

Medicaid Purchasing Administration



Physician-Related Services/ Healthcare Professional Services

Billing Instructions

[Chapter 388-531 WAC]

About This Publication

This publication supersedes all previous Department *Physician-Related Services Billing Instructions* published by the Medicaid Purchasing 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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11-10	Registered Nurse First Assistants (RNFAs)	3-31-2011	E.7
11-13	Changes to Policies Regarding Rehabilitation Services, Implantable Telescopes, Procedure Code Coverage, and Prior Authorization for Infiximab.	3-31-2011	B.26-B.29 D.6, D.20- D.22, D.26, F.9

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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).

Table of Contents

Important Contacts	vii
Other Important Numbers	ix
MPA Billing Instructions	x
Definitions	1

Section A: Introduction

Procedure Codes	A.1
Evaluation and Management (E/M) Documentation and Billing	A.1
Diagnosis Codes.....	A.2
Discontinued Codes	A.2
Scope of Coverage for Physician-Related and Healthcare Professional Services	A.2
Noncovered Services-General	A.4
Noncovered Physician-Related and Healthcare Professional Services	A.5
Who Can Provide and Bill for Physician-Related Services?	A.7
Noncovered Practitioners.....	A.8
Clients Enrolled in the Department’s Managed Care Organizations.....	A.9
By Report (BR).....	A.9
Codes for Unlisted Procedures (CPT codes xxx99)	A.9
Acquisition Cost (AC)	A.10
Conversion Factors	A.10
National Correct Coding Initiative.....	A.10
Services by Substitute Physician-How to Bill	A.11

Section B: Programs (Guidelines/Limitations)

Office and Other Outpatient Services	B.1
Children’s Primary Health Care.....	B.2
After Hours	B.3
Hospital Inpatient and Observation Care Services	B.3
Utilization Review (UR).....	B.8
Detoxification Services.....	B.8
Smoking Cessation.....	B.9
Emergency Physician-Related Services.....	B.12
End-Stage Renal Disease (ESRD)	B.13
Critical Care	B.14
Physician Standby Services	B.16

Table of Contents (cont.)

Section B: Programs (Guidelines/Limitations) Continued...

Prolonged Services..... B.17

Osteopathic Manipulative Therapy..... B.17

Newborn Care B.18

Neonatal Intensive Care Unit (NICU)/Pediatric Intensive Care Unit (PICU)..... B.19

Physician Care Plan Oversight..... B.21

Physicians Providing Service to Hospice Clients B.21

Domiciliary, Rest Home, or Custodial Care Services..... B.22

Home Evaluation and Management..... B.22

Telehealth..... B.22

Audiology B.26

Emergency Oral Health Services B.27

Client Eligibility..... B.27

Payment..... B.27

Provider Requirements..... B.28

Emergency Oral Health Benefit..... B.29

Billing for Services that Qualify for Emergency Oral Health Benefit Package B.38

Prior Authorization B.39

Services Excluded from the Emergency Health Benefit..... B.40

Vision Care Services (Includes Ophthalmological Services) B.22

Eye Examinations and Refraction Services B.41

Coverage for Additional Examinations and Refraction Services B.41

Visual Field Exams B.42

Vision Therapy..... B.42

Ocular Prosthetics B.42

Eye Surgery..... B.43

Vision Coverage Table B.45

Table of Contents (cont.)

Section C: Programs (Guidelines/Limitations) Continued...

Immunizations..... C.1
 Injectables C.2
 Allergen Immunotherapy C.8
 National Drug Code Format..... C.9

Section D: Programs (Guidelines/Limitations) Continued...

Psychiatric Services D.1
 Covered Services for Psychiatrists Using ICD-9-CM Diagnosis
 Codes 290.0-319 D.2
 Noncovered Services for Psychiatrists Using ICD-9-CM Diagnosis
 Codes 290.0-319 D.3
 Limitations for Inpatient Psychiatric Services D.3
 Limitations for Outpatient Psychiatric Services D.3
 Expanded Mental Health Services for Children D.4
 Pharmacological Management (CPT 90862)..... D.13
 Involuntary Treatment Act (ITA) D.14
 EPA Criteria for Neuropsychological Testing
 (CPT Codes 96118 and 96110)..... D.16
 Foot Care and Podiatric Services D.19
 Radiology Services D.25
 Pathology and Laboratory..... D.30

Section E: Programs (Guidelines/Limitations) Continued...

Chemotherapy Services E.1
 Hydration Therapy with Chemotherapy E.3
 Surgical Services..... E.4
 Registered Nurse First Assistants (RNFA)..... E.7
 Multiple Surgeries..... E.7
 Endoscopy Procedures E.8
 Other Surgical Policies E.8
 Apheresis..... E.13
 Bilateral Procedures E.13
 Pre/Intra/Post-Operative Payment Splits E.14
 Urology E.15
 Anesthesia..... E.17
 Major Trauma Services..... E.25
 Physician/Clinical Provider List E.30

Table of Contents (cont.)

Section F: Miscellaneous Services

Acute Physical Medicine and Rehabilitation (Acute PM&R) F.1
 Cochlear Implant Services for Clients 20 Years of Age and Younger F.1
 Collagen Implants F.1
 DDD Physical F.2
 Diabetes Education F.2
 Genetic Counseling and Genetic Testing..... F.2
 Group Clinical Visits for Clients with Diabetes or Asthma F.2
 HIV/Aids Counseling..... F.4
 Hyperbaric Oxygen Therapy..... F.4
 Irrigation of Venous Access Pump F.4
 Needle Electromyography (EMGs) F.5
 Nerve Conduction Study (NCS) F.5
 Osseointegrated Implants (BAHA) for Clients 20 Years of Age and Younger... F.6
 Out-of-State Hospital Admissions F.7
 Outpatient Cardiac Rehabilitation..... F.7
 Physical Therapy..... F.9
 TB Treatment Services F.9
 TB Treatment Services Performed by Non-Professional Providers F.9
 Ultraviolet Phototherapy F.10
 Ventilator Management F.10
 Vagus Nerve Stimulation (VNS) F.10

Section G: Reproductive Health Services

How Does the Department Define Reproductive Health Services? G.1
 Provider Requirements..... G.1
 Who Is Eligible? G.2
 What Services Are Covered? G.3

Physician Services Provided to Clients on the Family Planning Only Program

What Is the Purpose of the Family Planning Only Program? G.6
 Provider Requirements..... G.6
 Who Is Eligible? G.7
 What Services Are Covered? G.7
 What Drugs and Supplies Are Paid Under the Family Planning Only Program? G.9
 What Services Are Not Covered? G.10
 Payment..... G.11

Table of Contents (cont.)

Section G: Continued...

Maternity Care and Delivery G.11
 Prenatal Assessments Are Not Covered G.12
 Confirmation of Pregnancy G.12
 Global (Total) Obstetrical (OB) Care G.13
 Unbundling Obstetrical Care G.13
 Antepartum Care G.15
 Coding for Antepartum Care Only G.15
 Coding for Deliveries G.16
 Coding for Postpartum Care Only G.16
 Additional Monitoring for High-Risk Conditions G.17
 Labor Management G.17
 High-Risk Deliveries G.18
 Consultations G.19
 General Obstetrical Payment Policies and Limitations G.19
 HIV/AIDS Counseling/Testing G.20
 Billing the Department for Maternity Services In a Hospital Setting G.21
 Sterilization and Hysteroscopic Sterilization G.23
 Hysterectomies G.23
 Abortion Services (Drug Induced) G.23
 Abortion Center Contracts (Facility Fees) G.24

Section H: Prior Authorization

What Is Prior Authorization (PA)? H.1
 How Does the Department Determine PA? H.1
 Services Requiring Prior Authorization (PA) H.3
 “Write or Fax” Prior Authorization (PA) H.4
 Limitation Extensions (LE) H.5
 Expedited Prior Authorization (EPA) H.6
 Washington State EPA Criteria Coding List H.8
 Department-Approved Centers of Excellence (COE) H.14
 Services Performed in Department-Approved Centers of Excellence (COE) ... H.16
 Department-Approved Sleep Study Centers H.16
 Department-Approved Bariatric Hospitals and Their Associated Clinics H.18

Table of Contents (cont.)

Section I: Site of Service (SOS) Payment Differential	
How Are Fees Established for Professional Services Performed in Facility and Nonfacility Settings?.....	I.1
How Does the SOS Payment Policy Affect Provider Payments?.....	I.1
Does the Department Pay Providers Differently for Services Performed in Facility and Nonfacility Settings?.....	I.2
When Are Professional Services Paid at the Facility Setting Maximum Allowable Fee?	I.2
When Are Professional Services Paid at the Nonfacility Setting Maximum Allowable Fee?.....	I.3
Which Professional Services Have a SOS Payment Differential?.....	I.4
Fee Schedule Information	I.4
Section J: Medical Supplies and Equipment	
General Payment Policies	J.1
Supplies Included In Office Call (Bundled Supplies).....	J.2
Supplies Paid Separately When Dispensed from Provider’s Office/Clinic	J.5
Injectable Drug Codes	
What Drugs Are Covered?.....	J.9
Section K: CPT/HCPCS Modifiers	K.1
Anesthesia Modifiers	K.7
Section L: Billing and Claim Forms	
What Are the General Billing Requirements?	L.1
How Do I Bill for Multiple Services?.....	L.1
Completing the CMS-1500 Claim Form.....	L.1
How Do I Submit Professional Services on a CMS-1500 Claim Form For Medicare Crossovers?	L.2
What Does the Department Require from the Provider-Generated EOMB to Process a Crossover Claim?.....	L.3

Important Contacts

Note: This section contains important contact information relevant to Physician-Related Services. 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	<p>See the Department/MPA <i>Resources Available</i> web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html</p>
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	
Contacting Provider Enrollment	
Contacting the Provider Inquiry Hotline	
Pharmacy authorization	
How do I obtain prior authorization or a limitation extension?	

Physician-Related Services/Healthcare Professional Services

Topic	Contact Information
Forms available to submit authorization requests	<ul style="list-style-type: none">• Oral Enteral Nutrition Worksheet Prior Authorization Request, DSHS 13-743• Fax/Written Request Basic Information Form, DSHS 13-756• Pet Scan Information Form, DSHS 13-757• Bariatric Surgery Request Form, DSHS 13-785• Physical, Occupational, and Speech Therapy Limitation Extension Request, DSHS 13-786• Out of State Medical Services Request Form, DSHS 13-787• Tysabri (Natalizumab) J2323 Request, DSHS 13-832• Application for Chest Wall Oscillator, DSHS 13-841• Insomnia Referral Worksheet, DSHS 13-850• Xolair (Omalizumab), DSHS 13-852• Cimzia (Certolizumab pegol Inj.) , DSHS 13-885

Other Important Numbers

Acute PM&R Authorization FAX	1-360-725-1966
Client Assistance/Brokered Transportation Hotline (Clients Only)	1-800-562-3022
Chemically Using Pregnant (CUP) Women Program Information	1-360-725-1666
Disability Insurance	1-800-562-6074
Durable Medical Equipment (DME)/Prosthetics Authorization.....	1-800-562-3022
Fraud Hotline	1-800-562-6906
MPA Managed Care (Healthy Options) Enrollment	1-800-562-3022
Telecommunications Device for the Deaf (TDD)	1-800-848-5429
Third-Party Resource Hotline	1-800-562-3022
TAKE CHARGE	1-360-725-1652

Provider Field Representatives

To request specific training materials, email the Department at:
providerrelations@dshs.wa.gov or visit the Provider Training website at:
<http://www.dshs.wa.gov/provider/training.shtml#provider>.

Department/MPA Billing Instructions

Access to Baby & Child Dentistry (ABCD)
Acute Physical Medicine & Rehabilitation
(Acute PM&R)
Ambulance and Involuntary Treatment Act
(ITA) Transportation
Ambulatory Surgery Centers
Blood Bank Services
Chemical Dependency
Chemical-Using Pregnant (CUP) Women
Program
Childbirth Education
Chiropractic Services for Children
Dental Program for Clients Through Age 20
Dental Program for Clients of the Division of
Developmental Disabilities Who Are 21
Years of Age and Older
Diabetes Education Program
Early, Periodic Screening, Diagnosis, and
Treatment (EPSDT) Program
Enteral Nutrition
Family Planning Providers, MPA-Approved
Federally Qualified Health Centers (FQHC)
Hearing Hardware for Clients 20 Years of
Age and Younger
HIV/AIDS Case Management, Title XIX
(Medicaid)
Home Health Services (Acute Care Services)
Home Infusion Therapy/Parenteral Nutrition
Program
Hospice Services
Hospital-Based Inpatient Detoxification
Inpatient Hospital Services
Kidney Center Services
Long Term Acute Care (LTAC)
Maternity Support Services/Infant Case
Management
Medical Nutrition Therapy
Mental Health Services for Children
Neurodevelopmental Centers

Nondurable Medical Supplies & Equipment
(MSE)
Nursing Facilities
Occupational Therapy Program
Orthodontic Services
Oxygen Program
Physical Therapy Program
Physician-Related Services/Healthcare
Professional Services
Planned Home Births and Births in Birthing
Centers
Prenatal Diagnosis Genetic Counseling
Prescription Drug Program
Private Duty Nursing for Children
Prosthetic & Orthotic Devices
ProviderOne Billing and Resource Guide
Psychologist
Rural Health Clinic
Speech/Audiology
Tribal Health Program
Vision Hardware for Clients 20 Years of
Age and Younger
Wheelchairs, Durable Medical Equipment
(DME), and Supplies

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Department/MPA *Glossary* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide/Glossary.pdf 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 388-531-0050]

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.

Authorization number – A nine-digit number assigned by MPA 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.

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.

By report (BR) – A method of reimbursement in which MPA determines the amount it will pay for a service that is not included in MPA’s published fee schedules. MPA may request the provider to submit a “report” describing the nature, extent, time, effort, and/or equipment necessary to deliver the service.

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.

Community services office (CSO) – An office of the department that administers social and health services at the community level.

Covered service – A service that is within the scope of the eligible client’s medical care program, subject to the limitations in Chapter 388-531 WAC and other published WAC.

Current procedural terminology (CPT™) – A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association.

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; and
- (2) Offered the client an opportunity to ask questions about the procedure and to request information in writing; and
- (3) Given the client a copy of the consent form; and
- (4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257; and
- (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; and
 - (b) Alternatives to the procedure including potential risks, benefits, and consequences; and
 - (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.

Limitation extension – A process for requesting and approving reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which MPA routinely reimburses. Limitation extensions require prior authorization.

Physician-Related Services/Healthcare Professional Services

Maximum allowable fee – The maximum dollar amount that MPA reimburses a provider for specific services, supplies, and equipment.

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

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

Medically necessary – See WAC 388-500-0005.

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

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

Pound indicator (#) – A symbol (#) indicating a procedure code listed in MPA's fee schedules that is not covered.

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.

Remittance and status report (RA) – A report produced by MPA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

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.

Physician-Related Services/Healthcare Professional Services

Usual and customary fee – The rate that may be billed to the Department for certain services, supplies, or equipment. This rate may not exceed:

- 1) The usual and customary charge billed to the general public for the same services;
or
- 2) If the general public is not served, the rate normally offered to other contractors for the same services.

Unless otherwise noted, billing should reflect the usual and customary fee and not the Department's maximum allowable fee. Reimbursement is either the usual and customary fee or the Department's maximum allowable fee, whichever is less.

Introduction

Procedure Codes

The Department of Social & Health Services (the Department) uses the following types of procedure codes within these *Physician-Related Services Billing Instructions*:

- Current Procedure Terminology (CPT®); and
- Level II Healthcare Common Procedure Coding System (HCPCS).

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

Evaluation and Management (E/M) Documentation and Billing

The E/M service is based on key components listed in the CPT manual. Providers must use one of the following guidelines to determine the appropriate level of service:

- The *1995 Documentation Guideline for Evaluation & Management Services* is available online at: www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf.
- The *1997 Documentation Guideline for Evaluation & Management Services* is available online at: www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf.

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.

Diagnosis Codes

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

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

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

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

Discontinued Codes

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

Scope of Coverage for Physician-Related and Healthcare Professional Services [WAC 388-531-0100]

The Department covers healthcare services, equipment, and supplies listed in these billing instructions, according to Department rules and subject to the limitations and requirements in these billing instructions, when they are:

- Within the scope of an eligible client's medical assistance program. Refer to WAC 388-501-0060 and 388-501-0065; and
- Medically necessary as defined in WAC 388-500-0005.

The Department evaluates a request for a service that is in a covered category under the provisions of WAC 388-501-0165.

The Department 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 388-501-0169.

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Physician-Related Services/Healthcare Professional Services

The Department covers the following physician-related services and healthcare professional services, subject to the conditions listed in this section:

- Allergen immunotherapy services;
- Anesthesia services;
- Dialysis and end stage renal disease services (refer to the current *Kidney Center Services Billing Instructions*);
- Emergency physician services;
- ENT (ear, nose, and throat) related services;
- Early and periodic screening, diagnosis, and treatment (EPSDT) services (refer to the current *Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Billing Instructions*);
- Reproductive health services (refer to the current *MPA-Approved Family Planning Provider Billing Instructions*);
- Hospital inpatient services (refer to the current *Inpatient Hospital Billing Instructions*);
- Maternity care, delivery, and newborn care services (refer to the current *Maternity Support Services/Infant Case Management Billing Instructions*);
- Office visits;
- Vision-related services (see also the current *Vision Hardware for Clients 20 Years of Age and Younger Billing Instructions*);
- 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;

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Physician-Related Services/Healthcare Professional Services

- 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 Disabilities (refer to Section B of these billing instructions); and
- Other outpatient physician services.

The Department 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 Developmental Disabilities; or
- A screening pap smear, 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 Department accepts the Department's rules and fees as outlined in the agreement, which includes federal and state law and regulations, billing instructions, and Department issuances.

Noncovered Services-General [WAC 388-501-0070]

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

The Department reviews requests for noncovered healthcare services according to WAC 388-501-0160 as an Exception to Rule. To request a noncovered service, send a completed "Fax/Written Request Basic Information" form, DSHS #13-756, to the Department (see *Important Contacts* section).

Refer to the current Department/MPA *ProviderOne Billing and Resource Guide* for information regarding noncovered services and billing a Department client who is on a fee-for-service program.

Physician-Related Services/Healthcare Professional Services

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

- 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 Healthcare Professional Services [WAC 388-531-0150]

The Department 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 388-501-0165;
- Hair transplantation;
- Marital counseling or sex therapy;
- More costly services when the Department determines that less costly, equally effective services are available;

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Physician-Related Services/Healthcare Professional Services

- 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 these billing instructions;
- Physician-supplied medication, except those drugs administered by the physician in the physician's office;
- Physical examinations or routine checkups, except as provided in these billing instructions;
- 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; ((or))
 - ✓ 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; and
 - ✓ Hallux limitus.
- Except as provided in these billing instructions, 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;
- Nonemergent admissions and associated services to out-of-state hospitals or noncontracted hospitals in contract areas;
- Bilateral cochlear implantation; and

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Physician-Related Services/Healthcare Professional Services

- 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 clients of the Division of Developmental Disabilities.

Note: The Department 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); or
- A waiver program.

Who Can Provide and Bill for Physician-Related Services [WAC 388-531-0250 (1)]

The following enrolled providers are eligible to provide and bill for physician-related and healthcare professional services which they provide to eligible clients:

- Advanced Registered Nurse Practitioners (ARNPs);
- Federally Qualified Health Centers (FQHCs);
- Health Departments;
- Hospitals currently licensed by the Department of Health (DOH);
- Independent (outside) laboratories CLIA-certified to perform tests. See WAC [388-531-0800](#);
- Licensed marriage and family therapists, only as provided in WAC [388-531-1400](#);
- Licensed mental health counselors, only as provided in WAC [388-531-1400](#);
- Licensed radiology facilities;
- Licensed social workers, only as provided in WAC [388-531-1400](#) and [388-531-1600](#);
- Medicare-certified Ambulatory Surgery Centers (ASCs);
- Medicare-certified Rural Health Clinics (RHCs);
- Providers who have a signed agreement with the Department to provide screening services to eligible persons in the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) program;
- Registered Nurse First Assistants (RNFAs); and
- Persons currently licensed by the State of Washington DOH to practice any of the following:
 - ✓ Dentistry;
 - ✓ Medicine and osteopathy;
 - ✓ Nursing;
 - ✓ Optometry; or
 - ✓ Podiatry.

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Noncovered Practitioners [WAC 388-531-0250 (2)]

The Department does not pay for services performed by any of the following practitioners:

- Acupuncturists;
- Christian Science practitioners or theological healers;
- Counselors (i.e., M.A. and M.S.N.), except as provided in WAC 388-531-1400;
- Herbalists;
- Homeopaths;
- 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 Department to evaluate a client for bariatric surgery; or
 - ✓ As provided in WAC 388-531-1400.
- Any other licensed or unlicensed practitioners not otherwise specifically provided for in WAC 388-502-0010;
- Any other licensed practitioners providing services that the practitioner is not:
 - ✓ Licensed to provide; and
 - ✓ Trained to provide.

The Department pays practitioners listed above for physician-related and healthcare professional services 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); or
- A waiver program. [WAC 388-531-0250 (3)]

Clients Enrolled in the Department's Managed Care Organizations

Many Department clients are enrolled in one of the Department's 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 one of the Department's MCOs must obtain services through their MCO.

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 388-502-0160.

By Report (BR)

Services with a **BR** indicator in the fee schedule (Section J) 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 Department.

Codes for Unlisted Procedures (CPT codes XXX99)

Providers must bill using the appropriate procedure code. The Department 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 388-501-0165). 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 Department requires this for all its programs, as outlined in WAC 388-501-0050. If a provider does not verify the Department's coverage policy before performing a procedure, the Department may not pay for the procedure.

Acquisition Cost (AC)

Drugs with an AC indicator in the fee schedule (Appendix) 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 Department.

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

Conversion Factors

	7/1/07	1/1/08	7/1/08	7/1/09	7/1/10
Adult Primary Health Care	21.95	24.58	25.12	22.03	21.96
Anesthesia	21.20	21.20	21.20	21.20	21.20
Children's Primary Health Care	31.82	47.10	47.64	36.48	36.22
Clinical Lab Multiplication Factor	.830	.830	0.820	0.76	00.76
Maternity	42.35	42.35	44.20	43.54	43.50
All Other Procedure Codes	22.03	22.03	22.23	22.31	22.23

These conversion factors are multiplied by the relative value units (RVUs) to establish the rates the Department/MPA Physician-Related Services Fee Schedule.

