

Health and Recovery Services Administration



Physician-Related Services

Billing Instructions

[Chapter 388-531 WAC]

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How Can I Get DSHS/HRSA Provider Documents?

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

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Important Contacts

A provider may contact HRSA's toll-free lines for questions regarding HRSA programs. However, HRSA's response is based solely on the information provided to the representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern HRSA's programs. [WAC 388-502-0020(2)].

How can I use the Internet to...

Find information on becoming a DSHS provider?

Visit Provider Enrollment at:
<http://maa.dshs.wa.gov/provrel/>
Click on "Sign up to be a WA state Medical Assistance provider" and follow the on-screen instructions to find information on becoming a DSHS provider.

Ask questions about the status of my provider application?

Visit Provider Enrollment at:
<http://maa.dshs.wa.gov/provrel/>

- Click on "Sign up to be a WA State Medical Assistance provider."
- Click on "I want to sign up as a WA State Medical provider."
- Click on the link on the left side of the screen that says "What happens once I return my application?"

Submit a change of address or ownership?

Visit Provider Enrollment at:
<http://maa.dshs.wa.gov/provrel/>
Click on "I'm already a current provider" to submit a change of address or ownership.

If I don't have access to the Internet, how do I find information on becoming a DSHS provider, ask questions about the status of my provider application, or submit a change of address or ownership?

Call Provider Enrollment at:
800.562.3022 (option #2)

or write to:
HRSA Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9248
Olympia WA 98507-9248

Where can I view and download rates?

Visit HRSA's web site at
<http://maa.dshs.wa.gov/RBRVS/index.html>

How do I obtain DSHS forms?

To **view and download** DSHS forms, visit DSHS Forms and Records Management Service on the web: <http://www1.dshs.wa.gov/msa/forms/eforms.html>

To **have a paper copy sent** to you, contact DSHS Forms and Records Management Service:
Phone: 360.664.6047
Fax: 360.664.6186

Include in your request:

- Form number and name;
- Quantity you want;
- Your name;
- Your office/organization name; and
- Your complete mailing address.

How do I get copies of billing instructions?

To **view and download**, visit HRSA on the web: <http://maa.dshs.wa.gov/> Click on *Billing Instructions/Numbered Memoranda*.

To **have a paper copy sent to you:**

- Visit the Dept. of Printing on the web: <http://www.prt.wa.gov/> Click on *General Store; or*
- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at Fax 360.586.6361/ telephone 360.586.6360. (Orders may take up to 2 weeks to fill.)

Where do I call/look if I have questions regarding...

Payments, denials, general questions regarding claims processing, HRSA managed care plans?

HRSA Customer Service Center for Providers
<http://maa.dshs.wa.gov/provrel/>
800.562.3022, option 2 (toll free)
PO Box 45535
Olympia, WA 98504-5535
Fax: 360.725.2144 or 360.586.1209

Private insurance or third party liability, other than HRSA managed care plans?

Division of Customer Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
800.562.6136 (toll free)

Electronic Claims Submission Information?

DSHS HIPAA web site for free software and HIPAA-compliance information:

<http://maa.dshs.wa.gov/dshshipaa>

WinASAP and WAMedWeb

<http://www.acs-gcro.com/>
Select *Medicaid*, then *Washington State*

All other HIPAA transactions

<https://wamedweb.acs-inc.com/>

Where do I call/look if I have questions regarding Electronic Claims Submission Information? (cont.)

To use HIPAA Transactions and/or WinASAP 2003 enroll with ACS EDI Gateway by visiting ACS on the web at: http://www.acs-gero.com/Medicaid_Accounts/Washington_State_Medicaid/washington_state_medicaid.htm (click on “Enrollment”)

Or by calling: 800.833.2051.

Once the provider completes the EDI Provider Enrollment form and faxes or mails it to ACS, ACS will send the provider the web link and the information needed to access the web site. If the provider is already enrolled, but for some reason cannot access the WAMedWeb, then the provider should call ACS at 800.833.2051.

Federal HIPAA-compliance web site with practical advice for providers and the answers to frequently-asked questions (FAQ):

<http://www.cms.gov/hipaa>

How do I use the WAMedWeb to check on a client’s eligibility status?

If you would like to check client eligibility for free, call ACS at 800.833.2051 or HRSA at 866.562.3022 (option #2).

You may also access the WAMedWeb tutorial at: <http://dshs.dshs.wa.gov/WaMedWebTutor/>

Where do I send prior authorization and limitation extension requests?

Health and Recovery Services Administration
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
Fax: 360.586.1471

What forms are available to submit my authorization request?

- Fax/Written Request Basic Information Form (DSHS #13-756)
- Bariatric Surgery Request Form (DSHS #13-785)
- Out of State Medical Services Request Form (DSHS #13-787)
- Pet Scan Information Form (DSHS #13-757)
- Oral Enteral Nutrition Worksheet Prior Authorization Request (DSHS #13-743)
- Physical, Occupational, and Speech Therapy Limitation Extension Request (DSHS #13-786)
- TYSABRI (Natalizumab) J2323 Request (DSHS #13-832)
- Application for Chest Wall Oscillator (DSHS #13-841)

Other Important Numbers

Acute PM&R Authorization FAX	360.725.1966
Client Assistance/Brokered Transportation Hotline (Clients Only)	800.562.3022
Chemically Using Pregnant (CUP) Women Program Information	360.725.1666
Disability Insurance	800.562.6074
Durable Medical Equipment (DME)/Prosthetics Authorization.....	800.292.8064
Fraud Hotline	800.562.6906
HRSA Managed Care (Healthy Options) Enrollment	800.562.3022
Pharmacy Authorization (Providers Only).....	800.848.2842
Provider Inquiry Hotline (Providers Only)	800.562.3022 (option #2)
Telecommunications Device for the Deaf (TDD)	800.848.5429
Third-Party Resource Hotline.....	800.562.6136
TAKE CHARGE	360.725.1652

Provider Field Representatives

To request on-site billing training, call 800.562.3022 or email
HRSA at: ProvEducSupport@dshs.wa.gov.

HRSA 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 Age 21 and
Older
Dental Program for Clients Through Age 20
Early, Periodic Screening, Diagnosis, and
Treatment (EPSDT) Program
Enteral Nutrition
Family Planning Providers, HRSA-Approved
Federally-Qualified Health Centers (FQHC)
General Information Booklet
Healthy Options/Basic Health Plus/SCHIP
Instructions for Supplemental Billing,
Rebilling & Adjustments
Hearing Aids & Services
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
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
School Medical Services for Special
Education Students
Speech/Audiology Program
Tribal Health Program
Vision Care
Wheelchairs, Durable Medical Equipment
(DME), and Supplies

Definitions & Abbreviations

This section defines terms and abbreviations (includes acronyms) used in these billing instructions.

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 – HRSA official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Authorization number – A nine-digit number assigned by HRSA 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 HRSA determines the amount it will pay for a service that is not included in HRSA’s published fee schedules. HRSA may request the provider to submit a “report” describing the nature, extent, time, effort, and/or equipment necessary to deliver the service.

Client – An applicant for, or recipient of, DSHS medical care programs.

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.

Core provider agreement – The basic contract that HRSA holds with providers serving HRSA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

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.

Department – The state Department of Social and Health Services

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) - A program providing early and periodic screening, diagnosis and treatment to persons under 21 years of age who are eligible for Medicaid or the Children's Health Program.

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.

Explanation of benefits (EOB) – A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Expedited prior authorization (EPA) – A process designed by HRSA to eliminate the need for written prior authorization (see definition for “prior authorization”). HRSA establishes authorization criteria and identifies the criteria with specific codes. If the provider determines the client meets the criteria, the provider creates the authorization number using the specific HRSA-established codes.

Fee-for-service – The general payment method HRSA uses to reimburse providers for covered medical services provided to medical assistance clients when those services are not covered under HRSA’s Managed Care plans or State Children’s Health Insurance Program (SCHIP).

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.

Health and Recovery Services

Administration (HRSA) - The administration within the Department of Social and Health Services (DSHS) responsible for providing disability determinations, medical care, mental health, and alcohol/substance abuse treatment services for Washington State's most vulnerable citizens.

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 HRSA routinely reimburses. Limitation extensions require prior authorization.

Managed care – A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

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

Medicaid – The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

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

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

Medical identification card – The form DSHS uses to identify clients of medical programs. These cards are good only for the dates printed on them. Clients will receive a Medical Identification card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were formerly called medical coupons or MAID cards.

Medically necessary – A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, “course of treatment” may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- “Part A” covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- “Part B” is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor’s services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [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.

Patient identification code (PIC) – An alphanumeric code that is assigned to each Medical Assistance client and which consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birth date, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

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

Prior authorization – Written HRSA approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. *Expedited prior authorization and limitation extensions are forms of prior authorization.*

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

Provider or provider of service – An institution, agency, or person:

- Who has a signed agreement (Core Provider Agreement) with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department.

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 HRSA’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.

Third party – Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client.

Title XIX – The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

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 DSHS's maximum allowable fee. Reimbursement is either the usual and customary fee or DSHS's maximum allowable fee, whichever is less.

Washington administrative code (WAC)
– Codified rules of the State of Washington.

Introduction

Procedure Codes

The Department of Social & Health Services (DSHS) 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 DSHS-covered services. **Due to copyright restrictions, DSHS 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.

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Diagnosis Codes

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

DSHS 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.

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

Discontinued Codes

DSHS 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.

Noncovered Services [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.

DSHS 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 Form #13-756] to DSHS (see *Important Contacts* section).

Refer to DSHS’s *General Information Booklet* for information regarding noncovered services and billing a DSHS client who is on a fee-for-service program.

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

- Missed or canceled appointments;
- Adult preventive exams (except EPSDT exams for clients 20 years of age and younger and those clients with developmental disabilities);
- 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.

Who can provide and bill for physician-related services?

[WAC 388-531-0250]

The following enrolled providers are eligible to provide and bill for physician-related healthcare 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);

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Physician-Related Services

- Providers who have a signed agreement with DSHS 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.

Noncovered Practitioners [WAC 388-531-0250]

DSHS 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;
- Homoeopathists;
- 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 DSHS to evaluate a client for bariatric surgery; or
 - ✓ As provided in WAC 388-531-1400.

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- 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.

Clients Enrolled in DSHS's Managed Care Organizations

Many DSHS clients are enrolled in one of DSHS's managed care organizations (MCO). These clients have an HMO identifier in the HMO column on their DSHS Medical ID Card. They also receive an ID card from the MCO in which they are enrolled. Clients enrolled in one of DSHS'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 DSHS.

Codes for Unlisted Procedures (CPT codes XXX99)

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

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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 DSHS.

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

Conversion Factors

	7/1/06	7/1/07	1/1/08	7/1/08	7/1/09
Adult Primary Health Care	25.51	21.95	24.58	25.12	22.03
Anesthesia	20.99	21.20	21.20	21.20	21.20
Children's Primary Health Care	35.00	31.82	47.10	47.64	36.48
Clinical Lab Multiplication Factor	.820	.830	.830	0.820	0.76
Maternity	44.71	42.35	42.35	44.20	43.54
All Other Procedure Codes	22.93	22.03	22.03	22.23	22.31

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

National Correct Coding Initiative

DSHS 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 DSHS to control improper coding that may lead to inappropriate payment. DSHS 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.

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

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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 substituting physician's 7-digit Medicaid provider number in the servicing provider field on the HIPAA transaction (field 24J on the CMS-1500 Claim Form). If the physician does not have a Medicaid provider number, enter the physician's name.
- Enter the regular physician's name, address, and Medicaid provider number in the document level field for servicing provider information on the HIPAA transaction (field 33 on the CMS-1500 Claim Form).
- 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 Health and Recovery Services Administration (HRSA) 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: DSHS 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.

- One pre-operative E&M procedure by a physician for a dental client **prior to performing dental surgery** in an outpatient setting. Bill using dental diagnosis codes 520.1–525.9 as the primary diagnosis when billing E&M codes for pre-op services for dental surgery, along with the appropriate pre op diagnosis codes V72.81–V72.84) as the secondary diagnosis. For clients assigned to a DSHS managed care organization, bill DSHS directly for history and physical claims for dental surgery.

If emergency room visits or office calls are billed in combinations with laboratory, x-ray, or ancillary services, bill with diagnosis codes V72.81-V72.84 in the second diagnosis field. If one of these diagnoses is not in the second diagnosis field, DSHS pays the E&M, but denies the laboratory, x-ray, or ancillary services.

