Washington State Health Care Authority

Medicaid Provider Guide

Physician-Related Services/ Health Care Professional Services

[Chapter 182-531 WAC]

October 1, 2013

Washington State Health Care Authority

A Billing Instruction

About this guide

This publication, by the Health Care Authority (the agency), supersedes all previous *Physician-Related Services/Health Care Professional Medicaid Provider Guides* published by the agency.

What has changed?

Reason for Change	Effective Date	Subject	Change
Updates to policies, codes, and procedures (PN 13-56)	10-01-13	**Evaluation and Management** Physician Care Plan Oversight Physician supervision of a patient requiring complex and multidisciplinary care modalities	Clarified use of CPT codes 99339 and 99340 and requirements for documentation of care plan oversight.
		Surgery Digestive system Fecal microbiota therapy	Changed previous policy, based on FDA recommendations.
		Nervous system Facet neurotomy Spinal injections Diagnostic selective root block Sacroiliac joint injections Therapeutic/diagnostic epidural injections in the cervical, thoracic or lumbar spine	Updated section to reflect requirements for medical necessary review through Qualis Health and clarify policy and procedure requirements.

Reason for Change	Effective Date	Subject	Change
		Pathology and Laboratory Chemistry Fetal fibronectin	Added policy requirements for clarification.
		Maternity Care and Delivery Unbundling obstetrical care Coding for antepartum care only	Added instructions for the modifier to use (CG or TH) when clients move between managed care and fee for service. Added instructions for using modifier GB for clients.
		Supplies paid separately when dispensed from provider's office/clinic Casting materials	Clarified that fiberglass and plaster casting materials (HCPCS code Q4001-Q4051) is limited to one unit per limb per day.
		Billing and Claim Form Billing for outpatient hospital services in hospital-based clinics	Added billing instructions for outpatient hospital services in hospital-based clinics.
		Various	Made housekeeping changes, such as correcting division names and cross references.

Additional resources

To download and print agency provider notices and Medicaid provider guides, see the agency's Provider Publications website. For additional resources, see the agency's online list of Resources Available.

Copyright Disclosure

CPT copyright 2012 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

CDT 2013 Current Dental Terminology (including procedure codes, nomenclature, descriptors and other data contain therein) is copyright 2012© American Dental Association. All rights reserved.

Table of Contents

Definitions ..... **xii**

Introduction **15**

Acquisition cost (AC) 15
By report (BR) 15
Codes for unlisted procedures 15
Conversion factors 15
Diagnosis codes 16
Discontinued codes 16
National correct coding initiative 16
Procedure codes 17

Provider Eligibility **18**

Who may provide and bill for physician-related services? 18
Substitute physicians (locum tenens) 19
Which health care professionals does the agency not enroll? 19
Out-of-state hospital admissions 20

Client Eligibility **22**

Eligible clients 22
Clients enrolled in a managed care organization 22
Clients enrolled in hospice 22

Coverage - General **23**

Scope of coverage 23
Noncovered services - general 25
Noncovered - physician-related and health care professional services 26

Medical Policy Updates **28**

Policy updates effective 7/1/2013 28
Policy updates effective 4/14/2013 28
Policy updates effective 4/1/2013 28

Evaluation and Management (E/M) **29**

E/M documentation and billing 29
PAL (Partnership Access Line) 29
Office and other outpatient services 29
Office or other outpatient visit limits 29
New patient visits 30
Nursing facility services 30
Pre-operative visit prior to performing a dental service under anesthesia 30

Physical examination - clients of the DSHS' Developmental Disabilities Administration 31
Office visit related to Acomprosate, Naltrexone, Buprenorphyine, Nalozone 31
Behavior change intervention - smoking cessation 31
Services available 31
Washington State Tobacco Quit Line 31
Client eligibility 32
Payment for a smoking cessation referral 32
Smoking cessation referral for an evaluation for a smoking cessation prescription 32
Tobacco cessation for pregnant clients 33
Children's primary health care 36
Consultations 37
TB treatment services 37
Critical care 37
Billing for critical care 38
Where is critical care performed? 38
What is covered? 39
Domiciliary, rest home, or custodial care services 39
Emergency department services 40
Emergency physician-related services 40
Home services 40
Home evaluation and management 40
TB treatment services – performed by professional providers – in client's home 40
Hospital inpatient and observation care services 41
Admission status 41
Change in admission status 41
Payment 44
Other guidelines 44
Inpatient neonatal and pediatric critical care 45
Neonatal intensive care unit (NICU)/Pediatric intensive care unit (PICU) 45
Intensive (noncritical) low birth weight wervices (CPT codes 99478-99480) 47
Newborn care 47
Physicals for clients of DSHS' Developmental Disabilities Administration (DDA) 47
Physician care plan oversight 48
Physician supervision of a patient requiring complex and multidisciplinary care modalities 48
Preventative medicine services 49
HIV/AIDS counseling/testing 49
Prolonged services 49
Prolonged services with direct patient contact 49
Physician standby services 50
Telehealth 51
What is telehealth? 51
Who is eligible for telehealth? 51
When does the agency cover telehealth? 51

Originating site (location of client) 52
Distant site (location of consultant) 53

Anesthesia 54

General anesthesia 54
Regional anesthesia 56
Other 56
Teaching anesthesiologists 57
Physician fee schedule payment for services of teaching physicians 57
Anesthesia for dental 57
Anesthesia for maternity 58
Anesthesia for radiological procedures 59
Anesthesia payment calculation for services paid with base and time units 59

Surgery 60

Pain management services 60
Pain management procedure codes 60
Registered Nurse First Assistants (RNFA) 64
Billing/Payment 64
Bilateral procedures 64
Bundled services 65
Global surgery payment 67
Global surgery payment period 67
Multiple surgeries 68
Other surgical policies 68
Pre-/intra-/postoperative payment splits 70
Auditory system 71
Cochlear implant services (clients 20 years of age and younger) 71
Osseointegrated implants (BAHA) for clients 20 years of age and younger 71
Digestive system 72
Diagnostic upper endoscopy for GERD 72
Closure of enterostomy 73
Contrast material 73
Fecal microbiota therapy 73
Drug eluting stents 74
Cardiovascular 74
Angioscopy 74
Apheresis 74
Transcatheter aortic valve replacement (TAVR) 74
Female genital system 75
Hysterectomies 75
Integumentary system 76
Clarification of coverage policy for miscellaneous procedures 76
Male genital system 76
Circumcisions 76
Musculoskeletal system 76

Artificial disc replacement 76
Bone growth stimulators 77
Bone morphogenetic protein 2 for lumbar fusion 77
Bone morphogenetic protein 7 for lumbar fusion 77
Endoscopy procedures 78
Epiphyseal 78
Hip resurfacing 78
Hip surgery for femoroacetabular impingement (FAI) syndrome 78
Knee arthroscopy for osteoarthritis 79
Microprocessor-controlled lower limb prostheses (MCP) 79
Osteochondral allograft and autograft transplantation 79
Osteotomy reconstruction 80
Percutaneous kyphoplasty, vertebroplasty and sacroplasty 80
Sacroiliac joint arthrodesis 80
Robotic assisted surgery 81
Nervous system 81
Discography 81
Facet neurotomy 82
Implantable infusion pumps or implantable drug delivery systems (IDDS) 82
Spinal cord stimulation for chronic neuropathic pain 83
Spinal injections for diagnostic or therapeutic purposes (outpatient) 83
Transcutaneous electrical nerve stimulation (TENS) device 84
Sleep apnea 85
Surgical treatment for sleep apnea 85
Urinary systems 86
Collagen implants 86
Indwelling catheter 86
Urinary tract implants 86
Urological procedures with sterilizations in the description 87

Radiology Services 88

Radiology services – general limits 88
Radiology modifiers for bilateral procedures 88
Breast, Mammography 88
Mammograms 88
Diagnostic Radiology (Diagnostic Imaging) 89
Which procedures require a medical necessity review by Qualis Health? 89
Computed tomography angiography (CTA) 90
Consultation on x-ray examination 91
Coronary artery calcium scoring 91
Magnetic resonance imaging (MRI) 91
Portable x-rays 92
Ultrasound screening for abdominal aortic aneurysm 93
Virtual colonoscopy or computed tomographic colonography 93
Diagnostic Ultrasound 93
Obstetrical ultrasounds 93

Nuclear Medicine 94
Which procedures require a medical necessity review? 94
Radiopharmaceutical diagnostic imaging agents 95
Nuclear medicine - billing 95
Radiation Oncology 96
Intensity modulated radiation therapy (IMRT) 96
Proton beam radiation therapy 97

Pathology and Laboratory 98

Certifications 98
Independent laboratories - certification 98
Reference labs and facilities - CLIA certification 98
Anatomic Pathology 98
Pap smears 98
Chemistry 99
Cancer screens 99
Disease organ panels--automated multi-channel tests 100
Fetal fibronectin 101
Vitamin D screening and testing 102
Drug Testing 104
Drug screens 104
Suboxone drug screening policy 105
Immunology 105
HIV testing 105
Targeted TB testing with interferon-gamma release assays 106
Organ and disease-oriented panels 106
Automated multi-channel tests - payment 106
Disease organ panel - nonautomated multi-channel 107
Billing 108
Billing for laboratory services that exceed the lines allowed 108
Clinical laboratory codes 108
Coding and payment policies 108
Laboratory physician interpretation codes 110
Laboratory codes requiring modifier and PA clarification 110
Laboratory modifiers 110
Laboratory services referred by CMHC or DBHR-contracted providers 111
STAT laboratory charges 112

Medicine 115

Allergen and clinical immunology 115
Allergen immunotherapy 115
Audiology 116
Who is eligible to provide audiology services? 116
What type of equipment must be used? 117
Audiology billing 118

Audiology coverage table 118
Fee schedule 120
Cardiovascular 120
Heart catheterizations 120
Outpatient cardiac rehabilitation 120
Chemotherapy 122
Chemotherapy services 122
Irrigation of venous access pump 123
Dialysis - End-Stage Renal Disease (ESRD) 123
Inpatient visits for hemodialysis or outpatient non-ESRD dialysis services 123
Inpatient visits for dialysis procedures other than hemodialysis 124
Endocrinology 124
Continuous glucose monitoring 124
Hydration, therapeutic, prophylactic, diagnostic injections, infusions 125
Hydration therapy with chemotherapy 125
Therapeutic or diagnostic injections/infusions 125
Concurrent infusion 125
Immune Globulins, Serum, or Recombinant Products 126
Hepatitis B 126
Immune globulins 126
Rabies immune globulin (RIG) 126
Synagis 127
Medical genetics and genetic counseling services 127
Genetic counseling and genetic testing 127
Miscellaneous 129
After-hours 129
Neurology and neuromuscular procedures 129
Needle electromyography (EMGs) 129
Nerve conduction study (NCS) 130
Sleep medicine testing (sleep apnea) 130
Billing 133
Sleep center physician consultations and referral for cognitive behavioral therapy (CBT) 133
Opthalmology – vision care services 134
Eye examinations and refraction services 134
Coverage for additional examinations and refraction services 134
Visual field exams 135
Vision therapy 135
Ocular prosthetics 135
Eye surgery 136
Vision coverage table 137
Osteopathic manipulative therapy 143
Other services and procedures 144
Hyperbaric oxygen therapy 144
Psychiatry 145
Clozaril - case management 145

Pulmonary 145
Ventilator management 145
Special dermatological services 146
Ultraviolet phototherapy 146
Special services 146
Group clinical visits for clients with diabetes or asthma 146
Therapies (physical, occupational, and speech therapy) 147
Modifier required when billing 148
Vaccines/Toxoids (Immunizations) 148
Clients 19 years of age and older 148
Human papillomavirus (HPV) vaccine 149
Injectable and nasal flu vaccines 150

Maternity Care and Delivery 151

Prenatal assessments not covered 151
Confirmation of pregnancy 151
Global (total) obstetrical (OB) care 152
Unbundling obstetrical care 152
Antepartum care 153
Coding for antepartum care only 154
Coding for deliveries 155
Coding for postpartum care only 155
Additional monitoring for high-risk conditions 156
Labor management 156
High-risk deliveries 157
Consultations 158
General obstetrical payment policies and limitations 159
HIV/AIDS counseling/testing 160
Global (total) obstetrical (OB) care 160
Antepartum care only 161
Deliveries 161
Postpartum care only 161
Additional monitoring for high-risk conditions 162
Labor management 162
High-risk deliveries 162
Abortion services (drug induced) 163
Abortion center contracts (facility fees) 163

Medical Supplies and Equipment 165

General payment policies 165
Supplies included in an office call (bundled supplies) 166

Alcohol and Drug Abuse Treatment Services 169

Medical services for clients in residential chemical dependency treatment 169
Detoxification services 169

Blood, blood products, and related services **171**
Payment for blood and blood products 171
Fee schedule 177

Centers of Excellence (COE) **178**
List of approved COEs 178
Bariatric surgeries 178
Clients 21 through 59 years of age 178
Clients 18 through 20 years of age 178
Bariatric case management fee 179
Billing 179
Hemophilia treatment COEs WAC 182-531-1625 179
What criteria must be met to qualify as a COE for hemophilia treatment? 180
What documentation is required to continue as a qualified COE for hemophilia treatment? 181
Are managed care clients required to receive their hemophilia or von Willebrand-related products from a qualified COE? 181
Coverage table 181
Hysteroscopic sterilizations 182
Sleep studies 182
Transplants 183
Who is eligible for transplants? 183
Who is not eligible for transplants? 183
Which transplant procedures are covered? 183
Does the agency pay for skin grafts and corneal transplants? 184
Does the agency pay for organ procedure fees and donor searches? 184
Does the agency pay for experimental transplant procedures? 184

Drugs Professionally Administered **185**
Invoice requirements 185
Drug pricing 186
National drug code format 186
Physicians billing for compound drugs 187
Miscellaneous drugs requiring prior authorization 188
Drugs requiring written/fax prior authorization 188
Injectable drugs - limitations 189
Billing for injectable drugs and biologicals 190
Chemotherapy drugs 190
Billing for single-dose vials 191
Billing for multi-dose vials 191
Billing for oral anti-emetic drugs when part of a chemotherapy regimen 191
Rounding of units 192
Unlisted drugs 192
Botulinum toxin injections (Botox) 193
Collagenase injections 194
Hyalgan/Synvisc/Euflexxa/Orthovisc/Gel-One 194

Hydroxyprogesterone (17P) 195
Prolia/Xgeva 196
Verteporfin injection 196
Vivitrol 196

Foot Care Services 197

Are foot care services covered? 197
What foot care services does the agency pay for? 197
Acute conditions of the lower extremities by diagnosis 199
What foot care services does the agency not pay for? 202
May I bill the client for foot care services which the agency does not pay for? 203
How do I bill for foot care services? 203

Hospice 204

Physicians providing service to hospice clients 204
Concurrent care for children who are on hospice 204
Concurrent/curative care 204
Authorization for concurrent/curative services 205
Billing 207

Major Trauma Services 208

Increased payments for major trauma care 208
Client eligibility groups included in TCF payments to physicians 208
Client eligibility groups excluded from TCF payments to physicians 209
Services excluded from TCF payments to physicians 209
TCF payments to physicians 209
Enhanced rates for trauma care 209
Criteria for TCF payments to physicians 210
TCF payments to providers in transferred trauma cases 211
Billing for trauma care services 211
Adjusting trauma claims 212
Injury severity score (ISS) 212
Physician/clinical provider list 214

Oral Health 215

Access to Baby and Child Dentistry (ABCD) Program 215
What is the purpose of the ABCD program? 215
What dental services are billable by primary care medical providers? 215
Training and certification 216
Dental disease prevention services 216
Oral Surgery 217
Services performed by a physician or dentist specializing in oral maxillofacial surgery 217
Provider requirements 217
Oral surgery coverage table 218
Emergency Oral Health (EOH) 226

When does the agency pay for EOH services? 226
When does the agency deny a request for EOH services? 226
What services are covered under the EOH benefit? 227
EOH coverage table 229
EOH coverage table 232
Why is an EPA number required when billing for EOH services? 232
When is a signed waiver form required from the client? 233
How does the agency determine prior authorization for EOH? 233
What documentation must be submitted with a prior authorization request for EOH? 233

Prosthetic/Orthotics 234

Prosthetic & orthotics for podiatry and orthopedic surgeons only 234

Supplies paid separately when dispensed from provider's office/clinic 235

Casting materials 235
Inhalation solutions 235
Metered dose inhalers and accessories 235
Miscellaneous prosthetics & orthotics 235
Miscellaneous Supplies 236
Radiopharmaceutical diagnostic imaging agents 236
Urinary tract implants 236

Medical Necessity Review by Qualis Health 237

What is a medical necessity review by Qualis Health? 237
Who can request a review? 237
How do I register with Qualis Health? 238
Is authorization required for all Medicaid clients? 238
How do I submit a request to Qualis Health? 239
What is the Qualis Health reference number for? 240
When does the agency consider retroactive authorizations? 240
What are the authorization requirements for advanced imaging? 241
How does the agency's hierarchy of evidence protocol apply? 241
What are the authorization requirements for surgical procedures? 242
Surgical Modifiers 242
How does the agency's hierarchy of evidence protocol apply? 243
What criteria will Qualis Health use to establish medical necessity? 243
Is there a provider appeals process for Qualis Health? 243

Authorization 245

Prior authorization 245
What is prior authorization (PA)? 245
How does the agency determine PA? 245
Services requiring prior authorization (PA) 246
Documentation for prior authorization 249

Written or fax prior authorization (PA) 250
Limitation extension (LE) 251
What is an LE? 251
How do I request an LE authorization? 251
Expedited prior authorization (EPA) 251
Expedited prior authorization guidelines 252
Expedited Prior Authorization Criteria Coding List 253

Modifiers 264

CPT/HCPCS 264
Anesthesia 269

Site-of-Service (SOS) 271

Payment Differential 271

How are fees established for professional services performed in facility and nonfacility settings? 271
How does the SOS payment policy affect provider payments? 271
Does the agency pay providers differently for services performed in facility and nonfacility settings? 272
When are professional services paid at the facility setting maximum allowable fee? 272
When are professional services paid at the nonfacility setting maximum allowable fee? 273
Which professional services have a SOS payment differential? 274
Fee schedule information 274

Billing and Claim Form 275

What are the general billing requirements? 275
Billing for multiple services 275
Billing for outpatient hospital services in hospital-based clinics 275
How do I complete the CMS-1500 claim form? 276
Submitting professional services on a CMS-1500 claim form for Medicare crossovers 276
Utilization review 277

Definitions

This section defines terms and abbreviations, including acronyms, used in this guide. Please refer to the Medicaid agency's online Medical Assistance Glossary for a more complete list of definitions.

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

Acute care – Care provided for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent monitoring by a health care professional in order 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, as defined by ICD-9-CM diagnostic code. [WAC 182-531-0050]

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) – A number of 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.

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.

EPSDT provider – (1) A physician, advanced registered nurse practitioner (ARNP), or public health nurse certified as an EPSDT provider; ***or*** (2) a dentist, dental hygienist, audiologist, or optometrist who is an enrolled Medical Assistance provider and performs all or one component of the EPSDT screening.

HCPCS- See **Healthcare Common Procedure Coding System**.

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

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

(1) Disclosed and discussed the client's diagnosis.
(2) Offered the client an opportunity to ask questions about the procedure and to request information in writing.
(3) Given the client a copy of the consent form.
(4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257.
(5) Given the client oral information about all of the following:

    (a) The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure.
    (b) Alternatives to the procedure including potential risks, benefits, and consequences.
    (c) 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.

Medical consultant – Physicians employed by the agency who are authorities on the medical aspects of the Medical Assistance program. As part of their responsibilities, agency medical consultants:

- Serve as advisors in communicating to the medical community the scope, limit, and purpose of the program.
- Assist in the development of agency 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, agency policy, and community standards of medical care.
- Serve as advisors to agency 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 agency and various professional provider groups, health care systems (such as HMOs), and other state agencies.
- Serve as expert medical and program policy witnesses for agency at fair hearings.

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

Noncovered service or charge – A service or charge not reimbursed by the agency.

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

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

Resource based relative value scale (RBRVS) – A scale that measures the relative value of a medical service or

intervention, based on the amount of physician resources involved.

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

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

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.

Introduction

Acquisition cost (AC)

Drugs with an **AC** indicator in the fee schedule with billed charges of $1,100.00 or greater, or supplies with billed charges of $50.00 or greater, require a manufacturer's invoice in order to be paid. Attach the invoice to the claim, and if necessary, note the quantity given to the client in the *Comments* section of the claim form. **DO NOT** attach an invoice to the claim for procedure codes with an AC indicator in the fee schedule for drugs with billed charges under $1,100.00, or supplies with billed charges under $50.00, unless requested by the agency.

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

By report (BR)

Services with a **BR** indicator in the fee schedule with billed charges of $1,100.00 or greater require a detailed report in order to be paid. Attach the report to the claim. **DO NOT** attach a report to the claim for services with a BR indicator in the fee schedule with billed charges under $1,100.00 unless requested by the agency.

Codes for unlisted procedures

(CPT code XXX99)

Providers must bill using the appropriate procedure code. The agency 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. The agency requires this for all its programs, as outlined in WAC 182-501-0050. If a provider does not verify the agency's coverage policy before performing a procedure, the agency may not pay for the procedure.

Conversion factors

Conversion factors are multiplied by the relative value units (RVUs) to establish the rates in the agency's Physician-Related Services/Health Care Professionals Fee Schedule. View the agency's conversion factor table.

Diagnosis codes

The agency requires valid and complete ICD-9-CM diagnosis codes. When billing the agency, use the highest level of specificity (4th or 5th digits when applicable) or the services will be denied.

The agency does not cover the following diagnosis codes when billed as the primary diagnosis:

- E codes (Supplementary Classification).
- M codes (Morphology of Neoplasms).
- Most V codes.

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

Discontinued codes

The agency 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

The agency 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 the agency to control improper coding that may lead to inappropriate payment. The agency bases coding policies on:

- 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.

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

Procedure codes

The agency uses the following types of procedure codes within this Medicaid provider 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 agency-covered services. **Due to copyright restrictions, the agency publishes only the official short CPT descriptions. To view the full CPT description, please refer to a current CPT manual.**

Provider Eligibility

Who may provide and bill for physician-related services?

[WAC 182-531-0250 (1)]

The following health care professionals may request enrollment with the agency 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).
- Providers who have a signed agreement with the agency to provide screening services to eligible persons in the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) program.
- Registered Nurse First Assistants (RNFAs).
- Persons currently licensed by the State of Washington DOH to practice any of the following:
    - ✓ Dentistry.
    - ✓ Medicine and osteopathy.
    - ✓ Nursing.
    - ✓ Optometry.
    - ✓ Podiatry.

Substitute physicians (locum tenens)

The Omnibus Budget Reconciliation Act (OBRA) of 1990 permits physicians to bill under certain circumstances for services provided on a temporary basis (i.e., locum tenens) to their patients by another physician.

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

- Enter the NPI of the locum tenens physician who performed the substitute services on the HIPAA 837P transaction in the rendering provider field or field 24J on the CMS-1500 claim form.
- Any provider that will perform as a locum tenens provider that will treat a Medicaid client must be enrolled as a Medicaid provider in order for claims to be paid. For enrollment information, go to New Providers.
- Enter the billing provider information in the usual manner.
- Use modifier Q6 when billing.

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

- An informal reciprocal arrangement, billing for temporary services was limited to a period of 14 continuous days, with at least one day elapsing between 14-day periods.
- A locum tenens arrangement involving per diem or other fee-for-time compensation, billing for temporary services was limited to a period of 90 continuous days, with at least 30 days elapsing between 90-day periods.

Which health care professionals does the agency not enroll?

[WAC 182-531-0250 (2)]

The agency 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).
- Naturopaths.
- 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 the agency 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.

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

- The EPSDT program.
- A Medicaid program for qualified Medicare beneficiaries (QMB).
- A waiver program. [WAC 182-531-0250 (3)]

Out-of-state hospital admissions

(does not include border hospitals)

The agency 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.

The agency requires PA for elective, nonemergency care and only approves these services when:

- The client is on an eligible program (e.g., the Categorically Needy Program); and
- 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 the agency Medical Request Coordinator (see Resources Available).

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 Medicaid clients. Neither the agency 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, the agency and the BHSIA designee pays for inpatient psychiatric services provided in bordering cities and critical border hospitals. All claims for admissions to **out-of-state hospitals** are paid as **voluntary** legal status as the Involuntary Treatment Act applies only within the borders of Washington State.

Client Eligibility

Eligible clients

Please see the agency ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

> **Note:** Refer to the Scope of Healthcare Services Table web page for an up-to-date listing of Benefit Service Packages.

Clients enrolled in a managed care organization

Many agency clients are enrolled in one of the agency's contracted managed care organizations (MCO). These clients are identified in ProviderOne as being enrolled in an MCO. They also receive an ID card from the MCO in which they are enrolled. Clients enrolled in an agency-contracted MCO must obtain services through their MCO, unless otherwise noted.

> **Note:** A client's enrollment can change monthly. Providers who are not contracted with the plan must receive approval from ***both*** the plan 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 HMO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

Clients enrolled in hospice

The agency pays for hospice care for eligible clients. To be eligible, clients must be certified by a physician as terminally ill with a life expectancy of six months or less. Contact the local hospice agency and they will evaluate the client. Hospice will cover all services required for treatment of the terminal illness. These services must be provided by or through the hospice agency.

See "Hospice" for additional information.

Coverage - General

Scope of coverage

[WAC 182-531-0100]

The agency covers healthcare services, equipment, and supplies listed in this guide, according to agency 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.

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

The agency 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.

The agency covers the following physician-related services and healthcare professional services, subject to the conditions listed in this Medicaid provider guide:

- Allergen immunotherapy services.

- Anesthesia services.

- Dialysis and end stage renal disease services (refer to the agency's Kidney Center Services Medicaid Provider Guide).

- Emergency physician services.

- ENT (ear, nose, and throat) related services.

- Early and periodic screening, diagnosis, and treatment (EPSDT) services (refer to the agency's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medicaid Provider Guide).

- Reproductive health services (refer to the agency's Family Planning Provider Medicaid Provider Guide).

- Hospital inpatient services (refer to the agency's Inpatient Hospital Medicaid Provider Guide).

- Maternity care, delivery, and newborn care services (refer to the agency's Maternity Support Services/Infant Case Management Medicaid Provider Guide).
- Office visits.
- Vision-related services (see also the agency's Vision Hardware for Clients 20 Years of Age and Younger Medicaid Provider Guide).
- Osteopathic treatment services.
- Pathology and laboratory services.
- Physiatry and other rehabilitation services).
- Foot care and podiatry services.
- Primary care services.
- Psychiatric services, provided by a psychiatrist.
- Psychotherapy services for children.
- Pulmonary and respiratory services.
- Radiology services.
- Surgical 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.
- Oral healthcare services for emergency conditions for clients 21 years of age and older, except for clients of the Division of Developmental Administration with the Department of Social and Health Services (DSHS).
- Other outpatient physician services.

The agency 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 Division of Disabilities.
- A screening pap smear performed according to nationally recognized clinical guidelines, mammogram, or prostate exam.

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

Noncovered services - general

[WAC 182-501-0070]

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

The agency reviews requests for noncovered health care services according to WAC 182-501-0160 as an exception to rule. To request a noncovered service, send a completed "Fax/Written Request Basic Information" form, 13-756, to the agency (see Resources Available).

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

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

- 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; and
- Preventive medicine services (except EPSDT exams for clients 20 years of age and younger and those clients with developmental disabilities).

Noncovered - physician-related and health care professional services

[WAC 182-531-0150**]**

The agency does not cover the following:

- Acupuncture, massage, or massage therapy.
- Any service specifically excluded by statute.
- Care, testing, or treatment of infertility, frigidity, or impotency. This includes procedures for donor ovum, sperm, womb, and reversal of vasectomy or tubal ligation.
- Cosmetic treatment or surgery, except for medically necessary reconstructive surgery to correct defects attributable to trauma, birth defect, or illness.
- Experimental or investigational services, procedures, treatments, devices, drugs, or application of associated services, except when the individual factors of an individual client's condition justify a determination of medical necessity under WAC 182-501-0165.
- Hair transplantation.
- Marital counseling or sex therapy.
- More costly services when the agency determines that less costly, equally effective services are available.
- Vision-related services as follows:
  - ✓ Services for cosmetic purposes only.
  - ✓ Group vision screening for eyeglasses.
  - ✓ Refractive surgery of any type that changes the eye's refractive error. The intent of the refractive surgery procedure is to reduce or eliminate the need for eyeglass or contact lens correction. This does not include intraocular lens implantation following cataract surgery.
- Payment for body parts, including organs, tissues, bones and blood, except as allowed in this guide.
- Physician-supplied medication, except those drugs administered by the physician in the physician's office.

- Physical examinations or routine checkups, except as provided in this guide.

- Foot care to treat chronic acquired conditions of the foot such as, but not limited to:

  - ✓ Treatment of mycotic disease tinea pedis.
  - ✓ Removal of warts, corns, or calluses.
  - ✓ Trimming of nails and other regular hygiene care.
  - ✓ Treatment of flat feet.
  - ✓ Treatment of high arches (cavus foot).
  - ✓ Onychomycosis.
  - ✓ Bunions and tailor's bunion (hallux valgus).
  - ✓ Hallux malleus.
  - ✓ Equinus deformity of foot, acquired.
  - ✓ Cavovarus deformity, acquired.
  - ✓ Adult acquired flatfoot (metatarsus adductus or pes planus.
  - ✓ Hallux limitus.

- Except as provided in this guide, weight reduction and control services, procedures, treatments, devices, drugs, products, gym memberships, equipment for the purpose of weight reduction, or the application of associated services.

- Nonmedical equipment.

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

- Bilateral cochlear implantation.

- Routine or nonemergency medical and surgical dental services provided by a doctor of dental medicine or dental surgery for clients twenty one years of age and older, except for certain clients of DSHS' Developmental Disabilities Administration and clients who are pregnant.

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

- The EPSDT program.
- A Medicaid program for qualified Medicare beneficiaries (QMBs).
- A waiver program.

Medical Policy Updates

In accordance with WAC 182-501-0055, the agency has reviewed the recommendations of the Health Technology Assessment Clinical Committee (HTACC) (RCW 70.14.080 through 70.14.140) and has made the decision to adopt recommendations for the following technologies:

Policy updates effective 7/1/2013

- Hyperbaric oxygen therapy
- Vitamin D testing

Policy updates effective 4/14/2013

- Sleep apnea diagnosis

Policy updates effective 4/1/2013

- Coronary artery calcium scoring
- Diagnostic upper endoscopy for gastroesophageal reflux disease
- Discography
- Intensity modulated radiation therapy (IMRT)
- Osteochondral allograft and autograft transplantation
- Percutaneous kyphoplasty, vetebroplasty and sacroplasty
- Virtual colonoscopy and computed tomographic colography

For additional details and medical necessity criteria, see Health Technology Assessment Findings.

Evaluation and Management (E/M)

E/M documentation and billing

The evaluation and management (E/M) service is based on key components listed in the CPT manual. Providers must use either the 1995 or 1997 Documentation Guidelines for Evaluation & Management Services to determine the appropriate level of service.

Once the licensed practitioner chooses either the 1995 or 1997 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.

PAL (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. See also Primary Care Principles for Child Mental Health, by Robert Hilt, MD, Program Director, Partnership Access Line, Seattle Children's Hospital.

Office and other outpatient services

[WAC 182-531-0950]

Office or other outpatient visit limits

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: The agency 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

The agency pays one new patient visit, per client, per provider or group practice in a three-year period.

Note: A new patient is one who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

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

Nursing facility services

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. The agency pays for one nursing facility discharge per client, per stay.

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

Pre-operative visit prior to performing a dental service under anesthesia

One pre-operative evaluation and management (E/M) visit by a physician per client prior to performing a dental service under anesthesia. Bill using dental diagnosis codes 520.1-525.9 as the primary diagnosis along with the appropriate pre-op diagnosis codes V72.81 – V72.84 as the secondary diagnosis.

For clients assigned to an agency managed care organization, bill the agency directly for E/Ms for dental surgery (not oral surgery).

Physical examination - clients of the DSHS' Developmental Disabilities Administration

One physical examination per client, per 12 months for clients of DSHS' Developmental Disabilities Administration as identified in ProviderOne. Use HCPCS code T1023 with modifier HI and an ICD-9-CM diagnosis code from the range V79.3-V79.9 to bill for an examination.

Office visit related to Acomprosate, Naltrexone, Buprenorphyine, Nalozone

The agency pays for an office visit related to Acomprosate (Campral®), Naltrexone (ReVia®), Naltrexone (Vivitrol®) or Buprenorphine and Naloxone (Suboxone®). For billing, please see EPA information in Prior Authorization.

Behavior change intervention - smoking cessation

Smoking cessation, which can include free counseling 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 agency fee-for-service program. Clients enrolled in an agency-contracted managed care organization (MCO) must contact their MCO for information regarding the smoking cessation benefit.

Services available

Refer clients to the toll-free Washington State Tobacco Quit Line for one or more of the following free services:

- Telephone counseling and follow-up support calls through the quit line.
- Nicotine patches or gum through the quit line, if appropriate.
- Prescription medications recommended by the quit line. The client will then be referred back to the provider for a prescription, if appropriate.

Washington State Tobacco Quit Line

1-800-QUIT-NOW (1-800-784-8669)	English
1-877-2NO-FUME (1-877-266-3863)	Spanish

Client eligibility

- All Medicaid clients 18 years of age and older and all pregnant women regardless of age are eligible for smoking cessation services through the Tobacco Quit Line.

- Clients eligible for the Alien Emergency Medical (AEM) program or enrolled in the Family Planning Only or TAKE CHARGE programs are eligible for some of the above mentioned services; however, these clients **are not eligible** for prescription drugs and smoking cessation services provided by their primary care provider.

When a client is receiving counseling from the Tobacco Quit Line, the Tobacco Quit Line may recommend a smoking cessation prescription, if appropriate. The client will return to the provider's office with a form for the provider's review. Complete the form and fax it with a prescription to the agency (see Resources Available).

Payment for a smoking cessation referral

The agency will pay physicians and ARNP's for a smoking cessation referral (**T1016**) when all of the following are met:

- The client is pregnant or 18 years of age and older.

- The client presents a Services Card and is covered by a Benefit Services Package.

- The client is **not** eligible for the **AEM** program or enrolled in the **Family Planning Only or TAKE CHARGE** program.

- The referral is billed with ICD-9-CM diagnosis 305.1, 649.03, or 649.04.

- The client is evaluated, in person, for the sole purpose of counseling the client to encourage them to call and enroll in this smoking cessation program.

- The referral is not billed in combination with an evaluation and management office visit.

Smoking cessation referral for an evaluation for a smoking cessation prescription

The agency will pay physicians and ARNPs for a smoking cessation referral (**T1016**) for an evaluation for a smoking cessation prescription when all of the following are met:

- The client is pregnant or 18 years of age or older.
- The client is enrolled in this smoking cessation program.
- The client presents a Services Card and is covered by a Benefit Package.
- The client is **not** eligible for the **AEM** program or enrolled in the **Family Planning Only or TAKE CHARGE** program.
- The referral is billed with ICD-9-CM diagnosis 305.1, 649.03, or 649.04.
- Evaluate the client for a smoking cessation prescription, with or without the client present, complete the form, and fax it to the agency's Pharmacy Authorization Section, Drug Use and Review.
- The referral is not billed in combination with an evaluation and management office visit.