National Correct Coding Initiative

The Department 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 Department to control improper coding that may lead to inappropriate payment. The Department 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; and
- Review of current coding practices.

The Department may perform a post-pay review on any claim to ensure compliance with NCCI. NCCI rules will be enforced by the new ProviderOne payment system immediately upon implementation. Visit the NCCI on the web at: <http://www.cms.hhs.gov/physicians/cciedits>.

Services by Substitute Physician—How to Bill

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 regular physician's NPI for whom the substitute services were furnished on the HIPAA transaction (field 24J on the CMS-1500 Claim Form).
- Enter the locum tenens NPI and name in the claim notes field of the HIPAA transaction (field 19 of CMS-1500 claim form).
- 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.

Programs (Guidelines/Limitations)

Office and Other Outpatient Services [Refer to WAC 388-531-0950]

In addition to the limitations on services indicated in the fee schedule, the following limitations apply:

The Department of Social and Health Services (the Department) covers:

- One office or other outpatient visit per non-institutionalized client, per day for an individual provider (except for call-backs to the emergency room per WAC 388-531-0500).
- ✓ Certain procedures are included in the office call and cannot be billed separately.

Example: The Department 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.

- Two physician visits per month for a client residing in a nursing facility or an intermediate care facility. Nursing facility discharges (CPT code 99315 and 99316) are not included in the two-visit limitation. The Department pays for one nursing facility discharge per client, per day.

Office and Other Outpatient Services (cont.)

- One physical examination per client, per 12 months for clients with developmental disabilities as identified in ProviderOne. Use HCPCS procedure code T1023 with modifier HI and an ICD-9-CM diagnosis code from the range V79.3-V79.9 to bill for an examination.
- The Department pays one new patient visit, per client, per provider or group practice in a three-year period.
- Preventative screening services for certain conditions are covered in other sections of these billing instructions.

Children's Primary Health Care (CPT codes 99201-99215)

- The Department 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 who 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 birthdate in the client information fields. You must also add modifier HA in order for the service to be paid at the higher rate. If the mother is enrolled in a Department managed care plan, newborns will be enrolled in the same managed care plan as their mother.

After Hours

Afterhours 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 afterhours 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 afterhours service codes.

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

Hospital Inpatient and Observation Care Services

(CPT codes 99217-99239) [Refer to WAC 388-531-0750]

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.

What is 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 ICU or CCU) can be used to provide observation services. Level of care, not physical location of the bed, dictates admission status.

When is a change in admission status required?

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 Department 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; and
- Services greater than what is ordered by the physician or practitioner responsible for the client's hospital care.

Inpatient to Outpatient Observation Admission Status Change

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; and
- 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; and
 - ✓ 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 Admission Status Change

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; and
- 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; and
 - ✓ 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 Admission Status Change

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; and
- 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; and
 - ✓ 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 Admission Status Change

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; and
- 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; and
 - ✓ 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 Department may determine the admission status ordered is not supported by documentation in the medical record. The Department may consider payment made in this circumstance an overpayment and payment may be recouped or adjusted.

The Department covers:

- One inpatient hospital call per client, per day for the same or related diagnoses. The Department does not pay separately for the hospital call if it is included in the global surgery payment. (See the Surgical Services Section 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 Department pays providers for CPT codes 99221-99223 for scheduled hospital admissions during the follow-up period only when billed with a modifier 24.

Physician-Related Services/Healthcare Professional Services

The Department does not cover:

- 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 Department 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 Department 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 Department 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 a Department managed care organization during the hospital stay, the entire stay for physician services is paid FFS until the client is discharged. Enter the following on the claim:
 - ✓ The admission date to the hospital; and
 - ✓ “Continuous hospital care” (in the *claim notes* field).

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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 Department 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 retro UR is performed after healthcare services are provided and paid.
- Pre-payment retro UR is performed after healthcare services are provided but prior to payment.

Detoxification Services

The Department covers detoxification services for clients receiving alcohol and/or drug detoxification services in a Department-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 Department'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; and
- 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.

Physician-Related Services/Healthcare Professional Services

When the conditions on the previous page are met, providers must bill as follows:

Procedure Code	Modifier	Brief 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 detox hospital that has a detoxification-specific taxonomy can be billed directly to the Department.

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 Department fee-for-service program. For clients enrolled in managed care, contact the client's health plan for information regarding the smoking cessation benefit.

What services are 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; and
- Prescription medications recommended by the quit line. The client will then be referred back to their provider for a prescription, if appropriate.

The Washington State Tobacco Quit Line is:

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

Physician-Related Services/Healthcare Professional Services

Who is eligible to receive these services?

- All medical assistance 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 you to review. Complete the form and fax it with a prescription to the Department (see the *Important Contacts* section).

When will the Department pay for a smoking cessation referral?

The Department will pay physicians and ARNP's for a smoking cessation referral (**T1016**) when:

- 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.

Note: Refer to the *Scope of Healthcare Services Table* web page at: <http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html> for an up-to-date listing of Benefit Service Packages.

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

When will the Department pay for a smoking cessation referral for an evaluation for a smoking cessation prescription?

The Department will pay physicians and ARNP's for a smoking cessation referral (**T1016**) for an evaluation for a smoking cessation prescription when:

- 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 Services Package.

Note: Refer to the *Scope of Healthcare Services Table* web page at: <http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html> for an up-to-date listing of Benefit Service Packages.

- 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 Department Pharmacy Authorization Section, Drug Use and Review; **and**
- 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 Department at 1-800-562-3022.
- For more information about the Tobacco Quit Line, visit www.Quitline.com.
- To order brochures and business cards, go to <http://www.tobaccoprc.org/TCRC>.

Emergency Physician-Related Services (CPT codes 99281-99285)

[Refer to WAC 388-531-0500]

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

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

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	<p>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:</p> <ul style="list-style-type: none"> • Clients in an inpatient setting with ESRD; or • Clients receiving hemodialysis in an outpatient or inpatient setting who do not have ESRD. <p>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.</p>
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, 90947)

Procedure Codes Billed	Instructions
90945 and 90947	<p>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.</p> <p>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.</p>
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.

Physician-Related Services/Healthcare Professional Services

If a separately identifiable service is performed on the same day as a dialysis service, you may bill any of the following E&M procedures codes 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.

Critical Care (CPT codes 99291-99292) [Refer to WAC 388-531-0450]

Note: For neonatal or pediatric critical care services, see page B.19.

What is critical care?

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.

Physician-Related Services/Healthcare Professional Services

- 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; or
- Emergency care facility.

The Department 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 (36000, 36410, 36415, 36591, and 36600);
- Gastric intubation (43752 and 43753);
- Chest x-rays (71010, 71015, and 71020);
- Temporary transcutaneous pacing (92953);
- The interpretation of cardiac output measurements (93561-93562);
- Ventilator management (94002-94004, 94660, and 94662);

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Physician-Related Services/Healthcare Professional Services

- Pulse oximetry (94760 and 94762); or
- Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data) (99090).

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

Physician Standby Services (CPT code 99360)

[Refer to WAC 388-531-1250]

The Department 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 Department does not cover physician standby services when:

- The provider performs a surgery that is subject to the "global surgery policy" (refer to Section F);
- Billed in addition to any other procedure code, with the exception of CPT codes 99460 and 99465; or
- When the service results in an admission to a neonatal intensive care unit (CPT 99468) on the same day.

Prolonged Services (CPT codes 99354-99357) [Refer to WAC 388-531-1350]

The Department 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, 99304-99350
99355	99354 and one of the E&M codes required for 99354
99356	99221-99233, 99251-99255,
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 Codes” listed above **must** be billed on the **same** claim.

Osteopathic Manipulative Therapy (CPT codes 98925-98929)

[Refer to WAC 388-531-1050]

The Department 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	✓ pelvic
✓ cervical	✓ rib cage
✓ head	✓ sacral
✓ lower extremities	✓ thoracic
✓ lumbar	✓ upper extremities

Physician-Related Services/Healthcare Professional Services

- 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 Department **does not cover** physical therapy services performed by osteopathic physicians unless they are also physiatrists.

Newborn Care

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

The Department 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 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 Department 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).

**Neonatal Intensive Care Unit (NICU)/
Pediatric Intensive Care Unit (PICU) (CPT codes 99468-99480)**
[Refer to WAC 388-531-0900]

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 Department 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. You may report 99460 and 99477 when two distinct services are provided on the same day, but you must use modifier 25 with 99460. Bill 99460 with modifier 25 when you see a normal newborn 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 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).
- Codes 99291-99292 for critical care services provided in an outpatient setting when the client is 24 months of age or younger.

Physician-Related Services/Healthcare Professional Services

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 need to follow the national CCI edits as this list is not exhaustive:

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

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

Physician-Related Services/Healthcare Professional Services

Intensive (Noncritical) Low Birth Weight Services (99478-99480)

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

Physician Care Plan Oversight (CPT codes 99375, 99378, and 99380) [Refer to WAC 388-531-1150]

The Department 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 Department 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.

Physicians Providing Service to Hospice Clients

The Department 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 your 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.

The Department 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.

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Physician-Related Services/Healthcare Professional Services

When billing, primary physicians must put their NPI in field 33 of the CMS-1500 Claim Form. When billing, the consulting physician, other than the primary physician, must put the following on the CMS-1500 Claim Form:

- The primary physician name or clinic name and NPI the referring provider field of the HIPAA transaction (field 17 and 17a of the CMS-1500); and
- The consulting physician's performing NPI (PIN#) in the servicing provider field of the HIPAA transaction (field 24k of the CMS-1500) and group NPI (GRP#) in the pay-to provider number field of the HIPAA transaction (field 33 of the CMS-1500).

If not related to hospice care, when billing electronically, enter "Not related to hospice care" in the claim notes field of the HIPAA transaction.

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.

Home Evaluation and Management

The Department pays for Home Evaluation and Management (CPT codes 99341-99350) only when services are provided in place of service 12 (home).

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 Department 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.

Physician-Related Services/Healthcare Professional Services

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; or
- “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 Department will not pay separately for telehealth services for clients enrolled in a managed care plan. Clients enrolled in a Department 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 Department cover telehealth?

The Department 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 Department 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); and
- A federally qualified health center (FQHC).

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Physician-Related Services/Healthcare Professional Services

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 Department for the facility fee?

- *Hospital Outpatient:* When the originating site is a hospital outpatient department, 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 0789 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 department, 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 Department client through telehealth.

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

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

- Physicians (including Psychiatrists); and
- Advanced Registered Nurse Practitioners (ARNPs).

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Physician-Related Services/Healthcare Professional Services

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 99201-99215);
- Psychiatric intake and assessment (CPT code 90801);
- Individual psychotherapy (CPT codes 90804-90809); and
- Pharmacologic management (CPT codes 90862).

Note: Refer to other sections of these billing instructions for specific policies and limitation on these CPT codes.

How does the distant site bill the Department 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 Department for payment.

Audiology

[Refer to WAC 388-531-0375]

The Department 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 388-545-0700(1)(c)]

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

What Type of Equipment Must Be Used?

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

- For caloric vestibular testing (CPT procedure code 92543), bill one unit per irrigation. If necessary, you may bill up to four units for each ear.
- For sinusoidal vertical axis rotational testing (CPT procedure code 92546), bill 1 unit per velocity/per direction. If necessary, you may bill up to 3 units for each direction.

The Department 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 clues;
 - ✓ Is willing to undergo an extensive rehabilitation program;

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Physician-Related Services/Healthcare Professional Services

- ✓ 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; or
 - ✓ Has no other contraindications to surgery; and
- The procedure is performed in an inpatient hospital setting or outpatient hospital setting.

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

The Department covers replacement parts for BAHA and cochlear devices for clients 20 years of age and younger only. See the current *Speech/Audiology Billing Instructions* for more information.

The Department 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 Department is required.

Audiology Billing

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

Coverage Table

Note: Due to its licensing agreement with the American Medical Association, the Department publishes only the official, brief CPT® code descriptions. To view the full descriptions, please refer to your current CPT book.

Audiology				
Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
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
69210		Remove impacted ear wax		
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		
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		

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Physician-Related Services/Healthcare Professional Services

Audiology				
Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
92553		Audiometry, air & bone		
92555		Speech threshold audiometry		
92556		Speech audiometry, complete		
92557		Comprehensive hearing test		
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 >		
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

You may view the Department/MPA *Audiology Program Fee Schedule* online at

<http://hrsa.dshs.wa.gov/RBRVS/Index.html>

Emergency Oral Health Services

[Refer to WAC 388-531-1025]

This section does not apply to clients of the division of developmental disabilities. Refer to the *Dental Services for Clients of the Division of Developmental Disabilities Who Are 21 Years of Age and Older Billing Instructions*.

Client Eligibility

Clients age 21 and older are eligible for the oral healthcare services listed in this section, subject to coverage limitations.

Payment

The Department pays for oral healthcare services provided by a dentist to clients age 21 and older when the services provided:

- Are within the scope of the eligible client's medical care program;
- Are medically necessary as defined in WAC 388-500-0005;
- Are emergent and meet the criteria of coverage for emergency oral health benefit listed in the "Emergency Oral Health Benefit" section;
- Are documented in the client's record in accordance with Chapter 388-502 WAC;
- Meet the Department's prior authorization requirements, if there are any;
- Are within prevailing standard of care accepted practice standards;
- Are consistent with a diagnosis of teeth, mouth and jaw disease or condition;
- Are reasonable in amount and duration of care, treatment, or service;
- Are billed using only the allowed procedure codes listed in these billing instructions and the Physician-Related Services/Healthcare Professionals Fee Schedule; and

Physician-Related Services/Healthcare Professional Services

- Are documented with a comprehensive description of the client's presenting symptoms, diagnosis and services provided, in the client's record, including the following, if applicable:
 - ✓ Client's blood pressure, when appropriate;
 - ✓ A surgical narrative;
 - ✓ A copy of the post-operative instructions; and
 - ✓ A copy of all pre- and post-operative prescriptions.

Provider Requirements

- An appropriate consent form, if required, signed and dated by the client or the client's legal representative must be in the client's record.
- An anesthesiologist providing oral healthcare under this section must have a current provider's permit on file with the Department.
- A healthcare provider providing oral or parenteral conscious sedation, or general anesthesia, must meet:
 - ✓ The provider's professional organization guidelines;
 - ✓ The department of health (DOH) requirements in chapter 246-817 WAC; and
 - ✓ Any applicable DOH medical, dental, and nursing anesthesia regulations.
- Department-enrolled dental providers who are not specialized to perform oral and maxillofacial surgery (see WAC 388-535-1070(3)) must use only the current dental terminology (CDT) codes to bill claims for services that are listed in this section.
- Oral healthcare services must be provided in a clinic setting with the exception of trauma related services.

Emergency Oral Health Benefit

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 benefit when the services are done emergently. All services are subject to prior authorization when indicated.

The Department covers medical and surgical oral health services provided by a dentist, for clients 21 years of age and older, only when:

- Provided for the emergency treatment of pain, infection or trauma of the mouth, jaw, or teeth, including treatment of post-surgical complications, such as dry socket; or
- Part of a cancer treatment regimen or part of a pretransplant protocol.

Services Performed by a Dentist

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)**, one 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.

Physician-Related Services/Healthcare Professional Services

- **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;
 - Be retained by the provider as part of the client's record. The retained radiograph must be the original.
 - ✓ Duplicate radiographs must be submitted with prior authorization requests or when the department requests a copy of the client's dental record.
- **Pulpal debridement (CDT: D3221).** One gross pulpal debridement per client, per tooth, within a twelve-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.
- **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 being provided to a client.
- **Inhalation of nitrous oxide (CDT: D9230),** once per day.
- **House or extended care facility visits (CDT: D9410),** for emergency care as defined in this section.

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Physician-Related Services/Healthcare Professional Services

- **Emergency office visits after regularly scheduled hours (CDT: D9440).** The Department limits coverage 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).**

The Department covers the procedure codes in the following table when performed by a dentist to treat an acute oral health emergency.

Note: Use Expedited Prior Authorization (EPA) # 870000002 or 870000003 to indicate to the Department how clients meet emergency oral health criteria.

CDT Code	PA?	Description
D0140	N	Limit oral eval problm focus
D0220	N	Intraoral - periapical first film
D0230	N	Intraoral - periapical each additional film
D0330	N	Panoramic film
D3221	N	Gross pulpal debridement
D7140	N	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	N	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	N	Removal of impacted tooth - soft tissue
D7230	N	Removal of impacted tooth - partially bony
D7240	N	Removal of impacted tooth - completely bony
D7241	Y	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	N	Surgical removal of residual tooth roots (cutting procedure)
D9110	N	Palliative (emergency) treatment of dental pain-minor procedure
D9230	N	Analgesia, anxiolysis, inhalation of nitrous oxide
D9410	N	House/extended care facility call
D9440	N	Office visit - after regularly scheduled hours
D9610	N	Therapeutic drug injection, by report
D9930	N	Treatment of complications (post - surgical) - unusual circumstances, by report

Note: All of the previous authorization requirements related to either the procedure code itself or the site of service have not changed if and when the service is covered.

Services Performed by a Dentist Specialized in Oral Maxillofacial Surgery

The following services are covered under the emergency oral health benefit when provided by a dentist specialized in oral maxillofacial surgery. Services that are covered under the emergency oral health benefit 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 pre-transplant protocol:

- May be provided by dentists specialized in oral maxillofacial surgery; and
- Are billed using only the allowed procedure codes listed in the department’s published billing instructions and fee schedules.

The Department covers the procedure codes in the following table when performed by a dentist who specializes in oral maxillofacial surgery to treat an oral health emergency. Dentists who specialize in oral maxillofacial surgery may also be paid for performing the procedures list under the “Services Performed by a Dentist” section.

Procedure Code	PA?	Description
11000	N	Debride infected skin
11044	N	Debride tissue/muscle/bone
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

Physician-Related Services/Healthcare Professional Services

Procedure Code	PA?	Description
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
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
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
14040	N	Skin tissue rearrangement
15120	N	Skn splnt a-grft fac/nck/hf/g
15320	N	Apply skin allograft f/n/hf/g
15576	N	Form skin pedicle flap
20220	N	Bone biopsy, trocar/needle
20520	N	Removal of foreign body
20605	N	Drain/inject, joint/bursa
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
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
21025	N	Excision of bone, lower jaw
21026	N	Excision of facial bone(s)
21030	N	Excise max/zygoma b9 tumor
21034	N	Excise max/zygoma mlg tumor
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

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Physician-Related Services/Healthcare Professional Services

Procedure Code	PA?	Description
21060	Y	Remove jaw joint cartilage
21070	Y	Remove coronoid process
21076	Y	Prepare face/oral prosthesis
21077	Y	Prepare face/oral prosthesis
21081	Y	Prepare face/oral prosthesis
21100	N	Maxillofacial fixation
21110	N	Interdental fixation
21116	N	Injection, jaw joint x-ray
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
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
21345	N	Treat nose/jaw fracture

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Physician-Related Services/Healthcare Professional Services

Procedure Code	PA?	Description
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
21421	N	Treat mouth roof fracture
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
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
31515	N	Laryngoscopy for aspiration
31525	N	Dx laryngoscopy excl nb
31530	N	Laryngoscopy w/fb removal
40720	Y	Repair cleft lip/nasal
40800	N	Drainage of mouth lesion

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Physician-Related Services/Healthcare Professional Services

Procedure Code	PA?	Description
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
40830	N	Repair mouth laceration
40831	N	Repair mouth laceration
40840	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
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

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Physician-Related Services/Healthcare Professional Services

Procedure Code	PA?	Description
41826	N	Excision of gum lesion
41827	N	Excision of gum lesion
41828	N	Excision 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
42408	N	Excision 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
43200	N	Esophagus endoscopy
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
99201	N	Office/outpatient visit, new*
99211	N	Office/outpatient visit, est*
99231	N	Subsequent hospital care*
99241	N	Office Consultation*
99251	N	Inpatient Consultation*

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- B.40 -

Coverage Table

Note: All of the previous authorization requirements related to either the procedure code itself or the site of service have not changed if and when the service is covered.

Billing for Services that Qualify for Emergency Oral Health Benefit Package

For dates of service on and after January 1, 2011, the Department requires providers to use Expedited Prior Authorization (EPA) numbers at the header level of the claim to certify to the Department 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. If you are providing service 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.

Evaluation and Management Codes (formerly hospital visits and consults)

In addition to using the EPA numbers above, dentists specialized in oral surgery must use CPT codes and follow CPT rules when billing for evaluation and management of clients. The Department covers these services when a dentist specialized in oral surgery is called to the hospital or is sent a client from the hospital for an emergent condition (i.e., infection, fracture, or trauma).

When billing for these services, the following must be true:

- Services must be billed on an 837P HIPAA compliant claim form;
- Diagnosis code(s) must evidence the emergent need; and
- Services must be billed using one of the CPT procedure codes above and modifiers must be used if appropriate.

Billing the Client for Oral Health Care Services

- A waiver is not required when the client chooses to pay for a service that Medicaid has excluded from the client's benefit package. Refer to [WAC 388-502-0160](#), Billing a Client, for details about billing for excluded services (effective January 1, 2011).

Example: A dental client comes in and wants a crown. Medicaid has excluded crowns from the dental benefit for clients 21 years of age and older, so the provider is free to bill the client. No waiver is needed.

- A waiver is required when the client chooses to not have a treatment Medicaid covers, but prefers to pay for an excluded or noncovered treatment. Refer to [WAC 388-502-0160](#), Billing a Client, for details (effective January 1, 2011).

Example: A client comes in with an infection of the gum, which qualifies for emergency oral health treatment and a procedure in the set of covered emergency services is appropriate, but the client wants a root canal (an excluded service) instead of an extraction (an included service). The provider and the client must complete a waiver before this client can be billed.

Billing for All Dental-Related Services for Clients Served by the Division of Developmental Disabilities

For dates of service on and after January 1, 2011, the Department requires provider to use EPA number **870000004** at header level to indicate to the Department that the client is a client of the Division of Developmental Disabilities. Refer to the *Dental Services for Clients of the Division of Developmental Disabilities Who Are 21 Years of Age and Older Billing Instructions*. These billing instructions will be ready to view/download in January 2011.

Prior Authorization

The Department uses the determination process described in WAC 388-501-0165 for covered oral healthcare services for clients age 21 and older for an emergent condition that requires prior authorization (PA).