- 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. DSHS pays for one nursing facility discharge per client, per day.
- One physical examination per client, per 12 months for clients of the division of developmental disabilities as identified on the DSHS Medical ID Card. 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.

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Programs (Guidelines/Limitations)

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Office and Other Outpatient Services (cont.)

- DSHS 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)

- DSHS 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 one year of age **has not been issued** an individual Patient Identification Code (PIC), use the mother's or the father's PIC, and put a "B" in the **claim notes field. Indicate the child's name, gender, and birthdate in the client information fields. In addition, when billing for a baby using one of the parents' PIC, you must add modifier HA to CPT codes 99201-99215 only** in order for the service to be paid at the higher fee. If the mother is enrolled in a DSHS managed care plan, newborns will be enrolled in the same managed care plan as their mother.

After Hours

After hours office codes are payable in addition to other services only when the provider's office is not regularly open during the time the service is provided. An after hours procedure billed for a client treated in a 24-hour facility (e.g., emergency room) is payable only in situations where a provider who is not already on-call is called to the facility to treat a client. These codes are not payable when billed by emergency room physicians, anesthesiologists/anesthetists, radiologists, laboratory clinical staff, or other providers who are scheduled to be on call at the time of service. The client's file must document the medical necessity and urgency of the service. Only one code for after hours services will be paid per patient, per day, and a second "day" may not be billed for a single episode of care that carries over from one calendar day.

For example: If a clinic closes at 5pm and takes a break for dinner and then opens back up from 6pm-10pm, these services are not eligible for after hours service codes.

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

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Programs (Guidelines/Limitations)

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Changes are highlighted

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. DSHS 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.

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Programs (Guidelines/Limitations)

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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).

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Programs (Guidelines/Limitations)

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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, DSHS may determine the admission status ordered is not supported by documentation in the medical record. DSHS may consider payment made in this circumstance an overpayment and payment may be recouped or adjusted.

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DSHS covers:

- One inpatient hospital call per client, per day for the same or related diagnoses. DSHS 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: DSHS pays providers for CPT codes 99221-99223 for scheduled hospital admissions during the follow-up period only when billed with a modifier 24.

DSHS 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, DSHS 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. DSHS 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. DSHS does not pay providers separately for hospital discharge day management services.

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Physician-Related 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 DSHS 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).

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. DSHS 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.

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Programs (Guidelines/Limitations)

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Detoxification Services

DSHS covers detoxification services for clients receiving alcohol and/or drug detoxification services in a DSHS-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 DSHS’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
- Non-hospital based detoxification is not medically appropriate.

Note: For dates of service on and after September 1, 2007, the physician must indicate the hospital’s DSHS 7-digit provider number in the Comments field when billed electronically (field 32 on the CMS-1500 form). If the hospital’s provider number is not indicated on the claim, the claim will be denied.

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 <i>[bill for the initial admission]</i>	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 <i>[bill for any follow-up days]</i>	

Note: Managed Care Clients who are receiving detoxification services in a detox hospital that has a detoxification specific provider number can be billed directly to HRSA.

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 DSHS 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

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 DSHS Pharmacy Authorization Section at 1-360-725-1754.

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When will DSHS pay for a smoking cessation referral?

DSHS 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 DSHS Medical ID Card with one of the following Medical Program Identifiers:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP	Children’s Health Program
CNP CHIP	State Children’s Health Insurance Program
GA-U	General Assistance - Unemployable
LCP-MNP	Limited Casualty Program - Medically Needy Program

- 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 DSHS pay for a smoking cessation referral for an evaluation for a smoking cessation prescription?

DSHS 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 DSHS Medical ID Card with one of the following Medical Program Identifiers:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy
LCP-MNP	Limited Casualty Program - Medically Needy Program
GA-U	General Assistance - Unemployable

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When will DSHS pay for a smoking cessation referral for an evaluation for a smoking cessation prescription? (cont.)

- 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 DSHS 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 DSHS 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 DSHS 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.

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

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Programs (Guidelines/Limitations)

Memo 09-87

Changes are highlighted

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.

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Changes are highlighted

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.20.

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.

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Changes are highlighted

- 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.

DSHS covers:

- A maximum of 3 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 91105);
- 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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Changes are highlighted

Physician-Related 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]

DSHS 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.

DSHS 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.

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Changes are highlighted

Prolonged Services (CPT codes 99354-99357)

[Refer to WAC 388-531-1350]

DSHS 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]

DSHS 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

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Changes are highlighted

Physician-Related 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: DSHS **does not cover** physical therapy services performed by osteopathic physicians unless they are also psychiatrists.

Newborn Care

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

DSHS 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: DSHS 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).

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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.

DSHS 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.

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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:

- 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.

Intensive (Non-Critical) 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]

DSHS 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.

DSHS 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

DSHS 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.

DSHS 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

When billing, primary physicians must put their provider number 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 claim:

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

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

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Programs (Guidelines/Limitations)

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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 DSHS clients, particularly those in medically underserved areas of the state, improved access to essential health care services that may not otherwise be available without traveling long distances.

The following services are *not* covered as telehealth:

- Email, telephone, and facsimile transmissions;
- Installation or maintenance of any telecommunication devices or systems;
- Home health monitoring; 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.

DSHS will not pay separately for telehealth services for clients enrolled in a managed care plan. Clients enrolled in a DSHS managed care plan will have a plan indicator in the HMO column on their DSHS Medical ID Card. 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 DSHS cover telehealth?

DSHS 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 on page **B.22**.

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Programs (Guidelines/Limitations)

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Changes are highlighted

Originating Site (Location of Client)

What is an “originating site”?

An originating site is the physical location of the eligible DSHS 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).

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 DSHS 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, and is not reconciled in the monthly gross adjustment process.
- *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.

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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 DSHS client through telehealth.

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

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

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

What services are covered using telehealth?

Only the following services are covered using telehealth:

- Consultations (CPT codes 99241–99245 and 99251-99255);
- Office or other outpatient visits (CPT 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 DSHS 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 DSHS for payment.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

What is the purpose of the EPSDT program?

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a federal preventive health care benefit. The purpose of this program is to screen clients 20 years of age and younger in order to identify physical and/or mental health problems. If a physical or mental health problem is identified, the client should be treated or referred to an appropriate provider for treatment. EPSDT is designed to encourage continuing access to health care.

Access to and services for EPSDT are governed by federal rules at 42 CFR, Part 441, Subpart B.

DSHS's standard for coverage is that the services, treatment, or other measures must be:

- Medically necessary;
- Safe and effective; and
- Not experimental.

Who can provide EPSDT screenings?

- Physicians;
- Advanced Registered Nurse Practitioners (ARNPs);
- Physician Assistants (PAs);
- Nurses specially trained through the Department of Health (DOH); and
- Registered nurses working under the guidance of a physician or ARNP.

Who is eligible for EPSDT screenings?

DSHS covers EPSDT screenings provided to clients who:

- Are 20 years of age and younger; and
- Present a DSHS Medical ID card with one of the identifiers listed on the following page:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP – Children’s Health	CNP – Children’s Health Program
CNP – SCHIP	CNP – State Children's Health Insurance Program
LCP – MNP	Limited Casualty Program – Medically Needy Program

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Note: Please refer clients to their local Community Services Office (CSO) if they are 20 years of age and younger and their DSHS Medical ID card does not list one of the above medical program identifiers. The CSO will evaluate these clients for a possible change in their Medical Assistance program that would enable them to receive EPSDT screenings.

Are clients enrolled in one of DSHS's Managed Care plans eligible for EPSDT?

Yes! EPSDT screenings are included in the scope of service provided by DSHS's managed care plans. Clients who are enrolled in one of DSHS's managed care plans will have an identifier in the HMO column on their DSHS Medical ID Card.

Please refer managed care clients to their respective managed care plan's primary care provider (PCP) for coordination of necessary preventive health care services and medical treatments, including EPSDT services. Clients can contact their plan by calling the telephone number indicated on their DSHS Medical ID card.

Do not bill DSHS for EPSDT services. They are included in the managed care plan's reimbursement.

Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column on their DSHS Medical ID card will be "PCCM." These clients must obtain or be referred for services through the PCCM. The PCCM is responsible for coordination of care just like the Primary Care Provider (PCP) would be in a plan setting.

Note: To prevent billing denials, please check the client's DSHS Medical ID card prior to scheduling services and at the *time of the service* to make sure proper authorization or referral is obtained from the PCCM.

Billing for Infants Not Yet Assigned a Patient Identification Code (PIC)

Use the PIC of either parent for a newborn if the infant has not yet been issued a PIC. Enter indicator **B** in the *Comments* section of the claim form to indicate that the parent's PIC is being used for the infant. When using a parent's PIC for twins or triplets, etc., identify each infant separately (i.e., twin A, twin B), using a *separate claim form* for each. **Note: For parents enrolled in a DSHS managed care plan, the plan is responsible for providing medical coverage for the newborn(s).**

What are EPSDT screenings?

EPSDT screenings are defined by federal rules as "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development and nutritional status of infants, children and youth" that are provided as part of a health supervision program.

What is included in an EPSDT screening?

At a minimum, EPSDT screenings must include:

- A comprehensive health and developmental history, updated at each screening examination;
- A comprehensive physical examination performed at each screening examination;
- Appropriate vision testing;
- Appropriate hearing testing;
- Developmental assessment;
- Nutritional assessment;
- Appropriate laboratory tests;
- Dental/oral health assessment; including:
 - ✓ How to clean teeth as they erupt;
 - ✓ How to prevent baby bottle tooth decay;
 - ✓ How to look for dental disease;
 - ✓ Information on how dental disease is contracted;
 - ✓ Preventive sealant; and
 - ✓ Application of fluoride varnish, when appropriate;
- Health education and counseling; and
- Age appropriate mental health and substance abuse screening.

Licensed providers may perform these components separately; however, DSHS encourages the provider to perform as many of the components as possible to provide a comprehensive picture of the client's health.

Additional Screening Components

For fee-for-service clients, the following screening services may be billed in addition to the EPSDT screening components listed on the previous page:

- Appropriate audiometric tests (CPT codes 92552 and 92553);
- Appropriate laboratory tests, including testing for anemia; and
- Appropriate testing for blood lead poisoning in children in high risk environments (CPT code 83655). Use ICD-9-CM diagnosis code V15.86 or V82.5 (Special screening for other conditions, chemical poisoning, and other contamination) when billing.

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EPSDT

Memo 09-87

Changes are Highlighted

How often should EPSDT screenings occur?

The following are Washington State's schedules for health screening visits. Payment is limited to the recommended schedules listed below:

- Five total screenings during the first year of the child's life. Below is a recommended screening schedule for children from birth to one year of age.
 - ✓ 1st Screening: Birth to 6 weeks old
 - ✓ 2nd Screening: 2 to 3 months old
 - ✓ 3rd Screening: 4 to 5 months old
 - ✓ 4th Screening: 6 to 7 months old
 - ✓ 5th Screening: 9 to 11 months old
- Three screening examinations are recommended between the ages of 1 and 2 years.
- One screening examination is recommended per 12-month period for children ages 2 through 6.
- One screening examination is recommended per 24-month period for children ages 7 through 20, except foster care clients, who receive a screening examination every 12 months and within 30 days of foster care placement or official relative placement through the Children's Administration.

Foster Care Children

DSHS pays providers an enhanced rate for EPSDT screening exams for foster care clients who receive their medical services through DSHS's fee-for-service system. This applies to CPT codes 99381-99385 and 99391-99395 only.

DSHS updated the "other" column of the Medical ID Card by adding one of the following letters to indicate the child is in foster care:

- **D** (Division of Developmental Disabilities client in relative placement);
- **F** (Foster Care placement); or
- **R** (Relative placement).

If the Medical ID card indicates the child is in foster care, the provider must bill one of the above screening codes with modifier TJ to receive the enhanced rate.

DSHS pays providers for an EPSDT screening exam for foster care clients without regard to the periodicity schedule when the screening exam is billed with modifier TJ.

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Foster Children Initial Health Evaluation (IHE)

What is the purpose of an IHE?

The purpose of this evaluation is to identify any:

- Immediate medical, urgent mental health, or dental needs the child may have; and
- Additional health conditions of which the foster parents and caseworker should be aware.

Who is eligible?

Only clients 18 years of age and younger are eligible for an IHE.

What is included in an IHE?

