosis codes as the primary diagnosis during the newborn 28-day period. After 28 days and throughout the life of the patient, providers may use a newborn code as an additional diagnosis if the condition is still present.

General billing information

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**.

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

Service procedure codes

CPT® codes 99424, 99425, 99437, and 99491

Medical necessity criteria

HCA considers physician supervision of principle care management services or chronic care management services to be medically necessary as follows:

For physician supervision of principal care management services, all the following must be met:

- One complex chronic condition is expected to last at least 3 months, and places the client at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death.
- The complex chronic condition requires development, monitoring, or revision of the disease-specific care plan.
- The condition requires frequent adjustments in the medication regimen, or the management of the condition is unusually complex due to comorbidities, or both.
- Ongoing communication and care coordination between relevant practitioners furnishing care is provided by the billing provider.
- The first 30 minutes are personally provided by a provider, per calendar month.

For physician supervision of chronic care management services, all the following must be met:

- Two of more chronic conditions are expected to last at least 12 months, or until the death of the client.
- The chronic conditions place the client at significant risk of death, acute exacerbation/decompensation, or functional decline.
- Comprehensive care plan has been established, implemented, revised, or monitored.
- The first 30 minutes are personally provided by a provider, per calendar month.

Fee-for-service (FFS) billing instructions

Do not bill physician supervision of principle care management and chronic care management services together in the same calendar month for the same client.

If the medical necessity criteria for physician supervision of principal care management services are met, bill with EPA# 870001676. If medical necessity criteria for physician supervision of chronic care management services are met, bill with EPA# 870001677. If the client does not meet the EPA criteria, prior authorization is required.

Prolonged services

Prolonged services with direct patient contact

HCA covers prolonged services:

- Up to three hours per client, per diagnosis, per day.
- Following CMS guidelines for HCPCS codes G0316, G0317, G0318, and G2212. Providers must follow coding rules.

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.

Remote patient monitoring (RPM)

Service procedure codes

CPT® codes 99453, 99454, 99457, 99458, and 99091

Medical necessity criteria

- **Client-specific criteria.** The client must exhibit at least one of the following risk factors in each category:
  - Health care utilization:
    - Two or more hospitalizations in the prior 12-month period
    - Four or more emergency department admissions in the prior 12-month period
  - Other risk factors that present challenges to optimal care:
    - Limited or absent informal support systems
    - Living alone or being home alone for extended periods of time
    - A history of care access challenges
    - A history of consistently missed appointments with health care providers
- **Device-specific criteria.** The device must have both of the following:
  - Capability to directly transmit patient data to provider
  - An internet connection and capability to use monitoring tools

- **Disease-specific criteria.** In addition to meeting the previously defined general criteria, the client must have a qualifying diagnosis of congestive heart failure, chronic obstructive pulmonary disease, or hypertension.
  - Congestive heart failure (CHF): RPM to identify early signs or symptoms of decompensation
    - New York Heart Association (NYHA) class I-IV chronic, symptomatic heart failure; must be in stable condition and on optimized therapy
  - Chronic obstructive pulmonary disease (COPD): RPM for the purpose of monitoring COPD symptoms and health status
    - Clinical diagnosis of moderate to very severe (GOLD II–IV) COPD
  - Hypertension (HTN): RPM for the purpose of management of uncomplicated HTN
    - Client has been diagnosed with stage 1 or 2 HTN.

Fee-for-service (FFS) billing instructions

If medical necessity criteria are met, bill with EPA #**870001640**. If the medical necessity criteria are not met, prior authorization is required.

Quantitative limits

- Authorize for up to 180 days of monitoring.
- CPT® code 99453—may be billed 1x/episode
- CPT® codes 99454, 99457, and 99091—may be billed 1x/calendar month
- CPT® code 99458—follow coding rules

Documentation requirements

- Informed consent

General billing information

- CPT® code 99453 is encounter-eligible when performed by a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) encounter-qualified provider. Other RPM procedure codes are not RHC- or FQHC-encounter eligible.
- Direct Indian Health Service (IHS) Clinics, Tribal Clinics, and Tribal FQHCs—refer to HCA's **Tribal Health Billing Guide** to determine if the service qualifies for the IHS encounter rate.

Telemedicine

Refer to HCA's Provider Billing Guides and Fee Schedules webpage, under *Telehealth*, for more information on the following:

- Telemedicine policy, billing, and documentation requirements, under *Telemedicine policy and billing*
- Audio-only procedure code lists, under *Audio-only telemedicine*

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.
    - **Surgery:** The teaching physician's presence is not required during opening and closing of the surgical field.
    - **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:** Anesthesia provided in a hospital setting is paid by the MCO. Bill the MCO directly for dental anesthesia.

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.

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:

Payment Calculation
A. Multiply base units by 15.
B. Add total minutes to value from step A.
C. Divide anesthesia conversion factor by 15, to obtain the rate per minute.
D. Multiply total from Step B by the rate per minute in Step C.

The 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/professional health care 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 59, XE, XS, XP, or XU with any of the following CPT® codes.

CPT® code
11981*
11982*
11983*
20526*
20550
20551
20552
20553
20600
20605

CPT® code
20610
20612
27096
61790*
62264*
62270
62272
62273*
62280*
62281*
62282*
62284
62290
62291
62320*
62322*
62324*
62326*
62350*
62351*
62355*
62360*
62361*
62362*
62365*
63650*
63655*
63685*
63688*
64400*
64402*
64405*
64408*
64410*
64412*
64413*
64415*
64416*
64417*
64418*
64420*

CPT® code
64421*
64425*
64430*
64435*
64445*
64446*
64447*
64448*
64449*
64450*
64479*
64480*
64483*
64484*
64505*
64508*
64510*
64517*
64520*
64530*
64553*
64555*
64561*
64565*
64575*
64580*
64581*
64585*
64590*
64595*
64600*
64605*
64610*
64612*
64616*
64617*
64620*
64630*
64680*
64681*
64802*

CPT® code
64804*
64809*
64818*

Other Services

CPT® code
36400
36420
36425
36555
36566
36568
36580
36584
36589
36600
36620
36625
36660
62263
62287
63600
76000
76496
77001
77002
77003
93503
95970
95990

These CPT® codes are paid as a procedure using HCA's maximum allowable fee, not with base units and time.

Interoperative or postoperative therapeutic pain management

Service procedure codes

CPT® codes: 62320, 62321, 62322, 62323, 62324, 62325, and 62327

Medical necessity criteria

HCA considers therapeutic spinal injection or infusion for pain management to be medically necessary when used intraoperatively or postoperatively.

Fee-for-service (FFS) billing instructions

If medical necessity criteria are met, use EPA# 870001351. If the client does not meet the EPA criteria, prior authorization (PA) is required (see Prior authorization).

Peripheral nerve ablation

Based on review of the evidence provided by HTCC (20190118B—Peripheral Nerve Ablation for Limb Pain), 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 (RNFAs) are allowed to assist 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

CPT® Code	Short Description
99211-99223	Office visits, initial hospital observation care, and initial hospital inpatient care
99231-99239	Subsequent hospital care, observation or inpatient care services, and hospital discharge services
99241-99245	Office consultations
99291-99292	Critical care services
99307-99310	Subsequent nursing facility care
99324-99337	Domiciliary, rest home, or custodial care services
99347-99350	Home services

Ophthalmological Services

CPT® Code	Short Description
92012-92014	General ophthalmological services

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:

Modifier	Description
24	Unrelated E/M service by the same physician during a postoperative period (reason for the E/M service must be unrelated to the procedure)
25	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)
57	Decision for surgery (only applies to surgeries with a 90-day global period)

- 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.
  - 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 the 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 all the following:

- 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.

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).

Cardiovascular system

Angioscopy

Service procedure codes

CPT® code 35400

Medical necessity criteria

HCA considers angioscopy to be medically necessary. Providers must follow standard coding practices when billing and follow applicable agency rules.

Apheresis

Service procedure codes

CPT® codes 36511, 36512, 36513, 36514, 36516, and 36522

Medical necessity criteria

HCA considers apheresis to be medically necessary. Providers must follow standard coding practices when billing and follow applicable agency rules.

Cardiac stents

Service procedure codes

Professional claims

CPT® codes 92928, 92929, 92933, 92934, 92937, 92938, 92941, 92943, and 92944

Institutional claims

HCPCS codes C1874*, C1875*, C9600* C9601*, C9602*, C9603*, C9604*, C9605*, C9607*, and C9608*

*These Outpatient Prospective Payment System (OPPS) procedure codes are listed for providers billing for services using institutional claims. These procedure codes **pay only in OPPS**. See the fee schedule.

Medical necessity criteria

Based upon review of evidence provided by HTCC (20160115B—Cardiac Stents—Re-Review), HCA considers cardiac stents to be medically necessary with the follow criteria:

- Drug eluting stents (DES) or bare metal stents (BMS) are indicated for treatment.
- For patients being treated for stable angina, cardiac stenting with DES or BMS, with the following conditions:
  - Angina refractory to optimal medical therapy
  - Objective evidence of myocardial ischemia

Fee-for-service (FFS) billing instructions

When billing for cardiac stents, use one of the following place of service (POS) codes:

- 19—Off Campus-Outpatient hospital
- 21—Inpatient hospital
- 22—On Campus-Outpatient hospital

If the medical necessity criteria and the POS requirement are met, use EPA #870000422. If the client does not meet the EPA criteria, PA is required.

Carotid artery stenting

Service procedure codes

CPT® codes 37215 ,37216, 37217, 37246, and 37247

Medical necessity criteria

Based upon review of **evidence provided by HTCC (20130920B—Carotid Artery Stenting)**, HCA considers extracranial carotid artery stenting to be medically necessary when clients are at high surgical risk for carotid endarterectomy (CEA) and have one of the following:

- Symptomatic carotid artery stenosis >50%
- Asymptomatic carotid artery stenosis ≥80%

HCA does not consider carotid artery stenting to be medically necessary when performed for intracranial arteries.

General billing information

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

Extracorporeal membrane oxygenation therapy (ECMO)

Service procedure codes

CPT® codes 33946, 33947, 33948, 33949, 33951, 33952, 33953, 33954, 33955, 33956, 33957, 33958, 33959, 33962, 33963, 33964, 33965, 33966, 33969, 33984, 33986, 33987, 33988, and 33989

Medical necessity criteria

Based upon review of evidence provided by HTCC (20160318A—Extracorporeal Membrane Oxygenation Therapy [ECMO]), 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.

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:
  - The client is at end-stage heart failure.
  - There is documented ineligibility for human heart transplantation.
  - The client has either of the following:
  - 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

- 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:
  - Clients undergoing unprotected left main or last-remaining-conduit PCI with ejection fraction less than 35%
  - 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.

Percutaneous pulmonary valve implantation (PPVI)

Service procedure codes

CPT® code 33477

Medical necessity criteria

HCA considers percutaneous pulmonary valve implantation (PPVI) to be medically necessary when all the following are present:

- Diagnosis of right ventricular outflow tract (RVOT) dysfunction following prior RVOT repair
- 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
- One of the following diagnoses:
  - Nonrheumatic pulmonary valve disorders
  - Nonrheumatic pulmonary valve stenosis
  - Nonrheumatic pulmonary valve insufficiency
  - Nonrheumatic pulmonary valve stenosis with insufficiency
  - Other nonrheumatic pulmonary valve disorders
  - Nonrheumatic pulmonary valve disorder, unspecified
  - Tetralogy of Fallot
  - Congenital malformations of pulmonary and tricuspid valves
  - Pulmonary valve atresia
  - Congenital pulmonary valve stenosis
  - Congenital pulmonary valve insufficiency
  - Other congenital malformations of pulmonary valve

Fee-for-service (FFS) billing instructions

If medical necessity criteria for PPVI are met, **prior authorization** is required.

Transcatheter aortic valve replacement (TAVR)

Service procedure codes

CPT® codes 33361, 33362, 33363, 33364, 33365, 33366, 33367, 33368, and 33369

Medical necessity criteria

HCA considers transcatheter aortic valve replacement (TAVR) to be medically necessary when all the following conditions are met:

- It is used for the treatment of severe symptomatic aortic valve stenosis.
- The heart team and hospital are participating in a prospective, national, audited registry approved by the Centers for Medicare & Medicaid Services (CMS).
- Conditions of the CMS Medicare national coverage determinations have been met.
- The indication for TAVR has been approved by the FDA.
- The procedure is completed in an inpatient hospital setting (POS 21).

Documentation requirements

Maintain complete chart documentation, which includes evidence of severe symptomatic aortic valve stenosis through appropriate diagnostic imaging.

General billing information

Prior authorization is required.

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.

Varicose vein treatment

Service procedure codes

CPT® codes 36465, 36466, 36470, 36471, 36473, 36474, 36475, 36476, 36478, 36482, 36483, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37780, and 37785

Medical necessity criteria

Based upon review of **evidence provided by HTCC (20170519A—Selected Treatments for Varicose Veins)**, HCA considers treatment for varicose veins to be 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 be present and must have a diameter larger than 3 mm.

Treatments included in this policy are:

- Endovenous Laser Ablation
- Radiofrequency Ablation
- Sclerotherapy
- Phlebectomy

Contraindications for treatment for varicose vein include:

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

Fee-for-service (FFS) billing instructions

Varicose vein treatment requires a **medical necessity review by Comagine Health.**

Digestive system

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.

High-resolution anoscopy

Service procedure codes

CPT® codes 46601 and 46607

Medical necessity criteria

HCA considers high-resolution anoscopy (HRA) to be medically necessary when either of the following conditions are met:

- HRA is used for diagnosis of a suspicious anal lesion in an individual with abnormal anal physical findings.
- HRA guidance is used for biopsy and ablation of high-grade anal intraepithelial neoplasia.

HCA considers HRA to be experimental and investigational when used for the following purposes and therefore considers it as not medically necessary:

- When used for screening of asymptomatic persons.
- When used for surveillance after treatment of anal squamous cell carcinoma.

Fee-for-service (FFS) billing instructions

To receive payment, providers must follow HCA's EPA process and bill with EPA # 870001651. If EPA criteria is not met, PA is required.

Documentation requirements

Follow EPA documentation guidelines.

Diagnostic upper endoscopy for GERD

Service procedure codes

CPT® codes 43200, 43202, 43235, 43237, 43238, 43239, and 43242

Medical necessity criteria

Based upon review of **evidence provided by HTCC (20120518A—Upper Endoscopy for GERD and GI Symptoms)**, HCA considers diagnostic upper endoscopy for adults with gastroesophageal reflux disease (GERD) to be medically necessary for clients 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.

Closure of enterostomy

Medical necessity criteria

HCA considers closure of enterostomy to be medically necessary. Providers must follow standard coding practices when billing and follow applicable agency rules.

Fecal microbiota transplantation

Service procedure codes

CPT® code: 44705

HCPCS code: G0455 and J1440

Medical necessity criteria

Based upon review of **evidence provided by HTCC (20161118B—Fecal Microbiota Transplantation),** HCA considers fecal microbiota transplantation (FMT) to be medically necessary with the following criteria:

- Client has Clostridium difficile infection and has undergone a failed course of appropriate antibiotic therapy.
- FMT is not being used to treat clients diagnosed with inflammatory bowel disease.

Fee-for-service (FFS) billing instructions

Prior authorization is required for HCPCS code J1440. 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. If 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.

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 and instructions on how to complete the sterilization consent form are available in HCA's **Sterilization Supplemental Billing Guide**.

Circumcisions

Service procedure codes

CPT® codes 54150, 54160, and 54161

Medical necessity criteria

HCA considers circumcisions to be medically necessary 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 considers circumcisions (CPT® codes 54150, 54160, and 54161) to be medically necessary only with medical ICD diagnosis codes Phimosis, Balanoposthitis, or Balanitis Xerotica.

Integumentary system

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)**:
  - Breast cancer or a history of breast cancer
  - Tested positive for BRCA 1, BRCA 2, or other definitive genetic test for cancer
  - 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 are placed for cosmetic reasons.

CPT® Code	Short Description	Limitations
11920	Correct skin color defects 6.0 cm (use V10.3) (Tattoo)	Limited to the appropriate ICD dx codes
11921	Correct skin color 6.1-20.0 cm	Limited to the appropriate ICD dx codes
11960	Insertion tissue expander(s)	Limited to the appropriate ICD dx codes
11970	Replace tissue expander	Limited to the appropriate ICD dx codes
11971	Remove tissue expander(s)	Limited to the appropriate ICD dx codes
19301	Partial mastectomy	Limited to the appropriate ICD dx codes
19302	P-mastectomy w/ln removal	Limited to the appropriate ICD dx codes
19303	Mast simple complete	Limited to the appropriate ICD dx codes
19316	Suspension of breast	Limited to the appropriate ICD dx codes
19340	Immediate breast prosthesis	Limited to the appropriate ICD dx codes
19342	Delayed breast prosthesis	Limited to the appropriate ICD dx codes
19350	Breast reconstruction	Limited to the appropriate ICD dx codes
19357	Breast reconstruction	Limited to the appropriate ICD dx codes
19361	Breast reconstr w/lat flap	Limited to the appropriate ICD dx codes
19364	Breast reconstruction	Limited to the appropriate ICD dx codes
19367	Breast reconstruction	Limited to the appropriate ICD dx codes
19368	Breast reconstruction	Limited to the appropriate ICD dx codes
19369	Breast reconstruction	Limited to the appropriate ICD dx codes
19370	Surgery of breast capsule	Limited to the appropriate ICD dx codes

CPT® Code	Short Description	Limitations
19371	Removal of breast capsule	Limited to the appropriate ICD dx codes
19380	Revise breast reconstruction	Limited to the appropriate ICD dx codes
S2066	Breast GAP flap reconst	Limited to the appropriate ICD dx codes
S2067	Breast "stacked" DIEP/GAP	Limited to the appropriate ICD dx codes

Panniculectomy

Service procedure codes

CPT® code 15830

Medical necessity criteria

HCA considers panniculectomy to be medically necessary when **all** the following criteria are met:

- The pannus hangs at or below the level of the symphysis pubis.

AND

- The pannus causes a functional deficit due to severe physical deformity or disfigurement.

AND

- The surgery is expected to restore or improve the functional deficit.

AND

- The pannus is interfering with daily living.

AND

- The pannus causes a chronic and persistent skin condition that is refractory to at least 3 months of medical treatment and associated with at least one episode of cellulitis requiring systemic antibiotics (e.g., intertriginous dermatitis, panniculitis, cellulitis, or skin ulcerations).

