Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Department of Health
Community & Family Health

and

Medicaid Purchasing Administration
(MPA)

Prenatal Diagnosis Genetic Counseling

Billing Instructions

ProviderOne Readiness Edition

About This Publication

This publication supersedes all previous Department/MPA *Prenatal Diagnosis Genetic Counseling Billing Instructions* published by the Health and Recovery Services Administration, Washington State Department of Social and Health Services.

> **Note:** The Department now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

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How Can I Get Department/MPA Provider Documents?

To download and print Department/MPA provider numbered memos and billing instructions, go to the Department/MPA website at http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link).

Fee Schedule

You may view the Department's/MPA's Fee Schedules on-line at http://hrsa.dshs.wa.gov/RBRVS/Index.html

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Important Contacts

Note: This section contains important contact information relevant to prenatal diagnosis genetic counseling. For more contact information, see the Department/MPA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Department/MPA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Finding out about payments, denials, claims processing, or Department managed care organizations	
Electronic or paper billing	
Finding Department documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Department managed care	
Prior authorization, limitation extensions, or exception to rule	
Who do I contact for information regarding Regional Genetic Counseling clinics in my area?	Debra Lochner Doyle, MS, CGC Department of Health Genetic Counseling Section 1-253-395-6742

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for a more complete list of definitions.

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

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

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

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

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

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

Department – For the purposes of these billing instructions, "the Department" means the Department of Social and Health Services.

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

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

Genetic Counselor - An individual who:

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

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

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

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by the Department for specific services, supplies, or equipment.

Medical Identification card(s) – See *Services Card.*

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

ProviderOne – Department of Social and Health Services (the Department) primary provider payment processing system.

ProviderOne Client ID- A system-assigned number that uniquely identifies a single client within the ProviderOne system; the number consists of nine numeric characters followed by WA.
For example: 123456789WA.

Services Card – A plastic "swipe" card that the Department issues to each client on a "one- time basis." Providers have the option to acquire and use swipe card technology as one method to access up-to-date client eligibility information.

- The Services Card replaces the paper Medical Assistance ID Card that was mailed to clients on a monthly basis.
- The Services Card will be issued when ProviderOne becomes operational.
- The Services Card displays only the client's name and ProviderOne Client ID number.
- The Services Card does not display the eligibility type, coverage dates, or managed care plans.
- The Services Card does not guarantee eligibility. Providers are responsible to verify client identification and complete an eligibility inquiry.

About the Program

What Is the Purpose of the Prenatal Diagnosis Genetic Counseling Program?

The Prenatal Diagnosis Genetic Counseling program was established to ensure that all Department of Social & Health (the Department) clients have access to high quality, comprehensive prenatal genetic healthcare services. Rapid advances in the field of genetics may outpace many obstetrical providers' abilities to stay current in standards of genetics practice and/or understand the complex ramifications oftentimes associated with genetic testing.

In 1993, the Department of Health (DOH) and the Department established the Prenatal Diagnosis Genetic Counseling program to promote the use of genetic counselors. These healthcare professionals are nationally certified in the field of genetics and can ensure clients receive informed consent, particularly regarding reproductive issues. Funds in the DOH Division of Community & Family Health Genetic Services Section budget are used as the required state match for this payment program for prenatal diagnosis genetic counseling services.

Referrals

Prenatal diagnosis genetic counseling services are covered fee-for-service. No prior authorization is required. Clients in Medical Assistance fee-for-service and those enrolled in Healthy Options may self-refer or be referred by any provider. Clients in the Primary Care Case Management program must be referred by their Primary Care Case Manager. These services are available to all women/couples during their pregnancy and up to 90 days post-partum.

Client Eligibility

Who Is Eligible?

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

Please see the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Are Clients Enrolled in a Department Managed Care Plan Eligible? [Refer to WAC 388-538-060 and 095 or WAC 388-538-063 for GAU clients]

Who is eligible for Prenatal Genetic Counseling?

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

- Primary Care Case Management (PCCM) clients must be referred by their Primary Care Case Manager.

- The above clients are eligible for prenatal diagnosis genetic counseling during pregnancy and through the end of the month containing the 60th day after the pregnancy ends. These services may be provided in an office, outpatient, or inpatient hospital setting.

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

Prenatal procedures beyond genetic counseling must be requested directly through the client's Primary Care Provider (PCP) or PCCM provider. For PCCM clients, the referral number is required in field 17A on the CMS-1500 Claim Form.