An IHE includes the following:

- **Careful measurement of height and weight for all children, and head circumference for children younger than 3** – This may reveal growth delays or reflect poor nutritional or general health status.
- **Careful examination of the entire body to include the unclothing of each body surface at some point during the examination** - Because some children entering foster care have been victims of physical or sexual abuse, note and document the following:
 - ✓ Any signs of recent or old trauma;
 - ✓ Bruises;
 - ✓ Scars;
 - ✓ Deformities; or
 - ✓ Limitations in the function of body parts or organ systems.
- **Appropriate imaging studies to screen for a recent or healing fracture** - Consider if there is a history of physical abuse before placement or if signs of recent physical trauma are present.
- **Genital and anal examination (male or female).**
- **Laboratory tests for HIV and other sexually transmitted diseases** – Perform when indicated clinically or by history.
- **Documentation and prompt treatment of other infections and communicable diseases.**
- **Evaluation of the status of any known chronic illness** - To ensure that appropriate medications and treatments are available.

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Note: Discuss specific care instructions directly with the foster parents and caseworker.

What fee does DSHS pay?

Payment is set at the maximum allowable fee for children’s office calls.

To view the EPSDT fee schedule, go to www.hrsa.dshs.wa.gov/RBRVS/index.html.

Note: DSHS does not pay for an IHE on the same date of service as an EPSDT examination.

How do I bill?

When you provide a foster child with the IHE within 72 hours of entering out-of-home placement, bill DSHS using the following guidelines:

- Bill the appropriate evaluation and management (E&M) code (new patient codes 99201 – 99205 or established patient codes 99211 – 99215);
- Use ICD-9-CM diagnosis code V72.85 as the primary diagnosis; and
- Use modifier TJ.

If you bill an E&M code with the diagnosis code V72.85, but without modifier TJ, DSHS will deny the claim.

Important Note: The IHE is not an EPSDT examination because it is not as complex or thorough. If you feel an EPSDT examination is necessary, perform the EPSDT examination within 72 hours of out-of-home placement and bill DSHS for the exam. The child will not require the IHE.

What are the documentation requirements?

Providers must either:

- Document the IHE on the Foster Care Initial Health Evaluation form (DSHS 13-843); or
- Include documentation in the client’s record that addresses all elements addressed in the “What is included in an IHE” section of this memorandum or on the Foster Care Initial Health Evaluation form.

To view and download the Foster Care Initial Health Evaluation form, go to <http://www1.dshs.wa.gov/msa/forms/eforms.html> and scroll down to the appropriate form number.

Physician-Related Services

To receive the enhanced rate, providers are required to use either:

- The DSHS "Well Child Examination" forms for Infancy, Early Childhood, Late Childhood, and Adolescence [DSHS 13-683 A-E(x), 13-684 A-C(x), 13-685 A-C(x), and 13-686A-B(x)] (see Important Contacts section for information on obtaining DSHS forms); **or**
- Another charting tool with equivalent information.

To download an electronic copy of the Well Child Examination form, go to:

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

What are the time limits for scheduling requests for EPSDT screenings?

Requests for EPSDT screenings must be scheduled within the following time limits:

If an EPSDT screening is requested through...	For clients who are...	Must be scheduled within...
DSHS's Managed Care plans, Primary Care Case Management (PCCM), or Primary Care Providers (PCPs)	Infants – within the first 2 years of life.	21 days of request.
	Children – two years and older.	Six weeks of request.
	Receiving Foster Care – Upon placement	30 days of request, or sooner for children younger than 2 years of age.
Community Mental Health Center, Head Start, substance abuse provider, or Early Childhood Education and Assistance Program (ECEAP)	Birth through 20 years of age	14 days of the request.
Providers must ensure that when medically necessary services are identified during any EPSDT screening examination, appropriate treatment or referrals are made.		

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What if a medical problem is identified during an EPSDT screening?

If a medical problem is identified during a screening examination, the provider may:

- Refer the client to an appropriate DSHS provider or DSHS's Managed Care Plan provider, if applicable, for medical treatment; or
- Provide the service for the client (if it is within the provider's scope of practice).

Note: If the provider is using the parent's PIC code to bill Evaluation and Management (E&M) codes 99201-99215 for an infant who has not yet been assigned a PIC code, the provider must use modifier HA in order to be reimbursed at the higher rate for EPSDT services. **Modifier HA must be the first modifier following the CPT or HCPCS code.** Any additional modifier may be listed second.

If the provider chooses to treat the medical condition on the same day as the screening exam, the provider must bill the appropriate level E&M code with modifier 25 in order to receive additional reimbursement for the office visit. Providers must bill using the appropriate ICD-9-CM medical diagnosis code that describes the condition found. **The E&M code and the EPSDT screening procedure code must be billed on separate claim forms.**

Referrals

Chiropractic Services

Eligible clients may receive chiropractic services when a medical need for the services is identified through an EPSDT screening. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary chiropractic services.

Dental Services

Eligible clients may go to a dental provider without an EPSDT screen or referral.

Orthodontics

Eligible clients may go to an orthodontic provider without an EPSDT screen or referral. DSHS reimburses for orthodontics for children with cleft lip or palates or severe handicapping malocclusions **only**. DSHS does not reimburse for orthodontic treatment for other conditions.

Fetal Alcohol Syndrome (FAS) Screening

FAS is a permanent birth defect syndrome caused by the mother's consumption of alcohol during pregnancy. FAS is characterized by cognitive/behavioral dysfunction caused by structural and/or chemical alterations of the brain, and/or a unique cluster of minor facial anomalies, and is often accompanied by growth deficiency.

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As part of the EPSDT screen, every child six months of age or older should be screened for risk of exposure to maternal consumption of alcohol and for the facial characteristics of FAS. Children can be referred to a diagnostic clinic if there is known in-utero exposure to alcohol, or if there is suspicion of facial characteristics of FAS or microcephaly.

Medical Nutrition Therapy

If an EPSDT screening provider suspects or establishes a medical need for medical nutrition therapy, eligible clients may be referred to a certified dietitian to receive outpatient medical nutrition therapy. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary medical nutrition therapy.

DSHS pays for the procedure codes listed below when referred by an EPSDT provider. **Providers must document beginning and ending times that the service was provided in the client's medical record.**

Procedure Code	Limitations
97802	1 unit = 15 minutes; maximum of 2 hours (8 units) per year
97803	1 unit = 15 minutes; maximum of 1 hour (4 units) per day
97804	1 unit = 15 minutes; maximum of 1 hour (4 units) per day

Topical Fluoride (HCPCS codes D1203 and D1204)

DSHS covers topical fluoride for eligible clients according to DSHS's [Dental Program for Clients Through Age 20 Billing Instructions](#) and [Dental Program for Clients Age 21 and Older Billing Instructions](#).

Special Immunization Requirements for EPSDT Exams

DSHS pays for the administration of GARDASIL® (Human Papillomavirus [Types 6,11,16,18] Recombinant Vaccine) when providers bill with CPT code 90649 (H papilloma vacc 3 dose im) in the following manner:

- **For clients age 9-18 years of age:**

DSHS pays for the administration of GARDASIL® only if it is obtained at no cost from the Department of Health (DOH) through the Universal Vaccine Distribution program and the Federal Vaccines for Children program. DSHS pays for the administration of the vaccine only and not the vaccine itself. Bill for the administration by reporting the procedure code for the vaccine given with modifier SL (e.g. 90649 SL). **DSHS reimburses for the administration for those vaccines that are free from DOH.**

- **For clients age 19 and 20 years of age:**

Bill DSHS for the cost of the GARDASIL® vaccine itself by reporting procedure code 90649. DO NOT use modifier SL with any of the vaccines for clients 19 to 20 years of age. DSHS reimburses for the vaccine using DSHS's maximum allowable fee schedule. Bill DSHS for the vaccine administration using either CPT codes 90471 or 90472.

Note: DSHS will not reimburse for GARDASIL® for any other age group. DSHS limits payment for immunization administration to a maximum of two administration codes (e.g., one unit of 90471 and one unit of 90472).

GARDASIL® is administered in a series of three shots. To be paid by DSHS, the physician must prescribe and administer the GARDASIL® series only:

- After the physician has performed an EPSDT exam; and
- To eligible clients on Medicaid programs.

The EPSDT exam is only required prior to the first shot in the series. Clients on TAKE CHARGE, Family Planning Only, and the Alien Emergency Only program are not eligible for this service.

Immunizations - Children

(This applies to clients age 20 years and younger. For clients age 21 years and older, refer to “Immunizations-Adults” on page C.15.)

Immunizations covered under the EPSDT program are listed in the Fee Schedule. For those vaccines that are available at no cost from the Department of Health (DOH) through the Universal Vaccine Distribution program and the Federal Vaccines for Children program for children 18 years of age and under, DSHS pays only for the administration of the vaccine and not the vaccines themselves. These vaccines are identified in the Comments column of the Fee Schedule as “free from DOH.”

You must bill for the administration of the vaccine and for the cost of the vaccine itself as explained in this section.

Clients 18 years of age and younger – “Free from DOH”

- These vaccines are available at no cost from DOH. Therefore, DSHS pays only for administering the vaccine.
- Bill for the administration by reporting the procedure code for the vaccine given with modifier SL (e.g. 90707 SL). **DSHS reimburses for the administration for those vaccines that are free from DOH and are billed with modifier SL (e.g., 90707 SL).**
- DO NOT bill CPT codes 90471-90472 or 90465-90468 for the administration.
- 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, DSHS 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: The above policy **does not** apply to E&M CPT codes 99381-99385, and 99391-99395 used for EPSDT screening visits. DSHS will reimburse these procedure codes with the administration of the vaccine and the vaccine itself (if appropriate) without requiring a modifier 25 to be appended to the E&M codes.

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No Cost Immunizations from Department of Health		
Procedure Code	Description	Comments
90633	Hep a vacc, ped/adol, 2 dose	Free from DOH for children
90648	Hib vaccine, prp-t, im	Free from DOH for children
90649	H papilloma vacc 3 dose im	Effective for dates of service on & after May 1, 2007: Free from DOH for 9- to 18-year-olds; allowed for 19- to 20-year-olds at fee; all others non-covered.
90655	Flu vaccine no preserv 6-35m, im	Free from DOH for children
90656	Flu vaccine no preserv 3 yo & >, im	Free from DOH for children
90657	Flu vaccine, 6-35 mo, im	Free from DOH for children
90658	Flu vaccine age 3 yo & over, im	Free from DOH for children
90660	Flu vaccine, nasal	Free from DOH for children ages 3 to 18
90669	Pneumococcal vacc, ped <5, IM	Free from DOH for children
90680	Rotavirus vacc 3 dose, oral	Effective for dates of service on & after May 1, 2007: Covered only if free from DOH for children younger than age 1 (52 weeks).
90698	Dtap-hib-ipv vaccine, im	Effective for dates of service on & after 7/15/08: Covered only if free from DOH for children 0-18 years of age.
90700	Dtap vaccine, < 7 yo, im	Free from DOH for children
90702	Dt vaccine < 7 yo, im	Free from DOH for children
90707	Mmr vaccine, sc	Free from DOH for children
90710	MmrV vaccine, sc	Free from DOH for children only , Non-covered for Adults.
90713	Poliovirus, ipv, sc/im	Free from DOH for children
90714	Td vaccine no prsrv >= 7 yo, im	Free from DOH for children
90715	Tdap => 7 yo, im	Free from DOH for children
90716	Chicken pox vaccine, sc	Free from DOH for children
90723	Dtap-hep bi-ipv vaccine, im	Free from DOH for children only , Non-covered for Adults.
90732	Pneumococcal vaccine, sc/im	Free from DOH for children
90734	Meningococcal Vaccine, IM	Free from DOH for children 0-18. EPA required for 19 yrs and older
90744	Hepb vacc ped/adol 3 dose im	Free from DOH for children
90747	Hepb vacc, ill pat 4 dose im	Free from DOH for children
G9142	Influenza A H1N1, vaccine	Free from DOH for children and adults

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Clients 18 years of age and younger – “Not free from DOH”

- Bill DSHS for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with these vaccines. DSHS reimburses for the vaccine using DSHS’s maximum allowable fee schedule.

Note: Unless otherwise noted, billing should reflect the usual and customary fee and not DSHS’s maximum allowable fee. Reimbursement is either the usual and customary fee or DSHS’s maximum allowable fee, whichever is less.

- Bill DSHS for the vaccine administration using either CPT codes 90465-90468 or 90471-90472. **Do not** bill CPT codes 90465-90468 in combination with CPT codes 90471-90472. DSHS limits reimbursement for immunization administration to a maximum of two administration codes (e.g., one unit of 90465 and one unit of 90466, one unit of 90467 and one unit of 90468, or one unit of 90471 and one unit of 90472).