AND

- In addition to good hygiene practices, all the following treatments (unless contraindicated) have been tried and failed:
  - Topical antifungals

    AND
  - Topical or systemic corticosteroids

    AND
  - Local or systemic antibiotics

Documentation requirements

Documentation of all the following is **required** when requesting prior authorization:

- Photographs of the pannus

  AND
- The pannus hangs at or below the level of the symphysis pubis

  AND
- Functional deficit caused by the pannus due to severe physical deformity or disfigurement interfering with daily living

  AND
- The surgery is expected to restore or improve the functional deficit

  AND
- 3 consecutive months of the following:
  - Medical treatment of chronic and persistent skin conditions of the pannus (e.g., intertriginous dermatitis, panniculitis, cellulitis, or skin ulcerations), with at least **one** episode of cellulitis of the pannus requiring systemic antibiotics

    AND
  - Good hygiene practices documented, and **all** the following treatments have been tried and failed unless contraindicated:
    - Topical antifungals

      AND
    - Topical or systemic corticosteroid

      AND
    - Local or systemic antibiotics

Fee-for-service (FFS) billing instructions

Panniculectomy requires prior authorization.

Skin substitutes

Service procedure codes

CPT® codes 15271, 15272, 15273, 15274, 15275, 15276, 15277, and 15278

Medical necessity criteria

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

Fee-for-services (FFS) billing instructions

HCA pays for a maximum of 10 applications per client, per year. If the wound being treated requires greater than 10 applications per year, providers must request a limitation extension using a Skin Substitute Application Limitation Extension form (HCA 13-0143) (See HCA's Forms & Publications webpage).

Providers must bill skin substitutes provided in a professional setting with the associated application procedure code. See the **fee schedule** for skin substitutes in a professional setting.

HCA does not pay for reapplications if the initial treatment episode is not successful.

> **Note:** Alloderm (HCPCS Q4116) may be billed only when related to a diagnosis of breast cancer and when services are provided by a general surgeon or a plastic surgeon. Use EPA# 870001342 when billing.

Clarification of coverage policy for miscellaneous procedures

Limitations on coverage for certain miscellaneous procedures are listed below:

Procedure Code	Short Description	PA?	Limitations
11980	Implant hormone pellet(s)	Y	N/A
S0189	Testosterone pellet 75 mg	Y	N/A
S0139	Minoxidil, 10 mg	N	I10 (essential hypertension)

Musculoskeletal system

Artificial disc replacement

Service procedure codes

CPT® codes 22856, 22857, 22858, 22860, 22861, 22862, 22864, and 22865

Medical necessity criteria

Based on review of the evidence provided by HTCC (20170120B—Artificial Disc Replacement—Re-Review), HCA considers cervical artificial disc replacement to be medically necessary when **all the following are met**:

- Client must have advanced imaging and clinical evidence of corresponding nerve root or spinal cord compression.
- Client has failed or is an inappropriate candidate for non-operative care
- Client must meet FDA approved indications for use and not have any contraindications. FDA approval is device specific but includes both the following:
  - Skeletally mature clients
  - Disc replacement following one- or two-level discectomy for intractable symptomatic radiculopathy or myelopathy confirmed by client findings and imaging
- For two-level procedures, there is objective evidence of radiculopathy, myelopathy or spinal cord compression at two consecutive levels.

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

Fee-for-service (FFS) billing instructions

If medical necessity is met for cervical artificial disc replacement, HCA requires a medical necessity review by Comagine Health.

Bone growth stimulators

Service procedure codes

CPT® codes 20974, 20975, 20979, and E0749*

*This Outpatient Prospective Payment System (OPPS) code is listed here for providers billing for services using institutional claims. This code pays as it is set up in OPPS only.

Medical necessity criteria

Based upon review of evidence provided by HTCC (20090828B—Bone Growth Stimulation), HCA considers bone growth stimulators to be medically necessary with the following conditions:

Non-Spinal: Invasive and non-invasive bone growth stimulator

Client has one of the following:

- A nonunion of a long bone fracture (which includes clavicle, humerus, phalanx, radius, ulna, femur, tibia, fibula, metacarpal and metatarsal) where three months have elapsed since the date of injury without healing
- A failed fusion of a joint where a minimum of nine months has elapsed since the last surgery
- Diagnosed with congenital pseudarthrosis (noninvasive only)

Spinal: invasive and non-invasive bone growth stimulator

Prescribed by a neurologist, an orthopedic surgeon, or a neurosurgeon; and the client meets one of the following criteria:

- Has a failed spinal fusion where a minimum of nine months has elapsed since the last surgery
- Is post-op from a multilevel spinal fusion surgery
- Is post-op from spinal fusion surgery and there is a history of a previously failed spinal fusion

Ultrasonic non-invasive bone growth stimulator:

Client has both of the following:

- Nonunion confirmed by 2 radiographs minimum 90 days apart
- Physician statement of no clinical evidence of fracture healing

Fee-for-service (FFS) billing instructions

HCA requires prior authorization (PA) for these procedures to establish medical necessity.

Documentation requirements

Submit complete chart documents which identify medical necessity.

General billing information

For coverage information related to supplies for bone growth stimulator, please reference HCA's Medical Equipment and Supplies Billing Guide.

Cervical spinal fusion for degenerative disc disease

Service procedure codes

CPT® codes 22551, 22552, 22554, 22853, 22854, 22859, and 22600

Medical necessity criteria

Based upon review of evidence provided by HTCC (20130322B—Cervical Spinal Fusion for Degenerative Disc Disease), HCA considers cervical spinal fusion for degenerative disc disease to be medically necessary when all the following conditions are met:

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

HCA does not consider cervical spinal fusion to be medically necessary for neck pain without evidence of radiculopathy or myelopathy.

Fee-for-service (FFS) billing instructions

For clients 20 years of 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.

Cervical surgery for radiculopathy and myelopathy

Service procedure codes

CPT® codes 22220, 63001, 63015, 63020, 63035, 63040, 63043, 63045, 63075, 63076, 63081, 63082, 63300, and 63304

Medical necessity criteria

HCA considers cervical surgery for neck pain to be medically necessary when there is subjective, objective, and imaging evidence of radiculopathy or myelopathy.

Fee-for-service (FFS) billing instructions

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

- Anterior cervical discectomy with fusion (ACDF) – Refer to - Cervical spinal fusion for degenerative disc disease

- Total disc arthroplasty (TDA)
- Laminotomy
- Laminectomy with or without a fusion
- Laminoplasty
- Foraminotomy
- Corpectomy
- Repeat surgeries

Note: 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

Service procedure codes

CPT® code 28890

Medical necessity criteria

Based upon review of evidence provided by HTCC (20170317A—Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions), HCA does not consider extracorporeal shock wave therapy for musculoskeletal conditions to be medically necessary.

Hip resurfacing

Service procedure codes

CPT® code: 27299

HCPCS code: S2118

Medical necessity criteria

Based upon review of evidence provided by HTCC (20131114B—Hip Resurfacing—Re-Review), HCA does not consider hip resurfacing to be medically necessary.

Fee-for-service (FFS) billing instructions

For clients age 21 and older, HCA requires a medical necessity review by Comagine Health if CPT® code 27299 is billed for a service unrelated to hip surfacing.

Hip surgery for femoroacetabular impingement syndrome

Service procedure codes

CPT® codes 29914, 29915, 29916, 27299, and 29999

Medical necessity criteria

Based upon review of evidence provided by HTCC (20191122B—Hip Surgery for Femoroacetabular Impingement [FAI] Syndrome—Re-Review), HCA does not consider hip surgery to be medically necessary for treatment of femoroacetabular impingement (FAI) syndrome.

Fee-for-service (FFS) billing instructions

For clients age 21 and older, HCA requires a **medical necessity review by Comagine Health** if CPT® codes 29916, 27299, and 29999 are billed for a service unrelated to hip surgery for FAI syndrome.

Knee arthroscopy for osteoarthritis

Service procedure codes

CPT® codes 29874, 29877, and G0289

Medical necessity criteria

Based upon review of **evidence provided by HTCC (20080815B—Knee Arthroscopy for Osteoarthritis of the Knee)**, HCA does not consider knee arthroscopy for osteoarthritis to be medically necessary. HCA may consider arthroscopy for other reasons to be medically necessary.

Fee-for-service (FFS) billing instructions

The CPT® codes listed in the preceding *Service procedure codes* section require a **medical necessity review by Comagine Health** for clients age 21 and older.

Kyphoplasty, vertebroplasty, and sacroplasty

Service procedure codes

CPT® codes 22510, 22511, 22512, 22513, 22514, and 22515

Medical necessity criteria

Based on review of the **evidence provided by HTCC (20101210A—Vertebroplasty, Kyphoplasty, Sacroplasty)**, HCA does not consider kyphoplasty, vertebroplasty, and sacroplasty to be medically necessary for relief of pain and improvement of function for spinal fractures.

Lumbar fusion

Bone morphogenetic protein 2 for lumbar fusion

Service procedure codes

CPT® codes 22533, 22558, 22612, 22630, 22633, and 20930

Medical necessity criteria

Based on review of the evidence provided by HTCC (20120316B—Bone Morphogenetic Proteins for Use in Lumbar Fusion), HCA considers bone morphogenetic protein -2 (rhBMP-2) for use in lumbar fusion to be medically necessary as follows:

- 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.

HCA does not consider bone morphogenetic protein – 7 (rhBMP-7) for use in lumbar fusion to be medically necessary.

Fee-for-service (FFS) billing instructions

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.

Lumbar fusion for degenerative disc disease

Service procedure codes

CPT® codes 22533, 22558, 22612, 22630, 22633, 22853, 22854, and 22859

Medical necessity criteria

Based on review of the evidence provided by HTCC (20151120A—Lumbar Fusion for Degenerative Disc Disease—Re-Review), HCA does not consider lumbar fusion for degenerative disc disease to be medically necessary for clients with a diagnosis of degenerative disease.

Fee-for-service (FFS) billing instructions

HCA requires a medical necessity review by Comagine Health for associated spinal fusion procedures.

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:

CPT® Code	Short Description
27415	Allgrft implnt knee
27416	Autgrft implnt knee
29866	Autgrft implnt knee w/scope
29867	Allgrft implnt knee w/scope

Robotic assisted surgery

Service procedure codes

HCPCS code S2900

Medical necessity criteria

Based upon review of evidence provided by HTCC (20120518B—Robotic Assisted Surgery [RAS]), HCA considers robotic assisted surgery (RAS) to be medically necessary when HCA has determined that the underlying procedure is medically necessary. HCA does not pay separately for RAS.

General billing information

When billing for the underlying procedure, include RAS on the claim to track utilization and outcome. HCA monitors RAS through retrospective auditing of billing and the review of operative reports.

Sacroiliac joint fusion

Service procedure codes

CPT® codes 27279 and 27282

Medical necessity criteria

Based upon review of evidence provided by HTCC (20190118A—Sacroiliac Joint Fusion), 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 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.

Fee-for-services (FFS) billing instructions

If medical necessity criteria for sacroiliac joint fusion are met, HCA requires a medical necessity review by Comagine Health.

Total knee arthroplasty

Service procedure codes

CPT® codes 27437, 27438, 27440, 27441, 27445, 27446, and 27447

Medical necessity criteria

Based upon review of evidence provided by HTCC (20101022A—Total Knee Arthroplasty), HCA considers total knee arthroplasty to be medically necessary for treatment of end-stage osteoarthritis and rheumatoid arthritis of the knee:

- Total Knee Arthroplasty with Computer Navigation is a covered benefit.
- For individuals with uni-compartmental disease, uni-compartmental partial Knee Arthroplasty.

HCA does not consider multi-compartmental arthroplasty to be medically necessary (including bi-compartmental and bi-uni-compartmental).

Fee-for-service (FFS) billing instructions

Total knee arthroplasty requires a medical necessity review by Comagine Health.

Nervous system

Discography

Service procedure codes

CPT® codes 62290, 62291, 72285, and 72295

Medical necessity criteria

HCA considers discography to be medically necessary for the following conditions:

- 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.

Based upon review of evidence provided by HTCC (20080215A—Discography), HCA does not consider discography for clients with chronic low back pain and uncomplicated lumbar degenerative disc disease to be medically necessary.

Fee-for-services (FFS) billing instructions

If the medical necessity criteria for discography are met, prior authorization is required for clients age 21 and older. Prior authorization is not required for clients age 20 and younger.

Facet neurotomy

Service procedure codes

CPT® codes 64633, 64634, 64635, and 64636

Medical necessity criteria

Based upon review of evidence provided by HTCC (20140321B—Facet Neurotomy), HCA considers facet neurotomy to be medically necessary for the following:

- **Lumbar facet neurotomy—**Medically necessary when all the following are true:
  - The client is 18 years of age or older.
  - The client has at least six months of continuous, non-radicular low back pain referable to the facet joint.
  - The condition is unresponsive to other therapies including conservative care.
  - There are no other clear structural causes of the back pain.
  - There is no other pain syndrome affecting the spine.
  - For identification, diagnosis, and treatment, the client:
    - Must have at least 80% improvement in pain after each of two differential medial branch blocks, one short-acting; one long-acting
    - Has one or two joints per intervention, with documented, clinically significant improvement in pain and/or function for six months before further neurotomy at any level.
- **Cervical facet neurotomy for cervical pain—**Medically necessary when all the following are true:
  - Symptoms are limited to C3 - 4, through C6 - 7.
  - The client is 18 years of age or older.
  - The client has at least six months of continuous, non-radicular neck pain referable to the facet joint.

- The condition is unresponsive to other therapies, including conservative care.
- There are no other clear structural causes of neck pain.
- There is no other pain syndrome affecting the spine.
- For identification, diagnosis, and treatment, the client:
  - Must have 100% improvement in pain after each of two differential medial branch blocks, one short-acting and one long-acting.
  - Has one joint per each intervention, with documented, clinically significant improvement in pain and/or function for six months before further neurotomy at any level.

HCA does not consider facet neurotomy for the thoracic spine and headache to be medically necessary.

Fee-for-service (FFS) billing instructions

For clients 20 years of age and younger, HCA does not require prior authorization for lumbar and cervical facet neurotomy. For clients 21 years of age and older, lumbar and cervical facet neurotomy requires a **medical necessity review by Comagine Health**.

Lumbar radiculopathy or sciatica

Service procedure codes

CPT® codes 63030, 63035, 63042, 63044, 63047, 63048, 63056, 63057, 62380, 63090, and 63091

Medical necessity criteria

Based on review of the **evidence provided by HTCC (20180518A—Surgery for Lumbar Radiculopathy/Sciatica),** HCA considers surgery for lumbar radiculopathy or sciatica to be medically necessary for open discectomy or microdiscectomy with or without endoscopy (lumbar laminectomy, laminotomy, discectomy, foraminotomy) with 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)

  AND

- 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

Fee-for-service (FFS) billing instructions

If medical necessity criteria for lumbar radiculopathy or sciatica are met, HCA requires a **medical necessity review by Comagine Health.**

Implantable infusion pumps or implantable drug delivery systems

Service procedure codes

CPT® codes: 62350, 62362, 62351, 62360, and 62361

HCPCS codes: C1772*, C1889*, C1891*, C2626*, E0782*, E0783*, E0785*, and E0786*

*These Outpatient Prospective Payment System (OPPS) procedure codes are listed for providers billing for services using institutional claims. These procedure codes **pay only in OPPS**. See the **fee schedule**.

Medical necessity criteria

Based upon review of **evidence provided by HTCC (20080815A—Implantable Drug Delivery System for Chronic Noncancer Pain)**, HCA considers implantable drug delivery systems (infusion pump or IDDS) to be medically necessary for cancer pain or spasticity.

HCA does not consider implantable drug delivery systems to be medically necessary for the treatment of chronic, noncancer-related pain.

Fee-for-service (FFS) billing instructions

If the medical necessity criteria for implantable drug delivery systems are met, bill with EPA# 870001674. If the client does not meet the EPA criteria, **prior authorization** is required.

Spinal cord stimulation for chronic neuropathic pain

Based upon review of **evidence provided by HTCC (20100820B—Spinal Cord Stimulation)**, 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. **Prior authorization** is required.

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.

Vagal nerve stimulation (VNS)

Service procedure codes

CPT® codes: 61885, 61886, 64553, 64568

HCPCS codes: C1767*, C1778*, C1822*, L8679*, L8680*, L8682*, L8683*, L8685*, L8686*, L8687*, L8688*

*These Outpatient Prospective Payment System (OPPS) procedure codes are listed for providers billing for services using institutional claims. These procedure codes **pay only in OPPS**. See the fee schedule.

Medical necessity criteria

Based on review of evidence provided by HTCC (20200515B—Vagal Nerve Stimulation for Epilepsy and Depression—Re-Review), 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.

HCA does not consider VNS for treatment of depression or transcutaneous VNS to be medically necessary.

Fee-for-services (FFS) billing instructions

If medical necessity criteria are met, use EPA #870001554. If the client does not meet EPA criteria, PA is required.

Respiratory system

Bronchial thermoplasty for asthma

Service procedure codes

CPT® codes 31660 and 31661

Medical necessity criteria

Based upon review of **evidence provided by HTCC (20160520A—Bronchial Thermoplasty for Asthma)**, HCA does not consider bronchial thermoplasty for asthma to be medically necessary.

Endobronchial valves placement for severe emphysema

Service procedure codes

CPT® codes: 31647, 31651, 31648, and 31649

Medical necessity criteria

HCA considers endobronchial valve (EBV) placement for severe emphysema to be medically necessary when dyspnea is poorly controlled, and all the following are true:

- Forced expiratory volume (FEV1) is less than 50% of the predicted value
- Residual volume is greater than 150%
- Total lung capacity is greater than or equal to 100%
- Targeted lobe shows little to no collateral ventilation
- Client's activities of daily living are markedly restricted despite maximal medical management

Prior to EBV placement, the client must:

- Complete a pulmonary rehabilitation program
- Be abstinent from smoking of any kind for four consecutive months before the initial evaluation

HCA does not consider placement of EBV to be medically necessary when the following criteria are present:

- Disseminated malignancy or other severe progressive disease
- Severe pulmonary hypertension
- Other chronic respiratory diseases such as pulmonary fibrosis

Fee-for-Service Billing Instructions:

The client must have a primary diagnosis of J43.0, J43.1, J43.2, J43.8. J43.9, J93.8, J93.81, J93.82, J93.83, or J93.9. If the medical necessity criteria are met, use EPA# **870001678**. If the client does not meet the medical necessity criteria, prior authorization is required.

Sleep apnea

For information on sleep medicine testing, sleep centers, and sleep center centers of excellence, refer to HCA's Sleep Center Billing Guide.