Additional information:

- For more information about the smoking cessation benefit, call the agency at 1-800-562-3022.
- For more information, visit Washington State Department of Health's Tobacco Quit Line.
- For additional information, visit Smoke Free Washington.

Tobacco cessation for pregnant clients

Effective July 1, 2013, the agency pays for face-to-face counseling for tobacco cessation for pregnant clients. Tobacco cessation counseling complements the use of prescription and nonprescription smoking cessation products. These products are also covered by Medicaid.

Pregnant clients can receive provider-prescribed nicotine replacement therapy directly from a pharmacy and can obtain prescription medications for tobacco cessation without going through the Quitline. Clients must be actively receiving counseling services from their prescribing provider. The prescribing provider must add narrative to the prescription supporting that the prescriber is providing counseling.

Face-to-face visit requirements

The Clinical Practice Guideline, "Treating Tobacco Use and Dependence: 2008 Update" demonstrated that efficacious treatments for tobacco users exist and should become a part of standard caregiving.

Two components of counseling are especially effective, and clinicians are expected to use these when counseling patients making a quit attempt:

- Practical counseling (problem solving/skills training)
- Social support delivered as part of treatment

The guideline recommends that a practitioner should follow the "5 A's" of treating tobacco dependence, which include: **A**sk, **A**dvise, **A**ssess, **A**ssist, and **A**rrange follow-up.

For patients not ready to make a quit attempt, clinicians should use a brief intervention designed to promote the motivation to quit. Content areas that should be addressed can be captured by the "5 R's": **R**elevance, **R**isks, **R**ewards, **R**oadblocks, and **R**epetition. Research suggests that the "5 R's" enhance future quit attempts.

Providers must document the client's pregnancy status and estimated date of confinement in the medical record. Additionally, the provider must establish and document the client's motivation to quit tobacco use and provide an appropriate intervention based on client's readiness to change.

If a tobacco user currently is unwilling to make a quit attempt, clinicians should use the motivational treatments shown in the guideline to be effective in increasing future quit attempts.

For each visit, the provider needs to document the time and interventions used aimed at tobacco cessation.

Promotion of the motivation to quit

All patients entering a health care setting should have their tobacco use status assessed routinely. Clinicians should advise all tobacco users to quit and then assess a patient's willingness to make a quit attempt. For patients not ready to make a quit attempt at the time, clinicians should use a brief intervention designed to promote the motivation to quit.

Patients unwilling to make a quit attempt during a visit may lack information about the harmful effects of tobacco use and the benefits of quitting, may lack the required financial resources, may have fears or concerns about quitting, or may be demoralized because of previous relapse. Such patients may respond to brief motivational interventions that are based on principles of Motivational Interviewing (MI), a directive, patient-centered counseling intervention. There is evidence that MI is effective in increasing future quit attempts; however, it is unclear that MI is successful in boosting abstinence among individuals motivated to quit smoking.

Clinicians employing MI techniques focus on exploring a tobacco user's feelings, beliefs, ideas, and values regarding tobacco use in an effort to uncover any ambivalence about using tobacco. Once ambivalence is uncovered, the clinician selectively elicits, supports, and strengthens the patient's "change talk" (e.g., reasons, ideas, needs for eliminating tobacco use) and "commitment language" (e.g., intentions to take action to change smoking behavior, such as not smoking in the home). MI researchers have found that having patients use their own words to commit to change

is more effective than clinician exhortations, lectures, or arguments for quitting, which tend to increase rather than lessen patient resistance to change.

The four general principles that underlie MI are: (*1) express empathy, (2) develop discrepancy, (3) roll with resistance,* and *(4) support self-efficacy.* Specific MI counseling strategies that are based on these principles are listed in Strategy B1. Because this is a specialized technique, it may be beneficial to have a member of the clinical staff receive training in motivational interviewing. The content areas that should be addressed in a motivational counseling intervention can be captured by the "5 R's": relevance, risks, rewards, roadblocks, and repetition (Strategy B2). Research suggests that the "5 R's" enhance future quit attempts.

Providers must provide client educational materials on the benefits of not using tobacco products and document this in the client's record.

Provider types

Office-based practitioners (physicians, registered nurse practitioners, Physician-Assistants-Certified), Psychologists, Pharmacists

Benefit limitations

A cessation counseling attempt occurs when a qualified physician or other Medicaid-recognized practitioner determines that a beneficiary meets the eligibility requirements and initiates treatment with a cessation counseling attempt.

A cessation counseling attempt includes the following:

- Up to four cessation counseling sessions (one attempt = up to four sessions).
- Two cessation counseling attempts (or up to 8 cessation counseling sessions) are allowed every 12 months.

This limit applies to the client regardless of the number of providers a client may see for tobacco cessation.

Providers can request a Limitation Extension by submitting a request to the agency.

Documentation requirements

Keep patient record information on file for each Medicaid patient for whom a smoking and tobacco-use cessation counseling claim is made. Medical record documentation must include standard information along with sufficient patient history to adequately demonstrate that Medicaid coverage conditions were met. Documentation must include the client's EDC

Diagnosis codes should reflect that the condition the patient has that is adversely affected by tobacco use. Also, include if the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by tobacco use.

Billing codes

Procedure Code	Short Description	Comments
99407	Behav chng smoking > 10 min	Four cessation counseling sessions (one attempt = up to four sessions). Limited to one per day. Pregnant clients are eligible for two quit attempts annually.

ICD-9 CM diagnoses codes

Code	Description
649.03	Tobacco use dis-antepartum

Provider resources

AHRQ's Treating Tobacco Use and Dependence: 2008 Update– This site provides the DHHS Public Health Service Clinical Practice Guideline for Treating Tobacco Use and Dependence: 2008 Update (PHSG) and includes evidence-based treatment, provider and patient educational materials.

Helping Smokers Quit – A Guide for Clinicians

The National Partnership to Help Pregnant Smokers Quit

Children's primary health care

(CPT codes 99201-99215)

- The agency pays a higher payment rate for primary health care performed in the office setting (CPT codes 99201-99215) for children 20 years of age 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 mother'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 mother is enrolled in an agency-approved managed care organization (MCO), newborns will be enrolled in the same MCO as their mother.

Consultations

TB treatment services

Performed by professional providers – office visits only

The E/M codes 99201-99215 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 E/M 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 one of the following ICD-9-CM diagnosis codes:

Diagnosis Code	Description
010.00 – 018.96	Tuberculosis infections
795.51 795.52	Nonspecific reaction to tuberculin skin test
V01.1	Tuberculosis
V71.2	Observation for suspected tuberculosis
V74.1	Pulmonary tuberculosis

Critical care

(CPT codes 99291-99292) [WAC 182-531-0450]

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 25 months of age 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 24 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 of time spent providing critical care services, the physician must devote his or her full attention to the client and cannot provide services to any other patient during the same period of time.

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?

The agency covers:

- A maximum of three hours of critical care per client, per day.
- Critical care provided by the attending physician who assume(s) responsibility for the care of a client during a life-threatening episode.
- Critical care services provided by more than one physician if the services involve multiple organ systems (unrelated diagnosis). However, in the emergency room, payment for critical care services is limited to one physician.

The following services (with their corresponding CPT codes) are included in critical care. Do not bill these separately:

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

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

Domiciliary, rest home, or custodial care services

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

Emergency department services

Emergency physician-related services

(CPT codes 99281-99285) [WAC 182-531-0500]

- For services performed by the physician assigned to, or on call to, the emergency department, bill the agency 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 *Comments* field of the claim form.

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

Home services

Home evaluation and management

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

TB treatment services – performed by professional providers – in client's home

When billing for TB treatment services provided by professional providers in the client's home, Health Departments may also bill CPT codes 99341 and 99347.

For TB treatment services performed by nonprofessional providers in client's home, see TB treatment services for nonprofessional providers – office or client's home.

Hospital inpatient and observation care services

(CPT codes 99217-99239) [WAC 182-531-0750]

Inpatient admissions must meet intensity of service/severity of illness criteria for an acute inpatient level of care. Admission status changes must be noted in the client's chart.

Admission status

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

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

Change in admission status

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

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

Inpatient to outpatient observation

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

- The attending physician/practitioner and/or the hospital's utilization review staff determine that an inpatient client's symptoms/condition and treatment do not meet

medical necessity criteria for an acute inpatient level of care and do meet medical necessity criteria for an observation level of care.

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

- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the document must:

  - ✓ Be dated with the date of the change.

  - ✓ Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Outpatient observation to inpatient

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

- The attending physician/practitioner and/or the hospital's utilization review staff determine that an outpatient observation client's symptoms/condition and treatment meet medical necessity criteria for an acute inpatient level of care.

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

- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:

  - ✓ Be dated with the date of the change.

  - ✓ Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Inpatient or outpatient observation to outpatient

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

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

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

- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:

  ✓ Be dated with the date of the change.

  ✓ Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Outpatient surgery/procedure to outpatient observation or inpatient

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

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

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

- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:

  ✓ Be dated with the date of the change.

  ✓ Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Note: During post-payment retrospective utilization review, the agency may determine the chronic care management is not supported by documentation in the medical record. The agency may consider payment made in this circumstance an overpayment and payment may be recouped or adjusted.

Payment

The agency pays for:

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

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

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

The agency does not pay for:

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

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

Other guidelines

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

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

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

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

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

- Providers must satisfy the documentation requirements for both admission to and discharge from, inpatient or observation care in order to bill CPT codes 99234-99236. The length of time for observation care or treatment status must also be documented.
- When clients are fee-for-service (FFS) when admitted to a hospital and then enroll in an agency 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) [WAC 182-531-0900]

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.

The agency 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 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 (>2500 grams) or 99478-99480 (<2500 grams) must be used.

- Newborn resuscitation (CPT code 99464, 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); or
- Vascular access procedures (CPT codes 36400, 36405, and 36406).

Note: Procedure code 43752 may be billed separately when it is the only procedure code billed.

Intensive (noncritical) low birth weight wervices

(CPT codes 99478-99480)

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

Newborn care

(CPT 99460, 99461)

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

The agency 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.

Note: The agency covers circumcisions (CPT codes 54150, 54160, and 54161) ***only*** with medical ICD-9-CM diagnosis codes 605 (Phimosis), 607.1 (Balanoposthitis), or 607.81 (Balanitis Xerotica).

Physicals for clients of DSHS' Developmental Disabilities Administration (DDA)

The agency covers one physical every 12 months for clients of the Developmental Disabilities Administration with the Department of Social and Health Services. Use HCPCS code T1023

with modifier HI and an ICD-9-CM diagnosis code from the range V79.3-V79.9 to bill for an annual exam.

Physician care plan oversight

(CPT codes 99375, 99378, and 99380) [WAC 182-531-1150]

The agency 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.

The agency 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

The agency covers CPT codes 99339 and 99340 with prior authorization. For supervision services that are less than 30 minutes, use code 99339; and for services exceeding 30 minutes, use code 99340. There is a unit limit of one unit of CPT 99339 *or* one unit of CPT 99340 per calendar month. Claims are subject to post-payment review.

Clear documentation of care plan oversight is required by the agency, including:

- Time allocation
- Care plans
- Review of diagnostic reports and laboratory studies
- Treatment-related communications with other health care professionals and caregivers
- Adjustment of medical therapy

CPT Code	Short Description
99339	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
99340	Within a calendar month; 30 minutes or more

Preventative medicine services

HIV/AIDS counseling/testing

(CPT code 99401) [WAC 182-531-0600]

The agency covers two sessions of risk factor reduction counseling (CPT code 99401) counseling per client, each time tested (i.e., one pre- and one post-HIV/AIDS counseling/testing session).
Use ICD-9-CM diagnosis code V65.44 when billing CPT code 99401 for HIV/AIDS counseling.
The agency does not pay for HIV/AIDS counseling when billed with an E/M service unless the client is being seen on the same day for a medical problem and the E/M service is billed with a separately identifiable diagnosis code and with modifier 25.

Please see the agency's HIV/AIDS Case Management Medicaid Provider Guide for additional information on HIV/AIDS case management billing.

Prolonged services

(CPT codes 99354-99357) [WAC 182-531-1350]

Prolonged services with direct patient contact

The agency covers prolonged services:

- Up to three hours per client, per diagnosis, per day.

> **Note:** The time counted toward payment for prolonged E/M services includes only direct face-to-face contact between the provider and the client, whether or not the services were continuous.

- Only when the provider performs one of the services listed below for the client on the same day:

Prolonged CPT Code	Other CPT Code(s)
99354	99201-99215, 99241-99245, 99324-99337, 99341-99350, 90815
99355	99354 and one of the E/M codes required for 99354
99356	99218-99220, 99221-99233, 99251-99255, 99304-99310.
99357	99356 and one of the E/M codes required for 99356

Note: Both the prolonged services CPT code ***and*** any of the "Other CPT Code(s)" listed above **must** be billed on the **same** claim.

Physician standby services

(CPT code 99360) [WAC 182-531-1250]

The agency 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.

The agency 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, with the exception of 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.

Telehealth

What is telehealth?

Telehealth is when a health care practitioner uses interactive real-time audio and video telecommunications to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located.

Using telehealth when it is medically necessary enables the health care practitioner and the client to interact in real-time communication as if they were having a face-to-face session. Telehealth allows agency clients, particularly those in medically underserved areas of the state, improved access to essential health care services that may not otherwise be available without traveling long distances.

The following services are ***not*** covered as telehealth:

- Email, telephone, and facsimile transmissions.
- Installation or maintenance of any telecommunication devices or systems.
- Home health monitoring.
- "Store and forward" telecommunication based services. (Store and forward is the asynchronous transmission of medical information to be reviewed at a later time by the physician or practitioner at the distant site).

Who is eligible for telehealth?

Fee-for-service clients are eligible for medically necessary covered health care services delivered via telehealth. The referring provider is responsible for determining and documenting that telehealth is medically necessary. As a condition of payment, the client must be present and participating in the telehealth visit.

The agency will not pay separately for telehealth services for clients enrolled in a managed care plan. Clients enrolled in an agency managed care plan are identified as such in ProviderOne. Managed care enrollees must have all services arranged and provided by their primary care providers (PCP). Contact the managed care plan regarding whether or not the plan will authorize telehealth coverage. It is not mandatory that the plan pay for telehealth.

When does the agency cover telehealth?

The agency covers telehealth through the fee-for-service program when it is used to substitute for a face-to-face, "hands on" encounter for only those services specifically listed in this section.

Originating site (location of client)

What is an "originating site"?

An originating site is the physical location of the eligible agency client at the time the professional service is provided by a physician or practitioner through telehealth. Approved originating sites are:

- The office of a physician or practitioner.
- A hospital.
- A critical access hospital.
- A rural health clinic (RHC).
- A federally qualified health center (FQHC).

Is the originating site paid for telehealth?
Yes. The originating site is paid a facility fee per completed transmission.

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

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

- **Hospital Inpatient**: When the originating site is an inpatient hospital, there is no payment to the originating site for the facility fee.
- **Critical Access Hospitals**: When the originating site is a critical access hospital outpatient agency, payment is separate from the cost-based payment methodology. To receive payment for the facility fee, critical access hospitals must bill revenue code 0789 on the same line as HCPCS code Q3014.

- **FQHCs and RHCs:** When the originating site is an FQHC or RHC, bill for the facility fee using HCPCS code Q3014. This is not considered an FQHC or RHC service and is not paid as an encounter.

- **Physicians' Offices:** When the originating site is a physician's office, bill for the facility fee using HCPCS code Q3014.

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

Distant site (location of consultant)

What is a "distant site"?

A distant site is the physical location of the physician or practitioner providing the professional service to an eligible agency client through telehealth.

Who is eligible to be paid for telehealth services at a distant site?

The agency pays the following provider types for telehealth services provided within their scope of practice to eligible agency clients:

- Physicians (including psychiatrists); and
- Advanced registered nurse practitioners (ARNPs).

What services are covered using telehealth?

Only the following services are covered using telehealth:

- Consultations (CPT codes 99241–99245 and 99251-99255).
- Office or other outpatient visits (CPT codes 99201-99215).
- Psychiatric intake and assessment (CPT code 90791 or 90792).
- Individual psychotherapy (CPT codes 90832, +90833; 90834, +90836; 90837, +90838).
- Visit for drug monitoring (HCPCS code M0064).

Note: Refer to other sections of this guide for specific policies and limitation on these CPT codes. For additional information on mental health, see Mental Health Services for Children, Psychiatric and Psychological Services.

How does the distant site bill the agency for the services delivered through telehealth?

The payment amount for the professional service provided through telehealth by the provider at the distant site is equal to the current fee schedule amount for the service provided.

Use the appropriate CPT codes **with modifier GT** (via interactive audio and video telecommunications system) when submitting claims to the agency for payment.

Anesthesia

[WAC 182-531-0300]

General anesthesia

- The agency 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.

- The agency pays for CPT code 01922 for noninvasive imaging or radiation therapy when:

  - ✓ The client is 17 years of age or younger; or
  - ✓ There are client-specific reasons why the procedure cannot be performed without anesthesia services. Documentation must be kept in the client's medical record.

- The agency pays providers for covered anesthesia services performed by one of the following:

  - ✓ Anesthesiologist;
  - ✓ Certified registered nurse anesthetist (CRNA); or
  - ✓ Other providers who have a contract with the agency to provide anesthesia services.

- For each client, the anesthesia provider must:

  - ✓ 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; and
  - ✓ Provide indicated postanesthesia care.

- In addition, 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 as long as 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. The agency has assigned flat fees for these codes.

- The agency 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, the agency follows CPT code descriptions.

- The agency 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 anesthesia for surgical abortions (CPT code 01965 or 01966), indicate in the *Comments* section of the claim form "voluntary or induced abortion."

- When billing the following procedures, use only the CPT codes indicated below:

  - ✓ Vasectomies: 00921 (not covered for clients on the TAKE CHARGE program);
  - ✓ Hysterectomies: 00846, 00944, 01962-01963, or 01969;
  - ✓ Sterilizations: 00851; and
  - ✓ Abortions: 01965 or 01966.

- 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, the agency pays each provider 50% of the allowed amount. The agency 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 of the claim form. The agency calculates the base units.

Regional anesthesia

- Bill the agency the appropriate procedure code (e.g. epidural CPT code 62319) with no time units and no anesthesia modifier. The agency 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.

Other

- The agency does not pay separately for moderate sedation. The agency considers moderate sedation as bundled with the procedure code.

- Patient acuity does not affect payment levels. Qualifying circumstances (CPT codes 99100, 99116, 99135, and 99140) are considered bundled and are not paid separately.

- The agency 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, in order to receive payment. The agency will determine payment amount after review of the documentation.

Teaching anesthesiologists

The agency pays teaching anesthesiologists for supervision of anesthesiology residents as follows:

- When supervising ***one*** resident only, the teaching anesthesiologist must bill the agency 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 the agency 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 for dental admissions. To bill for dental anesthesia, providers must use CPT anesthesia code 00170 with the appropriate anesthesia modifier.

Refer to the agency's Dental-Related Services Medicaid Provider Guide for information on billing for office-based anesthesia for dental procedures.

Note: Bill the agency directly for dental anesthesia for all clients, including those enrolled in an agency-contracted managed care plan.

Anesthesia for maternity

[WAC 182-531-0300(9)]

- The agency pays a maximum of 6 hours (360 minutes) of anesthesia for labor and delivery time (CPT codes 01960, 01961, 01967 and 01968) per delivery, including multiple births and/or cesarean section delivery.

  Exception: The following obstetrical anesthesia codes are not subject to the 6-hour (360 minute) limitation: CPT codes 01962-01966 or 01969.

- When billing more than one time-limited anesthesia code, the total time may not exceed 6 hours (360 minutes).

- Bill the applicable CPT anesthesia code with applicable modifier and time. To determine time for obstetric epidural anesthesia during normal labor and delivery and C-sections, time begins with insertion and ends with removal for a maximum of 6 hours per delivery.

- CPT codes 01968 and 01969 are anesthesia add-on codes to be used for cesarean delivery and cesarean hysterectomy following anesthesia given for a planned vaginal delivery. An additional base of 3 is allowed for 01968 and an additional base of 5 is allowed for 01969, in conjunction with the base of 5 for 01967. The time involved with each portion of the procedure should be reported with the appropriate CPT code.

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

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

Anesthesia for radiological procedures

[WAC 182-531-0300 (2) and (7)]

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:

- The client must be 17 years of age or younger; or
- 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 the agency on request.

Anesthesia payment calculation for services paid with base and time units

- The agency'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.

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

.

Surgery

[WAC 182-531-1700]

The agency requires prior authorization for selected surgical procedures. Providers must check the Physician-Related Services Fee Schedule for those surgical services that require either PA or EPA.

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 the agency's-assigned maximum allowable fee for the procedure code.
- When billing for pain management and other services that are payable using the agency's-assigned maximum allowable fee, do not use anesthesia modifiers. The agency 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 procedure 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 with any of these procedure codes.

Procedure Code	Short Description
11981*	Insert drug implant device
11982*	Remove drug implant device
11983*	Remove/insert drug implant
20526*	Ther injection carp tunnel
20550	Inj tendon/ligament
20551	Inj tendon origin/insertion
20552	Inj trigger point 1/2 muscl
20553	Inject trigger points 3/>
20600	Drain/inject joint/bursa

Procedure Code	Short Description
20605	Drain/inject joint/bursa
20610	Drain/inject joint/bursa
20612	Aspirate/inj ganglion cyst
27096	Inject sacroiliac joint
61790*	Treat trigeminal nerve
62264*	Epidural lysis on single day
62270	Spinal fluid tap diagnostic
62272	Drain cerebro spinal fluid
62273*	Inject epidural patch
62280*	Treat spinal cord lesion
62281*	Treat spinal cord lesion
62282*	Treat spinal canal lesion
62284	Injection for myelogram
62290	Inject for spine disk x-ray
62291	Inject for spine disk x-ray
62310*	Inject spine cerv/thoracic
62311*	Inject spine lumbar/sacral
62318*	Inject spine w/cath, c/t
62319*	Inject spine w/cath lmb/scrl
62350*	Implant spinal canal cath
62351*	Implant spinal canal cath
62355*	Remove spinal canal catheter
62360*	Insert spine infusion device
62361*	Implant spine infusion pump
62362*	Implant spine infusion pump
62365*	Remove spine infusion device
63650*	Implant neuroelectrodes
63655*	Implant neuroelectrodes
63685*	Insrt/redo spine n generator
63688*	Revise/remove neuroreceiver
64400*	N block inj trigeminal
64402*	N block inj facial
64405*	N block inj occipital
64408*	N block inj vagus
64410*	N block inj phrenic
64412*	N block inj spinal accessor
64413*	N block inj cervical plexus
64415*	N block inj brachial plexus
64416*	N block cont infuse b plex
64417*	N block inj axillary
64418*	N block inj suprascapular
64420*	N block inj intercost sng

Procedure Code	Short Description
64421*	N block inj intercost mlt
64425*	N block inj ilio-ing/hypogi
64430*	N block inj pudendal
64435*	N block inj paracervical
64445*	N block inj sciatic sng
64446*	N blk inj sciatic cont inf
64447*	N block inj fem single
64448*	N block inj fem cont inf
64449*	N block inj lumbar plexus
64450*	N block other peripheral
64479*	Inj foramen epidural c/t
64480*	Inj foramen epidural add-on
64483*	Inj foramen epidural l/s
64484*	Inj forament epidural add-on
64505*	N block spenopalatine gangl
64508*	N block carotid sinus s/p
64510*	N block stellate ganglion
64517*	N block stellage ganglion
64520*	N block lumbar/thoracic
64530*	N block inj celiac pelus
64553*	Implant neuroelectrodes
64555*	Implant neuroelectrodes
64561*	Implant neuroelectrodes
64565*	Implant neuroelectrodes
64575*	Implant neuroelectrodes (PA)
64580*	Implant neuroelectrodes (PA)
64581*	Implant neuroelectrodes (PA)
64585*	Revised/remove neuroelectrode (PA)
64590*	Insrt/redo pn/gastr stimul (PA)
64595*	Revise/rmv pn/gastr stimul (PA)
64600*	Injection treatment of nerve
64605*	Injection treatment of nerve
64610*	Injection treatment of nerve
64612*	Destroy nerve face muscle
64613*	Destroy nerve spine muscle
64620*	Injection treatment of nerve

Procedure Code	Short Description
64630*	Injection treatment of nerve
64640*	Injection treatment of nerve
64680*	Injection treatment of nerve
64681*	Injection treatment of nerve
64802*	Remove sympathetic nerves
64804*	Remove sympathetic nerves
64809*	Remove sympathetic nerves
64818*	Remove sympathetic nerves

Other Services

Procedure Code	Short Description
36400	Bl draw < 3 yrs fem/jugular
36420	Vein access cutdown < 1 yr
36425	Vein access cutdown > 1 yr
36555	Bl exchange/transfuse non-nb
36566	Insert tunneled cv cath
36568	Insert picc cath
36580	Replace cvad cath
36584	Replace picc cath
36589	Removal tunneled cv cath
36600	Withdrawal of arterial blood
36620	Insertion catheter artery
36625	Insertion catheter artery
36660	Insertion catheter artery
62263	Epidural lysis mult sessions
62287	Percutaneous diskectomy
63600	Remove spinal cord lesion
76000	Fluoroscope examination
76496	Fluoroscopic procedure
77001	Fluoroguide for vein device
77002	Needle localization by xray
77003	Fluoroguide for spine inject
93503	Insert/place heart catheter
95970	Analyze neurostim no prog
95990	Spin/brain pump refil & main

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

Registered Nurse First Assistants (RNFA)

Registered Nurse First Assistants (RNFAs) are allowed to assistant at surgeries within their scope of practice. Use modifier "AS" to bill the agency for these services.

New RNFA providers must meet the following criteria:

- Licensed in Washington State as a Registered Nurse in good standing;
- Work under the direct supervision of the performing surgeon; and
- Hold current certification as a certified nurse operating room (CNOR).

Submit the following documentation to the agency 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; and

- Proof of liability insurance.

Billing/Payment

Bilateral procedures

- If a procedure is done bilaterally and is not identified by its terminology as a bilateral procedure, bill the procedure with modifier 50. Bill as a single line item on the claim.

- 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.

- 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:

Procedure Code	Short Description
E/M Services	
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	
92012-92014	General ophthalmological services

The E/M codes listed above 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)
79	Unrelated procedure or service by the same physician during the postoperative 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 postdischarge 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 of 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; and

  - ✓ 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.

- The agency allows separate payment for:

  - ✓ The initial evaluation to determine need for surgery;

  - ✓ Preoperative visits that occur two or more days before the surgery. Use the specific medical diagnosis for the client. Do not use V72.83-V72.85;

  - ✓ 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; and

  - ✓ 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:
  - ✓ 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; and
  - ✓ Change and removal of tracheostomy tubes.
- Additional medical or surgical services required because of complications that do not require additional operating room procedures.

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

Global surgery payment period

- The global surgery payment period applies to any provider who participates in the surgical procedure. These providers include:
  - ✓ The surgeon;
  - ✓ The assistant surgeon (modifiers 80, 81, or 82);
  - ✓ Two surgeons (modifier 62);
  - ✓ Team surgeons (modifier 66);
  - ✓ Anesthesiologists and CRNAs; and
  - ✓ 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, the agency pays providers as follows:

- 100% of the agency's maximum allowable fee for the most expensive procedure; plus,
- 50% of the agency'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 may adjust claims electronically in ProviderOne (preferred) or send in a paper claim adjustment.

Other surgical policies

- Use modifiers 80, 81, and/or 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.

- Use modifier "AS" for an assistant at surgery for PA-Cs, ARNPs, or Clinical Nurse Specialists – **do not use modifier 80**.

- A properly completed consent form must be attached to all claims for sterilization and hysterectomy procedures. (See the Sterilization Supplemental Medicaid Provider Guide and hysterectomy procedures.)

- Microsurgery ***Add On Code 69990***
  CPT indicates that code 69990 is not appropriate when using magnifying loupes or other corrected vision devices. Also, 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).

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

- The agency pays for the following procedure codes which include breast removal and breast reconstruction for clients who have breast cancer or history of breast cancer, burns, open wound injuries, or congenital anomalies of the breast. The following list of diagnosis codes must be used; **otherwise the service requires prior authorization (PA)**.

- Removal of failed breast implants with ICD-9-CM diagnosis code 996.54 requires PA. The agency will pay to remove implants (CPT codes 19328 and 19330) but will not replace them if they were placed for cosmetic reasons.

- The agency requires EPA for reduction mammoplasties (CPT code 19318) and for mastectomy for gynecomastia for men (CPT code 19300). See Expedited Prior Authorization for more information.

CPT Code(s)	Short Description	Limitations
11920	Correct skin color defects 6.0 cm (use V10.3) (Tattoo)	Limited to ICD-9-CM diagnoses: • V10.3 • 174.0-175.9 • 233.0 • 757.6 • 759.9 • 879.0-879.1 • 906.0 • 906.8 • 942.00-942.59
11921	Correct skin color 6.1-20.0 cm	
11960	Insertion tissue expander(s)	
11970	Replace tissue expander	
11971	Remove tissue expander(s)	
19301	Partical mastectomy	
19302	P-mastectomy w/ln removal	
19303	Mast simple complete	
19304	Mast subq	
19316	Suspension of breast	
19340	Immediate breast prosthesis	
19342	Delayed breast prosthesis	
19350	Breast reconstruction	
19357	Breast reconstruction	
19361	Breast reconstr w/lat flap	
19364	Breast reconstruction	
19366	Breast reconstruction	
19367	Breast reconstruction	
19368	Breast reconstruction	
19369	Breast reconstruction	
19370	Surgery of breast capsule	
19371	Removal of breast capsule	
19380	Revise breast reconstruction	
S2066	Breast GAP flap reconst	
S2067	Breast "stacked" DIEP/GAP	

- Salpingostomies (CPT codes 58673 and 58770) are payable only for a tubal pregnancy (ICD-9-CM diagnosis code 633.10 and 633.11).

- 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.

Pre-/intra-/postoperative payment splits

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

The agency has adopted Medicare's payment splits, as listed below. If Medicare has not assigned a payment split to a procedure, the agency uses a payment split of 10% / 80% / 10% if modifiers 54, 55, 56, and 78 are used.

Code Range	Operative System	Pre-	Intra-	Postoperative
10000 - 19499	Integumentary	10%	71%	19%
20000 - 29909	Musculoskeletal	10%	69%	21%
30000 - 32999	Respiratory	10%	76%	14%
33010 - 37788	Cardiovascular	09%	84%	07%
37790 - 37799	Cardiovascular	08%	83%	09%
38100 - 38115	Hemic/Lymphatic	11%	73%	16%
38120 - 38300	Hemic/Lymphatic	09%	84%	07%
38305 - 38999	Hemic/Lymphatic	11%	73%	16%
39000 - 39599	Mediastinum/Diaphragm	09%	84%	07%
40490 - 43641	Digestive	09%	81%	10%
43651 - 43652	Digestive	11%	76%	13%
43653 - 49999	Digestive	09%	81%	10%
50010 - 53899	Urinary	08%	83%	09%
54000 - 55980	Male Genital	10%	80%	10%
56300 - 56399	Laparoscopy/Hysteroscopy	09%	81%	10%
56405 - 58999	Female Genital	12%	74%	14%
59000 - 59899	Maternity	17%	60%	23%
60000 - 60605	Endocrine	09%	82%	09%
60650 - 60699	Endocrine	09%	84%	07%
61000 - 64999	Nervous System	11%	76%	13%
65091 - 68899	Eye/Occular	10%	70%	20%
69000 - 69979	Auditory	07%	79%	14%

Auditory system

Cochlear implant services (clients 20 years of age and younger)

[Refer to WAC 182-531-0200(4) (c)]

The agency does not cover bilateral cochlear implantation. Unilateral cochlear implantation (CPT code 69930) requires EPA (see Prior Authorization). If a client does not meet the EPA criteria, PA is required.

The agency covers replacement parts for cochlear devices through the agency's Hearing Aids and Services Program ***only***. The agency pays only those vendors with a current core provider agreement that supply replacement parts for cochlear implants and bone-anchored hearing aids (BAHA).

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

CPT Codes	Short Description	Comments
69930	Implant cochlear device	No corresponding removal codes specific to cochlear devices.
69715	Temple bne implnt w/stimulat	

Osseointegrated implants (BAHA) for clients 20 years of age and younger

Insertion or replacement of osseointegrated implants (BAHA) (CPT codes 69714-69718; HCPCS L8693) requires prior authorization (PA) (refer to Prior Authorization).

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

The agency covers replacement parts for BAHA through the agency's Hearing Hardware for Clients 20 Years of Age and Younger Program ***only***. The agency pays only those vendors with a current Core Provider Agreement that supply replacement parts for cochlear implants and BAHA.

Note: The agency does not pay for new BAHA for clients 21 years of age and older. The agency considers requests for removal or repair of previously implanted BAHA for clients 21 years of age and older when medically necessary. PA is required.

CPT Code	Short Description	Notes
69710	Implant/replace hearing aid	Replacement procedure includes removal of the old device
69711	Remove/repair hearing aid	
69714	Implant temple bone w/stimul	
69715	Temple bne implnt w/stimulat	
69717	Temple bone implant revision	

Digestive system

Diagnostic upper endoscopy for GERD

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

- Failure of an adequate trial of medical treatment to improve or resolve symptoms

  -OR-

- Presence of 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.

CPT Code	Short Description
43200	Esophagus endoscopy
43202	Esophagus endoscopy biopsy
43234	Upper gi endoscopy exam
43235	Uppr gi endoscopy diagnosis
43239	Upper gi endoscopy biopsy

Closure of enterostomy

Mobilization of splenic flexure (CPT code 44139) is not paid when billed with enterostomy procedures (CPT codes 44625 and 44626). CPT code 44139 must be used only in conjunction with partial colectomy (CPT codes 44140-44147).

Contrast material

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

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

To bill for LOCM, use the appropriate HCPCS procedure codes: Q9951, Q9965, Q9966 or Q9967. The brand name of the LOCM and the dosage must be documented in the client's record.

Fecal microbiota therapy

Fecal microbiota therapy requires prior authorization.

FDA position update:

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

HCPCS Code	Short Description
G0455	Fecal microbiota prep instil

Drug eluting stents

The agency pays for drug eluting stents when the technology criteria are met. This procedure requires EPA. See expedited prior authorization (EPA) criteria for EPA #422.

Cardiovascular

Angioscopy

The agency pays for one unit of angioscopy (CPT code 35400), per session.

Apheresis

Therapeutic apheresis (CPT codes 36511-36516) includes payment for all medical management services provided to the client on the date of service. The agency pays for only one unit of either CPT code per client, per day, per provider.

Separate payment is not allowed for the following procedures on the same date that therapeutic apheresis services are provided, unless a significant and separately identifiable condition exists which is reflected by the diagnosis code and billed with modifier 25:

CPT Code	Short Description
99211	Office/outpatient visit est
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est
99231	Subsequent hospital care
99232	Subsequent hospital care
99233	Subsequent hospital care

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

Transcatheter aortic valve replacement (TAVR)

(CPT codes 33361-33365, and HCPCS code 0318T)

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

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

Note: The agency 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.