Coverage

What Is Covered?

The Department pays for:

- One initial prenatal genetic counseling service billable for each 30 minutes up to 90 minutes; **and**

- Two follow-up prenatal genetic counseling encounters, billable for each 30 minutes up to 90 minutes per encounter, per pregnancy (within an 11-month period).

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

A follow-up visit involves the consultant's re-evaluation of a client for whom he/she previously rendered an opinion or advice.

What Is Not Covered?

The Department does not cover telephone or email consultations for prenatal diagnosis genetic counseling.

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Provider Requirements

Who Is Eligible for Payment from the Department to Provide Prenatal Diagnosis Genetic Counseling?

Only a prenatal diagnosis genetic counseling service provider (referred to as an "agency" in these billing instructions) is eligible for payment from the Department to provide prenatal diagnosis genetic counseling. The agency must have at least one board-certified genetic counselor on staff who works with, and is supervised by, a practicing physician. The American Board of Genetic Counseling determines board certification/eligibility.

What Is My Responsibility as a Prenatal Diagnosis Genetic Counseling Provider?

- Agencies must provide prenatal diagnosis genetic counseling services according to policies and guidelines provided in these billing instructions and in the Department Core Provider Agreement.

- The Department requires prenatal genetic counselors to:

  - ✓ Be able to elicit and interpret individual and family histories;
  - ✓ Know medical aspects of problems encountered in genetic service programs;
  - ✓ Know genetic and mathematic principles well enough to understand the limitations, significance, and interpretations of specialized laboratory and clinical procedures and to transmit and interpret genetic information to patients and families;
  - ✓ Be skilled in the interviewing and counseling techniques required to:

    - ➢ Elicit necessary information from the patient or family to reach appropriate conclusions about treatment and needs;
    - ➢ Anticipate areas of difficulty and conflict;
    - ➢ Help the families and individuals recognize and cope with their emotional and psychological needs;
    - ➢ Transmit pertinent information effectively;
    - ➢ Recognize situations that require referral;
    - ✓ Be knowledgeable enough about available health care resources to make appropriate referrals; and
    - ➢ Facilitate community referrals as indicated.

How Do I Become Registered as a Service Provider?

1. Obtain a Core Provider Agreement from the Department or DOH Genetic Services Section.

2. Send:

   (a) The completed Core Provider Agreement
   (b) An ABMG/ABGC certification or a letter verifying genetic counselor's eligibility to sit for the upcoming examination; and
   (c) Each qualified genetic counselor's National Provider Identification number (NPI); and
   (d) A photocopy of the supervising physician's license to:

   Debra Lochner Doyle, MS, CGC
   Department of Health
   Genetic Services Section
   20435 72nd Ave. S. Suite 200
   Kent, WA 98032
   1-253-395-6742
   email: debra.lochnerdoyle@doh.wa.gov

3. The Genetic Services Section staff will send a copy of approved Provider Agreement forms to the Department. This will serve as a written request to the Department for authorizing the facility to bill for prenatal diagnosis genetic counseling.

4. After receiving the approval for acceptance as a prenatal diagnosis genetic counseling provider, you may bill *retroactively* for services provided in accordance with Department policies for clients (up to one year from the date of service).

Patient Authorization to Disclose Health Care Information

- Agencies must adhere to the Uniform Health Care Information Act (UHCIA), which prohibits agencies from releasing client information without the client's consent. **A valid authorization for disclosure must**:

  - ✓ Identify the nature of the information to be disclosed;
  - ✓ Identify the name, address, and institutional affiliation of the person to whom the information is to be disclosed;
  - ✓ Identify the physician or other health care provider who is to make the disclosure; and
  - ✓ Be in writing and be dated and signed by the patient.

- The expiration date of a valid disclosure authorization may not be more than 90 days in the future. If no date is specified, the authorization expires 90 days after it is signed. Furthermore, a patient may revoke a disclosure authorization at any time, unless it is required for payments to health care providers or other substantial action has been taken in reliance on the authorization.

- The UHCIA also contains provisions regarding patient representatives' access to records, retention and safeguarding patient records by providers, and remedies against providers who do not comply with the UHCIA.