Surgical treatment for sleep apnea

Service procedure codes

CPT® codes 21121, 21122, 21141, 21145, 21196, 21198, 21199, 21685, 41120, 42140, 42145, and 42160

Medical necessity criteria

Based upon review of **evidence provided by HTCC (20120316A—Sleep Apnea Diagnosis and Treatment in Adults)**, HCA considers surgical treatment for obstructive sleep apnea (OSA) or upper airway resistance syndrome (UARS) to be medically necessary when all the following criteria are met:

- The client is age 18 years or older
- The provider is a state approved provider
- Consistent with the Medicare Local Coverage Determination (L34526) for Surgical Treatment of Obstructive Sleep Apnea.

Fee-for-service (FFS) billing instructions

If the medical necessity criteria for surgical treatment for sleep apnea are met, HCA requires **prior authorization.**

> **Note:** For surgical treatment for dental procedures, refer to HCA's Dental-Related Services Billing Guide or Orthodontic Services Billing Guide.

Urinary systems

Indwelling catheter

Service procedure codes

CPT® codes: 51702 and 51703

Medical necessity criteria

HCA considers insertion for indwelling catheters to be medically necessary. Indwelling catheters are separately reimbursable only when used to treat a temporary obstruction and when performed in an office setting. Providers must follow standard coding practices when billing and follow applicable agency rules. Refer to a CPT® book for complete code descriptions, definitions, and guidelines.

Note: Insertion of an indwelling catheter is bundled when performed on the same day or during the postoperative period of a major surgery as a major surgery.

Periurethral collagen bulking agents

Service procedure codes

CPT® codes: 51715 and 95028

HCPCS codes: L8603, L8604, and L8606

Diagnosis codes: N36.42, N36.43, and N39.3

Medical necessity criteria

HCA considers periurethral collagen bulking agents to be medically necessary when all the following are present:

- The client has a diagnosis of intrinsic (urethral) sphincter deficiency (ISD) or stress urinary incontinence (SUI).
- The client has shown no incontinence improvement through other noninvasive treatment for at least 12 months (e.g., Kegel exercises, biofeedback, or pharmacotherapies).
- A pre-treatment skin test was completed with the collagen bulking agent and the client has no evidence of hypersensitivity.

Documentation requirements

The following documentation must be kept in the client's file and made available upon HCA's request:

- Diagnosis of ISD or SUI
- Failure of other non-invasive treatment for at least 12 months (e.g., Kegel exercises, biofeedback, or pharmacotherapies)
- Documented negative collagen sensitivity

Fee-for-service (FFS) billing instructions

If the medical necessity criteria for periurethral collagen bulking agents are met, bill with EPA# 870001675. If the client does not meet the EPA criteria, **prior authorization** is required.

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

When billing for bilateral procedures:

- Bill the procedure on two separate lines using modifier 50 on one line only.
- 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 services/professional health care 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)

Head/neck	70450	70460	70470	70486	70487	70488
Abdomen	74150	74160	74170			
Pelvis	72192	72193	72194			
Abdomen & Pelvis	74176	74177	74178			

- 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)

Head	70551	70552	70553
C – Spine	72141	72142	72156
L- Spine	72148	72149	72158
Upper Extremity	73221	73222	73223
Breast	77046	77047	77048
Breast	77049	C8903*	
Breast	C8905*	C8906*	C8907*
Breast	C8908*		
Lower Extremity	73721	73722	73723

*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

Service procedure codes

CPT® codes: 77046, 77047, 77048, and77049

HCPCS codes C8903*, C8904*, C8905*, C8906*, C8907*, and C8908*

*These Outpatient Prospective Payment System (OPPS) procedure codes are listed for providers billing for services using institutional claims. These procedure codes **pay only in OPPS**. See the **fee schedule**.

Medical necessity criteria

Based upon review of **evidence provided by HTCC (20100820A—Breast MRI)**, 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.

Fee-for-service (FFS) billing instructions

If medical necessity criteria are not met, HCA requires a **medical necessity review by Comagine Health.**

Cardiac magnetic resonance angiography (CMRA)

Service procedure codes

CPT® codes 75557 and 75561

Medical necessity criteria

Based upon review of **evidence provided by HTCC (20130920A—Cardiac Nuclear Imaging)**, the Health Care Authority (HCA) considers cardiac magnetic resonance angiography (CMRA) to be medically necessary for all the following:

- Adults and children with known or suspected coronary vessel anomalies or congenital heart disease
- Stable symptomatic adults with known or suspected coronary artery disease (CAD) when the following conditions are met:
  - Have a consultation with a cardiologist
  - The patient is unable to tolerate or safely participate in other noninvasive anatomic or functional testing.

General billing information

HCA does not consider CMRA to be medically necessary in coronary artery bypass graft (CABG) patients without CAD symptoms, or in those requiring cardiac lead placement, unless vascular anomalies are suspected.

Noninvasive cardiac imaging

Service procedure codes

- HCA does not require authorization for the following CPT® codes: 75574, 93350, 93351, 93352, and 75580.
- HCA requires prior authorization for the following CPT® codes, and the medical necessity review is performed by Comagine Health: 78429, 78430, 78431, 78432, 78433, 78434, 78451, 78452, 78453, 78454, 78459, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78491, 78492, 78494.

  See Medical necessity review by Comagine Health for additional information.

Medical necessity criteria

Based upon review of **evidence provided by HTCC (20211105A—Noninvasive Cardiac Imaging)**, HCA considers the following noninvasive_cardiac imaging technologies to be medically necessary with the following conditions:

- Stress echocardiography for either of the following:
  - Symptomatic adult patients (18 years of age or older) at intermediate or high risk of coronary artery disease (CAD)
  - Adult patients with known CAD who have new or worsening symptoms
- Single Positron Emission Tomography (SPECT) for patients under the same conditions as stress echocardiography when stress echocardiography is not technically feasible or clinically appropriate
- Positron Emission Tomography (PET) for patients under the same conditions as SPECT, when SPECT is not technically feasible or clinically appropriate
- Coronary Computed Tomographic Angiography (CCTA) for either of the following:
  - Symptomatic adult patients (18 years of age or older) at intermediate or high risk of CAD
  - Adult patients with known CAD who have new or worsening symptoms
- CCTA with Fractional Flow Reserve (FFR) for patients under the same conditions as CCTA, when further investigation of functional significance of stenoses is clinically indicated

Documentation requirements

Providers must document the medical necessity criteria and any other tried and failed procedures/imaging in the client's medical record.

General billing information

HCA does not consider noninvasive cardiac imaging technologies to be medically necessary in asymptomatic individuals, follow-up of prior abnormal cardiac imaging studies, myocardial viability, preoperative evaluation, and patients presenting for evaluation of cardiac pathologies other than CAD.

Contrast material

Service procedure codes

HCPCS codes: Q9951, Q9965, Q9966, and Q9967

Medical necessity criteria

HCA considers contrast material to be separately reimbursable only for 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

Fee-for-service (FFS) billing instructions

HCA does not pay separately for contrast material. Refer to HCA's Professional Administered Drug Fee Schedule.

Documentation requirements

Providers must document the brand name of the LOCM and the dosage in the client's health care record.

Consultation on X-ray examination

General billing information

When billing a consultation, the consulting physician must bill the specific X-ray code with modifier 26 (professional component).

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

Coronary artery calcium scoring

Service procedure codes

CPT® codes 75571, 0623T, 0624T, 0625T, and 0626T

Medical necessity criteria

Based upon review of evidence provided by HTCC (20091120A—Coronary Artery Calcium Scoring), HCA does not consider coronary artery calcium scoring to be medically necessary.

Imaging for rhinosinusitis

Service procedure codes

CT: CPT® codes 70450, 70460, 70486, 70487, and 70488

MRI: CPT® codes 70540, 70542, and 70543

Medical necessity criteria

Based upon review of the evidence provided by HTCC (20150515A—Imaging for Rhinosinusitis), 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.

Fee-for-service (FFS) billing instructions

If medical necessity criteria are met for CT imaging of the sinus, use EPA# 870001423. If the client does not meet EPA criteria, you must submit a PA request to Comagine Health.

If medical necessity criteria are met for MRI of the sinus, use EPA# 870001422. If the client does not meet EPA criteria, you must submit a PA request to Comagine Health.

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-related services/professional health care services fee schedule** for authorization requirements for MRIs.

Upright MRI

Medical necessity criteria

Based upon review of **evidence provided by HTCC (20070501—Upright/Positional MRI)**, HCA does not consider upright MRI to be medically necessary (See WAC **182-501-0070(4))**.

Portable X-rays

Service procedure codes

HCPCS code R0070 and HCPCS code R0075 with modifiers UN, UP, UQ, UR, or US

Medical necessity criteria

HCA considers portable x-rays to be medically necessary when all the following are present:

- Portable X-ray services are furnished in a client's home or nursing facility
- Skeletal films involving extremities, pelvis, vertebral column, or skull
- Chest or abdominal films that do not involve the use of contrast media
- Diagnostic mammograms

General billing information

Bill for transportation of X-ray equipment as follows:

- R0070 - If there is only one patient, bill one unit.
- 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 Apple Health 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:

Procedure Code	Short Description
R0070	Transport portable x-ray
R0075-UN	Transport port x-ray multipl-2 clients seen
R0075-UP	Transport port x-ray multipl-3 clients seen
R0075-UQ	Transport port x-ray multipl-4 clients seen
R0075-UR	Transport port x-ray multipl-5 clients seen
R0075-US	Transport port x-ray multipl-6 or more clients seen

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

Service procedure codes

CPT® code 76706

Medical necessity criteria

HCA considers ultrasound screening for abdominal aortic aneurysm to be medically necessary when a client meets at least one of the following conditions:

- Has a family history of an abdominal aortic aneurysm
- Was assigned male at birth, is between 65 and 75 years of age, and has smoked at least 100 cigarettes in lifetime

General billing information

When billing, use the most appropriate diagnosis code (e.g., Z13.6).

Virtual colonoscopy or computed tomographic colonography

Service procedure codes

CPT® code 74263

Medical necessity criteria

Based upon review of evidence provided by HTCC (20080215B – Computed Tomographic Colonography), HCA does not consider virtual colonoscopy or computed tomographic colonography for routine colorectal cancer screening to be medically necessary.

Screening and monitoring tests for osteopenia/ osteoporosis

Service procedure codes

CPT® codes 77080, 77081, 77085, and 77086

Medical necessity criteria

Based upon review of evidence provided by HTCC (20141121A—Screening and Monitoring Tests for Osteopenia/Osteoporosis), HCA considers screening and monitoring tests for osteopenia/osteoporosis to be medically necessary with the following conditions:

Condition	Criteria

Initial bone mineral density testing with dual x-ray absorptiometry (DXA)	**Asymptomatic persons assigned female at birth**
	The client must meet 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
	The client must meet one 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
	• Other conditions known to be associated with low bone mass including, but not limited to:
	  ○ Patients receiving ARIMIDEX
	  ○ Bariatric surgery
	  ○ Celiac disease
	  ○ Cushing Syndrome

Condition	Criteria
Repeat bone mineral density testing with dual x-ray absorptiometry (DXA)	The client must meet 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 ** "T-Score" refers to the result of a DXA scan compared to a reference population

Note:

- Once treatment for osteoporosis has begun, HCA does not consider serial monitoring with DXA to be medically necessary.

- HCA does not consider monitoring osteoporosis with DXA to be medically necessary when it is due to the development of a fragility fracture only.

Fee-for-services (FFS) billing instructions

- If the medical necessity criteria are met for **initial bone mineral density testing with dual x-ray absorptiometry (DXA),** use EPA #870001363.
- If the medical necessity criteria are met for **repeat bone mineral density testing with dual x-ray absorptiometry (DXA)**, us EPA #870001364.
- If the client does not meet the EPA criteria, prior authorization is required.

Functional neuroimaging for primary degenerative dementia or mild cognitive impairment

Service procedure codes

CPT® codes: 70554, 70555, 78607, 78608, and 78609

Medical necessity criteria

Based upon review of the **evidence provided by HTCC (20150116A—Functional Neuroimaging for Primary Degenerative Dementia or Mild Cognitive Impairment)**, 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)

Fee-for-service (FFS) billing instructions

HCA uses the following processes when considering the medical necessity for functional neuroimaging on conditions other than primary degenerative dementia or mild cognitive impairment:

- The HCA prior authorization process for CPT® codes 70554 and 70555
- A **Medical necessity review by Comagine Health** for CPT® code 78608

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)**

CPT® code	Short description
78071	Parathyrd planar w/wo subtrj
78451	Ht muscle image spect sing
78452	Ht muscle image spect mult
78453	Ht muscle image planar sing
78454	Ht musc image planar mult

- **PET scans**

CPT® code	Short description
78608	Brain
78811	Limited Area
78812	Skull base to mid thigh
78813	Full Body

- **PET-CT scans**

CPT® code	Short description
78814	Limited Area (Chest, head, neck)
78815	Skull base to mid thigh
78816	Whole body

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)

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

Fee-for-service (FFS) billing instructions

HCA may allow separate payments (acquisition cost) for radiopharmaceutical diagnostic agents or may require a **medical necessity review by Comagine Health**, depending on the procedure code billed. To determine if a procedure code is separately payable, covered, not covered, or requires a **medical necessity review by Comagine Health**, see HCA's **Physician-related services/professional health care services fee schedule**.

> **Note:** To review coverage for radiopharmaceutical therapeutics, see HCA's Professional Administered Drug Fee Schedule.

Positron emission tomography (PET) scans for lymphoma

Service procedure codes

CPT® codes 78811, 78812, 78813, 78814, 78815, and 78816

Medical necessity criteria

- Based upon review of **evidence provided by HTCC (20110916A—Proton Emission Tomography (PET) Scans for Lymphoma),** HCA 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.

Fee-for-service (FFS) billing instructions

PET scans for lymphoma require a **medical necessity review by Comagine Health**.

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)

Service procedure codes

CPT® codes 77301, 77385*, 77386*, 77332, 77333, 77334, 77338, 77370, G6015, and G6016

*These Outpatient Prospective Payment System (OPPS) procedure codes are listed for providers billing for services using institutional claims. These procedure codes **pay only in OPPS**. See the **fee schedule**.

Medical necessity criteria

Based upon review of evidence provided by HTCC (20120921A—Intensity Modulated Radiation Therapy (IMRT), HCA considers intensity modulated radiation therapy (IMRT) to be medically necessary with the following conditions:

Condition	Authorization
To spare adjacent critical structures to prevent toxicities within client's expected life span	Expedited prior authorization. The following criteria must be met: • Any cancer that would require radiation to focus on the head/neck/chest/abdomen/pelvic area. • Clinical documentation is required that states which critical structure is spared. **For example:** "Critical structure spared is bladder." • 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

Fee-for-service (FFS) billing instructions

If medical necessity criteria are met, use EPA #870001374. If the client does not meet the EPA criteria, PA is required.

Proton beam therapy

Based upon review of evidence provided by HTCC (20190517A—Proton Beam Therapy—Re-Review), 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 (SRS)

Service procedure codes

Neurosurgery: CPT® codes 61796, 61797, 61798, 61799, 61800, 63620, and 63621

Radiation: CPT® codes 77371, 77372, 77373, 77432, and 77435

Medical necessity criteria

Based on review of the **evidence provided by HTCC (20230623A—Stereotactic Radiation Surgery and Stereotactic Body Radiation Therapy)**, HCA considers stereotactic radiation surgery (SRS) to be medically necessary for the treatment of central nervous system (CNS) and metastatic tumors when all the following are met:

- Patient functional status score from one of the following is greater than or equal to
  - Client Karnofsky score is greater than or equal to 50
    OR
  - Eastern Cooperative Oncology Group (ECOG) is less than or equal to 2
- Evaluation includes multidisciplinary team analysis including a surgical specialist and radiation oncologist input and is documented in the chart.

Fee-for-service (FFS) billing instructions

If medical necessity criteria are met, use EPA #870001658. If the client does not meet EPA criteria, PA is required.

Documentation requirements

Follow HCA's EPA documentation guidelines.

Stereotactic body radiation therapy (SBRT)

Service procedure codes

CPT® codes 32701, 77370, 77373, 77435

Medical necessity criteria

Based on review of the evidence provided by HTCC (20230623A—Stereotactic Radiation Surgery and Stereotactic Body Radiation Therapy), HCA considers stereotactic body radiation therapy (SBRT) to be medically necessary for the treatment of spine and paraspinal cancer, localized prostate cancer, non-small cell, renal, and small cell lung cancer, pancreatic adenocarcinoma, oligometastatic disease, hepatocellular carcinoma, and cholangiocarcinoma.

In addition to each EPA requirement listed in the following table, the evaluation, which includes the multidisciplinary team analysis, including a surgical specialist's and radiation oncologist's input, must be in the client's chart.

EPA Requirements

Condition	EPA number	Medical necessity criteria
Spine and Paraspinal Cancer	870001661	The following conditions must be present: primary and secondary tumors involving spine parenchyma, meninges/dura, or immediately adjacent bony structures
Located Prostate Cancer	870001662	The following conditions must be present: very low, low, and intermediate risk prostate cancer, as defined by NCCN based on stage, Gleason score, and PSA level
Non-Small Cell Lung Cancer (NSCLC)	870001663	When **all** the following conditions have been met: • Stage I and Stage II (node negative) • Tumor is deemed to be unresectable or patient is deemed too high risk or declines operative intervention.
Small Cell Lung Cancer (SCLC)	870001664	When the following conditions have been met: • Operative intervention declined **AND** • Stage I and Stage II (node negative) and **at least one** of the following: o Tumor is deemed to be unresectable o Client is deemed too high risk for surgery

Condition	EPA number	Medical necessity criteria
Pancreatic Adenocarcinoma	870001665	When the following conditions have been met: • Operative intervention declined **AND** • Non-metastatic disease and is either deemed not a candidate for induction chemotherapy or has already undergone induction chemotherapy and **at least one** of the following: o Tumor is deemed to be unresectable o Client is deemed too high risk for surgery
Oligometastatic disease	870001666	When **all** the following conditions have been met: • Five or fewer total metastatic lesions (maximum 3 per organ) • Controlled primary tumor • Life expectancy greater than 6 months
Hepatocellular carcinoma	870001667	When **all** the following conditions have been met: • Liver confined disease • Five or fewer lesions • Life expectancy greater than 6 months

Condition	EPA number	Medical necessity criteria
Cholangiocarcinoma	870001668	When the following conditions are met: • Non-metastatic disease **AND** • **At least one** of the following is met: o Tumor is deemed to be unresectable. o Client is deemed too high risk for surgery. o Operative intervention declined
Renal	870001669	When the following conditions are met: • Nonmetastatic disease **AND** • **At least one** of the following: o Tumor is deemed to be unresectable. o Client is deemed too high-risk for surgery. o Operative intervention declined

HCA does not consider SBRT to be medically necessary for the treatment of primary tumor of bone, head, and neck, adrenal, melanoma, Merkel cell, breast, ovarian, and cervical cancers.