Female genital system

Hysterectomies

[WAC 182-531-1550(10)]

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

- Cancer; or
- 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.
- Federal regulations prohibit payment for hysterectomy procedures until a properly completed consent form is received. To comply with this requirement, surgeons, anesthesiologists, and assistant surgeons must obtain a copy of a completed agency-approved consent form to attach to their claim.
- **ALL** hysterectomy procedures require a properly completed agency-approved consent form, 13-365, regardless of the client's age or the ICD-9-CM diagnosis.
- Submit the claim and completed agency-approved consent form (see Resources Available).

Download the Hysterectomy Consent Form, 13-365.

Integumentary system

Clarification of coverage policy for miscellaneous procedures

Limitations on coverage for certain miscellaneous procedures are listed below:

Procedure Code	Short Description	Limitation Restricted to ICD-9-CM
11980	Implant hormone pellet(s)	257.2, 174.0-174.9
S0139	Minoxidil, 10 mg	401.0-401.9 (essential hypertension)
S0189	Testosterone pellet 75 mg	257.2, 174.0-174.9 and only when used with CPT code 11980

Male genital system

Circumcisions

(CPT codes 54150, 54160, and 54161)

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

- Phimosis (ICD-9-CM 605);
- Balanoposthitis (ICD-9-CM 607.1); or
- Balanitis Xerotica (ICD-9-CM 607.81).

Musculoskeletal system

Artificial disc replacement

The agency pays for Cervical Disc Replacement (CPT codes 22856 and 22861) when the technology criteria are met. These procedures require a medical necessity review by Qualis Health.

The agency pays for Lumbar Disc Replacement (CPT codes 22857, 22862, and 22865) when the technology criteria are met. These procedures require a medical necessity review by Qualis Health.

Bone growth stimulators

The agency pays for bone growth stimulators (CPT codes 20974, 20975, and 20979) when the technology criteria are met. These procedures require prior authorization (PA) to establish medical necessity.

Bone morphogenetic protein 2 for lumbar fusion

The agency requires that the following criteria be met for the use of bone morphogenetic protein -2 (rhBMP-2):

- Clients are 18 years of age and older;
- It is used only in the lumbar spine;
- It is used in primary anterior open or minimally invasive fusion at **one** level between L4 and S1; or
- 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.

Note: The agency requires a medical necessity review by Qualis Health for associated spinal fusion procedures. Include the following in the request for authorization:

- The anticipated use of BMP -2 and
- The miscellaneous code **22899**; or
- Diagnosis code 84.52, insertion of recombinant bone morphogenetic protein.

Bone morphogenetic protein 7 for lumbar fusion

The agency will not pay for bone morphogenetic protein – 7 (**rhBMP-7)** as supporting clinical evidence has not been established.

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.
- The agency 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 17 years of age and younger.

Hip resurfacing

The agency pays for total hip resurfacing arthroplasty as an alternative to total hip arthroplasty when all of the following conditions are met:

- A diagnosis of osteoarthritis or inflammatory arthritis;
- The individual has failed nonsurgical management and is a candidate for total hip arthroplasty; and
- The device is FDA-approved.

Hip surgery for femoroacetabular impingement (FAI) syndrome

Medical necessity has not been established for hip surgery to treat Femoroacetabular Impingement Syndrome (FAI).

Knee arthroscopy for osteoarthritis

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

Microprocessor-controlled lower limb prostheses (MCP)

Microprocessor-controlled lower limb prostheses (MCP) for the knee is considered medically necessary for the following conditions:

- Functional levels 3 or 4, (level 2 is under agency review); and
- Experienced user, (exceptions are under agency review).

MCP must be used with manufacturers' specifications. Prior authorization is required.

For additional information and authorization requirements, see the agency's Prosthetic & Orthotic Devices Medicaid Provider Guide.

Note: Microprocessor-controlled lower limb prostheses (MCP) for the feet and ankle are not considered medically necessary.

Osteochondral allograft and autograft transplantation

The agency 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 of 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; and
- 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.

Effective April 1, 2013, the following codes are covered and require a medical necessity review by Qualis Health for clients 21 years of age and older:

CPT Code	Short Description
29866	Autgrft implnt knee w/scope
29867	Allgrft implnt knee w/scope
29868	Meniscal trnspl knee w/scpe

Osteotomy reconstruction

Procedure Code	Short Description	Does not require PA when billed with ICD-9-CM diagnoses
21198	Reconstr lwr jaw segment	170.1 or 802.20 – 802.35

Percutaneous kyphoplasty, vertebroplasty and sacroplasty

The agency does ***not*** recognize percutaneous kyphoplasty, vertebroplasty and sacroplasty as medically necessary for relief of pain and improvement of function for spinal fractures.

CPT Code	Short Description
22520	Percut vertebroplasty thor
22521	Percut vertebroplasty lumb
22522	Percut vertebroplasty addl
22523	Percut kyphoplasty thor
22524	Percut kyphoplasty lumbar
22525	Percut kyphoplasty add-on
72291	Perq verte/sacroplsty fluor
72292	Perq verte/sacroplsty ct
0200T	Perq sacral augmt unilat inj
0201T	Perq sacral augmt bilat inj

Sacroiliac joint arthrodesis

Sacroiliac joint fusion, including minimally invasive and percutaneous sacroiliac joint fusion, for the treatment of chronic low back pain is considered to be **not medically necessary** and is not covered. The agency will consider requests for exception to rule for severe traumatic injury.

CPT Code	Short Description
27280	Arthrodesis, sacroiliac joint (including obtaining graft)

Robotic assisted surgery

Although robotic assisted surgery (RAS) may be considered medically necessary, the agency does not pay separately for HCPCS code S2900 and reimburses only for the underlying procedure.

The agency requires billing providers to bill for RAS in order to track utilization and outcome. The agency will monitor RAS through retrospective auditing of HCPCS code S2900, ICD-9 diagnosis code 14.42, and the review of operative reports.

Nervous system

Discography

The following procedures require prior authorization from the agency for clients 21 years of age and older. Prior authorization is not required for client 20 years of age and younger.

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

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

CPT Code	Short Description
62290	Inject for spine disk x-ray
62291	Inject for spine disk x-ray
72285	Discography cerv/thor spine
72295	X-ray of lower spine disk

Facet neurotomy

The following policy applies to facet neurotomy:

- Facet neurotomy requires a medical necessity review through Qualis Health using an established online questionnaire.
- There must be a minimum of twelve months between procedures per level per side.
- No more than 2 spinal nerves bilaterally or 3 spinal nerves unilaterally are allowed per date of service
- Requests for a third or subsequent procedure for any spinal nerve require submission of chart notes to Qualis for clinical review.
- The clinician must provide clear documentation in the medical record from the period between procedures that shows both:
  - ✓ Improved functional status for the patient.
  - ✓ A decrease in the use of pain medications.

Procedure code	Short Description	ICD-9 Diagnosis Code
64633	Destroy cerv/thor facet jnt	04.2
+64634	Destroy c/th facet jnt addl (List separately in addition to code for primary procedure)	04.2
64635	Destroy lumb/sac facet jnt	04.2
+64636	Destroy l/s facet jnt addl (List separately in addition to code for primary procedure)	04.2

Implantable infusion pumps or implantable drug delivery systems (IDDS)

The agency pays for CPT codes 62318, 62319, 62350, 62351, 62360, 62361 when medically necessary and only for the indications below:

- Cancer pain; and
- Spasticity.

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

Spinal cord stimulation for chronic neuropathic pain

The agency does not recognize spinal cord stimulation for chronic neuropathic pain as medically necessary. The agency will consider requests for other diagnoses. CPT codes 64575, 64580, 64581, 64585 and 64595 require prior authorization (PA) through the agency.

Spinal injections for diagnostic or therapeutic purposes (outpatient)

The agency requires medical necessity reviews for spinal injection procedures, including diagnostic selective nerve root block through Qualis Health, which uses an established online questionnaire. (See Qualis Health in this guide for additional information.)

Diagnostic selective nerve root block

The agency requires a medical necessity review for the diagnostic selective nerve root block through Qualis 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 twelve-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.

Transcutaneous electrical nerve stimulation (TENS) device

The agency does *not* cover TENS devices, related supplies and services for independent home-use.

Vagus nerve stimulation (VNS)

[Refer to WAC 182-531-0200(h)]

The agency considers VNS for the treatment of epilepsy as medically necessary only for management of epileptic seizures in patients 12 years of age and older who have a medically refractory seizure disorder.

VNS procedures can be performed in an inpatient hospital or outpatient hospital setting.

The agency requires prior authorization for VNS (CPT codes 61885, 61886, 64568, 64569, 64570). Prior authorization is not required for VNS programming (CPT codes 95970, 95974, and 95975) performed by a neurologist.

The agency does not pay for VNS and related procedures for a diagnosis of depression (CPT 64553-64565, 64590-64595, 95970, 95974, and 95975).

VNS for the treatment of depression has no evidence to support coverage.

Sleep apnea

Surgical treatment for sleep apnea

The agency requires prior authorization for the following surgical treatment for obstructive sleep apnea (OSA) or upper airway resistance syndrome (UARS) when billed with diagnosis code 327.23 (obstructive sleep apnea) or 780.57 (unspecified sleep apnea):

Procedure Codes	Short Descriptions
21199	Reconstr lwr jaw w/advance
21685	Hyoid myotomy & suspension
42120	Remove palate/lesion
42140	Excision of uvula
42145	Repair palate pharynx/uvula
42160	Treatment mouth roof lesion
42299	Palate/uvula surgery

See also Sleep Medicine Testing.

Urinary systems

Collagen implants

The agency pays for CPT code 51715 and HCPCS codes L8603, L8604 and/or L8606 only when the diagnosis code is 599.82 (Intrinsic sphincter deficiency). See Medical Supplies and Equipment – Urinary Tract Implants for limitations.

Indwelling catheter

- Separate payment is allowed for insertion of a temporary, indwelling catheter when it is used to treat a temporary obstruction and is performed in a physician's office.
- Bill for the insertion of the indwelling catheter using CPT code 51702 or 51703.
- The agency pays providers for insertion of an indwelling catheter only when performed in an office setting.
- Insertion of an indwelling catheter is bundled when performed on the same day as a major surgery.
- Insertion of an indwelling catheter is bundled when performed during the postoperative period of a major surgery.

Urinary tract implants

(CPT code 51715)

Prior to inserting a urinary tract implant, the provider must:

- Have urology training in the use of a cystoscope and must have completed a urinary tract implant training program for the type of implant used.
- Document that the client has shown no incontinence improvement through other therapies for at least 12 months prior to collagen therapy.
- Administer and evaluate a skin test for collagen sensitivity (CPT code 95028) over a four-week period prior to collagen therapy. A negative sensitivity must be documented in the client's record.

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

Urological procedures with sterilizations in the description

These procedures may cause the claim to stop in the agency's payment system and trigger a manual review as a result of the agency'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 *Comments* section of the claim:

- Not sterilized; or
- Not done primarily for the purpose of sterilization.

Radiology Services

[WAC 182-531-1450]

Radiology services – general limits

- The agency 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 form.
- 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; and
  - ✓ X-rays in excess of two views.

Note: The agency does not pay for radiology services with diagnosis code V72.5. Providers must bill the appropriate medical ICD-9-CM code.

Radiology modifiers for bilateral procedures

- Bill the procedure on two separate lines using modifier 50 on one line only.
- Bill **modifier LT or RT** on separate lines when a radiological procedure is performed on the right and/or left side or extremity.
- Do not use modifier 50, LT, or RT if the procedure is defined as bilateral.

Breast, Mammography

Mammograms

The agency has adopted the National Cancer Institute (NCI) recommendations regarding screening mammograms (procedure codes 77052, 77057, and G0202). For clients age 40 and over, one annual screening mammogram is allowed per calendar year. Screening mammograms for clients 39 years of age and younger require prior authorization.

Diagnostic Radiology (Diagnostic Imaging)

Which procedures require a medical necessity review by Qualis Health?

[WAC 182-531-1450]

The agency requires prior authorization for selected procedures

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

Computed Tomography (CT)			
Head	70450	70460	70470
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	77058	77059	C8903*
	C8904*	C8905*	C8906*
	C8907*	C8908*	
Lower Extremity	73721	73722	73723

*Required for outpatient hospital claims

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

Advanced imaging services do **NOT** require prior authorization when billed with either of the following place of service (POS):

- (POS) 21 (Inpatient Hospital); or
- (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" as follows:

Paper Billers	Electronic billers
Box 19 on the CMS-1500 Form	In the ***Comments*** section

A radiologist who performed a professional interpretation, referred to as a "read- only," on an outpatient advanced image must be added to the agency's authorization record to receive payment.

- Contact the agency at 1-800-562-3022, 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 and click on number 7. 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 my facility" in the comments field of the claim.

Computed tomography angiography (CTA)

The agency pays for CTA when the technology criteria are met. CPT code 75574 is restricted to place of service 21, 22, 23.

The agency **will** pay for CTA when

- Using computed tomography machines with 64-slice or better capability; ***and***
- The following medical necessity criteria are met:

  - ✓ Patients have low to intermediate risk of coronary artery disease; and
  - ✓ Investigation of acute chest pain is conducted in an emergency department or hospital setting;

The agency ***will not*** pay for CTA when:

- Using a CT scanner that uses lower than 64-slice technology; ***or***
- The procedure is not medically necessary as follows:

  - ✓ Patients are asymptomatic or at high risk of coronary artery disease; and
  - ✓ Investigation of coronary artery disease is conducted outside of the emergency department or hospital setting.

Consultation on x-ray examination

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

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

Coronary artery calcium scoring

The agency does ***not*** recognize computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium as medically necessary.

Prior authorization from the agency is required for CPT code 75571.

Magnetic resonance imaging (MRI)

- Please check the Physician's Related Services fee schedule for authorization requirements for MRIs.

- The agency is implementing the Washington State Health Technology Clinical Committee (HTCC's) decision that uMRI (upright MRI) is **experimental and investigational;** therefore,

according to WAC 182-501-0165, uMRI is a "D" level evidence that is not supported by any evidence regarding its safety and efficacy. Medicaid will not reimburse unless one of the following criteria is met:

- ✓ The client must have a humanitarian device exemption; or
- ✓ There must be a local Institutional Review Board protocol in place.

Portable x-rays

- Portable x-ray services furnished in a client's home or nursing facility and payable by the agency are limited to the following:
  - ✓ Skeletal films involving extremities, pelvis, vertebral column, or skull;
  - ✓ Chest or abdominal films that do not involve the use of contrast media; or
  - ✓ Diagnostic mammograms.
- 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 form for each medicaid client seen.*** The agency 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 agency's payment for procedure codes R0070 and R0075 includes setup. 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
(HCPCS G0389)

The agency covers ultrasound screening for abdominal aortic aneurysm only when:

- Billed with diagnosis code V81.2 (special screening for other and unspecified cardiovascular conditions); and

- A client meets at least one of the following conditions:

  - ✓ Has a family history of an abdominal aortic aneurysm; or
  - ✓ Is a male who is between 65 and 75 years old and has smoked at least 100 cigarettes in his lifetime.

Virtual colonoscopy or computed tomographic colonography

The agency does ***not*** recognize computed tomographic colonography for routine colorectal cancer screening as medically necessary.

CPT Code	Description
74261	Ct colonography dx
74262	Ct colonography dx w/dye
74263	Ct colonography screening

Diagnostic Ultrasound

Obstetrical ultrasounds

Routine ultrasounds for average risk pregnant women are considered medically necessary with limitations. The agency considers two ultrasounds per average risk singleton pregnancy as medically necessary. The agency pays for:

- One routine ultrasound in the first trimester (less than 13 weeks gestational age) for the purpose of:

  - ✓ Identifying fetal aneuploidy; or
  - ✓ Anomaly; and/or;
  - ✓ Dating confirmation.

- Once for the purpose of anatomy screening between 16 and 22 weeks gestation.

The agency does not pay for:

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

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

Note: Additional ultrasounds are subject to postpayment review.

Nuclear Medicine

Which procedures require a medical necessity review?

[WAC 182-531-1450]

The agency requires prior authorization for selected procedures

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

Cardiac Imaging (SPECT)	
Ht muscle image spect sing	78451
Ht muscle image spect mult	78452
Ht muscle image planar sing	78453
Ht musc image planar mult	78454

PET Scans	
Brain	78608
Limited Area	78811
Skull base to mid thigh	78812
Full Body	78813

PET-CT Scans	
Limited Area (Chest, head, neck)	78814
Skull base to mid thigh	78815
Whole body	78816

- PET Scans and MRI/MRAs are limited to one per day.

Advanced imaging services do **NOT** require PA when billed with either of the following place of service (POS):

- (POS) 21 (Inpatient Hospital); or
- (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" as follows:

Paper Billers	Electronic billers
Box 19 on the CMS-1500 Form	In the ***Comments*** section

A radiologist who performed a professional interpretation, referred to as a "read- only", on an outpatient advanced image must be added to the agency's authorization record to receive payment. Please contact the agency at 1-800-562-3022, 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 my facility" in the comments field of the claim.

Radiopharmaceutical diagnostic imaging agents

- When performing nuclear medicine procedures, separate payment is allowed for radiopharmaceutical diagnostic imaging agents (HCPCS Q9945-Q9951).

- The agency allows the following CPT codes for radiopharmaceutical therapy without PA: CPT codes 79101, 79445, and 79005.

Nuclear medicine - billing

When billing the agency 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; or

- 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); or
- ✓ CPT code 78806 (radionuclide localization of abscess; whole body) and 78807 (radionuclide localization of abscess; SPECT).

Radiation Oncology

Intensity modulated radiation therapy (IMRT)

IMRT is considered **medically necessary** for the treatment of:

- **Head and neck cancers**
  - ✓ See EPA 870001313.
  - ✓ All other diagnoses not listed in the EPA require prior authorization.
- **Prostate cancer**
  - ✓ See EPA 870001313.
- **To spare adjacent critical structures to prevent toxicities within expected life span**
  - ✓ Prior authorization required.
- **Undergoing treatment in the context of evidence collection/submission of outcome data**
  - ✓ Prior authorization required.

Procedure Code	Short Description
77301	Radiotherapy dose plan imrt
77338	Design mlc device for imrt
77370	Radiation physics consult
77418	Radiation tx delivery imrt
0073T	Delivery comp imrt

Proton beam radiation therapy

Retroactive to April 1, 2013, the following procedure codes for proton beam radiation therapy require prior authorization (PA):

Procedure Code	Short Description	PA
77520	Proton trmt simple w/o comp	Yes
77522	Proton trmt simple w/comp	Yes
77523	Proton trmt intermediate	Yes
77525	Proton treatment complex	Yes

Pathology and Laboratory

[WAC 182-531-0800 and WAC 182-531-0850]

Certifications

Independent laboratories - certification

Independent laboratories must be certified according to Title XVII of the Social Security Act (Medicare) to receive payment from Medicaid. The agency 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 the agency in order to receive payment from the agency.

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

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

Anatomic Pathology

Pap smears

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

- Use CPT codes 88147-88154, 88164-88167, and HCPCS P3000-P3001 for conventional Pap smears.
- The agency pays for thin layer preparation CPT codes 88142-88143 and 88174-88175. The agency does not pay providers for HCPCS codes G0123-G0124 and G0141-G0148. The agency pays for thin layer Paps at Medicare's payment levels. Thin layer preparation and conventional preparation CPT codes cannot be billed in combination.

- Use CPT codes 88141 and 88155 in conjunction with codes 88142-88143 and 88164-88167.
- Use the appropriate medical diagnosis if a condition is found.
- The agency pays providers for one routine Pap smear per client, per calendar year only. The agency considers routine Pap smears to be those billed with an ICD-9-CM diagnosis of V76.2, V72.31, V76.47, or V25.40-V25.49. For clients on the TAKE CHARGE or Family Planning Only programs, use diagnosis codes from the V25 series diagnosis codes, excluding V25.3.
- The agency does not pay providers for CPT code 88112 with diagnosis V72.3 or V76.2.

Chemistry

Cancer screens

(HCPCS codes G0101, G0103-G0105 and CPT code 82270)

The agency covers the following cancer screenings:

- Cervical or vaginal;
- Prostate;
- Colorectal;
- Pelvic/breast exams;
- Screening sigmoidoscopies;
- Colonoscopies; and
- PSA testing.

HCPCS Code	Short Description	Limitations	Payable Only With Diagnosis Code(s)
G0101	CA screen; pelvic/breast exam	Females only One every 11 to 12 months or as indicated by nationally recognized clinical guidelines. *[Use for Pap smear professional services]*	V25.40-V25.49, V72.31, V76.2, or V76.47
G0103	PSA screening	Once every 12 months when ordered	Any valid ICD-9-CM code other than high risk (e.g., V76.44)
G0104	CA screen; flexi sigmoidscope	Clients age 50 and older who are not at high risk Once every 48 months	Any valid ICD-9-CM code other than high risk (e.g., V76.51)
G0105*	Colorectal scrn; hi	Clients at high risk for	High risk 555.1, 555.0, 555.2,

HCPCS Code	Short Description	Limitations	Payable Only With Diagnosis Code(s)
	risk ind	colorectal cancer One every 24 months	555.9, 556.0-556.6, 556.8, 556.9, 558.2, 558.9, V10.05, V10.06, V12.72, V84.09, V16.0, or V18.51
82270	Occult blood, feces	N/A	Any valid ICD-9-CM code (e.g., V76.51)
G0121*	Colon CA scrn; not high risk ind	Clients age 50 and older Once every 10 years	Any valid ICD-9-CM code other than high risk (e.g., V76.51)
G0122	Colon CA scrn; barium enema	Clients age 50 and older Once every 5 years	Any valid ICD-9-CM code other than high risk (e.g., V76.51)

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

Disease organ panels--automated multi-channel tests

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

Procedure Code	Short Description
82040	Albumin; serum
82247	Bilirubin; total
82248	Bilirubin; direct
82310	Calcium; total
82330	Calcium, ionized
82374	Carbon dioxide (bicarbonate)
82435	Chloride; blood
82465	Cholesterol, serum, total
82565	Creatine; blood
82947	Glucose; quantitative
82977	Glutamyltransferase, gamma (GGT)
83615	Lactate dehydrogenase (LD) (LDH)
84075	Phosphatase, alkaline
84100	Phosphorous inorganic (phosphate)
84132	Potassium; serum
84155	Protein; total, except refractometry
84295	Sodium; serum
84450	Transferase; apartate amino (AST)(SGOT)
84460	Transferase; alanine amino (AST)(SGPT)
84478	Tryglycerides
84520	Urea nitrogen; quantitative
84550	Uric acid; blood
85004	Automated diff wbc count

Procedure Code	Short Description
85007	B1 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 test***s must be billed on the same claim form when performed for a client by the same provider*** on the same day.

Fetal fibronectin

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

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

The use of fetal fibronectin assays is considered to be not medically necessary for the following indications:

- No symptoms of preterm birth (there is no clinical evidence that treating women with no labor symptoms or high risk for premature delivery benefits mother or baby)
- Routine screening or determination of risk of preterm delivery in asymptomatic women
- Outpatient tests and the woman awaits test results at home

- Monitoring of asymptomatic women at high-risk for preterm labor (PTL)
- Women not requiring induction due to likelihood of delivery within 24 to 48 hours
- Ruptured membranes or advanced cervical dilation (3 cm or more)
- Imminent birth

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

CPT Code	Short Description
82731	Fetal fibronectin, cervicovaginal secretions, semi-quantitative

ICD-9 diagnoses codes that support medical necessity

ICD-9 Code	Short Description
622.5	Incompetence of cervix
640.00-649.82	Complications mainly related to pregnancy
654.50-654.54	Cervical incompetence during pregnancy, childbirth and the puerperium
655.7	Decreased fetal movement
659.4-659.6	Other indications for care or intervention related to labor and delivery
789	Abdominal pain
v22.1	Supervision of other normal pregnancy
v23.41	Supervision of pregnancy with history of preterm labor
v23.5	Supervision of pregnancy with other poor reproductive history
v28.82	Encounter for screening for risk of preterm labor

Vitamin D screening and testing

(CPT code 82306, 82652)

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

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

- Chronic kidney disease stage 3 or greater
- End stage renal disease
- Evaluation of hypo- or hypercalcemia
- Hypocalcemia and hypomagnesemia of newborn
- Hypophosphatemia

- Hypoparathyroidism
- Intestinal malabsorption including
  - ✓ Blind loop syndrome
  - ✓ Celiac disease
  - ✓ Pancreatic Steatorrhea
- Secondary hyperparathyroidism
- Hypervitaminosis D
- Osteomalacia
- Osteopenia
- Rickets
- In the setting of other laboratory or imaging indicators of vitamin D deficiency for:
  - ✓ Calculus of kidney or ureter
  - ✓ Chronic liver disease in the absence of alcohol dependency
  - ✓ Protein-calorie malnutrition

Vitamin D testing (1,25-dihydroxyvitamin D, calcitriol, CPT 82652) may be considered medically necessary as a second tier test for the following conditions:

- Disorders of calcium metabolism
- Familial hypophosphatemia
- Fanconi syndrome
- Hypoparathyroidism or hyperparathyroidism
- Vitamin D resistant rickets
- Tumor induced osteomalacia
- Sarcoidosis

CPT Code	Short Description	ICD-9 Dx Code
82306	Vitamin d 25 hydroxy	**As appropriate:** 135, 252.0-252.08, 252.1, 261-262, 263.0, 263.9, 268.0, 268.1, 268.2, 275.3, 275.40, 275.41, 275.42, 275.8, 278.4, 284.09, 571.9, 572.8, 573.9, 579.0-579.9, 585.3-585.5, 585.9, 585.6, 588.81, 592.0, 592.1, 592.9, 594.1, 594.8, 594.9, 753.3, 733.90, 775.4
82652	Vit d 1 25-dihydroxy	

Drug Testing

Drug screens

The agency pays for drug screens when:

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

Refer to the agency's Physician-Related Fee Schedule for covered drug screening codes.

The Agency has adopted the Agency Medical Directors' Group (AMDG) drug screening guidelines outlined in the Agency Medical Directors' Interagency Guidelines. For more information, please go online at:

- Interagency Guidelines on Opioid Dosing for Chronic Non-Cancer Pain
- Opioid Guidelines and DOH Pain Management Rules

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

The agency does not pay for:

- Routine drug screening panels; or
- Monitoring for program compliance in either a residential or outpatient drug or alcohol treatment program.

Note: Labs must offer single drug testing. Drug screening must be medically indicated and the reason for the specific drug screening must be documented in the client record. Lab slips must be signed by the prescribing provider.

When monitoring a client for drug/alcohol use, please refer the client to a Division of Behavioral Health and Rehabilitation (DBHR)-approved program for evaluation and treatment. Clients

served by these programs may receive drug/alcohol screening according to an established treatment plan determined by their treating provider.

For clients in the DBHR-contracted methadone treatment programs and pregnant women in DBHR-contracted treatment programs, drug screens are paid through a contract issued to one specific laboratory by DBHR, not through the agency.

Suboxone drug screening policy

Urine drug screens for benzodiazepines, amphetamine/methamphetamine, cocaine, methadone, opiates, and barbiturates must be done before each prescription is dispensed during the first month of therapy.

The prescriber must fax the pharmacy with confirmation that the drug screen has been completed to release the next 14-day supply. The fax must be retained in the pharmacy for audit purposes. After the first month of therapy, urine drug screens are to be done at time intervals determined to be appropriate by the prescriber.

The provider must be certified and approved to prescribe Buprenorphine-Suboxone.
The provider must have a CLIA waiver.

Enter the following information on the 837P, DDE professional, or CMS-1500 Claim Form:

- ICD-9-CM diagnosis codes 304.00-304.03;
- HCPCS code G0431 QW – limited to one per day and CPT code 80102 are covered only for ICD-9-CM diagnoses 304.00-304.03; and
- "Certified bupren provider" in the comments field on the:
  - ✓ 837P claim,
  - ✓ Claim notes field of the DDE, or
  - ✓ Field 19 of the CMS-1500 paper claim.

Bill with EPA number 870000050. See Prior Authorization for additional information.

Immunology

HIV testing

The agency pays providers for HIV testing (CPT codes 86701-86703) for ICD-9-CM diagnosis codes 042, 079.53, V01.79, V08, V22.0, V22.1, V22.2 or V28.89 only.

Targeted TB testing with interferon-gamma release assays

Targeted TB testing with interferon-gamma release assays may be considered medically necessary for **clients five years of age and older** for the following conditions:

- History of positive tuberculin skin test or previous treatment for TB disease; or
- History of vaccination with BCG (Bacille Calmette-Guerin); or
- Recent immigrants (within 5 years) from countries that have a high prevalence of tuberculosis; or
- Residents and employees of high-risk congregate settings (homeless shelters, correctional facilities, substance abuse treatment facilities); or
- Clients with an abnormal chest x-ray (CXR) consistent with old or active TB; or
- Clients undergoing evaluation or receiving TNF alpha antagonist treatment for rheumatoid arthritis, psoriatic arthritis, or inflammatory bowel disease;

AND

- Client agrees to remain compliant with treatment for latent tuberculosis infection if found to have a positive test.

The tuberculin skin test is the preferred method of testing for children under the age of 5.

CPT Code	Short Description
86480	Tb test cell immun measure
86481	Tb ag response t-cell susp

Providers must follow the agency's expedited prior authorization (EPA) process to receive payment for targeted TB testing. See **EPA #1325** in EPA Criteria Coding List.

Organ and disease-oriented panels

Automated multi-channel tests - payment

For individual automated multi-channel tests, providers are paid on the basis of 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 form.

- 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 form.
- Bill any other individual tests as a separate line item on the claim form.

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 the agency'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, the agency 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

CPT Code	Short Description
86900	Blood typing, ABO
86901	Blood typing, Rh(D)
87340	Hepatitis b surface ag, eia

Billing

Billing for laboratory services that exceed the lines allowed

- Providers who bill on hardcopy CMS-1500 Claim Forms are allowed up to 6 lines per claim. Direct entry, claim batch or 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 field 19 when billing on a hardcopy CMS-1500 Claim Form or in the *Comments* section when billing electronically. Total each claim separately.

- If the agency 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 (preferred) or send in a paper claim adjustment. 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 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.

- The agency expects independent laboratories to bill hospitals for the technical component of anatomic pathology services furnished to hospital inpatients and outpatients. To prevent duplicate payment, the agency 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.
- The agency pays for one blood draw fee (CPT codes 36415-36416 or 36591) per day.
- The agency 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 agency-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 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. **The agency does not pay a laboratory for procedures billed using ICD-9-CM diagnosis codes V72.6, V72.62, V72.63, or V72.69 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®. The agency 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 an RSN, providers must:

  ✓ Put "Referred by the RSN" in the *Comments* section of the claim form; and
  ✓ Include the managed care denial with their claim when billing the agency.

Laboratory physician interpretation codes

The following codes are clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. The actual performance of the tests is paid for under the laboratory fee schedule. Modifier TC must not be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense, and malpractice expense.

81200-81479				
84181		86255	86327	87207
83020	84182	86256	86334	88371
84165	85390	86320	86335	88372
84166	85576	86325	87164	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. The agency does not pay for laboratory procedures billed using ICD-9-CM diagnosis codes V72.6, V72.62, V72.63, or V72.69. 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. The agency recognizes this modifier as ***informational only***. **This modifier is *not* appropriate to use for billing repeat tests or to indicate the test was not done as a panel.**

Modifier 90

Reference (Outside) Laboratory: When a laboratory sends a specimen to a reference (outside) laboratory, the referring laboratory may bill for the reference laboratory (pass-through billing) by adding modifier 90 to the laboratory procedure code. *The reference laboratory NPI must be entered in the performing number field on the claim form.*

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; or
- 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 agency managed care plan for laboratory services, the laboratory **must bill the agency directly.** 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 the agency;
- The laboratory must bill with a mental health, substance abuse, or alcohol abuse diagnosis; and
- The screen must meet the criteria in "Drug Screens."

To bill for laboratory services, laboratories **must** put the CMHC or DBHR-contracted referring provider National Provider Identifier (NPI) number in the "referring provider" field of the claim

form. CMHC and DBHR-contracted services are excluded from the agency'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 tests listed below:

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
80100	Drug screen qualitate/multi
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
80196	Assay of salicylate
80197	Assay of tacrolimus
80198	Assay of theophylline
81000	Urinalysis nonauto w/scope

Procedure Code	Short Description
81001	Urinalysis auto w/scope
81002	Urinalysis nonauto w/o scope
81003	Urinalysis auto w/o scope
81005	Urnalysis
82003	Assay of acetaminophen
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
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

Procedure Code	Short Description
85046	Reticyte/hgb concentrate
85049	Automated platelet count
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
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

[Refer to WAC 182-531-0950(10)]

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.

The agency will pay for **50 units** (CPT 95165) per client, per year.
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.

Audiology

[WAC 182-531-0375]

The agency may pay for speech/audiology program services for conditions that are the result of medically recognized diseases and defects.

Who is eligible to provide audiology services?

[WAC 182-531-0375]

Audiologists who are appropriately licensed or registered to provide speech/audiology services within their state of residence to agency clients.

What type of equipment must be used?

Audiologists must use annually calibrated electronic equipment, according to RCW 18.35.020.

- For caloric vestibular testing (CPT code 92543), bill one unit per irrigation. If necessary, providers may bill up to four units for each ear.

- For sinusoidal vertical axis rotational testing (CPT code 92546), bill 1 unit per velocity/per direction. If necessary, providers may bill up to 3 units for each direction.

The agency covers, with prior authorization, the implantation of a unilateral cochlear device for clients 20 of age and younger with the following limitations:

- The client meets one of the following:
  - ✓ Has a diagnosis of profound to severe bilateral, sensorineural hearing loss.
  - ✓ Has stimulable auditory nerves but has limited benefit from appropriately fitted hearing aids (e.g., fail to meet age appropriate auditory milestones in the best aided condition for young children, or score of <10 or equal to 40% correct in the best aided condition on recorded open-set sentence recognition tests).
  - ✓ Has the cognitive ability to use auditory cues.
  - ✓ Is willing to undergo an extensive rehabilitation program.
  - ✓ Has an accessible cochlear lumen that is structurally suitable for cochlear implantation.
  - ✓ Does not have lesions in the auditory nerve and/or acoustic areas of the central nervous system.
  - ✓ Has no other contraindications to surgery.
- And the procedure is performed in an inpatient hospital setting or outpatient hospital setting.

The agency covers osseointegrated bone anchored hearing aids (BAHA) for clients 20 years of age and younger with prior authorization.

The agency covers replacement parts for BAHA and cochlear devices for clients 20 years of age and younger only. See the current Hearing Hardware for Clients 20 Years of Age and Younger Medicaid Provider Guide for more information.

The agency considers requests for removal or repair of previously implanted bone anchored hearing aids (BAHA) and cochlear devices for clients 21 years of age and older only when medically necessary. Prior authorization from the agency is required.

Audiology billing

The outpatient rehabilitation benefit limits ***do not apply*** to therapy services provided and billed by audiologists. Audiologists (and physicians) must use ***AF modifier*** when billing**.**

Audiology coverage table

Note: Due to its licensing agreement with the American Medical Association, the agency publishes only the official, CPT® code short descriptions. To view the long descriptions, please refer to a current CPT book.