The Department requires a dental provider who is requesting PA to submit sufficient objective clinical information to establish medical necessity. The request must be submitted in writing on the General Information for Authorization form, DSHS 13-835, which may be obtained at <http://dshs.wa.gov/msa/forms/eforms.html>.

Physician-Related Services/Healthcare Professional Services

The Department may request additional information as follows:

- Additional radiographs (X rays);
- Study models;
- Photographs; and
- Any other information as determined by the Department.

The Department may require second opinions and/or consultations before authorizing any procedure.

When the Department authorizes an oral healthcare service for a client, that authorization indicates only that the specific service is medically necessary and emergent, it is not a guarantee of payment. The authorization is valid for six months and only if the client is eligible and the service is covered in the client's healthcare benefit package on the date of service.

The Department 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 department program;
- Is covered by an agency or other entity outside the department; or
- Fails to meet the clinical criteria, limitations, or restrictions in this section.

Services Excluded from the Emergency Health Benefit

- Excluded services that are essential to the completion of previously authorized services are covered. (e.g., client needs nonemergent extractions in 2011 of teeth prior to delivery of dentures that were authorized in 2010).
- Excluded services that are not essential to the completion of previously authorized services are not covered.
- Extractions being done in preparation for authorized dentures will be covered by the Department. Please put "Related to Dentures" in the claim comment field to certify that dentures are approved by the Department.

Note: Excluded services are not subject to Exception to the Rule (ETR).

Vision Care Services

(Includes Ophthalmological Services)

[Refer to WAC 388-531-1000]

Eye Examinations and Refraction Services

The Department 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 Division of Developmental Disabilities.

Coverage for Additional Examinations and Refraction Services

The Department covers additional examinations and refraction services outside the limitation described above 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 Division of Developmental Disabilities, regardless of age.
 - ✓ Providers must follow the Department's expedited prior authorization (EPA) process to receive payment for clients 21 years of age or older. See **EPA # 610** in Section H – *Authorization*. 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 Department 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; and
- The medical basis for the frequency of testing.

Vision Therapy

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

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

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

Ocular Prosthetics

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

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

Please refer to the current Department/MPA *Prosthetic and Orthotic Devices Billing Instructions* for more information on coverage for ocular prosthetics.

Eye Surgery

Cataract Surgery

The Department 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 endophthalmitis; or
 - ✓ Increased ocular pressure in a person who is blind and is experiencing ocular pain.

Strabismus Surgery [WAC 388-531-1000]

The Department 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 Department does not require authorization.
18 years of age or older	<p>Covered when the clinical criteria are met. To receive payment, providers must follow the expedited prior authorization (EPA) process. The clinical criteria are:</p> <ul style="list-style-type: none"> • The client has double vision; and • The surgery is not being performed for cosmetic reasons. <p>To receive payment for clients 18 years of age or older, providers must use the Department's EPA process (refer to Section H).</p>

Blepharoplasty or Blepharoptosis Surgery

The Department covers blepharoplasty or blepharoptosis surgery when all of the clinical criteria are met. To receive payment, providers must follow the Department'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, 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 Department publishes only the official, brief CPT® procedure code descriptions. To view the entire description, please refer to your current CPT book.

Procedure Code	Modifier	Brief Description	PA?	Policy/ Comments	Maximum Allowable Fee
Contact Lens Services					
92070		Fitting of contact lens	No	(Does not include any follow-up days)	On-line Fee Schedules*
Spectacle Fitting fees, monofocal					
92340		Fitting of spectacles	No		On-line Fee Schedules
92352		Special spectacles fitting	No		
Spectacle Fitting fees, bifocal					
92341		Fitting of spectacles	No		On-line Fee Schedules
Spectacle Fitting fees, multifocal					
92342		Fitting of spectacles	No		On-line Fee Schedules
92353		Special spectacles fitting	No		
Other					
92354		Special spectacles fitting	Yes		On-line Fee Schedules
92355		Special spectacles fitting	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		

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

***Note:** To view the Department's maximum allowable fees for any of these codes, download the Department/MPA Vision Care Fee Schedule at: <http://hrsa.dshs.wa.gov/rbrvs/index.html>.

Physician-Related Services/Healthcare Professional Services

General Ophthalmological Services					
92002		Eye exam, new patient	No		<u>On-line Fee Schedules*</u>
92004		Eye exam, new patient	No		
92012		Eye exam established pat	No		
92014		Eye exam & treatment	No		
Special Ophthalmological Services					
92015		Refraction	No		<u>On-line Fee Schedules</u>
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		

***Note:** To view the Department’s maximum allowable fees for any of these codes, download the Department/MPA Vision Care Fee Schedule at: <http://hrsa.dshs.wa.gov/rbrvs/index.html>.

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Physician-Related Services/Healthcare Professional Services

92083		Visual field examination(s)	No		On-line Fee Schedules*
92083	TC	Visual field examination(s)	No		
92083	26	Visual field examination(s)	No		
92100		Serial tonometry exam(s)	No		
92120		Tonography & eye evaluation	No		
92130		Water provocation tonography	No		
92135		Ophthalmic dx imaging	No		
92135	TC	Ophthalmic dx imaging	No		
92135	26	Ophthalmic dx imaging	No		
92136		Ophthalmic biometry	No		
92136	TC	Ophthalmic biometry	No		
92136	26	Ophthalmic biometry	No		
92140		Glaucoma provocative tests	No		

***Note:** To view the Department’s maximum allowable fees for any of these codes, download the Department/MPA Vision Care Fee Schedule at: <http://hrsa.dshs.wa.gov/rbrvs/index.html>.

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Physician-Related Services/Healthcare Professional Services

Ophthalmoscopy					
92225		Special eye exam, initial	No		On-line Fee Schedules*
92226		Special eye exam, subsequent	No		
92230		Eye exam with photos	No		
92235		Eye exam with photos	No		
92235	TC	Eye exam with photos	No		
92235	26	Eye exam with photos	No		
92240		Icg angiography	No		
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			

***Note:** To view the Department’s maximum allowable fees for any of these codes, download the Department/MPA Vision Care Fee Schedule at: <http://hrsa.dshs.wa.gov/rbrvs/index.html>.

Physician-Related Services/Healthcare Professional Services

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	
92275		Electroretinography	No	
92275	TC	Electroretinography	No	
92275	26	Electroretinography	No	
92283		Color vision examination	No	
92283	TC	Color vision examination	No	
92283	26	Color vision examination	No	
92284		Dark adaptation eye exam	No	
92284	TC	Dark adaptation eye exam	No	
92284	26	Dark adaptation eye exam	No	
92285		Eye photography	No	
92285	TC	Eye photography	No	
92285	26	Eye photography	No	
92286		Internal eye photography	No	
92286	TC	Internal eye photography	No	
92286	26	Internal eye photography	No	
92287		Internal eye photography	No	

[On-line Fee Schedules](#)

***Note:** To view the Department's maximum allowable fees for any of these codes, download the Department/MPA Vision Care Fee Schedule at:
<http://hrsa.dshs.wa.gov/rbrvs/index.html>.

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- B.52 -

Programs (Guidelines/Limitations)

Physician-Related Services/Healthcare Professional Services

Contact Lens Services					
92310		Contact lens fitting	No		On-line Fee Schedules*
92311		Contact lens fitting	No		
92312		Contact lens fitting	No		
92313		Contact lens fitting	No		
Ocular Prosthesis					
Please refer to the current Department/MPA <i>Prosthetic and Orthotic Devices Billing Instructions</i> for more information on coverage for ocular prosthetics.					
Contact Lens Services					
92314		Prescription of contact lens	No		On-line Fee Schedules
92315		Prescription of contact lens	No		
92316		Prescription of contact lens	No		
92317		Prescription of contact lens	No		

***Note:** To view the Department’s maximum allowable fees for any of these codes, download the Department/MPA Vision Care Fee Schedule at:
<http://hrsa.dshs.wa.gov/rbrvs/index.html>.

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Immunizations

DOH supplies free vaccines for children 0-18 years only. This section applies to clients 21 years of age and older. For clients 20 years of age and younger, refer to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Billing Instructions at:

http://hrsa.dshs.wa.gov/download/Billing_Instructions_Webpages/EPSDT.html

- Bill the Department for the cost of the vaccine itself by reporting the procedure code for the vaccine given.
- The Department reimburses providers for the vaccine using the Department's maximum allowable fee schedule.
- 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 **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 you bill the E&M code without modifier 25 on the same date of service as a vaccine administration, the Department will deny the E&M code.

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

Note: Meningococcal vaccines (CPT procedure codes 90733 and 90734) require EPA, please see Section H.

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 or 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 a Department managed care plan, the plan is responsible for providing medical coverage for the newborn(s).**

Injectables

- **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.
- **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.

Physician-Related Services/Healthcare Professional Services

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.
- **Correct Coding for Various Immune Globulins** – Bill the Department for immune globulins using the HCPCS procedure codes listed below. The Department 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

- The Department pays for injectable (see fee schedule) and nasal flu vaccines (CPT 90660) from October 1-March 31 of each year.

Note: CPT 90660 is covered by the Department for clients 19-49 years of age.

Therapeutic or Diagnostic Injections/Infusions (CPT codes 96360-96379) [Refer to WAC 388-531-0950]

- If no other service is performed on the same day, you may bill a subcutaneous or intramuscular injection code (CPT code 96372) in addition to an injectable drug code.
- The Department does not pay separately for intravenous infusion (CPT codes 96372-96379) if they are provided in conjunction with IV infusion therapy services (CPT codes 96360-96361 or 96365-96368).
- The Department pays for only one “initial” intravenous infusion code (CPT codes 96360, 96365, or 96374) per encounter unless:
 - ✓ Protocol requires you to use 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.

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Physician-Related Services/Healthcare Professional Services

- The Department 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 Department denies the E&M code 99211. However, you may bill other E&M codes on the same date of service using modifier 25 to indicate that a significant and separately identifiable service was provided. If you do not use modifier 25, the Department will deny the E&M code.
- **Concurrent Infusion:** The Department pays for concurrent infusion (CPT code 96368) only once per day.

Hyalgan/Synvisc/Euflexxa/Orthovisc

- The Department reimburses only orthopedic surgeons, rheumatologists, and physiatrists for Hyalgan, Synvisc, Euflexxa, or Orthovisc.
- The Department allows a maximum of 5 Hyalgan, 3 Euflexxa, or 3 Orthovisc intra-articular injections **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 your claim.
- This series of injections may be repeated at 12-week intervals.

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	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

Providers must bill for Synvisc, using the following HCPCS code:

HCPCS Code	Description	Limitations
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.

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Physician-Related Services/Healthcare Professional Services

- 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).
- You must bill both the injection CPT code and HCPCS drug code on the same claim form.

Clarification of Coverage Policy for Certain Injectable Drugs

In certain circumstances, the Department limits coverage for some procedures and/or injectable drugs given in a physician's office to specific diagnoses or provider types only. This policy is outlined in previous memoranda. Although specific memoranda have been superseded, the policy regarding limited coverage for some procedures and/or injectable drugs remains in effect.

Limitations on coverage for certain injectable drugs are listed below:

Procedure Code	Brief 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)
J1055	Medroxyprogester acetate inj (depo provera)	Females-only diagnoses V25.02, V25.40, V25.49, V25.9. (contraceptive mgmt) allowed once every 67 days 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)
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)

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Physician-Related Services/Healthcare Professional Services

Procedure Code	Brief Description	Limitation Restricted to ICD-9-CM
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)
Q3025	IM inj interferon beta 1-a	340 (multiple sclerosis)
Q3026	Subc inj interferon beta-1a	340 (multiple sclerosis)
J2323	Natalizumab injection	340 (multiple sclerosis). 555.0, 555.1, 555.2, 555.9 (crohn's disease). Requires PA. See <i>Important Contacts</i> section for information on where to obtain the authorization form.

Clarification of Coverage Policy for Miscellaneous Procedures

- Limitations on coverage for certain miscellaneous procedures are listed below:

Procedure Code	Brief 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

Verteporfin Injection (HCPCS code J3396)

Verteporfin injections are limited to ICD-9-CM diagnosis code 362.52 (exudative senile macular degeneration).

Clozaril Case Management

- Providers must bill for Clozaril case management using CPT code 90862 (pharmacologic management).
- The Department reimburses only physicians, psychiatrists, ARNPs, and pharmacists for Clozaril case management.
- The Department reimburses providers for one unit of Clozaril case management per week.
- The Department 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 Department does not pay for Clozaril case management when billed on the same day as any other psychiatric-related procedures.

Botulism Injections (HCPCS code J0585, J0587, J0775)

The Department requires PA for HCPCS codes J0585 and J0587 **regardless of the diagnosis**. The Department requires PA for CPT code 95874 when needle electromyography for guidance is used.

The Department approves Botulism injections with PA:

- For the treatment of:
 - ✓ Cervical dystonia;
 - ✓ Blepharospasm; and
 - ✓ Lower limb spasticity associated with cerebral palsy in children; and
 - ✓ Nonsurgical treatment for Dupuytren's contracture (J0775 only)
- As an alternative to surgery in patients with infantile esotropia or concomitant strabismus when:
 - ✓ Interference with normal visual system development is likely to occur; and
 - ✓ Spontaneous recovery is unlikely.

Vivitrol (J2315)

The Department requires prior authorization for Vivitrol. It is also available when prior authorized through the pharmacy Point-of Sale (POS) system.

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Allergen Immunotherapy [Refer to WAC 388-531-0950(10)]

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	<ul style="list-style-type: none"> ✓ One injection (CPT code 95115 or 95117); <i>and</i> ✓ One antigen/antigen preparation (CPT codes 95145-95149, 95165 or 95170).
Antigen/antigen preparation for stinging/biting insects	<ul style="list-style-type: none"> ✓ CPT codes 95145-95149 and 95170
All other antigen/antigen preparation services (e.g., dust, pollens)	<ul style="list-style-type: none"> ✓ CPT code 95144 for single dose vials; <i>or</i> ✓ CPT code 95165 for multiple dose vials.
Allergist prepared the extract to be injected by another physician	<ul style="list-style-type: none"> ✓ CPT code 95144
Allergists who billed the complete services (CPT codes 95120-95134) and used treatment boards	<ul style="list-style-type: none"> ✓ One antigen/antigen preparation (CPT 95145-95149, 95165, and 95170); and ✓ One injection (CPT code 95115 or 95117).
Physician injects one dose of a multiple dose vial	<ul style="list-style-type: none"> ✓ 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	<ul style="list-style-type: none"> ✓ 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.

National Drug Code Format

All providers are required to use the 11-digit National Drug Code (NDC) when billing the Department 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 388-530-1050]
- 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 123456789 when, in fact, the correct NDC is 01234056789. Make sure that the NDC is listed as an 11-digit number, inserting any leading zeros missing from the 5-4-2 groupings, as necessary. *The Department 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**, you must 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

Physician-Related Services/Healthcare Professional Services

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, you must list the additional drugs must be listed 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.

Psychiatric Services [Refer to WAC 388-531-1400]

MPA-enrolled providers contracted with, or employed by, Community Mental Health Agencies must not bill fee-for-service (FFS) and report a Regional Support Network (RSN) encounter on the same service date when providing services to clients eligible for RSN services that meet access to care standards. Reportable services for Community Mental Health Agency clients meeting RSN access-to-care standards are authorized and purchased separately under the RSN Pre-paid Inpatient Health Plan.

Note: These billing instructions are not for use by Psychologists. Refer to the current Department/MPA *Psychologist Billing Instructions* for a description of the Psychology program. To view the billing instructions online, go to <http://hrsa.dshs.wa.gov/download/BI.html>.

General Guidelines

- The Department pays a maximum of one psychiatric service procedure code per client, per day.
- Psychiatrists must bill using one procedure code for the total time spent on direct client care during each visit. Making inpatient rounds is considered direct client care and includes any one of the following:
 - ✓ Individual psychotherapy (CPT codes 90804-90809, 90810-90815*, 90816-90822, and 90823-90829*);
 - ✓ Family psychotherapy (CPT code 90847);
 - ✓ Group psychotherapy (CPT codes 90853 and 90857);
 - ✓ Electroconvulsive therapy (CPT codes 90870); or
 - ✓ Pharmacological management (CPT code 90862).
- When performing both psychotherapy services and an E&M service during the same visit, use the appropriate psychiatric procedure code that includes the E&M services [e.g., CPT code 90805 (outpatient psychotherapy with E&M) or CPT code 90817 (inpatient psychotherapy with E&M)].
- A psychiatrist may not bill for a medical physical examination in the hospital (CPT codes 99221-99233) in addition to a psychiatric diagnostic or evaluation interview examination (CPT code 90801 for adults or 90802 for children).
- The Department pays psychiatrists for the CPT codes listed in the following tables only when billed in combination with the diagnoses listed in the table. **For each date of service billed, the diagnosis on the detail line must indicate the specific reason for the visit.**
- Psychiatric sleep therapy is not covered.

***Interactive psychotherapy is limited to clients 20 years of age and younger.**

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Covered Services for Psychiatrists Using ICD-9-CM Diagnosis Codes 290.0-319

Inpatient Hospital

Covered Procedure	CPT Codes
Initial Hospital Care	99221-99223
Subsequent Hospital Care	99231-99233
Inpatient Consultation	99251-99255
Inpatient Psychotherapy	90816-90822, 90823-90829*

*Codes 90823-90829 are limited to clients 20 years of age and younger.

Outpatient Hospital

Covered Procedure	CPT Codes
Observation	99234-99239
Psychotherapy	90804-90815
Consultation	99241-99245

Office

Covered Procedure	CPT Codes
Consultation	99241-99245
Psychotherapy	90804-90815

Other Psychiatric Services

Covered Procedure	CPT Codes
Psychiatric Diagnostic Interview	90801, 90802
Other Psychotherapy	90845, 90847, 90853
Other Psychiatric Services	90862-90870, 90899
Case Management Service	
• Team Conferences	99367
• Telephone Calls	99441-99443

The Department does not pay for the following psychotherapy codes when billed with office E&M codes:

90805	90807	90809	90811	90813	90815	90817
90819	90822	90824	90827	90829		

The following procedure codes are limited to clients 20 years of age and younger: 90823-90829, 90810-90815, and 90802.

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Noncovered Services for Psychiatrists Using ICD-9-CM Diagnosis Codes 290.0-319

The Department does not cover the following services for psychiatrists using ICD-9-CM diagnosis codes 290.0-319:

- Office visits (99201-99215);
- Emergency department visits (99281-99288);
- Nursing facility services (99304-99318);
- Domiciliary home or custodial care services (99324-99340);
- Home services (99341-99359); and
- Stand-by services (99360).

Limitations for Inpatient Psychiatric Services

- Admissions for acute, community psychiatric inpatient care require PA from the designated Division of Behavioral Health and Recovery (DBHR) Designees which are referred to as the Regional Support Networks (RSNs). The hospital obtains the prior authorization. Please see the list of RSNs at the Division of Mental Health's web site: <http://www.dshs.wa.gov/dbhr/rsn.shtml>.
- The Department does not cover physician services for clients admitted for voluntary psychiatric admissions on the psychiatric indigent inpatient PII program who are covered under the "MIP-EMER No out-of-state care" Benefit Service Package.
- Psychiatric diagnostic interview examinations (CPT codes 90801 and 90802) are limited to one in a calendar year per provider. PA is required if a second examination is needed because of a change in a client's condition or if they have a change in legal status (i.e., voluntary to involuntary or involuntary to voluntary). CPT code 90802 is limited to those clients who are 20 years of age and younger.

Limitations for Outpatient Psychiatric Services

Outpatient psychiatric services are not allowed for clients on the General Assistance Unemployable (GAU) program, except for medication adjustment (CPT code 90862).

Expanded Mental Health Services for Children

Note: The services in this section must be provided in a healthcare professional's office.

For clients 18 year of age and younger the Department will:

- Increase the number of hours allowed for psychotherapy up to a maximum of 20 hours per calendar year; and
- Allow more providers to perform these mental health services.

Who is eligible for the expanded benefits?

Due to new legislation intended to improve access to mental health services for children who do not meet the Regional Support Network (RSN) Access to Care Standards, the Department is expanding mental health services for clients 18 years of age and younger who are eligible through one of the following Benefit Service Packages:

- Categorically Needy Program (CNP);
- Children's Health Program (CNP);
- State Children's Health Insurance Program (SCHIP); or
- Limited Casualty – Medically Needy Program (LCP-MNP).

Clients enrolled in Healthy Options plans will have this new benefit. Please contact the client's plan for more information. (Refer to RCW 74.09.521.)

Note: Please note that this benefit is for children who do not meet the RSN's access to care standards. If it is medically necessary, therapists need to transition care of the child to the RSN, as appropriate to the child's condition.

How many hours will the Department pay for?

The Department will pay providers one psychiatric service per day, up to a maximum of 20 hours, which includes the evaluation, per eligible client, per calendar year for the expanded services listed on page D.9. This may include some hours delivered by one provider and other hours delivered by another provider.

How do I know how many hours of a client's benefit have been billed for?

It is the provider's responsibility not to provide services beyond the client's maximum benefit.

Contact the Department by calling **1-800-562-3022 (TTY): 1-800-848-5429** to find out how many hours of a client's benefit have already been billed. The Department will not pay for services exceeding the 20-hour maximum per calendar year limitation unless the provider has requested and obtained a limitation extension from the Department.

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Physician-Related Services/Healthcare Professional Services

What will I do if the client has exhausted the maximum benefit?

Fee-For-Service:

If clients need additional visits after they have used their first 20-hour-per-calendar-year benefit, please have them evaluated by the RSN whether they meet criteria for additional services or meet the access to care standard. Include an RSN denial or assessment from an RSN-contracted community mental health center with the request to the Department.

The provider must request and obtain a limitation extension from the Department following the requirements found in WAC 388-501-0169 including:

- Justification of medical necessity;
- Description of services provided and outcomes obtained in treatment to date;
- Expected outcome of extended services; and
- An RSN denial or assessment from an RSN-contracted community mental health center must be included with the request to the Department.

Note: For the Department to authorize payment, a completed Basic Information Form, DSHS 13-756, must be faxed to the Department (see *Important Contacts* section).

Healthy Options Managed Care:

For any additional Healthy Options Managed Care outpatient mental health services needed for clients who have exhausted their 20 hour per calendar year benefit limit, the provider must request and obtain a limitation extension from the client's MCO following the MCO identified requirements and process.