Fee-for-services (FFS) billing instructions

Use the appropriate EPA number for each condition. If the client does not meet EPA criteria, PA is required.

Documentation requirements

Follow HCA's EPA documentation guidelines.

Tumor treating fields

Based upon review of **evidence provided by HTCC (20160115A—Novocure [Tumor Treating Fields])**, 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 visit the Department of Health website.

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 program, see the **Family Planning Billing Guide**.

Screening exams

Cancer screens

(HCPCS codes G0101, G0102, G0103-G0105, G0121, and CPT® codes 71271, 82270, 81519, and 81528)

HCA covers the following cancer screenings:

- Cervical or vaginal
- Colonoscopies
- Colorectal
- Colorectal sDNA FIT test
- Lung (low dose CT)
- Oncology genomic testing (breast)
- Pelvic/breast exams
- Prostate
- PSA testing
- Screening sigmoidoscopies

CPT® or HCPCS Code	Short Description	Limitations
G0101	CA screen; pelvic and clinical breast examination	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.
G0103	PSA screening	Once every 12 months when ordered for clients age 50 and older
G0104	CA screen; flexi sigmoidscope	Clients age 45 and older who are not at high risk Once every 48 months
G0105*	Colorectal scrn; hi risk ind	Clients at high risk for colorectal cancer One every 24 months

CPT® or HCPCS Code	Short Description	Limitations
71271	Ct thorax lung cancer scr c-	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.
82270	Occult blood, feces	N/A
81519	Genomic testing (breast)	Requires EPA (see EPA #870001386 and EPA #870001420)
G0121*	Colon CA scbrn; not high risk ind	Clients age 45 and older Once every 10 years
81528	sDNA FIT test	Clients age 45-75 who are average risk. Once every 3 years. PA required to exceed limits. (Do not report CPT® code 81528 in conjunction with CPT® codes 81275 or 82274.)

***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:

CPT® Code	Short Description
82040	Assay of serum albumin
82247	Bilirubin total
82248	Bilirubin direct
82310	Assay of calcium
82330	Assay of calcium
82374	Assay blood carbon dioxide

CPT® Code	Short Description
82435	Assay of blood chloride
82465	Assay bld/serum cholesterol
82565	Assay of creatinine
82947	Assay glucose blood quant
82977	Assay of ggt
83615	Lactate (ld) (ldh) enzyme
84075	Assay alkaline phosphatase
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay of protein serum
84295	Assay of serum sodium
84450	Transferase (ast) (sgot)
84460	Alanine amino (alt) (sgpt)
84478	Assay of triglycerides
84520	Assay of urea nitrogen
84550	Assay of blood/uric acid
85004	Automated diff wbc count
85007	Bl smear w/diff wbc count
85009	Manual diff wbc count b-coat
85027	Complete cbc automated

- 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.

Vitamin D screening and testing

Service procedure codes

CPT® codes 82306 and 82652

Medical necessity criteria

Based upon review of **evidence provided by HTCC (20121116B—Vitamin D Screening and Testing)**, HCA considers Vitamin D testing to be medically necessary with the following conditions:

- 25-hydroxy Vitamin D, calcidiol (CPT® code 82306):
  - 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
  - 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

- 25-dihydroxy Vitamin D, calcitriol (CPT® code 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

HCA does not consider routine Vitamin D screening for the general population to be medically necessary.

Blood lead screening tests (federal Medicaid testing requirements)

Per federal guidelines, blood lead screening tests are required for all children enrolled in Apple Health (Medicaid) as follows:

- At ages 12 months and 24 months
- At ages 24 to 72 months if no record of a previous blood lead screening test exists

Providers must perform a risk assessment at every checkup as appropriate. Providers may refer to the Department of Health's website for more information on recommended lead risk assessment tools, blood lead testing methods, requirements for reporting blood lead screening test results, and lead exposure risk mapping.

> **Note**: Completion of a risk assessment does not meet the federal Medicaid requirement for blood lead screening tests. The requirement is met only when the blood lead screening tests (or a catch-up blood lead screening test) are conducted.

COVID-19 testing

> **Note:** Testing must be performed by a Clinical Laboratory Improvement Amendments (CLIA)-certified lab unless the test is designated by the FDA as a CLIA-waived test. Z11.59 and Z20.822 are covered diagnosis codes.

Over-the-counter (OTC) COVID-19 testing

Refer to HCA's coverage policy for OTC COVID-19 testing for pharmacists and pharmacies in HCA's Prescription Drug Program Billing Guide.

COVID-19 molecular and antigen testing

Service Procedure Codes

CPT® codes: 87635, 87636, 87637, 87913, 87426, 87428, and 87811

HCPCS codes: U0001 and U0002

Medical Necessity Criteria

HCA considers molecular and antigen COVID-19 testing to be medically necessary when all the following are present:

- Targeted testing:
  - Test is being used for diagnostic purposes
  - Results of the test will be used for medical management of the client's illness
  - Test is ordered by a qualified provider
  - Client does not have a primary diagnosis of screening for COVID 19
- Multiplex or panel testing:
  - The client requires hospitalization
  - Test is ordered by a qualified provider
  - Test is being used for diagnostic purposes
  - Results of the test will be used for medical management of the client's illness
  - Limited to place of service 19, 21, 22, and 23
  - Client does not have a primary diagnosis of suspected exposure of COVID 19 or screening for COVID 19

HCA does not consider qualitative COVID 19 molecular testing (CPT® code 87913) to be medically necessary.

HCA does not consider at home molecular tests to be medically necessary.

Fee-for-Service Billing Instructions:

When the medical necessity criteria are met, HCA allows two molecular tests per client, per month and four antigen tests per client, per month.

COVID-19 antibody testing

Service procedure codes

CPT® codes 86328, 86408, 86409, 86413, and 86769

Medical necessity criteria

Antibody testing currently has clinical applicability only in specific circumstances and is not recommended for the general public on a broad scale. Per the Centers for Disease Control (CDC) Interim Guidelines for COVID-19, antibody testing should not be used to determine immune status in individuals until the presence, durability, and duration of immunity is established.

The antibody test is used by a clinician to initiate or change the management of a client's care. A representative example of this occurs in cases where a client has late complications of COVID-19 illness, such as multisystem inflammatory syndrome in children.

Fee-for-service (FFS) billing instructions

HCA limits antibody tests to one per calendar year, per client. If additional tests are needed, providers may submit a limitation extension request to HCA.

Drug testing for substance use disorder (SUD)

Service procedure codes

CPT® codes 80305, 80306, 80307, G0480, G0481, G0482, and G0483

Medical necessity criteria

HCA considers drug testing for substance use disorder (SUD) to be medically necessary when ordered by a provider (physician, physician's assistant, advanced registered nurse practitioner, etc.) as part of a medical evaluation and:

- Testing is required to assess suitability for medical tests or treatment being provided by the provider.
- When it is being used to monitor clients receiving medication for opioid use disorder (MOUD). Presumptive or confirmatory, or both, coverage is as follows:
    - HCA considers presumptive or in-office testing with point of care immunoassays (IA) to be medically necessary to:
        - Confirm the use of prescribed substances
        - Identify the presence of illicit or nonprescribed substances

- HCA considers confirmatory or definitive testing with gas chromatography–mass spectrometry (GCMS) or liquid chromatography-tandem mass spectrometry (LCMS) to be medically necessary when done to:
  - Confirm an unexpected result (of presumptive test)
  - Identify drugs or metabolites that cannot be detected on a presumptive test

HCA does not consider drug testing for SUD to be medically necessary when performed with serial quantitative testing to monitor levels of drug metabolites.

Fee-for-service (FFS) billing instructions

Providers may bill only one of the following HCPCS codes per client, per day: G0480, G0481, G0482, and G0483. If additional tests are needed, providers may submit a limitation extension (LE) request to HCA.

HCA reimburses:

- Up to 24 presumptive tests per client, per year
- Up to 12 definitive tests (follow-up tests to presumptive tests) per client, per year
- HCPCS codes G0480, G0481, G0482 and G0483 at the same rate

Documentation requirements

Documentation must include all the following:

- Client-specific rationale for the test being performed or ordered (such as, client's medical history, clinical presentation, etc.)
- Details showing how the test results will be used to inform the client's treatment plan
- The following definitive test documentation:
  - Clinical signs or symptoms suggesting active use
  - Information showing that the test was based on the result of the presumptive test if the test is being used as confirmatory
  - Information supporting the specific test being requested is required and is based on client reports, clinical exam findings, or local drug surveillance reports suggesting that a substance is present and available in the region. If the definitive test is being used to find a drug which is not a part of the presumptive test, that should be noted.

HCA does not allow these tests to be performed via telemedicine.

Note:

- HCA may conduct a postpay review to ensure that policy requirements have been met, specifically when both a presumptive and definitive test are ordered on the same day. If these requirements were not met at the time of billing, HCA may recoup payment.
- HCA requires prior authorization for any procedure codes not listed in this policy.
- For clients under fee-for-service, behavioral health agencies should refer to HCA's Substance Use Disorder Billing Guide. For clients enrolled in an HCA-contracted managed care organization, refer to HCA's Service Encounter Reporting Instructions.

Drug screening for chronic noncancer pain

For treatment of chronic noncancer pain, HCA has adopted the Agency Medical Directors' Group (AMDG) drug screening guidelines outlined in the AMDGs' interagency guidelines.

Enhanced reimbursement rate for medication for opioid use disorder (MOUD)

Service procedure codes

CPT® codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99251, 99252, 99253, 99254, and 99255

Medical necessity criteria

HCA considers MOUD to be medically necessary when **all the following** are met:

- The client has an opioid use disorder diagnosis listed on the claim.

  AND

- The provider:
  - Bills for treating a client with a qualifying diagnosis for opioid use disorder.

  AND

  - Provides opioid-related counseling during the visit.

The purpose of this enhanced reimbursement is to increase client access to evidence-based treatment using MOUD.

Fee-for-service (FFS) billing instructions

One enhanced reimbursement rate, per client, per day is allowed. 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.

If all criteria are met, use EPA #870001537. If the criteria are not met, PA is required.

General billing information

Providers are subject to post-pay review to ensure the EPA criteria for the rate enhancement are met. If the criteria 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

Service procedure codes

CPT® codes 86480 and 86481

Medical necessity criteria

HCA considers targeted TB testing with interferon-gamma release assays to be medically necessary for **clients** at high risk of developing TB based on guidance from the Centers for Disease Control and Prevention (CDC). For coverage information for children, refer to HCA's EPSDT Well-Child Program Billing Guide.

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 (20180518B—Pharmacogenetic Testing for Patients Being Treated With Oral Anticoagulants)**, 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 (20170120A—Pharmacogenomic Testing for Selected Conditions)**, 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:

CPT® Code	Short Description
83718	Assay of lipoprotein
84443	Assay thyroid stim hormone
85025	Automated hemogram
85651	Rbc sed rate, nonautomated
86255	Fluorescent antibody, screen
86430	Rheumatoid factor test
86592	Blood serology, qualitative
86644	CMV antibody
86694	Herpes simplex test
86705	Hep b core antibody, test
86709	Hep a antibody, igm
86762	Rubella antibody
86777	Toxoplasma antibody
86803	Hep c ab test, confirm
86850	RBC antibody screen
86900	Blood typing, ABO
86901	Blood typing, Rh(D)
87340	Hepatitis b surface ag, eia

Gene expression

- Based upon review of the evidence provided by HTCC (20180316A—Gene Expression Profile Testing of Cancer Tissue), 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.
- Per NCCN guidelines for diagnosis of thyroid cancer, HCA considers molecular gene analysis of thyroid nodules that have been determined as "inconclusive" after fine needle aspiration to be medically necessary when the criteria in EPA #870001642 is met.
- 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. 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)).

Testosterone testing

Service procedure codes

CPT® codes 84402, 84403, and 84410

Medical necessity criteria

Based upon review of evidence provided by HTCC (20150320A—Testosterone Testing), HCA considers testosterone testing to be medically necessary for clients assigned male at birth who are age 18 and older when **at least one** of the following conditions are met:

- Suspected or known primary hypogonadism
- Suspected or known secondary hypogonadism with an organic cause, such as one of the following:
  - Pituitary disorders
  - Suprasellar tumor
  - Medications suspected to cause hypogonadism
  - HIV with weight loss
  - Osteoporosis
- Physical signs of hypogonadism

- The following symptoms of sexual dysfunction (all three criteria from European male aging study):
  - Poor morning erection
  - Low sexual desire
  - Erectile dysfunction
- Monitoring of testosterone therapy

Fee-for-service (FFS) billing Instructions

For clients assigned male at birth who are age 18 and over, use EPA #870001368, if medical necessity criteria are met. If the client does not meet the medical necessity criteria, PA is required.

> **Note:** EPA is not required for clients assigned female at birth of any age or for clients assigned male at birth who are age 17 and younger. If related to Transhealth, refer to HCA's Transhealth Program Billing Guide.

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:
  - For separate and distinct times
  - Up to two separate blood draw fees for CPT® codes 36415 or 36591 per day
  - 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 services/professional health care 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 QW

Modifier QW is used to indicate the diagnostic lab service is a Clinical Laboratory Improvement Amendment (CLIA)-waived test and the provider has a Certificate of Waiver. Include the QW modifier when appropriate.

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.
- 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:

Procedure Code	Short Description
G0306	CBC/diffwbc w/o platelet
G0307	CBC without platelet
80047	Metabolic panel ionized ca
80048	Metabolic panel total ca
80051	Electrolyte panel
80069	Renal function panel
80076	Hepatic function panel
80156	Assay, carbamazepine total
80162	Assay of digoxin
80170	Assay of gentamicin
80164	Assay dipropylacetic acid
80178	Assay of lithium
80184	Assay of phenobarbital
80185	Assay of phenytoin total
80188	Assay primidone
80192	Assay of procainamide
80194	Assay of quinidine
80197	Assay of tacrolimus
80198	Assay of theophylline

Procedure Code	Short Description
81000	Urinalysis nonauto w/scope
81001	Urinalysis auto w/scope
81002	Urinalysis nonauto w/o scope
81003	Urinalysis auto w/o scope
81005	Urinalysis
82009	Test for acetone/ketones
82040	Assay of serum albumin
82055	Assay of ethanol
82150	Assay of amylase
82247	Bilirubin total
82248	Bilirubin direct
82310	Assay of calcium
82330	Assay of calcium
82374	Assay blood carbon dioxide
82435	Assay of blood chloride
82550	Assay of ck (cpk)
82565	Assay of creatinine
82803	Blood gases any combination
82945	Glucose other fluid
82947	Assay glucose blood quant
83615	Lactate (LD) (LDH) enzyme
83633	Test urine for lactose
83664	Lamellar bdy fetal lung

Procedure Code	Short Description
83735	Assay of magnesium
83874	Assay of myoglobin
83880	Assay of natriuretic peptide
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay of protein serum
84157	Assay of protein other
84295	Assay of serum sodium
84302	Assay of sweat sodium
84450	Transferase (AST)(SGOT)
84484	Assay of troponin quant
84512	Assay of troponin qual
84520	Assay of urea nitrogen
84550	Assay of blood/uric acid
84702	Chorionic gonadotropin test
84704	Hcg free betachain test
85004	Automated diff wbc count
85007	Bl smear w/diff wbc count
85025	Complete cbc w/auto diff wbc
85027	Complete cbc automated
85032	Manual cell count each
85046	Reticyte/hgb concentrate
85049	Automated platelet count

Procedure Code	Short Description
85378	Fibrin degrade semiquant
85380	Fibrin degradj d-dimer
85384	Fibrinogen activity
85396	Clotting assay whole blood
85610	Prothrombin time
85730	Thromboplastin time partial
86308	Heterophile antibody screen
86367	Stem cells total count
86403	Particle agglut antbdy scrn
86880	Coombs test
86900	Blood typing ABO
86901	Blood typing rh (d)
86920	Compatibility test spin
86921	Compatibility test incubate
86922	Compatibility test antiglob
86923	Compatibility test electric
86971	Rbc pretx incubatj w/enzymes
87205	Smear gram stain
87210	Smear wet mount saline/ink
87281	Pneumocystis carinii ag if
87327	Cryptococcus neoform ag eia
87400	Influenza a/b ag eia
89051	Body fluid cell count

Procedure Code	Short Description
86367	Stem cells total count
86923	Compatibility test electric
88720	Bilirubin total transcut
88740	Transcutaneous carboxyhb
88741	Transcutaneous methb

Medicine

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 units 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.

Service Provided	What should I bill?
Injection and antigen/antigen preparation for allergen immunotherapy	One injection (CPT® code 95115 or 95117); **and** One antigen/antigen preparation (CPT® codes 95145-95149, 95165 or 95170).
Antigen/antigen preparation for stinging/biting insects	CPT® codes 95145-95149 and 95170
All other antigen/antigen preparation services (e.g., dust, pollens)	CPT® code 95144 for single dose vials; **or** CPT® code 95165 for multiple dose vials.
Allergist prepared the extract to be injected by another physician	CPT® code 95144
Allergists who billed the complete services (CPT® codes 95120-95134) and used treatment boards	One antigen/antigen preparation (CPT® codes 95145-95149, 95165, and 95170); **and** One injection (CPT® code 95115 or 95117).
Physician injects one dose of a multiple dose vial	Bill for the total number of doses in the vial and an injection code
Physician or another physician injects the remaining doses at subsequent times	Bill only the injection service

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.

Behavioral services and screening

Autism screening for children

Service procedure codes

CPT® code 96110

Refer to HCA's **EPSDT Well-Child Program Billing Guide** for more information.

For more information about applied behavioral health (ABA) see HCA's **Applied Behavior Analysis (ABA) Program Billing Guide**.

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 the 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

Resource	Language/Method
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 program 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 program 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 (**HCPCS code 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 (HCPCS code 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.
- 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

Depression screening

Service Procedure Codes

CPT® code 96127 and 96160

Medical Necessity Criteria

HCA considers depression screening to be medically necessary. Providers must follow standard coding practices when billing and follow applicable HCA rules.

General Billing Information

When billing for clients age 20 and younger, see HCA's **Early and Periodic Screening, Diagnosis, and Treatment Well-Child Program Billing Guide**.