For example:

- ✓ One unit of 90465* and one unit of 90466*;
- ✓ One unit of 90467* and one unit of 90468*; or
- ✓ One unit of 90471 and one unit of 90472.

Note: DSHS pays for the above starred (*) administration codes **only** when the physician counsels the client/family at the time of the administration and the vaccine **is not** available free of charge from the Health Department.

- Providers **must** bill the above administration codes on the **same** claim as the procedure code for the vaccine.

Clients age 19-20 years – All Vaccines

- Bill DSHS for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with any of the vaccines for clients 19-20 years of age, regardless of whether the vaccine is available free-of-charge from DOH or not. DSHS pays for the vaccine using DSHS's maximum allowable fee schedule.

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

- 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.

Note: Meningococcal vaccines (CPT procedure codes 90733 and 90734) require EPA, please see Section I. For clients 18 years of age and younger, DSHS does not require authorization when the vaccine is free from DOH.

Immunizations-Adults

(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 “Immunizations-Children”)

- Bill HCPCS code G9142 for the administration of H1N1 (Swine Flu) vaccine.
- Bill DSHS for the cost of the vaccine itself by reporting the procedure code for the vaccine given.
- DSHS reimburses providers for the vaccine using DSHS’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, DSHS 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: The above policy **does not** apply to E&M CPT codes 99381-99385, and 99391-99395 used for EPSDT screening visits. DSHS will reimburse these procedure codes with the administration of the vaccine and the vaccine itself (if appropriate) without requiring a modifier 25 to be appended to the E&M codes.

Note: Meningococcal vaccines (CPT procedure codes 90733 and 90734) require EPA, please see page I.9.

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Synagis®

Note: DSHS does not reimburse immune globulins that are obtained free of charge.

Requirements for Administration and Authorization of Synagis® for 2009 - 2010 RSV Season

DSHS requires providers to follow the 2009 updated guidelines established by the American Academy of Pediatrics (AAP) for the administration of Synagis®.

Note: *This information relates only to those clients NOT enrolled in a DSHS managed care organization (MCO). For clients enrolled in a DSHS MCO, please refer to the coverage guidelines in the enrollee's plan.*

Respiratory Syncytial Virus (RSV)/Synagis® Season

DSHS has established the RSV/ Synagis® season as December 1, 2009 through April 30, 2010. DSHS monitors RSV incidence as reported by laboratories throughout the state and may change the dates based on the data collected.

Unless otherwise notified by DSHS, these dates are firm.

Criteria for Administration of Synagis® to DSHS Clients

DSHS requires that the following guidelines and standards of care be applied to clients considered for RSV/Synagis® prophylaxis during the RSV season. DSHS established these guidelines and standards using the AAP guidelines revised and updated in 2009.

Children younger than 2 years of age at the beginning of the coverage season (i.e., born after December 1, 2007) are covered for up to a maximum of five doses for the season, regardless of start of treatment in relation to season start and end dates, if they have one of the following conditions:

✓ **Children with Chronic Lung Disease (CLD):**

- *For their first RSV season with CLD, clients who have required medical therapy (supplemental oxygen, bronchodilator, diuretic, or corticosteroid therapy) for CLD within 6 months prior to the anticipated start of the RSV/ Synagis® season (i.e., after June 1, 2009);*

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- **For their second RSV season with CLD, clients who continue to require medical therapy, or if treatment with Synagis is ordered by a neonatologist, pediatric intensivist, pulmonologist, or infectious disease specialist.**
- ✓ **Asthma** - Children with asthma who are on daily inhaled steroid therapy, but have persistent symptoms require evaluation by an asthma specialist or pulmonologist prior to authorization for Synagis®;
- ✓ **Immunocompromised** – Children with, for example, severe combined immunodeficiency or advanced acquired immunodeficiency syndrome;
- ✓ **Hemodynamically significant cyanotic, or acyanotic congenital heart disease and ONE of the following:**
 - Receiving medication to control congestive heart failure;
 - Moderate to severe pulmonary hypertension;
 - Undergoing surgical procedures that use cardiopulmonary bypass; or
 - Infants with cyanotic heart disease.

Note: DSHS does *not* authorize Synagis® for the following groups of infants and children with congenital heart disease:

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus);
- Infants with lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure; and
- Infants with mild cardiomyopathy who are not receiving medical therapy for the condition.

- ✓ **Children younger than 12 months of age at the beginning of the RSV/Synagis® season (i.e., born after Dec 1, 2008) with significant congenital abnormalities of the airway or a neuromuscular condition that compromises handling of respiratory tract secretions** - These clients are covered for a maximum of five doses for the season during the first year of life only;
- ✓ **Children born at 28 weeks and 6 days gestation or earlier and younger than 12 months of age at the beginning of the RSV/Synagis® season (i.e., born after December 1, 2008)** – These clients are covered for a maximum of five doses for the season, regardless of start of treatment in relation to RSV season start and end dates;

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✓ Children born at 29 weeks and 0 days through 31 weeks and 6 days gestation and younger than 6 months of age at the beginning of the RSV/Synagis® season (i.e., born after June 1, 2009) – These clients are covered for a maximum of five doses for the season, regardless of start of treatment in relation to RSV season start and end dates;

✓ Children born at 32 weeks and 0 days through 34 weeks and 6 days gestation, younger than 3 months of age at the beginning of the RSV/Synagis® season (i.e., born after September 1, 2009), and having one of the following risk factors:

➤ Attending child care; or

➤ Living with siblings younger than five years of age.

Children who qualify under these criteria should receive Synagis® only until they reach 3 months of age and may receive a maximum of **three** doses of Synagis® during the season. This means that some children may only receive one or two doses, because of their age, during the RSV/Synagis® season. Payment for any doses beyond the three allowed or administered after 3 months of age will be considered an overpayment subject to recoupment.

Other Considerations When Administering Synagis®

Administer the first dose of Synagis® 48 to 72 hours before discharge or promptly after discharge to infants who qualify for prophylaxis during the RSV/Synagis® season.

If an infant or child who is receiving Synagis® immunoprophylaxis experiences a breakthrough RSV infection, continue administering monthly prophylaxis for the maximum allowed doses as above.

Note: DSHS does not authorize Synagis® for children with cystic fibrosis.

Authorization and Billing Procedures

Please direct questions or concerns regarding billing and authorization of Synagis® to DSHS's Pharmacy Authorization Unit at 1-800-848-2842. Fax prior authorization requests on completed DSHS prior authorization form(s) to 1-360-725-2122.

Bill DSHS using the following guidelines:

✓ Synagis® may be dispensed and billed by a retail pharmacy for administration by a physician, or may be billed by the physician's office;

✓ Pharmacies bill through standard pharmacy Point-of-Sale electronic claim submission using the appropriate National Drug Code for the product dispensed;

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- ✓ Physician's offices billing directly for Synagis® must bill on a CMS-1500 or comparable electronic billing format using Current Procedural Terminology (CPT) code 90378;
- ✓ When requesting authorization for Synagis® use the "Request For Synagis (Not Managed Care/Healthy Options)" form, DSHS 13-771, and clearly indicate on page 2 whether a pharmacy or a physician's office is billing DSHS.

Criteria for Coverage or Authorization

Note: Criteria for coverage or authorization vary depending on the patient's age at the start of the RSV season.

Clients Younger than One Year of Age for the Duration of RSV/Synagis® Season (Dates of Birth May 1, 2009 – April 30, 2010)

DSHS requires providers to use and accurately apply the "Criteria for Administration of Synagis® to DSHS Clients." Billing for Synagis® outside of these guidelines will be considered an overpayment and will be subject to recoupment.

DSHS will continue to cover Synagis® for clients younger than one year of age without authorization, as long as utilization is appropriate. In this case, physicians and pharmacies are not required to submit paperwork or obtain pre-approval for the administration of Synagis®.

Clients Reaching One Year of Age During RSV/Synagis® Season (Dates of Birth December 1, 2008 – April 30, 2009)

DSHS requires prior authorization to administer Synagis® to DSHS clients who are:

- ✓ Under one year of age at the start of RSV/Synagis® season; and
- ✓ Will reach their first birthday prior to the end of the season.

Prior authorization is required to administer Synagis® to children one year of age and older. Request authorization by faxing the "Request For Synagis (Not Managed Care/Healthy Options)" form, DSHS 13-771.

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**Clients Between One and Two Years of Age at the Beginning of RSV/Synagis® Season
(Dates of Birth December 1, 2007 – November 30, 2008)**

Prior authorization is required to administer Synagis® to DSHS clients one year of age and older at the start of RSV/Synagis® season. Request authorization by faxing the “Request For Synagis (Not Managed Care/Healthy Options)” form, DSHS 13-771.

**Clients Older than Two Years of Age at the Beginning of RSV/Synagis® Season
(Dates of Birth prior to December 1, 2007)**

DSHS does not pay for administering Synagis® to clients older than two years of age.

Weight Changes for Clients One Year of Age and Older During RSV/Synagis® Season

The quantity of Synagis® authorized for administration of Synagis® to clients one year of age and older is dependent upon their weight at the time of administration.

If you have obtained authorization for a quantity of Synagis® that no longer covers the client's need due to weight gain, complete and fax the “Request For Additional MG's of Synagis® Due to Client Weight Increase” form, DSHS 13-770. DSHS will update the authorization to reflect an appropriate quantity and fax back confirmation of the increased dosage.

Evaluation of Authorization Requests

DSHS physicians will evaluate requests for authorization to determine whether the client falls within 2009 AAP guidelines for the administration of Synagis®. DSHS will fax an approval or denial to the requestor.

Please allow at least five business days for DSHS to process the authorization request. You may verify the status of a pending authorization by calling the Medical Assistance Customer Service Center at 1-800-562-3022.

DSHS forms may be downloaded at the DSHS/HRSA forms website at:
<http://www.dshs.wa.gov/msa/forms/eforms.html>.

National Drug Code Format

- **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. **DSHS 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

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.

Physician-Related Services

- **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.
- **Varicella Zoster** (CPT code 90396) - Each one unit billed equals one 125-unit vial, with a maximum reimbursement of five vials per session.
- **Rabies Immune Globulin (RIG) (CPT codes 90375-90376)**
 - ✓ RIG is given based on .06 ml per pound of body weight. The dose is rounded to the nearest tenth of a milliliter (ml). Below are the recommended dosages up to 300 pounds of body weight:

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

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

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

Examples:

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

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

- DSHS pays for injectable (see fee schedule) and nasal flu vaccines (CPT 90660) from October 1-March 31 of each year. **Note:** CPT 90660 is free from DOH for clients 3-18 years of age and is covered by DSHS for clients 19-49 years of age.

Therapeutic or Diagnostic Injections

(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.
- DSHS 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).
- DSHS 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

- DSHS 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, DSHS 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, DSHS will deny the E&M code.
- **Concurrent Infusion:** DSHS pays for concurrent infusion (CPT code 96368) only once per day.

Hyalgan/Synvisc/Euflexxa/Orthovisc

- DSHS reimburses only orthopedic surgeons, rheumatologists, and physiatrists for Hyalgan, Synvisc, Euflexxa, or Orthovisc.
- DSHS allows a maximum of 5 Hyalgan, 3 Synvisc, 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
J7325	Synvisc inj per dose	One unit equals a full course of treatment per knee

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Physician-Related 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 injections for Hyalgan or 3 injections for Synvisc, Euflexxa, and Orthovisc.
- 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, DSHS 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

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).

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Clozaril Case Management

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

Botulism Injections (HCPCS code J0585 and J0587)

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

DSHS approves Botulism injections with PA:

- For the treatment of:
 - ✓ Cervical dystonia;
 - ✓ Blepharospasm; and
 - ✓ Lower limb spasticity associated with cerebral palsy in children; and
- 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.

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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.

Vivitrol (J2315)

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

Vision Care Services (Includes Ophthalmological Services)

Who is eligible for vision care? [WAC 388-544-0100 (1)]

Clients with one of the following medical program identifiers on their DSHS Medical Identification cards are eligible for vision care:

Medical Program Identifier	Medical Program Description
CNP	Categorically Needy Program
CNP – CHIP	Categorically Needy Program – State Children’s Health Insurance Program
LCP – MNP	Limited Casualty Program – Medically Needy Program
GA-U No Out of State Care	General Assistance-Unemployable – No Out of State Care (except in designated bordering cities)
General Assistance	ADATSA

Limited Coverage:

- DSHS covers vision care under Emergency Medical Only program (may also be referred to as the alien emergency medical (AEM) program) **only** when the services are directly related to an emergency medical condition, and prior authorization is obtained.
- For Qualified Medicare Beneficiary (QMB-ONLY) clients, DSHS only pays secondary to Medicare if Medicare pays or applies the service to the deductible.