Audiology				
Procedure Code	**Modifier**	**Short Description**	**EPA/PA**	**Policy/ Comments**
69210		rmvl impacted cerumen spx 1/both ears		
92506		Speech/hearing evaluation		Limit of one per year, per client
92507*		Speech/hearing therapy		
92508*		Speech/hearing therapy		
92551		Pure tone hearing test air		
92611		Motion fluoroscopy/swallow		
92630		Aud rehab pre-ling hear loss		
92633		Aud rehab postling hear loss		
97532*		Cognitive skills development		One 15 minute increment equals one visit
97533*		Sensory integration		One 15 minute increment equals one visit
92540		Basic vestibular evaluation		
92540	26	Basic vestibular evaluation		
92540	TC	Basic vestibular evaluation		
92541	26	Spontaneous nystagmus test		
92541	TC	Spontaneous nystagmus test		
92541		Spontaneous nystagmus test		
92542	26	Positional nystagmus test		
92542	TC	Positional nystagmus test		
92542		Positional nystagmus test		
92543	26	Caloric vestibular test		
92543	TC	Caloric vestibular test		

Audiology				
Procedure Code	Modifier	Short Description	EPA/PA	Policy/ Comments
92543		Caloric vestibular test		
92544	26	Optokinetic nystagmus test		
92544	TC	Optokinetic nystagmus test		
92544		Optokinetic nystagmus test		
92545	26	Oscillating tracking test		
92545	TC	Oscillating tracking test		
92545		Oscillating tracking test		
92546	26	Sinusoidal rotational test		
92546	TC	Sinusoidal rotational test		
92546		Sinusoidal rotational test		
92547		Supplemental electrical test		
92550		Tympanometry & reflex thresh		
92552		Pure tone audiometry, air		
92553		Audiometry, air & bone		
92555		Speech threshold audiometry		
92556		Speech audiometry, complete		
92557		Comprehensive hearing test		
92558		Evoked auditory test qual		
92567		Tympanometry		
92568		Acoustic reflex testing		
92570		Acoustic immittance testing		
92579		Visual audiometry (vra)		
92582		Conditioning play audiometry		
92584		Electrocochleography		
92585	26	Auditor evoke potent, compre		
92585	TC	Auditor evoke potent, compre		
92585		Auditor evoke potent, compre		
92586		Auditor evoke potent, limit		
92587	26	Evoked auditory test		
92587	TC	Evoked auditory test		
92587		Evoked auditory test		
92588	26	Evoked auditory test		
92588	TC	Evoked auditory test		
92588		Evoked auditory test		
92601		Cochlear implt f/up exam < 7		
92602		Reprogram cochlear implt < 7		
92603		Cochlear implt f/up exam 7 >		
92604		Reprogram cochlear implt 7 >		

Audiology				
Procedure Code	Modifier	Short Description	EPA/PA	Policy/ Comments
92620		Auditory function, 60 min		
92621		Auditory function, + 15 min		
92625		Tinnitus assessment		
92626		Eval aud rehab status		
92627		Eval aud status rehab add-on		

Fee schedule

View the agency's Audiology Program Fee Schedule online.

Cardiovascular

Heart catheterizations

When a physician performs cardiac catheterization in a setting where the physician does not own the equipment (e.g., a hospital or ASC), the agency 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.

Please refer to the agency's Physician-Related/Professional and Emergent Oral Healthcare Services Fee Schedule for covered codes and status indicators**.**

Outpatient cardiac rehabilitation

The agency covers outpatient cardiac rehabilitation in a hospital outpatient agency for eligible clients who:

- Are referred by a physician.
- Have coronary artery disease (CAD).
- Do not have specific contraindications to exercise training.
- Have:
    - ✓ A recent documented history of acute myocardial infarction (MI) within the preceding 12 months.
    - ✓ Had coronary angioplasty (coronary artery bypass grafting [CABG].

- ✓ Percutaneous transluminal coronary angioplasty [PTCA]).
- ✓ Stable angina.

Bill physician services with CPT code 93798 or HCPCS G0422 that includes continuous ECG monitoring (per session) with one of the following diagnosis codes:

410.00-410.92 (Acute myocardial infarction)	413.0-413.9 (Angina pectoris)
V45.81 (Aortocoronary bypass status)	V45.82 (Percutaneous transluminal coronary angioplasty status)

Note: Cardiac rehabilitation does not require PA, and it is only approved for the above diagnoses.

The agency **does not** cover CPT code 93797 or HCPCS G0423.

The outpatient cardiac rehab program hospital facility must have all of the following:

- A physician on the premise at all times, 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.
- Nonphysician 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 a client:
  - ✓ Exhibits symptoms such as excessive fear or anxiety associated with cardiac disease; or
  - ✓ Has a diagnosed mental, psychoneurotic, or personality disorder.

- Continuous cardiac monitoring during exercise or ECG rhythm strip used to evaluate a client's exercise prescription.

The agency covers up to 24 sessions (usually 3 sessions a week for 4-6 weeks) of cardiac rehab exercise sessions (phase II) per event. The clients must have continuous ECG monitoring. The agency covers continued participation in cardiac rehab exercise programs beyond 24 sessions only on a case-by case basis with prior authorization.

Chemotherapy

Chemotherapy services

[WAC 182-531-0950(11)]

Bill the appropriate chemotherapy administration CPT code for each drug administered.

The agency'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.

- The agency pays for only one "initial" drug administration code (CPT code 96409 or 96413) per encounter unless:

  - ✓ Protocol requires the use of two separate IV sites; or
  - ✓ 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.

- The agency does not pay for Evaluation and Management (E/M) CPT code 99211 on the same date of service as the following drug administration codes: 96401-96549. If billed in combination with one of these drug administration codes, the agency will deny the E/M code 99211. However, providers may bill other E/M codes on the same date of service using modifier 25 to indicate that a significant and separately identifiable E/M service was provided. If modifier 25 is not used, the agency will deny the E/M code.

- **Items and services not separately payable with drug administration:**
  Some items and services are included in the payment for the drug administration service, and the agency does not pay separately for them. These services include, but are not limited to:

  - ✓ 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; and
- ✓ Syringes and supplies.

- **Infusion vs. push:**
  An intravenous or intra-arterial push is defined as:

  - ✓ An injection in which the health care professional who administers the substance or drug is continuously present to administer the injection and observe the patient; OR
  - ✓ An infusion of 15 minutes or less.

Note: Drug, infusion, and injection codes must be billed on the same claim form.

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, the agency will deny the E/M code.

Dialysis - End-Stage Renal Disease (ESRD)

Inpatient visits for hemodialysis or outpatient non-ESRD dialysis services

(CPT codes 90935 and 90937)

Procedure Codes Billed	Instructions
90935 and 90937	Bill these codes for the hemodialysis procedure with all E/M services related to the client's renal disease on the day of the hemodialysis procedure. Bill these codes for the following clients: • Clients in an inpatient setting with ESRD; or • Clients receiving hemodialysis in an outpatient or inpatient setting who do not have ESRD. **Bill using ICD-9-CM diagnosis code 585.6 or the appropriate diagnosis code (584.5-586) for clients requiring dialysis but who do not have ESRD.**
90935	Bill using procedure code 90935 if only one evaluation is required related to the hemodialysis procedure.
90937	Bill using procedure code 90937 if a re-evaluation(s) is required during a hemodialysis procedure on the same day.

Inpatient visits for dialysis procedures other than hemodialysis

(e.g., peritoneal dialysis, hemofiltration, or continuous renal replacement therapies)
(CPT codes 90945 and 90947)

Procedure Codes Billed	Instructions
90945 and 90947	Bill these codes for E/M services related to the client's renal disease on the day of the procedure that includes peritoneal dialysis, hemofiltration, or continuous renal replacement. **Bill using ICD-9-CM diagnosis code 585.6 or the appropriate diagnosis code (584.5-586) for clients requiring dialysis but who do not have ESRD.**
90945	Bill using procedure code 90945 if only one evaluation is required related to the procedure.
90947	Bill using procedure code 90947 if a re-evaluation(s) is required during a procedure on the same day.

If a separately identifiable service is performed on the same day as a dialysis service, any of the following E/M procedures codes may be billed with modifier 25:

- 99201-99205 Office or Other Outpatient Visit: New Patient.
- 99211-99215 Office or Other Outpatient Visit: Established Patient.
- 99221-99223 Initial Hospital Care: New or Established Patient.
- 99238-99239 Hospital Discharge Day Management Services.
- 99241-99245 Office or Other Outpatient Consultations: New or Established Patient; and
- 99291-99292 Critical Care Services.

Endocrinology

Continuous glucose monitoring

The agency pays for continuous glucose monitoring (CGM) for clients 18 years of age and younger only.

The agency pays for the in-home use of professional or diagnostic CGM for a 72 hour monitoring period with Expedited Prior Authorization (EPA). See EPA #**1312.**

The agency pays for CGM longer than 72 hours with prior authorization. See the Home Infusion Therapy/Parenteral Nutrition Program Medicaid Provider Guide for criteria.

Hydration, therapeutic, prophylactic, diagnostic injections, infusions

Hydration therapy with chemotherapy

Intravenous (IV) infusion of saline (CPT codes 96360-96371) is not paid separately when administered at the same time as chemotherapy infusion (CPT codes 96413- 96417). Separate payment is allowed for IV infusion when administered separately from the chemotherapy infusion. In this case, bill using the IV infusion code with modifier 59.

Therapeutic or diagnostic injections/infusions

(CPT codes 96360-96379) [WAC 182-531-0950]

- If no other service is performed on the same day, a subcutaneous or intramuscular injection code (CPT code 96372) may be billed in addition to an injectable drug code.

- The agency does not pay separately for intravenous infusion (CPT codes 96372-96379) if they are provided in conjunction with IV infusion therapy services (CPT codes 96360-96361or 96365-96368).

- The agency pays for only one "initial" intravenous infusion code (CPT codes 96360, 96365, or 96374) per encounter unless:

  - Protocol requires the use of two separate IV sites; or
  - 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.

- The agency does not pay for CPT code 99211 on the same date of service as drug administration CPT codes 96360-96361, 96365-96368, or 96372-96379. If billed in combination, the agency denies the E/M CPT code 99211. However, other E/M codes may be billed on the same date of service using modifier 25 to indicate that a significant and separately identifiable service was provided. If modifier 25 is not used, the agency will deny the E/M code.

Concurrent infusion

The Agency pays for concurrent infusion (CPT code +96368) only once per day.

Immune Globulins, Serum, or Recombinant Products

Hepatitis B

(CPT code 90371) - Reimbursement is based on the number of 1.0 ml syringes used. Bill each 1.0 ml syringe used as 1 unit.

Immune globulins

Bill the agency for immune globulins using the HCPCS procedure codes listed below. The agency 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
	Q4087, Q4088, Q4091, and Q4092

Rabies immune globulin (RIG)

(CPT codes 90375-90376)

- RIG is given based on .06 ml per pound of body weight. The dose is rounded to the nearest tenth of a milliliter (ml). Below are the recommended dosages up to 300 pounds of body weight:

Pounds	Dose
0-17	1 ml
18-34	2 ml
35-50	3 ml
51-67	4 ml
68-84	5 ml
85-100	6 ml
101-117	7 ml
118-134	8 ml
135-150	9 ml

Pounds	Dose
151-167	10 ml
168-184	11 ml
185-200	12 ml
201-217	13 ml
218-234	14 ml
235-250	15 ml
251-267	16 ml
268-284	17 ml
285-300	18 ml

- RIG is sold in either 2 ml or 10 ml vials.
- One dose is allowed per episode.
- Bill one unit for each 2 ml vial used per episode.

Examples:

- ✓ If a client weighs 83 pounds, three 2 ml vials would be used. The number of units billed would be three; or
- ✓ If a client weighs 240 pounds, both one 10 ml vial and three 2 ml vials or eight 2 ml vials could be used. The number of units billed would be eight.

Synagis

(CPT code 90378)

See the EPSDT Screening Components Section and the Client Eligibility Section in the EPSDT Medicaid Provider Guide for information on Synagis.

Medical genetics and genetic counseling services

Genetic counseling and genetic testing

The agency covers genetic counseling for all FFS adults and children when performed by a physician.

To bill for genetic counseling, use diagnosis code V26.33 genetic counseling and the appropriate E/M code.

The agency covers genetic counseling (CPT 96040) when performed by a health care professional appropriately credentialed by the Department of Health (DOH). For policy and billing information for genetic counselors, refer to the agency's Prenatal Genetic Counseling Medicaid Provider Guide.

The agency requires prior authorization (PA) for the following codes. Use the General Information for Authorization form, 13-835 and Fax/Written Request Basic Information form, 13-756.

Procedure Code	Short Description	Comments
S3854	Gene profile panel breast	PA; requests must also include a signed Oncotype DX™ (S3854) Request Form, 13-908
81201	Apc gene full sequence	PA
81202	Apc gene known fam variants	PA
81203	Apc gene dup/delet variants	PA
81206	Bcr/abl1 gene major bp	PA
81207	Bcr/abl1 gene minor bp	PA
81208	Bcr/abl1 gene other bp	PA
81209	Blm gene	PA
81210	Braf gene	PA
81211	Brca1&2 seq & com dup/del	PA
81212	Brca1&2 185&5385&6174 var	PA
81213	Brca1&2 uncom dup/del var	PA
81214	Brca1 full seq & com dup/del	PA
81215	Brca1 gene known fam variant	PA
81216	Brca2 gene full sequence	PA
81217	Brca2 gene known fam variant	PA
81321	Pten gene full sequence	PA
81322	Pten gene known fam variant	PA
81323	Pten gene dup/delet variant	PA

Certain genetic testing procedure codes need PA. Physicians must obtain PA if required for certain genetic tests and must give both the PA number and the appropriate genetic testing modifier to the laboratory or when the laboratory bills so they can bill correctly. Providers must check the Physician-Related Services Fee Schedule for services that require either PA or EPA.

Note: DOH-approved genetic counselors provide counseling for pregnant women (fee for service and healthy option clients) up to the end of the month containing the 60th day after the pregnancy ends. This service does not require authorization. To locate the nearest DOH-approved genetic counselor call DOH at (253) 395-6742.

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 6pm-10pm, these services are not eligible for after-hours service codes.

Note: This policy does not include radiologists, pathologists, emergency room physicians, or anesthesiologists. The agency does not pay these providers for after hour service codes.

Neurology and neuromuscular procedures

Needle electromyography (EMGs)

The agency 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	
95863	Muscle test 3 limbs	
95864	Muscle test 4 limbs	
95865	Muscle test larynx	Limited to one unit per day
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.

CPT Code	Short Description	Limits
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
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

Sleep medicine testing (sleep apnea)

[WAC 182-531-1500]

This policy is effective April 14, 2013. Sleep studies include polysomnography (PSG) and multiple sleep latency testing (MSLT). The agency covers attended, full-channel, PSG and MSLT when:

- Ordered by the client's physician.
- Performed in an agency-designated center of excellence (COE) that is an independent diagnostic testing facility, sleep laboratory, or outpatient hospital.
- Results are used to:
  - ✓ Establish a diagnosis of narcolepsy or sleep apnea.
  - ✓ Evaluate a client's response to therapy, such as continuous positive airway pressure (CPAP).

Provider requirements

To be paid for providing sleep studies to eligible clients, the facility must:

- Be a sleep study COE. See Centers of Excellence – Sleep Studies.
- Be currently accredited by the American Academy of Sleep Medicine (AASM) and continuously meet the accreditation standards of AASM.
- Have at least one physician on staff who is board certified in sleep medicine.
- Have at least one registered polysomnographic technologist (RPSGT) in the sleep lab when studies are being performed.

Coverage for clients 21 years of age and older

For clients 21 years of age and older, the agency covers:

- Full-night, in-laboratory PSG for either of the following:
  - ✓ Confirmation of obstructive sleep apnea (OSA) in an individual with signs or symptoms consistent with OSA (e.g., loud snoring, awakening with gasping or choking, excessive daytime sleepiness, observed cessation of breathing during sleep, etc.).
  - ✓ Titration of positive airway pressure therapy when initial PSG confirms the diagnosis of OSA, and positive airway pressure is ordered.
- Split-night, in-laboratory PSG in which the initial diagnostic portion of the PSG is followed by positive airway pressure titration when the PSG meets either of the following criteria:
  - ✓ The apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) is greater than or equal to fifteen events per hour with a minimum of thirty events.
  - ✓ The AHI or RDI is greater than or equal to five and less than or equal to fourteen events per hour with a minimum of ten events with documentation of either of the following:
    - ➢ Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia.
    - ➢ Hypertension, ischemic heart disease, or history of stroke.

Coverage for clients 20 years of age and younger

For clients 20 years of age and younger, the agency considers any of the following indications as medically necessary criteria for a sleep study:

- OSA suspected based on clinical assessment.
- Obesity, Trisomy 21, craniofacial abnormalities, neuromuscular disorders, sickle cell disease, or mucopolysaccharidosis (MPS), prior to adenotonsillectomy in a child.
- Residual symptoms of OSA following mild preoperative OSA.
- Residual symptoms of OSA in a child with preoperative evidence of moderate to severe OSA, obesity, craniofacial anomalies that obstruct the upper airway, or neurologic disorder following adenotonsillectomy.
- Titration of positive airway pressure in a child with OSA;
- Suspected congenital central alveolar hypoventilation syndrome or sleep-related hypoventilation due to neuromuscular disorder or chest wall deformities.
- Primary apnea of infancy.
- Evidence of a sleep-related breathing disorder in an infant who has experienced an apparent life threatening event.
- Child being considered for adenotonsillectomy to treat OSA.
- Clinical suspicion of an accompanying sleep-related breathing disorder in a child with chronic asthma, cystic fibrosis, pulmonary hypertension, bronchopulmonary dysplasia, or chest wall abnormality.

Noncoverage

The agency does not cover sleep studies:

- When the sleep study is an unattended home study.
- When documentation for a repeat study does not indicate medical necessity (e.g., no new clinical documentation indicating the need for a repeat study).
- For the following indications, except when an underlying physiology exists (e.g., loud snoring, awakening with gasping or choking, excessive daytime sleepiness, observed cessation of breathing during sleep, etc.):

- ✓ Chronic insomnia.
- ✓ Snoring.

Billing

Agency-approved sleep centers must:

- Use CPT codes 95782, 95783, 95805, and 95807-95811 for sleep study services.
- Enter the approved agency sleep center's NPI where the sleep study/polysomnogram or multiple sleep latency testing was performed. Refer to Centers of Excellence for appropriate location of agency-approved sleep center. Enter the COE NPI in box 32 on the CMS-1500 claim form. When billing electronically, note the COE NPI in the *Comments* section.
- Sleep studies are limited to rule out obstructive sleep apnea or narcolepsy.

The following is a list of approved diagnoses for sleep studies:

278.01	278.03	307.46	307.47	307.48
327.10	327.11	327.12	327.20	327.21
327.23	327.24	327.25	327.26	327.27
327.29	327.40	327.41	327.42	327.51
327.00	347.01	347.10	347.11	780.09
780.51	780.53	780.54	780.55	780.56
780.57	780.58	780.59	786.04	799.02

Note: When billing on a paper CMS-1500 claim form, note the COE NPI in field 32. When billing electronically, note the COE NPI in the *Comments* section.

Sleep center physician consultations and referral for cognitive behavioral therapy (CBT)

The agency requires a sleep consultation with a physician who is Board Certified in Sleep Medicine at an agency-approved sleep center for any eligible client receiving more than six months of continuous nightly use of any of the following insomnia drugs:

- Generic Zolpidem, Ambien®, Ambien CR®
- Sonata®
- Lunesta®
- Rozerem®

Continuous nightly use of the above insomnia drugs may be necessary for some clients, but it may not be appropriate for others. The agency covers the following drugs without prior authorization within the following limits:

Drug	Limitations
Rozerem®	30 tablets/30 days for maximum of 90 days of continuous use
Generic Zolpidem, Ambien®, Ambien CR®, Sonata®, and Lunesta®	30 tablets/30 days for first fill, then 10 tablets/30 days

The agency will send a letter to the prescribing provider and the client when a sleep consultation is required, and a referral for cognitive behavioral therapy (CBT) may be recommended.

Opthalmology – vision care services

[WAC 182-531-1000]

Eye examinations and refraction services

The agency covers, without prior authorization (PA), eye examinations and refraction and fitting services with the following limitations:

- Once every 24 months for asymptomatic clients 21 years of age or older;
- Once every 12 months for asymptomatic clients 20 years of age or younger; or
- Once every 12 months, regardless of age, for asymptomatic clients of the Developmental Disabilities Administration (DDA).

Coverage for additional examinations and refraction services

The agency 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;
- The client is on medication that affects vision; or
- The service is necessary due to lost or broken eyeglasses/contacts. In this case:

- ✓ No type of authorization is required for clients 20 years of age or younger or for clients of the Developmental Disabilities Administration (DDA), regardless of age.

- ✓ Providers must follow the agency's expedited prior authorization (EPA) process to receive payment for clients 21 years of age or older. See **EPA # 610** in Expedited Criteria Coding List. Providers must also document the following in the client's file:

  - ➢ The eyeglasses or contacts are lost or broken; and
  - ➢ The last examination was at least 18 months ago.

Visual field exams

The agency covers visual field exams for the diagnosis and treatment of abnormal signs, symptoms, or injuries. Providers must document all of 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

The agency covers orthoptics and vision therapy which involves a range of treatment modalities including:

- Lenses.
- Prisms.
- Filters.
- Occlusion or patching.
- Eye exercises/vision training/orthoptics/pleoptics, which are used for eye movement and fixation training.

The agency requires PA for eye exercises/vision training/orthoptics/pleoptics.

Ocular prosthetics

The agency covers ocular prosthetics when provided by any of the following:

- An ophthalmologist.
- An ocularist.
- An optometrist who specializes in prosthetics.

Please refer to the agency's Prosthetic and Orthotic Devices Medicaid Provider Guide for more information on coverage for ocular prosthetics.

Eye surgery

Cataract surgery

The agency covers cataract surgery, without PA, when the following clinical criteria are met:

- Correctable visual acuity in the affected eye at 20/50 or worse, as measured on the Snellen test chart; or
- One or more of the following conditions:
  - ✓ Dislocated or subluxated lens.
  - ✓ Intraocular foreign body.
  - ✓ Ocular trauma.
  - ✓ Phacogenic glaucoma.
  - ✓ Phacogenic uveitis.
  - ✓ Phacoanaphylactic endopthalmitis.
  - ✓ Increased ocular pressure in a person who is blind and is experiencing ocular pain.

The agency does not cover the following procedure codes:

Procedure Code	Short Description	Policy/ Comments
C1840	Telescopic intraocular lens	Not Covered
C9732	Insert ocular telescope pros	Not Covered

Strabismus surgery

The agency covers strabismus surgery as follows:

Clients	Policy
17 years of age or younger	The provider must clearly document the need in the client's record. The agency does not require authorization.
18 years of age or older	Covered when the clinical criteria are met. To receive payment, providers must follow the expedited prior authorization (EPA) process. The clinical criteria are: • The client has double vision; and • The surgery is not being performed for cosmetic reasons. To receive payment for clients 18 years of age or older, providers must use the agency's EPA process.

Blepharoplasty or blepharoptosis surgery

The agency covers blepharoplasty or blepharoptosis surgery when all of the clinical criteria are met. To receive payment, providers must follow the agency's EPA process. The clinical criteria are:

- The client's excess upper eyelid skin is blocking the superior visual field; and
- The blocked vision is within 10 degrees of central fixation using a central visual field test.

Implantable miniature telescope

The implantable miniature telescope, CPT code 66999, is used in clients with untreated, end stage, age related macular degeneration. It is a visual aid for clients with low vision, and like the other adult low vision aids, is considered vision hardware. Like all vision hardware, this is not included in the clients' benefit package for clients 21 years of age and older.

Vision coverage table

Due to its licensing agreement with the American Medical Association, the agency publishes only the official, CPT® procedure code short descriptions. To view the long description, please refer to a current CPT book.

Procedure Code	Modifier	Short Description	PA?	Policy/ Comments	Maximum Allowable Fee
Contact Lens Services					
92071		Contact lens fitting for tx		Ages 21-99 2 fittings every 24 months. Ages 0-20 2 fittings every 12 months.	On-line Vision Care Fee Schedule
92072		Fit contact lens for managmnt		Ages 21-99 2 fittings every 24 months. Ages 0-20 2 fittings every 12 months limited to diagnosis range 371.60 to 371.62	On-line Vision Care Fee Schedule

Procedure Code	Modifier	Short Description	PA?	Policy/ Comments	Maximum Allowable Fee
Spectacle Fitting fees, monofocal					
92340		Fit spectacles monofocal	No		On-line Vision Care Fee Schedule
92352		Fit aphakia spectcl monofocl	No		
Spectacle Fitting fees, bifocal					
92341		Fit spectacles bifocal	No		On-line Vision Care Fee Schedule
Spectacle Fitting fees, multifocal					
92342		Fit spectacles multifocal	No		On-line Vision Care Fee Schedule
92353		Fit aphakia spectcl multifoc	No		

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

Procedure Code	Modifier	Short Description	PA?	Policy/ Comments	Maximum Allowable Fee
Other					
92354		Fit spectacles single system	Yes		On-line Vision Care Fee Schedule
92355		Fit spectacles compound lens	Yes		
92370		Repair & adjust spectacles	No	Applies only to clients 20 years of age and younger.	
92371		Repair & adjust spectacles	No	Applies only to clients 20 years of age and younger.	
92499		Eye service or procedure	No		
General Ophthalmological Services					
92002		Eye exam new patient	No		On-line Vision Care Fee Schedule*
92004		Eye exam new patient	No		
92012		Eye exam establish patient	No		

Procedure Code	Modifier	Short Description	PA?	Policy/ Comments	Maximum Allowable Fee
92014		Eye exam&tx estab pt 1/>vst	No		
Special Ophthalmological Services					
92015		Determine refractive state	No		On-line Vision Care Fee Schedule
92018		New eye exam & treatment	No		
92019		Eye exam & treatment	No		
92020		Special eye evaluation	No		
92025		Corneal topography	Yes		
92025	TC	Corneal topography	Yes		
92025	26	Corneal topography	Yes		
92060		Special eye evaluation	No		
92060	TC	Special eye evaluation	No		
92060	26	Special eye evaluation	No		
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	No		

Procedure Code	Modifier	Short Description	PA?	Policy/ Comments	Maximum Allowable Fee
		examination(s)			
92100		Serial tonometry exam(s)	No		
92133		Cmptr ophth img optic nerve	No	**Limit 1 per calendar year**	
92133	TC	Cmptr ophth img optic nerve	No		
92133	26	Cmptr ophth img optic nerve	No		
92134		Cptr ophth dx img post segmt	No	Limited to 2 times per calendar year.	
92134		Cptr ophth dx img post segmt	No	EPA required. Limited to 12 per calendar year. EPA# 870000051	On-line Vision Care Fee Schedule
92135	TC	Ophth dx imaging post seg	No		
92135	26	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					
92225		Special eye exam initial	No		
92226		Special eye exam subsequent	No		
92230		Eye exam with photos	No		On-line Vision Care Fee Schedule
92235		Eye exam with photos	No		
92235	TC	Eye exam with photos	No		
92235	26	Eye exam with photos	No		

Procedure Code	Modifier	Short Description	PA?	Policy/ Comments	Maximum Allowable Fee
92240		Icg angiography	No		
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			
V2631		Iris support intraoclr lens			
V2632		Post chmbr intraocular lens			On-line Vision Care Fee Schedule
Other Specialized Services					
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		On-line Vision Care Fee Schedule
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	No		

Procedure Code	Modifier	Short Description	PA?	Policy/ Comments	Maximum Allowable Fee
		exam			
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					
92310		Contact lens fitting	No		On-line Vision Care Fee Schedule
92311		Contact lens fitting	No		
92312		Contact lens fitting	No		
92313		Contact lens fitting	No		
Ocular Prosthesis Please refer to the agency's Prosthetic and Orthotic Devices Medicaid Provider Guide for more information on coverage for ocular prosthetics.					
Contact Lens Services					
92314		Prescription of contact lens	No		On-line Vision Care Fee Schedule
92315		Prescription of contact lens	No		
92316		Prescription of contact lens	No		
92317		Prescription of contact lens	No		

Osteopathic manipulative therapy

(CPT codes 98925-98929) [WAC 182-531-1050]

The agency covers:

- Ten (10) osteopathic manipulations per client, per calendar year.
- Osteopathic Manipulative Therapy (OMT) services only when provided by an osteopathic physician licensed under chapter 18.71 RCW.
- OMT services by body regions. Body regions are defined as:

  - ✓ abdomen and viscera
  - ✓ cervical
  - ✓ head
  - ✓ lower extremities
  - ✓ lumbar
  - ✓ pelvic
  - ✓ rib cage
  - ✓ sacral
  - ✓ thoracic
  - ✓ upper extremities

- One OMT procedure code in the range 98925-98929 per client, per day. Bill using the CPT code that describes the number of body regions involved. For example, if three body regions are manipulated, bill one unit of CPT code 98926.
- An E/M service (billed with modifier 25) in addition to the OMT, under one of the following circumstances:

  - ✓ When a provider diagnoses the condition requiring OMT and provides the therapy during the same visit;
  - ✓ When the existing condition fails to respond to OMT or significantly changes, requiring E/M services beyond those considered included in the manipulation codes; or
  - ✓ When the provider treats the client for a condition unrelated to the OMT during the same encounter.

  Justification for the E/M and OMT services must be documented and retained in the client's record for review.

Note: The agency **does not cover** physical therapy services performed by osteopathic physicians unless they are also physiatrists.

Other services and procedures

Hyperbaric oxygen therapy

(CPT code 99183 and HCPCS C1300)

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
C1300	HYPERBARIC Oxygen

Hyperbaric oxygen therapy requires EPA. See Expedited Prior Authorization Criteria Coding List, EPA#425. If the client does not meet the EPA criteria, prior authorization (PA) is required (see Prior Authorization). 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 C1300.

Psychiatry

Clozaril - case management

- Physicians, psychiatrists, and ARNPs must bill for Clozaril case management using HCPCS code M0064, visit for drug monitoring.
- For Pharmacist billing, refer to the Prescription Drug Program Medicaid Provider Guide.
- Put "Clozaril Case Management" in the claim notes field on the claim.
- The agency reimburses providers for one unit of Clozaril case management per week.
  - ✓ The agency reimburses providers for Clozaril case management when billed with ICD-9-CM diagnosis codes 295.00 – 295.95 only.
  - ✓ Routine venipuncture (CPT code 36415) and a blood count (CBC) may be billed in combination when providing Clozaril case management.
- The agency does not pay for Clozaril case management when billed on the same day as any other psychiatric-related procedures.

For additional information, see Mental Health Services for Children, Psychiatric and Psychological Services).

Pulmonary

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, the agency will deny the E/M code.

Special dermatological services

Ultraviolet phototherapy

The agency does not cover ultraviolet phototherapy (CPT code 96910) when billed with ICD-9-CM diagnosis code 709.01 (vitiligo). The agency considers this a cosmetic procedure.

Special services

Group clinical visits for clients with diabetes or asthma

Overview of the program

The intent of the Diabetes and Asthma Group Clinical Visits program is to provide clinical services and educational counseling to agency clients who have been diagnosed with diabetes or asthma. These visits are limited to groups of two or more clients and are payable only to physicians or advanced registered nurse practitioners (ARNPs). However, participation from other professional staff, including physician assistants, physical therapists, nurses, and nutritionists, is encouraged.

Program requirements

- Prior to a group clinical visit, the provider must perform an assessment of individual client medical information and document the proposed treatment plan for each client.
- The group clinical visit must be led by a physician or ARNP, but may include other staff as well.
- The group clinical visit must last at least one hour and include:
  - ✓ A group discussion on clinical issues to promote long-term disease control and self-management. This discussion should include at least one of the following topics:
    - ➢ Prevention of exacerbation or complications.
    - ➢ Proper use of medications and other therapeutic techniques (spacers, peak flow meter use; glucose measurement, foot care, eye exams, etc.).
    - ➢ Living with a chronic illness.
  - ✓ A question and answer period.

- ✓ The collection of prevention-based care data needed to monitor chronic illness (e.g., weight and blood pressure).
- ✓ Short (approximately 5-10 minutes per client) one-on-one visits to gather needed data and establish an individual management plan with the client.

- The following must be documented in the medical record:

  - ✓ Individual management plan, including self-management capacity.
  - ✓ Data collected, including physical exam and lab findings.
  - ✓ Patient participation.
  - ✓ Beginning and ending time of the visit.

Billing and reimbursement

Providers must use the following CPT code when billing for diabetes or asthma group counseling visits, subject to the limitations in the table below. Providers must bill visits in increments of one-hour units (one hour = one unit). Multiple units may be billed on the same day.

CPT Code	Restricted to Diagnoses	Visit Limitations
99078	Diabetes: 250.00-250.93 Asthma: 493.00-493.92	Limited to four (4) one-hour units per calendar year, per client, per condition

Note: The agency pays only for the time that a client spends in the group clinical visit.

Other limitations

The agency does not reimburse a diabetes or asthma group clinical visit in conjunction with an office visit or other outpatient evaluation and management (E/M) codes for the same client, same provider, and same condition on the same day.

A diabetes group clinical visit may be billed on the same day as a Department of Health (DOH) - approved diabetes education core module as long as the times documented in the medical record indicate two separate sessions.

Therapies (physical, occupational, and speech therapy)

Physicians, Podiatrists, Advanced Registered Nurse Practitioners (ARNP), Physician Assistants Certified (PA-C), and Wound Care Center Specialty Physicians - Billing

The outpatient rehabilitation benefit limits ***do not apply*** to therapy services provided and billed by physicians, podiatrists, ARNPs, PA-Cs, and wound care center specialty physicians.

Modifier required when billing

Physicians, podiatrists, ARNPs, and PA-Cs, and wound care center specialty physicians must use the following modifier when billing for PT/OT/ST services:

Modality	Modifiers
PT/OT/ST	AF

Note: For additional information, refer to the Outpatient Rehabilitation Medicaid Provider Guide.

Vaccines/Toxoids (Immunizations)

Clients 19 years of age and older

This section applies to clients 19 years of age and older. Refer to the Injectable Drugs fee schedule for a listing of covered vaccines for clients 19 years of age and older. Codes with a fee are paid according to the Injectable Drugs fee schedule.

Note: DOH supplies free vaccines for children 0-18 years only. For clients 18 years of age and younger, refer to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medicaid Provider Guide.

- Bill the agency for the cost of the vaccine by reporting the procedure code for the vaccine given.
- Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).
- Providers are reimbursed for the vaccine using the agency's maximum allowable fee schedule.
- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

If an immunization is the only service provided, bill only for the administration of the vaccine and the vaccine itself (if appropriate). Do not bill an E/M code unless a significant and separately identifiable condition exists and is reflected by the diagnosis. In this case, bill the E/M code with

modifier 25. If the E/M code is billed without modifier 25 on the same date of service as a vaccine administration, the agency will deny the E/M code.

Exception: If an immunization is the only service provided (e.g., an immunization only clinic) a brief history of the client must be obtained prior to the administration of the vaccine. CPT code 99211 may be billed with modifier 25. The brief history must be documented in the client record.

Note: Meningococcal vaccines (CPT codes 90733 and 90734) require EPA. See **EPA#421**.