For depression screening for prenatal and postpartum clients, see HCA's **Pregnancy-Related Services Billing Guide**.

Caregiver/birthing parent depression screening

HCA covers the following for caregiver/birthing parent depression screening:

CPT® code	Short description	Comments
96160	Pt-focused hlth risk assmt	Caregiver/birthing parent depression screening completed by the caregiver's provider during the 12 months postpartum. Bill under the caregiver's ProviderOne ID number.
96161	Caregiver health risk assmt	Caregiver/birthing parent depression screening is required at well-child checkups for caregivers/birthing parents of infants up to age 12 months. HCA reimburses caregiver depression screens for up to two caregivers per checkup. Use for fee-for-service clients with the infant's ProviderOne ID number.

What if a problem is identified as the result of a screening?

When a screening indicates a possible problem, the screening provider must ensure the client receives necessary services, including referring the client to an appropriate provider for an assessment where a diagnosis and plan of care are developed. Health care professionals may provide services for clients when services are within their scope of practice. To be reimbursed, providers must indicate the screening outcome by including one of the modifiers listed below. Providers must document in the client's record the name of the screening tool, the score, and what referrals were made.

Modifier	Description
U1	No need identified (negative screen). Indicates screening score within a normal range.
U2	Need identified (positive screen). Indicates risk, concern, impairment, or identification of a developmental and/or behavioral disorder.

Note: Providers are responsible for having adequate training to administer and interpret screening tools, including determining screening outcome.

Developmental and behavioral health screening

HCA covers screening for developmental and behavioral health for children and youth 20 years of age and younger.

For further information, see the **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Well-Child Program Billing Guide**.

Group clinical visits for clients with diabetes or asthma

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.

Service procedure codes

Use CPT® code 99078 when billing for this service.

Medical necessity criteria

HCA considers group clinical visits for clients with diabetes or asthma to be medically necessary when the following criteria are met:

- 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

Fee-for-service (FFS) billing instructions

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.

CPT® Code	Restricted to Diagnoses	Visit Limitations
99078	Diabetes and asthma	Limited to four (4) one-hour units per calendar year, per client, per condition If requesting additional units, see **Limitation extension (LE)**

Note: Bill only for the time that a client spends in the group clinical visit.

Documentation requirements

Document all the following 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

General billing information

Do not bill 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.

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.

CPT® Code	Short Description
96156	Hlth bhv assmt/reassessment
96158	Hlth bhv ivntj indiv 1st 30
96159	Hlth bhv ivntj indiv ea addl
96164	Hlth bhv ivntj grp 1st 30
96165	Hlth bhv ivntj grp ea addl
96167	Hlth bhv ivntj fam 1st 30
96168	Hlth bhv ivntj fam ea addl

CPT® Code	Short Description
96170	Hlth bhv ivntj fam wo pt 1st
96171	Hlth bhv ivntj fam w/o pt ea

For additional information on code descriptions and billing for health and behavior codes, visit the **Resources for behavioral health providers webpage**.

HIV/AIDS counseling/testing

Service procedure codes

Use CPT® code 99401 when billing for this service.

General billing information

Providers may bill two sessions of risk factor reduction 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 for HIV/AIDS counseling.

Do not bill for HIV/AIDS counseling when billing for 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.

See HCA's **HIV/AIDS Case Management Billing Guide** for additional information on HIV/AIDS case management billing.

Neuropsychological testing

For Neuropsychological testing, see HCA's **Mental Health Services Billing Guide**.

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.

SDOH risk assessment

Service Procedure Codes

HCPCS code: G0136

CPT® codes (qualifying visits): G0463, 59400, 59410, 59425, 59426, 59430, 59510, 59515, 59610, 59614, 59618, 59622, 90791, 96156, 96158, 96159, 99204, 99205, 99214, 99215, 99244, 99245, 99344, 99345, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, and 99397

Medical Necessity Criteria

HCA considers SDOH risk assessments to be medically necessary. SDOH risk assessments must be provided with an evidence-based SDOH risk screening assessment and billed in conjunction with a qualifying visit. SDOH is reimbursed only once per client, every 6 months unless the client is 24 months of age or younger. For more information, see HCA's **EPSDT Well-Child Program Billing Guide**.

Documentation Requirements

Providers must document the SDOH risk assessment in the client's health care record using an evidence-based SDOH risk assessment which includes:

- CMS The Accountable Health Communities Health-Related Social Needs Screening Tool; or,
- Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE)
- Other qualified evidence-based SDOH risk screening tool

> **Note:** The SDOH risk screening is not intended to be for routine screening and is not payable with low-level evaluation and management codes.

Cardiovascular

Catheter ablation for supraventricular tachyarrhythmias

Service procedure codes

(CPT® codes 93653, 93655, 93656, 93657)

Medical necessity criteria

Based upon review of **evidence provided by HTCC (20130517B—Catheter Ablation Procedures for Supraventricular Tachyarrythmias (SVTA)**, 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.

HCA does not consider catheter ablation for adults medically necessary for other nonreentrant supraventricular tachycardias.

Heart catheterizations

General billing information

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.

Outpatient cardiac rehabilitation

Program requirements

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

Clinical policy for outpatient cardiac rehabilitation

Service procedure codes

CPT® codes: 93797 and 93798

HCPCS codes: G0422 and G0423

Medical necessity criteria

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.

Fee-for-service (FFS) billing instructions

The initial series of cardiac rehabilitation sessions does not require PA, and it is only approved for the diagnoses listed under *Medical necessity criteria*. Bill the appropriate procedure code with one of the following diagnoses:

- Acute myocardial infarction
- Angina pectoris
- Aortocoronary bypass status
- Percutaneous transluminal coronary angioplasty status

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.

Chemotherapy

Chemotherapy services

Service procedure codes

Use CPT® codes 96409, 96411, 96413, 96417, and 96523 when billing for these services.

General billing information

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.
- Bill 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).
- **Items and services not separately payable with drug administration**:

  Some items and services are included in the payment for the drug administration service, so do not bill separately for these services. 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/push 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: Bill drug, infusion, and injection codes on the same claim.

How do I bill for Avastin® (*bevacizumab*)?

Retroactive to dates of service on and after April 1, 2022, HCA reimburses for Avastin® (*bevacizumab*) when billed following the requirements in HCA's Prescription Drug Program Billing Guide.

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/professional health care services fee schedule for services that require PA.

Dialysis

Outpatient end-stage renal disease (ESRD)

For Outpatient End-Stage Renal Disease (ESRD) policy information, refer to HCA's Kidney Center Services Billing Guide.

Hemodialysis for inpatient or non-ESRD outpatient visits

Service procedure codes

CPT® codes 90935, 90937, and 90940

Medical necessity criteria

HCA considers hemodialysis for inpatient or non-ESRD outpatient visits to be medically necessary. Providers must follow standard coding practices when billing and follow applicable agency rules.

Fee-for-services (FFS) billing instructions

For outpatient non-ESRD visits, bill using the appropriate diagnosis code for clients requiring dialysis but who do not have ESRD. For outpatient ESRD policy information, refer to HCA's Kidney Center Services Billing Guide.

Documentation requirements

When billing for services using CPT® code 90940, a detailed report may be needed. For more information, refer to Definitions, under "By report" or the fee schedule.

Inpatient visits for dialysis procedures other than hemodialysis

(e.g., peritoneal dialysis, hemofiltration, or continuous renal replacement therapies)

Service procedure codes

CPT® codes 90945 and 90947

Medical necessity criteria

HCA considers inpatient dialysis procedures other than hemodialysis (e.g., peritoneal dialysis, hemofiltration, or continuous renal replacement therapies) to be medically necessary. Providers must follow standard coding practices when billing and follow applicable agency rules.

Fee-for-services (FFS) billing instructions

For outpatient non-ESRD visits, bill using the appropriate diagnosis code for clients requiring dialysis but who do not have ESRD. For outpatient ESRD policy information, refer to HCA's Kidney Center Services Billing Guide.

Endocrinology

Professional or diagnostic continuous glucose monitoring

Service procedure codes

CPT® codes 95249 and 95250

Medical necessity criteria

HCA considers professional or diagnostic continuous glucose monitoring (CGM) to be medically necessary when:

- The client meets **any of the following** criteria:
  - Has a diagnosis of type 1 diabetes and does not own a personal CGM device

    -OR-
  - Has a diagnosis of type 2 diabetes and **both of the following**:
    - Is on insulin or other injectable hypoglycemic agents
    - Has frequent hypoglycemic episodes or hypoglycemic unawareness

    -OR-
  - Is suspected to have primary islet cell hypertrophy or persistent hyperinsulinemia hypoglycemia of infancy

    -AND-
- The CGM meets **all the following** criteria:
  - Is used for no more than 72 hours
  - Is ordered by an appropriately licensed provider
  - Is provided by an FDA-approved CGM device

Fee-for-service (FFS) billing instructions

If medical necessity criteria are met, use EPA# 870001312. If the criteria are not met, PA is required.

General billing information

Services are subject to the following limitations:

- Two per client every 12 months
- Billable no sooner than every 30 days

Note: For personal, long-term CGM supplies, see HCA's Home Infusion Therapy/Parenteral Nutrition Program Billing Guide for policy.

Gastroenterology

Diagnostic capsule endoscopy

Service Procedure Codes

CPT® codes: 91110, 91111, and 91113

Medical Necessity Criteria

HCA considers diagnostic capsule endoscopy to be medically necessary when all the following are true:

- The client has obscure or occult gastrointestinal (GI) bleeding
- The client has had a colonoscopy and esophagogastroduodenoscopy (EGD) that is normal or inconclusive within the past 12 months
- The client has a diagnosis of one or more of the following:
  - Suspected Crohn's disease
  - Known Crohn's disease
  - Suspected small bowel lesion
  - Celiac disease
  - Peutz-Jeghers syndrome (PJS) by genetic testing, clinical findings, or family history
- The client does not have a history of gastrointestinal obstruction

Fee-for-Service Billing Instructions

If the medical necessity criteria are met, prior authorization is required.

Documentation Requirements

When submitting a prior authorization request, a complete Capsule Endoscopy Authorization form (HCA 13-0144) (See HCA's Forms & Publications webpage) history and physical, results of colonoscopy, and results of EGD is required.

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

Whole genome sequencing

Service Procedure Codes

CPT® codes: 81425, 81426, and 81427

Medical Necessity Criteria

Based upon review of evidence provided by HTCC (**20240614A – Whole genome sequencing**), HCA considers whole genome sequencing testing to be medically necessary for the evaluation of unexplained congenital, neurodevelopmental, or neurodegenerative 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 client 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)

    OR

    - **TWO of the following** criteria are met:
        - Significant abnormality affecting at minimum, a single organ system
        - Unexplained cognitive changes in adulthood

- Profound global developmental delay or intellectual disability
- 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

AND all the following is true:

- Other circumstances (e.g., environmental exposures, injury, or infection) 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, or both, warrant testing of multiple genes and **ONE of the following**:
  - Whole genome sequencing 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)
  - Whole genome sequencing results may preclude the need for 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 or American Board of Genetic Counseling certified genetic counselor.

HCA does not consider whole genetic sequencing medically necessary for carrier testing for "at risk" relatives and prenatal or preimplantation testing.

Fee-for-Service Billing Instructions

Clients may receive one whole genome sequencing in a lifetime, except for CPT® code 81426, which is allowed two times per lifetime. If medical necessity criteria above are met, submit a completed Whole Genome Sequencing Prior Authorization form (HCA 13-0142) (See HCA's Forms & Publications webpage). See Prior Authorization.

Documentation Requirements

Submit a completed Whole Genome Sequencing Prior Authorization form (HCA 13-0142)cap (See HCA's Forms & Publications webpage) with required documentation.

Hydration, therapeutic, prophylactic, diagnostic injections, infusions

Hydration therapy with chemotherapy

Service procedure codes

Refer to the appropriate fee schedule for covered procedure codes.

General billing information

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

Service procedure codes

CPT® codes 96360, 96361, 96365, 96366, 96367, 96368, 96369, 96370, 96371, 96372, 963763, 96374, 96375, 96376, 96377, and 96379

Medical necessity criteria

HCA considers therapeutic or diagnostic injections/infusion to be medically necessary. Providers must follow standard coding practices when billing and follow applicable agency rules.

Concurrent infusion

Concurrent infusion (CPT® code +96368) is paid for 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.

Noncovered CPT® Code	Covered HCPCS Code
90281	J1460-J1560
90283	J1566
90284	J1562
90291	J0850
90384	J2790
90385	J2790
90386	J2792
90389	J1670
	J1568, J1569, J1572, J1561

Rabies immune globulin (RIg)

Service procedure codes

CPT® 90375 and 90376

Medical necessity criteria

HCA considers RIg to be medically necessary for post-exposure treatment. Providers must follow standard coding practices when billing and follow applicable HCA rules.

Note: HCA determines medical necessity for the rabies vaccine according to the recommendations and guidelines of the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP)

General billing information

See HCA's Professional administered drugs fee schedule for further information on reimbursement.

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 genetic counseling other than prenatal, use ICD diagnosis code Z71.83 and the appropriate E/M code.

HCA covers genetic counseling (CPT 96041) 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 Physician-related services/professional health care 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**)

See HCA's Pregnancy-Related Services Billing Guide.

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.

Apple Health expansion enrollees ages 19 and 20

The following coverage information applies to those clients enrolled in Apple Health Expansion and who are ages 19 and 20:

Well exams for clients ages 19 and 20

Service Procedure Codes

CPT® codes 99385 and 99395

Medical Necessity Criteria

HCA considers well exams for clients ages 19 and 20 to be medically necessary when all the following are included. Providers must follow standard coding practices when billing and follow applicable HCA rules:

- Initial/interval health history and a family health history
- Measurements – height, weight, and blood pressure
- Sensory screening – vision and hearing*

> **Note:** Audiometric testing may be billed in addition to the E/M codes using CPT® codes 92551 and 92552.

- Behavioral health screening*
- Physical exam
- Procedures, including immunizations and laboratory tests*
- Oral health
- Anticipatory guidance

Documentation Requirements

Providers must document in the client's medical record that each required element under *Medical necessity criteria* was completed at the visit and what the findings were.

General Billing Information

Separately billable services for well exams are indicated under *Medical necessity criteria* with an asterisk (*).

Behavioral health screening for clients ages 19 and 20

Service Procedure Codes

CPT® codes 96127 and 96160

Medical Necessity Criteria

HCA considers behavioral health screening to be medically necessary. For billing instructions, refer to Developmental and behavioral health screening.

Vaccines for clients ages 19 and 20

Medical Necessity Criteria

HCA considers vaccines for clients ages 19 - and 20 to be medically necessary. For billing instructions, refer to **Vaccines/Toxoids (Immunizations)**.

Neurology and neuromuscular procedures

Needle electromyography (EMGs)

HCA has adopted Medicare-established limits for billing needle EMGs (CPT® codes 95860 – 95870) as follows:

CPT® Code	Short Description	Limits
95860	Muscle test one limb	Extremity muscles innervated by three nerves, or four spinal levels must be evaluated with a minimum of five muscles studied.
95861	Muscle test 2 limbs	Extremity muscles innervated by three nerves, or four spinal levels must be evaluated with a minimum of five muscles studied.
95863	Muscle test 3 limbs	Extremity muscles innervated by three nerves, or four spinal levels must be evaluated with a minimum of five muscles studied.
95864	Muscle test 4 limbs	Extremity muscles innervated by three nerves, or four spinal levels must be evaluated with a minimum of five muscles studied.
95865	Muscle test larynx	Limited to one unit per day

CPT® Code	Short Description	Limits
95866	Muscle test hemidiaphragm	Limited to one unit per day
95869	Muscle test thor paraspinal	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.
95870	Muscle test nonparaspinal	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).
95885	Musc tst done w/ nerv tst lim	3 units
95886	Musc test done w/n test comp	3 units
95887	Musc tst done w/n tst nonext	1 unit

Nerve conduction study (NCS)

CPT® Code	Short Description	Limits
95907	Motor&/sens 1-2 nrv cndj tst	1-2 studies
95908	Motor&/sens 3-4 nrv cndj tst	3-4 studies
95909	Motor&/sens 5-6 nrv cndj tst	5-6 studies
95910	Motor&/sens 7-8 nrv cndj tst	7-8 studies

CPT® Code	Short Description	Limits
95911	Motor&/sens 9-10 nrv cndj tst	9-10 studies
95912	Motor&/sens 11-12 nrv cndj tst	11-12 studies
95913	Motor&/sens 13 or more nrv cndj tst	13 or more

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):

CPT® Code	Short Description
92071	Contact lens fitting for tx
92072	Fit contact lens for managmnt
92310	Contact lens fitting
92311	Contact lens fitting
92312	Contact lens fitting
92313	Contact lens fitting
92340	Fit spectacles monofocal
92341	Fit spectacles bifocal
92342	Fit spectacles multifocal
92352	Fit aphakia spectcl monofocl
92353	Fit aphakia spectcl multifoc
92354	Fit spectacles single system
92355	Fit spectacles compound lens

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:

CPT® Code	Short Description
92314	Prescription of contact lens
92315	Rx contact lens aphakia 1 eye
92316	Rx contact lens aphakia 2 eye
92317	Rx comeoscleral contact lens
92370	Repair & adjust spectacles
92371	Repair & adjust spectacles

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:
    - 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).
    - 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 92065, 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
  - 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 code:

Procedure Code	Short Description	Policy/Comments
C1840	Telescopic intraocular lens	Not Covered

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

Procedure Code	Short Description	Policy/Comments
0402T	Colgn cross-link crn med sep	Covered

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:

Clients	Policy
Age 17 or younger	The provider clearly documents the need in the client's record. HCA does not require authorization.
Age 18 or older	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.

Blepharoplasty or blepharoptosis surgery

HCA considers blepharoplasty or blepharoptosis surgery to be medically necessary when all the following clinical criteria are 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.

To receive payment, providers must follow HCA's EPA process and bill with EPA# 870000630. See **Expedited prior authorization (EPA)**.

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 **Physician-related services/professional health care services fee schedule**.

Contact Lens Services

CPT® Code	Modifier	Short Description	PA	Policy/Comments
92071		Contact lens fitting for tx	No	Ages 21-99 2 fittings every 24 months. Ages 0-20 1 fittings every 12 months for asymptomatic clients. Part of July 1, 2021, update[3]

[3] See Vision hardware fitting fees billable to the client's MCO for more information.