No Coverage:

Clients with Family Planning Only and TAKE CHARGE medical program identifiers do **not** have vision care coverage.

DSHS Managed Care Clients [Refer to WAC 388-544-0100 (2)]

Clients with an identifier in the HMO column on their DSHS Medical ID cards are enrolled in one of DSHS's managed care plans and are covered for vision care services as follows:

- **Eye exams, refractions, and/or visual fields** must be requested and provided directly through the client's managed care plan. Clients can contact their plans by calling the telephone number listed on their Medical ID card;
- **Eyeglass frames, lenses, and contact lenses** must be ordered from DSHS's contractor. These items are covered fee-for-service. (See Section E – *Where and How do I Order?*) Use the guidelines found in this billing instruction for clients enrolled in a DSHS managed care plan.

Primary Care Case Management (PCCM) clients will have the PCCM identifier in the HMO column on their Medical ID cards. Please make sure these clients have been referred by their PCCM prior to receiving services. The referral number is required in field **17a** on the CMS-1500 Claim Form. (See Section M - *Billing* for further information.)

Note: For further information on DSHS's managed care plans, see DSHS's website: <http://hrsa.dshs.wa.gov/HealthyOptions>.

Coverage – Examinations and Refractions

When does DSHS cover eye examinations and refraction services?

[Refer to WAC 388-544-0250 (1)]

DSHS covers eye examinations and refraction services for asymptomatic clients as follows:

- For **adults** (clients 21 years of age or older): Once every 24 months;
- For **children** (clients 20 years of age or younger): Once every 12 months;
- For **clients of the Division of Developmental Disabilities** (regardless of age): Once every 12 months.

The provider must document the diagnosis and/or treatment in the client's record to justify the frequency of examinations and other services.

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Vision Care Services
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Exams/Refractions Due to Medical Conditions or Medication

[Refer to WAC 388-544-0250 (2)]

DSHS covers medically necessary nursing facility visits (procedure codes 99307 – 99310). There must be communication between the attending physician and the consulting specialist regarding the resident's specific needs. Group vision screenings are not covered (see *Noncovered Services* in Section D).

DSHS covers eye examinations and refraction services as often as medically necessary when:

- The provider is diagnosing or treating the client for a medical condition that has symptoms of vision problems or disease (e.g., glaucoma, conjunctivitis, corneal abrasion/laceration, etc.); or
- The client is on medication that affects vision.

Exams/Refractions Due to Lost or Broken Hardware

[Refer to WAC 388-544-0250 (3)]

DSHS covers eye examinations/refractions outside the time limitations listed on page D.2 when the eye examination/refraction is necessary due to lost or broken eyeglasses/contacts. To receive payment:

- For **adults** (clients 21 years of age or older), providers must follow the expedited prior authorization (EPA) process (see Section I – *Authorization EPA# 870000610*) and 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;
- For **children** (clients 20 years of age or younger), DSHS does **not** require prior authorization;
- For **clients of the Division of Developmental Disabilities** (regardless of age), DSHS does **not** require prior authorization.

Visual Field Exams [Refer to WAC 388-544-0250 (4)]

DSHS covers visual field exams (e.g., CPT® codes 92081, 92082, and 92083) for the diagnosis and treatment of abnormal signs, symptoms, or injuries.

Note: DSHS does not pay for visual field exams that are done by simple confrontation. Use Medicare criteria for the billing of visual field services for DSHS clients. Your records must support the medical necessity for the visual field tests.

To receive payment, 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.

Coverage – Eyeglasses (Frames and/or Lenses) and Repair Services

When does DSHS cover eyeglasses (frames and/or lenses)?

[Refer to WAC 388-544-0300 (1)]

DSHS covers eyeglasses for asymptomatic clients as follows:

- For **adults** (clients 21 years of age or older): Once every 24 months;
- For **children** (clients 20 years of age or younger): Once every 12 months;
- For **clients of the Division of Developmental Disabilities** (regardless of age): Once every 12 months.

Clinical Criteria for Asymptomatic Clients

DSHS covers eyeglasses for asymptomatic clients when the client meets the following clinical criteria:

- The client has a stable visual condition (see Definitions section – *stable visual condition*);
- The client’s treatment is stabilized;
- The client’s prescription is less than 18 months old; and
- One of the following minimum correction needs **in at least one eye** is documented in the client’s file:
 - ✓ Sphere power equal to, or greater than, plus or minus 0.50 diopter;
 - ✓ Astigmatism power equal to, or greater than, plus or minus 0.50 diopter; or
 - ✓ The add power equal to or greater than 1.0 diopter for bifocals or trifocals.

Note: DSHS limits eyeglass payment to specific frames, lenses, and contact lenses as offered by the DSHS contractor. DSHS pays a fitting fee **only** for frames, lenses, and contact lenses provided by or obtained through DSHS’s contractor.

Accommodative Esotropia or Strabismus [WAC 388-544-0300 (2)]

DSHS covers eyeglasses and/or lenses for clients who are 20 years of age or younger with a diagnosis of accommodative esotropia or any strabismus correction. In this situation, the client is not subject to the clinical criteria in Section I.

Durable or Flexible Frames [WAC 388-544-0300 (3)]

DSHS covers selected frames called “durable” or “flexible” frames through DSHS’s contracted supplier when the client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period. Providers must follow the expedited prior authorization process (see Section I – *Authorization EPA# 870000619, EPA# 870000620*).

Nonallergenic Frames [WAC 388-544-0300 (4)]

DSHS covers the cost of coating contract eyeglass frames to make the frames nonallergenic if the client has a medically diagnosed and documented allergy to the materials in the available eyeglass frames.

Incidental Repairs [WAC 388-544-0300 (5)]

DSHS pays for incidental repairs to a client's eyeglass frames when **all** of the following apply:

- The provider typically charges the general public for the repair or adjustment;
- The contractor's one year warranty period has expired; **and**
- The cost of the repair does not exceed DSHS's cost for replacement frames.

Note: Incidental repairs are billable by ophthalmologists, optometrists, and opticians.

Eyeglass repair parts and materials may be ordered from the state contractor or any manufacturer of optical devices and will be paid up to DSHS's maximum allowable fee for repair.

Replacement Frames and/or Lenses [Refer to WAC 388-544-0300 (6)]

DSHS covers replacement eyeglass frames and/or lenses that have been lost or broken. To receive payment:

- For **adults** (clients 21 years of age or older) providers must follow the expedited prior authorization process (see Section I – *Authorization EPA# 870000615, EPA# 870000618*);
- For **children** (clients 20 years of age or younger) DSHS does **not** require prior authorization;
- For **clients of the Division of Developmental Disabilities** (regardless of age) DSHS does **not** require prior authorization.

Back-up Eyeglasses [Refer to WAC 388-544-0300 (7)]

DSHS covers one pair of back-up eyeglasses when contact lenses are medically necessary and the contact lenses are the client's primary visual correction aid (see Contact Lenses, page D.11). DSHS limits back-up eyeglasses as follows:

- For **adults** (clients 21 years or older): Once every 6 years.
- For **children** (clients 20 years or younger): Once every 2 years.
- For clients **of the Division of Developmental Disabilities** (regardless of age): Once every 2 years.

Coverage – Plastic Eyeglass Lenses and Services

When does DSHS cover eyeglass lenses and services?

[Refer to WAC 388-544-0350 (1)]

DSHS covers the following plastic scratch-resistant eyeglass lenses:

- Single vision lenses;
- Round or flat top D-style bifocals;
- Flat top trifocals; and
- Slab-off and prism lenses (including Fresnel lenses).

Note: DSHS's contractor supplies **all** plastic eyeglass lenses with a scratch-resistant coating.

Replacing Bifocal or Trifocal Eyeglass Lenses

[Refer to WAC 388-544-0350 (2)]

DSHS allows bifocal eyeglass lenses to be replaced with trifocal or single vision lenses, or trifocal lenses to be replaced with bifocals or single vision lenses when all of the following apply:

- A client has attempted to adjust to the bifocals or trifocals for at least 60 days;
- The client is unable to make the adjustment; and
- The bifocal or trifocal lenses being replaced are returned to the provider.

High Index Eyeglass Lenses [Refer to WAC 388-544-0350 (3)]

DSHS covers high index lenses for clients who require one of the following in at least one eye:

- A spherical refractive correction of plus or minus 8.0 diopters or greater; or
- A cylinder correction of plus or minus 3.0 diopters or greater.

To receive payment, providers must follow the expedited prior authorization process (see Section I- *Authorization EPA# 870000625*).

Tinting [Refer to WAC 388-544-0350 (4)]

DSHS covers the tinting of plastic lenses through DSHS’s contracted lens supplier when the client’s medical need is diagnosed and documented as one or more of the following chronic (expected to last longer than 3 months) eye conditions causing photophobia:

Medical Problems	ICD-9-CM Diagnosis Codes
Blindness	369.00 - 369.9
Chronic corneal keratitis	370.00 - 370.07
Chronic iritis, iridocyclitis (uveitis)	364.10 - 364.11 364.51 - 364.59
Diabetic retinopathy	362.01 - 362.06
Fixed pupil	379.42 - 379.49
Glare from cataracts	366.00 - 366.9
Macular degeneration	362.50 - 362.66
Migraine disorder	346.00 - 346.91
Ocular albinism	270.2
Optic atrophy and/or optic neuritis	377.10 - 377.63
Rare photo-induced epilepsy conditions	345.00 - 345.91
Retinitis pigmentosa	362.74

Photochromatic Eyeglass Lenses [Refer to WAC 388-544-0350 (5)]

DSHS covers both *tinted* lenses and *photochromatic* lenses for appropriate medical conditions.

Tinted lenses are colored lenses that remain the same color indoors and outdoors.

Photochromatic lenses are lenses that darken when they are exposed to sunlight (photochromatic lenses do not darken as well inside automobiles).

DSHS covers photochromatic lenses when the client’s medical need is diagnosed and documented as related to either of the following:

Medical Problems	ICD-9-CM Diagnosis Codes
Ocular Albinism	270.2
Retinitis pigmentosa	362.74

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Polycarbonate Eyeglass Lenses [Refer to WAC 388-544-0350 (6)]

DSHS covers polycarbonate lenses for clients of the Division of Developmental Disabilities.

DSHS covers polycarbonate lenses for clients who aren't clients of the Division of Developmental Disabilities as follows:

Medical Problems	ICD-9-CM Diagnosis Codes
For clients who are blind in one eye and need protection for the other eye, regardless of whether a vision correction is required	369.60 - 369.69 369.70 - 369.76
For infants and toddlers with motor ataxia	331.89, 781.2 334.0 - 334.9, 781.3
For clients 20 years of age or younger who are diagnosed with strabismus	378.00 - 378.9
For clients 20 years of age or younger who are diagnosed with amblyopia	368.01 - 368.03

Requests for Eyeglass Lenses Only [Refer to WAC 388-544-0350 (7)]

DSHS covers requests for lenses only (lenses without frames) for clients who own their own eyeglass frames not purchased by DSHS when:

- The eyeglass frames are serviceable; and
- The size and style of the required lenses meet DSHS's contract requirements. The lenses must be compatible with DSHS's contracted frames.

Note: Due to time, exposure to elements, and concealed damage, working with a client's frames can be unpredictable. DSHS and DSHS's contractor **do not** accept responsibility for these frames.

Replacements due to Lost or Broken Eyeglass Lenses

[Refer to WAC 388-544-0350 (8)(a)]

DSHS covers replacement eyeglass lenses that have been lost or broken. To receive payment:

- For **adults** (clients 21 years of age or older) providers must follow the expedited prior authorization process (see Section I – *Authorization EPA# 870000623*);
- For **children** (clients 20 years of age or younger) DSHS does not require prior authorization;
- For **clients of the Division of Developmental Disabilities** (regardless of age) DSHS does not require prior authorization.

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Replacements due to Refractive Changes [WAC 388-544-0350 (8)(b) and (c)]

DSHS covers eyeglass lens replacements due to refractive changes, without regard to time limits, when caused by one of the following:

- **Eye surgery, the effect(s) of prescribed medication, or one or more diseases affecting vision.** For each of these, all of the following must be documented in the client's file:
 - ✓ The client has a stable visual condition (see Definitions section for a definition of *stable visual condition*);
 - ✓ The client's treatment is stabilized;
 - ✓ The lens correction must have a 1.0 or greater diopter change between the sphere or cylinder correction in at least one eye; **and**
 - ✓ The previous and new refraction.