Code	Short Description	Comments
Q2034	Agriflu vaccine	Clients 19 years of age and older only
Q2035	Afluria vacc, 3 yrs & >, im	Clients 19 years of age and older only
Q2036	Flulaval vacc, 3 yrs & >, im	Clients 19 years of age and older only
Q2037	Fluvirin vacc, 3 yrs & >, im	Clients 19 years of age and older only
Q2038	Fluzone vacc, 3 yrs & >, im	Clients 19 years of age and older only
Q2039	NOS flu vacc, 3 yrs & >, im	Clients 19 years of age and older only

Note: Refer to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medicaid Provider Guide for clients 18 years of age and younger.

Human papillomavirus (HPV) vaccine

The agency pays for the administration of GARDASIL® HPV (Types 6, 11, 16, 18) Recombinant Vaccine as follows:

- **For clients who are 9 through 18 years of age**, please refer to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medicaid Provider Guide**.**

- **For clients who are 19 through 26 years of age:**

  - ✓ GARDASIL® must be prescribed and administered in a series of three shots.

  - ✓ When billing for only the GARDASIL® vaccine and not the administration, use either procedure code 90649 or 90650 on the claim.

  - ✓ Bill the agency for the administration of GARDASIL® to eligible Medicaid clients, by using either procedure code 90471 or 90472.

  - ✓ DO NOT use modifier SL on claims for any of the types of vaccines.

The agency uses the maximum allowable fee schedule to pay claims for vaccines.

Clients enrolled in TAKE CHARGE, Family Planning Only, and the Alien Emergency Only programs are not eligible for this service.

Billing for infants not yet assigned a ProviderOne client ID

Use the mother'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 mom'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 mom's ProviderOne Client ID for twins, triplets, etc., identify each infant separately (i.e., twin A, twin B), using a *separate claim form* for each. **Note: For a mother enrolled in an agency managed care organization (MCO), the MCO is responsible for providing medical coverage for the newborn(s).**

Injectable and nasal flu vaccines

The agency pays for injectable (see Injectable Drugs Fee Schedule) and nasal flu vaccines (CPT code 90660).

Note: CPT code 90660 is covered by the agency for clients 19 through 49 years of age.

Maternity Care and Delivery

Prenatal assessments not covered

The agency does not cover prenatal assessments. If a client is seen for reasons other than routine antepartum or postpartum care, providers must bill using the appropriate Evaluation and Management (E/M) procedure code with a medical diagnosis code. E/M codes billed with ICD-9-CM diagnosis codes V22.0-V22.2 will be denied if listed as the principal diagnosis.

Exception: Providers must bill E/M codes for antepartum care if ***only*** 1-3 antepartum visits are done.

Confirmation of pregnancy

If a client presents with signs or symptoms of pregnancy and the purpose of the client's visit is to confirm the pregnancy, bill this visit using the appropriate level E/M code, if the obstetrical (OB) record is not initiated. If the OB record is initiated at this visit, then the visit is considered part of the global OB package and must not be billed separately.

If some other source has confirmed the pregnancy and the provider wants to do his/her own confirmation, bill this visit using the appropriate level E/M code if the OB record is not initiated. If the OB record is initiated at this visit, the visit is considered part of the global OB package and must not be billed separately.

If the purpose of the client's visit is to confirm the pregnancy and the OB record is not initiated, bill using the diagnosis code(s) for the signs and/or symptoms the client is having [e.g. suppressed menstruation (ICD-9-CM diagnosis code 626.8)]. Do not bill using the pregnancy diagnosis codes (e.g. V22.0-V22.2) unless the OB record is initiated at this visit. If the OB record is initiated at this visit, the visit is considered part of the global package.

See ultrasonography in pregnancy in this guide.

The agency does not pay separately for CerviLenz. It is considered bundled into the practice expense.

Global (total) obstetrical (OB) care

Global OB care (CPT codes 59400, 59510, 59610, or 59618) includes all the following:

- Routine antepartum care in any trimester;
- Delivery; and
- Postpartum care.

If the provider furnishes all of the client's antepartum care, perform the delivery, and provide the postpartum care, the provider **must bill** using one of the global OB procedure codes.

Use HCPCS code 0500F along with the appropriate billing code on the first prenatal visit. The agency is tracking the date a client begins receiving obstetrical care (date the OB record is initiated). Please note this date by entering HCPCS code 0500F with ICD-9-CM diagnosis codes V22.0-V22.2 on the claim.

Note: When billing global Obstetrical Services, the place of service code must correspond with the place where the child was born (for example: 25).

When more than one provider in the same clinic (same group NPI) sees the same client for global maternity care, the agency pays only one provider for the global (total) obstetrical care.

Providers who are in the same clinic who **do not** have the same group NPI ***must not*** bill the agency the global (total) obstetrical care procedure codes. In this case, the OB services must be "unbundled" and the antepartum, delivery, or postpartum care must be billed separately.

Note: **Do not** bill the agency for maternity services until all care is completed.

Unbundling obstetrical care

In the situations described below, providers may not be able to bill the agency for global OB care. In these cases, it may be necessary to "unbundle" the OB services and bill the antepartum, delivery, and postpartum care separately, as the agency may have paid another provider for some of the client's OB care, or a provider may have been paid by another insurance carrier for some of the client's OB care.

When a client transfers to a practice late in the pregnancy…

- If the client has had antepartum care elsewhere, the subsequent provider must not bill the global OB package. Bill the antepartum care, delivery, and postpartum care separately. The provider that had been providing the antepartum care bills for the services that he/she performed. Therefore, if the subsequent provider bills the global OB package, that provider is billing for some antepartum care that another provider has claimed.

- OR –

- If the client did not receive any antepartum care prior to coming to the provider's office, bill the global OB package.

  In this case, the provider may actually perform all of the components of the global OB package in a short time. The agency does not require this provider to perform a specific number of antepartum visits in order to bill for the global OB package.

If a client moves to another provider (not associated with the providers practice), moves out of the area prior to delivery, or loses the pregnancy…

When physician A has seen the client for part of the antepartum care and has transferred the client to physician B for care, and physician B is billing separately for the antepartum care being delivered, physician B enters "transfer of care" in the comments field on the 837P claim, the claims notes field of the DDE, or field 19 on the CMS-1500 paper claim.

Physician B bills only those services actually provided to these clients.

If a client changes insurance during her pregnancy…

Often, a client is fee-for-service at the beginning of her pregnancy and enrolled in an agency managed care organization for the remainder of her pregnancy. The agency is responsible for paying only those services provided to the client while she is on fee-for-service. The managed care organization (MCO) pays for services provided after the client is enrolled with the plan.

The agency encourages early prenatal care and is actively enrolling new clients into the Healthy Options program. If a client is on fee-for-service and is enrolling in a Healthy Options plan at the beginning of her pregnancy, consider billing the first visit as a secondary confirmation of pregnancy using ICD-9-CM diagnosis code 626.8 with the appropriate level of office visit as described under the "Confirmation of Pregnancy" section.

When a client changes from one plan to another, bill those services that were provided while she was enrolled with the original plan to the original carrier, and those services that were provided under the new coverage to the new plan. The provider must unbundle the services and bill the antepartum, delivery, and postpartum care separately. For clients who move in and out of managed care and fee for service, use TH and CG modifiers to unbundle the codes.

Antepartum care

Per CPT guidelines, the agency considers routine antepartum care for a normal, uncomplicated pregnancy to consist of:

- Monthly visits up to 28 weeks gestation.
- Biweekly visits to 36 weeks gestation.
- Weekly visits until delivery.

Antepartum care includes:

- Initial and subsequent history.
- Physical examination.
- Recording of weight and blood pressure.
- Recording of fetal heart tones.
- Routine chemical urinalysis.
- Maternity counseling, such as risk factor assessment and referrals.

Necessary prenatal laboratory tests may be billed in addition to antepartum care, **except for the following tests** (CPT codes 81000, 81001, 81002, 81003, and 81007).

Coding for antepartum care only

If it is necessary to unbundle the OB package and bill separately for antepartum care, bill as follows:

- If the client had a ***total*** of one to three antepartum visits, bill the appropriate level of **E/M service with modifier TH** for each visit, with the date of service the visit occurred and the appropriate diagnosis.

Modifier TH: Obstetrical treatment/service, prenatal or postpartum

- If the client had a ***total*** of four to six antepartum visits, bill using **CPT code 59425** with a "1" in the units box. Bill the agency using the date of the last antepartum visit in the “to and from” fields.

- If the client had a ***total*** of seven or more visits, bill using **CPT code 59426** with a "1" in the units box. Bill the agency using the date of the last antepartum visit in the “to and from” fields.

Do not bill antepartum care only codes in addition to any other procedure codes that include antepartum care (i.e. global OB codes).

When billing for antepartum care, ***do not bill*** using CPT E/M codes for the first three visits, then CPT code 59425 for visits four through six, and then CPT code 59426 for visits seven and on. These CPT codes are used to bill only the ***total*** number of times the client was seen for all antepartum care during her pregnancy, and ***may not*** be billed in combination with each other during the entire pregnancy period.

For those clients who have maternity-related issues and diagnosis(es), the provider should use the appropriate E&M code with the modifier GB.

Note: Do not bill the agency until all antepartum services are complete. Hospital care for pregnant women can be billed concurrently.

Coding for deliveries

If it is necessary to unbundle the OB package and bill for the delivery only, bill the agency using one of the following CPT codes:

- 59409 (vaginal delivery only).
- 59514 (cesarean delivery only).
- 59612 [vaginal delivery only, after previous cesarean delivery (VBAC)].
- 59620 [cesarean delivery only, after attempted vaginal delivery after previous cesarean delivery (attempted VBAC)].

If a provider does not furnish antepartum care, but performs the delivery and provides postpartum care, bill the agency one of the following CPT codes:

- 59410 (vaginal delivery, including postpartum care).
- 59515 (cesarean delivery, including postpartum care).
- 59614 (VBAC, including postpartum care).
- 59622 (attempted VBAC, including postpartum care).

Coding for postpartum care only

If it is necessary to unbundle the OB package and bill for postpartum care only, bill the agency using CPT code 59430 (postpartum care only).

If a provider furnishes all of the antepartum and postpartum care, but does not perform the delivery, bill the agency for the antepartum care using the antepartum care only codes, along with CPT code 59430 (postpartum care only).

Do not bill CPT code 59430 (postpartum care only) in addition to any procedure codes that include postpartum care.

Postpartum care includes office visits for the six week period after the delivery and includes family planning counseling and contraceptive management.

Additional monitoring for high-risk conditions

When providing **additional monitoring** for high-risk conditions in excess of the CPT guidelines for normal antepartum visits, bill using E/M **codes 99211-99215 with modifier UA.** The office visits may be billed in addition to the global fee ***only after*** exceeding the CPT guidelines for normal antepartum care. Providers must bill with a primary diagnosis that identifies that the high risk condition is pregnancy related; i.e. 640 – 674.9 or V23.0 – V23.9.

A condition that is classifiable as high-risk **alone** does not entitle the provider to additional payment. Per CPT guidelines, it must be medically necessary to see the client **more often** than what is considered routine antepartum care in order to qualify for additional payments. ***The additional payments are intended to cover additional costs incurred by the provider as a result of more frequent visits.*** **For example:**

> Client A is scheduled to see her provider for her antepartum visits on January 4, February 5, March 3, and April 7. The client attends her January and February visits, as scheduled. However, during her scheduled February visit, the provider discovers the client's blood pressure is slightly high and wants her to come in on February 12 to be checked again. At the February 12 visit, the provider discovers her blood pressure is still slightly high and asks to see her again on February 18. The February 12 and February 18 visits are outside of her regularly scheduled antepartum visits and outside of the CPT guidelines for routine antepartum care since she is being seen more often than once per month. The February 12 and February 18 visits may be billed separately from the global antepartum visits using the appropriate E/M codes with modifier UA, and the diagnosis must represent the medical necessity for billing additional visits. **A normal pregnancy diagnosis (i.e. V22.0 – V22.2) will be denied outside of the global antepartum care**. ***It is not necessary to wait until all services included in the routine antepartum care are performed to bill the extra visits, as long as the extra visits are outside of the regularly scheduled visits.***

Labor management

Providers may bill for labor management ***only*** when another provider (outside of the first provider's group practice) performs the delivery. If a provider performed all of the client's antepartum care, admitted the client to the hospital during labor, delivered the baby, and performed the postpartum care, **do not** bill the agency for the hospital admission or for labor management. These services are included in the global OB package.

If, however, a provider performed all of the client's antepartum care and admitted the client to the hospital during labor, but another provider (outside of the first provider's group practice) takes over delivery, the global OB package must be unbundled and the providers must bill separately for antepartum care, the hospital admission, and the time spent managing the client's

labor. The client must be in active labor and admitted to a hospital when the referral to the delivering provider is made.

To bill for labor management in the situation described above, bill the agency for one of the hospital admission CPT **codes 99221-99223 with modifier TH**.

In addition to the hospital admission, the agency pays providers for **up to three hours** of labor management using prolonged services CPT **codes 99356-99357 with modifier TH**.

Payment for prolonged services is *limited to three hours per client, per pregnancy*, regardless of the number of calendar days a client is in labor, or the number of providers who provide labor management.

Labor management may not be billed by the delivering provider, or by any provider within the delivering provider's group practice.

Note:

1. The Agency pays for prolonged services CPT codes for labor management only when the provider performs the hospital admission and labor management services on the same day.

2. The hospital admission code and prolonged services code(s) **must** be billed on the same claim form with the same dates of services.

High-risk deliveries

Delivery includes management of uncomplicated labor and vaginal delivery (with or without episiotomy, with or without forceps) or cesarean section. If a complication occurs during delivery resulting in an unusually complicated, high-risk delivery, the agency pays providers an additional add-on fee. Bill the high-risk add-on fee by **adding modifier TG to the delivery code** (e.g. 59400 TG or 59409 TG).

Modifier TG: Complex/high level of care

The ICD-9-CM diagnosis code ***must clearly*** demonstrate the medical necessity for the high-risk delivery add-on (e.g. a diagnosis of fetal distress). A normal delivery diagnosis is not paid an additional high-risk add-on fee, even if the mother had a high-risk condition during the antepartum period.

Bill only *ONE* line of service (e.g. 59400 TG) to receive payment for BOTH the delivery and the high-risk add-on. *DO NOT* bill the delivery code (e.g. 59400) on one line of the claim form and the high-risk add-on (e.g. 59400 TG) on a second line of the claim form.

A physician who provides stand-by attendance for high-risk delivery can bill CPT code 99360 and resuscitation CPT code 99465, when appropriate.

Note: The agency **does not** pay an assistant surgeon, RNFA, or co-surgeon for a high-risk delivery add-on. Payment is limited to one per client, per pregnancy (even in the case of multiple births).

Consultations

If another provider refers a client during her pregnancy for a consultation, bill the agency using consultation CPT codes 99241-99245. If an inpatient consultation is necessary, bill using CPT codes 99251 – 99255 or for a follow-up bill using CPT codes 99231-99233. The referring physician's name and NPI must be listed in the "Referring Physician" field on the claim form.

If the consultation results in the decision to perform surgery (i.e. a cesarean section), the agency pays the consulting physician for the consultation as follows:

- If the consulting physician does not perform the cesarean section, bill the agency the appropriate consultation code.
- If the consulting physician performs the cesarean section and does the consultation **two or more days prior to the date of surgery**, bill the agency the appropriate **consultation code with modifier 57** (e.g. 99241-57).

The agency does not pay the consulting physician if the following applies:

- If the consulting physician performs the cesarean section and does the consultation **the day before or the day of the cesarean section**, the consultation is bundled within payment for the surgery. **Do not bill** the agency for the consultation in this situation.

Bill consultations with an appropriate ICD-9-CM medical diagnosis code. The medical necessity (i.e. sign, symptom, or condition) must be demonstrated. The agency does not pay providers for a consultation with a normal pregnancy diagnosis code (e.g. V22.0-V22.2).

The agency pays consulting OB/GYN providers for an external cephalic version (CPT code 59412) and a consultation when performed on the same day.

General obstetrical payment policies and limitations

- The agency pays a multiple vaginal delivery (for twins, triplets, etc.) at 100% for the first baby. When billing for the second or third baby, bill using the delivery-only code (CPT code 59409 or 59612) for each additional baby. Payment for each additional baby will be 50% of the delivery-only code's maximum allowance. Bill each baby's delivery on a separate line. Identify on the claim form as "twin A" or "twin B," etc.

- The agency pays for multiple births by cesarean delivery at 100% for the first baby. No additional payment will be made for additional babies.

- Physician assistants-certified (PA-C) must bill for assisting during a C-section on their own claim form using modifier 80, 81, or 82 to the delivery-only code (e.g. 59514-80). The claim must be billed using the PA-C's NPI.
- Physician assistants (PA) must bill for an assist by adding modifier 80, 81, or 82 to the delivery-only code (e.g. 59514-80).

- RNFAs assisting at C-sections may **only** bill using CPT code 59514 or 59620 with modifier 80.

- To bill for anesthesia during delivery, see Anesthesia for Maternity .

- For deliveries in a birthing center, refer to the agency's Planned Home Births and Births in Birthing Centers Medicaid Provider Guide.

- For deliveries in a home birth setting, refer to the agency's Planned Home Births and Births in Birthing Centers Medicaid Provider Guide.

Note: Maternity Support Services/Infant Case Management (MSS/ICM) is a program designed to help pregnant women and their newborns gain access to medical, social, educational and other services. This program provides a variety of services for both the woman and/or her child in the home or clinic throughout pregnancy and up to 60 days after delivery. For information on MSS/ICM, refer to the agency's Maternity Support Services/Infant Case Management Medicaid Provider Guide.

HIV/AIDS counseling/testing

[Refer to WAC 182-531-0600]

See HIV/AIDS counseling/testing for coverage policy.

Exceptions: The agency pays for counseling visits when billed with an E/M service on the same day when:

1) The client is being seen for a medical problem and modifier 25 is billed; or
2) The client is being seen for an antepartum visit and modifier TH is used.

The agency does not pay for a counseling visit if the client is being seen only to confirm pregnancy and an office visit is billed, because the counseling is considered part of the office visit.

The agency covers HIV testing (86701-86703) for pregnant women when billed with the following diagnosis codes: V22.0, V22.1, V22.2, or V28.89.

The following tables summarize billing the agency for maternity-related services.

Global (total) obstetrical (OB) care

Service	Procedure Code/Modifier	Short Description	Limitations
Confirmation of pregnancy	99201-99215	Office visits	Code the sign or symptom (e.g. suppressed menstruation)
Global OB care	59400	Obstetrical care	Includes all antepartum, delivery, and postpartum care; bill after all services are complete; limited to one per client, per pregnancy; additional vaginal deliveries for multiple bills must be billed with the appropriate delivery-only code.
	59510	Cesarean delivery	
	59610	Vbac delivery	
	59618	Attempted vbac delivery	

Antepartum care only

Service	Procedure Code/Modifier	Short Description	Limitations
Antepartum care (bill ***only one*** of these codes to represent the total number of times the client was seen for antepartum care)	99201-99215 TH	Offices visits, antepartum care 1-3 visits only, with OB service modifier	Limited to 3 units when used for routine antepartum care. Modifier TH must be billed.
	59425	Antepartum care only	Limited to one unit per client, per pregnancy, per provider
	59426	Antepartum care only	Limited to one unit per client, per pregnancy, per provider.

Deliveries

Service	Procedure Code/Modifier	Short Description	Limitations
Delivery only	59409	Obstetrical care	Must not be billed with any other codes that include deliveries; assist at c-section must be billed with delivery-only code with modifier 80.
	59514	Cesarean delivery only	
	59612	Vbac delivery only	
	59620	Attempted VBAC delivery only	
Delivery with postpartum care	59410	Obstetrical care	Must not be billed with any other codes that include deliveries; must not be billed with postpartum only code; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed using the appropriate delivery-only code.
	59515	Cesarean delivery	
	59614	Vbac care after delivery	
	59622	Attempted vbac after care	

Postpartum care only

Service	Procedure Code/Modifier	Short Description	Limitations
Postpartum care only	59430	Care after delivery	Must not be billed with any other codes that include postpartum care; limited to one per client, per pregnancy.

Additional monitoring for high-risk conditions

Service	Procedure Code/Modifier	Short Description	Limitations
Additional visits for antepartum care due to high-risk conditions	99211-99215 UA	Office/outpatient visit est	Must not be billed with a normal pregnancy diagnosis (V22.0-V22.2); diagnosis must detail need for additional visits; must be billed with modifier UA.

Labor management

Service	Procedure Code/Modifier	Short Description	Limitations
Labor management (may only be billed when another provider takes over and delivers the infant)	99221-99223 TH	Initial hospital care	Prolonged services are limited to 3 hours per client, per pregnancy; must be billed with modifier TH; **must not be billed by delivering provider**. Admit code with modifier TH and the prolonged services code(s) **must be billed on the same claim form.**
	+99356 TH **Limited to 1 unit**	Prolonged service inpatient	
	+99357 TH **Limited to 4 units**	Prolonged service inpatient	

High-risk deliveries

Service	Procedure Code/Modifier	Short Description	Limitations
High-risk delivery *[Not covered for assistant surgeons, co-surgeons, or RNFA]*	Add modifier TG to the delivery code (e.g. 59400 TG)	Complex/high level of care	Diagnosis must demonstrate medical necessity; not paid with normal delivery diagnosis; limited to one per client, per pregnancy. Bill only **ONE** line of service (e.g. 59400 TG) for **BOTH** the delivery and high-risk add-on.

Abortion services (drug induced)

- Methotrexate and misoprostol are two drugs approved by the Food and Drug Administration (FDA) for use in inducing abortions.

  ✓ J9260 Methotrexate sodium, 50 mg
  ✓ S0191 Misoprostol, oral, 200 mcg

- When these drugs are used for abortion services, providers must bill using the appropriate ICD-9-CM abortion diagnosis code. Other medical services (laboratory, history/physical, ultrasound, etc.) performed at the time of the drug administration must be billed on the same claim as the abortion drugs.

- Rho(D) immune globulin must be billed using the appropriate HCPCS codes.

- Clients enrolled in an agency managed care organization (MCO) may self-refer outside the MCO for abortions.

RU-486 Abortion Drug

The agency pays for RU-486 for medically induced abortions provided through physicians' offices using the codes in the following table. Office visits, laboratory tests, and diagnostic tests performed for the purpose of confirming pregnancy, gestational age, and successful termination must be billed on the same claim form as the abortion drugs.

Bill HCPCS Code	Short Description
S0190	Mifepristone, oral, 200 mg
S0191	Misoprostol, oral, 200 mcg

Abortion centers (nonhospital-based) must be approved by the agency to be able to bill for facility fee payments. To become an abortion center provider, fax a request to the agency's program manager at (360) 725-1966.

Abortion center contracts (facility fees)

For providers who currently have an abortion center contract with the agency, facility fees are payable only for surgical abortions. Do not bill facility fee charges for drug-induced abortions not requiring surgical intervention. The agency pays the contractor facility fees for surgical abortion services once per abortion, per eligible client. Clients on the Family Planning Only program are not eligible for abortions. Please refer them to their local Community Service Office to request a change in their eligibility since they are pregnant. Clients enrolled in an agency managed care organization can self-refer for abortions.

Contracted facility fee payment includes all room charges, equipment, supplies, and drugs (including anti-anxiety, antibiotics, and pain medications, but excluding Rho(D) immune globulins). **Payment is limited to one special agreement facility fee per client, per abortion.** The facility fee is not payable per visit, even though a particular procedure or case may take several days or visits to complete. The facility fee does not include professional services, lab charges, or ultrasound and other x-rays, which can be billed separately.

Medical Supplies and Equipment

General payment policies

- The agency 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). The agency pays providers separately for only those MSE listed see Supplies Included in an Office Call-Bundled Supplies.

- The agency does not pay providers separately for surgical trays, as these are bundled within the appropriate surgical procedure. The fees for these procedures include the cost of the surgical trays.

- Procedure codes for MSE that do not have a maximum allowable fee and cost less than $50.00 are paid at acquisition cost. A manufacturer's invoice must be maintained in the client's records for MSE under $50.00 and made available to the agency upon request. **DO NOT send in an invoice with a claim** for MSE under $50.00 unless requested by the agency.

- Procedure codes for MSE that do not have a maximum allowable fee and cost $50.00 or more are paid at acquisition cost. **A copy of the manufacturer's invoice must be attached** to the claim for MSE costing $50.00 or more.

Note: Refer to Resources Available 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. The agency 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 *Comments* section of the claim form.

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
A4300	Cath impl vasc access portal
A4301	Implantable access syst perc
A4305	Drug delivery system >=50 ML
A4306	Drug delivery system <=50 ml

HCPCS Code	Short Description
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
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
A4557	Lead wires, pair

HCPCS Code	Short Description
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
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 Drug Abuse Treatment Services

Medical services for clients in residential chemical dependency treatment

(For current Medicaid clients)

The agency will pay medical professionals (within their scope of practice) for the following services when the practitioner provides services at a Residential Chemical Dependency Treatment Center (place of service 55).

Service	Procedure Code	Notes
E/M services	99201-99205; 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; Labs 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.

Detoxification services

The agency covers detoxification services for clients receiving alcohol and/or drug detoxification services in a Division of Behavioral Health and Recovery (DBHR)-enrolled hospital-based detoxification center or 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 the agency's Chemical-Using Pregnant (CUP) Women program.

- Inpatient psychiatric care is not medically necessary and an approval from the Regional Support Network (RSN) is not appropriate.
- Nonhospital-based detoxification is not medically appropriate.

Note: Physicians must indicate the hospital's NPI in field 32 on the CMS-1500 Claim Form or in the *Comments* field when billed electronically. If the hospital's NPI is not indicated on the claim, the claim will be denied.

When the conditions above are met, providers must bill as follows:

Procedure Code	Modifier	Short Description	Limitations
H0009		Alcohol and/or drug services [*bill for the initial admission*]	Limited to one per hospitalization. Restricted to ICD-9-CM diagnosis codes 292.0-292.9, 303.00-305.03, 305.20-305.93, and 790.3.
H0009	TS	Alcohol and/or drug services with follow-up service modifier [*bill for any follow-up days*]	

Note: Managed care clients who are receiving detoxification services in a detoxification hospital that has a detoxification-specific taxonomy can be billed directly to the agency.

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; and
- ✓ Immunoglobulins.

Payment for blood and blood products

- The agency does not pay for blood or blood products that are donated.
- The agency pays for the covered service charges necessary in handling and processing blood and blood products.

Procedure Code	Modifier	Short Description	EPA/PA	Policy/ Comments
36415		Routine venipuncture		
36416		Capillary blood draw		
36430		Blood transfusion service		
36450		Bl exchange/transfuse nb		
36511		Apheresis wbc		
36512		Apheresis rbc		
36516		Apheresis, selective		
36522		Photopheresis		
38205		Harvest allogenic stem cell		
38206		Harvest auto stem cells		
38207		Cryopreserve stem cells		
38208		Thaw preserved stem cells		
38209		Wash harvest stem cells		
38210		T-cell depletion of harvest		
38211		Tumor cell deplete of harvest		
38212		Rbc depletion of harvest		
38213		Platelet deplete of harvest		

Procedure Code	Modifier	Short Description	EPA/PA	Policy/ Comments
38214		Volume deplete of harvest		
38215		Harvest stem cell concentrate		
78120		Red cell mass single		
78120	26	Red cell mass single		
78120	TC	Red cell mass single		
78121		Red cell mass multiple		
78121	26	Red cell mass multiple		
78121	TC	Red cell mass multiple		
82143		Amniotic fluid scan		
82247		Bilirubin total		
82248		Bilirubin direct		
82668		Assay of erythropoietin		
82784		Assay, iga/igd/igg/igm each		
82803		Blood gases any combination		
83020		Hemoglobin electrophoresis		
83020	26	Hemoglobin electrophoresis		
83030		Fetal hemoglobin chemical		
84460		Alanine amino (ALT) (SGPT)		
85002		Bleeding time test		
85013		Spun microhematocrit		
85014		Hematocrit		
85018		Hemoglobin		
85032		Manual cell count each		
85049		Automated platelet count		
85130		Chromogenic substrate assay		
85210		Clot factor ii prothrom spec		
85220		Blood clot factor v test		
85230		Clot factor vii proconvertin		
85240		Clot factor viii ahg 1 stage		
85245		Clot factor viii vw ristoctn		
85246		Clot factor viii vw antigen		
85247		Clot factor viii multimetric		
85250		Clot factor ix ptc/chrstmas		
85260		Clot factor x stuart-power		
85270		Clot factor xi pta		
85280		Clot factor xii Hageman		
85290		Clot factor xiii fibrin stab		
85291		Clot factor xiii fibrin scrn		
85292		Clot factor fletcher fact		
85293		Clot factor wght kininogen		
85300		Antithrombin iii activity		
85301		Antithrombin iii antigen		
85302		Clot inhibit prot c antigen		

Procedure Code	Modifier	Short Description	EPA/PA	Policy/ Comments
85303		Clot inhibit prot c activity		
85305		Clot inhibit prot s total		
85306		Clot inhibit prot s free		
85307		Assay activated protein c		
85335		Factor inhibitor test		
85362		Fibrin degradation products		
85366		Fibrinogen test		
85370		Fibrinogen test		
85378		Fibrin degrade semiquant		
85384		Fibrinogen activity		
85385		Fribrinogen antigen		
85410		Fibrinolytic antiplasminogen		
85420		Fibrinolytic plasminogen		
85421		Fibrinolytic plasminogen		
85460		Hemoglobin fetal		
85461		Hemoglobin fetal		
85475		Hemolysin acid		
85520		Heparin assay		
85576		Blood platelet aggregation		
85576	26	Blood platelet aggregation		
85597		Phospholipid pltlt neutraliz		
85610		Prothrombin time		
85635		Reptilase test		
85660		RBC sickle cell test		
85670		Thrombin time, plasma		
85705		Thromboplastin inhibition		
85730		Thromboplastin time partial		
85732		Thromboplastin time partial		
85999		Hematology procedure		
86021		WBC antibody identification		
86022		Platelet antibodies		
86023		Immunoglobulin assay		
86078		Phys blood bank serv reactj		
86317		Immunoassay infectious agent		
86329		Immunodiffusion nes		
86592		Syphilis test non-trep qual		
86593		Syphilis test non-trep quant		
86644		CMV antibody		
86645		CMV antibody IgM		
86687		Htlv-i antibody		
86688		Htlv-ii antibody		
86689		Htlv/hiv confirmj antibody		
86701		Hiv-1antibody		

Procedure Code	Modifier	Short Description	EPA/PA	Policy/ Comments
86702		Hiv-2 antibody		
86703		Hiv-1/hiv-2 1 result antbdy		
86704		Hep b core antibody total		
86705		Hep b core antibody igm		
86706		Hep b surface antibody		
86711		John cunningham antibody		Effective 1/1/13
86793		Yersinia antibody		
86803		Hepatitis c ab test		
86804		Hep c ab test confirm		
86805		Lymphocytotoxicity assay		
86807		Cytotoxic antibody screening		
86821		Lymphocyte culture mixed		
86828		Hla class i&ii antibody qual		Effective 1/1/13
86829		Hla class i/ii antibody qual		Effective 1/1/13
86830		Hla class i phenotype qual		Effective 1/1/13
86831		Hla class ii phenotype qual		Effective 1/1/13
86832		Hla class i high defin qual		Effective 1/1/13
86833		Hla class ii high defin qual		Effective 1/1/13
86834		Hla class i semiquant panel		Effective 1/1/13
86835		Hla class ii semiquant panel		Effective 1/1/13
86849		Immunology procedure		
86850		RBC antibody screen		
86860		RBC antibody elution		
86870		RBC antibody identification		
86880		Coombs test		
86885		Coombs test indirect qual		
86886		Coombs test indirect titer		
86890		Autologous blood process		
86891		Autologous blood op salvage		
86900		Blood typing abo		
86901		Blood typing rh (d)		
86902		Blood type antigen donor ea		
86904		Blood typing patient serum		
86905		Blood typing rbc antigens		
86906		Blood typing rh phenotype		
86920		Compatibility test spin		
86921		Compatibility test incubate		
86922		Compatibility test antiglob		
86923		Compatibility test electric		
86927		Plasma fresh frozen		
86930		Frozen blood prep		
86931		Frozen blood thaw		
86932		Frozen blood freeze/thaw		

Procedure Code	Modifier	Short Description	EPA/PA	Policy/ Comments
86940		Hemolysins/agglutinins auto		
86941		Hemolysins/agglutinins		
86945		Blood product/irradiation		
86950		Leukacyte transfusion		
86960		Vol reduction of blood/prod		
86965		Pooling blood platelets		
86970		Rbc pretx incubatj w/chemical		
86971		Rbc pretx incubatj w/enzymes		
86972		Rbc pretx incubatj w/density		
86975		Rbc serum pretx incubj drugs		
86976		Rbc serum pretx id dilution		
86977		Rbc serum pretx incubj/inhib		
86978		Rbc pretreatment serum		
86985		Split blood or products		
86999		Transfusion procedure		
87340		Hepatitis b surface ag eia		
87390		Hiv-1 ag eia		
87391		Hiv-2 ag eia		
87449		Ag detect nos eia mult		
88240		Cell cryopreserve/storage		
88241		Frozen cell preparation		
90281		Human ig im		
90283		Human ig iv		
90287		Botulinum antitoxin		
90288		Botulism ig iv		
90291		Cmv ig iv		
90296		Diphtheria antitoxin		
90371		Hep b ig im		
90375		Rabies ig im/sc		
90376		Rabies ig heat treated		
90378		Rsv mab im 50mg		
90384		Rh ig full-dose im		
90385		Rh ig minidose im		
90386		Rh ig iv		
90389		Tetanus ig im		
90396		Varicella-zoster ig im		
90399		Immune globulin		
96360		Hydration iv infusion init		
96361		Hydrate iv infusion add-on		
96365		Ther/proph/diag iv inf init		
96366		Ther/proph/diag iv inf addon		
96367		Tx/proph/dg addl seq iv inf		
+96368		Ther/diag concurrent inf		

Procedure Code	Modifier	Short Description	EPA/PA	Policy/ Comments
96372		Ther/proph/diag inj sc/im		
96373		Ther/proph/diag inj ia		
96374		Ther/proph/diag inj iv push		
99001		Specimen handling pt-lab		
99090		Computer data analysis		
99195		Phlebotomy		
P9010		Whole blood for transfusion		
P9011		Blood split unit		
P9012		Cryoprecipitate each unit		
P9016		RBC leukocytes reduced		
P9017		Plasma 1 donor frz w/in 8 hr		
P9019		Platelets, each unit		
P9020		Platelet rich plasma unit		
P9021		Red blood cells unit		
P9022		Washed red blood cells unit		
P9023		Frozen plasma, pooled, sd		
P9031		Platelets leukocytes reduced		
P9032		Platelets, irradiated		
P9033		Platelets leukoreduced irrad		
P9034		Platelets, pheresis		
P9035		Platelet pheres leukoreduced		
P9036		Platelet pheresis irradiated		
P9037		Plate pheres leukoredu irrad		
P9038		RBC irradiated		
P9039		RBC deglycerolized		
P9040		RBC leukoreduced irradiated		
P9041		Albumin (human),5%, 50ml		
P9043		Plasma protein fract,5%,50ml		
P9044		Cryoprecipitatereducedplasma		
P9045		Albumin (human), 5%, 250 ml		
P9046		Albumin (human), 25%, 20 ml		
P9047		Albumin (human), 25%, 50ml		
P9048		Plasmaprotein fract,5%,250ml		
J0850		Cytomegalovirus imm iv/vial		
J1460		Gamma globulin 1 CC inj		
J1559		Hizentra injection		
J1560		Gamma globulin > 10 CC inj		
J1561		Gamunex-C/Gammaked		
J1566		Immune globulin, powder		
J1568		Octagam Injection		
J1569		Gammagard liquid injection		
J1599		Ivig non-lyophilized, NOS		
J1670		Tetanus immune globulin inj		

Procedure Code	Modifier	Short Description	EPA/PA	Policy/ Comments
J2597		Inj desmopressin acetate		
J2790		Rho d immune globulin inj		
J2791		Rhophylac injection		
J2792		Rho(D) immune globulin h, sd		
J7178		Human fibrinogen conc inj		Effective 1/1/13 Replaces Q2045
J7197		Antithrombin iii injection		

Fee schedule

To view the Fee Schedule, see the agency's:

- Physician-Related/Professional Health Care Services Fee Schedule; and
- Injectable Drugs Fee Schedule.