Disclosing Patient Information *Without* the Patient's Consent [RCW 70.02.050]

- A health care provider may disclose health care information about a patient without the patient's authorization to the extent a recipient needs to know the information, if the disclosure is:

  - ✓ To a person who the provider reasonably believes is providing health care to the patient;

  - ✓ To any other person who requires health care information for health care education, or to provide planning, quality assurance, peer review, or administrative, legal, financial, or actuarial services to the health care provider; or for assisting the health care provider in the delivery of health care and the health care provider reasonably believes that the person:

    - ➢ Will not use or disclose the health care information for any other purpose; and
    - ➢ Will take appropriate steps to protect the health care information;

- ✓ To any other health care provider reasonably believed to have previously provided health care to the patient, to the extent necessary to provide health care to the patient, unless the patient has instructed the health care provider in writing not to make the disclosure;

- ✓ To any person if the health care provider reasonably believes that disclosure will avoid or minimize an imminent danger to the health or safety of the patient or any other individual, however there is no obligation under this chapter on the part of the provider to so disclose;

- ✓ Oral, and made to immediate family members of the patient, or any other individual with whom the patient is known to have a close personal relationship, if made in accordance with good medical or other professional practice, unless the patient has instructed the health care provider in writing not to make the disclosure;

- ✓ To a health care provider who is the successor in interest to the health care provider maintaining the health care information;

- ✓ For use in a research project that an institutional review board has determined:

  - ➢ Is of sufficient importance to outweigh the intrusion into the privacy of the patient that would result from the disclosure;
  - ➢ Is impracticable without the use or disclosure of the health care information in individually identifiable form;
  - ➢ Contains reasonable safeguards to protect the information from redisclosure;
  - ➢ Contains reasonable safeguards to protect against identifying, directly or indirectly, any patient in any report of the research project; and
  - ➢ Contains procedures to remove or destroy at the earliest opportunity, consistent with the purposes of the project, information that would enable the patient to be identified, unless an institutional review board authorizes retention of identifying information for purposes of another research project;

- ✓ To a person who obtains information for purposes of an audit, if that person agrees in writing to:

  - ➢ Remove or destroy, at the earliest opportunity consistent with the purpose of the audit, information that would enable the patient to be identified; and
  - ➢ Not to disclose the information further, except to accomplish the audit or report unlawful or improper conduct involving fraud in payment for health care by a health care provider or patient, or other unlawful conduct by the health care provider;

- ✓ To an official of a penal or other custodial institution in which the patient is detained;
- ✓ To provide directory information, unless the patient has instructed the health care provider not to make the disclosure;
- ✓ In the case of a hospital or health care provider to provide, in cases reported by fire, police, sheriff, or other public authority, name, residence, sex, age, occupation, condition, diagnosis, or extent and location of injuries as determined by a physician, and whether the patient was conscious when admitted.

- A health care provider [must] disclose health care information about a patient without the patient's authorization if the disclosure is:
  - ✓ To federal, state, or local public health authorities, to the extent the health care provider is required by law to report health care information; when needed to determine compliance with state or federal licensure, certification or registration rules or laws; or when needed to protect the public health;
  - ✓ To federal, state, or local law enforcement authorities to the extent the health care provider is required by law;
  - ✓ To county coroners and medical examiners for the investigations of deaths;
  - ✓ Pursuant to compulsory process in accordance with RCW 70.02.060.

Notifying Clients of Their Right to Make Their Own Health Care Decisions

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give all adult clients written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Department 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; and
- Record keeping requirements.

Billing Procedures Specific to this Program

- Agencies must bill the Department on the CMS-1500 Claim Form for services using their NPI number as well as the taxonomy for Prenatal Genetic Counseling which is 170300000X.

- Although providers have up to one year to bill to facilitate reconciliation of our account and payment for unused funds, Prenatal Diagnosis Genetic Clinics with approved Core Provider Agreements ("agencies") are asked to submit billings within 120 days of the date of service.

Completing the CMS-1500 Claim Form

> **Note:** Refer to the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for general instructions on completing the CMS-1500 Claim Form.

The following CMS-1500 Claim Form instructions relate to Prenatal Diagnosis Genetic Counseling:

Field No.	Name	Entry
24B	**Place of Service**	These are the only appropriate code(s) for Washington State Medical Assistance. **Code** — **To Be Used For** 21 — Inpatient hospital 22 — Outpatient hospital 11 — Office

Fee Schedule

You may view the Department/MPA Prenatal Diagnosis Genetic Counseling Fee Schedule on-line at: http://hrsa.dshs.wa.gov/RBRVS/Index.html#P