To receive payment, providers must follow the expedited prior authorization process (see Section I – *Authorization EPA# 870000622*).

- **Headaches, blurred vision, or difficulty with school or work.** For each of these, all of the following must be documented in the client's file:
 - ✓ Copy of the current prescription (the prescription is less than 18 months old);
 - ✓ Date of last dispensing, if known;
 - ✓ Absence of a medical condition that is known to cause temporary visual acuity changes (e.g., diabetes, pregnancy, etc.); **and**
 - ✓ A refractive change of at least .75 diopter or greater between the sphere or cylinder correction in at least one eye.

To receive payment, providers must follow the expedited prior authorization process (see Section I- *Authorization EPA# 870000624*).

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Vision Care Services
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Coverage – Contact Lenses and Services

What types of contact lenses and services does DSHS cover?

[Refer to WAC 388-544-0400 (1) through (3)]

DSHS covers the following types of contact lenses as the client’s primary refractive correction method when a client has a spherical correction of plus or minus 6.0 diopters or greater in at least one eye. In order to qualify for the spherical correction, the prescription may be from either the glasses or the contact lenses prescriptions and/or written in either “minus cyl” or “plus cyl” form. (See below for exceptions to the plus or minus 6.0 diopter criteria):

1. **Conventional soft or rigid gas permeable** contact lenses that are prescribed for daily wear;
2. **Disposable** contact lenses that are prescribed for daily wear and have a monthly or quarterly planned replacement schedule, as follows:
 - 12 pairs of monthly replacement contact lenses; or
 - 4 pairs of 3-month replacement contact lenses.

Medical Problems	ICD-9-CM Diagnosis Code
Hypermetropia	367.0
Myopia	367.1

Exception:

For clients diagnosed with **high anisometropia**, DSHS covers the contact lenses above when the client’s refractive error difference between the two eyes is plus or minus 3.0 diopters and eyeglasses cannot reasonably correct the refractive errors.

Medical Problems	ICD-9-CM Diagnosis Code
High anisometropia	367.31

A client who qualifies for contact lenses as the primary refractive correction method must choose one style of contact lenses from those listed in #1 or #2 above for each 12-month period of coverage.

Soft Toric Contact Lenses [Refer to WAC 388-544-0400 (4)]

DSHS covers soft toric contact lenses for clients with astigmatism requiring a cylinder correction of plus or minus 1.0 diopter in at least one eye. The client must have a spherical correction of plus or minus 6.0 diopters or greater in at least one eye.

Medical Problems	ICD-9-CM Diagnosis Code
Astigmatism	367.20 - 367.22

Specialty Contact Lens Designs [Refer to WAC 388-544-0400 (5)]

DSHS covers specialty contact lens designs for clients who are diagnosed with one or more of the following:

Medical Problems	ICD-9-CM Diagnosis Code
Aphakia	379.31 743.35
Keratoconus	371.60-371.62 743.41
Corneal softening	371.23

Replacement Contact Lenses – Lost or Damaged

[Refer to WAC 388-544-0400 (6)(a) and (c)]

DSHS covers replacement contact lenses once every 12 months for lost or damaged contact lenses. To receive payment:

- For **adults** (clients 21 years of age or older): Providers must follow the expedited prior authorization process (see Section I – *Authorization EPA# 870000627*);
- For **children** (clients 20 years of age or younger): DSHS does not require prior authorization;
- For **clients of the Division of Developmental Disabilities** (regardless of age): DSHS does not require prior authorization.

Replacement Contact Lenses – Surgery/Medication/Disease
[Refer to WAC 388-544-0400 (6)(b) and (c)]

DSHS covers replacement contact lenses as often as medically necessary when all of the following apply:

- One of the following cause the vision change:
 - ✓ Eye surgery;
 - ✓ The effect(s) of prescribed medication; or
 - ✓ One or more diseases affecting vision; **and**
- The client has a stable visual condition (see Definitions section – *stable visual condition*); **and**
- The client’s treatment is stabilized; **and**
- The lens correction has a 1.0 or greater diopter change in at least one eye between the sphere or cylinder correction. The previous and new refraction must be documented in the client’s record.

To receive payment for replacement contacts related to surgery, medication, or disease:

- For **adults** (clients 21 years of age or older): Providers must follow the expedited prior authorization process (see Section I – *Authorization EPA# 870000621*);
- For **children** (clients 20 years of age or younger): DSHS does not require prior authorization;
- For **clients of the Division of Developmental Disabilities** (regardless of age): DSHS does not require prior authorization.

Therapeutic Contact Bandage Lenses [Refer to WAC 388-544-0400 (7)]

DSHS covers therapeutic contact bandage lenses only when needed immediately after either of the following:

Medical Problems	ICD-9-CM Code or CPT Code
Eye injury	ICD-9-CM codes 871.0-871.9
Eye surgery	CPT codes 65091-67599, 68020-68399

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Coverage – Ocular Prosthetics/Surgeries

When does DSHS cover ocular prosthetics?

[Refer to WAC 388-544-0500]

DSHS covers medically necessary ocular prosthetics when provided by any of the following enrolled/contracted providers:

- Ophthalmologists;
- Ocularists; or
- Optometrists who specialize in orthotics.

When does DSHS cover cataract surgery?

[Refer to WAC 388-544-0550 (1) and (2)]

DSHS covers cataract surgery when:

- The surgery is included in the scope of care for the client's medical program;
- The surgery is medically necessary; and
- The provider clearly documents the need in the client's record.

DSHS considers cataract surgery to be medically necessary when the client has:

- 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 blind person experiencing ocular pain.

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Vision Care Services
Changes are highlighted

When does DSHS cover surgery for strabismus?

[WAC 388-544-0550 (3)]

DSHS covers strabismus surgery as follows:

- For clients 17 years of age and younger, when medically necessary. The provider must clearly document the need in the client's record;
- For clients 18 years of age and older, when:
 - ✓ The client has double vision; and
 - ✓ The surgery is not performed for cosmetic reasons.

To receive payment for clients 18 years of age and older, providers must use DSHS's expedited prior authorization process (see Section I – *Authorization EPA# 870000631*).

When does DSHS cover surgery for blepharoplasty/ blepharoptosis?

[WAC 388-544-0550 (4)]

DSHS covers blepharoplasty or blepharoptosis surgery for noncosmetic reasons when:

- The excess upper eyelid skin impairs the vision by blocking the superior visual field; and
- The vision is blocked to within ten degrees of central fixation using a central visual field test.

Noncovered Services

What services does DSHS not cover?

[Refer to WAC 388-544-0475 and WAC 388-544-0100 (2)]

DSHS does not cover the following:

- Executive style eyeglass lenses;
- Bifocal contact lenses;
- Daily and two week disposable contact lenses;
- Contact lenses prescribed for extended wear*, except when used as therapeutic contact bandage lenses or for aphakic clients;
- Services for cosmetic purposes only;
- Glass lenses, including those that darken when exposed to light;
- Group vision screening for eyeglasses;
- Nonglare or anti-reflective lenses;
- Progressive lenses;
- 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 corrections. (This does not include intraocular lens implantation following cataract surgery);
- Sunglasses and accessories that function as sunglasses (e.g., "clip-ons"); and
- Upgrades at private expense to avoid DSHS's contract limitation (e.g., frames that are not available through DSHS's contract or noncontract frames or lenses for which the client or other person pays the difference between DSHS's payment and the total cost).

DSHS evaluates a request for any service that is listed as noncovered in this chapter under the provisions of WAC 388-501-0160.

DSHS evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions when medically necessary, under the standards for covered services in WAC 388-501-0165.

DSHS evaluates a request for a service in a covered category that has been determined to be experimental or investigational under WAC 388-531-0550, according to the provisions of WAC 388-501-0165.

***Note regarding extended wear contact lenses:** DSHS's opinion is that the prolonged use of overnight wear may increase the risk of corneal swelling and ulceration. Therefore, DSHS approves their use in limited situations where they are used as a therapeutic contact bandage lens or for aphakic clients.

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Vision Care Services
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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.

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

Note: These billing instructions are not for use by Psychologists. Refer to DSHS's *Psychologist Billing Instructions* for a description of the psychology program. To view the billing instructions online, go to <http://hrsa.dshs.wa.gov> (click *Provider Publications/Fee Schedules* and then *Billing Instructions*).

General Guidelines

- DSHS 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).
- DSHS 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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Psychiatric Services
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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

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

DSHS 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 Mental Health Division 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://www1.dshs.wa.gov/mentalhealth/rsndirectory.shtml>.
- DSHS does not cover physician services for clients admitted for voluntary psychiatric admissions on the psychiatric indigent inpatient PII program who receive a Medical ID Card with the identifier "MIP-EMER No out-of-state care."
- 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.

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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

Effective for dates of service on and after July 1, 2008, for clients 18 year of age and younger the Health and Recovery Services Administration (DSHS) 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, DSHS is expanding mental health services for clients 18 years of age and younger who are eligible through one of the following programs:

- 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.)

How many hours will DSHS pay for?

DSHS 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 E.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 DSHS 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. DSHS 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 DSHS.

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

Fee-For-Service:

For any additional fee-for service 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 DSHS 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; and
- Expected outcome of extended services.

Note: For DSHS to authorize payment, a completed Basic Information Form, DSHS 13-756, must be faxed to 1-360-586-1471.

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 DSHS for a client, contact Provider Relations at 1-800-562-6188.

Who may provide the expanded services?

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 DSHS 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 in this memo to be eligible to provide expanded services.

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 DSHS's Mental Health Division for individuals whose condition meets the RSN Access to Care Standards,
- Managed Care Organizations (MCOs) which are under contract with DSHS's Division of Health Care Services' 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 DSHS on-line at:

<http://www1.dshs.wa.gov/Mentalhealth/crisis.shtml>

RSN Community Psychiatric Inpatient Services:

RSNs authorize and pay for all medically necessary community psychiatric inpatient services ([WAC 388-550-2600](http://www1.dshs.wa.gov/CommunityPsychiatricInpatientServices).) To refer a client for community psychiatric inpatient services, contact your local RSN.

To find the appropriate RSN and contact information, visit DSHS on-line at:

<http://www1.dshs.wa.gov/Mentalhealth/rsnmap.shtml>

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 Mental Health Division (MHD) 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. The ACS are established by DSHS and are approved by the Centers for Medicare and Medicaid Services (CMS).

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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.

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 DSHS on-line at:

<http://www1.dshs.wa.gov/Mentalhealth/publications.shtml>

Services Provided by Psychiatrists

For Clients 18 years of age and Younger

Psychiatrists may bill one psychiatric service per day, up to a maximum of 20 hours, which includes the evaluation, per client, per calendar year for clients 18 years and younger using the following procedure codes:

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		
90845		
90847		
90853		
90857		
90865		
90870		
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. Psychiatrists can also bill other procedures listed on page E.3 which are not subject to the 20-hour visit limitation.

*DSHS 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-per-calendar-year maximum unless a significant change in the client's circumstances requires an additional exam and the provider obtains prior authorization for the additional exam.

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

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For Clients 19 years of age and Older

- DSHS 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 DSHS 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:

HRSA
Provider Enrollment
PO Box 45562
626 – 8th Avenue SE
Olympia, WA 98504-5562

For more information, contact Provider Enrollment at <http://hrsa.dshs.wa.gov/providerenroll%20> or call 1-800-562-3022, option 2, then 5.

Physician-Related Services

Psychiatric ARNPs that meet the requirements listed on page E.10 are approved to bill the expanded mental health services for children (see *Psychiatric ARNP Code Table 1*) 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.

*DSHS 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

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 E.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	

DSHS 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.

DSHS does not pay psychiatric ARNPs for psychotherapy for adults 21 and over. DSHS pays one psychiatric diagnostic interview examination 90801 or 90802 once a calendar year. Office visits 99201 – 99215 cannot be billed for psychotherapy.

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Psychiatric Services
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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) who are detained under the provisions of the Involuntary Treatment Act (ITA) as defined by chapters 71.05 and 71.34 RCW, the MHD designee authorizes and pays for services provided to clients who are receiving medical assistance. When the client is in the process of applying for medical assistance, payment by the MHD designee is subject to the eligibility determination.