For more information, including verification of the number of hours already paid by the Department for a client, contact the Department (see *Important Contacts* section).

Who may provide the expanded services?

Effective for dates of service on and after July 1, 2008 the following list of mental health professionals, as defined in [RCW 71.34.020](#) and licensed by the Department of Health, may provide and bill the Department fee-for-service for the expanded mental health services to children:

- **Psychiatrist:** Licensed Psychiatrist;
- **Psychologist:** Licensed Psychologist;
- **Psychiatric Nurse:** Licensed Advanced Registered Nurse Practitioner;
- **Social Worker:** Licensed Independent Clinical Social Worker or Advanced Social Worker;
- **Marriage and Family Therapist:** Licensed Marriage and Family Therapist; and
- **Mental Health Professionals:** Licensed Mental Health Counselor.

Note: Mental health professionals must meet the provider requirements listed within these billing instructions to be eligible to provide expanded services.

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What Are the Requirements that Providers Must Meet as Mental Health Professionals?

To be eligible to provide and bill the Department fee-for-service for mental health services, mental health professionals must:

- Be licensed by DOH and be in good standing without restriction.
- Have a minimum of two years experience in the diagnosis and treatment of children, youth, and their families (experience may be a combination of pre and post licensure and may include supervised internships completed as part of a master's degree curriculum). The equivalent of one year of full-time experience must be under the supervision of a mental health professional trained in child and family mental health."

Note: A licensed psychiatrist may provide services and bill the Department without meeting this minimum experience requirement.

How are children's mental health services administered?

Children's outpatient mental health services are available through:

- Regional Support Networks (RSNs) which are under contract with the Department's Division of Behavioral Health and Recovery (DBHR) for individuals whose condition meets the RSN Access to Care Standards,
- Managed Care Organizations (MCOs) which are under contract with the Department's Healthy Options program for individuals enrolled with an MCO whose condition does not meet the RSN Access to Care Standards, or
- Professionals with individual Core Provider Agreements who will accept payment on a Fee-For-Service (FFS) basis for individuals not enrolled with an MCO whose condition does not meet the RSN access to care standards.

What services do the Regional Support Networks cover?

RSN Crisis Services:

Crisis mental health services are provided upon request, 24-hours a day, 7 days a week and are available to anyone who needs them regardless of ability to pay. All RSN's publish a toll free crisis number in local phone books.

To find numbers for crisis intervention services, visit the Department on-line at:

<http://www.dshs.wa.gov/dbhr/rsn.shtml>

RSN Community Psychiatric Inpatient Services:

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Physician-Related Services/Healthcare Professional Services

RSNs authorize and pay for all medically necessary community psychiatric inpatient services ([WAC 388-550-2600](#)). To refer a client for community psychiatric inpatient services, contact your local RSN.

To find the appropriate RSN and contact information, visit the Department on-line at:
<http://www.dshs.wa.gov/pdf/dbhr/mh/WashingtonStateRSNmap.pdf>

RSN Access to Care Standards:

In addition to providing crisis intervention services and community inpatient services, the RSNs also manage the public mental health services that are delivered by DBHR licensed and RSN contracted community mental health agencies to individuals who are Medicaid or SCHIP eligible who also meet the Access to Care Standards (ACS). As resources allow, some medically necessary services may be provided to indigent clients who meet the ACS, however this is determined at the local level. ACS are established by the Department and are approved by the Centers for Medicare and Medicaid Services (CMS).

Note: If you are treating or evaluating a child or youth who appears to meet the ACS, contact the local RSN to make a referral for an intake evaluation.

Physician-Related Services/Healthcare Professional Services

To meet the ACS for children and youth, the following five conditions must be true:

1. The child or youth is determined to have a mental illness that is listed as a covered diagnosis found in the ACS under “Covered Childhood Disorders”,
2. The impaired level of functioning and corresponding need(s) identified must be as a result of mental illness,
3. The intervention is deemed reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness,
4. The child or youth is expected to benefit from the intervention, and
5. The unmet need(s) of the child or youth cannot be appropriately met by any other formal or informal system or support.

To learn more about the ACS, visit the Department on-line at:

<http://www.dshs.wa.gov/dbhr/mhpublications.shtml>

Physician-Related Services/Healthcare Professional Services

For Clients 19 years of age and Older

- The Department limits outpatient psychotherapy and electroconvulsive therapy in any combination for clients 19 years of age and older to one hour per day, per client, up to a total of 12 hours per calendar year. This includes family or group psychotherapy. The following codes are included in the allowed 12 hours:

90804	90805	90806	90807	90808	90809	90810
90811	90812	90813	90814	90815	90845	90847
90853	90857	90865	90870	90899		

Note: Pharmacological management is not subject to the 12-visit limitation.

Services Provided by Psychiatric Advanced Registered Nurse Practitioners (ARNPs)

Provider Requirements

Psychiatric ARNPs may bill the expanded mental health services to children when they have met the following provider requirements:

To provide the services listed in the code tables on the following pages, mental health professionals must:

- Be licensed by DOH and be in good standing without restriction.
- Have a minimum of two years experience in the diagnosis and treatment of children and youth, and their families; at least one year must have been under the supervision of a mental health professional trained in child and family mental health.

Note: A licensed psychiatrist may provide services and bill the Department without meeting this minimum experience requirement.

Enrollment

How do I enroll to provide mental health services to children?

To enroll you must:

- Obtain a National Provider Identifier (NPI) from the federal government;
- Complete a Core Provider Agreement (if you are already an enrolled provider you must send in this additional information to bill for these services);
- Write and sign a letter attesting to your experience in providing mental health services to children, youth and their families as described above (the letter does not need to be notarized); and
- Send all of the above to the Provider Enrollment (see the *Important Contacts* section).
For more information, contact Provider Enrollment.

Physician-Related Services/Healthcare Professional Services

Psychiatric ARNPs that meet the requirements **listed within these billing instructions** are approved to bill the expanded mental health services for children (see *Psychiatric ARNP Code Table 1 below*) and may bill one psychiatric service per day, up to 20 hours, per calendar year, **for clients 18 years of age and younger**. This includes the diagnostic interview exam (90801 or 90802).

These psychiatric ARNPs may also bill the CPT codes in *Psychiatric ARNP Code Table 2* **for clients of any age**.

PSYCHIATRIC ARNP CODE TABLE 1		
CPT Procedure Code	ICD-9 CM Diagnosis Code	Limitations
90801*	Must be billed with these diagnosis codes: 290.0-319.	One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90802*		One psychiatric diagnostic interview exam allowed per client, per provider, per calendar year.
90804		
90805		
90806		
90807		
90808		
90809		
90810		
90811		
90812		
90813		
90814		
90815		
90847		
90853		
90857		
90899		

Note: When a client is seen for a psychiatric service as listed above, and medication management is necessary, a psychiatric ARNP or a physician may bill medication management (CPT code 90862) on the same day.

*The Department pays for only one psychiatric diagnostic interview exam (90801 or 90802) per client, per provider, per calendar year. This exam is included in the 20-hour limitation unless a significant change in the client’s circumstances requires an additional exam and the provider obtains prior authorization.

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Physician-Related Services/Healthcare Professional Services

When a psychiatric ARNP is performing both psychotherapy services and Evaluation & Management (E&M) services during the same visit, use the appropriate psychiatric CPT procedure code that includes the E&M service (e.g., CPT code 90805)

Note: Pharmacological management is not subject to the 12-visit limitation.

Psychiatric ARNPs **who have not applied or do not meet the requirements on page D.10** may bill for the services in *Psychiatric ARNP Code Table 2* only, for clients of any age. When billing, you must use a psychiatric diagnosis code in the range of 290.0-319:

PSYCHIATRIC ARNP CODE TABLE 2	
Covered Procedure	CPT Codes
Initial Hospital Care	99221-99223
Subsequent Hospital Care	99231-99233
Observation Hospital	99234-99239
Psychiatric Diagnostic Interview	90801, 90802
Pharmacological Management	90862
Case Management Services	99367
• Team Conferences	99441-99443
• Telephone Calls	

The Department does not pay the same provider for psychiatric procedure codes and E&M procedure codes on the same date of service unless there are two separate visits and the provider bills using modifier 25 to indicate a significant and separately identifiable condition exists and is reflected by the diagnosis.

The Department does not pay psychiatric ARNPs for psychotherapy for adults 21 and over. The Department pays one psychiatric diagnostic interview examination 90801 or 90802 once a calendar year. Office visits 99201 – 99215 cannot be billed for psychotherapy. Pharmacologic management 90862 can be billed when prescribing medication, use and review of medication with no more than minimal medical psychotherapy.

Pharmacological Management (CPT 90862)

Pharmacological management refers to the in-depth management of psychopharmacological agents, which are medications with the potential for serious side effects. It represents a skilled aspect of care for a client who has been determined to have a mental illness. The focus of a pharmacological management visit is the use of medication for relief of the client's signs and symptoms of mental illness. When the client continues to experience signs and symptoms of mental illness that require discussion beyond minimal psychotherapy, the focus of the service is broader and is considered psychotherapy rather than pharmacological management.

Pharmacological management (CPT 90862):

- May be billed when prescribing the medication(s) and when reviewing the effects of the prescribed medication(s), with no more than minimal medical psychotherapy.
- Is intended for use for clients who are being managed primarily by psychotropic medications.
- Must be provided during a face-to-face visit with the client, unless it is part of a qualified telehealth visit.

Documentation Requirements

The medical record must be clear, concise, and complete. A check-off list by itself is not accepted as complete documentation. The treating provider must document in the medical record that pharmacologic management was reasonable and medically necessary. The claim and the medical record must list the diagnosis that most accurately describes the condition that necessitated pharmacological management.

Documentation of medical necessity for pharmacological management must address **all of the following** information in the client's medical record in legible format:

- Date and time.
- Diagnosis – update at least annually.
- Interim medication history.
- Current symptoms and problems, including any physical symptoms.
- Problems, reactions, and side effects, if any, to medications and/or ECT.
- Current mental status exam.
- Any medication modifications.
- The reasons for medication adjustments/changes or continuation.
- Desired therapeutic drug levels, if applicable.
- Current laboratory values, if applicable.
- Anticipated physical and behavioral outcome(s).

Involuntary Treatment Act (ITA)

For persons over the age of 12 (see “Age of Consent” below) detained under the provisions of the Involuntary Treatment Act (ITA) as defined by chapters 71.05 and 71.34 RCW, DBHR designees authorize and pay for services provided to clients receiving medical assistance. When the client is in the process of applying for medical assistance, payment by the DBHR designee is subject to eligibility determination.

The Department pays for services provided to clients detained under ITA law when the client either refuses to apply for, or does not qualify for, any medical assistance program as described. These stays are paid for through the use of state funds allocated to DBHR.

Unlike the PII program, under ITA, the Department *does* cover the ancillary charges for physicians, transportation (including ambulance), or other costs associated with an involuntary hospital inpatient psychiatric hospitalization.

For all clients involuntarily detained under Chapter 71.34 and 71.05 RCW, physicians and/or psychiatric advanced registered nursing practitioners may bill the Department for psychiatric services under the Involuntary Treatment Act according to the following guidelines:

- Each involuntarily committed person must be examined and evaluated by a licensed physician and/or psychiatric advanced registered nursing practitioner within 24 hours of admission or payment will be denied. This evaluation may be used for both treatment purposes and court testimony. Bill admissions through the emergency room using either CPT code 90801 or 90802.
- A day's rounds, along with any one of the following, constitute direct client care: narcosynthesis, brief (up to one hour) individual psychotherapy, multiple/family group therapy, group therapy, or electroconvulsive therapy.
- A court may request another physician or psychiatric advanced registered nursing practitioner evaluation.
- The Department pays for physician and/or psychiatric advanced registered nursing practitioner evaluations and consultations to the court regarding the need for continued involuntary psychiatric hospitalization of a client. Documentation of the time required for actual testimony must be maintained in the client's medical record. Only one court testimony is paid per hearing. Bill using the medical testimony code (CPT code 99075) for time spent doing court testimony.
- **Psychologist services** are covered *only* for provision of a psychological evaluation of detained clients. (See the Department's *Psychologist Billing Instructions* for related policy and/or procedure codes).

Physician-Related Services/Healthcare Professional Services

- **Out-of-state hospitals** must obtain authorization from the appropriate DBHR designee for all Medicaid clients. Neither the Department nor the DBHR designee pays for inpatient services for non Medicaid clients if provided outside of State of Washington. An exception is for clients who are qualified for the General Assistant – Unemployable (GAU) program. For these clients, the Department and the DBHR designee pays for inpatient psychiatric services provided in bordering cities and critical access 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.

Note: One unit = 10 minutes. A maximum of five units is allowed.

- Additional costs for court testimony are paid from county ITA administrative funds.

EPA Criteria for Neuropsychological Testing

(CPT codes 96118 and 96119)

Note: If the client does not meet the EPA criteria listed in this section, the Department requires PA for the testing. In addition, the Department requires providers to request PA for testing that exceeds 15 hours per calendar year.

Services(s)	Neuropsychological testing of adults, age 16 and over, in an outpatient or inpatient setting.
Providers	<p>The Department pays only “qualified” providers for administering neuropsychological testing to eligible Department clients. To be “qualified,” providers must be:</p> <ul style="list-style-type: none"> • Currently licensed in Washington state to practice psychology and/or clinical neuropsychology; and • Either: <ul style="list-style-type: none"> ✓ Board-certified in clinical neuropsychology by the American Board of Clinical Neuropsychology; or ✓ Have adequate education, training, and experience as defined by having completed all of the following: <ul style="list-style-type: none"> ➤ A doctoral degree in psychology from an accredited university training program; ➤ An internship, or its equivalent, in a clinically relevant area of professional psychology; and ➤ The equivalent of two full-time years of experience and specialized training, at least one of which is at the post-doctoral level, in the study and practice of clinical neuropsychology and related neurosciences. These two years must include supervision by a clinical neuropsychologist.
Billing Codes	96118 and 96119 may be billed with EPA # 870001207 if all the criteria in this section are met.

Neuropsychological Testing (cont.)

<p>Billing and Payment Limits</p>	<p>A qualified provider may bill 96118 alone if he or she administers the test. If a technician administers the test, 96119 must be billed with 96118 to account for the professional interpretation and report of test results.</p> <p>Up to a maximum of 15 hours per calendar year for a combination of CPT 96118 and 96119 are allowed for patients who meet the criteria specified here.</p> <div style="border: 1px solid black; background-color: #e0f0ff; padding: 5px; margin: 10px auto; width: fit-content;"> <p>Note: If the client does not meet the criteria in this section or requires more than 15 hours of testing, the provider must request PA.</p> </div>
<p>Criteria</p>	<p>The following are four groups of criteria that apply in different circumstances.</p> <p>To assist with rehabilitation efforts and manage outcomes in inpatient physical medicine and rehabilitation (PM&R) patients, criteria in Group 1 must be met.</p> <p>For outpatient or non-PM&R inpatient settings, criteria in any one of groups 1-4 must be met.</p> <p>Group 1</p> <ul style="list-style-type: none"> • The patient to be evaluated has, or is suspected to have, an acquired injury to the brain as a result of traumatic brain injury, stroke, multiple sclerosis, aneurysm, anoxia, dementia, neoplasm, or chemotherapy; • The patient is of working or school age (age 16 and older); • The patient was functioning normally (was able to attend school, work competitively, or live independently) prior to the brain disorder; • The patient has potential to return to important areas of role functioning (e.g., work, school, or independent living); AND • Testing will be used only in conjunction with functionally based rehabilitation, not “cognitive” rehabilitation.

Neuropsychological Testing (cont.)

Criteria (cont.)	<p>Group 2</p> <p>The client is suspected to have a diagnosis of dementia or multiple sclerosis based on one of the following:</p> <ul style="list-style-type: none"> • Client or family complaints; • A head CT (computed tomography scan); or • A mental status examination or other medical examination. <p>This suspected diagnosis is not confirmed or able to be differentiated from the following:</p> <ul style="list-style-type: none"> • Normal aging; • Mild concussion; • Depression; or • Focal neurological impairments. <p>A firm diagnosis would change the medical treatment plan, clinical management, or aid important client or family decisions.</p> <p>Group 3</p> <p>The client is undergoing brain surgery for epilepsy, a tumor, or Parkinson’s disease, and neuropsychological testing may help:</p> <ul style="list-style-type: none"> • Guide the surgeon in the goal of sparing healthy brain tissue or sites that are critical to some major function such as language; or • Identify poor candidates for neurological surgery due to dementia (e.g., in cases where deep brain stimulation implants are being considered to manage intractable tumors). <p>Group 4</p> <p>The client is being considered for surgery (e.g., a lung transplant), and neuropsychological testing may help identify if the client is a poor candidate for general surgery (e.g., in cases where cognitive impairment from chronic hypoxia or other risk factors make it unlikely that the person can accurately follow a rigorous post transplant protocol to prevent organ rejection).</p>
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Note: If the client does not meet the criteria in this section, the provider must request prior authorization (PA). Fax the request to MPA at 1-360-586-1471.

Foot Care Services for Clients 21 years of Age and Older

[Refer to WAC 388-531-1300]

What Is Covered?

The Department covers foot care services as listed in this section when those services are provided by any of the following healthcare providers and billed to the Department 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; or
- Advanced registered nurse practitioners (ARNP).

The Department covers evaluation and management visits to assess and diagnose conditions of the lower extremities. Once diagnosis is made, the department covers treatment if the criteria in 388-531-1300 (4)(a) are met.

What Does the Department Pay For?

Note: Treatment of the lower extremities 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 388-531-1300 (4)(a)

The Department pays for:

- ✓ Acute inflammatory processes such as, but not limited to tendonitis;
- ✓ Circulatory compromise such as, but are not limited to:
 - Lymphedema;
 - Raynaud's disease;
 - Thromboangiitis obliterans; and
 - Phlebitis.
- ✓ Injuries, fractures, sprains, and dislocations;
- ✓ Gout;
- ✓ Lacerations, ulcerations, wounds, blisters;
- ✓ Neuropathies, e.g., reflex sympathetic dystrophy secondary to diabetes;
- ✓ Charcot Arthropathy;

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Physician-Related Services/Healthcare Professional Services

- ✓ Osteomyelitis;
 - ✓ Post-op complications.
- Warts, corns, or calluses in the presence of an acute condition such as infection and pain effecting the client's ability to ambulate as a result of the warts, corns or calluses and meets criteria in in the table entitled "Acute Conditions of the Lower Extremities by Diagnosis" and meets criteria per WAC 388-531-1300 (4)(a).
 - ✓ Soft tissue conditions, such as, but are not limited to:
 - Rashes;
 - Infections (fungal, bacterial);
 - Gangrene;
 - Cellulitis of lower extremities;
 - Soft tissue tumors; and,
 - Neuroma.
 - ✓ Nail bed Infections (paronychia); and
 - ✓ Tarsal tunnel syndrome.
 - Trimming and/or debridement of nails to treat as applicable condition from the conditions in the table entitled "Acute Conditions of the Lower Extremities by Diagnosis" and meets criteria per WAC 388-531-1300 (4)(a).

The Department pays for one treatment in a 60 day period. The Department 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 table entitled "Acute Conditions of the Lower Extremities by Diagnosis" and meets criteria per WAC 388-531-1300 (4)(a).
 - Impression casting to treat one of the conditions in the table entitled "Acute Conditions of the Lower Extremities by Diagnosis" and meets criteria per WAC 388-531-1300 (4)(a).

The Department includes 90 day follow-up care in the reimbursement;

Physician-Related Services/Healthcare Professional Services

- Custom fitted and/or custom molded orthotic devices to treat one of the conditions in the table entitled “Acute Conditions of the Lower Extremities by Diagnosis” and meets criteria per WAC 388-531-1300 (4)(a).
 - ✓ The Department'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); and
 - ✓ The Department 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 Department 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 Department does not pay podiatric physicians or surgeons for X-rays for any part of the body other than the foot or ankle.

Note: The Department does not pay for treatment of chronic acquired conditions of the lower extremities. The Department will pay for prescriptions per the [*Prescription Drug Program Billing Instructions*](#)

Physician-Related Services/Healthcare Professional Services

Acute Conditions of the Lower Extremities by Diagnosis

CODE	CONDITION	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 Necrosis 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
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	Thromboangiitis 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

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Physician-Related Services/Healthcare Professional Services

CODE	CONDITION	CODE	CONDITION
454.2	Varicose Vein or Stasis Dermatitis with Inflammation and Ulceration	845.11	Sprain or Strain of Tarsometatarsal Ligament
457.1	Lymphedema	845.12	Sprain or Strain of Metatarsaophalangeal
681.1	Cellulitis/Abscess Toe	845.13	Sprain or Strain of Interphalangeal, Toe
681.11	Paronychia of Toe	845.19	Sprain or Strain Other
681.9	Cellulitis and Abscess of Unspecified Digit	891.00	Open Wound Ankle - Without Complication
682.6	Cellulitis, Abscess of Ankle/Leg	891.1	Open Wound Ankle - With Tendon Involvement
682.7	Cellulitis, Abscess of Foot or Heel, except Toes	891.2	Open Wound Ankle - Complicated
703.0	Ingrowing Nail with Infection	892.0	Open Wound Foot, Except Toes-Without Complication
707.07	Pressure Ulcer or Decubitus of Heel	892.1	Open Wound Foot, Except Toes-Complicated
707.13	Ulcer of Ankle, Except Pressure Ulcer	892.2	Open Wound Foot, Except Toes - with Tendon Involvement
707.14	Ulcer Heel/Midfoot, Except Pressure Ulcer	893.0	Open Wound Toes
707.15	Ulcer Other Part of Foot/Toe, Except Pressure Ulcer	893.1	Open Wound Toes-Complicated,
709.3	Degenerative Skin Disorders; Necrobiosis Lipoidica	893.2	Open Wound Toes - with Tendon Involvement
713.5	Arthropathy Associated with Neurological Disorders	894.0	Multiple open wounds of lower extremity - Without Complication
718.47	Contracture of Ankle or Foot Joint	894.1	Multiple open wounds of lower extremity - With Complication
726.7	Enthesopathy of Ankle and Tarsus, Unspecified	894.2	Multiple open wounds of lower extremity - With Tendon Involvement
726.71	Tendonitis Achilles	895.0	Traumatic Amputation of Toes (Complete) (Partial) - Without Complication
726.72	Tibial Tendonitis	895.1	Traumatic Amputation of Toes (Complete) (Partial) - Complication
726.79	Tendonitis Peroneal	896.0	Traumatic Amputation of Foot, Unilateral (Complete) (Partial) - Without Complication

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CODE	CONDITION	CODE	CONDITION
726.9	Capsulitis	896.1	Traumatic Amputation of Foot, Unilateral (Complete) (Partial) - With Complication
726.91	Exostosis (Bone spur)	896.2	Traumatic Amputation of Foot, Bilateral (Complete) (Partial) - Without Complication
727.06	Tenosynovitis of Foot and Ankle	896.3	Traumatic Amputation of Foot, Bilateral (Complete) (Partial) - With Complication
727.67	Achilles Tendon Rupture, Non-traumatic	916.3	Blister ankle, infected
727.68	Ruptur of Other Foot and Ankle Tendons, Non-traumatic	917.2	Blister Foot, No Infection
728.71	Plantar Fascial Fibromatosis	917.3	Blister foot with infection
728.86	Necrotizing Fasciitis	924.2	Hematoma of Ankle or Foot, Excluding Toe
729.1	Myalgia and Myositis	924.3	Subungual (Toenail) Hematoma
729.6	Foreign Body in Soft Tissue	958.92	Traumatic Compartment Syndrome of Lower Extremity
729.72	Non-Traumatic Compartment Syndrome of the Lower Extremity	959.7	Injury Foot, Ankle or Leg
730.06	Infection of Bone Lower Leg, Acute	991.5	Chilblains
730.07	Infection of Bone Foot or Ankle, Acute	996.6	Complication of Post-operative Implant
730.16	Osteomyelitis of Lower Leg, Chronic	998.32	Dehiscence of External Operation (Surgical) Wound
730.17	Osteomyelitis of Foot or Ankle, Chronic	998.59	Post operative Abscess/Infection
730.26	Unspecified Osteomyelitis, Lower Leg	998.83	Non-healing Surgical Wound

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What Does the Department Not Pay For?