CPT® Code	Modifier	Short Description	PA	Policy/Comments
92072		Fit contact lens for managmnt	No	Ages 21-99 2 fittings every 24 months. Ages 0-20 2 fittings every 12 months limited to the appropriate diagnosis code. Part of July 1, 2021, update[2]

Spectacle Fitting fees, monofocal

CPT® Code	Modifier	Short Description	PA	Policy/Comments
92340		Fit spectacles monofocal	No	Part of July 1, 2021, update[4]
92352		Fit aphakia spectcl monofocl	No	Part of July 1, 2021, update[3]

Spectacle Fitting fees, bifocal

CPT® Code	Modifier	Short Description	PA	Policy/Comments
92341		Fit spectacles bifocal	No	Part of July 1, 2021, update[3]

Spectacle Fitting fees, multifocal

CPT® Code	Modifier	Short Description	PA	Policy/Comments
92342		Fit spectacles multifocal	No	Part of July 1, 2021, update[3]

[4] See Vision hardware fitting fees billable to the client's MCO for more information.

CPT® Code	Modifier	Short Description	PA	Policy/Comments
92353		Fit aphakia spectcl multifoc	No	Part of July 1, 2021, update[3]

Note: Fitting fees are **not** currently covered by Medicare and may be billed directly to HCA without attaching a Medicare denial.

Other

CPT® Code	Modifier	Short Description	PA	Policy/Comments
92354		Fit spectacles single system	Yes	Part of July 1, 2021, update[5]
92355		Fit spectacles compound lens	Yes	Part of July 1, 2021, update[4]
92370		Repair & adjust spectacles	No	Applies only to clients age 20 and younger.
92371		Repair & adjust spectacles	No	Applies only to clients age 20 and younger.
92499		Eye service or procedure	Yes	

General Ophthalmological Services

CPT® Code	Modifier	Short Description	PA	Policy/Comments
92002		Eye exam new patient	No	
92004		Eye exam new patient	No	

[5] See Vision hardware fitting fees billable to the client's MCO for more information.

CPT® Code	Modifier	Short Description	PA	Policy/Comments
92012		Eye exam establish patient	No	
92014		Eye exam&tx estab pt 1/>vst	No	

Special Ophthalmological Services

CPT® Code	Modifier	Short Description	PA	Policy/Comments
92015		Determine refractive state	No	
92018		New eye exam & treatment	No	
92019		Eye exam & treatment	No	
92020		Special eye evaluation	No	
92025		Corneal topography	Yes	EPA required. Limited to 2 per calendar year. EPA #870001609
92025	TC	Corneal topography	Yes	EPA required. Limited to 2 per calendar year. EPA #870001609
92025	26	Corneal topography	Yes	EPA required. Limited to 2 per calendar year. EPA #870001609
92060		Special eye evaluation	No	
92060	TC	Special eye evaluation	No	
92060	26	Special eye evaluation	No	

CPT® Code	Modifier	Short Description	PA	Policy/Comments
92065		Orthoptic/pleoptic training	Yes	
92065	TC	Orthoptic/pleoptic training	Yes	
92065	26	Orthoptic/pleoptic training	Yes	
92081		Visual field examination(s)	No	
92081	TC	Visual field examination(s)	No	
92081	26	Visual field examination(s)	No	
92082		Visual field examination(s)	No	
92082	TC	Visual field examination(s)	No	
92082	26	Visual field examination(s)	No	
92083		Visual field examination(s)	No	
92083	TC	Visual field examination(s)	No	
92083	26	Visual field examination(s)	No	
92100		Serial tonometry exam(s)	No	
92133		Cmptr ophth img optic nerve	No	Limited to 1 per calendar year
92133		Cmptr ophth img optic nerve	No	Limited to 1 per calendar year

CPT® Code	Modifier	Short Description	PA	Policy/Comments
92133		Cmptr ophth img optic nerve	No	Limited to 1 per calendar year
92134		Cptr ophth dx img post segmt	No	First 2 procedures per calendar year do not require PA when medically necessary.
92134		Cptr ophth dx img post segmt	Yes	EPA required if additional procedures are medically necessary. Limited to 12 per calendar year. EPA #870000051.
92135	TC	Ophth dx imaging post seg	No	
92136		Ophthalmic biometry	No	
92136	TC	Ophthalmic biometry	No	
92136	26	Ophthalmic biometry	No	
92140		Glaucoma provocative tests	No	

Ophthalmoscopy

Procedure Code	Modifier	Short Description	PA	Policy/Comments
92230		Eye exam with photos	No	
92235		Eye exam with photos	No	
92235	TC	Eye exam with photos	No	
92235	26	Eye exam with photos	No	
92240		Icg angiography	No	

Procedure Code	Modifier	Short Description	PA	Policy/Comments
92240	TC	Icg angiography	No	
92240	26	Icg angiography	No	
92250		Eye exam with photos	No	
92250	TC	Eye exam with photos	No	
92250	26	Eye exam with photos	No	
92260		Ophthalmoscopy/ Dynamometry	No	
V2630		Anter chamber intraocul lens	No	
V2631		Iris support intraoclr lens	No	
V2632		Post chmbr intraocular lens	No	

Other Specialized Services

CPT® Code	Modifier	Short Description	PA	Policy/Comments
92265		Eye muscle evaluation	No	
92265	TC	Eye muscle evaluation	No	
92265	26	Eye muscle evaluation	No	
92270		Electro-oculography	No	
92270	TC	Electro-oculography	No	
92270	26	Electro-oculography	No	

CPT® Code	Modifier	Short Description	PA	Policy/Comments
92275		Electroretinography	No	
92275	TC	Electroretinography	No	
92275	26	Electroretinography	No	
92283		Color vision examination	No	
92283	TC	Color vision examination	No	
92283	26	Color vision examination	No	
92284		Dark adaptation eye exam	No	
92284	TC	Dark adaptation eye exam	No	
92284	26	Dark adaptation eye exam	No	
92285		Eye photography	No	
92285	TC	Eye photography	No	
92285	26	Eye photography	No	
92286		Internal eye photography	No	
92286	TC	Internal eye photography	No	
92286	26	Internal eye photography	No	
92287		Internal eye photography	No	

Contact Lens Services

CPT® Code	Modifier	Short Description	PA	Policy/Comments
92310		Contact lens fitting	No	Part of July 1, 2021, update[6]
92311		Contact lens fitting	No	Part of July 1, 2021, update[5]
92312		Contact lens fitting	No	Part of July 1, 2021, update[5]
92313		Contact lens fitting	No	Part of July 1, 2021, update[5]
92314		Prescription of contact lens	No	
92315		Prescription of contact lens	No	
92316		Prescription of contact lens	No	
92317		Prescription of contact lens	No	

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.

Osteopathic Manipulative therapy

Service procedure codes

CPT® codes 98925, 98926, 98927, 98928, and 98929)

[6] See Vision hardware fitting fees billable to the client's MCO for more information.

Medical necessity criteria

HCA considers osteopathic manipulative therapy to be medically necessary when all the following are present:

- Services are provided by either an osteopathic physician licensed under **chapter 18.71 RCW** or a naturopathic physician licensed under **chapter 18.36A RCW**.
- Providers follow standard coding practices when billing and follow applicable agency rules. Refer to the most recent CPT® book for complete code descriptions, definitions, and guidelines.

Fee-for-service (FFS) billing instructions

HCA covers up to 10 manipulative therapy treatments per client, per calendar year. If the client requires more than 10 visits per year, providers must complete a **limitation extension,** which must be approved and processed before rendering services.

> **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

Procedure Code	Short Description
99183	Hyperbaric oxygen therapy
G0277	Hyperbaric oxygen

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.

Stem cell therapy for musculoskeletal conditions

Based upon review of **evidence provided by HTCC (20200612A—Stem Cell Therapy for Musculoskeletal Conditions),** HCA does not consider stem cell therapy for musculoskeletal conditions to be medically necessary.

Tinnitus

Based upon review of **evidence provided by HTCC (20200515A—Tinnitus: Noninvasive, Nonpharmacologic Treatments)**, 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

Transcranial magnetic stimulation

Based upon review of **evidence provided by HTCC (20230317A—Transcranial Magnetic Stimulation (TMS)**, HCA considers transcranial magnetic stimulation for the treatment of selected conditions to be medically necessary. For more information, refer to HCA's **Mental Health Services Billing Guide**.

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.

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:

Modality	Modifiers
PT/OT/ST	AF

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)

Service procedure codes

CPT® codes: 90471, 90472, 90473, 90474, 90480, and 99401

HCPCS code: M0201

Medical necessity criteria

HCA covers **all** vaccines administered according to the current Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommended Immunization Schedule.

Clients from birth through age 18

For clients 18 years of age and younger, see HCA's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Well-Child Program Billing Guide.

Fee-for-service (FFS) billing instructions

Clients age 19 and older

For a complete list of all covered vaccines and reimbursements for clients age 19 and older, please refer to HCA's Professional administered drugs fee schedule.

When billing HCA:

- The claim must include the CPT® code for each vaccine product given.
- Include the appropriate vaccine administration CPT® codes on the same claim form.
- For COVID-19 vaccines, bill administration CPT® code 90480.
- If an immunization is the only service provided, bill only for the vaccine and for the administration of the vaccine.

Stand-alone vaccine counseling

Providers may bill for stand-alone vaccine counseling.

- Stand-alone vaccine counseling refers to when a client or caregiver, or both, receives counseling about a vaccine from a health care practitioner, but the client does not actually receive the vaccine dose at the same time as the counseling (i.e., no vaccine delivery or injection occurs during the practitioner visit)
- To receive reimbursement, providers must bill using CPT® code 99401 with diagnosis code Z71.85 (encounter for immunization safety) in the primary position on the claim.

Vaccination in the home

HCA pays an additional fee for administering the COVID-19 vaccine in the home (HCPCS code M0201) for the following situations.

The client:

- Is generally unable to leave the home, and if they do leave home, it requires a considerable and taxing effort.
- Has a disability or faces clinical, socioeconomic, or geographical barriers to getting a COVID-19 vaccine in settings other than their home.
- Faces challenges that significantly reduce their ability to get vaccinated outside the home, such as challenges with transportation, communication, or caregiving.

Provider Reimbursement for COVID-19 Vaccine Counseling Visits

Providers who counsel clients about COVID-19 vaccine information and availability can bill in the following ways (review CPT® guidelines for code guidance):

- If the provider is already seeing the client for a prescheduled visit, and counseling for COVID-19 vaccination increases complexity of the visit or the time spent with the client, the provider may account for this by choosing the appropriate evaluation and management (E/M) level.
- The provider may bill CPT® code 99401 using modifier 25 in addition to billing an E/M visit. The E/M visit in this case does not include the time spent on COVID counseling.
- The provider may bill CPT® code 99401 individually if no E/M visit occurred and COVID vaccine counseling was provided.

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 actual 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 actual 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.

HCPCS Code	Short Description
99070	Special supplies phys/qhp
A4206	1 CC sterile syringe&needle
A4207	2 CC sterile syringe&needle
A4208	3 CC sterile syringe&needle
A4209	5+ CC sterile syringe&needle
A4211	Supp for self-adm injections
A4212	Non coring needle or stylet
A4213	20+ CC syringe only
A4215	Sterile needle
A4220	Infusion pump refill kit
A4244	Alcohol or peroxide, per pint
A4245	Alcohol wipes per box
A4246	Betadine/phisohex solution
A4247	Betadine/iodine swabs/wipes
A4252	Blood ketone test or strip
A4253	Blood glucose/reagent strips
A4256	Calibrator solution/chips
A4258	Lancet device each
A4259	Lancets per box
A4262	Temporary tear duct plug
A4263	Permanent tear duct plug
A4265	Paraffin
A4270	Disposable endoscope sheath

HCPCS Code	Short Description
A4300	Cath impl vasc access portal
A4301	Implantable access syst perc
A4305	Drug delivery system >=50 ML
A4306	Drug delivery system <=50 ml
A4310	Insert tray w/o bag/cath
A4311	Catheter w/o bag 2-way latex
A4312	Cath w/o bag 2-way silicone
A4313	Catheter w/bag 3-way
A4314	Cath w/ drainage 2-way latex
A4315	Cath w/ drainage 2-way silcne
A4316	Cath w/ drainage 3-way
A4320	Irrigation tray
A4330	Stool collection pouch
A4335*	Incontinence supply
A4338*	Indwelling catheter latex
A4340*	Indwelling catheter special
A4344*	Cath indw foley 2 way silicn
A4346*	Cath indw foley 3 way
A4351	Straight tip urine catheter
A4352	Coude tip urinary catheter
A4353	Intermittent urinary cath
A4354	Cath insertion tray w/bag
A4355	Bladder irrigation tubing

HCPCS Code	Short Description
A4356*	Ext ureth clmp or compr dvc
A4357*	Bedside drainage bag
A4358*	Urinary leg or abdomen bag
A4361*	Ostomy face plate
A4362*	Solid skin barrier
A4364*	Adhesive, liquid or equal
A4367*	Ostomy belt
A4368*	Ostomy filter
A4397	Irrigation supply sleeve
A4398*	Ostomy irrigation bag
A4399*	Ostomy irrig cone/cath w brs
A4400*	Ostomy irrigation set
A4402	Lubricant per ounce
A4404*	Ostomy ring each
A4421*	Ostomy supply misc
A4455	Adhesive remover per ounce
A4461	Surgicl dress hold non-reuse
A4463	Surgical dress holder reuse
A4465	Non-elastic extremity binder
A4470	Gravlee jet washer
A4480	Vabra aspirator
A4550	Surgical tray
A4556	Electrodes, pair

HCPCS Code	Short Description
A4557	Lead wires, pair
A4558	Conductive paste or gel
A4649	Surgical supply
A5051*	Pouch clsd w barr attached
A5052*	Clsd ostomy pouch w/o barr
A5053*	Clsd ostomy pouch faceplate
A5054*	Clsd ostomy pouch w/flange
A5055*	Stoma cap
A5061*	Pouch drainable w barrier at
A5062*	Drnble ostomy pouch w/o barr
A5063*	Drain ostomy pouch w/flange
A5071*	Urinary pouch w/barrier
A5072*	Urinary pouch w/o barrier
A5073*	Urinary pouch on barr w/flng
A5081*	Continent stoma plug
A5082*	Continent stoma catheter
A5083*	Stoma absorptive cover
A5093*	Ostomy accessory convex inse
A5102*	Bedside drain btl w/wo tube
A5105*	Urinary suspensory
A5112*	Urinary leg bag
A5113*	Latex leg strap
A5114*	Foam/fabric leg strap

HCPCS Code	Short Description
A5120	Skin barrier, wipe or swab
A5121*	Solid skin barrier 6x6
A5122*	Solid skin barrier 8x8
A5126*	Disk/foam pad +or- adhesive
A5131*	Appliance cleaner
A6021	Collagen dressing <=16 sq in
A6022	Collagen drsg>16<=48 sq in
A6023	Collagen dressing >48 sq in
A6024	Collagen dsg wound filler
A6025	Silicone gel sheet, each
A6154	Wound pouch, each
A6231	Hydrogel dsg <=16 sq in
A6232	Hydrogel dsg>16<=48 sq in
A6233	Hydrogel dressing >48 sq in
A6413	Adhesive bandage, first-aid

Alcohol and Substance Abuse

This section identifies professional services related to alcohol and substance abuse. For further coverage information related to substance abuse, please refer to HCA's Substance Use Disorder Program Billing Guide.

Medical services for clients in residential chemical dependency treatment

HCA pays 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).

Service	CPT® Code	Comments
E/M Services	99202-99205; 99211-99215	
Basic Laboratory Services (e.g., dipsticks)	81000; 81002; 81025; 82948	
Venipuncture	36415	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

Clients requiring additional nonemergency medical services such as wound care must go to the provider's office or another medical setting.

Screening, Brief Interventions, and Referral to Treatment (SBIRT)

Service procedure codes

CPT® codes 99408 and 99409

Medical necessity criteria

HCA considers alcohol and substance misuse counseling through screening, brief interventions, and referral to treatment (SBIRT) to be medically necessary when provided by, or under the supervision of, a certified or licensed health care professional within the scope of their practice and who has completed appropriate training for SBIRT.

Fee-for-service (FFS) billing instructions

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 HCA limits brief interventions to four sessions per client, 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.

Who is eligible to become a certified SBIRT provider?

The following practitioners may provide services within the scope of practice as defined in state law:

- Licensed advanced registered nurse practitioners (ARNP)
- Licensed dentist
- Licensed dental hygienists
- Licensed marriage and family therapists
- Licensed marriage and family therapist associates
- Licensed mental health counselors
- Licensed mental health counselor associates
- Licensed psychologist
- Licensed physician
- Licensed physician assistant
- Licensed advance social workers
- Licensed advance social worker associates
- Licensed independent social workers
- Licensed independent social worker associates
- Certified substance use disorder professionals (SUDP)
- Certified behavioral health support specialists

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:

- **HCA's Substance use treatment webpage**, *How do I become SBIRT certified?*
- An education program that includes SBIRT training that the practitioner has completed, and the provider has documentation showing the training was included. Visit HCA's Substance use treatment webpage, *Tools and resources for substance use professionals*.

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

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

Substance-use disorder individual and group counseling

Service procedure codes

CPT® codes 96164, 96165, 96167, 96168, 96170, and 96171

HCPCS codes H0001, H0004, and H0050

See Fee-for-service (FFS) billing instructions for more details.

Medical necessity criteria

HCA considers substance-use disorder (SUD) counseling to be medically necessary when all the following are present:

- Provided by a substance-use disorder professional (SUDP)
- An appropriate American Society of Addiction Medicine (ASAM) assessment completed by a SUDP to plan individual services and supports for SUD treatment
- Billed using servicing taxonomy 101YA0400X.

Note: SUDP trainees may not bill for these services.