Centers of Excellence (COE)

[WAC 182-531-0650]

The following services must be performed in an agency-approved Center of Excellence (COE).

List of approved COEs

See the agency's list of approved COEs for hysteroscopic sterilizations, sleep centers, and transplants.

Bariatric surgeries

[WAC 182-531-1600 and 182-550-2301]

Bariatric surgery must be performed in an agency-approved hospital and **requires PA**.

Agency-Approved Bariatric Hospital and Associated Clinics	Location
Sacred Heart Medical Center, Rockwood Bariatric Specialists	Spokane, WA
University of Washington Medical Center, University of Washington Specialty Surgery Center	Seattle, WA
Oregon Health Science University, OHSU Surgery Center	Portland, OR

Clients 21 through 59 years of age

The agency 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 the agency a completed "Bariatric Surgery Request" form, 13-785 (see Resources Available).

Clients 18 through 20 years of age

The agency covers medically necessary bariatric surgery for clients 18 through 20 years of age:

- For the laparoscopic gastric band procedure (CPT code 43770);
- When prior authorized;
- When performed in an approved hospital with a bariatric surgery program; and
- In accordance with WAC 182-531-1600.

Bariatric case management fee

The agency 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 the agency.

Clients enrolled in a managed care organization (MCO) are eligible for bariatric surgery under fee-for-service when prior authorized. Clients enrolled in an MCO who have had their surgery prior authorized by the agency and who have complications following bariatric surgery are covered fee-for-service for these complications 90 days from the date of the agency-approved bariatric surgery. The agency requires authorization for these services. Claims without authorization will be denied.

Billing

Providers must bill with their approved COE facility NPI using the following billing guidelines:

- Electronic billers (837p) must put the COE-approved facility NPI in the Comments field of the electronic claim.
- Paper billers must put the COE-approved facility NPI in field 32 on the CMS-1500 claim form.

Note: When private insurance or Medicare has paid as primary insurance and the provider is billing the agency as secondary insurance, the agency does not require PA or that the transplant, sleep study, or bariatric surgery be done in a Center of Excellence or agency-approved hospital.

Hemophilia treatment COEs

WAC 182-531-1625
(For administration in the home only)

To be paid by the agency for hemophilia and von Willebrand-related products for administration to fee-for-service 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: The agency does not require the use of an approved hemophilia treatment COE to obtain hemophilia and von Willebrand-related products when:

- ✓ The agency is not the primary payer;
- ✓ The client receives the product in an outpatient hospital or clinic setting for nonroutine or urgent care needs; or
- ✓ 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:
Puget Sound Blood Center – Seattle
Hemophilia Center at Oregon Health Science University (OHSU) – Portland

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 of the following:

- Have a Core Provider Agreement with the agency;
- 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 the agency 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; and

  - ✓ Listing in the Hemophilia Treatment Center (HTC) directory.

- Submit requests to:

Hemophilia Treatment COE
Health Care Authority - Healthcare Services
PO Box 45506
Olympia WA 98504-5506

- Receive written approval including conditions of payment and billing procedures from the agency.

What documentation is required to continue as a qualified COE for hemophilia treatment?

The HTC must annually submit to the agency:

- 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; and

- 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.

Coverage table

Procedure Code	Short Description
J7180	Factor XIII anti-hem factor
J7183	Wilate injection
J7185	Xyntha inj
J7186	Antihemophilic viii/vwf comp
J7187	Humate-P, inj
J7189	Factor viia
J7190	Factor viii
J7191	Factor VIII (porcine)
J7192	Factor viii recombinant NOS

Procedure Code	Short Description
J7193	Factor IX non-recombinant
J7194	Factor ix complex
J7195	Factor IX recombinant
J7198	Anti-inhibitor

Hysteroscopic sterilizations

[WAC 182-531-1550(10)]

The agency pays only approved COEs for hysteroscopic sterilization procedures. Upon approval, the provider will receive an approval letter with the EPA number for billing hysteroscopic sterilization procedures and the provider's name is placed on the agency-approved COE list for hysteroscopic sterilizations.

Information on sterilization and the current sterilization form samples and instructions are available Sterilization Supplemental Medicaid Provider Guide.

Sleep studies

[WAC 182-531-1500]

Becoming an agency-approved sleep center

To become an agency-approved COE, a sleep center must send the following documentation to the Health Care Authority, c/o Provider Enrollment, PO Box 45510, Olympia, WA 98504-5510:

- A completed Core Provider Agreement.
- Copies of the following:
  - ✓ The sleep center's current accreditation certificate by AASM.
  - ✓ Either of the following certifications for at least one physician on staff:
    - ➢ Current certification in sleep medicine by the American Board of Sleep Medicine (ABSM).
    - ➢ Current subspecialty certification in sleep medicine by a member of the American Board of Medical Specialties (ABMS).
  - ✓ The certification of an RPSGT who is employed by the sleep center.

Note: Sleep centers must request reaccreditation from AASM in time to avoid expiration of COE status with the agency.

At least one physician on staff at the sleep center must be board certified in sleep medicine. If the only physician on staff who is board certified in sleep medicine resigns, the sleep center must ensure another physician on staff at the sleep center obtains board certification or another board-certified physician is hired. The sleep center must then send provider enrollment a copy of the physician's board certification.

If a certified medical director leaves a COE, the COE status does not transfer with the medical director to another sleep center.

The COE must maintain a record of the physician's order for the sleep study.

For further information, see sleep medicine testing.

Transplants

[WAC 182-550-1900]

Who is eligible for transplants?

The agency pays for medically necessary transplant procedures only for eligible agency 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?

The agency covers the following transplant procedures when the transplant procedures are performed in a hospital designated by the agency 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.

  The agency 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 the agency pay for skin grafts and corneal transplants?

The agency pays for skin grafts and corneal transplants to any qualified hospital when medically necessary.

Does the agency pay for organ procedure fees and donor searches?

The agency 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. The agency requires PA for more than 15 tests.

To bill for donor services:

- Use the client's ProviderOne Client ID, and
- The appropriate V59 series diagnosis code as the principal diagnosis code.

  For example, if billing a radiological exam on a potential donor for a kidney transplant, bill V59.4 for the kidney donor and use V70.8 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 V70.8 as a principal diagnosis will cause the line to be denied.

Does the agency pay for experimental transplant procedures?

The agency does not pay for experimental transplant procedures. In addition, the agency 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; and
- 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(1)]

The agency covers outpatient drugs, including over-the-counter drugs listed on the agency's Covered Over-the-Counter Drug 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); and
- 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, refer to the agency's Prescription Drug Program Medicaid Provider Guide.

Note: The agency requires prior authorization (PA) for all drugs new to market until reviewed by the agency's Drug Evaluation Matrix Committee according to WAC 182-530-3100. This applies to all products billed under miscellaneous codes or product specific procedure codes.

The agency'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 when billed charges exceed $1,100.00 per line item OR when billing for compounded drugs. If needed, the agency will request any other necessary documentation after receipt of the claim.

This requirement applies to **all drugs** administered in the provider's office, including those drugs with an assigned CPT or HCPCS code, and those drugs billed using either unlisted drug code J3490 or J9999.

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 the agency upon request.

Drug pricing

The agency follows Medicare's drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, the agency prices the drug at a percentage of the Average Wholesale Price (AWP). The agency updates the rates each time Medicare's rate is updated, up to once per quarter. Unlike Medicare, the agency effective dates are based on dates of service, not the date the claim is received. For HCPCS codes where Medicare does not establish a rate, the agency determines the maximum allowances for covered drugs using the following methodology:

1. For a single-source drug or biological, the AWP equals the AWP of the single product.

2. For a multi-source drug or biological, the AWP is equal to the median AWP of all of the generic forms of the drug or biological, or the lowest brand-name product AWP, whichever is less. A "brand-name" product is defined as a product that is marketed under a labeled name that is other than the generic chemical name for the drug or biological.

3. After determining the AWP according to #1 and #2 above, the agency multiplies the amount by 0.84 to arrive at the fee schedule maximum allowance.

National drug code format

All providers are required to use the 11-digit National Drug Code (NDC) when billing the Agency for drugs 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 in order 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 123456789when, 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. ***The Agency will deny claims for drugs billed without a valid 11-digit NDC.***

Electronic 837-P Claim Form Billing Requirements

Providers must continue to identify the drug given by reporting the drug's CPT or HCPCS code in the **PROFESSIONAL SERVICE Loop 2400, SV101-1 and the corresponding 11-digit NDC in DRUG IDENTIFICATION Loop 2410, LIN02 and LIN03.** In addition, the units reported in the "units" field in PROFESSIONAL SERVICE Loop 2400, SV103 and SV104 must continue to correspond to the description of the CPT or HCPCS code.

CMS-1500 Claim Form Billing Requirements

When billing using a **paper** CMS-1500 Claim Form for **two or fewer drugs on one claim form,** list the 11-digit NDC in ***field 19*** of the claim form must be listed **exactly** as follows (*not all required fields are represented in the example*):

19. 54569549100 Line 2 / 00009737602 Line 3

Line	Date of Service	Procedure Code	Charges	Units
1	07/01/07	99211	50.00	1
2	07/01/07	90378	1500.00	2
3	07/01/07	J3420	60.00	1

DO NOT attempt to list more than two NDCs in field 19 on the paper CMS-1500 Claim Form. When billing for more than 2 drugs, list the additional drugs on additional claim forms. **Do not bill more than 2 drugs per claim form.**

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 of the products with NDCs and quantities used in the compound. Claims are manually priced per the invoice.

Miscellaneous drugs requiring prior authorization

Short Description	Procedure Code	Form Number
Acetaminophen injection	J0131	Basic Information form 13-756
Brentuximab Vedotin inj	J9042	Basic Information form 13-756
Belimumab injection	J0490	Basic Information form 13-756
Certolizumab pegol inj	J0718	Request form 13-885
Ceftaroline fosamil inj	J0712	Basic Information form13-756
Denosumab injection	J0897	Basic Information form 13-756
Epoprostenol injection	J1325	Basic Information form 13-756
Icatibant injection	J1744	Basic Information form 13-756
Ipilimumab injection	J9228	Basic Information form 13-756
Lumizyme injection	J0221	Basic Information form 13-756
Mannitol for inhaler	J7665	Basic Information form 13-756
Methylnaltrexone Inj	J2212	Basic Information form 13-756
Natalizumab injection	J2323	Request form 13-832
Omalizumab injection	J2357	Basic Information form 13-756
Pegloticase injection	J2507	Basic Information form 13-756
Porfimer sodium injection	J9600	Basic Information form 13-756

The agency requires prior authorization for all new drugs to market until reviewed by the agency's Drug Evaluation Matrix committee 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 to view the drugs that require authorization.

Drugs requiring written/fax prior authorization

Drugs requiring written/fax 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.

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 Restricted to ICD-9-CM
J0637	Caspofungin acetate	112.84 (candiadal esophagitis); 117.3 (aspergillosis)
J0725	Chorionic gonadotropin/1000u	752.51 (Undescended testis)
J1050	Injection, Medroxyprogester acetate, 1 mg (depo provera)	Females-only diagnoses V25.02, V25.40, V25.49, V25.9. (contraceptive mgmt) allowed once every 67 days. **Therapeutic dose for contraception is 150 mg.** Males-diagnosis must be related to cancer
J1212	Dimethyl sulfoxide 50% 50 ML	595.1 (chronic intestinal cystitis)
J1595	Injection glatiramer acetate	340 (multiple sclerosis)
J1756	Iron sucrose injection	585.1-585.9 (chronic renal failure)
J2323	Natalizumab injection	340 (multiple sclerosis). 555.0, 555.1, 555.2, 555.9 (crohn's disease). Requires PA. See Resources Available for information on where to obtain the authorization form.
J2325	Nesiritide	No diagnosis restriction. Restricted use only to cardiologists
J2501	Paricalcitol	585.6 (chronic renal failure)
J2916	Na ferric gluconate complex	585.6 (chronic renal failure)
J3285	Treprostinil, 1 mg	416.0-416.9 (chronic pulmonary heart disease)
J3420	Vitamin B12 injection	123.4, 151.0-154.8, 157.0-157.9, 197.4-197.5, 266.2, 281.0-281.3, 281.9, 284.0, 284.8-284.9, 555.9, 579.0-579.9, 648.20-648.24
J3465	Injection, voriconazole	117.3 (aspergillosis)
J3487	Zoledronic acid (Zometa®), 1 mg	198.5, 203.00, 203.01, 275.42 (hypercalcemia)
J3488	Zoledronic acid (Reclast®), 1 mg	731.0, 733.01
J9041	Bortezomib injection	200.40 – 200.48 (mantle cell lymphoma) or 203.00-203.01 (multiple myeloma and immunoproliferative neoplasms)
Q2051	Zoledronic acid, not otherwise specified, 1 mg	198.5, 203.00, 203.01, 275.42 (hypercalcemia), 731.0, 733.01
Q3025	IM inj interferon beta 1-a	340 (multiple sclerosis)
Q3026	Subc inj interferon beta-1a	340 (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 form to be paid the appropriate amount. For drugs priced at "acquisition cost," providers must:

- Include a copy of the manufacturer's invoice for each line item in which **billed charges** exceed $1,100.00; or
- 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 retained in the client's record.

Chemotherapy drugs

(J9000-J9999)

The following payment guidelines apply to chemotherapy drugs (HCPCS codes J9000-J9999):

- The agency's maximum allowable fee per unit is based on the HCPCS description of the chemotherapy drug.
- The agency follows Medicare's drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, the agency continues to price the drug at 84% of the Average Wholesale Price (AWP).
- 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 the agency for a chemotherapy drug using an unlisted drug code.

Billing for single-dose vials

For single-dose vials, bill the total amount of the drug contained in the vial(s), including partial vials. Based on the unit definition for the HCPCS code, the agency 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 the agency'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).

Billing for multi-dose vials

For multi-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, the agency 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 multi-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 the agency'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

In order to bill the agency for oral anti-emetic drugs (HCPCS codes Q0163-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 one of the ICD-9-CM diagnosis codes140.0-208.90, 230.0-239.9, or V58.1; and
- Submitted on the same claim form 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 the total amount of the drug contained in the vial(s), including partial vials. Based on the unit definition for the HCPCS code, the agency 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 the agency'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 Multi-Dose Vials:

For multi-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, the agency 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 multi-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 the agency'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 and J9999)

When it is necessary to bill the agency for a drug using an unlisted drug code, providers must report the National Drug Code (NDC) of the drug administered to the client. The agency 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; and
  - ✓ 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); and
- The drug must not be excluded from coverage.
- For claims billed using a paper CMS-1500 claim form, list the required information in field 19 of the claim form.
- For claims billed using an electronic CMS-1500 claim form, list the required information in the *Comments* section of the claim form.
- For claims billed using an electronic 837P claim form, list the required NDC information in DRUG IDENTIFICATION Loop 2410, LIN02, and LIN03. List the dosage given to the client in the *Comments* section of the claim form.

See Vaccines/Toxoids (Immunizations) within this provider guide for more detailed information on NDC billing.

Note: If there is an assigned HCPCS code for the administered drug, providers **must bill** the agency using the appropriate HCPCS code. ***DO NOT*** bill using an unlisted drug code for a drug that has an assigned HCPCS code. The agency 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 Injectable Drugs Fee Schedule.

Botulinum toxin injections (Botox)

(HCPCS code J0585, J0586, J0587, J0588, and CPT codes 52287 and 64615)

The agency requires prior authorization for the following procedure codes:

- HCPCS codes J0585, J0586, J0587, J0588 and CPT codes 52287 and 64615 **regardless of the diagnosis**; and
- CPT code 95874 when needle electromyography is used for guidance during the injection.

Submission of an authorization request must be in writing on the General Information for Authorization form, 13-835 along with a completed Botulinum Toxin Provider Questionnaire form, 13-003.

Collagenase injections

(HCPCS code J0775, CPT codes 20527 and 26341)

The agency requires prior authorization for HCPCS code J0775, CPT codes 20527 and 26341.

Hyalgan/Synvisc/Euflexxa/Orthovisc/Gel-One

- The Agency reimburses only orthopedic surgeons, rheumatologists, and physiatrists for Hyalgan, Synvisc, Euflexxa, Orthovisc, or Gel-One*.

  *The Agency requires prior authorization for Gel-One. Use the Basic Information form, 13-756.

- The Agency allows a maximum of 5 Hyalgan, 3 Euflexxa, 3 Orthovisc, or 1 Gel-One intra-articular injection **per knee** for the treatment of pain in osteoarthritis of the knee. Identify the left knee or the right knee by adding the modifier LT or RT to the claim.

- This series of injections may be repeated at 12-week intervals.

Note: The Agency requires PA for any off label use of these products. Failure to obtain PA will result in denied payment or recoupment.

The injectable drug must be billed after all injections are completed.

- Providers must bill for Hyalgan, Synvisc, Euflexxa, and Orthovisc using the following HCPCS codes:

HCPCS Code	Short Description	Limitations
J7321	Hyalgan/supartz inj per dose	Maximum of 5 injections. Maximum of 5 units
J7323	Euflexxa inj per dose	Maximum of 3 injections. Maximum of 3 units
J7324	Orthovisc inj per dose	Maximum of 3 injections. Maximum of 3 units
J7325	Synvisc inj per dose	One unit equals one mg. One injection covers a full course of treatment per knee. Limited to one injection per knee in a six-month period. Maximum of 48 units per knee, per course of treatment.
J7326	Gel-One inj per dose	Maximum of 1 injection per year, requires PA. Effective 1/1/2012

- Hyalgan, Synvisc, Euflexxa, and Orthovisc injections are covered only with the following ICD-9-CM diagnosis codes:

Diagnosis Code	Description
715.16	Osteoarthritis, localized, primary lower leg.
715.26	Osteoarthritis, localized, secondary, lower leg.
715.36	Osteoarthritis, localized, not specified whether primary or secondary, lower leg.
715.96	Osteoarthritis, unspecified whether generalized or localized, lower leg.

- The injectable drugs must be billed after all injections are completed.
- Bill CPT injection code 20610 each time an injection is given, up to a maximum of: 5 Hyalgan injections, 3 Euflexxa injections, 3 Orthovisc injections, and 1 or 3 Synvisc injections (depending on formula).
- Bill both the injection CPT code and HCPCS drug code on the same claim form.

Hydroxyprogesterone (17P)

The agency will cover the use of Alpha Hydroxyprogesterone (17P) as one strategy to reduce the incidence of premature births. The American College of Obstetricians and Gynecologists (ACOG) has indicated that 17P may be of benefit to pregnant women with:

- A singleton gestation; and
- A history of prior spontaneous preterm delivery (between 20 weeks gestation and 36 weeks, 6 days gestation) which was:
  - ✓ Due to preterm labor; or
  - ✓ A spontaneous delivery due to unknown etiology.

The agency will reimburse providers (with the exception of hospitals) without prior authorization for 17P and its administration as follows:

- 17P must be purchased by the provider from a sterile compounding pharmacy;
- The compound is individually produced on a client by client basis; and
- One dose per week is covered during week 16 through week 36 of pregnancy,

Reimbursement for the commercially marketed form of 17P (Makena®) with HCPCS code J1725 is not available to administering providers. Makena® is available only to dispensing pharmacies and requires prior authorization. Authorization for reimbursement to a dispensing pharmacy for Makena® requires documented medical justification of the reason an individually compounded form of 17P is not appropriate for the client.

Reimbursement for 17P

The agency will reimburse providers for 17P with the following documentation:

- On the claim, enter the NDC for the main ingredient in the compound on the line level;
- Insert the word "*compound*" in the notes field;
- Use procedure code J3490; and
- Attach the invoice from the pharmacy showing all of the products with NDCs and quantities used in the compound. The claim will be paid manually according to the information on the attached invoice.

Prolia/Xgeva

The Agency covers denosumab injection (Prolia® and Xgeva®) as follows:

- Prior authorization is required; and
- Providers bill the Agency using HCPCS code J0897.

When submitting HCA form 13-835 to request PA, field 15 must contain the brand name (Prolia® or Xgeva®) of the requested product. The Agency will reject requests for J0897 without this information. Providers must complete all other required fields.

Verteporfin injection

(HCPCS code J3396)

Verteporfin injections are limited to ICD-9-CM diagnosis code 362.52 (exudative senile macular degeneration).

Vivitrol

(HCPCS J2315)

The agency requires prior authorization for Vivitrol. It is also available when prior authorized through the pharmacy Point-of Sale (POS) system.

Foot Care Services

[WAC 182-531-1300]

This section addresses care of the lower extremities (foot and ankle) referred to as foot care and applies to clients 21 years of age and older.

Are foot care services covered?

The agency covers foot care services for clients 21 years of age and older as listed in this section when those services are provided by any of the following healthcare providers and billed to the agency using procedure codes and diagnosis codes that are within their scope of practice:

Note: Care of the lower extremity is defined as foot and ankle care.

- 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).

The agency covers evaluation and management visits to assess and diagnose conditions of the lower extremities. Once diagnosis is made, the agency covers treatment if the criteria in WAC 182-531-1300 (4)(a) are met.

What foot care services does the agency pay for?

The agency 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. (WAC 182-531-1300 (4)(a))

Note: Providers may request an exception to rule 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.

The agency pays for:

- Treatment of acute inflammatory processes such as:

  - ✓ Circulatory compromise such as, but not limited to:
    - ➢ Lymphedema.
    - ➢ Raynaud's disease.
    - ➢ Thromboangiitis obliterans.
    - ➢ Phlebitis.

  - ✓ Charcot Arthropathy.
  - ✓ Gout.
  - ✓ Injuries, fractures, sprains, and dislocations.
  - ✓ Lacerations, ulcerations, wounds, blisters.
  - ✓ Neuropathies, e.g., reflex sympathetic dystrophy secondary to diabetes.
  - ✓ Osteomyelitis.
  - ✓ Postoperative complications.
  - ✓ Tendonitis.

- Removal of warts, corns, or calluses in the presence of an acute condition such as infection and pain affecting the client's ability to ambulate as a result of the warts, corns or calluses. The condition must meet the criteria in the "Acute Conditions of the Lower Extremities by Diagnosis" table and in WAC 182-531-1300 (4)(a).

- Treatment of soft tissue conditions, such as, but not limited to:

  - ✓ Rashes.
  - ✓ Infections (fungal, bacterial).
  - ✓ Gangrene.
  - ✓ Cellulitis of lower extremities.
  - ✓ Soft tissue tumors.
  - ✓ Neuroma.

- Treatment of nail bed infections (paronychia).

- Treatment of tarsal tunnel syndrome.

- Trimming and/or debridement of nails to treat an applicable condition in the Acute Conditions of the Lower Extremities by Diagnosis table and in WAC 182-531-1300 (4)(a).

- The agency pays for one treatment in a 60-day period. The agency covers additional treatments in this period if documented in the client's medical record as being medically necessary.

- A surgical procedure to treat one of the conditions in the "Acute Conditions of the Lower Extremities by Diagnosis" table and the criteria in WAC 182-531-1300 (4)(a).

- Impression casting to treat one of the conditions in the "Acute Conditions of the Lower Extremities by Diagnosis" table and the criteria in WAC 182-531-1300 (4)(a).

- Custom fitted and/or custom molded orthotic devices to treat one of the conditions in the "Acute Conditions of the Lower Extremities by Diagnosis" table and the criteria in WAC 182-531-1300 (4)(a).

  - ✓ The agency'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).

  - ✓ The agency 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.

The agency includes 90-day follow-up care in the reimbursement.

Acute conditions of the lower extremities by diagnosis

Dx Code	Condition	Dx Code	Condition
239.2	Soft Tissue Tumor	730.27	Unspecified Osteomyelitis, Ankle and Foot
249.60-249.61	Secondary Diabetes Mellitus with Neurological Manifestations	730.96	Unspecified Infection of Bone, Lower Leg
250.60 – 250.73	Diabetes with Neurological Manifestations & Peripheral Circulatory Disorders	730.97	Unspecified Infection of Bone, Ankle and Foot
274.0	Gouty Arthropathy	732.5	Juvenile Osteochondritis of Foot
337.22	Reflex Sympathetic Dystrophy of Lower Extremity	733.4	Aseptic Necrosis of Bone
337.29	Reflex Sympathetic Dystrophy of Other Specified Site	733.44	Aseptic Necrois of Talus
338.3	Neoplasm Related Pain	733.81	Non-union Fracture
338.4	Chronic Pain Syndrome	733.94	Stress fracture of Metatarsals
355.5	Tarsal Tunnel Syndrome	733.95	Stress fracture of other bone in ankle or foot
355.6	Lesion of plantar nerve	755.67	Anomalies of Foot; Tarsal Coalition
355.71	Causalgia of Lower Limb	785.4	Gangrene (Necrosis)
355.9	Mononeuritis of Lower Limb	824.0 - 827.1	Fractures of Foot & Ankle Diagnoses Codes

Dx Code	Condition	Dx Code	Condition
356.8	Peripheral Neuropathy	838.00 – 838.19	Dislocation/Subluxation of Foot Diagnoses Codes
357.2	Diabetic Neuropathy	845.0	Sprain or Strain of Ankle
440.23	Arteriosclerosis of the Extremities with Ulceration	845.00	Sprain or Strain unspecified site
440.24	Arteriosclerosis of the extremities with Gangrene	845.01	Sprain or Strain of Deltoid Ligament (Ankle)
443.0	Raynaud's Disease	845.02	Sprain or Strain of Calcaneofibular Ligament Ankle
443.1	Thromoangiitis Obliterans (Buerger's Disease)	845.03	Sprain or Strain of Tibiofibular Ligament (Distal)
443.9	Peripheral Vascular Disease	845.09	Tendon Rupture Ankle Traumatic
451.2	Phlebitis, Lower Extremities	845.10	Sprain or Strain of Foot
453.40-453.42	Deep Vein Thrombosis of Lower Extremity	845.10	Tendon Rupture Foot Traumatic
454.0	Varicose veins or Stasis Dermatitis of Lower Extremities with Ulceration	845.11	Sprain or Strain of Tarsometatarsal Ligament
454.2	Varicose Vein or Stasis Dermatitis with Inflammation and Ulceration	845.12	Sprain or Strain of Metatarsaophalangeal
457.1	Lymphedema	845.13	Sprain or Strain of Interphalangeal, Toe
681.1	Cellulitis/Abscess Toe	845.19	Sprain or Strain Other
681.11	Paronychia of Toe	891.00	Open Wound Ankle - Without Complication
681.9	Cellutlitis and Abscess of Unspecified Digit	891.1	Open Wound Ankle - With Tendon Involvement
682.6	Cellulitis, Abscess of Ankle/Leg	891.2	Open Wound Ankle - Complicated
682.7	Cellulitis, Abscess of Foot or Heel, except Toes	892.0	Open Wound Foot, Except Toes-Without Complication
703.0	Ingrowing Nail with Infection	892.1	Open Wound Foot, Except Toes-Complicated
707.07	Pressure Ulcer or Decubitus of Heel	892.2	Open Wound Foot, Except Toes - with Tendon Involvement
707.13	Ulcer of Ankle, Except Pressure Ulcer	893.0	Open Wound Toes
707.14	Ulcer Heel/Midfoot, Except Pressure Ulcer	893.1	Open Wound Toes-Complicated,
707.15	Ulcer Other Part of Foot/Toe, Except Pressure Ulcer	893.2	Open Wound Toes - with Tendon Involvement
709.3	Degenerative Skin Disorders; Necrobiosis Lipoidica	894.0	Multiple open wounds of lower extremity - Without Complication
713.5	Arthropathy Associated with Neurological Disorders	894.1	Multiple open wounds of lower extremity - With Complication
718.47	Contracture of Ankle or Foot Joint	894.2	Multiple open wounds of lower extremity - With Tendon Involvement
726.7	Enthesopathy of Ankle and Tarsus,	895.0	Traumatic Amputation of Toes (

Dx Code	Condition	Dx Code	Condition
	Unspecified		Complete) (Partial) - Without Complication
726.71	Tendonitis Achilles	895.1	Traumatic Amputation of Toes (Complete) (Partial) - Complication
726.72	Tibial Tendonitis	896.0	Traumatic Amputation of Foot, Unilateral (Complete) (Partial) - Without Complication
726.79	Tendonitis Peroneal	896.1	Traumatic Amputation of Foot, Unilateral (Complete) (Partial) - With Complication
726.9	Capsulitis	896.2	Traumatic Amputation of Foot, Bilateral (Complete) (Partial) - Without Complication
726.91	Exostosis (Bone spur)	896.3	Traumatic Amputation of Foot, Bilateral (Complete) (Partial) - With Complication
727.06	Tenosynovitis of Foot and Ankle	916.3	Blister ankle, infected
727.67	Achilles Tendon Rupture, Non-traumatic	917.2	Blister Foot, No Infection
727.68	Ruptur of Other Foot and Ankle Tendons, Non-traumatic	917.3	Blister foot with infection
728.71	Plantar Fascial Fibromatosis	924.2	Hematoma of Ankle or Foot, Excluding Toe
728.86	Necrotizing Fasciitis	924.3	Subungual (Toenail) Hematoma
729.1	Myalgia and Myositis	958.92	Traumatic Compartment Syndrome of Lower Extremity
729.6	Foreign Body in Soft Tissue	959.7	Injury Foot, Ankle or Leg
729.72	Non-Traumatic Compartment Syndrome of the Lower Extremity	991.5	Chilblains
730.06	Infection of Bone Lower Leg, Acute	996.6	Complication of Post-operative Implant
730.07	Infection of Bone Foot or Ankle, Acute	998.32	Dehiscence of External Operation (Surgical) Wound
730.16	Osteomyelitis of Lower Leg, Chronic	998.59	Post operative Abscess/Infection
730.17	Osteomyelitis of Foot or Ankle, Chronic	998.83	Non-healing Surgical Wound
730.26	Unspecified Osteomyelitis, Lower Leg		

What foot care services does the agency not pay for?

The agency does not pay for:

Treatment of or follow-up office visits for chronic acquired conditions of the lower extremities. The agency pays for prescriptions using the criteria found in the Prescription Drug Program Medicaid Provider Guide.

Foot care, unless the client meets criteria and conditions outlined in WAC 182-531-1300 as follows:

- Routine foot care, such as but not limited to:
  - ✓ Cutting or removing warts, corns and calluses;
  - ✓ Treatment of tinea pedis; and
  - ✓ 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; and
  - ✓ Onychomycosis.
- Any other service performed in the absence of localized illness, injury, or symptoms involving the foot.

The agency does not pay for the following radiology services:

- Bilateral X-rays for a unilateral condition; or
- X-rays in excess of three views; or
- X-rays that are ordered before the client is examined.

The agency does not pay 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 the agency does not pay for?

A waiver is required when clients choose to pay for a foot care service to treat a condition not listed in the "Acute Conditions of the Lower Extremities by Diagnosis" table. 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?

The agency 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 listed in the "Acute Conditions of the Lower Extremities by Diagnosis" table 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.

The agency 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 the agency 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 the agency. If Medicare does cover the service, bill Medicare first.

Hospice

Physicians providing service to hospice clients

The Medicaid agency 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; and
- 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 accordance with the Patient Protection and Affordable Care Act, clients 20 years of age 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.

Concurrent/curative care

Unless otherwise specified within this guide, curative treatment, related services, or related medications requested for clients 20 years of age and younger are subject to the Medicaid agency's specific program rules governing those services or medications.

Services included under the Medicaid agency's concurrent/curative care benefit

The following services aimed at achieving a disease-free state are included under the curative care benefit paid for by the Medicaid agency:

- Radiation
- Chemotherapy
- Diagnostics, including laboratory and imaging
- Licensed healthcare professional services
- Inpatient and outpatient hospital care

- Surgery
- Medication
- Equipment and related supplies
- Ancillary services, such as medical transportation

All of the above services require Prior Authorization by procedure code to obtain payment. To determine other prior authorization requirements on specific services, please refer to the Medicaid agency's program-specific Fee Schedule.

Authorization for concurrent/curative services

The agency requires authorization for all concurrent/curative care. Community providers must request authorization for these services, including treatment planning, actual treatment, and related medications. The authorization will span the timeframe anticipated for the episode of care. Prior authorization requests for concurrent/curative treatment and medications are subject to medical necessity review under WAC 182-501-0165.

Note: See Prior Authorization for the documentation required for prior authorization.

Providers must submit a comprehensive treatment plan including any treatment protocols, the estimated timeframe for treatment, and any ancillary services.

Once the treatment plan is reviewed by the agency and approved, please follow the guidelines in the box on next page *if*:

- Additional services are needed; and/or
- There are additional providers who will be administering care related to the approved concurrent treatment plan.

To request authorization for other treatments or services to an approved plan of concurrent care treatment authorization:

- Call the agency at 1-800-562-3022, ext. 15471 from 8:00 a.m. to 11:30 a.m.; or

- Submit additional information to a request as follow.

  ✓ Go to **Document Submission Cover Sheets**.
  ✓ Click on 7. **PA (Prior Authorization) Pend Forms**.
  ✓ In the box, put the Reference (authorization) number from the agency and press enter. This generates the barcode.
  The ProviderOne Reference (authorization) number for this request can be found using the ProviderOne authorization inquiry feature and the number is listed above the client's ID number on the PA Utilization screen.
  ✓ Print and attach only the additional information behind the barcode sheet and fax to the number on the bottom of the page.

Do **NOT** submit with an office coversheet.
The Barcode form *must* be the first page of the fax.

The Medicaid agency will notify the hospice agency when there is an approval or denial for hospice curative treatment. It is the hospice agency's responsibility to continue to coordinate care.

- If the concurrent/curative treatment, related services, or related medications are not covered by the Medicaid agency, the provider must request an exception to rule (ETR) under WAC 182-501-0160. Requests for exception to rule are subject to a medical necessity review under WAC 182-501-0165.

- If the Medicaid agency denies a request for a covered service, refer to WAC 182-502-0160 that specifies when a provider or a client may be responsible to pay for a covered service.

Billing

When billing for services **unrelated to the terminal illness**, providers must bill the agency directly.

To receive payment:

- The provider must put their NPI in the referring provider field of the HIPAA transaction (field 17 and 17a of the CMS-1500); and

- If not related to hospice care, when billing electronically, enter "*Not related to hospice care*" in the claim notes field of the HIPAA transaction or field 19 of the CMS-1500 claim form.