The Department does not pay for treatment of or follow-up office visits for chronic acquired conditions of the lower extremities. The Department will pay for prescriptions per the [Prescription Drug Program Billing Instructions](#).

Foot care, unless the client meets criteria and conditions outlined in WAC 388-531-1300 as follows:

- Routine foot care, such as but not limited to:
 - ✓ Treatment of tinea pedis;
 - ✓ Cutting or removing warts, corns and calluses; and
 - ✓ Trimming, cutting, clipping, or debriding of nails.
- Nonroutine foot care, such as, but not limited to treatment of:
 - ✓ Flat feet;
 - ✓ 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.

Any other service performed in the absence of localized illness, injury, or symptoms involving the foot

The Department does not reimburse providers for any of the following radiology services:

- Bilateral x-rays for unilateral condition;
- X-rays in excess of three views;
- X-rays that are ordered before the client is examined;

The Department does not reimburse podiatrists for x-rays for any part of the body other than the foot or ankle.

Note: Clients may request an Exception to Rule for treatment of those conditions not listed above. See WAC 388-501-0160

Billing the Client for Noncovered Services

A waiver is required when clients choose to pay for a foot care service to treat a condition not listed in Figure 1. Requesting an ETR is optional for the client. See [WAC 388-502-0160](#) Billing the Client for details.

How to Bill for Foot Care Services

The Department will only pay for treatment of an acute condition 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 (from Table 1) 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 Department 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 Department 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 Department. If Medicare does cover the service, bill Medicare first.

Radiology Services [Refer to WAC 388-531-1450]

General Limitations on Radiology Services

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

Other Limitations

- PET Scans and MRI/MRAs are limited to one per day.
- Multiple CT Scans are allowed only if done at different times of the day or if modifiers LT or RT are attached.
- The Department 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.

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.

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To bill for LOCM, use the appropriate HCPCS procedure codes Q9945-Q9951. The brand name of the LOCM and the dosage must be documented in the client's record.

Radiopharmaceutical Diagnostic Imaging Agents

- When performing nuclear medicine procedures, separate payment is allowed for radiopharmaceutical diagnostic imaging agents (Q9945-Q9951).
- The Department allows the following CPT codes for radiopharmaceutical therapy without PA: CPT codes 79101, 79445, and 79005.

Ultrasound Screening for Abdominal Aortic Aneurysm (HCPCS procedure code G0389)

The Department 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.

Outpatient PET Scans

The Department no longer offers Expedited Prior Authorization (EPA) for PET Scans. All covered PET Scans require written or faxed PA.

Mammograms

The Department has adopted the National Cancer Institute (NCI) recommendations regarding screening mammograms (CPT 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 requires PA.

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.

Anesthesia for Radiological Procedures [Refer to WAC 388-531-0300 (2) and (7)]

General anesthesia is allowed for radiological procedures for children and/or non-cooperative 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 non-invasive 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 non-invasive 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 Department on request.

Magnetic Resonance Imaging (MRI)

- Please check the fee schedule for authorization requirements for MRIs.
- The Department is implementing the Washington State Health Technology Clinical Committee (HTCC's) decision that uMRI (upright MRI) is **experimental and investigational**; therefore, pursuant to WAC 388-501-0165, 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.

Nuclear Medicine

When billing the Department 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).

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).

Physician-Related Services/Healthcare Professional Services

Portable X-Rays

- Portable x-ray services furnished in a client's home or nursing facility and payable by the Department 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. ***You must bill using a separate claim form for each Department client seen.*** The Department pays the fee for procedure code R0075 divided by the number of clients, as outlined by the modifiers in the following table:

Procedure Code	Brief 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 Department'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.

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 Department 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.

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Pathology and Laboratory

[Refer to WAC 388-531-0800 and WAC 388-531-0850]

Certification

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

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 Department in order to receive payment from the Department.

To obtain a CLIA certificate and number, or to resolve questions concerning your CLIA certification, call 1-206-361-2805 or write to:

DOH - Office of Laboratory Quality Assurance
1610 NE 150th Street
Shoreline, WA 98155
1-206-361-2805 (phone); 1-206-361-2813 (fax)

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. Refer to the table below for those codes with both a technical and professional component.

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.

83020	84181	86255	86327	87207
83912	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 Department 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.

Cancer Screens (HCPCS codes G0101, G0103-G0105, 82270)

The Department covers the following cancer screenings:

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

HCPCS Code	Brief Description	Limitations	Payable Only With Diagnosis Code(s)
G0101	CA screen; pelvic/breast exam	Females only One every 12 months <i>[Use for Pap smear professional services]</i>	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 risk ind	Clients at high risk for colorectal cancer One every 24 months	High risk 555.1, 555.0, 555.2, 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 Department’s payment is reduced when billed with modifier 53 (discontinued procedure).

Physician-Related Services/Healthcare Professional Services

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.
- Physicians must bill using their NPI for laboratory services provided by their technicians under their supervision.
- An independent laboratory and/or hospital laboratory must bill using its NPI for any services performed in its facility.
- The Department pays for one blood draw fee (CPT codes 36415-36416 or 36591) per day.
- The Department 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 Department-approved genetic counselor to be paid for certain genetic testing that requires PA. All genetic testing must be billed with the appropriate genetic testing modifier.
- CPT code 83037 [hemoglobin glycosylated (A1C)] no longer requires PA when performed in a physician's office; however, it can be billed only once every three months.

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Physician-Related Services/Healthcare Professional Services

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 Department 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) that was provided.**

- CPT code 87999 can be used for billing the monogram Trofile test for AIDS patients when physicians are prescribing the drug Selzentry®. CPT code 87999 is paid By Report.

Drug Screens

The Department 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.
- Please refer to the Department’s Fee Schedule for covered drug screening codes.

The Department has adopted the drug screening guidelines outlined in the Agency Medical Directors Interagency Guidelines. For more information, please visit the following webpages:

- <http://www.agencymeddirectors.wa.gov/>
- <http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf>
- <http://www.agencymeddirectors.wa.gov/activity/start.asp>

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)

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Physician-Related Services/Healthcare Professional Services

The Department does not pay for:

- Routine drug screening panels.

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.

- Monitoring for program compliance in either a residential or outpatient drug or alcohol treatment program.

When clients need to be monitored for drug/alcohol use, please refer them to a DBHR-approved program for evaluation/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 Department.

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 is certified and approved to prescribe Buprenorphine-Suboxone (see # Memo 03-58 MAA). 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 304.01-304.03;
- CPT codes G0431 QW – limited to one per day and 80102 are covered only for ICD-9-CM diagnoses 304.01-304.03; and
- “Certified bupren provider” in the comments field on the 837P claim, the claim notes field of the DDE, or field 19 of the CMS-1500 paper claim.

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Laboratory Services Referred by Community Mental Health Center (CMHC) or DBHR-Contracted Providers

When CMHC or DBHR-contracted providers refer clients enrolled in a Department managed care plan for laboratory services, the laboratory **must bill the Department 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 Department;
- The laboratory must bill with a mental health, substance abuse, or alcohol abuse diagnosis; and
- The screen must meet the criteria above 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 Department’s managed care contracts.

Disease Organ Panels--Automated Multi-Channel Tests

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

Procedure Code	Brief 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
82550	Creatine kinase (CK)
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; aspartate amino (AST)(SGOT)
84460	Transferase; alanine amino (AST)(SGPT)
84478	Tryglycerides
84520	Urea nitrogen; quantitative
84550	Uric acid; blood
85004	Automated diff wbc count
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.
- Each test and/or panel must be billed on a separate line.
- All automated/non-automated tests **must be billed on the same claim form when performed for a client by the same provider** on the same day. For laboratory services that exceed the lines allowed per claim, see next page.

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 Department pays a claim with one or more automated/non-automated lab tests, providers must bill any additional automated/non-automated 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 you adjust the claim with the paid automated/non-automated lab tests using the comment "**additional services.**"

Payment for Automated Multi-Channel Tests

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 Department’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 Department 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--Non-automated 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 non-automated multi-channel tests are:

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

Laboratory Modifiers

Modifier QP

Modifier QP indicates documentation is on file showing that the lab test(s) was ordered individually or ordered as a CPT®-recognized panel. The Department 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 lab 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.).

Pap Smears

For professional services related to Pap smears, refer to the Cancer Screens Section (page D.13).

- Use CPT codes 88147-88154, 88164-88167, and P3000-P3001 for conventional Pap smears.
- The Department pays for thin layer preparation CPT codes 88142-88143 and 88174-88175. The Department does not pay providers for HCPCS codes G0123-G0124 and G0141-G0148. The Department 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 Department pays providers for one routine Pap smear per client, per calendar year only. The Department 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 Department does not pay providers for CPT code 88112 with diagnosis V72.3 or V76.2.

Physician-Related Services/Healthcare Professional Services

HIV Testing

The Department 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.

Blood Bank Services

The following blood bank HCPCS codes are now reimbursed at Acquisition Cost (AC).

Procedure Code	Brief Description
J1559	Injection , Immune Globulin (Hizentra), 100mg
J7184	Wilate Injection
J7196	Antithrombin Recombinant
J7185	Xyntha, inj.
J7186	Antihemophilic viii/vwf comp
J7187	Inj Vonwillebrand factor IU
J7189	Factor VIIa
J7190	Factor VIII
J7191	Factor VIII (porcine)
J7192	Factor VIII recombinant
J7193	Factor IX non-recombinant
J7194	Factor IX complex
J7195	Factor IX recombinant
J7197	Antithrombin III injection
J7198	Anti-inhibitor

STAT Lab 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.

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Physician-Related Services/Healthcare Professional Services

The STAT charge is paid only with the tests listed below:

Procedure Code	Brief Description
G0306	CBC/diffwbc w/o platelet
G0307	CBC without platelet
80047	Metabolic panel ionized ca
80048	Basic metabolic panel
80051	Electrolyte panel
80069	Renal function panel
80076	Hepatic function panel
80100	Drug screen, qualitate/multi
80101	Drug screen, single
80156	Assay, carbamazepine, total
80162	Assay of digoxin
80164	Assay, dipropylacetic acid
80170	Assay of gentamicin
80178	Assay of lithium
80184	Assay of phenobarbital
80185	Assay of phenytoin, total
80188	Assay primidone
80192	Assay of procainamide
80194	Assay of procainamide
80196	Assay of salicylate
80197	Assay of tacrolimus
80198	Assay of theophylline
81000	Urinalysis, nonauto w/scope
81001	Urinalysis, auto w/scope
81002	Urinalysis, nonauto w/o scope
81003	Urinalysis, auto, w/o scope
81005	Urinalysis
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: pH, pO ₂ & pCO ₂
82945	Glucose other fluid
82947	Assay, glucose, blood quant

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Physician-Related Services/Healthcare Professional Services

Procedure Code	Brief Description
83615	Lactate (LD) (LDH) enzyme
83663	Test urine for lactose
83664	Lamellar bdy, fetal lung
83735	Assay of magnesium
83874	Assay of myoglobin
83880	Natriuretic peptide
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay of protein
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	Troponin qualitative
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	Differential WBC count
85025	Complete cbc w/auto diff wbc
85027	Automated hemogram
85032	Manual cell count, each
85046	Automated hemogram
85049	Automated platelet count
85378	Fibrin degradation
85380	Fibrin degradation, vte
85384	Fibrinogen
85396	Clotting assay, whole blood
85610	Prothrombin time
85730	Thromboplastin time, partial
86308	Heterophile antibodies
86367	Stem cells, total count
86403	Particle agglutination test
86880	Coombs test
86900	Blood typing, ABO
86901	Blood typing, Rh (D)
86920	Compatibility test
86921	Compatibility test
86922	Compatibility test
86923	Compatibility test, electric
86971	RBC pretreatment
87205	Smear gram stain
87210	Smear, wet mount, saline/ink

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Physician-Related Services/Healthcare Professional Services

Procedure Code	Brief Description
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, transcutaneous
88740	Transcutaneous carboxyhb
88741	Transcutaneous methb

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Chemotherapy Services [Refer to WAC 388-531-0950(11)]

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

The Department'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 Department 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 Department 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 Department 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 Department 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 Department 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: You must bill drug, infusion, and injection codes on the same claim form.

Chemotherapy Drugs

The following payment guidelines apply to chemotherapy drugs (HCPCS codes J9000-J9999):

- The Department's maximum allowable fee per unit is based on the HCPCS description of the chemotherapy drug.
- The Department's maximum allowable fee is equal to Medicare's drug methodology of 106% of the average sales price. If a Medicare fee is unavailable for a particular drug, the Department will continue to price the drug at 86% of average wholesale price (AWP).
- Preparation of the chemotherapy drug is included in the payment for the administration of the drug.

Note: Refer to Section K of these billing instructions for information on when it is necessary to bill the Department 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 Department 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 Department'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 Department 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 Department'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].

Oral Anti-Emetic Drugs

In order to bill the Department 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 codes 140.0-208.90, 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).

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.

Surgical Services [Refer to WAC 388-531-1700]

Providers must check the Physician-Related Services Fee Schedule for those surgical services that require either PA or EPA.

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

- 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); and
 - ✓ Anesthesiologists and CRNAs.

Physician-Related Services/Healthcare Professional 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	Summary of 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:

<u>Modifier</u>	<u>Description</u>
-----------------	--------------------

- | | |
|------|--|
| • 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. |

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Physician-Related Services/Healthcare Professional Services

- A provider (other than the surgeon) who provides all postoperative care (including all inpatient postoperative care) before discharge, must bill subsequent hospital care codes (CPT codes 99231-99233) for the inpatient hospital care, and the surgical code with modifier 55 for the post-discharge care. The surgeon must bill the surgery code with modifier 54.
 - Providers who perform only the follow-up services for minor procedures performed in emergency departments 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 Department 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).

Department-Approved Hospitals for Bariatric Surgery

See Section I for information on bariatric surgery.

Registered Nurse First Assistants (RNFA)

Registered Nurse First Assistants (RNFAs) are allowed to assist at surgeries within their scope of practice. Use modifier 80 to bill the Department for these services.

Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

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 Department 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 "AORN standards for RN first assistant education programs" (See AORN Standards for RN First Assistant Education Programs in: *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.

Multiple Surgeries

When multiple surgeries are performed on the same client, during the same operative session, The Department pays providers as follows:

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

Physician-Related Services/Healthcare Professional Services

To expedite payment of your claims, bill all surgeries performed during the same operative session on the same claim.

If a partial payment is made on a claim with multiple surgeries, providers must adjust the paid 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.

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 Department 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.

Other Surgical Policies

- Use modifiers 80, 81, and/or 82 to bill for an assistant surgeon. An assist at major surgery is paid at 20% of the surgical procedure's maximum allowable fee. The multiple surgery rules apply for surgery assists.
- A properly completed consent form must be attached to all claims for sterilization and hysterectomy procedures (see Section H).
- ***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 Department 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.

Physician-Related Services/Healthcare Professional Services

- The Department 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 Department will pay to remove implants (CPT codes 19328 and 19330) but will not replace them if they were placed for cosmetic reasons.
- The Department requires EPA for reduction mammoplasties (CPT code 19318) and for mastectomy for gynecomastia for men (CPT code 19300). See section I for more information.

CPT Code(s)	Brief Description	Limitations
11920-11921	Correct skin color defects (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
11960	Insertion of tissue expander(s)	
11970	Replace tissue expander	
11971	Remove tissue expander(s)	
19301	Removal of breast tissue	
19302	Remove breast tissue, nodes	
19303	Removal of breast	
19304	Removal of breast	
19316	Suspension of breast	
19340	Immediate breast prosthesis	
19342	Delayed breast prosthesis	
19350	Breast reconstruction	
19357	Breast reconstruction	
19361	Breast reconstruction	
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 reconstruction w/gap flap	
S2067	Breast reconstruction	

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

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Physician-Related Services/Healthcare Professional Services

- 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.

Surgical Treatment for Sleep Apnea

The Department requires PA for surgical treatment for obstructive sleep apnea (OSA) or upper airway resistance syndrome (UARS) (see procedures listed below) when billed with diagnosis code 327.23 (obstructive sleep apnea) or 780.57 (unspecified sleep apnea):

- 21199;
- 21685;
- 42120;
- 42140;
- 42145;
- 42160; or
- 42299.

Epiphyseal

Epiphyseal surgical procedures (CPT codes 25450, 25455, 27185, 27475, 27477-27485, 27742, and 27730-27740) are allowed only for clients age 17 and younger.

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).

Angioscopy

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

Physician-Related Services/Healthcare Professional Services

Medical Policy Updates

In accordance with WAC 388-501-0055, the Department 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:

- Knee Arthroscopy
- Artificial Disc Replacement
- Transcutaneous Electrical Nerve Stimulation (TENS) device
- Drug Eluting Stents
- Bone Growth Stimulators
- Computed Tomography Angiography (CTA)
- Implantable Infusion Pumps
- Spinal Cord Stimulation for Chronic Neuropathic Pain
- Hip Resurfacing

For additional details and medical necessity criteria, go online at:

<http://www.hta.hca.wa.gov/assessments.html>

Knee Arthroscopy for Osteoarthritis

The Department does not recognize lavage, debridement and/or shaving of the knee (CPT 29877) as medically necessary when these are the only procedure(s) performed during the arthroscopy. Under the above circumstances CPT Code 29877 is not reimbursable. The Department will pay for arthroscopies done for other diagnostic and therapeutic purposes.

Artificial Disc Replacement

The Department pays for Cervical Disc Replacement medical necessity criteria are met and requires prior authorization (PA). CPT codes 22856 and 22861.

The Department pays for Lumbar Disc Replacement medical necessity criteria are met and requires prior authorization (PA). CPT codes 22857, 22862, and 22865.

Transcutaneous Electrical Nerve Stimulation (TENS) device

Effective for dates of service on and after April 1, 2010, the Department does *not* cover TENS devices, related supplies and services for independent home-use.

Physician-Related Services/Healthcare Professional Services

Drug Eluting Stents

The Department will pay for drug eluting stents when the medical necessity criteria are met and requires EPA. See Section I for Expedited Prior Authorization (EPA) Criteria.

Bone Growth Stimulators

The Department will pay for bone growth stimulators when medical necessity criteria are met and requires prior authorization (PA). CPT codes 20974, 20975 and 20979.

Computed Tomography Angiography (CTA)

The Department will pay for CTA when the medical necessity criteria are met and requires PA. CPT code 75574 is restricted to POS 21, 22, 23

Implantable Infusion Pumps or Implantable Drug Delivery Systems (IDDS)

The Department will pay 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 Department does not recognize Spinal Cord Stimulation for chronic neuropathic pain as medically necessary. The Department will consider requests for other diagnoses.

Hip Resurfacing

Total hip resurfacing arthroplasty is medically necessary as an alternative to total hip arthroplasty when all of the following conditions are met:

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

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Apheresis

Therapeutic apheresis (CPT codes 36511-36516) includes payment for all medical management services provided to the client on the date of service. The Department 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 they are billed with modifier 25:

- Established patient office and other outpatient visits (CPT codes 99211-99215); and
- Subsequent hospital care (CPT codes 99231-99233).

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

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.

Pre-/Intra-/Postoperative Payment Splits

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

The Department has adopted Medicare's payment splits, as listed below. If Medicare has not assigned a payment split to a procedure, the Department uses a payment split of 10% / 80% / 10% if the above modifiers 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/Ocular	10%	70%	20%
69000 - 69979	Auditory	07%	79%	14%

Urology

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
- Balnitis Xerotica (ICD-9-CM 607.81).

Urinary Tract Implants

Prior to inserting a urinary tract implant (CPT code 51715), 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 Section K for those urinary tract implants covered by the Department. **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 Department's payment system and trigger a manual review as a result of the Department'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, you must note one of the following in the *Comments* section of your claim:

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

Physician-Related Services/Healthcare Professional Services

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 Department 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 post-operative period of a major surgery.

Osteotomy Reconstruction

Procedure Code	Brief Description	Does not require PA when billed with ICD-9-CM diagnoses
21198		170.1 or 802.20 – 802.35

Anesthesia [Refer to WAC 388-531-0300]

General Anesthesia

- The Department 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 Department 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 Department 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 Department 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 post-anesthesia 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.

Physician-Related Services/Healthcare Professional Services

- 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 Department has assigned flat fees for these codes.
- The Department 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 Department follows CPT code descriptions.
- The Department 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), you must indicate in the *Comments* section of the claim form "voluntary or induced abortion."
- When billing the following procedures, use only the 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 Department pays each provider 50% of the allowed amount. The Department limits payment in this circumstance to 100% of the total allowed payment for the service.