Fee-for-service (FFS) billing instructions

Procedure Code	Short description	Comments	Servicing taxonomy
HCPCS H0001	Alcohol and/or drug assess	Assessment is limited to once per day, per client, for each new and returning client.	101YA0400X
HCPCS H0004	Alcohol and/or drug services	Individual therapy sessions are limited to up to 3 hours per day, per client.	101YA0400X
HCPCS H0050	Alcohol/drug service 15 min	This is for brief interventions.	101YA0400X
CPT® 96164	Hlth bhv ivntj grp 1st 30	Must be face-to-face. Group therapy sessions are limited to 11 units per day, per client (1 unit of "first 30 minutes" and 10 units of "each additional 15 minutes."	101YA0400X
CPT® 96165	Hlth bhv ivntj grp ea addl	Must be face-to-face. Must be billed on the same claim as CPT® code 96164. Group therapy sessions are limited to 11 units per day, per client (1 unit of "first 30 minutes" and 10 units of "each additional 15 minutes."	101YA0400X
CPT® 96167	Hlth bhv ivntj fam 1st 30	Must be face-to-face, with the client present. Family therapy sessions are limited to 11 units per day, per client (1 unit of "first 30 minutes" and 10 units of "each additional 15 minutes."	101YA0400X
CPT® 96168	Hlth bhv ivntj fam ea addl	Must be face-to-face, with the client present. Must be billed on the same claim as CPT® code 96167. Family therapy sessions are limited to 11 units per day, per client (1 unit of "first 30 minutes" and 10 units of "each additional 15 minutes."	101YA0400X

Procedure Code	Short description	Comments	Servicing taxonomy
CPT® 96170	Hlth bhv ivntj fam wo pt 1st	Must be face-to-face, without the client present. Family therapy sessions are limited to 11 units per day, per client (1 unit of "first 30 minutes" and 10 units of "each additional 15 minutes." HCA follows NCCI policy unless a waiver is granted to HCA on certain codes. **Note:** When family members attend an individual session, whether in lieu of or along with the client, the session may be billed only once, regardless of the number of family members present.	101YA0400X
CPT® 96171	Hlth bhv ivntj fam w/o pt ea	Must be face-to-face, without the client present. Must be billed on the same claim as CPT® code 96170. Family therapy sessions are limited to 11 units per day, per client (1 unit of "first 30 minutes" and 10 units of "each additional 15 minutes." HCA follows NCCI policy unless a waiver is granted to HCA on certain codes. **Note:** When family members attend an individual session, whether in lieu of or along with the client, the session may be billed only once, regardless of the number of family members present.	101YA0400X

Withdrawal management services

Service procedure codes

Use HCPCS code H0009 or HCPCS code H0009 with modifier TS when billing for these services. (See table under General billing information.)

Medical necessity criteria

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 Substance-Using Pregnant Person (SUPP) program.
- Inpatient psychiatric care is not medically necessary.
- The person meets medical necessity criteria for hospital withdrawal management services.

General billing information

When the medically necessary conditions are met, bill using the following information:

HCPCS Code	Modifier	Short Description	Limitations	Comments
H0009		Alcohol and/or drug services	Limited to one per hospitalization. Restricted to the appropriate ICD diagnosis codes.	Bill for the initial admission.
H0009	TS	Alcohol and/or drug services	Limited to one per hospitalization. Restricted to the appropriate ICD diagnosis codes.	Bill for any follow-up days using follow-up service modifier.

Note: The hospital's NPI must be included in the Claim Note section when billing electronically; otherwise, the claim will be denied.

See HCA's **Inpatient Hospital Services Billing Guide** and **Substance Use Disorder Program Billing Guide** for more information.

How do I bill for take-home naloxone?

For information on billing for take-home naloxone, see HCA's **Prescription Drug Program Billing Guide.**

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 HTCC (20160520B—Autologous Blood and Platelet Rich Plasma Injections), 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 services/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?

Annually, the HTC must 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

Procedure Code	Short Description
J7170	emicizumab-kxwh inj - Hemlibra
J7175	Coagadex (Coagulation Factor X (Human) for Inj.
J7179	Vonvendi (Von Willebrand Factor (Recomb) for Inj.)
J7180	Factor xiii anti-hem factor
J7181	Factor xiii recomb a-subunit
J7182	Factor viii recomb novoeight
J7183	Wilate injection
J7185	Xyntha inj
J7186	Antihemophilic viii/vwf comp
J7187	Humate-P, inj
J7188	Factor viii anti-hemophilic factor, recomb, (obizur)
J7189	Factor viia - Novoseven
J7190	Factor viii- Hemofil M
J7192	Factor viii recombinant NOS
J7193	Factor IX non-recombinant
J7194	Factor ix complex
J7195	Factor IX recombinant
J7198	Anti-inhibitor - FEIBA
J7199	Hemophilia clotting factor, not otherwise classified

Procedure Code	Short Description
J7200	Factor ix recombinan rixubis
J7201	Factor ix fc fusion recomb
J7202	Idelvioni (Coagulation Factor IX (RECOMB) (RIX-FP) For Inj.
J7204	Factor viii, antihemophilic factor (recombinant), (esperoct), glycopegylated-exei
J7205	Factor viii fc fusion recomb – Eloctate
J7207	Adynovate (Antihemophilic Factor Recomb Pegylated for Inj.)
J7208	Injection, factor viii, (antihemophilic factor, recombinant), pegylated-aucl, (jivi)
J7209	Factor viii nuwiq recomb 1iu
J7210	Factor viii, anti-hemophilic, recombinant (afstyla)
J7211	Injection, factor viii, (antihemophilic factor, recombinant), (kovaltry)
J7212	Factor viia (antihemophilic factor, recombinant)-jncw (sevenfact)

Sleep studies

For information on becoming an HCA-approved sleep center, refer to-the Sleep Centers Billing Guide.

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 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.

Drugs excluded from MCO responsibility (billed to 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 excluded from MCO responsibility (billed to FFS) table on HCA's website. (See WAC 182-538-095[5].)

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:

Procedure Code	Short Description	Limitation
J0637	Caspofungin acetate	B37.81, B44.9, B48.4, B44.2, B44.7, B44.1, B44.0, B44.89
J0725	Chorionic gonadotropin/1000u	Q53.01, Q53.02, Q53.10, Q53.11, Q53.12, Q53.20, Q53.21, Q53.22, Q53.9, R01.0
J1212	Dimethyl sulfoxide 50% 50 ML	N30.10, N30.11, N30.20, N30.21
J1595	Injection glatiramer acetate	340 G35 (multiple sclerosis)

Procedure Code	Short Description	Limitation
J1640	Hemin, 1 mg	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.
J1756	Iron sucrose injection	N18.1 – N18.9 (chronic kidney disease)
J2323	Natalizumab injection	Multiple sclerosis G35 Crohn's disease Requires PA. Use *TYSABRI J2323 Request* form 13-832. See **Where can I download HCA forms?**
J2325	Nesiritide	No diagnosis restriction Restricted use only to cardiologists
J2501	Paricalcitol	N18.6 (End stage renal disease)
J2916	Na ferric gluconate complex	N18.6 (End stage renal disease)
J3398	(Luxturna) (Voretigeme neparvovec-rzyl)	May only be provided by a Washington Apple Health-enrolled provider who is certified by the drug manufacturer to administer the product
J3465	Injection, voriconazole	B44.9, B48.4, B44.2, B44.7, B44.1, B44.0, B44.89
J9041	Bortezomib injection	C83.10 – C83.19, C90.00, C90.01

Procedure Code	Short Description	Limitation
J3490	(Yescarta) Axicabtagene ciloleucel suspension for IV infusion	May only be provided by a Washington Apple Health enrolled provider who is certified by the drug manufacturer to administer the product
Q2042	(Kymriah) Tisageneleucel suspension for IV infusion	May only be provided by a Washington Apple Health enrolled provider who is certified by the drug manufacturer to administer the product
Q3027	Inj beta interferon im 1 mcg	G35 (multiple sclerosis)
Q3028	Inj beta interferon sq 1 mcg	G35 (multiple sclerosis)

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 actual 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.

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 = 2 (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:

I. **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 = 2 (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 a medical necessity review by Comagine Health for botulinum toxin injections (Botox). Submit HCA's *Botulinum Toxin Request* (13-003) form with the request to Comagine Health.

Collagenase injections

HCPCS code J0775

HCA requires prior authorization for collagenase injection. Refer to HCA's Professional administered drugs fee schedule.

Hyaluronic acid (HA)/Platelet-rich plasma (PRP)

Based upon review of evidence provided by HTCC (20230721A—Hyaluronic Acid/Platelet Rich Plasma for Knee and Hip OA), HCA does not consider hyaluronic acid (HA) and platelet-rich plasma (PRP) to be medically necessary for the treatment of knee and hip osteoarthritis.

Long-acting injectable buprenorphine

HCA covers long-acting injectable buprenorphine products when provided to Apple Health clients. Prior authorization is not required.

For Apple Health fee-for-service (FFS) clients in an inpatient hospital or psychiatric hospital admission status, providers must bill long-acting injectable buprenorphine as part of the professional services on the last date of discharge.

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.

Radiopharmaceutical: Therapeutic

Procedure codes
CPT® codes 79101, 79445, and 79005

Fee-for-services (FFS) billing instructions
HCA does not require prior authorization for the procedure codes listed above.

Spinraza™
See Outpatient Hospital Services Billing Guide for information.

Synagis®

What are the requirements for the 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** is considered an overpayment and will be subject to recoupment.

HCA continues 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 (PA) 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 *Pharmacy Information Authorization* form (13-835A). After HCA reviews the request, the provider 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 the request, the provider 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 a provider 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. Providers 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 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.

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:
  - Acute inflammatory processes such as, but not limited to, tendonitis
  - Circulatory compromise such as, but not limited to:
    - Lymphedema
    - Raynaud's disease
    - Thromboangiitis obliterans
    - Phlebitis
  - Injuries, fractures, sprains, and dislocations
  - Gout
  - Lacerations, ulcerations, wounds, blisters
  - Neuropathies (e.g., reflex sympathetic dystrophy secondary to diabetes and charcot arthropathy
  - Osteomyelitis
  - Postoperative complications

- 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.

See the Hospice Services Billing Guide when billing for concurrent care treatment – life prolonging/curative treatment.

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 Medical Assistance
- Alien Emergency Medical
- Family Planning Only

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:

Trauma care payment = Base rate x 275%

Criteria for TCF payments to physicians

Physicians and clinical providers receive TCF payments from HCA:

Section1

- 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 includes 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
  - 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
- 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).

Medical Respite Care (Fee-for-Service Clients Only)

Service procedure code
HCPCS code T2033

Description/Background
Medical respite care (MRC) provides post-acute care for people experiencing homelessness who are too ill or frail to recover from a physical illness or injury while living on the streets, but who no longer require a hospital stay. Under ESSB 5693, HCA has funding to pay for MRC for Apple Health fee-for-service (FFS) clients through dates of service on and before June 30, 2025.

> **Note**: For clients enrolled in an HCA-contracted MCO with an IMC, contact the appropriate plan for information about MRC. When billing an MCO for MRC services, continue to use HCPCS code G9006.

Service description
Service procedure code T2033 is considered to encompass key components of MRC models under the National Institute for Medical Respite Care (NIMRC), defined as:

- 24-hour access to a bed
- Three meals per day
- Transportation to all medical appointments
- Access to a phone for telehealth and/or communications related to medical needs
- A safe space to store personal items
- A wellness check at least once every 24 hours by medical respite staff (clinical or nonclinical)

Provider requirements

MRC providers must meet all the following requirements:

- Any provider performing as a medical respite provider treating Apple Health clients 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.
- Meet the **Standards for Medical Respite Care Programs**
- Complete HCA's Attestation for Respite Providers (**see Where can I download HCA forms**? and search for "attestation for medical respite care provider"). Send the completed form to HCA.

HCA notifies the provider when the attestation has been approved.

Providers must notify HCA by email if they no longer meet the requirements to provide MRC as described in this section.

> **Note:** HCA may conduct a post pay review to ensure MRC requirements have been met. If these requirements were not met at the time of billing, HCA may recoup payment.

Facility requirements

A facility that provides MRC services must meet local codes and ordinances for licensing, safety, and occupancy.

Client eligibility

MRC services are available to Apple Health FFS clients (including dual-eligible, FFS clients) who meet all the following:

- Are experiencing homelessness
- Have medical and behavioral health issues
- Meet one of the following:
    - Have recently been discharged from a hospital setting (including emergency room visits)
    - Are referred from a medical clinic (e.g., primary care clinic, federally qualified health center, urgent care facility, mobile medical clinic, or street medicine team) and both of the following are true:
        - Clients have an acute medical condition that can be safely managed in a sheltered outpatient setting
        - Medical respite care is necessary to provide the conditions to support recovery from the acute medical condition

Clients must meet the facility's requirements to receive MRC services.

Fee-for-service (FFS) billing instructions

Retroactive to dates of service on and after July 1, 2022, HCA pays a daily rate for MRC services. For each day of MRC services rendered, providers may submit a claim using HCPCS code T2033 (residential care, not otherwise specified (NOS) waiver; per diem). Enter the date of service only, leaving the admit date blank.

Retroactive to dates of service on and after July 1, 2022, HCA may pay for some additional services provided to a client during a medical respite stay when medically necessary, such as behavioral health services, professional services, or hospice. For more information, go to HCA's **provider billing guides and fee schedules webpage** and select the appropriate billing guide.

Oral Health

Access to Baby and Child Dentistry (ABCD)/MouthMatters program

For policy and billing information on HCA's Access to Baby and Child Dentistry (ABCD)/MouthMatters program, see HCA's Access to Baby and Child Dentistry/MouthMatters Billing Guide.

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

See HCA's Orthodontic Services Billing Instructions.

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:

HCPCS Code	Short Description	Policy Comments
A5500	Diab shoe for density insert	Limit 1 per client, per year
A5501	Diabetic custom molded shoe	Limit 1 per client, per year
A5503	Diabetic shoe w/roller/rocker	Limit 1 per client, per year
A5504	Diabetic shoe with wedge	Limit 1 per client, per year
A5505	Diab shoe w/metatarsal bar	Limit 1 per client, per year
A5506	Diabetic shoe w/offset heal	Limit 1 per client, per year
A5507	Modification diabetic shoe	Requires PA
A5512	Multi den insert direct form	Limit 1 per client, per year
A5513	Multi den insert custom mold	Limit 1 per client, per year
L1902	Afo ankle gauntlet	
L1906	Afo multiligamentus ankle su	
L3000	Ft insert ucb berkeley shell	EPA required
L3030	Foot arch support remov prem	EPA required
L3140	Abduction rotation bar shoe	
L3150	Abduct rotation bar w/o show	
L3170	Foot plastic heel stabilizer	PA required
L3215	Orthopedic ftwear ladies oxf	EPA required. Noncovered for clients age 21 and older.
L3219	Orthopedic mens shoes oxford	EPA required. Noncovered for clients age 21 and older.

HCPCS Code	Short Description	Policy Comments
L3310	Shoe lift elev heel/sole neo	Limit 1 per client, per year
L3320	Shoe lift elev heel/sole cor	Limit 1 per client, per year
L3334	Shoe lifts elevation heel /i	Limit 1 per client, per year
L3340	Shoe wedge sach	PA required
L3350	Shoe heel wedge	PA required
L3360	Shoe sole wedge outside sole	PA required
L3400	Shoe metatarsal bar wedge ro	PA required
L3410	Shoe metatarsal bar between	PA required
L3420	Full sole/heel wedge between	PA required
L3430	Shoe heel count plast reinfor	Limit 1 per client, per year
L4350	Ankle control orthosi prefab	Fractures only
L4360	Pneumatic walking boot prefab	Fractures only; PA required
L4386	Non-pneum walk boot prefab	PA required

(For authorization requirements, follow the **Prosthetic and Orthotic Devices Billing Guide**.)

Supplies paid separately when dispensed from provider's office/clinic

Casting materials

Service procedure codes

Refer to HCA's Physician-related services/professional health care services fee schedule for coverage information.

General billing information

HCA considers casting material to be medically necessary. HCA reimburses separately for casting material when dispensed in a provider office or clinic. Fiberglass and plaster casting materials are 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.

Providers must follow standard coding practices when billing and follow applicable agency rules. Refer to the current CPT® book for complete code descriptions, definitions, and guidelines.

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

HCPCS Code	Short Description
A4614	Hand-held PEFR meter
A4627	Spacer bag/reservoir

Miscellaneous prosthetics and orthotics

HCPCS Code	Short Description
L0120	Cerv flexible non-adjustable
L0220	Thor rib belt custom fabrica
L1810	Ko elastic with joints

HCPCS Code	Short Description
L1820	Ko elas w/ condyle pads & jo
L1830	Ko immobilizer canvas longit
L3650	Shlder fig 8 abduct restrain
L3807	WHFO, no joint, prefabricated
L3908	Wrist cock-up non-molded
L8000	Mastectomy bra
L8600	Implant breast silicone/eq

For additional information and authorization requirements, see HCA's **Prosthetic and Orthotic Devices Billing Guide**.

Miscellaneous supplies

HCPCS Code	Short Description
A4561	Pessary rubber, reusable, any type
A4562	Pessary, reusable, nonrubber, any type
A4565	Slings
A4570	Splint
L8695	External recharge sys extern. (**Requires PA)**

Urinary tract implants

See important policy limitations in Urinary systems.

HCPCS Code	Short Description
L8603	Collagen imp urinary 2.5 ml
L8604	Dextranomer/hyaluronic acid
L8606	Synthetic implnt urinary 1ml

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 policy and billing information pertaining to HCA's Transhealth Program, refer to HCA's Transhealth Program Billing Guide**.**

Washington State Health Care Authority

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. Refer to the **Physician-related services/professional health care services fee schedule** for those codes requiring review by Comagine Health.

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 services/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. When 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 Comagine Health.
- 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 are 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

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 services/professional health care 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 services/professional health care 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:

- 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.

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
- Osteopathic manipulative therapy (more than HCA's published limits)

- Molecular pathology tests as specified on HCA's **Physician-related services/health care professional services fee schedule**
- Panniculectomy
- Hematopoietic progenitor cell boost (CPT® code 38243)
- Vagal nerve stimulator insertion

  For coverage, vagal 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)

  For undergoing treatment in the context of evidence collection/submission of outcome data
- The following surgical procedure codes require **medical necessity review by Comagine Health**:

CPT® Code	Short Description
22899	Spine surgery procedure
23929	Shoulder surgery procedure
24999	Upper arm/elbow surgery
27299	Pelvis/hip joint surgery
27599	Leg surgery procedure
29999	Arthroscopy of joint

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 listed on the 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?**

Some forms available to submit PA requests

The following are forms available to submit PA requests:

- *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

Drug name (brand)	HCPCS code(s)	Form number
acetaminophen injection	J0131	13-756
alglucosidase alfa (Lumizyme) IV inj	J0221	13-756
belimumab (Benlysta) IV inj	J0490	13-756
botulinum toxin inj	J0585 J0586 J0587 J0588	13-003
burosumab-twza (Crysvita) inj	J0584	13-0064
ceftaroline fosamil (Teflaro) IV inj	J0712	13-756
certolizumab pegol (Cimzia) inj	J0717	13-885
denosumab (Prolia) inj	J0897	13-756
elapegademase-lvlr (Revcovi) IM inj	J35990	13-0062
eteplirsen (Exondys 51) IV inj	J1428	13-0012
infliximab (Remicade) IV inj.	J1745	13-897
ipilimumab (Yervoy) IV inj.	J9228	13-756
IV iron	J1756 J2916 Q0138 Q0139 J1439	13-0013
lutetium lu 177 dotatate (Lutathera) IV inj	A9513	13-0060
mannitol for inhaler	J7665	13-756
mepolizumab (Nucala) inj	J2182	13-0011
natalizumab (Tysabri) IV inj	J2323	13-832

Drug name (brand)	HCPCS code(s)	Form number
nivolumab (Opdivo) IV inj	J9299	13-0010
omalizumab (Xolair) inj	J2357	13-852a
pegloticase (Krystexxa) inj	J2507	13-756
pertuzumab (Perjeta) IV inj	J9306	13-916
porfimer sodium (Photofrin) inj	J9600	13-756
ustekinumab (Stelara) inj	J3357	13-898
voretigeme neparvovec-rzyl (Luxturna) susp	J3398	13-0059

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).