When billing services **for concurrent/curative care**, providers must bill the agency directly with the prior authorization number on the claim.

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 (the agency) receive funding from the TCF to help support provider groups involved in the state's trauma care system.

The agency uses its TCF funding to draw federal matching funds. The agency 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:

(a) 13 or greater for adults;
(b) 9 or greater for pediatric patients (under 15 years of age); or
(c) Less than (a) or (b) for a trauma patient **received** in transfer by a Level I, II, or III trauma center.

Beginning with dates of service on and after July 1, 2012, physicians/clinical providers also receive enhanced rates for qualified trauma care services provided to managed care enrollees who meet trauma program eligibility criteria.

Client eligibility groups included in TCF payments to physicians

Claims for trauma care services provided to the following client groups are eligible for enhanced rates:

- Medicaid (Title XIX)
- CHIP (Title XXI)
- Medical Care Services (Aged, Blind, and Disabled (ABD)
- Apple Health for Kids (Children's Health)

Client eligibility groups excluded from TCF payments to physicians

Claims for trauma care services provided to the following client groups are **not** eligible for enhanced rates:

- Refugee Assistance.
- Alien Emergency Medical.
- Family Planning Only/TAKE CHARGE.
- Basic Health.
- Basic Health Plus.

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

The agency pays a physician an enhanced rate for a qualifying trauma care service, using the **lesser** of the agency's maximum allowable fee or the provider's billed amount as the base rate to which an enhancement percentage is applied. The enhancement percentage is applied at the line-item level since not all services qualify for an enhanced rate.

The agency has a fixed amount to spend on supplemental payments for trauma care. The agency may adjust the enhancement percentage to ensure TCF expenditures do not exceed the amount appropriated to the agency for the state fiscal year.

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 the agency:

1) For "qualified" trauma care services. Qualified trauma care services are those that meet the ISS specified in subsection (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:

    (a) The follow-up surgical procedures are directly related to the qualifying traumatic injury.

    (b) The follow-up surgical procedures were planned during the initial acute episode of care (inpatient stay).

    (c) 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.

2) For hospital-based services only, except as specified in (4).

3) Only for trauma cases that meet the ISS of:

    (a) Thirteen or greater for an adult trauma patient (a client age 15 or older); or

    (b) Nine or greater for a pediatric trauma patient (a client younger than age 15); or

    (c) 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.

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 subsection (1) above, may be provided in other approved care settings, such as Medicare-certified ambulatory surgery centers.

5) At a rate determined by the agency. The enhanced rates are subject to the following limitations:

    (a) Laboratory and pathology charges are not eligible for enhanced payments from the TCF. Laboratory and pathology services are paid at the lesser of the agency's current FFS rate or the billed amount.

    (b) Technical component only (TC) charges for radiology services are not eligible for enhanced rates when billed by physicians. (These are facility charges.)

(c) 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. The agency 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, the agency 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 the agency. 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

The agency 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 one year** from the date of service on the initial claim. See WAC 182-502-0150(11).

A claim which included a trauma service may be submitted for adjustment beyond 365 calendar days when the reason for the adjustment request is other than TCF payment (e.g., adding lab procedures, correcting units of service).

> **Note:** The agency 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. Paper claims received outside of regular business hours get a Julian date stamp on the following business day. 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, the agency 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 14 years of age 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; and
  - ✓ External.
- The ISS values range from 1 to 75. Generally, a higher ISS indicates more serious injuries.

Additional Information

For information on the following:

Statewide trauma system
Designated trauma services
Trauma service designation
Trauma registry
Trauma Care Fund (TCF)

Go to:
Department of Health
Office of Community Health Systems at:
http://www.doh.wa.gov/PublicHealthandHealthcareProviders/EmergencyMedicalServicesEMSSystems/TraumaSystem.aspx

For information on **payment policy**, contact:

Office of Hospital Finance
Health Care Authority
(360) 725-1835

For information on a specific **trauma claim**, contact:

Customer Service Center
1-800-562-3022

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).

Oral Health

Access to Baby and Child Dentistry (ABCD) Program

What is the purpose of the ABCD program?

The purpose of the ABCD program is to increase access to preventive dental services for Medicaid-eligible infants, toddlers, and preschoolers five years of age and younger. To find out more about the ABCD program, visit Access to Baby & Child Dentistry.

What dental services are billable by primary care medical providers?

The agency pays primary care medical providers for delivering periodic oral evaluations, topical application of fluoride, and family oral health education as follows:

Payment CDT Code	ICD-9-CM Diagnosis Code	Description	Maximum Allowable Fee	Limitations
D0120	V20.2	Periodic oral evaluation	$29.46	*One periodic oral evaluation is allowed every six months through age 5 per provider, per client
D1206	V20.2	Topical application of fluoride varnish	$13.25	**Effective 1/1/2013.** **Up to 3 times in a 12-month period through age 6, per provider, per client; 2 times in a 12-month period for ages 7-18, per provider, per client.
D1208	V20.2	Topical application of fluoride	$13.25	**Up to 3 times in a 12-month period through age 6, per provider, per client; 2 times in a 12-month period for ages 7-18, per provider, per client.
D9999	V20.2	Family oral health education	$27.58	*One visit per day per family, per provider. Up to 2 visits in a 12-month period through age 5 per provider, per client.

* The agency pays only certified providers for these services.
See Training and Certification for more information on how to become certified.

** D1206 and D1208 are not allowed on the same day. The fluoride limit per provider, per client for D1206 and D1208 is the combined total of the two; not per code. The codes are considered equivalent and a total of 3 or 2 fluorides are allowed, not 3 or 2 of each.

Training and certification

To become trained and certified to provide the services in the table above, primary care medical providers must complete a class offered by Washington Dental Service Foundation (WDSF). The 1 ½ hour continuing medical education (CME) class is given in-office or in community settings and teaches providers to deliver the following preventive services:

- Links between oral health and total health.
- Oral health screening and risk assessment.
- Providing oral health education and anticipatory guidance to clients and families.
- Application of topical fluoride.
- Billing.
- Referrals for dental care.

Please contact WDSF at mcaplow@deltadentalwa.com or 206-473-9542 for questions about current certification or for scheduling certification training.

Dental disease prevention services

The agency pays enhanced fees to *certified* participating primary care medical providers for delivering the following services:

- **Periodic oral evaluations.**

- **Topical application of fluoride** (fluoride varnish).

- **Family oral health education.** An oral health education visit must include all of the following, when appropriate:

  - **"Lift Lip" training:** Show the parent(s)/guardian(s) how to examine the child using the lap position. Ask if the parent(s)/guardian(s) feel comfortable doing this once per month;

  - **Oral hygiene training:** Demonstrate how to position the child to clean the teeth. Record that this was demonstrated;

  - **Risk assessment for early childhood caries:** Assess the risk of dental disease for the child. Obtain a history of previous dental disease activity for this child and any siblings from the parent(s)/guardian(s). Also note the dental health of the parent(s)/guardian(s);

- **Dietary counseling:** Talk with the parent(s)/guardian(s) about the need to use a cup, rather than a bottle, when giving the child anything sweet to drink. Note that dietary counseling delivered;

- **Discussion of fluoride supplements:** Discuss fluoride supplements with the parent(s)/guardian(s). Let the parent/guardian know fluoride supplements are covered under the agency's Prescription Drug program. Fluoride prescriptions written by the primary care medical provider may be filled at any Medicaid-participating pharmacy. Ensure that the child is not already receiving fluoride supplements;

- **Documentation:** in the client's file or the client's designated adult member's (family member or other responsible adult) file to record the activities provided.

Oral Surgery

Services performed by a physician or dentist specializing in oral maxillofacial surgery

[WAC 182-535-1094, WAC 182-531-1025]

Provider requirements

[WAC 182-531-1025(2),(3),(4), (5)]

- 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 the agency.

- A health care provider providing oral or parenteral conscious sedation, or general anesthesia, must meet all of 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.

- Agency-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 Coverage Table. (See WAC 182-535-1070(3))

Oral surgery coverage table

The agency covers the following services:

Note: Dentists who specialize in oral maxillofacial surgery may also bill for performing the procedures listed in the Emergency Oral Health Benefit.

Procedure Code	PA?	Short Description
10060	N	Drainage of skin abscess
10120	N	Remove foreign body
10140	N	Drainage of hematoma/fluid
11000	N	Debride infected skin
11012	N	Deb skin bone at fx site
11042	N	Deb subq tissue 20 sq cm/<
11044	N	Deb bone 20 sq cm/<
11100	N	Biopsy, skin lesion
11101	N	Biopsy, skin add-on
11440	N	Exc face-mm b9+marg 0.5 < cm
11441	N	Exc face-mm b9+marg 0.6-1 cm
11442	N	Exc face-mm b9+marg 1.1-2 cm
11443	N	Exc face-mm b9+marg 2.1-3 cm
11444	N	Exc face-mm b9+marg 3.1-4 cm
11446	N	Exc face-mm b9+marg > 4 cm
11640	N	Exc face-mm malig+marg 0.5 <
11641	N	Exc face-mm malig+marg 0.6-1
11642	N	Exc face-mm malig+marg 1.1-2
11643	N	Exc face-mm malig+marg 2.1-3
11644	N	Exc face-mm malig+marg 3.1-4
11646	N	Exc face-mm mlg+marg > 4 cm
12001	N	Repair superficial wound(s)
12002	N	Repair superficial wound(s)
12004	N	Repair superficial wound(s)
12005	N	Repair superficial wound(s)
12011	N	Repair superficial wound(s)
12013	N	Repair superficial wound(s)
12014	N	Repair superficial wound(s)
12015	N	Repair superficial wound(s)
12016	N	Repair superficial wound(s)
12031	N	Intmd wnd repair s/tr/ext
12032	N	Intmd wnd repair s/tr/ext
12034	N	Intmd wnd repair s/tr/ext
12035	N	Intmd wnd repair s/tr/ext
12036	N	Intmd wnd repair s/tr/ext
12051	N	Intmd wnd repair face/mm

Procedure Code	PA?	Short Description
12052	N	Intmd wnd repair face/mm
12053	N	Intmd wnd repair face/mm
12054	N	Intmd wnd repair, face/mm
12055	N	Intmd wnd repair face/mm
12056	N	Intmd rpr face/mm 20.1-30.0
13121	N	Cmplx rpr s/a/l 2.6-7.5 cm
13122	N	Cmplx rpr s/a/l addl 5 cm/>
13131	N	Repair of wound or lesion
13132	N	Repair of wound or lesion
13133	N	Repair wound/lesion add-on
13150	N	Repair of wound or lesion
13151	N	Repair of wound or lesion
13152	N	Repair of wound or lesion
13153	N	Repair wound/lesion add-on
13160	N	Late closure of wound
14040	N	Skin tissue rearrangement
15120	N	Skn splt a-grft fac/nck/hf/g
15320	N	Apply skin allogrft f/n/hf/g
15576	N	Form skin pedicle flap
15732	N	Muscle-skin graft head/neck
17110	N	Destruct b9 lesion 1-14
20220	N	Bone biopsy, trocar/needle
20520	N	Removal of foreign body
20552	N	Inj trigger point 1/2 muscl
20605	N	Drain/inject, joint/bursa
20615	N	Treatment of bone cyst
20670	N	Removal of support implant
20680	N	Removal of support implant
20690	N	Apply bone fixation device
20692	N	Apply bone fixation device
20902	N	Removal of bone for graft
20926	N	Removal of tissue for graft
20955	N	Fibula bone graft, microvasc
20969	N	Bone/skin graft, microvasc
20970	N	Bone/skin graft, iliac crest
21010	N	Incision of jaw joint
21013	N	Exc face tum deep < 2 cm
21015	N	Resect face tum < 2 cm
21016	N	Resect face tum 2 cm/>
21025	N	Excision of bone, lower jaw
21026	N	Excision of facial bone(s)
21029	N	Contour of face bone lesion
21030	N	Excise max/zygoma b9 tumor
21034	N	Excise max/zygoma mlg tumor

Procedure Code	PA?	Short Description
21040	N	Excise mandible lesion
21044	N	Removal of jaw bone lesion
21045	Y	Extensive jaw surgery
21046	N	Remove mandible cyst complex
21047	N	Excise lwr jaw cyst w/repair
21048	N	Remove maxilla cyst complex
21049	N	Excis uppr jaw cyst w/repair
21050	Y	Removal of jaw joint
21060	Y	Remove jaw joint cartilage
21070	Y	Remove coronoid process
21073	N	Mnpj of tmj w/anesth
21076	Y	Prepare face/oral prosthesis
21077	Y	Prepare face/oral prosthesis
21079	Y	Prepare face/oral prosthesis
21080	Y	Prepare face/oral prosthesis
21081	Y	Prepare face/oral prosthesis
21082	Y	Prepare face/oral prosthesis
21083	Y	Prepare face/oral prosthesis
21084	Y	Prepare face/oral prosthesis
21085	Y	Prepare face/oral prosthesis
21086	Y	Prepare face/oral prosthesis
21087	Y	Prepare face/oral prosthesis
21088	Y	Prepare face/oral prosthesis
21089	Y	Prepare face/oral prosthesis
21100	N	Maxillofacial fixation
21110	N	Interdental fixation
21116	N	Injection, jaw joint x-ray
21120	Y	Reconstruction of chin
21121	Y	Reconstruction of chin
21122	Y	Reconstruction of chin
21123	Y	Reconstruction of chin
21141	Y	Reconstruct midface, lefort
21142	Y	Reconstruct midface, lefort
21143	Y	Reconstruct midface, lefort
21145	Y	Reconstruct midface, lefort
21146	Y	Reconstruct midface, lefort
21147	Y	Reconstruct midface, lefort
21150	Y	Reconstruct midface, lefort
21151	Y	Reconstruct midface, lefort
21154	Y	Reconstruct midface, lefort
21155	Y	Reconstruct midface, lefort
21159	Y	Reconstruct midface, lefort
21160	Y	Reconstruct midface, lefort
21193	Y	Reconst lwr jaw w/o graft

Procedure Code	PA?	Short Description
21194	Y	Reconst lwr jaw w/graft
21195	Y	Reconst lwr jaw w/o fixation
21196	Y	Reconst lwr jaw w/fixation
21198	Y	Reconstr lwr jaw segment
21206	Y	Reconstruct upper jaw bone
21208	Y	Augmentation of facial bones
21209	Y	Reduction of facial bones
21210	Y	Face bone graft
21215	Y	Lower jaw bone graft
21230	Y	Rib cartilage graft
21240	Y	Reconstruction of jaw joint
21242	Y	Reconstruction of jaw joint
21243	Y	Reconstruction of jaw joint
21244	Y	Reconstruction of lower jaw
21245	Y	Reconstruction of jaw
21246	Y	Reconstruction of jaw
21247	Y	Reconstruct lower jaw bone
21248	Y	Reconstruction of jaw
21249	Y	Reconstruction of jaw
21255	Y	Reconstruct lower jaw bone
21295	Y	Revision of jaw muscle/bone
21296	Y	Revision of jaw muscle/bone
21315	N	Closed tx nose fx w/o stablj
21320	N	Closed tx nose fx w/ stablj
21330	N	Open tx nose fx w/skele fixj
21337	N	Closed tx septal&nose fx
21338	N	Open nasoethmoid fx w/o fixj
21343	N	Open tx dprsd front sinus fx
21344	N	Open tx compl front sinus fx
21345	N	Treat nose/jaw fracture
21346	N	Treat nose/jaw fracture
21347	N	Treat nose/jaw fracture
21348	N	Treat nose/jaw fracture
21355	N	Treat cheek bone fracture
21356	N	Treat cheek bone fracture
21360	N	Treat cheek bone fracture
21365	N	Treat cheek bone fracture
21366	N	Treat cheek bone fracture
21386	N	Opn tx orbit fx periorbital
21387	N	Opn tx orbit fx combined
21390	N	Opn tx orbit periorbtl implt
21406	N	Opn tx orbit fx w/o implant
21407	N	Opn tx orbit fx w/implant
21421	N	Treat mouth roof fracture

Procedure Code	PA?	Short Description
21422	N	Treat mouth roof fracture
21423	N	Treat mouth roof fracture
21431	N	Treat craniofacial fracture
21432	N	Treat craniofacial fracture
21433	N	Treat craniofacial fracture
21435	N	Treat craniofacial fracture
21436	N	Treat craniofacial fracture
21440	N	Treat dental ridge fracture
21445	N	Treat dental ridge fracture
21450	N	Treat lower jaw fracture
21451	N	Treat lower jaw fracture
21452	N	Treat lower jaw fracture
21453	N	Treat lower jaw fracture
21454	N	Treat lower jaw fracture
21461	N	Treat lower jaw fracture
21462	N	Treat lower jaw fracture
21465	N	Treat lower jaw fracture
21470	N	Treat lower jaw fracture
21480	N	Reset dislocated jaw
21485	N	Reset dislocated jaw
21490	N	Repair dislocated jaw
21495	N	Treat hyoid bone fracture
21497	N	Interdental wiring
21550	N	Biopsy of neck/chest
21555	Y	Exc neck les sc < 3 cm
29800	Y	Jaw arthroscopy/surgery
29804	Y	Jaw arthroscopy/surgery
30580	N	Repair upper jaw fistula
30600	N	Repair mouth/nose fistula
31000	N	Irrigation, maxillary sinus
31030	N	Exploration, maxillary sinus
31032	N	Explore sinus remove polyps
31225	N	Removal of upper jaw
31502	N	Change of windpipe airway
31515	N	Laryngoscopy for aspiration
31525	N	Dx laryngoscopy excl nb
31530	N	Laryngoscopy w/fb removal
31600	N	Incision of windpipe
31603	N	Incision of windpipe
31830	Y	Revise windpipe scar
38510	N	Biopsy/removal lymph nodes
38700	N	Removal of lymph nodes neck
38724	N	Removal of lymph nodes neck
40490	N	Biopsy of lip

Procedure Code	PA?	Short Description
40510	N	Partial excision of lip
40700	N	Repair cleft lip/nasal
40701	N	Repair cleft lip/nasal
40702	N	Repair cleft lip/nasal
40720	Y	Repair cleft lip/nasal
40800	N	Drainage of mouth lesion
40801	N	Drainage of mouth lesion
40804	N	Removal, foreign body, mouth
40805	N	Removal, foreign body, mouth
40806	N	Incision of lip fold
40808	N	Biopsy of mouth lesion
40810	N	Excision of mouth lesion
40812	N	Excise/repair mouth lesion
40814	N	Excise/repair mouth lesion
40816	N	Excision of mouth lesion
40819	N	Excise lip or cheek fold
40830	N	Repair mouth laceration
40831	N	Repair mouth laceration
40840	N	Reconstruction of mouth
40842	N	Reconstruction of mouth
40845	Y	Reconstruction of mouth
41000	N	Drainage of mouth lesion
41005	N	Drainage of mouth lesion
41006	N	Drainage of mouth lesion
41007	N	Drainage of mouth lesion
41008	N	Drainage of mouth lesion
41009	N	Drainage of mouth lesion
41010	N	Incision of tongue fold
41015	N	Drainage of mouth lesion
41016	N	Drainage of mouth lesion
41017	N	Drainage of mouth lesion
41018	N	Drainage of mouth lesion
41100	N	Biopsy of tongue
41105	N	Biopsy of tongue
41108	N	Biopsy of floor of mouth
41110	N	Excision of tongue lesion
41112	N	Excision of tongue lesion
41113	N	Excision of tongue lesion
41114	N	Excision of tongue lesion
41115	N	Excision tongue fold
41116	N	Excision of mouth lesion
41120	N	Partial removal of tongue
41130	Y	Partial removal of tongue
41135	N	Tongue and neck surgery

Procedure Code	PA?	Short Description
41520	N	Reconstruction tongue fold
41530	Y	Tongue base vol reduction
41599	N	Tongue and mouth surgery
41800	N	Drainage of gum lesion
41805	N	Removal foreign body, gum
41821	N	Excision of gum flap
41822	N	Excision of gum lesion
41823	N	Excision of gum lesion
41825	N	Excision of gum lesion
41826	N	Excision of gum lesion
41827	N	Excision of gum lesion
41828	N	Excision of gum lesion
41830	N	Removal of gum tissue
41850	N	Treatment of gum lesion
41899	Y	Dental surgery procedure
42100	N	Biopsy roof of mouth
42104	N	Excision lesion, mouth roof
42106	N	Excision lesion, mouth roof
42180	Y	Repair palate
42182	Y	Repair palate
42200	N	Reconstruct cleft palate
42205	N	Reconstruct cleft palate
42210	N	Reconstruct cleft palate
42215	N	Reconstruct cleft palate
42220	N	Reconstruct cleft palate
42225	N	Reconstruct cleft palate
42226	Y	Lengthening of palate
42227	Y	Lengthening of palate
42235	Y	Repair palate
42260	N	Repair nose to lip fistula
42280	N	Preparation, palate mold
42281	N	Insertion, palate prosthesis
42330	N	Removal of salivary stone
42335	N	Removal of salivary stone
42405	N	Biopsy of salivary gland
42408	N	Excision of salivary cyst
42409	N	Drainage of salivary cyst
42440	N	Excise submaxillary gland
42450	N	Excise sublingual gland
42500	N	Repair salivary duct
42505	N	Repair salivary duct
42600	N	Closure of salivary fistula
42700	N	Drainage of tonsil abscess
42720	N	Drainage of throat abscess

Procedure Code	PA?	Short Description
42725	N	Drainage of throat abscess
43200	N	Esophagus endoscopy
64400	N	N block inj trigeminal
64600	Y	Injection treatment of nerve
64774	N	Remove skin nerve lesion
64784	N	Remove nerve lesion
64788	N	Remove skin nerve lesion
64790	N	Removal of nerve lesion
64792	N	Removal of nerve lesion
64795	N	Biopsy of nerve
64864	N	Repair facial nerve
64910	N	Nerve repair w/allograft
70300	N	X-ray exam of teeth
70310	N	X-ray exam of teeth
99201	N	Office/outpatient visit, new*
99202	N	Office/outpatient visit, new*
99203	N	Office/outpatient visit new*
99204	N	Office/outpatient visit new*
99205	N	Office/outpatient visit new*
99211	N	Office/outpatient visit, est*
99212	N	Office/outpatient visit est*
99213	N	Office/outpatient visit est*
99214	N	Office/outpatient visit est*
99215	N	Office/outpatient visit est*
99231	N	Subsequent hospital care*
99232	N	Subsequent hospital care*
99233	N	Subsequent hospital care*
99241	N	Office consultation*
99243	N	Office consultation*
99245	N	Office consultation*
99251	N	Inpatient consultation*
99253	N	Inpatient consultation*

*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 form;
- Services must be billed using one of the CPT codes above and modifiers must be used if appropriate.

Emergency Oral Health (EOH)

When does the agency pay for EOH services?

[WAC 182-531-0125(1)]

The agency pays for oral health care services provided by a dentist for clients 21 years of age and older when the services provided are:

- Within the scope of the eligible client's medical care program.
- Medically necessary as defined in WAC 182-500-0070;
- Emergency services and meet the criteria of coverage for emergency oral health care benefit.
- Documented in the client's record in accordance with Chapter 182-502 WAC.
- Prior authorized, if required.
- Within prevailing standard of care accepted practice standards.
- Consistent with a diagnosis of teeth, mouth and jaw disease or condition.
- Reasonable in amount and duration of care, treatment, or service.
- Billed using only the allowed procedure codes listed in this provider guide and the Physician-Related Services/Health Care Professionals Fee Schedule.
- Documented in the client's record with a comprehensive description of the presenting symptoms, diagnosis and services provided and including the following, as applicable:
    - ✓ The client's blood pressure, when appropriate;
    - ✓ A surgical narrative;
    - ✓ A copy of the postoperative instructions; and
    - ✓ A copy of all preoperative and postoperative prescriptions.

When does the agency deny a request for EOH services?

The agency denies a request for an emergency oral healthcare service when the requested service:

- Is not covered in the client's healthcare benefit package;
- Is covered by another agency program;

- Is covered by an agency or other entity outside the agency; or
- The service fails to meet the clinical criteria, limitations, or restrictions for EOH.

What services are covered under the EOH benefit?

[WAC 182-531-1025(7)]

Medical and surgical services provided by a doctor of dental medicine or dental surgery, which, if provided by a physician, are considered a physician service, are included in the emergency oral health care benefit when the services are done on an emergency basis. All services are subject to prior authorization when indicated.

The following set of services are covered under the emergency oral health benefit when provided by a dentist to **assess and treat pain, infection, or trauma** of the mouth, jaw, or teeth, **including treatment of post-surgical complications**, such as dry socket and **services that are part of a cancer treatment regimen, or part of a pretransplant protocol**:

- **Emergency examination (CDT: D0140):** Limited to one examination allowed per presenting problem, performed as a limited oral evaluation to:
  - ✓ Evaluate the client's symptom of pain;
  - ✓ Make a diagnosis; and
  - ✓ Develop or implement a treatment plan, including a referral to another healthcare professional, such as an oral surgeon; or
  - ✓ **A second evaluation** if the treatment initiated is conservative, such as prescribed antibiotics, and a subsequent visit is necessary for definitive treatment, such as tooth extraction. The treatment plan must be documented in the client's record.
- **Diagnostic radiographs (x-rays) (CDT: D0220, D0230, D0330).**
  - ✓ Radiographs include:
    - ➢ Periapical; and
    - ➢ Panoramic films, limited to one every three years.
  - ✓ Radiographs must:
    - ➢ Be required to make the diagnosis;
    - ➢ Support medical necessity;
    - ➢ Be of diagnostic quality, dated and labeled with the client's name; and
    - ➢ Be retained by the provider as part of the client's record. The radiograph retained in the client's record must be the original.

Note: Duplicate radiographs must be submitted with prior authorization requests or when the agency requests a copy of the client's dental record.

- **Pulpal debridement (CDT: D3221).** Limited to one (1) gross pulpal debridement, per client, per tooth, within a 12-month period.

- **Extractions and surgical extractions for symptomatic teeth (CDT: D7140, D7210, D7220, D7230, D7240, D7241, D7250).** Limited to:

  - ✓ Extraction of a nearly erupted or fully erupted tooth or exposed root;
  - ✓ Surgical removal of an erupted tooth only;
  - ✓ Surgical removal of residual tooth roots; and
  - ✓ Extraction of an impacted wisdom tooth when the tooth is not erupted.

- **Incision and drainage of abscess (CDT: D7510, D7520)** for treatment of dental pain or infection. Uncomplicated dental-related intraoral and extraoral soft tissue incision and drainage of abscess. The agency does not cover this service when combined with an extraction or root canal treatment. Do not bill drainage of abscess in conjunction with palliative treatment.

- **Palliative (emergency) treatment (CDT: D9110)** for the treatment of dental pain, during a limited oral evaluation appointment. Limited to one per client, per six-month period.

- **Local anesthesia and regional blocks** as part of the global fee for any procedure provided to an eligible client.

- **Inhalation of nitrous oxide (CDT: D9230):** Limited to once per day.

- **House or extended care facility visits (CDT: D9410),** for emergency care, up to two house/extended care facility calls (visits) per facility, per provider.

- **Hospital call (CDT: D9420)** – Limited to one hospital call (visit), including emergency care, per day, per provider, per client, and not in combination with a surgical code unless the decision for surgery is a result of the visit.

- **Emergency office visits after regularly scheduled hours (CDT: D9440).** Limited to one emergency visit per day, per provider.

- **Therapeutic drug injections (CDT: D9610)** including drugs and/or medicaments (pharmaceuticals) only when used with general anesthesia.

- **Treatment of post-surgical complications, such as dry socket (CDT: D9930).**

EOH coverage table

(Infection, pain, trauma, cancer treatment regimen, and protocol of joint replacement)

The agency covers the procedure codes in the following table when performed by a dentist to treat an acute oral health emergency.

CDT Code	PA?	Description
D0140	N	Limit oral eval problm focus
D0220	N	Intraoral periapical first
D0230	N	Intraoral periapical ea add
D0330	N	Panoramic image
D3221	N	Gross pulpal debridement
D7140	N	Extraction erupted tooth/exr
D7210	N	Rem imp tooth w mucoper flp
D7220	N	Impact tooth remov soft tiss
D7230	N	Impact tooth remov part bony
D7240	N	Impact tooth remov comp bony
D7241	Y	Impact tooth rem bony w/comp
D7250	N	Tooth root removal
D7510	N	I&d absc intraoral soft tiss
D7520	N	I&d abscess extraoral
D9110	N	Tx dental pain minor proc
D9230	N	Analgesia
D9410	N	Dental house call
D9420	N	Hospital/ASC call
D9440	N	Office visit after hours
D9610	N	Dent therapeutic drug inject
D9930	N	Treatment of complications

In addition to the codes above, the following set of services are covered under the emergency oral health care benefit **when provided by a dentist** to assess and treat conditions of the mouth, jaw, or teeth as part of a **cancer treatment regimen**, part of a **pretransplant protocol**, or **major joint replacements**. Other conditions will be considered on a case-by-case basis with prior authorization.

- **Comprehensive oral evaluation (CDT D0150):** Limited to one per client, per provider/clinic, when performed as a comprehensive oral evaluation to:
  - ✓ Evaluate the client's symptom of pain;
  - ✓ Make a diagnosis; and
  - ✓ Develop or implement a treatment plan, including a referral to another health care professional, such as an oral surgeon.

- **Radiographs (x-rays) (CDT D0210, D0270, D0272, D0273, D0274)**:

  - ✓ An intraoral complete series, once in a three-year period only if the agency has not paid for a panoramic X-ray for the same client in the same three-year period. The intraoral complete series includes 14-22 periapical and posterior bitewings. The agency limits reimbursement for all x-rays to a total payment of no more than the payment for a complete series.

  - ✓ Medically necessary periapical X-rays that are not included in a complete series for diagnosis in conjunction with definitive treatment, such as root canal therapy. Documentation supporting medical necessity must be included in the client's record.

  - ✓ An occlusal intraoral X-ray once in a two-year period, for clients 20 years of age and younger.

  - ✓ A maximum of four bitewing X-rays (once per quadrant) once every 12 months.

- **Prophylaxis – Adult (CDT D1110):** Limited to one every 12 months, per client, to ensure client is infection-free.

- **Periodontal scaling and root planing (CDT D4341, D4342):** Limited to once per quadrant, per client, in a two-year period for clients 19 years of age and older and only when:

  - ✓ The client has X-ray evidence of periodontal disease.

  - ✓ The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease.

  - ✓ The client's clinical condition meets current published periodontal guidelines.

  - ✓ Performed at least two years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment.

  The agency considers ultrasonic scaling, gross scaling, or gross debridement to be included in the procedure and not a substitution for periodontal scaling and root planing.

  The agency pay for periodontal scaling and root planing only when the services are not performed on the same date of service as prophylaxis, periodontal maintenance, gingivectomy, or gingivoplasty.

- **Perdiodontal Maintenance (D4910):** Limited to once per client in a 12 month period for clients 19 years of age and older only when:

- ✓ The client has X-ray evidence of periodontal disease.
- ✓ The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease.
- ✓ The client's clinical condition meets current published periodontal guidelines.
- ✓ The client has had periodontal scaling and root planing after but not within 12 months from the date of completion of periodontal scaling and root planing, or surgical periodontal treatment.

The agency pays for periodontal maintenance only if performed at least 12 calendar months after receiving prophylaxis, periodontal scaling and root planing, gingivectomy, or gingivoplasty.

- **Complete Dentures (D5110 and D5120)**: The agency covers complete dentures, as follows:
  - ✓ A complete denture, including an overdenture, when prior authorized and meets the agency's coverage criteria.
  - ✓ Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat (placement) date of the complete denture is considered part of the complete denture procedure and is not paid separately.
  - ✓ Replacement of an immediate denture with a complete denture, if the complete denture is prior authorized at least six months after the seat date of the immediate denture.
  - ✓ Complete dentures are limited to:
    - One initial maxillary complete denture and one initial mandibular complete denture per client, per the client's lifetime.
    - One replacement maxillary complete denture and one replacement mandibular complete denture per client, per the client's lifetime.
- Replacement of a complete denture or overdenture only if prior authorized, and only if the replacement occurs at least five years after the seat date of the complete denture or overdenture being replaced. The replacement denture must be prior authorized.

EOH coverage table

(Cancer, pretransplant or joint replacement)

CDT Code	PA?	Description
D0150	N	Comprehensive oral evaluation – new or established patient
D0210	N	Intraoral – complete series (including bitewings)
D0270	N	Bitewing – single film
D0272	N	Bitewing – two films
D0273	N	Bitewing – three films
D0274	N	Bitewing – four films
D1110	N	Prophylaxis – adult
D4341	N	Periodontal scaling and root planning – four or more teeth per quadrant
D4342	N	Periodontal scaling and root planning – one to three teeth per quadrant
D4910	N	Periodontal maintenance
D5110*	Y	Complete denture – maxillary
D5120*	Y	Complete denture – mandibular

Will only be considered for those clients who have lost their teeth as a result of cancer treatment.

Note: All of the previous authorization requirements related to the procedure code or the site of service have not changed.

Why is an EPA number required when billing for EOH services?

Providers must use Expedited Prior Authorization (EPA) numbers at the claim level to certify that the services provided meet the qualifications of the emergency oral health benefit. Failure to bill with an EPA number will result in claim denial.

The use of EPA numbers does not override the need for site-of-service authorization. For service provided in other than an office setting, prior authorization is still required.

- To bill for services that are for pain, infection, or trauma use EPA number **870000002** at the header level.

- To bill for services that are part of a cancer treatment regimen or part of a pre-transplant protocol, use EPA number **870000003** at the header level.

Note: Failure to bill with the appropriate EPA number at the header level will result in claim denial.

When is a signed waiver form required from the client?

- When the client chooses to pay for a service that Medicaid excludes from the client's benefit package, a waiver **IS NOT** required. Refer to WAC 182-502-0160, Billing a Client, for details about billing for excluded services.

- When the client chooses not have a treatment Medicaid covers, but prefers to pay for an excluded or noncovered treatment, a waiver **IS** required. Refer to WAC 182-502-0160, Billing a Client, for details.

Note: Excluded services are not subject to exception to rule (ETR).

How does the agency determine prior authorization for EOH?

The agency uses the determination process described in WAC 182-501-0165 for covered oral healthcare services for clients age 21 and older for a condition resulting in emergency care that requires prior authorization (PA).

What documentation must be submitted with a prior authorization request for EOH?

[WAC 182-531-1025(8)]

The agency requires a dental provider who is requesting PA to submit sufficient objective clinical information to establish medical necessity. Submission of an authorization request must be in writing on the General Information for Authorization form, 13-835.

The agency may request additional information as follows:

- Additional radiographs (X rays).
- Study models.
- Photographs.
- Any other information as determined by the agency.

The agency may also require second opinions and/or consultations before authorizing any procedure.

When the agency authorizes an oral health care service for a client, that authorization indicates only that the specific service is medically necessary and an emergency and is not a guarantee of payment.

Note: The authorization is valid for six months **and only if the client is eligible and the service is covered** in the client's health care benefit package on the date of service.