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Physician-Related Services/Healthcare Professional Services

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

Regional Anesthesia

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

- 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 Department 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 Department will determine payment amount after review of the documentation.

Anesthesia for Maternity [Refer to WAC 388-531-0300(9)]

- The Department 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).

Physician-Related Services/Healthcare Professional Services

- 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 Department'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 Payment Calculation for Services Paid with Base and Time Units

- The Department'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.

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 appropriate Department dental billing instructions for information on billing for office-based anesthesia for dental procedures. Download any of the Department's current dental billing instructions at: <http://hrsa.dshs.wa.gov/ProvRel/Dental/Dental.html>.

Note: Bill the Department directly for dental anesthesia for all clients, including those enrolled in a Department managed care plan.

Teaching Anesthesiologists

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

- When supervising *one* resident only, the teaching anesthesiologist must bill the Department 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 Department the appropriate anesthesia procedure codes with **modifier QK**. Payment to the teaching anesthesiologist will be 50% of the allowed amount for each case supervised.

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

See next page for Pain Management Procedure Codes

Physician-Related Services/Healthcare Professional Services

*Due to copyright restrictions, the Department publishes only official brief CPT descriptions
To view the full CPT description, please refer to your current CPT manual.*

The listings shown below are not guaranteed to be all-inclusive and are provided for convenience purposes only.

The 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	Brief Description
11981*	Insert drug implant device
11982*	Remove drug implant device
11983*	Remove/insert drug implant
20526*	Ther injection, carpal tunnel
20550	Inject tendon/ligament/cyst
20551	Inject tendon origin/insert
20552	Inject trigger point, 1 or 2
20553	Inject trigger points, >3
20600	Drain/inject, joint/bursa
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 spinal fluid
62273*	Treat epidural spine lesion
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 c/t
62311*	Inject spine l/s (cd)
62318*	Inject spine w/cath, c/t
62319*	Inject spine w/cath l/s (cd)
62350*	Implant spinal canal cath
62351*	Implant spinal canal cath
62355*	Remove spinal canal cath
62360*	Insert spine infusion device
62361*	Implant spine infusion pump
62362*	Implant spine infusion pump
62365*	Remove spine infusion device

Procedure Code	Brief Description
63650*	Implant neuroelectrodes
63655*	Implant neuroelectrodes
63685*	Implant neuroreceiver
63688*	Revise/remove neuroreceiver
64400*	Injection for nerve block
64402*	Injection for nerve block
64405*	Injection for nerve block
64408*	Injection for nerve block
64410*	Injection for nerve block
64412*	Injection for nerve block
64413*	Injection for nerve block
64415*	Injection for nerve block
64416*	Injection for nerve block
64417*	Injection for nerve block
64418*	Injection for nerve block
64420*	Injection for nerve block
64421*	Injection for nerve block
64425*	Injection for nerve block
64430*	Injection for nerve block
64435*	Injection for nerve block
64445*	Injection for nerve block
64446*	Injection for nerve block
64447*	Injection for nerve block
64448*	Injection for nerve block
64449*	Injection for nerve block
64450*	Injection for nerve block

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Physician-Related Services/Healthcare Professional Services

Procedure Code	Brief Description
64479*	Inj foramen epidural add-on
64480*	Inj foramen epidural add-on
64483*	Inj foramen epidural l/s
64484*	Inj forament epidural add-on
64505*	Injection for nerve block
64508*	Injection for nerve block
64510*	Injection for nerve block
64517*	N block stellage ganglion
64520*	Injection for nerve block
64530*	Injection for nerve block
64553*	Implant neuroelectrodes
64555*	Implant neuroelectrodes
64560*	Implant neuroelectrodes
64561*	Implant neuroelectrodes
64565*	Implant neuroelectrodes
64575*	Implant neuroelectrodes
64577*	Implant neuroelectrodes
64580*	Implant neuroelectrodes
64581*	Implant neuroelectrodes
64585*	Revised/remove neuroelectrode
64590*	Implant neuroreceiver
64595*	Revise/remove neuroreceiver
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
64622*	Destr paravertbrl nerve l/s
64626*	Destr paravertbrl nerve c/t
64627*	Destr paravertbrl nerve add-on
64630*	Injection treatment of nerve
64640*	Injection treatment of nerve
64680*	Injection treatment of nerve
64681*	Injection treatment of nerve

Procedure Code	Brief Description
64802*	Remove sympathetic nerves
64804*	Remove sympathetic nerves
64809*	Remove sympathetic nerves
64818*	Remove sympathetic nerves

Other Services

Procedure Code	Brief Description
36400	Drawing blood
36420	Establish access to vein
36425	Establish access to vein
36555	Insert non-tunnel cv cath
36566	Insert tunneled cv cath
36568	Insert tunneled cv cath
36580	Replace tunneled cv cath
36584	Replace tunneled cv cath
36589	Removal tunneled cv cath
36600	Withdrawal of arterial blood
36620	Insertion catheter, artery
36625	Insertion catheter, artery
36660	Insertion catheter, artery
62263	Lysis epidural adhesions
62287	Percutaneous discectomy
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 refill & main

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

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 Department of Social and Health Services (the Department) receive funding from the TCF to help support provider groups involved in the state's trauma care system. The Department uses its TCF funding to draw federal matching funds. The Department makes supplemental payments to designated trauma centers and pays enhanced rates to physicians for trauma cases that meet specified criteria.

The enhanced rates are available for trauma care services provided to fee-for-service Medical Assistance clients with Injury Severity Scores (ISS) of 13 or greater for adults and 9 or greater for pediatric (under 15 years of age).

TCF Payments to Hospitals

A **hospital** is eligible to receive TCF payments from the Department if the hospital:

- Is designated by DOH as a trauma service center (or “recognized” by DOH if in a bordering city);
- Is a Level 1, Level 2, or Level 3 designated trauma service center;
- Meets the provider requirements in WAC 388-550-5450 and other applicable WAC;
- Meets the billing requirements in WAC 388-550-5450 and other applicable WAC; and
- Submits all information DOH requires to ensure trauma services are being provided.

For a list of the Designated Trauma Services, check DOH's website at:
http://www.doh.wa.gov/hsqa/emstrauma/download/designation_list.pdf

Physician-Related Services/Healthcare Professional Services

TCF Payments to Physicians

Physicians and other clinical providers who are members of Designated Trauma Services receive TCF payments from the Department:

- 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 fee-for-service 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 initial injury;
 - (b) The follow-up procedures were planned during the initial acute episode of injury; and
 - (c) The plan for the follow-up surgical procedure(s) is clearly documented in the medical record of the client’s original hospitalization for the traumatic injury.
- 2) For hospital-based services only, except as specified in subsection (4).
- 3) Only for trauma cases that meet the ISS of:
 - (a) Thirteen or greater for an adult trauma patient (a client age fifteen or older); or
 - (b) Nine or greater for a pediatric trauma patient (a client younger than age fifteen).
- 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 ambulatory surgery centers.
- 5) At a rate determined by the Department. The enhanced rates are subject to the following limitations:
 - (a) The Department monitors the payments from the TCF during each state fiscal year (SFY) and makes necessary adjustments to the rate to ensure that total payments from the TCF for the biennium will not exceed the legislative appropriation for that biennium.
 - (b) Laboratory and pathology charges are not eligible for enhanced payments from the TCF.

TCF Payments to Hospitals and Physicians in Transfer Cases

When a trauma case is transferred from one hospital to another, the Department makes TCF payments to physicians and other eligible clinical providers, according to the ISS score 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 the eligible providers on their teams who furnished qualified trauma services are eligible for increased payments from the TCF. The transfer must have been 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 enhanced payments.
- If the transferred case is below the ISS threshold, only the **receiving** hospital and the eligible providers on its team who furnished qualified trauma services are eligible for increased payments from the TCF. The receiving hospital and clinical team are eligible for enhanced payments regardless of the ISS for the transferred case.

Payment

Physicians and clinical providers are paid on a claim-specific basis for the qualified trauma care services they provide. The Department uses the lesser of its maximum allowable fee or the billed amount as the base rate to which the enhancement percentage is applied.

Hospitals receive a percentage of a periodic payment amount. Each hospital's percentage of the periodic payment amount depends on the total qualified trauma care provided by the hospital for the state fiscal year to date, measured against the total qualified trauma care provided by designated Levels 1-3 hospitals during the same period.

The total payments from the TCF for a biennium cannot exceed the TCF amount appropriated by the legislature for that biennium. The Department has the authority to take whatever actions are needed to ensure it stays within the current TCF appropriation.

The Department distributes TCF payments to eligible providers who submit trauma claims with the appropriate trauma modifier or claim identifier within the time frames specified by the Department.

Each qualifying trauma service and/or procedure on the physician's or other clinical provider's claim is paid at the lesser of the Department's current fee-for-service (FFS) rate, or the billed amount, multiplied by the TCF enhancement percentage. Charges for laboratory and pathology services and/or procedures are not eligible for enhanced payments from the TCF and are paid at the lesser of the Department's current FFS rate or the billed amount.

Claims Excluded from Enhanced Payment for Trauma Services

Claims for trauma care provided to clients enrolled in the Department's managed care organizations are **not** eligible for increased payments from the TCF.

Laboratory and pathology charges are **not** eligible for increased payments from the TCF.

Billing

To bill the Department for qualified trauma care services provided by physicians and clinical providers, add modifier **ST** to the appropriate procedure code. The modifier **ST** *must* be entered in the modifier field of the 837P claim, the claim notes field of the DDE, or field 19 of the CMS-1500 paper claim to receive the enhanced payment.

If it is necessary to bill using two or more modifiers on a detail line and modifier 26 (professional component) is one of the modifiers:

- Bill modifier **ST** in the first modifier field; and
- Modifier 26 (professional component) in the second modifier field.

Bill all other multiple modifier combinations by using modifier 99 in the first modifier field, modifier **ST** in the second modifier field, and other applicable modifiers in the third and fourth modifier fields. Billing all payment modifiers with modifier 99, except the modifier **ST**/26 combination, ensures appropriate payment.

Adjusting Trauma Claims

The Department considers a provider's request for a TCF claim adjustment only if the Department receives the adjustment request within one year from the date of service on the initial claim.

The Department does not make any TCF payment for an otherwise eligible claim when the request to adjust such a trauma claim for purposes of getting enhanced payment is received by the Department beyond 365 calendar days from the date of service. See WAC [388-502-0150](#) for other time limits applicable to trauma claims.

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, the higher the score, the more serious are the patient's injuries.

For Additional Information

Please see numbered memorandum number 03-53-MAA for additional information.

For information on **trauma service designation, trauma registry, and/or injury severity scores (ISS)**, contact:

**Department of Health
Office of Emergency Medical & Trauma Prevention
1-360-236-2871 or 1-800-458-5281.**

For information on **payment**, contact:

**Office of Hospital Rates
Medicaid Purchasing Administration
1-360-725-1835**

For information on a specific **Medicaid trauma claim**, contact:

**Customer Service Center
1-800-562-3022**

Physician/Clinical Provider List

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
Pulmonologist
Radiologist
Thoracic Surgeon
Urologist
Vascular Surgeon

Note: Many procedures are not included in the enhanced payment program for major trauma services.

Miscellaneous Services

Acute Physical Medicine and Rehabilitation (Acute PM&R)

Inpatient PM&R is limited to Department-contracted facilities. Please see the Department's [Acute PM&R Billing Instructions](#) for more details.

Cochlear Implant Services for Clients 20 Years of Age and Younger [Refer to WAC 388-531-0200(4) (c)]

The Department does not cover bilateral cochlear implantation. Unilateral cochlear implantation (CPT code 69930) requires EPA (see section I). If a client does not meet the EPA criteria PA is required.

The Department covers replacement parts for cochlear devices through the Department/MPA Hearing Aids and Services Program *only*. The Department 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 Department does not pay for new cochlear implantation for clients 21 years of age and older. The Department 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	Description	Notes
69930	Cochlear device implantation, with or without mastoidectomy	There are no corresponding removal codes specific to cochlear devices.
69715	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy	

Collagen Implants

The Department pays for CPT code 51715 and HCPCS codes L8603 and L8606 only when the diagnosis code is 599.82 (Intrinsic sphincter deficiency). See Section K for limitations.

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DDD Physical

The Department covers one physical every 12 months for clients with disabilities. 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.

Diabetes Education (HCPCS Code G0108 and G0109) [WAC 388-550-6300]

Please refer to the current Department/MPA Diabetes Education Billing Instructions at: http://hrsa.dshs.wa.gov/download/Billing_Instructions_Webpages/Diabetes_Education_BI.html.

Genetic Counseling and Genetic Testing

The Department 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.

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.

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 1-253-395-6742.

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 Department 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.

Physician-Related Services/Healthcare Professional Services

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.); or
 - 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); and
 - ✓ 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; and
 - ✓ 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 chart 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 Department pays only for the time that a client spends in the group clinical visit.

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Other Limitations

The Department 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.

HIV/AIDS Counseling

The Department covers two sessions of risk factor reduction counseling (CPT code 99401) counseling per client, each time tested. **[Refer to WAC 388-531-0600]** Use ICD-9-CM diagnosis code V65.44 when billing CPT code 99401 for HIV/AIDS counseling. The Department 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 Department's [*HIV/AIDS Case Management, Title XIX \(Medicaid\) Billing Instructions*](#) for additional information on HIV/AIDS case management billing.

Hyperbaric Oxygen Therapy (CPT 99183)

Hyperbaric oxygen therapy requires EPA- see section I. If the client does not meet the EPA criteria, PA is required.

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, you must use modifier 25 to report a separately identifiable medical service. If you do not use modifier 25, the Department will deny the E&M code.

Needle Electromyography (EMGs)

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

CPT Code	Brief Description	Limits
95860 95861 95863 95864	Needle EMG; one extremity with or without related paraspinal areas two extremities... three extremities... four extremities...	<ul style="list-style-type: none"> Extremity muscles innervated by three nerves or four spinal levels must be evaluated with a minimum of five muscles studied.
95865	Muscle test, larynx	<ul style="list-style-type: none"> Limited to one unit per day.
95866	Muscle test, hemidiaphragm	<ul style="list-style-type: none"> Limited to one unit per day.
95869	Needle EMG; thoracic paraspinal muscles	<ul style="list-style-type: none"> Limited to one unit per day. For this to pay with extremity codes 95860-95864, test must be for T3-T11 areas only; T1 or T2 alone are not separately payable.
95870	Needle EMG; other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters	<ul style="list-style-type: none"> 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).

Nerve Conduction Study (NCS)

CPT Code	Brief Description	Limits
95900, 95903, and 95904	Nerve Conduction Study	Each nerve constitutes one unit of service

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 Section I - Prior Authorization).

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

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

Note: The Department does not pay for new BAHA for clients 21 years of age and older. The Department 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 Codes	Description	Notes
69710	Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone	Replacement procedure includes removal of the old device
69711	Removal or repair of electromagnetic bone conduction hearing device in temporal bone	
69714	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	
69715	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy	
69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	

Out-of-State Hospital Admissions (does not include border hospitals)

The Department pays for emergency care at an out-of-state hospital, not including hospitals in bordering cities, only for Medicaid and SCHIP clients on an eligible program. See WAC 388-501-0175 for recognized bordering cities.

The Department requires PA for elective, non-emergency 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, DSHS 13-787, with additional required documentation attached, to the Department Medical Request Coordinator (See *Important Contacts*).

Providers must obtain prior authorization from the appropriate MHD designee for **out-of-state psychiatric hospital admissions** for all Medicaid clients. Neither the Department nor the MHD designee pays for inpatient services for non-Medicaid clients if those services are provided outside of State of Washington. An exception is clients who are qualified for the General Assistance – Unemployable (GAU) program. For these clients, the Department and the MHD 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.

Outpatient Cardiac Rehabilitation

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

- Are referred by a physician;
- Have coronary artery disease (CAD);
- Do not have specific contraindications to exercise training; and
- 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]); and/or
 - ✓ Stable angina.

Physician-Related Services/Healthcare Professional Services

Bill physician services with procedure code 93798 or 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); or

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

The Department **does not** cover procedure code 93797 or 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; and
 - ✓ Under the direct supervision of a physician;
- Non-physician personnel that are employees of the hospital;
- Stress testing:
 - ✓ To evaluate a patient's suitability to participate in the program;
 - ✓ To evaluate chest pain;
 - ✓ To develop exercise prescriptions; and
 - ✓ 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; and
- Continuous cardiac monitoring during exercise or ECG rhythm strip used to evaluate a client's exercise prescription.

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Physician-Related Services/Healthcare Professional Services

The Department 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 Department covers continued participation in cardiac rehab exercise programs beyond 24 sessions only on a case-by case basis with preauthorization.

Physical Therapy

Physicians, Advanced Registered Nurse Practitioners, and Physician Assistants - Billing

The outpatient rehabilitation benefit limits *do not apply* to therapy services provided and billed by physicians, advanced registered nurse practitioners (ARNPs), and physician assistants-certified (PA-Cs).

Physicians, ARNPs, and PA-Cs must use the following modifier:

MODALITY	MODIFIERS
PT/OT/ST	AF

TB Treatment Services

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).

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.

TB Treatment Services Performed by Non-Professional Providers

Health Departments billing for TB treatment services provided by **non-professional 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
795.5	Nonspecific reaction to tuberculin skin test
V01.1	Tuberculosis
V71.2	Observation for suspected tuberculosis
V74.1	Pulmonary tuberculosis

Ultraviolet Phototherapy

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

Ventilator 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 Department will deny the E&M code.

Vagus Nerve Stimulation (VNS) [Refer to WAC 388-531-0200(h)]

Vagus nerve stimulation (CPT codes 61885, 61886, and 61888) requires prior authorization (refer to Section H - Prior Authorization).

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

Prior authorization is not required for VNS programming (CPT codes 95970, 95974, and 95975) performed by a neurologist.

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

Reproductive Health Services

How Does the Department Define Reproductive Health Services? [WAC 388-532-001]

The Department defines reproductive health services as those services that:

- Assist clients to avoid illness, disease, and disability related to reproductive health;
- Provide related and appropriate, medically-necessary care when needed; and
- Assist clients to make informed decisions about using medically safe and effective methods of family planning.

Provider Requirements [Refer to WAC 388-532-110]

To be paid by the Department for reproductive health services provided to eligible clients, physicians, and advanced registered nurse practitioners (ARNPs), and licensed midwives must:

- Meet the requirements in [Chapter 388-502 WAC Administration of Medical Programs - Providers](#);
- Provide only those services that are within the scope of their licenses;
- Educate clients on Food and Drug Administration (FDA)-approved prescription birth control methods and over-the-counter (OTC) birth control supplies and related medical services;
- Provide medical services related to FDA-approved prescription birth control methods and OTC birth control supplies upon request; and
- Prescribe FDA-approved prescription birth control methods and OTC birth control supplies upon request.

Note: Providers who are unable to meet all of the requirements above must refer the client to an appropriate provider.

See the *Department-Approved Family Planning Providers Billing Instructions* for more information on how to become a Department-approved family planning provider and more information on the Family Planning Only program.

Who Is Eligible? [Refer to WAC 388-532-100(1)]

The Department covers limited, medically necessary reproductive health services for clients who are on a Benefit Service Package (BSP) that covers reproductive health services.

Note: Refer to the *Scope of Coverage Chart* web page at: <http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html> for an up-to-date listing of Benefit Service Packages.

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.

Note: Family Planning Only clients are **only** eligible to receive services that are related to the prevention of unintended pregnancy and for sterilizations. They are **not** eligible for other reproductive health services that include maternity care and abortion.

Limited Coverage:

- The Department covers reproductive health services under Emergency Medical Only programs **only** when the services are directly related to an emergency medical condition.
- The Department pays only Medicare premium copays, coinsurance, and deductibles for Qualified Medicare Beneficiary clients.

What Services Are Covered? [Refer to WAC 388-532-120]

Services for Women

- **A routine gynecological examination (G0101) (cervical, vaginal, and breast screening examination)**, is allowed once per year as medically necessary when billed with one of the following diagnosis codes:
 - ✓ V72.31 routine gynecological exam with pap cervical smear;
 - ✓ V76.47 routine vaginal pap smear; or
 - ✓ V76.2 cervical pap smear without general gynecological exam.

If it is necessary to see the client on the same day for a medical problem, you may bill using the appropriate E&M code (99201 – 99215) with a separately identifiable diagnosis using modifier 25. **Note:** The Department will not pay for two E&M visits on the same day.

Note: All services provided to Family Planning Only clients must have a primary focus and diagnosis of family planning (the ICD-9-CM V25 series diagnosis codes, excluding V25.3).

Note: The Department does not pay for preventive health exams for clients 21 years of age and older.

- **FDA-approved prescription contraception method**
(see the Department/MPA *Prescription Drug Program Billing Instructions*);
- **OTC contraceptives, drugs, and supplies**
(see the Department/MPA *Prescription Drug Program Billing Instructions*);
- **Maternity-related services;**
- **Abortions;**
- **Sterilization procedures when:**
 - ✓ Requested by the client; and
 - ✓ Performed in an appropriate setting for the procedure.

Note: The surgeon's initial office visit for sterilization is covered when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days prior to the surgery.

Services for Women (continued)

- **Screening and treatment for STD-I**, including laboratory tests and procedures;

Note: For HIV testing use CPT® 86703. **The Department does not cover HIV testing and counseling for Family Planning Only clients.**

- **Education** for FDA-approved contraceptives, natural family planning, and abstinence;
- **Screening mammograms (CPT 77057)** for clients 40 years of age and older, once per calendar year. Clients 39 years of age and younger require prior authorization (see section I).
- **Colposcopy** and related medically necessary follow-up services.
- **Emergency contraception (e.g., Plan B®)** – Providers may bill for emergency contraception medication under HCPCS J3490 with modifier FP. Please refer to the Department/MPA [MPA-Approved Family Planning Providers Billing Instructions](#) for details.
- **Implanon (HCPCS code J7307)**

The Department pays for the contraceptive implant system, Implanon.

To bill for Implanon, providers must:

- Bill with ICD-9 Diagnosis V25.5;
- Use CPT procedure code 11981 with ICD-9 diagnosis code V25.5 for the insertion of the device;
- Use CPT procedure code 11982 with ICD-9 diagnosis code V25.43 for the removal of the device;
- Use CPT procedure code 11983 with ICD-9 diagnosis code V25.43 to remove the device with reinsertion on the same day; and
- Enter the NDC in Box 19 on the CMS-1500 Claim Form or in the comments field on an electronic claim and send in an invoice with your billing.