The MHD designee also authorizes services that are 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.

Unlike the PII program, under ITA, DSHS *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 may provide 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 or psychiatrist 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 copy of the Initial Certification Authorization for Admission to Inpatient Psychiatric Care form (DSHS 13-821) that a hospital completes for prior authorization from the designated RSN must accompany the claim. If the client is admitted longer than 20 days, the physician must include a copy of the Extension Certification Authorization for Continued Inpatient Psychiatric Care form (DSHS 13-822). You may view/download these forms at <http://www1.dshs.wa.gov/msa/forms/eforms.html>.
- A court may request another physician or psychiatrist evaluation.
- DSHS pays for physician and psychiatrist 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.

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Physician-Related Services

- **Psychologist services** are covered *only* for provision of a psychological evaluation of detained clients. (See DSHS's *Psychologist Billing Instructions* for related policy and/or procedure codes). As with all other claims, an authorization form must accompany the claim. Attaching the authorization form serves as verification of the involuntary status.
- **Out-of-state hospitals** must obtain authorization from the appropriate MHD designee for all Medicaid clients. Neither DSHS nor the MHD 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, DSHS and the MHD 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.

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Psychiatric Services
Changes Highlighted

EPA Criteria for Neuropsychological Testing (CPT codes 96118 and 96119)

Note: If the client does not meet the EPA criteria listed in this section, DSHS requires PA for the testing. In addition, DSHS 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>DSHS pays only “qualified” providers for administering neuropsychological testing to eligible DSHS 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.

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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 HRSA at 1-360-586-1471.

Podiatric Services [Refer to WAC 388-531-1300]

- DSHS pays podiatrists for:
 - ✓ Those procedure codes and diagnosis codes that are within their scope of practice;
 - ✓ Routine foot care only when a medical condition affecting the legs or feet (such as diabetes or arteriosclerosis obliterans) requires an M.D., D.O., or podiatrist to perform this care.

Examples of a medical condition include, but are not limited to:

- Limitation of ambulation due to mycosis.
- Likelihood that absence of treatment will result in significant medical complications.
- ✓ Those orthotics listed on pages **K.6 and K.7**. If prior authorization (PA) or expedited prior authorization (EPA) is required, see Section I.

Note: 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.

- ✓ 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.
- Medicare does not pay for orthotics and casting. Providers may bill DSHS directly for those services without submitting a Medicare denial, unless the client's Medical ID Card indicates *QMB - Medicare only*, in which case the orthotics and casting is not covered by DSHS.
- Biomechanical evaluation (the evaluation of the foot that includes various measures and manipulations necessary for the fitting of an orthotic) is included in the orthotic fee.

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Podiatric Services
Changes Highlighted

Limitations

- Local nerve blocks for subregional anatomic areas (such as the ankle and foot) are included in the payment for the surgical procedure and are not paid separately.
- Payment for debridement of nails is limited to a maximum of one treatment in a 60-day period.
- DSHS pays podiatrists for covered, diagnostic, radiologic services of the ankle and foot only when the client is examined before the x-ray is ordered.

What is not covered?

- X-rays for soft tissue diagnosis;
- Bilateral x-rays for unilateral condition;
- X-rays in excess of two views;
- X-rays that are ordered before the client is examined;
- X-rays for any part of the body other than the foot or ankle;
- Treatment of flat feet; and
- Treatment of fungal (mycotic) disease.

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: DSHS 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.
- DSHS 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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Radiology Services
Changes Highlighted

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).
- DSHS 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)

DSHS 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

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

Mammograms

DSHS 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.

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Radiology Services
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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 DSHS on request.

Magnetic Resonance Imaging (MRI)

- Please check the fee schedule for authorization requirements for MRIs.
- DSHS 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.

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Radiology Services
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Nuclear Medicine

When billing DSHS 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).

Portable X-Rays

- Portable x-ray services furnished in a client’s home or nursing facility and payable by DSHS 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 DSHS client seen.*** DSHS 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: DSHS’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), DSHS 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. DSHS 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 DSHS in order to receive payment from DSHS.

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, do not bill with a modifier. The professional component for physician interpretation must be billed using modifier 26. Laboratories performing both the professional and the technical components must bill the code without a modifier for the technical and with modifier 26 for the professional. These services may be billed either on separate lines or on separate claim forms. 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

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Pathology and Laboratory Services

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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. DSHS 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)

DSHS 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 sigmoidoscope	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, DSHS’s payment is reduced when billed with modifier 53 (discontinued procedure).

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 provider number for laboratory services provided by their technicians under their supervision.
- An independent laboratory and/or hospital laboratory must bill using its provider number for any services performed in its facility.
- DSHS pays for one blood draw fee (CPT codes 36415-36416 or 36591) per day.
- DSHS 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 DSHS-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.

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. **DSHS 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.

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Drug Screens

- DSHS pays for drug screens only 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.
 - ✓ 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 CMS-1500 Claim Form:
 - ICD-9-CM diagnosis codes 304.01-304.03;
 - CPT codes 80101, 80102, or 80103 QW are covered only for ICD-9-CM diagnoses 304.01-304.03. The maximum combined total allowable is 2 units per day; and
 - “Certified bupren provider” in field 19.
- DSHS does not pay for drug screens to **monitor** any of the following:
 - ✓ Program compliance in either a residential or outpatient drug or alcohol treatment program;
 - ✓ Drug or alcohol use by a client when the screen is performed by a provider in a private practice; or
 - ✓ Suspected drug use by clients living in a residential setting such as a group home.

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

- For clients in the Division of Alcohol and Substance Abuse (DASA) contracted methadone treatment programs and pregnant women in DASA-contracted treatment programs, drug screens are paid through a contract issued to one specific laboratory by DASA, not through DSHS.

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

When CMHC or DASA-contracted providers refer clients enrolled in a DSHS managed care plan for laboratory services, the laboratory **must bill DSHS 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 DASA-contracted provider who has a core provider agreement with DSHS;
- 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 seven-digit CMHC or DASA-contracted referring provider identification number assigned by DSHS in the “referring provider” field of the claim form. CMHC and DASA-contracted services are excluded from DSHS’s managed care contracts.

Disease Organ Panels--Automated Multi-Channel Tests

DSHS 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. ***However, do not bill separately for any individual tests that are included in the panel.*** Duplicate tests will be denied. Panel codes must be billed if all individual tests in the panel are performed.
- 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.

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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, magnetic tape, 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 DSHS 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 on an Adjustment Request form [DSHS# 525-109]. Refer to the Important Contacts section for ordering/downloading DSHS forms. 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 DSHS’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, DSHS 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 (see page E.24 for information on modifier 91).

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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. DSHS 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 provider number must be entered in the performing number field on the claim form.*

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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 E.13).

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

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HIV Testing

DSHS 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
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

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, pO2 & pCO2
82945	Glucose other fluid

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Physician-Related Services

Procedure Code	Brief Description
82947	Assay, glucose, blood quant
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

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Physician-Related Services

Procedure Code	Brief Description
87205	Smear gram stain
87210	Smear, wet mount, saline/ink
87281	Pneumocystis carinii, ag, if
87327	Cryptococcus neoform ag, eia
87400	Influenza a/b, ag, eia
89051	Body fluid cell count
86367	Stem cells, total count
86923	Compatibility test, electric
88720	Bilirubin, total, 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.

DSHS'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.
- DSHS 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.
- DSHS 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, DSHS 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, DSHS 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 DSHS 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.

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Chemotherapy Services
Changes are highlighted

Chemotherapy Drugs

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

- DSHS's maximum allowable fee per unit is based on the HCPCS description of the chemotherapy drug.
- DSHS'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, DSHS 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.

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, DSHS 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 DSHS'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, DSHS 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 DSHS'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].

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Chemotherapy Services
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Unlisted Drugs:

When it is necessary to bill DSHS for a chemotherapy drug using an unlisted drug code, you must report the National Drug Code (NDC) of the drug administered to the client. In order to make appropriate payment, DSHS uses the NDC when unlisted drug codes are billed.

Claims *must* be billed with the following:

- The dosage given to the client;
- The 11-digit NDC; and.
- One unit of service.

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.

Note: If there is an assigned HCPCS code for the administered drug, DSHS **must be billed** using the appropriate HCPCS code. **DO NOT** use an unlisted drug code to bill for a drug that has an assigned HCPCS code. DSHS will recoup payment made for any drugs that were paid under an unlisted drug code if an assigned HCPCS code exists for the administered drug.

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, DSHS 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 DSHS upon request.

Oral Anti-Emetic Drugs

In order to bill DSHS 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.

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

Providers must check the fee schedule (see Appendix) 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.

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Surgical Services
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Physician-Related 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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Surgical Services
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Physician-Related 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.
- DSHS 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).

DSHS-Approved Hospitals for Bariatric Surgery

See Section I for information on bariatric surgery.

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Surgical Services
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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 DSHS for these services. Current RNFA providers who want to assist at surgeries need to submit their Certification as a Certified Nurse Operating Room (CNOR) from the Certification Board Perioperative Nursing to:

**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
- Submit the following documentation to DSHS along with the Core Provider Agreement:
 - ✓ Certification as a Certified Nurse Operating Room (CNOR) from the Certification Board Perioperative Nursing;
 - ✓ Proof of Allied Health Personnel privileges in the hospital where the surgeries are performed; and
 - ✓ Certification as an RNFA from the Certification Board of Perioperative Nursing.

RNFAs who are current providers or who wish to bill only for cesarean sections (CPT codes 59514 and 59620) **are not required** to submit the Certification as an RNFA from the Certification Board Perioperative Nursing.

Multiple Surgeries

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

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

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 using a DSHS Adjustment Request form [DSHS 525-109]. Refer to Important Contacts page for information on ordering/downloading DSHS forms.

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RNFAs

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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.
- DSHS 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).

DSHS 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.

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Endoscopy and Other Surgical

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Physician-Related Services

- DSHS 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. DSHS will pay to remove implants (CPT codes 19328 and 19330) but will not replace them if they were placed for cosmetic reasons.
- DSHS 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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Bilateral Procedures
Changes are Highlighted

Physician-Related 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

DSHS 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

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

Apheresis

Therapeutic apheresis (CPT codes 36511-36516) includes payment for all medical management services provided to the client on the date of service. DSHS 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.

DSHS has adopted Medicare's payment splits, as listed below. If Medicare has not assigned a payment split to a procedure, DSHS 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%

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Pre-/Intra-/Postoperative Payment

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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 DSHS. **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 DSHS's payment system and trigger a manual review as a result of DSHS'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.

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Urology

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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.
- DSHS 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

- DSHS 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.
- DSHS 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.
- DSHS 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 DSHS 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.

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Anesthesia
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Physician-Related 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. DSHS has assigned flat fees for these codes.
- DSHS 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, DSHS follows CPT code descriptions.
- DSHS 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, DSHS pays each provider 50% of the allowed amount. DSHS limits payment in this circumstance to 100% of the total allowed payment for the service.
- Providers must report the number of actual anesthesia minutes (calculated to the next whole minute) in the appropriate field of the claim form. DSHS calculates the base units.

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**Anesthesia
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Regional Anesthesia

- Bill DSHS the appropriate procedure code (e.g. epidural CPT code 62319) with no time units and no anesthesia modifier. DSHS 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.
- DSHS 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. DSHS will determine payment amount after review of the documentation.

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

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

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

- When billing more than one time-limited anesthesia code, the total time may not exceed 6 hours (360 minutes).
- Bill the applicable CPT anesthesia code with applicable modifier and time. To determine time for obstetric epidural anesthesia during normal labor and delivery and C-sections, time begins with insertion and ends with removal for a maximum of 6 hours per delivery.

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Anesthesia
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Physician-Related Services

- 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 DSHS'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

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

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

Teaching Anesthesiologists

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

- When supervising *one* resident only, the teaching anesthesiologist must bill DSHS 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 DSHS 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 DSHS's-assigned maximum allowable fee for the procedure code.
- When billing for pain management and other services that are payable using DSHS's-assigned maximum allowable fee, do not use anesthesia modifiers. DSHS 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

*Due to copyright restrictions, DSHS 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

Procedure Code	Brief Description
62365*	Remove spine infusion device
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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Anesthesia

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Physician-Related 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
64550*	Apply neurostimulator
64553*	Implant neuroelectrodes
64555*	Implant neuroelectrodes
64560*	Implant neuroelectrodes
64561*	Implant neuroelectrodes
64565*	Implant neuroelectrodes
64573*	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

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

Other Services

Procedure Code	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 diskectomy
63600	Remove spinal cord lesion
76000	Fluoroscope examination
76496	Fluoroscopic procedure
77001	Fluoroguide for vein device
77002	Needle localization by xray
77003	Fluoroguide for spine inject
93503	Insert/place heart catheter
95970	Analyze neurostim, no prog
95990	Spin/brain pump refill & main

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

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Chemotherapy Services
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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 (DSHS) receive funding from the TCF to help support provider groups involved in the state's trauma care system. DSHS uses its TCF funding to draw down federal matching funds, and pays enhanced rates to designated trauma services and physicians for trauma cases that meet specified criteria.