Prosthetic/Orthotics

Prosthetic & orthotics for podiatry and orthopedic surgeons only

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 shoe	
L3170	Foot plastic heel stabilizer	PA required
L3215	Orthopedic ftwear ladies oxf	EPA required. Noncovered for clients age 21 years of age and older
L3219	Orthopedic mens shoes oxford	EPA required. Noncovered for clients age 21 years of age and older
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
L4380	Pneumatic knee splint	
L4386	Non-pneum walk boot prefab	PA required

(For authorization requirements, follow the Prosthetic and Orthotic Devices Medicaid Provider Guide.)

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

Casting materials

Bill the appropriate HCPCS code (Q4001-Q4051) for fiberglass and plaster casting materials limited to one unit per limb per day. Do not bill for the use of a cast room. Use of a cast room is considered part of a provider's practice expense.

Inhalation solutions

Refer to the Injectable 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 & orthotics

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

HCPCS Code	Short Description
L8000	Mastectomy bra
L8010	Mastectomy sleeve
L8600	Implant breast silicone/eq

For additional information and authorization requirements, please see the agency's Prosthetic & Orthotic Devices Medicaid Provider Guide.

Miscellaneous Supplies

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

Radiopharmaceutical diagnostic imaging agents

Refer to the Injectable Drugs Fee Schedule for those specific codes for imaging agents that are paid separately.

Urinary tract implants

See important policy limitations in Surgery - 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.

Medical Necessity Review by Qualis Health

What is a medical necessity review by Qualis Health?

The Agency contracts with Qualis Health to provide web-based access for reviewing medical necessity for:

- Outpatient advanced imaging services
- Select surgical procedures
- Outpatient advanced imaging
- Spinal injections, including diagnostic selective nerve root blocks

Qualis Health conducts the review of the request to establish medical necessity, but **does not** issue authorizations. Qualis Health forwards its recommendations to the agency for final authorization determination. The procedure codes that require review by Qualis Health can be found in the Physician-Related/Professional Health Care Services fee schedule.

> **Note:** This process through Qualis Health is for 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 Qualis Health. If initiating the request for authorization, the physician must include the name and billing NPI of the facility where the procedure will be performed. If a facility is requesting the authorization, the request must include the name and billing NPI of the physician performing the procedure.

> **Note:** Billing entities such as clearinghouses ***do not*** request authorization through Qualis Health or the agency.

How do I register with Qualis Health?

In order to submit requests to Qualis Health, providers must:

- Register as a provider through OneHealthPort.
- Register with Qualis Health iEXCHANGE® as a Washington State Medicaid provider. (For questions about the iEXCHANGE® process, contact Qualis Health's iEXCHANGE® help line at 1-888-213-7513).
- Be familiar with the criteria that will be applied to requests.
- Use iEXCHANGE® upon completion of the registration process and receipt of logon and password information.

For more information about the web-based utilization review, see iExchange®.
Qualis offers on-line training and a printable WA Medicaid Training Manuals.
Note: A username and password is needed for Washington State Medicaid even if a provider is already a registered provider with Washington State Labor and Industries.

Is authorization required for all Medicaid clients?

No. Authorization through Qualis Health is required ONLY for Medicaid clients who are currently eligible and enrolled in fee-for-service as the primary insurance.

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; or
- Medicaid through the Emergency Related Services Only (ESRO)-non-citizen program. **Exception:** Submit surgical authorization requests for clients covered by ERSO when the client is:

*Being treated for cancer or end stage renal disease (see WAC 182-507-0120); or
*Living in a nursing home (see WAC 182-507-0125).

If one of the above applies, the agency will reject the request for authorization regardless of Qualis Health's medical necessity determination.

REMINDER: Check client eligibility before submitting a request!

An agency 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 Qualis 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 Qualis Health.

Fax or Telephone Option Through Qualis Health

Fax and telephone requests are **only** available 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 Qualis Health. Once supporting documentation is received, Qualis Health will open a case in their system by:

- Entering the information; and
- Responding to the provider with a Qualis Health reference number.

Once all necessary clinical information is received (either electronically or via fax), Qualis Health staff will:

- Conduct the medical necessity review; and
- Forward a recommendation to the agency.

Qualis Health will process telephone and fax requests during normal business hours. Faxed requests can be sent at any time and Qualis Health will process them the following business day.

Qualis Health provides the following toll-free numbers:

- WA Medicaid (phone) 888-213-7513
- WA Medicaid (fax) 888-213-7516

What is the Qualis Health reference number for?

Upon successful submission of a request through iEXCHANGE® or when a request has been faxed to Qualis Health, a provider will receive a 9-digit Qualis Health reference number starting with the prefix 913 (e.g. 913-xxx-xxx). The Qualis Health reference number provides verification that Qualis Health reviewed the request.

A **Qualis 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 agency-issued ProviderOne authorization number is received. The agency approves or denies authorization requests based on recommendations from Qualis Health.

For questions regarding the status of an authorization, need to update an authorization, or have general questions regarding an authorization, please contact the agency at 1- 800-562-3022, ext. 52018.

Note: The agency has 15 calendar days from the time Qualis Health receives a request for authorization to provide a written determination.

When does the agency consider retroactive authorizations?

The agency considers retroactive authorization when the following applies:

- 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; or
- 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 Qualis 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 Qualis Health and can be printed out for provider convenience.

Some radiology codes continue to require prior authorization (PA) from the agency, but not from Qualis Health. Please check the Physician-Related/Professional Services Fee Schedule.

Note: The PA requirement is for diagnostics provided as urgent and scheduled. The agency 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 the agency's hierarchy of evidence protocol apply?

The criteria in the online Qualis Health questionnaires represent "B" level of evidence under WAC 182-501-0165. In other words, this represents the clinical/treatment guideline* the agency 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); or

- Singular Type II, III, or IV evidence in combination with agency-recognized:

  - ✓ Clinical guidelines*; or
  - ✓ Treatment pathways*; or
  - ✓ 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, the agency'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 Qualis Health.

Surgical services require agency authorization regardless of place of service or when performed as:

- Urgent;
- An emergency; or
- A scheduled surgery.

If the client is younger than 21 years of age, prior authorization for the surgical procedure may not be required. Refer to the Physician-Related/Professional Services Fee Schedule to determine if a procedure is exempt by client's age.

Surgical Modifiers

Co-Surgeons, Assistants, Team Surgeries, and other surgical modifiers

When requesting an authorization for any surgical procedure requiring a medical necessity review by Qualis Health, please 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 Fact Sheet or CMS's Claims Processing Manual for Physicians/Nonphysician Practitioners.

When submitting an authorization request for a surgical service that requires additional surgeons, please include the following on the request:

- The appropriate modifier(s);
- If available, each surgeon's billing NPI; and
- Clinical justification for an assistant surgeon, co-surgeon, or surgical team.

Enter the information above in the "Communication" box when:

- The case is loaded through Qualis Health iEXCHANGE®; or
- Submitted by fax, on the request for surgical authorization form.

How does the agency's hierarchy of evidence protocol apply?

Hierarchy of Evidence (See WAC 182-501-0165)

The agency recognizes the criteria described as "B" level of evidence.
If the request meets medical necessity criteria, the request will be approved.

What criteria will Qualis Health use to establish medical necessity?

The agency has instructed Qualis Health to use the following surgical procedure criteria to establish medical necessity:

- Health Technology Assessment (HTA) Program*;
- Labor and Industries (LNI); or
- InterQual criteria.

Exceptions: *Medicaid does not require clients to participate in a structured, intensive, multi-disciplinary program (SIMP) as required in the HTA's decision for spinal fusion and artificial disc replacement surgery.

If there is an applicable HTA criterion, the criterion will serve as the benchmark for the medical necessity review. If there are no HTA 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 Qualis Health?

Yes. If the agency denies authorization as a result of a recommendation from Qualis Health, Qualis Health offers providers an appeal process. Request an appeal as follows:

- Prepare a written request for appeal to Qualis Health indicating the Qualis Health reference number (starting with 913…) for which the appeal is requested; and
- Fax the request for appeal along with any appropriate clinical notes, laboratory, and imaging reports to be considered with the appeal to Qualis 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 Qualis 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, Qualis 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 Qualis Health's provider appeal process is available online at Qualis Health (Washington State Medicaid).

If Qualis Health ultimately recommends the authorization be denied ***and*** Washington Medicaid agrees, the client has the right to appeal to the Administrative Hearings Office.

Authorization

[WAC 182-531-0200]

Authorization is the agency'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 prior authorization.**

Prior authorization

What is prior authorization (PA)?

The prior authorization (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. The agency reviews requests for payment for noncovered healthcare services according to WAC 182-501-0160 as an exception to rule.

For psychiatric inpatient authorizations, see the agency's Inpatient Hospital Billing Medicaid Provider Guide, Section F.

The agency's authorization requirements are met through the following authorization processes:

- Written/fax prior authorization;
- Expedited prior authorization (EPA); and
- Limitation extensions (LE).

> **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 prior authorization, see Authorization for Services.

How does the agency determine PA?

The agency reviews PA requests in accordance with WAC 182-501-0165. The agency utilizes evidence-based medicine to evaluate each request. The agency 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 and/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, the agency reviews all evidence submitted and will do one of the following:

- Approve the request;
- Deny the request if the requested service is not medically necessary; or
- Request the provider to submit additional justifying information within 30 days. When the additional information is received, the agency 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, the agency will deny the requested service.

When the agency denies all or part of a request for a covered service or equipment, the agency 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 the agency 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 the agency's action was taken;
- Is in sufficient detail to determine what additional or different information might be provided to challenge the agency'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; and
- Includes example(s) of lesser cost alternatives that permit the affected party to prepare an appropriate response.

Services requiring prior authorization (PA)

[WAC 182-531-0200 (4)-(6)]

The agency requires prior authorization for the following:

- Abdominoplasty.
- Bariatric surgery.
- BRA tests (CPT codes 81206 – 81217).
- Eating disorders (diagnosis and treatment for clients 21 years of age and older);
- Elective surgical procedures (the agency may require a second opinion and/or consultation before authorizing).

When requesting surgery, please 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 Fact Sheet or CMS's Claims Processing Manual for Physicians/Nonphysician Practitioners.

- Hysterectomies and other surgeries of the uterus – see fee schedule for codes requiring PA. This policy applies to all ages.
- Inpatient hospital stays for acute physical medicine and rehabilitation (PM&R).
- Mometasone sinus implant (S1090).
- Oncotype DX - S3854.
- Osseointegrated/bone anchored hearing aids (BAHA) (for clients 20 years of age and younger).
- Osteopathic manipulative therapy (in excess of the agency's published limits).
- Other Genetic Testing (CPT codes 81321-81323, 81201-81203).
- Panniculectomy.
- Removal or repair of previously implanted BAHA or cochlear device for clients 21 years of age and older when medically necessary.
- Transplj hematopoietic boost (CPT code 38243).
- Unilateral cochlear implants (for clients 20 years of age and younger).
- Vagus nerve stimulator insertion.

  For coverage, vagus nerve stimulator insertion must be performed in an inpatient or outpatient hospital facility and for reimbursement, provides must attach the invoice to the claim.

- Intensity Modulated Radiation Therapy (IMRT)

  When requesting IMRT, providers must submit an initial request for treatment planning (CPT code 77301) to the agency. Once a treatment plan is established, the number of treatment units needed must be submitted to the existing prior authorization number using the process below. The agency expedites requests for treatment planning.

  To submit additional information to a request, use the following instructions:

  ✓ Go to Document Submission Cover Sheets

  ✓ Scroll down and click on number 7. 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.

  TIP – The ProviderOne authorization number for this type of request can be found using the ProviderOne authorization inquiry feature. The ProviderOne

authorization number is listed above the client's ID number on the PA Utilization screen.

- ✓ Print the Pend form and use it as the cover sheet to attach the additional information.
- ✓ Fax all pages to the agency using the fax number on the bottom of the Pend form.

Note: The Pend form MUST be the first page of the fax.

Submit a new treatment request only when:

- ✓ 6 months has elapsed since the last request; or
- ✓ The treatment plan has changed.

- The following surgical procedure codes require prior authorization (PA) through the agency:

Procedure 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 the following:

1. Use General Information for Authorization form, 13-835.
2. One authorization request per client.
3. Attach one Basic Information form, 13-756 for each surgeon.
4. Be sure to include appropriate modifier(s).
5. Indicate in box 30 this is for co-surgeon, surgical team, or surgical assistant; and
6. List each surgeon’s billing NPI on the appropriate forms.

Documentation for prior authorization

Authorization Documentation	
How do I obtain prior authorization or a limitation extension?	For all requests for prior authorization or limitation extensions, 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 Basic Information Form, 13-756, if there is not a form specific to the service being requested, and all the documentation is listed on this form with any other medical justification. Fax the request to: 1-866-668-1214. See the agency's Resources Available web page.

Forms Available to Submit Authorization Requests

- Botulinum Toxin Provider Questionaire, 13-003
- Application for Chest Wall Oscillator, 13-841
- Bariatric Surgery Request Form, 13-785
- Fax/Written Request Basic Information Form, 13-756
- Insomnia Referral Worksheet, 13-850
- Oral Enteral Nutrition Worksheet, 13-743
- Out of State Medical Services Request Form, 13-787

Forms Available to Submit Authorization Requests for Medication

- Acetaminophen Injection, J0131, use Basic Information form, 13-756
- Alglucosidase alfa (lumizyme) 10 mg, J0221, use Basic Information form, 13-756
- Belimumab injection, J0490, use Basic Information form, 13-756
- Cimzia (Certolizumab pegol Inj.), J0718, use Request form, 13-885
- Ceftaroline fosamil injection, J0712, use Basic Information form, 13-756
- Ipilimumab injection, J9228, use Basic Information form, 13-756
- Mannitol for inhaler, J7665, use Basic Information form, 13-756
- Pegloticase injection, J2507, use Basic Information form, 13-756
- Photofrin (Porfimer Sodium Inj.) 75mg, J9600, use Basic Information form, 13-756
- Prolia (Denosumab Inj.), J0897, use Basic Information form, 13-756
- Tysabri (Natalizumab Inj.) J2323, use Request form, 13-832

Written or fax prior authorization (PA)

Written or fax PA is an authorization process available to providers when a procedure's EPA criteria have not been met or the covered procedure requires PA. Procedures that require PA are listed in the fee schedule. The agency does not retrospectively authorize any healthcare services that require PA after they have been provided except when a client has delayed certification of eligibility.

When submitting an authorization request, provide the following documentation:

- General Information for Authorization form, 13-835. This form must be page one of the mailed/faxed request and must be typed.
- The program form. This form must be attached to the request.
- Charts and justification to support the request for authorization.

Submit prior authorization requests (with forms and documentation) to:

- **By Fax:** 1-866-668-1214.

- **By Mail:**
  Authorization Services Office
  PO Box 45535
  Olympia, WA 98504-5535

For a list of forms and where to send them, please refer to Documentation for Prior Authorization**.** Be sure to complete all information requested. The agency returns incomplete requests to the provider.

Submission of photos and x-rays for medical and DME requests

For submitting photos and x-rays for medical and DME requests, use the FastLook™ and FastAttach™ services provided by Medical Electronic Attachment, Inc. (MEA).

Register with MEA by:

- Going to www.mea-fast.com/.
- Selecting Provider Registration (on the menu bar below the banner).
- Entering "FastWDSHS" in the blue promotional code box.

Contact MEA at 1-888-329-9988, ext. 2, with any questions.
When this option is chosen, fax the request to the agency and indicate the MEA# in the NEA field (box 18) on the PA Request Form. *There is an associated cost, which will be explained by the MEA services.*

Note: See the agency's ProviderOne Billing and Resource Guide for more information on requesting authorization.

Limitation extension (LE)

What is an LE?

LE is an authorization of services beyond the designated benefit limit allowed in Washington Administration Code (WAC) and agency Medicaid provider guides.

Note: A request for a limitation extension 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 Coding List for criteria. If the EPA process is not applicable, an LE must be requested in writing and receive agency approval prior to providing the service.

The written request must state all of the following:

1. The name and ProviderOne Client ID of the client;
2. The provider's name, ProviderOne Client ID, and fax number;
3. Additional service(s) requested;
4. The primary diagnosis code and CPT code; and
5. Client-specific clinical justification for additional services.

For a list of forms and where to send them, refer to Resources Available.

Expedited prior authorization (EPA)

EPA is designed to eliminate the need for written authorization. The agency establishes authorization criteria and identifies the criteria with specific codes, enabling providers to create an EPA number using those codes.

To bill the agency for diagnostic conditions, procedures and services that meet the EPA criteria on the following pages, the provider must **create a 9-digit EPA number.** The first five or six digits of the EPA number must be **870000**. The last 3 or 4 digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria (see EPA Criteria Coding

List for codes). Enter the EPA number on the billing form in *the authorization number field*, or in the *Authorization or Comments* section when billing electronically.

Example: The 9-digit authorization number for a client with the following criteria would be **870000421:**

Client is 11 years of age through 55 years of age and is in one of the "at risk" groups because the client meets one of the following:

1) Has terminal complement component deficiencies;
2) Has anatomic or functional asplenia;
3) Is a microbiologist who is routinely exposed to isolates of ***Neisseria meningitidis***; or
4) Is a freshman entering college who will live in a dormitory.

870000 = first six digits of all expedited prior authorization numbers. **421**= last three digits of an EPA number indicating that the above criteria is met.

The agency denies claims submitted without a required EPA number.

The agency 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 the agency on request. If the agency determines the documentation does not support the criteria being met, the claim will be denied.

Note: The agency requires written/fax PA when there is no option to create an EPA number.

Expedited prior authorization guidelines

Documentation

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 the agency's request. If the agency 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 the Enteral Nutrition Medicaid Provider Guide.

Expedited Prior Authorization Criteria Coding List

The first five or six digits of the EPA number must be **870000**. The last 3 or 4 digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria

EPA Code	Service Name	CPT/HCPCS/ Dx Code	Criteria
047	Office visit related to prescribing Acomprosate (Campral®) for alcohol dependency.	**CPT:** 99201-99215 **Dx:** 303.90 to 303.93	Clients must be enrolled in DBHR-certified treatment
048	Office visit related to prescribing Naltrexone (ReVia®) for alcohol or opiate dependency.	**CPT:** 99201-99215 **Dx:** 303.90 to 303.93; 304.00-304.03	Clients must be enrolled in DBHR-certified treatment
049	Office visit related to administering Naltrexone (ReVia®) for alcohol or opiate dependency.	**CPT:** 99201-99215 **Dx:** 303.90 to 303.93; 304.00-304.03	Clients must be enrolled in DBHR-certified treatment
050	Office visit related to prescribing buprenorphine and naloxone (SUBOXONE®) opiate dependency. Drug Screening related to prescribing buprenorphine and naloxone (SUBOXONE®) opiate dependency.	**CPT:** 99201-99215 **Dx:** 304.00-304.03 Drug Screening: **HCPCS code** G0431 QW – limited to one per day and **CPT:** 80102. **Dx:** 304.00-304.03	The provider must be certified and approved to prescribe Buprenorphine-Suboxone. The provider must have a CLIA waiver Urine drug screens for benzodiazepines, amphetamine/methamphetamine, cocaine, methadone, opiates, and barbiturates must be done before each prescription is dispensed during the first month of therapy. Clients must be enrolled in DBHR-certified treatment

EPA Code	Service Name	CPT/HCPCS/ Dx Code	Criteria
051	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral, retina.	**CPT:** 92134	Effective 1/1/2012. 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 Code	Service Name	CPT/HCPCS/ Dx Code	Criteria
241	Reduction Mammoplasties/ Mastectomy for Gynecomastia	**CPT:** 19318, 19300 **Dx**: 611.1 and 611.9 only	A female with a diagnosis for ***hypertrophy of the breast*** with: 1) Photographs in client's chart, *and* 2) Documented medical necessity including: a) Back, neck, and/or shoulder pain for a minimum of one year, directly attributable to macromastia, *and* b) Conservative treatment not effective; *and* 3) Abnormally large breasts in relation to body size with shoulder grooves, *and* 4) Within 20% of ideal body weight, *and* 5) Verification of minimum removal of 500 grams of tissue from each breast.
242	Reduction Mammoplasties/ Mastectomy for Gynecomastia	**CPT:** 19318, 19300 **Dx**: 611.1 and 611.9 only	A male with a diagnosis for **gynecomastia**: 1) Pictures in clients' chart, *and* 2) Persistent tenderness and pain, *and* 3) If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than one year.
250	Other Reduction Mammoplasties/ Mastectomy for Gynecomastia for a Male or Female with Diagnosis of 611.1 Or 611.9	**CPT:** 19300 and 19318	Reduction mammoplasty or mastectomy, not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.

EPA Code	Service Name	CPT/HCPCS/ Dx Code	Criteria
421	Meningococcal Vaccine	**CPT:** 90734 (Conjugate Vaccine – Menactra®)	Client is 19 through 55 years of age[1] and is in one of the "at risk" groups because the client meets one of the following: 1) Not routinely recommended for ages 19-21, but may be administered as catch-up vaccination for those who have not received a dose after their 16th birthday; 2) Has persistent complement deficiencies; 3) Has anatomic or functional asplenia; 4) Are at risk during a community outbreak attributable to a vaccine serogroup; 5) Infected with human immunodeficiency virus (HIV), if another indication for vaccination exists; 6) Is a microbiologist who is routinely exposed to isolates of N. meningitidis; or 7) Is a freshman entering college who will live in a dormitory.
422	Placement of Drug Eluting Stent and Device	**HCPCS:** C1874, C1875, C9601, C9602, C9603, C9604, C9605, C9606, C9607, and C9608 (837I/UB-04 only)	The agency pays for drug eluting stents when: 1) Medically necessary; and 2) One or more of the following criteria are met: a) Stent diameter is 3 mm or less; b) Length of stent(s) is longer than 15 mm placed within a single vessel; c) Stents are placed to treat in-stent restenosis; d) For patients with diabetes mellitus;or e) For treatment of left main coronary disease.

[1] For clients 11 through 20 years of age, refer to the EPSDT Medicaid Provider Guide.

EPA Code	Service Name	CPT/HCPCS/ Dx Code	Criteria
423	Cochlear Implants for Clients 20 Years of Age and Younger	**CPT:** 69930, **HCPCS:** L8614 (837I/UB-04 only) **Dx:** 389.10-389.18	The agency will reimburse for cochlear implantation only when the products come from a vendor with a Core Provider Agreement with the agency, there are no other contraindications to surgery, and **Note**: Bilateral cochlear implantation is not covered. **one** of the following must be true: 1) **Unilateral cochlear implantation** for clients age 18 through 20 with post-lingual hearing loss and clients (age 12 months-17 years) with prelingual hearing loss when all of the following are true: a) The client has a diagnosis of profound to severe bilateral, sensorineural hearing loss; b) The client has stimulable auditory nerves but has limited benefit from appropriately fitted hearing aids (e.g., fail to meet age-appropriate auditory milestones in the best-aided condition for young children, or score of less than ten or equal to 40% correct in the best-aided condition on recorded open-set sentence recognition tests; c) The client has the cognitive ability to use auditory clues; d) The client is willing to undergo an extensive rehabilitation program; e) There is an accessible cochlear lumen that is structurally suitable for cochlear implantation; f) The client does not have lesions in the auditory nerve and/or acoustic areas of the central nervous system; and

EPA Code	Service Name	CPT/HCPCS/ Dx Code	Criteria
			Note: Refer to the agency's Hearing Hardware for Clients 20 Years of Age and Younger Medicaid Provider Guide for replacement parts for cochlear implants.
424	Meningococcal Vaccine	**CPT:** 90733 (Polysaccharide vaccine – Menomune®)	Client meets at least 1 of the 5 criteria for use of the meningococcal vaccine outlined for EPA code 421 (CPT code 90734) and **one of the following is true**: 1) The client is one of the following: a) 2 years of age through 10 years of age; or b) Older than 55 years of age. 2) The conjugate vaccine is not available.
425	Hyperbaric Oxygen Therapy	**CPT:** 99183 **HCPCS:** C1300 (837I/UB-04 only)	All of the following must be true: 1) The diagnosis is 250.70-250.83; and 2) Patient has type 1 or type 2 diabetes and has a lower extremity wound that is due to diabetes; and 3) Patient has a wound classified as Wagner grade 3 or higher; and 4) Hyperbaric oxygen therapy is being done in combination with conventional diabetic wound care.
610	Visual Exam/Refraction (Optometrists/Ophthalmologists only)	**CPT:** 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: 1) Glasses are broken or lost or contacts that are lost or damaged; **and** 2) Last exam was at least 18 months ago. **Note**: EPA # is not required when billing for children or clients with developmental disabilities.

EPA Code	Service Name	CPT/HCPCS/ Dx Code	Criteria
630	Blepharoplasties	**CPT:** 15822, 15823, and 67901-67908	Blepharoplasty for noncosmetic reasons when *both* of the following are true: 1) The excess upper eyelid skin impairs the vision by blocking the superior visual field; and 2) On a central visual field test, the vision is blocked to within 10 degrees of central fixation.
631	Strabismus Surgery	**CPT:** 67311-67340 **Dx:** 368.2	Strabismus surgery for clients 18 years of age and older when *both* of the following are true: 1) The client has a strabismus-related double vision (diplopia), ICD-9 Dx 368.2; and 2) It is not done for cosmetic reasons.
For Neuropsychological testing, please refer to the Mental Health Services for Children, Psychiatric and Psychological Services Medicaid Provider Guide.			
1300	Injection, Romiplostim, 10 Microgram	**HCPCS:** J2796	**All of the following must apply:** 1) Documented diagnosis of Idiopathic Thrombocytopenic Purpura (ITP); 2) Patient must be at least 18 years of age; 3) Inadequate response (reduction in bleeding) to: a. Immunoglobulin treatment; and b. Corticosteroid treatment; or c. Splenectomy. 4) Prescriber and client must be enrolled in NEXUS.

EPA Code	Service Name	CPT/HCPCS/ Dx Code	Criteria
1302	Hysterectomies for Cancer	**CPT:** 58150, 58152, 58180, 58200, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58545, 58546, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573	Client must have a diagnosis of cancer requiring a hysterectomy as part of the treatment plan** **Dx:** 179, 182.0, 182.1, 182.8, 183-183.9, 184-184.9. 198.6, 198.82, V10.4-V10.44.
1303	Hysterectomies - Complications and Trauma	**CPT:** 58150, 58152, 58180, 58200, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58545, 58546, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573,	Client must have a complication related to a procedure or trauma (e.g., postprocedure complications; postpartum hemorrhaging requiring a hysterectomy; trauma requiring a hysterectomy) **Dx:** 641.2X, 641.9X.

EPA Code	Service Name	CPT/HCPCS/ Dx Code	Criteria
1312	Continuous Glucose Monitoring (CGM)	**CPT:** 95250, 95251	**Allowed only for clients 18 years of age and younger** for the in-home use of professional or diagnostic CGM for a 72-hour period. The client must: • Have diabetes mellitus (DM); • Be insulin dependent; and • Have had one or more severe episodes of hypoglycemia (blood glucose less than or equal to 50 mg/dl) *requiring assistance from another person, or complicated by a hypoglycemia-induced seizure. The CGM must be: • Ordered by a pediatrician; and • Provided by an FDA-approved CGM device. Verification with self-monitoring of blood glucose (SMBG) is needed prior to adjusting insulin. Do not use the CGM results to adjust insulin. **Limit:** 2 monitoring periods of 72 hours each, per client, every 12 months. ***"Requiring assistance**" means that the client does not recognize the symptoms of hypoglycemia and/or is unable to respond appropriately.

EPA Code	Service Name	CPT/HCPCS/ Dx Code	Criteria
1313	Intensity Modulated Radiation Therapy (IMRT)	**CPT:** 77301, 77338, 77370, 77418, 0073T	**Head and neck cancers:** **ICD-9 Dx:** 140.0-149.9, 160.0-161.9, 170.0-170.1, 171.0, 195.0, 200.0-202.0. All other diagnoses require prior authorization. **Prostate cancer:** **ICD-9 Dx:** 185 ✓ As primary treatment for prostate cancer without prostatectomy and without metastases as primary therapy or in combination with brachytherapy. ✓ For post-prostatectomy treatment (Prostate bed or whole pelvis) of prostate cancer without metastases as adjuvant radiation therapy immediately following prostatectomy. ✓ Salvage therapy for failed primary treatment. ✓ Salvage therapy for failed prostatectomy (positive margins, positive lymph nodes, or confirmed failure of PSA to fall to undetectable levels). ✓ Salvage therapy for suspected recurrence of localized prostate cancer. ✓ All other clinical presentations require prior authorization.
1321	Orencia (abatacept)	J0129	**Effective April 1, 2013** 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.

EPA Code	Service Name	CPT/HCPCS/ Dx Code	Criteria
1325	Targeted TB testing with interferon-gamma release assays	**CPT:** 86480, 86481 **Dx**: 555.0-555.9, 556.0-557.0, 696.0, 714.0, 795.51, v03.2, v12.01	**Effective July 1, 2013** Targeted TB testing with interferon-gamma release assays may be considered medically necessary for clients **five years of age and older** for the following conditions: • History of positive tuberculin skin test or previous treatment for TB disease; or • History of vaccination with BCG (Bacille Calmette-Guerin); or • Recent immigrants (within 5 years) from countries that have a high prevalence of tuberculosis; or • Residents and employees of high-risk congregate settings (homeless shelters, correctional facilities, substance abuse treatment facilities); or • Clients with an abnormal CXR consistent with old or active TB; or • Clients undergoing evaluation or receiving TNF alpha antagonist treatment for rheumatoid arthritis, psoriatic arthritis, or inflammatory bowel disease; **AND** • Client in agreement to remain in compliance with treatment for latent tuberculosis infection if found to have a positive test. The tuberculin skin test is the preferred method of testing for children under the age of 5.

Modifiers

[WAC 182-531-1850(10) and (11)]

CPT/HCPCS

Italics indicate additional agency 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 the agency'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. *In order to receive payment, a contract with the agency 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 the agency.*

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 the agency'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**: 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. 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 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 performing number field on the 1500 Claim Form or electronic claim record. 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 in the course of 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.

FP Service provided as part of Family Planning Program.

HA Child/Adolescent program

LT **Left Side**: Used to identify procedures performed on the left side of the body. *The agency requires this modifier with some procedure codes for proper payment.*

QP **Documentation is on file showing that the lab test(s) was ordered individually or ordered as a CPT recognized panel other than automated profile codes**. *This modifier is now used **FOR INFORMATION ONLY**. Internal control payment methodology for automated multi-channel test is applied. This modifier is **not** appropriate to use when billing for repeat tests or to indicate not as a panel.*

Q6 **Physician Services**: Services furnished by a locum tenens physician. *For informational purposes only; no extra allowance is allowed.*

RT **Right Side**: Used to identify procedures performed on the right side of the body. *The agency requires this modifier with some procedure codes for proper payment.*

SL **State-supplied Vaccine**: *This modifier must be used with those immunization procedure codes indicated in section C to identify those 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. *In order to receive payment, a contract with the agency is required if services are performed in a hospital setting.*

TG **Complex/high level of care.**

TH **Obstetrical treatment/services, prenatal or postpartum**: *To be used only for those maternity services outlined in Services Requiring Prior Authorization [e.g. antepartum care requiring only 1-3 visits (CPT codes 99201-99215 TH) and labor management (CPT codes 99221-99223 TH)].*

TJ **Child/Adolescent Program**: *To be used for enhancement payment for foster care children screening exams.*

TS **Follow-up service:** *To be used with HCPCS procedure code H0009 and for selected Applied Behavior Analysis (ABA) services (see the Mental Health Services for Children, Psychiatric and Psychological Services).*

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.*

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 (SOS) 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, the agency's fee schedule amounts are established using three relative value unit (RVU) components: work, practice expense, and malpractice expense. The agency 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; or

- **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); and

- 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 the agency pay providers differently for services performed in facility and nonfacility settings?

Yes. When a provider performs a professional service in a facility setting, the agency 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, the agency 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 the agency also makes a payment to a facility. In most cases, the agency 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
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

FACILITY SETTING (cont.)

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 the agency must include the appropriate Medicare **two-digit place of service code.** The agency will deny claims with single-digit place of service codes.

Due to Medicare's consolidated billing requirements, the agency 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 (CPT codes 97001-97799), 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 the agency 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, the agency 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
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
20	Urgent Care Facility
32	Nursing Facility

NONFACILITY SETTING (cont.)

Place of Service Code	Place of Service Description
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 the agency must include the appropriate Medicare **two-digit place of service code.** The agency will deny claims with single-digit place of service codes.

Which professional services have a SOS payment differential?

Most of the services with an SOS payment differential are from the surgery, medicine, and E/M ranges of CPT codes. However, some HCPCS, CPT radiology, pathology, and laboratory codes also have an SOS payment differential.

Fee schedule information

- Maximum allowable fees for all codes, including CPT codes and selected HCPCS codes, are listed in the fee schedule.
- In the fee schedule, the agency identifies procedure codes that may require prior authorization. However, this list may not be all-inclusive. Prior authorization, limitations, or requirements detailed in agency medicaid provider guides and Washington Administrative Code (WAC) remain applicable.
- The agency's fee schedules are available for download in Excel.

Billing and Claim Form

What are the general billing requirements?

Providers must follow the agency 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 the agency 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 procedure 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 form to be considered for payment.

Billing for outpatient hospital services in hospital-based clinics

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

- If the Department of Health (DOH) has not designated the clinic as a hospital-based entity, the clinic must submit to the agency a CMS-1500 or 837P claim form containing both:

  - ✓ The facility and the professional fees in field 24F.
  - ✓ The place of service (POS) 11 (office setting) in field 24B.

  Medicare and Medicaid policy prohibit the hospital from billing a facility fee in this circumstance. The Medicaid agency will reimburse the clinic the nonfacility setting fee. This single claim comprises the total payment for the services rendered

- If DOH has designated the clinic as a hospital-based entity, for the Medicaid agency to reimburse the clinic and the associated hospital for services provided to Medicaid-eligible clients, the following must happen:

  - ✓ The clinic must submit to the agency a CMS-1500 or 837P claim form containing both:

    - ➢ The professional fees in field 24F
    - ➢ POS 22 (outpatient setting) in field 24B

  - ✓ The hospital must submit to the agency a UB-04 or 837I claim form with the facility fees in form locator 47.

  These two billings comprise the total payment for the services rendered.

In the circumstances described above, clinics must follow current instructions in this Medicaid provider guide related to office setting and outpatient services.

How do I complete the CMS-1500 claim form?

Note: Refer to the agency ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 Claim Form.

Submitting professional services on a CMS-1500 claim form for Medicare crossovers

For services paid for, and/or applied to, the deductible by Medicare:

- Medicare should forward the claim to the agency. If the claim is not received by the agency, please resolve that issue prior to billing a paper claim to reduce the possibility of claim denial and the need to resubmit.

- Complete the claim form as if billing for a non-Medicare client.

- Always attach the Medicare Explanation of Medicare Benefits (EOMB).

- Do not indicate any payment made by Medicare in field 29. Enter only payments made by non-Medicare, third-party payers (e.g., Blue Cross) in field 29 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 the agency's Tribal Health Program Medicaid Provider 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 1500 Claim Form 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 healthcare 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 healthcare services provided in relation to the condition(s) being treated.

The agency uses InterQual® ISDR Level of Care 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 healthcare services.

- Retrospective UR is performed following the provision of healthcare services and includes both post-payment and pre-payment review.
- Post-payment retrospective UR is performed after healthcare services are provided and paid.
- Pre-payment retrospective UR is performed after healthcare services are provided but prior to payment.