Note: The Department pays for Implanon only once every three years, per client.

Services for Men

The Department covers the following reproductive health services for men:

- **Office visits** where the primary focus and diagnosis is contraceptive management (including vasectomy counseling) and/or where there is a medical concern;
- **OTC contraceptives, drugs, and supplies** (as described in the current Department/MPA *Prescription Drug Program Billing Instructions*);
- **Sterilization procedures when:**
 - ✓ Requested by the client; and
 - ✓ Performed in an appropriate setting for the procedure.

Note: The physician's initial office visit for sterilization is covered when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days prior to the surgery.

- **Screening and treatment for STD-I**, including laboratory tests and procedures;

Note: For HIV testing use CPT 86703.

- **Education** for FDA-approved contraceptives, natural family planning, and abstinence; and
- **Prostate cancer screening** for men when ordered by a physician, physician assistant, or ARNP. See the *Billing and Claim Forms* section specifics.

Note: The Department does not pay for preventive health exams for clients 21 years of age and older.

Physician Services Provided to Clients on the Family Planning Only Program

What Is the Purpose of the Family Planning Only Program?

[Refer to WAC 388-532-500]

The purpose of the Family Planning Only program is to provide family planning services at the end of a pregnancy to women who received medical assistance benefits during their pregnancy.

The primary goal of the Family Planning Only program is to prevent an unintended subsequent pregnancy. Women receive this benefit automatically regardless of how or when the pregnancy ends. This 10-month benefit follows the 60-day post pregnancy coverage by the Department.

Men are not eligible for the Family Planning Only program.

When the pregnant woman applies for medical assistance, the Community Services Office (CSO) worker identifies the woman's expected date of delivery. At the end of the 60-day postpartum period, the woman automatically receives an informational flyer and a Services Card. If her pregnancy ends for any reason other than delivery, she **must** notify the CSO to receive the Services Card.

Provider Requirements [Refer to WAC 388-532-520]

To be paid by the Department for services provided to clients eligible for the Family Planning Only program, physicians and advanced registered nurse practitioners (ARNPs) must:

- Meet the requirements in Chapter 388-502 WAC, *Administration of Medical Programs - Provider* rules;
- Provide only those services that are within the scope of their licenses;
- Educate clients on Food and Drug Administration (FDA)-approved prescription birth control methods and over-the-counter (OTC) birth control supplies and related medical services;
- Provide medical services related to FDA-approved prescription birth control methods and OTC birth control supplies upon request; and
- Prescribe FDA-approved prescription birth control methods and OTC birth control supplies upon request.

Note: Providers who are unable to meet all of the provider requirements must refer the client to an appropriate provider.

Who Is Eligible? [WAC 388-532-510]

A woman is eligible for Family Planning Only services if:

- She received medical assistance benefits during her pregnancy; or
- She is determined eligible for a retroactive period (see the *Definitions & Abbreviations* section) covering the end of the pregnancy.

What Services Are Covered? [Refer to WAC 388-532-530]

Note: All services provided to Family Planning Only clients must have a primary focus and diagnosis of family planning (the ICD-9-CM V25 series, excluding V25.3).

The Department covers the following services under the Family Planning Only program:

- **Cervical, vaginal, and breast cancer screening examination**, once per year as medically necessary. The examination must be:
 - ✓ Provided according to the current standard of care; and
 - ✓ Conducted at the time of an office visit with a primary focus and diagnosis of family planning (ICD-9-CM V25 series diagnosis codes, excluding v25.3).
- **FDA-approved prescription contraception methods**
(see the Department/MPA *Prescription Drug Program Billing Instructions* for requirements)
- **OTC contraceptives, drugs, and supplies**
(see the Department/MPA *Prescription Drug Program Billing Instructions*)
- **Sterilization** procedures that meet the requirements of the Department/MPA *Physician-Related Services Billing Instructions*, if it is:
 - ✓ Requested by the client; and
 - ✓ Performed in an appropriate setting for the procedure.

Note: The surgeon's initial office visit for sterilization is covered when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days prior to the surgery.

Physician-Related Services/Healthcare Professional Services

- **Screening and treatment for STD-I**, including laboratory tests and procedures only when the screening and treatment is:
 - ✓ Performed in conjunction with an office visit that has a primary focus and diagnosis of family planning (ICD-9-CM V25 series diagnosis codes, excluding v25.3); and
 - ✓ Medically necessary for the client to safely, effectively, and successfully use, or continue to use, her chosen contraceptive method.
- **Education** for FDA-approved contraceptives, natural family planning, and abstinence.
- **Implanon (CPT code J7307)**

The Department pays for the contraceptive implant system, Implanon.

To bill for Implanon, providers must:

- ✓ Bill with ICD-9 Diagnosis V25.5;
- ✓ Use CPT procedure code 11981 with ICD-9 diagnosis code V25.5 for the insertion of the device;
- ✓ Use CPT procedure code 11982 with ICD-9 diagnosis code V25.43 for the removal of the device;
- ✓ Use CPT procedure code 11983 with ICD-9 diagnosis code V25.43 to remove the device with reinsertion on the same day; and
- ✓ Enter the NDC in Box 19 on the CMS-1500 Claim Form or in the comments field on an electronic claim and send in an invoice with your billing.

Note: The Department pays for Implanon only once every three years, per client.

What Drugs and Supplies Are Paid Under the Family Planning Only Program?

The Department pays for the following family planning-related drugs and contraceptives prescribed by a physician:

Absorbable Sulfonamides	Nitrofurantoin Derivatives
Anaerobic antiprotozoal – antibacterial agents	Oral contraceptives
Antibiotics, misc. other	Quinolones
Antifungal Agents	Tetracyclines
Antifungal Antibiotics	Vaginal Antibiotics
Cephalosporins – 1st generation	Vaginal antifungals
Cephalosporins – 2nd generation	Vaginal lubricant preparations
Cephalosporins – 3rd generation	Vaginal Sulfonamides
Condoms	
Contraceptives, injectables	
Contraceptives, intravaginal	
Contraceptives, intravaginal, systemic	
Contraceptives, transdermal	
Diaphragms/cervical caps	
Intrauterine devices	
Macrolides	

Drugs for Sterilizations

Antianxiety Medication – Before Sterilization Procedure

- Diazepam
- Alprazolam

Pain Medication – After Sterilization Procedure

- Acetaminophen with Codeine #3
- Hydrocodone Bit/ Acetaminophen
- Oxycodone HCl/Acetaminophen 5/500
- Oxycodone HCl/ Acetaminophen

Over-the-counter, non-prescribed contraceptive supplies (e.g., condoms, spermicidal foam, cream, gel, sponge, etc.,) may also be obtained with a Medical ID Card in a 30-day supply through a pharmacy.

Contraceptive hormone prescriptions must be written for three or more months, with a maximum of 12 months, unless there is a clinical reason to write the prescription for less than three months.

Note: All services provided to Family Planning Only clients **must** have a primary focus and diagnosis of family planning (the ICD-9-CM V25 series diagnosis codes, excluding V25.3).

What Services Are *Not* Covered? [WAC 388-532-540]

Medical services are not covered under the Family Planning Only program unless those services are:

- Performed in relation to a primary focus and diagnosis of family planning (ICD-9-CM V25 series diagnosis codes, excluding V25.3); and
- Medically necessary for the client to safely, effectively, and successfully use, or continue to use, their chosen contraceptive method.

Abortions are **not** covered under the Family Planning Only program.

Note: If the client is only covered by the Family Planning Only program but she is pregnant, please refer the client to her local Community Services Office (CSO) to be evaluated for a possible change in her medical assistance program that would enable her to receive full scope of care.

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Physician-Related Services/Healthcare Professional Services

Inpatient Services: The Department does not pay for inpatient services under the Family Planning Only program. However, inpatient costs may be incurred as a result of complications arising from covered family planning services. If this happens, providers of inpatient services must submit a complete report to the Department of the circumstances and conditions that caused the need for the inpatient services in order for the Department to consider payment under WAC 388-501-0160.

A complete report includes:

- A copy of the billing (UB-04 Claim Form, CMS-1500 Claim Form);
- Letter of explanation;
- Discharge summary; and
- Operative report (if applicable).

Fax the complete report to the Department. See the *Important Contacts* section.

Payment [Refer to WAC 388-532-550, WAC 388-530-1425, and WAC 530-1700(4)]

Fee Schedule: The Department limits payment under the Family Planning Only program to visits and services that:

- Have a primary focus and diagnosis of family planning as determined by a qualified, licensed medical practitioner (ICD-9-CM V25 series diagnosis codes, excluding V25.3); and
- Are medically necessary for the client to safely, effectively, and successfully use, or continue to use, their chosen contraceptive method.

Maternity Care and Delivery

Prenatal Assessments Are Not Covered

The Department 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.

Exception: Providers must bill E&M codes for antepartum care if *only* 1-3 antepartum visits are done, as discussed later in these billing instructions.

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.

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 Department 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 Department 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 Department the global (total) obstetrical care procedure codes. In this case, the OB services must be "unbundle" and the antepartum, delivery, or postpartum care must be billed separately.

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

Unbundling Obstetrical Care

In the situations described below, providers may not be able to bill the Department 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 Department 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.

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Physician-Related Services/Healthcare Professional Services

- 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 Department 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 another physician has seen the client for part of the antepartum care and has transferred the client to you for care, and you are billing separately for the antepartum care you are delivering, enter "transfer of care" in the comments field on the 837P claim, the claim notes field of the DDE, or field 19 on the CMS-1500 paper claim.

Bill only those services you 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 a Department managed care organization for the remainder of her pregnancy. The Department is responsible for paying only those services provided to the client while she is on fee-for-service. The managed care organization pays for services provided after the client is enrolled with the plan.

The Department 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.

Antepartum Care

Per CPT guidelines, the Department 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; and
- 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; and
- Maternity counseling, such as risk factor assessment and referrals.

Necessary prenatal laboratory tests may be billed in addition to antepartum care, **except for dipstick tests** (CPT codes 81000, 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 Department 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 Department 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).

Physician-Related Services/Healthcare Professional Services

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 you saw the client for all antepartum care during her pregnancy, and **may not** be billed in combination with each other during the entire pregnancy period.

Note: Do not bill the Department 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, you must bill the Department using one of the following CPT codes:

- 59409 (vaginal delivery only);
- 59514 (cesarean delivery only);
- 59612 [vaginal delivery only, after previous cesarean delivery (VBAC)]; or
- 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 Department one of the following CPT codes:

- 59410 (vaginal delivery, including postpartum care);
- 59515 (cesarean delivery, including postpartum care);
- 59614 (VBAC, including postpartum care); or
- 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, you must bill the Department 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 Department 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.

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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.

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 Department 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.

Physician-Related Services/Healthcare Professional Services

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

In addition to the hospital admission, the Department 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: The hospital admission code and the prolonged services code(s) **must** be billed on the same claim form.

Note: The Department pays for labor management only when the provider performs the above services on the same day.

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 Department 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 Department **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 Department 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 Department pays the consulting physician for the consultation as follows:

- If the consulting physician does not perform the cesarean section, bill the Department 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 Department the appropriate **consultation code with modifier 57** (e.g. 99241-57).

The Department 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 Department for the consultation in this situation.

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

The Department 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 Department pays a multiple vaginal delivery (for twins, triplets, etc.) at 100% for the first baby. When billing for the second or third baby, you must 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 Department pays for multiple births by cesarean delivery at 100% for the first baby. No additional payment will be made for additional babies.
- A physician or physician assistant certified (PA-C) may bill for an assist at c-section by adding modifier 80, 81, or 82 to the delivery only code (e.g. 59514-80). Payment is 20% of the delivery-only code's maximum allowance.

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Physician-Related Services/Healthcare Professional Services

- Physician assistants (PA) must bill for an assist at c-section **on the same claim form** as the physician performing the delivery by adding modifier 80, 81, or 82 to the delivery-only code (e.g. 59514-80). The claim must be billed using the delivering physician's NPI.
- RNAs assisting at c-sections may **only** bill using CPT code 59514 or 59620 with modifier 80.
- To bill for anesthesia during delivery, see the Anesthesia section in Section F of these billing instructions.
- For deliveries in a birthing center, refer to the current Department/MPA *Births in Birthing Centers Billing Instructions*. For deliveries in a home birth setting, refer to the current Department/MPA *Planned Home Births Billing Instructions*.

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 Department/MPA *Maternity Support Services/Infant Case Management Billing Instructions*.

HIV/AIDS Counseling/Testing

The Department covers one pre- and one post-HIV/AIDS counseling/testing session (CPT Code 99401) per client each time the client is tested for HIV/AIDS. [**Refer to WAC 388-531-0600**]

Use ICD-9-CM diagnosis code V65.44 when billing CPT code 99401 for HIV/AIDS counseling. The Department does not pay for counseling visits when billed with an E&M service on the same day.

Exceptions:

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

For your convenience, a table summarizing “Billing the Department for Maternity Services” is included on the following pages.

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**Billing the Department for Maternity Services
In a Hospital Setting**

Global (Total) Obstetrical (OB) Care

Service	Procedure Code/Modifier	Summary of Description	Limitations
Confirmation of pregnancy	99201-99215	Office visits	Code the sign or symptom (e.g. suppressed menstruation)
Global OB care	59400	Total OB care, vaginal delivery	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	Total OB care, c-section	
	59610	Total OB care, VBAC	
	59618	Total OB care, attempted VBAC	

Antepartum Care Only

Service	Procedure Code/Modifier	Summary of Description	Limitations
Antepartum care (bill <i>only one</i> of these codes to represent the total number of times you saw the client 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, 4-6 visits	Limited to one unit per client, per pregnancy, per provider
	59426	Antepartum care, 7+ visits	Limited to one unit per client, per pregnancy, per provider.

Deliveries

Service	Procedure Code/Modifier	Summary of Description	Limitations
Delivery only	59409	Vaginal delivery only	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	C-Section delivery only	
	59612	VBAC delivery only	
	59620	Attempted VBAC delivery only	
Delivery with postpartum care	59410	Vaginal delivery including postpartum 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	C-Section delivery with postpartum care	
	59614	VBAC including postpartum care	
	59622	Attempted VBAC including postpartum care	

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Changes are highlighted

Billing the Department for Maternity Services In a Hospital Setting

Postpartum Care Only

Service	Procedure Code/Modifier	Summary of Description	Limitations
Postpartum care only	59430	Postpartum care only	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	Summary of Description	Limitations
Additional visits for antepartum care due to high-risk conditions	99211-99215 UA	Office visits with OB service modifier	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	Summary of Description	Limitations
Labor management (may only be billed when another provider takes over and delivers the infant)	99221-99223 TH	Hospital admit services with OB services modifier	Prolonged services are limited to 3 hours per client, per pregnancy; must be billed with modifier TH; must not be billed by delivering provider.
	+99356 Limited to 1 unit	Prolonged services, inpatient setting, 1 st hour	
	+99357 Limited to 4 units	Prolonged services, inpatient setting, each add'l 30 minutes	

High-Risk Deliveries

Service	Procedure Code/Modifier	Summary of Description	Limitations
High-risk delivery <i>[Not covered for assistant surgeons, co-surgeons, or RNFA]</i>	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.

Sterilization and Hysteroscopic Sterilization

You may view information on sterilization and the current sterilization form samples and instructions on the Department/MPA website at:

<http://hrsa.dshs.wa.gov/download/sterilization.pdf>.

Hysterectomies [Refer to WAC 388-531-1550(10)]

- 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 Department-approved consent form to attach to their claim.
- **ALL** hysterectomy procedures require a properly completed Department-approved consent form, regardless of the client's age or the ICD-9-CM diagnosis.
- Submit the claim and completed Department-approved consent form (see *Important Contacts* section).

Download the Hysterectomy Consent Form, DSHS 13-365, at:

<http://www1.dshs.wa.gov/msa/forms/eforms.html>

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 a Department managed care organization may self refer outside their plan for abortions.

RU-486 Abortion Drug

The Department 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	Description
S0190	Mifepristone, oral, 200 mg
S0191	Misoprostol, oral, 200 mcg

Abortion centers (non hospital-based) must be approved by the Department to be able to bill for facility fee payments. To become an abortion center provider, fax a request to the program manager at 1-360-586-1471.

Abortion Center Contracts (Facility Fees)

For providers who currently have an abortion center contract with the Department, facility fees are payable only for surgical abortions. Do not bill facility fee charges for drug-induced abortions not requiring surgical intervention. The Department 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 a Department 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.

Prior Authorization

[Refer to WAC 388-531-0200]

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 Department reviews requests for payment for noncovered healthcare services according to WAC 388-501-0160 as an Exception to Rule. For Community Inpatient Psychiatric Inpatient authorization, see Section F of the Department/MPA [Inpatient Hospital Billing Instructions](#).

The Department's PA requirements are met through the following authorization processes:

- Limitation extensions (LE);
- Written/fax; and
- Expedited prior authorization (EPA).

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, please go to:
<http://hrsa.dshs.wa.gov/authorization/>.

How Does the Department Determine PA?

The Department reviews PA requests in accordance with WAC 388-501-0165. The Department utilizes evidence-based medicine to evaluate each request. The Department 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 Department 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

Physician-Related Services/Healthcare Professional Services

- Request the provider to submit additional justifying information within 30 days. When the additional information is received, the Department 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 Department will deny the requested service.

When the Department denies all or part of a request for a covered service or equipment, the Department 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 department 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 department's action was taken;
- Is in sufficient detail to determine what additional or different information might be provided to challenge the department'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)

[Refer to WAC 388-531-0200 (4)-(6)]

Prior authorization is required for the following:

- Abdominoplasty;
- All inpatient hospital stays for acute physical medicine and rehabilitation (PM&R);
- Unilateral cochlear implants for clients 20 years of age and younger;
- Diagnosis and treatment of eating disorders for clients 21 years of age and older;
- Osteopathic manipulative therapy in excess of the department's published limits;
- Panniculectomy;
- Bariatric surgery; and
- Vagus nerve stimulator insertion, which also:
 - ✓ For coverage, must be performed in an inpatient or outpatient hospital facility; and
 - ✓ For reimbursement, must have the invoice attached to the claim.
- Osseointegrated/bone anchored hearing aids (BAHA) for clients 20 years of age and younger;
- Removal or repair of previously implanted BAHA or cochlear device for clients 21 years of age and older when medically necessary.

The Department may require a second opinion and/or consultation before authorizing any elective surgical procedure.

Note: Children six years of age and younger do not require authorization for hospitalization.

“Write or Fax” Prior Authorization (PA)

What is “write or fax” PA?

“Write 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. Procedures that are marked with a # sign are noncovered. The Department 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 you must provide the following documentation:

- General Information for Authorization form, DSHS 13-835. This form must be page one of your mailed/faxed request, and must be typed. (Required)
- The program form. This form must be attached to your request. These forms are available at: <http://www1.dshs.wa.gov/msa/forms/eforms.html>. (Required)
- Charts and justification to support your request for authorization.

This documentation should be submitted:

- **By Fax**

Fax prior authorization requests to 1-866-668-1214.

- **By Mail**

Mail prior authorization requests to:

Authorization Services Office
PO Box 45535
Olympia, WA 98504-5535

For a list of forms and where to send them, please refer to the Important Contacts section. Forms are available at: <http://www1.dshs.wa.gov/msa/forms/eforms.html>. Be sure to complete all information requested. The Department returns incomplete requests to the provider.

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 Department/MPA billing instructions.

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 a LE authorization?

Some LE authorizations are obtained by using the EPA process. Refer to the EPA section pages H.6-H.11 for criteria. If the EPA process is not applicable, an LE must be requested in writing and receive the Department 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. Copy of last prescription and date of last dispense;
5. The primary diagnosis code and CPT® code; and
6. Client-specific clinical justification for additional services.

For a list of forms and where to send them, please refer to the Important Contacts section.

Expedited Prior Authorization (EPA)

EPA is designed to eliminate the need for written authorization. The Department establishes authorization criteria and identifies the criteria with specific codes, enabling providers to create an EPA number using those codes.

To bill the Department 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 pages H.6-H.11 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 has 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 *N. 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 Department denies claims submitted without a required EPA number.

The Department 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 Department on request. If the Department determines the documentation does not support the criteria being met, the claim will be denied.

Note: The Department 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 Department's request. If the Department determines the documentation does not support the EPA criteria being met, the claim will be denied.

You must complete the Oral Enteral Nutrition Worksheet Expedited Prior Authorization Request, DSHS 13-761, for clients who meet EPA criteria for oral enteral nutrition. The completed form must be kept in the client's chart and a copy sent to the pharmacy or medical vendor supplying the oral enteral nutrition product. This form is available at:

<http://www1.dshs.wa.gov/msa/forms/eforms.html>

If the client does not meet the EPA criteria, the Oral Enteral Nutrition Worksheet Expedited Prior Authorization Request form, DSHS 13-761, must be completed and sent to a pharmacy or medical vendor supplying the oral enteral nutrition product.

Washington State Expedited Prior Authorization Criteria Coding List

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 <i>hypertrophy of the breast</i> with: <ol style="list-style-type: none"> 1) Photographs in client's chart, <i>and</i> 2) Documented medical necessity including: <ol style="list-style-type: none"> a) Back, neck, and/or shoulder pain for a minimum of one year, directly attributable to macromastia, <i>and</i> b) Conservative treatment not effective; <i>and</i> 3) Abnormally large breasts in relation to body size with shoulder grooves, <i>and</i> 4) Within 20% of ideal body weight, <i>and</i> 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 : <ol style="list-style-type: none"> 1) Pictures in clients' chart, <i>and</i> 2) Persistent tenderness and pain, <i>and</i> 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.