Fax

If providers chose to submit a faxed 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 faxed request and must be typed.
- The program form, if available. This form must be attached to the request.
- Charts and justification to support the request for authorization.

Submit faxed PA requests (with forms and documentation) to (866) 668-1214.

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 HCA's online submission process. See the self-service training resources below:

- DDE authorization for medical providers
- DDE authorization for DME providers

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 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.

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 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).

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
870000051	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.

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria

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

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
870000422	Placement of cardiac stent	See Service procedure codes for Cardiac stents	See medical necessity criteria for cardiac stents.
870000425	Hyperbaric Oxygen Therapy	**CPT® code**: 99183 **HCPCS code**: G0277 (Institutional only)	See medical necessity criteria for hyperbaric oxygen therapy.

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
870000610	Visual Exam/Refraction (Optometrists/ Ophthalmologists only)	**CPT® codes**: 92014-92015	**Eye Exam/Refraction - Due to loss or breakage**: 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: • Glasses are broken or lost or contacts that are lost or damaged • Last exam was at least 18 months ago **Note**: EPA # is not required when billing for children or clients with developmental disabilities.
870000630	Blepharoplasties	**CPT® codes**: 15822, 15823, and 67901, 67902, 67903, 67904, 67906, 67908	See medical necessity criteria.
870000631	Strabismus Surgery	**CPT® codes**: 67311, 67312, 67314, 37316, 67318, 67320, 67331, 67332, 67334, 67335, 67340 **Dx Code**: H53.2	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

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria

870001300	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

870001302	Hysterectomies for Cancer	**CPT® codes**: 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.

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
870001303	Hysterectomies - Complications and Trauma	**CPT® codes**: 58150, 58152, 58180, 58200, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58546, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573	Client must have a complication related to a procedure or trauma (e.g., postprocedure complications; postpartum hemorrhaging requiring a hysterectomy; trauma requiring a hysterectomy)
870001312	Professional or diagnostic continuous glucose monitoring (CGM)	See Service procedure codes for Professional or diagnostic continuous glucose monitoring (CGM)	See medical necessity criteria for Professional or diagnostic continuous glucose monitoring (CGM)
870001321	Orencia (abatacept)	**HCPCs code**: 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.
870001325	Targeted TB testing with interferon-gamma release assays	**CPT® codes**: 86480, 86481	See Medical necessity criteria.
870001342	Alloderm	**CPT® Code**: Q4116	See Medical necessity criteria for skin substitutes.

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria

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	See **Service procedure codes for interoperative or postoperative therapeutic pain management**	See medical necessity criteria for interoperative or postoperative therapeutic pain management.

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	See medical necessity criteria for **Initial bone mineral density testing with dual x-ray absorptiometry (DXA)**.

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
870001364	Bone mineral density testing with dual x-ray absorptiometry (DXA) - repeat test	**CPT® codes**: 77080 and 77081	See medical necessity criteria for Repeat bone mineral density testing with dual x-ray absorptiometry (DXA).
870001368	Testosterone testing	See Service procedure codes for Testosterone testing	See Medical necessity criteria for Testosterone testing
870001371	Orthoptic/ pleoptic training	**CPT® code**: 92065,_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**: 92065, 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)
870001373	Orthoptic/ pleoptic training	**CPT® code**: 92065, 97530 **Dx**: H53.30 with secondary dx of TBI	Documented diagnosis of convergence insufficiency, convergence excess, or binocular dysfunction with a secondary diagnosis of traumatic brain injury (TBI)
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

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
870001658	Stereotactic radiation surgery (SRS)	**CPT® codes:** 61796, 61797, 61798, 61799, 61800, 63620, 63621, 77371, 77372, 77373, 77432, and 77435	See medical necessity criteria for stereotactic radiation surgery (SRS)
870001661	Stereotactic body radiation therapy (SBRT): Spine and paraspinal cancer	**CPT® codes:** 32701, 77370, 77373, and 77435	See medical necessity criteria for stereotactic body radiation therapy (SBRT)
870001662	Stereotactic body radiation therapy (SBRT): Located prostate cancer	**CPT® codes:** 32701, 77370, 77373, and 77435	See medical necessity criteria for stereotactic body radiation therapy (SBRT)
870001663	Stereotactic body radiation therapy (SBRT): Non-Small cell lung cancer (NSCLC)	**CPT® codes:** 32701, 77370, 77373, and 77435	See medical necessity criteria for stereotactic body radiation therapy (SBRT)
870001664	Stereotactic body radiation therapy (SBRT): Small cell lung cancer (SCLC)	**CPT® codes:** 32701, 77370, 77373, and 77435	See medical necessity criteria for stereotactic body radiation therapy (SBRT)
870001665	Stereotactic body radiation therapy (SBRT): Pancreatic adenocarcinoma	**CPT® codes:** 32701, 77370, 77373, and 77435	See medical necessity criteria for stereotactic body radiation therapy (SBRT)
870001666	Stereotactic body radiation therapy (SBRT): Oligometastatic disease	**CPT® codes:** 32701, 77370, 77373, and 77435	See medical necessity criteria for stereotactic body radiation therapy (SBRT)

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
870001667	Stereotactic body radiation therapy (SBRT): Hepatocellular carcinoma	**CPT® codes:** 32701, 77370, 77373, and 77435	See medical necessity criteria for stereotactic body radiation therapy (SBRT)
870001668	Stereotactic body radiation therapy (SBRT): Cholangiocarci-noma	**CPT® codes:** 32701, 77370, 77373, and 77435	See medical necessity criteria for stereotactic body radiation therapy (SBRT)
870001669	Stereotactic body radiation therapy (SBRT): Renal	See Service procedure codes for Stereotactic body radiation therapy (SBRT)	See medical necessity criteria for Stereotactic body radiation therapy (SBRT)
870001678	Endobronchial valves placement for severe emphysema	See Service procedure codes for Endobronchial valves placement for severe emphysema	See medical necessity criteria for Endobronchial valves placement for severe emphysema
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

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
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
870001546	Gene expression profile (breast cancer) MammaPrint	81521	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

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
870001547	Gene expression profile (breast cancer) Mammostrat	81599	Breast cancer gene expression testing is covered when all the following conditions are met: • Stage 1 or 2 cancer • The test result will help the patient make decisions about hormone therapy
870001548	Gene expression profile (breast cancer) Breast Cancer Index	81518	The client must be all the following: • HR+ • Lymph node negative (LN-) or lymph node positive (LN+) with 1-3 positive nodes • Early stage (stage 1-2) • Distant recurrence free • Considering hormone/endocrine therapy
870001549	Gene expression profile (prostate cancer) Oncotype Dx prostate cancer assay	0047U	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
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

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
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.
870001642	mRNA gene analysis (thyroid nodules)	81546	All the following must be met: • Clients with one or more thyroid nodules with a history or characteristics suggesting malignancy such as: o Nodule growth over time o Family history of thyroid cancer o Hoarseness, difficulty swallowing or breathing o History of exposure to ionizing radiation o Hard nodule compared with rest of gland consistency o Presence of cervical adenopathy • Have an indeterminate follicular pathology on fine needle aspiration Covered once per client, per lifetime. A second test may be requested through the PA process for a second, unrelated thyroid nodule with indeterminate pathology.

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
870001419	Teledermatology	**CPT® code**: 99211-99214, 99231-99233, 99241-99243, 99252 and 99253	**Note: Effective for dates of service on and after November 1, 2024**, this EPA will end. Providers who would like to provide services via store and forward may do so under E-consults. Dermatologists may provide this consultative service or provide services directly to clients in-person or via telemedicine. See HCA's *Telemedicine Policy Billing Guide* for more information. 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.
870001422	Magnetic Resonance Imaging (MRI) of the sinus for rhinosinusitis	**CPT® code**: 70540, 70542, and 70543	See medical necessity criteria for imaging for rhinosinusitis.

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
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	See medical necessity criteria for imaging for rhinosinusitis.
870001427	Initial psychiatric collaborative care management	**CPT® code**: 99492 **HCPCS code:** G0512, G2214	To be used to initiate new episode of care when there has been less than a 6-month lapse in services: • Provider has identified a need for a new episode of care for an eligible condition • There has been less than 6 months since the client has received any CoCM services
870001428	Subsequent psychiatric collaborative care management	**CPT® code**: 99493 **HCPCS code:** G0512	To be used to continue the episode of care after 6th month when: • Identified need to continue CoCM episode of care past initial 6 months • Client continues to improve as evidenced by improved score from a validated clinical rating scale • Targeted goals have not been met • Patient continues to actively participate in care
870001537	Enhanced reimbursement rate for medication for opioid use disorder	See Service procedure codes for Enhanced reimbursement rate for medication for opioid use disorder	See medical necessity criteria for Enhanced reimbursement rate for medication for opioid use disorder

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
870001554	Vagal nerve stimulation (VNS)	See Service procedure codes for vagal nerve stimulation.	See medical necessity criteria for vagal nerve stimulation.

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria

870001603	BRCA Genetic Testing	81162, 81163, 81164, 81165, 81166, 81167, 81212, 81215, 81216, 81217	Client must be *one* of the following:
			• Of any age with a *known* pathogenic gene variant in a cancer susceptibility gene or with a blood relative with a *known* gene variant in a cancer susceptibility gene
			• Diagnosed at any age with *any* of the following:
			  ○ Ovarian cancer
			  ○ Pancreatic cancer
			  ○ Metastatic prostate cancer
			  ○ Breast cancer or a high grade (Gleason score > 7) prostate cancer and of Ashkenazi Jewish ancestry
			• With a breast cancer diagnosis meeting any of the following:
			  ○ Breast cancer diagnosed < age 50
			  ○ Triple negative breast cancer diagnosed age < age 60
			  ○ Two breast cancer primaries
			  ○ Breast cancer at any age *and* both of the following:
			  ➢ One or more close blood relatives* with *any* of the following:
			  ▪ Breast cancer < age 50
			  ▪ Breast cancer in person assigned male at birth
			  ▪ Pancreatic cancer
			  ▪ High grade or metastatic prostate cancer
			  ➢ Two or more close blood relatives* with breast cancer at any age
			*First-, second-, and third-degree relatives

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
870001609	Corneal topography	92025	Limited to two tests per calendar year. Client has one of 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
870001640	Remote patient monitoring	**CPT® code:** 99453, 99454, 99457, 99458, 99091	• **Client-specific criteria.** The client must exhibit at least one of the following risk factors in each category: ○ Health care utilization: ▪ Two or more hospitalizations in the prior 12-month period ▪ Four or more emergency department admissions in the prior 12-month period ○ Other risk factors that present challenges to optimal care: ▪ Limited or absent informal support systems ▪ Living alone or being home alone for extended periods of time ▪ A history of care access challenges ▪ A history of consistently missed appointments with health care providers • **Device-specific criteria.** The device must have both of the following:

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
			○ Capability to directly transmit patient data to provider ○ An internet connection and capability to use monitoring tools • **Disease-specific criteria.** In addition to meeting the previously defined general criteria, the client must have a qualifying diagnosis of congestive heart failure, chronic obstructive pulmonary disease, or hypertension. ○ Congestive heart failure (CHF): RPM to identify early signs or symptoms of decompensation ▪ New York Heart Association (NYHA) class I-IV chronic, symptomatic heart failure; must be in stable condition and on optimized therapy ○ Chronic obstructive pulmonary disease (COPD): RPM for the purpose of monitoring COPD symptoms and health status ▪ Clinical diagnosis of moderate to very severe (GOLD II–IV) COPD ○ Hypertension (HTN): RPM for the purpose of management of uncomplicated HTN ▪ Client has been diagnosed with stage 1 or 2 HTN. The following are the documentation requirements: • Informed consent
870001645	Gene sequence analysis panel	**CPT® code:** 81418	Covered only for determining eligibility for medication therapy if required or recommended in the FDA labelling for that medication, in Table One of the FDA Table of Pharmacogenetic Associations. These tests have unproven clinical utility for decisions regarding medications when not

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
			required in the FDA labeling (e.g., psychiatric, anticoagulant, opioids).
870001646	Gene sequence analysis panel	**CPT® code:** 81441	Client must: • Be clinically diagnosed with IBMFS and used for diagnostic, not screening, purposes • Have a history of unexplained cytopenias • Have a family history of similar cytopenias, AA, MDS/AML, or clinical stigmata of the IBMFSs • Have a prenatal diagnosis of an at-risk fetus, after confirmation of variant(s) in the parent(s). Must not be used for carrier testing unless one partner is a known carrier.

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
870001647	Targeted genomic sequence analysis panel	**CPT® code:** 81449	Covered as diagnostic test only if one of the following are true: • The requested testing is a companion diagnostic test per the FDA label for the member's cancer type and specific treatments being considered • At least five tumor markers included in the panel individually meet criteria for the tumor type based on one of the following: o All criteria are met from a test-specific guideline if one is available o An oncology therapy FDA label requires results from the tumor marker test to use the therapy effectively or safely for the member's cancer type o NCCN guidelines include the tumor marker test in the management algorithm for that particular cancer type and all other requirements are met (e.g., specific pathology findings, staging); however, the tumor marker must be explicitly included in the guidelines and not simply included in a footnote as an intervention that "may be considered"

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
870001648	Targeted genomic sequence analysis panel	**CPT® code:** 81451	Covered as diagnostic test only if one of the following are true: • The requested testing is a companion diagnostic test per the FDA label for the member's cancer type and specific treatments being considered • At least five tumor markers included in the panel individually meet criteria for the tumor type based on one of the following: o All criteria are met from a test-specific guideline if one is available o An oncology therapy FDA label requires results from the tumor marker test to use the therapy effectively or safely for the member's cancer type o NCCN guidelines include the tumor marker test in the management algorithm for that particular cancer type and all other requirements are met (e.g., specific pathology findings, staging); however, the tumor marker must be explicitly included in the guidelines and not simply included in a footnote as an intervention that "may be considered"

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
870001649	Targeted genomic sequence analysis panel	**CPT® code:** 81456	Covered as diagnostic test only if one of the following are true: • The requested testing is a companion diagnostic test per the FDA label for the member's cancer type and specific treatments being considered • At least five tumor markers included in the panel individually meet criteria for the tumor type based on one of the following: ○ All criteria are met from a test-specific guideline if one is available ○ An oncology therapy FDA label requires results from the tumor marker test to use the therapy effectively or safely for the member's cancer type ○ NCCN guidelines include the tumor marker test in the management algorithm for that particular cancer type and all other requirements are met (e.g., specific pathology findings, staging); however, the tumor marker must be explicitly included in the guidelines and not simply included in a footnote as an intervention that "may be considered"
870001650	Targeted genomic sequence analysis panel	**CPT® code:** 87467	Both of the following must be true: • Client has a confirmed diagnosis of Hepatitis B Virus infection based on positive HBsAg, Anti-HBs antibody, or Anti-core antigen (anti-HBc) antibody test • The result must be used to monitor response to treatment
870001651	Diagnostic anoscopy and biopsy	**CPT® codes:** 46601 and 46607	See Medical necessity criteria for Diagnostic anoscopy and biopsy.

EPA Number	Service Name	CPT®/ HCPCS/ Dx	Criteria
870001674	Implantable infusion pumps or implantable drug delivery systems	See Service procedure codes for Implantable infusion pumps or implantable drug delivery systems	See Medical necessity criteria for Implantable infusion pumps or implantable drug delivery systems *These Outpatient Prospective Payment System (OPPS) procedure codes are listed for providers billing for services using institutional claims. These procedure codes **pay only in OPPS**. See the **fee schedule**.
870001675	Periurethral collagen bulking agents	See Service procedure codes for Periurethral collagen bulking agents	See Medical necessity criteria for Periurethral collagen bulking agents
870001676	Physician supervision of principal care management services	See Service procedure codes for Physician supervision of a patient requiring complex and multidisciplinary care modalities	See Medical necessity criteria for Physician supervision of a patient requiring complex and multidisciplinary care modalities
870001677	Physician supervision of chronic care management services	See Service procedure codes for Physician supervision of a patient requiring complex and multidisciplinary care modalities	See Medical necessity criteria for Physician supervision of a patient requiring complex and multidisciplinary care modalities

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.

Q5: **Physician Services:** Service furnished under a reciprocal billing arrangement by a substitute physician

Q6: **Physician Services:** Service furnished under a fee-for-time compensation arrangement by a substitute physician

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.

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:

FACILITY SETTING

Place of Service Code	Place of Service Description
06	Indian Health Service – provider based
08	Tribal 638 – provider based
19	Off Campus-Outpatient Hospital
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgery Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility

Place of Service Code	Place of Service Description
34	Hospice
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility

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

Place of Service Code	Place of Service Description
04	Homeless Shelter
05	Indian Health – Free Standing
07	Tribal 638 – Free Standing

Place of Service Code	Place of Service Description
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
20	Urgent Care Facility
27	Outreach Site/Street
32	Nursing Facility
33	Custodial Care Facility
49	Independent Clinic
50	Federally Qualified Health Center
54	Intermediate Care Facility
55	Residential Substance Abuse Treatment Facility
57	Nonresident Substance Abuse Treatment Facility
60	Mass Immunization Center
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

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 an 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 on HCA's **Provider 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:
    - 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.
    - The hospital must submit to HCA an electronic institutional claim with the facility fees 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 does the provider notify HCA of a date of birth or date of death?

To report a date of birth or date of death, send a secured email to **mmishelp@hca.wa.gov**. Include the following information in the email:

- TCN #
- ProviderOne client ID
- Client's name
- Date of birth
- Date of death

How does a provider notify HCA of discrepancy in date of birth, date of death, or gender?

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 #
- ProviderOne client ID
- Client's name
- Date of birth
- Date of death
- Client's gender (if related to transhealth, see HCA's Transhealth Program Billing Guide)

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.

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.