Physician-Related Services/Healthcare Professional Services

EPA Code	Service Name	CPT/HCPCS/Dx Code	Criteria
421	Meningococcal Vaccine	CPT: 90734 (Conjugate Vaccine – Menactra®)	<p>Client is 21 years of age through 55 years of age¹ and meets in one of the “at risk” groups because the client has one of the following:</p> <ol style="list-style-type: none"> 1) Has terminal complement component deficiencies; 2) Has anatomic or functional asplenia; 3) Is a microbiologist who is routinely exposed to isolates of N. meningitidis; or 4) Is a freshman entering college who will live in a dormitory.
422	Placement of Drug Eluting Stent and Device	HCPCS: C1874, C1875, G0290 and G0291 (837I/UB-04 only)	<p>The Department pays for drug eluting stents when:</p> <ol style="list-style-type: none"> 1) Medically necessary; and 2) One or more of the following criteria are met: <ol style="list-style-type: none"> a) Stent diameter of 3 mm or less; b) Length of stent(s) of 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.
423	Cochlear Implants for Clients 20 Years of Age and Younger	CPT: 69930, HCPCS: L8614 (837I/UB-04 only) DX: 389.10-389.18	<p>The Department will only reimburse for cochlear implantation when the products come from a vendor with a Core Provider Agreement with the Department.</p> <p>Note: Bilateral cochlear implantation is not covered.</p> <p>When one of the following is true:</p> <ol style="list-style-type: none"> 1) Unilateral cochlear implantation for client age 18 through 20 with post-lingual hearing

¹ For clients age 11 through 20, refer to the EPSDT Billing Instructions.

Physician-Related Services/Healthcare Professional Services

EPA Code	Service Name	CPT/HCPCS/Dx Code	Criteria
			<p>loss and clients (age 12 months-17 years) with prelingual hearing loss when all of the following are true:</p> <ul style="list-style-type: none"> a) The client has a diagnosis of profound to severe bilateral, sensorineural hearing loss; b) The client has stimuable 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) Client does not have lesions in the auditory nerve and/or acoustic areas of the central nervous system; and g) There are no other contraindications to surgery. <p>Note: Replacement parts for cochlear implants for clients 20 years of age and younger have been moved to the Hearing Hardware for Clients 20 Years of Age and Younger Program. Refer to the Department/MPA Hearing Hardware for Clients 20 Years of Age and Younger Billing Instructions for more information.</p>

Physician-Related Services/Healthcare Professional Services

EPA Code	Service Name	CPT/HCPCS/Dx Code	Criteria
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)	When both of the following are true: 1) The diagnosis is 250.70-250.83; and 2) 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 that are broken or lost or contacts that are lost or damaged; and 2) Last exam was at least 18 months ago. Note: You do not need an EPA # when billing for children or clients with developmental disabilities.
630	Blepharoplasties	CPT: 15822, 15823, and 67901-67908	Blepharoplasty for noncosmetic reasons when <i>both</i> of the following are true: 1) The excess upper eyelid skin impairs the vision by blocking the superior visual field; 2) On a central visual field test, the vision is blocked to within 10 degrees of central fixation.

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Physician-Related Services/Healthcare Professional Services

EPA Code	Service Name	CPT/HCPCS/Dx Code	Criteria
631	Strabismus Surgery	CPT: 67311-67340 DX: 368.2	Strabismus surgery for clients 18 years of age and older when <i>both</i> of the following are true: 1) The client has a strabismus-related double vision (diplopia), ICD-9-CM diagnosis code 368.2; and 2) It is not done for cosmetic reasons.
1207	Neuropsychological Testing	CPT: 96118 and 96119	Refer to Section D for criteria.
1209	Laboratory Testing	CPT: 83900, 83909, 88384, and 88385	Limited to 15 donor screenings when both of the following criteria is met: 1. The client is undergoing or has had a hematopoietic cell transplant; and 2. The transplant is being done at a Department-approved Center of Excellence.
1300	Injection, Romiplostim, 10 Micrograms	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. 5) Documented diagnosis of Idiopathic Thrombocytopenic Purpura (ITP); 6) Patient must be at least 18 years of age;

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Physician-Related Services/Healthcare Professional Services

EPA Code	Service Name	CPT/HCPCS/Dx Code	Criteria
			7) Inadequate response (reduction in bleeding) to: <ul style="list-style-type: none"> a. Immunoglobulin treatment; and b. Corticosteroid treatment; or c. Splenectomy. 8) Prescriber and Client must be enrolled in NEXUS.

Department-Approved Centers of Excellence (COE)

[Refer to WAC 388-531-0650]

The Department pays for medically necessary transplant procedures only for eligible Department clients who are not otherwise subject to a managed care organization (MCO) plan. Clients eligible under the Alien Emergency Medical (AEM) program are not eligible for transplant coverage.

The Department covers the following transplant procedures when the transplant procedures are performed in a hospital designated by the Department 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.
- Non-solid organs include bone marrow and peripheral stem cell transplants.

The Department pays for skin grafts and corneal transplants to any qualified hospital when medically necessary.

The Department 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 Department requires PA for more than 15 tests. Use the recipients ProviderOne Client ID when billing for these donor services. To bill for donor services, use 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 388-531-1750, 388-550-1900, 388-550-2100, and 388-550-2200.

Note: Use of V70.8 as a principal diagnosis will cause the line to be denied.

The Department does not pay for experimental transplant procedures. In addition, the Department 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.

Physician-Related Services/Healthcare Professional Services

The Department 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.

The following services must be performed in a Department-approved Center of Excellence (COE) and **do not require prior authorization (PA)**. See the next page for a list of COEs.

Sleep studies (CPT codes 95805, 95807-95811). Refer to WAC 388-531-1500 and 388-550-6350.

Bariatric Surgery must be performed in a Department-approved hospital and **requires PA**.

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 you are billing the Department as secondary insurance, the Department does not require PA or that the transplant, sleep study, or bariatric surgery be done in a Center of Excellence or Department-approved hospital.

Services Performed in Department-Approved Centers of Excellence (COE) [Refer to WAC 388-531-0650]

To view the Department-Approved Centers of Excellence list for Hysteroscopic Sterilizations, Sleep Study, and Transplant Centers of Excellence visit the Department on line at:

<http://hrsa.dshs.wa.gov/HospitalPymt/>

Department-Approved Sleep Study Centers

[Refer to WAC 388-531-1500 and 388-550-6350]

Providers must:

- Use CPT codes 95805 and 95807-95811 for sleep study services.
- Enter the approved Department sleep center's NPI where the sleep study/polysomnogram or multiple sleep latency testing was performed. (Refer to previous page for appropriate location of Department-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.
- Obtain an ENT consult for children younger than 10 years of age prior to study.
- Sleep studies are limited to rule out obstructive sleep apnea or narcolepsy.

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

327.10	327.20	327.27	780.51
327.11	327.21	327.42	780.53
327.12	327.23	327.51	780.54
327.14	327.26	347.00-347.11	780.57

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 Department requires a sleep consultation with a physician who is Board Certified in Sleep Medicine at a Department-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 Department 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 Department 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.

Department-Approved Bariatric Hospitals and Their Associated - Clinics [WAC 388-531-1600 and 388-550-2301]

Department-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

The Department covers medically necessary bariatric surgery for clients ages 21 to 59 in an approved hospital with a bariatric surgery program in accordance with WAC 388-531-1600. Prior authorization is required. To begin the authorization process, providers should fax the Department a completed “Bariatric Surgery Request” form, DSHS # 13-785 (see Important Contacts).

The Department covers medically necessary bariatric surgery for clients ages 18-20:

- 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 388-531-1600.

Bariatric Case Management Fee

The Department may authorize up to 34 units of a bariatric case management fee as part of the Stage II bariatric surgery approval. One unit of procedure 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 Department.

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 Department and who have complications following bariatric surgery are covered fee-for-service for these complications 90 days from the date of the Department-approved bariatric surgery. The Department requires authorization for these services. Claims without authorization will be denied.

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 Department's fee schedule amounts are established using three relative value unit (RVU) components: work, practice expense, and malpractice expense. The Department 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
- **Non-facility setting maximum allowable fees (NFS Fee)** - Paid when the provider performs the service in a non-facility 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 Department Pay Providers Differently for Services Performed in Facility and Nonfacility Settings?

Yes. When a provider performs a professional service in a facility setting, the Department 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 non-facility setting, the Department 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 Department also makes a payment to a facility. In most cases, the Department 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

Physician-Related Services/Healthcare Professional Services

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 Department must include the appropriate Medicare **two-digit place of service code**. The Department will deny claims with single-digit place of service codes.

Due to Medicare's consolidated billing requirements, the Department 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 Department 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 Department 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

Physician-Related Services/Healthcare Professional Services

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	Non-Resident 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 Department must include the appropriate Medicare **two-digit place of service code**. The Department 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 Department identifies procedure codes that may require prior authorization. However, this list may not be all-inclusive. Prior authorization, limitations, or requirements detailed in Department/MPA billing instructions and Washington Administrative Code (WAC) remain applicable.
- Section L contains rate setting methodology and unit rounding instructions for injectable drug codes.
- Many Department/MPA fee schedules are available for download in Excel format online at: <http://hrsa.dshs.wa.gov/RBRVS/Index.html>.

CPT codes and descriptions only are copyright 2010 American Medical Association

Changes are highlighted

- I.4 -

Site of Service (SOS) Payment Diff.

Medical Supplies and Equipment

General Payment Policies

- The Department 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 the list beginning on page K.2).
- 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 list beginning on page K.2). The Department pays providers separately for only those MSE listed beginning on page K.5.
- The Department 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 Department upon request. **DO NOT send in an invoice with a claim** for MSE under \$50.00 unless requested by the Department.
- 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 the *Important Contacts* section 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 Department 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	Brief Description
99070	Special supplies
A4206	Syringe with needle, sterile 1cc
A4207	Syringe with needle, sterile 2cc
A4208	Syringe with needle, sterile 3cc
A4209	Syringe with needle, sterile 5cc
A4211	Supplies for self-administered injections
A4212	Huber-type needle, each
A4213	Syringe, sterile, 20 CC or greater
A4215	Needles only, sterile, any size
A4220	Refill kit for implantable infusion pump
A4244	Alcohol or peroxide, per pint
A4245	Alcohol wipes, per box
A4246	Betadine or phisohex solution, per pint
A4247	Betadine or iodine swabs/wipes, per box
A4252	Blood ketone test or strip
A4253	Blood glucose test, per 50 strips
A4256	Normal, low and high cal solution/chips
A4258	Spring-powered device for lancet, each
A4259	Lancets, per box of 100
A4262	Temporary lacrimal duct implant, each
A4263	Permanent lacrimal duct implant, each
A4265	Paraffin, per pound
A4270	Disposable endoscope sheath, each
A4300	Implantable access partial/catheter
A4301	Implantable access total system
A4305	Disposable drug delivery system, flow rate 50 ML or more per hour
A4306	Disposable drug delivery system, flow rate 5 ML or less per hour
A4310	Insertion tray w/o drainage bag
A4311	Insertion tray without drainage bag

Physician-Related Services/Healthcare Professional Services

HCPCS Code	Brief Description
A4312	Insertion tray without drainage bag
A4313	Insertion tray without drainage bag
A4314	Insertion tray with drainage bag
A4315	Insertion tray with drainage bag
A4316	Insertion tray with drainage bag
A4320	Irrigation tray for bladder
A4330	Perianal fecal collection pouch
A4335*	Incontinence supply; miscellaneous
A4338*	Indwelling catheter; Foley type
A4340*	Indwelling catheter; Spec type
A4344*	Indwelling catheter; Foley type
A4346*	Indwelling catheter; Foley type
A4351	Intermittent urinary catheter
A4352	Intermittent urinary catheter
A4353	Catheter insert tray with cath/tube/bag
A4354	Insertion tray with drainage bag
A4355	Irrigation tubing set
A4356*	External urethral clamp device
A4357*	Bedside drainage bag, day or night
A4358*	Urinary leg bag; vinyl
A4361*	Ostomy faceplate
A4362*	Skin barrier; solid, 4 x 4
A4364*	Adhesive for ostomy or catheter
A4367*	Ostomy belt
A4368*	Ostomy filter, each
A4397	Irrigation supply; sleeve
A4398*	Irrigation supply; bags
A4399*	Irrigation supply; cone/catheter
A4400*	Ostomy irrigation set
A4402	Lubricant
A4404*	Ostomy rings
A4421*	Ostomy supply; miscellaneous
A4455	Adhesive remover or solvent
A4461	Surgical dressing holder, nonreusable, each
A4463	Surgical dressing holder, reusable, each
A4465	Non-elastic binder for extremity
A4470	Gravlee jet washer
A4480	Vabra aspirator
A4550	Surgical tray
A4556	Electrodes (e.g., apnea monitor)
A4557	Lead wires (e.g., apnea monitor)
A4558	Conductive paste or gel
A4649	Surgical supply; miscellaneous

Physician-Related Services/Healthcare Professional Services

HCPCS Code	Brief Description
A5051*	Ostomy pouch, closed; with barrier
A5052*	Ostomy pouch, closed; without barrier
A5053*	Ostomy pouch, closed; use on faceplate
A5054*	Ostomy pouch, closed; use on barrier
A5055*	Stoma cap
A5061*	Ostomy pouch, drainable; with barrier
A5062*	Ostomy pouch, drainable; without barrier
A5063*	Ostomy pouch, drainable; use on barrier
A5071*	Pouch, urinary; with barrier
A5072*	Pouch, urinary; without barrier
A5073*	Pouch, urinary; use on barrier
A5081*	Continent device ; plug
A5082*	Continent device ; catheter
A5083*	Stoma absorptive cover
A5093*	Ostomy accessory; convex insert
A5102*	Bedside drainage bottle
A5105*	Urinary supensory; with leg bag
A5112*	Urinary leg bag; latex
A5113*	Leg strap; latex, per set
A5114*	Leg strap; foam or fabric
A5120	Skin barrier, wipe or swab
A5121*	Skin barrier; solid, 6 x 6
A5122*	Skin barrier; solid, 8 x 8
A5126*	Adhesive; disc or foam pad
A5131*	Appliance cleaner
A6021	Collagen dressing <=16 sq in
A6022	Collagen drsg>6<=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

Supplies Paid Separately When Dispensed from a Provider's Office/Clinic

Miscellaneous Supplies

HCPCS Code	Brief Description
A4561	Pessary rubber, any type
A4562	Pessary, nonrubber, any type
A4565	Slings
A4570	Splint
L8695	External recharge sys extern, requires PA

Casting Materials

Bill the appropriate HCPCS code (Q4001-Q4051) for fiberglass and plaster casting materials. Do not bill for the use of a cast room. Use of a cast room is considered part of a provider's practice expense.

Metered Dose Inhalers and Accessories

HCPCS Code	Brief Description
A4614	Peak flow meter
A4627	Spacer bag, or reservoir, with/without mask (for use with metered does inhaler)

Inhalation Solutions

Refer to the fee schedule for those specific codes for inhalation solutions that are paid separately.

Radiopharmaceutical Diagnostic Imaging Agents

Refer to the fee schedule for those specific codes for imaging agents that are paid separately.

Miscellaneous Prosthetics & Orthotics

HCPCS Code	Brief Description
L0120	Collar-philadelphia child
L0220	Thoracic, rib belt, custom fabricated
L1810	Knee brace hinged
L1820	Action neoprene brace, knee
L1830	Knee immobilizer 24" universal
L3650	Shoulder abduction pillow
L3807	WHFO, extension assist, with inflatable palmer air support, with or without thumb extension
L3908	Wrist comfort form all sizes
L8000	Post mastectomy implants bra
L8010	Breast binder
L8600	Breast implants

Note: See page K.7 for Misc. prosthetics and orthotics that only Podiatrists and Orthopedic Surgeons can bill for.

Urinary Tract Implants

See important policy limitations for urinary tract implants in Section F.

HCPCS Code	Brief Description
L8603	Collagen implant, urinary tract, per 2.5 ml syringe
L8606	Synthetic implant, urinary tract, per 1 ml syringe

Note: The Department does not pay providers for L8603 and L8606 if the implants are done outside the physician's office.

The Department covers the first five (5) implants only, using a combination of L8603 and/or L8606, per client. Each 2.5 ml syringe of L8603 or each 1 ml syringe of L8606 is one implant.

Podiatry and Orthopedic Surgeons

The following codes are payable only to podiatrists and orthopedic surgeons:

HCPCS Code	Brief Description
A5500	Diab shoe for density insert
A5501	Diabetic custom molded shoe
A5503	Diabetic shoe w/roller/rocker
A5504	Diabetic shoe with wedge
A5505	Diab shoe w/metatarsal bar
A5506	Diabetic shoe w/offset heal
A5507	Modification diabetic shoe (requires PA)
A5512	Multi den insert direct form
A5513	Multi den insert custom mold
L1902	Boot-walkabout med/large
L1906	Canvas ankle brace
L3000	Ft insert ucb berkeley shell. EPA required.
L3030	Foot arch support remov prem. EPA required.
L3100	Hallus-valgus nght dynamic s
L3140	Abduction rotation bar shoe
L3150	Abduct rotation bar w/o shoe
L3170	Foot plastic foot stabilizer. PA required.
L3215	Orthopedic ftwear ladies oxf. EPA required.
L3219	Orthopedic mens shoes oxford. EPA required.
L3230	Custom shoes depth inlay.
L3310	Shoe lift elev heel/sole neo. EPA required.
L3320	Shoe lift elev heel/sole cor. EPA required.

Podiatry and Orthopedic Surgeons (cont.)

HCPCS Code	Brief Description
L3334	Shoe lifts elevation heel /i. EPA required.
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 refor
L4350	Air support – purple med/large
L4360	Walker, pneumatic s-m-l PA required.
L4380	Aircast infrapatellar band
L4386	Diabetic walker PA required.

Injectable Drug Codes

What Drugs *Are* Covered? [Refer to WAC 388-530-2000 (1)]

The Department covers outpatient drugs, including over-the-counter drugs listed on the Department's Covered Over-the-Counter Drug list, as defined in WAC 388-530-1050, 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 388-530-1050;
- The drug is not excluded from coverage (see —WAC 388-530-2000 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 388-530-7500 which describes the drug rebate program.

For more information go to:

http://hrsa.dshs.wa.gov/download/Billing_Instructions/Prescription_Drug/Prescription_Drug_Program_BI.pdf

The Department's fees for injectable drug codes are the maximum allowances used to pay covered drugs and biologicals administered in a provider's office only.

The Department 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 Department prices the drug at a percentage of the Average Wholesale Price (AWP). The Department updates the rates each time Medicare's rate is updated, up to once per quarter. Unlike Medicare, the Department 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 Department 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 Department multiplies the amount by 0.84 to arrive at the fee schedule maximum allowance.

Physician-Related Services/Healthcare Professional Services

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. You must 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 Drug (J9000-J9999)

- 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).
- The Department 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 Department continues to price the drug at 84% of the Average Wholesale Price (AWP).

All Other Drugs

- Bill number of units used based on the description of the drug code.
- Claims with HCPCS code J3490 must:
 - ✓ Include the NDC in the correct format depending on the claim media and the amount of the drug administered to the client in the claim notes field; and
 - ✓ Must be billed with one unit only.
- The Department 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 Department continues to price the drug at 84% of the Average Wholesale Price (AWP).

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 Section I.

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 Department 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 Department’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 Department 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 Department’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].

Synagis (CPT® code 90378)

See Section C for information on Synagis.

Unlisted Drugs (J3490 and J9999)

When it is necessary to bill the Department for a drug using an unlisted drug code, providers must report the National Drug Code (NDC) of the drug administered to the client. The Department 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 388-530-1050 (see —WAC 388-530-2000 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 Section C of these billing instructions for more detailed information on NDC billing.

Note: If there is an assigned HCPCS code for the administered drug, providers **must bill** the Department using the appropriate HCPCS code. **DO NOT** bill using an unlisted drug code for a drug that has an assigned HCPCS code. The Department 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 fee schedule. The fee schedule may be accessed on the Department's web site at: <http://hrsa.dshs.wa.gov/RBRVS/index.html>

Invoice Requirements

A copy of the manufacturer's invoice showing the **actual acquisition cost** of the drug must be attached to the claim **ONLY** when billed charges exceed \$1,100.00 per line item. If billed charges are less than \$1,100.00 per line item, **DO NOT** attach the invoice or any other paperwork to your claim. If needed, the Department 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 Department upon request.

CPT/HCPCS Modifiers

[Refer to WAC 388-531-1850(10) and (11)]

Italics indicate additional Department 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 Department'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 Department is required if services are performed in a hospital setting.*

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Physician-Related Services/Healthcare Professional Services

- 32: **Mandated Services:** *For informational purposes only; no extra allowance is allowed.*
- 47: **Anesthesia by Surgeon:** *Not covered by the Department.*
- 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 Department'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.

Physician-Related Services/Healthcare Professional Services

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 (E&M) service provided the day before the day of surgery that resulted in the initial decision to perform the surgery may be identified by adding the modifier 57 to the appropriate level of E&M service. *This does not apply to minor surgeries (those with a follow-up period of less than 90 days).*
- 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). *This modifier is for informational purchases only; no extra allowance is allowed.*

Physician-Related Services/Healthcare Professional Services

- 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). *A physician assistant, employed by a physician, must use the physician's NPI and must bill on the same claim form as the physician/surgeon if the physician assistant does not have an NPI. Payment is 20% of the maximum allowance.*
- 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.*

Physician-Related Services/Healthcare Professional Services

- 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.
- 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 Department 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 Department 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 Department is required if services are performed in a hospital setting.*
- TG **Complex/high level of care.**

Physician-Related Services/Healthcare Professional Services

- TH **Obstetrical treatment/services, prenatal or postpartum:** *To be used only for those maternity services outlined in Section H [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 GP:** *To be used for enhancement payment for foster care children screening exams.*
- TS **Follow-up service:** *To be used only with HCPCS procedure code H0009.*
- UA **M/Caid Care Lev 10 State Def.**
- UN **Two patients served:** *To be used only with CPT code R0075.*
- UP **Three patients served:** *To be used only with CPT code R0075.*
- UQ **Four patients served:** *To be used only with CPT code R0075.*
- UR **Five patients served:** *To be used only with CPT code R0075.*
- US **Six or more patients served:** *To be used only with CPT code R0075.*

Anesthesia Modifiers

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. ***This modifier is not covered by the Department.***

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.

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.*

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.

How Do I Bill 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.

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 Physician-Related Services:

Field Number	Instructions
24B	See Section J for correct place of service codes. These are the only appropriate place of service codes.
24D	Enter the appropriate procedure code for the services being billed. See the fee schedule. Modifier: When appropriate enter a modifier from the list found in Section L.
24H	When billing the Department for one of the EPSDT screening procedure codes, enter an X in this field.

How Do I Submit 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 Department. If the claim is not received by the Department, 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 current Department/MPA *Tribal Health Program Billing Instructions*.

What Does the Department Require from 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; and
- 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; and
- Text that is font size 12.