The supplemental payments program for trauma care was discontinued on May 5, 2002. The legislature reinstated funding for the program beginning with dates of service on and after July 1, 2003.

The enhanced rates are available for trauma 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 DSHS if the hospital:

- Is designated by DOH as a designated trauma service center (or "recognized" by DOH if in a bordering city);
- Is designated as a Level 1, Level 2, or Level 3 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

TCF Payments to Physicians

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

- 1) For only those trauma services that are designated by DSHS as "qualified." Qualified services are those that meet the ISS specified in number 3 below. Qualified services also include surgical services provided to eligible fee-for-service medical assistance clients within six months of the date of the qualifying injury when the following conditions are met:
 - (a) The follow-up surgical procedures are directly related to the 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 number (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 number (1) above, may be provided in other approved care settings, such as ambulatory surgery centers.
- 5) At a rate determined by DSHS. The enhanced rates are subject to the following limitations:
 - (a) DSHS 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.

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**Major Trauma Services
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TCF Payments to Hospitals and Physicians in Transfer Cases

When a trauma case is transferred from one hospital to another, DSHS 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 qualified trauma services they provide. DSHS 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 fixed quarterly amount. Each hospital's percentage depends on the total qualified trauma care provided by the hospital during the relevant quarter, 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. DSHS has the authority to take whatever actions are needed to ensure it stays within the current TCF appropriation.

DSHS distributes increased payments from the TCF only when eligible trauma claims are submitted with the appropriate trauma modifier within the time frames specified by DSHS.

Each qualifying trauma service and/or procedure on the physician's claim or other clinical provider's claim is paid at the lesser of DSHS'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 DSHS's current FFS rate or the billed amount.

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Major Trauma Services
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Claims Excluded from Enhanced Payment for Trauma Services

Claims for trauma care provided to clients enrolled in DSHS'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

Bill DSHS for qualified trauma services by adding modifier **ST** to the appropriate procedure code. The modifier ST must be entered on the CMS-1500 Claim Form 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. Claims billed inappropriately must be rebilled on DSHS's blue Adjustment Request Form [DSHS Form # 525-109].

Adjusting Trauma Claims

DSHS considers a provider's request for a TCF claim adjustment to add the trauma modifier to a qualified service in order to receive the enhanced fee, or to adjust the enhanced payment only if DSHS receives the claim within one year from the date of service on the initial claim.

DSHS does not make any TCF payment for an otherwise eligible claim for an SFY after the date specified by DSHS as the last date to make adjustments to a trauma claim for that SFY. WAC [388-502-0150\(7\)](#) does not apply to TCF payments.

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
Health and Recovery Services Administration
1-360-725-1835**

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

**DSHS's Provider Relations Unit
1-800-562-3022, option 2**

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**Major Trauma Services
Changes are Highlighted**

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.

Physical Therapy

Which providers are eligible to provide physical therapy?

[Refer to WAC 388-545-500(1)]

- Licensed physical therapists or physiatrists; or
- Physical therapist assistants supervised by licensed physical therapists.

Where must physical therapy services be provided?

[WAC 388-545-500(3)(a)(f)]

HRSA pays eligible providers for physical therapy services provided as part of an outpatient treatment program in the following settings:

- In an office, home, or outpatient hospital setting;

Note: Physical therapy may be performed by a home health agency as described in Chapter 388-551 WAC, or as part of an acute physical medicine and rehabilitation (Acute PM&R) program as described in Acute PM&R subchapter 388-550 WAC.

- In a neurodevelopmental center;
- In a school district or educational service district facility as part of an individual education plan (IEP) or individualized family service plan (IFSP), as described in WAC 388-537-0100; or
- For children two years of age and younger with disabilities, in natural environments including the home and community settings in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

Referral and Documentation Process

Adults (Age 21 and older) [Refer to WAC 388-545-500 (5)]

Providers must document in a client's medical record that physical therapy services provided to clients age 21 and older are medically necessary. Such documentation may include justification that physical therapy services:

- Prevent the need for hospitalization or nursing home care;
- Assist a client in becoming employable;

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**Physical Therapy
Changes are Highlighted**

Physician-Related Services

- Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or
- Are part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

Children (Age 20 and younger)

The EPSDT screening provider must:

- Determine if there is a medical need for physical therapy; and
- Document the medical need and the referral in the child's medical record.

The provider must:

- Keep referral information on file in the form of a prescription, notes from telephone calls, etc.;
- Contact the referring EPSDT provider for information concerning the need for physical therapy services; and
- Keep the referring and/or continuing care provider apprised of the assessment, prognosis, and progress of the referred child.

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**Physical Therapy
Changes are Highlighted**

Coverage [WAC 388-545-500(4)]

DSHS pays providers for only those covered physical therapy services listed in this section when they are:

- Within the scope of an eligible client's medical care program;
- Medically necessary and ordered by a physician, physician assistant, or an ARNP;
- Begun within 30 days of the date ordered;
- For conditions which are the result of injuries and/or medically recognized diseases and defects; and
- Within accepted physical therapy standards.

Note: DSHS does not limit covered physical therapy services for clients 20 years of age and younger.

Coverage for adults (age 21 and older) [Refer to WAC 388-545-500 (8)]

DSHS covers without prior authorization the following physical therapy services per client, per diagnosis:

- One physical therapy evaluation (in addition to the 48 program unit limitation below) per calendar year;
- 48 physical therapy program units per calendar year;
- One visit to instruct the client in the application of transcutaneous electrical neurostimulator (TENS) per lifetime;
- Two DME needs assessments per calendar year (in addition to the 48 program units). Two 15-minute units are allowed per DME needs assessment; and
- One wheelchair needs assessment per calendar year (in addition to the two DME needs assessment). Four 15-minute units are allowed per wheelchair assessment).

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**Physical Therapy
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Physician-Related Services

DSHS covers up to 96 physical therapy program units per calendar year *in addition* to the original 48 units only when:

- The client is diagnosed with one of the following conditions:

ICD-9-CM Diagnosis Codes	Condition
315.31-315.9, 317-319	Medically necessary conditions for individuals identified as having developmental disabilities
343.0 - 343.9	Cerebral palsy
741.90-741.93	Meningomyelocele
758.0	Down syndrome
781.2 - 781.3	Symptoms involving nervous and musculoskeletal systems, lack of coordination
800.00 - 829.1	Surgeries involving extremities – Fractures
851.00 - 854.19	Intracranial injuries
880.00 - 887.7	Surgeries involving extremities - Open wounds with tendon involvement
941.00 - 949.5	Burns
950.0 - 957.9, 959.01 - 959.9	Traumatic injuries

Note: The conditions above **must** be listed as the primary diagnosis on the claim.

-OR-

- The client no longer needs nursing services, but continues to require specialized outpatient physical therapy following an approved Acute PM&R stay within the previous 12 months for the following conditions:

ICD-9-CM Diagnosis Codes	Condition
854.00-854.19	Traumatic brain injury
900.82, 344.00- 344.09, 344.1	Spinal cord injury (paraplegia and/or quadriplegia)
436	Recent or recurrent stroke
340	Restoration of the levels of function due to secondary illness or loss for multiple sclerosis
335.20	Amyotrophic lateral sclerosis
343.0 – 343.9	Cerebral palsy
357.0	Acute infective polyneuritis (Guillain-Barre' syndrome)

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ICD-9-CM Diagnosis Codes	Condition
941.40-941.49, 941.50-941.59, 942.40-942.49, 942.50-942.59, 943.40-943.49, 943.50-943.59, 944.40-944.48, 944.50-944.58, 945.40-945.49, 945.50-945.59, 946.4, 946.5	Extensive severe burns
344.00-344.09, 707.00-707.09	Skin flaps for sacral decubitus for quads only
890.0 - 897.7, 887.6 - 887.7	Open wound of lower limb, bilateral limb loss

Physical Therapy Program Limitations

DSHS does not cover duplicate services for occupational and physical therapy for the same client when both providers are performing the same or similar procedure(s).

[WAC 338-545-500 (11)]

Note: A program unit is based on the CPT® code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes. If time is included in the CPT description, the beginning and ending times of each therapy modality must be documented in the client’s medical record.

The following are considered part of the physical therapy program 48-unit limitation:

- Application of a modality to one or more areas not requiring direct patient contact (CPT codes 97010-97028).
- Application of a modality to one or more areas requiring direct patient contact (CPT codes 97032-97039).
- Therapeutic exercises (CPT codes 97110-97139).
- Manual therapy (CPT code 97140).
- Therapeutic procedures (CPT code 97150).
- Prosthetic training (CPT code 97761).

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Physician-Related Services

- Therapeutic activities (CPT code 97530).
- Self-care/home management training (CPT code 97535).
- Community/work reintegration training (CPT code 97537).
- Physical performance test or measurement (CPT code 97750). Do not use to bill for an evaluation (CPT code 97001) or re-evaluation (CPT code 97002).
- Assistive technology assessment (CPT code 97755).

The following are not included in the physical therapy program 48-unit limitation:

- Muscle testing (CPT codes 95831-95852). DSHS covers one muscle testing procedure per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical therapy CPT codes.
- Physical therapy evaluation (CPT code 97001). Use for reporting the initial evaluation before the plan of care is established by the physical therapist or the physician. This procedure is not used for re-evaluating the client's condition and establishing the plan of care.
- Physical therapy re-evaluation (CPT code 97002). Allowed once per client, per calendar year. Use for reporting the re-evaluation of a client who has been under a plan of care established by a physician or physical therapist. This procedure is for re-evaluating the client's condition and revising the plan of care under which the client is being treated.
- Cognitive testing (CPT code 96125). Allowed once per client, per calendar year.
- Orthotics fitting and training upper and/or lower extremities (CPT code 97760). DSHS covers two units per day. This procedure can be billed alone or with other physical therapy CPT codes.
- Active wound care management involving selective and non-selective debridement (CPT codes 97597, 97598, and 97602). The following conditions apply:
 - ✓ DSHS covers one unit of CPT code 97597, 97598, and 97602 per client, per day, per wound. Providers may not bill CPT codes 97597, 97598, and 97602 in conjunction with each other for the same wound; however, CPT codes 97597, 97598, and 97602 may be billed in conjunction with each if they are for separate wounds.
 - ✓ Providers must not bill CPT codes 97597, 97598, and 97602 in addition to CPT codes 11040-11044.

Note: For multiple wounds, use modifier 59.

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**Physical Therapy
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Physician-Related Services

- Checkout for orthotic/prosthetic use (CPT code 97762). DSHS covers two 15-minute units per day. This procedure can be billed alone or with other physical therapy CPT codes.
- Wheelchair management (CPT code 97542).
- Wheelchair needs assessment (CPT code 97542). DSHS covers one wheelchair needs assessment per client, per calendar year, limited to four 15-minute units per assessment. Indicate on the claim that this is a wheelchair needs assessment.
- DME needs assessments (CPT code 97762). DSHS covers two DME needs assessments per client, per calendar year, limited to two 15-minute units per assessment. Indicate on the claim that this is a DME needs assessment.
- Splints (refer to Section K for those splints covered in a provider's office).

How do I request approval to exceed the limits?

For clients 21 years of age and older who need physical therapy in addition to existing program unit limitations, the provider must request a Limitation Extension (LE). See Section I – Prior Authorization.

Are school medical services covered?

DSHS covers physical therapy services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to DSHS's *School Medical Services Billing Instructions*. (See Important Contacts.)

What is not covered? [WAC 388-545-500(12)]

DSHS does not pay separately for physical therapy services that are included as part of the payment for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

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**Physical Therapy
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Miscellaneous Services

Acute Physical Medicine and Rehabilitation (Acute PM&R): Inpatient PM&R is limited to DSHS-contracted facilities.

DDD Physical: DSHS 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.

HIV/AIDS Counseling: DSHS covers two sessions of risk factor reduction counseling (CPT code 99401) for HIV/AIDS 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. DSHS 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.

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

CPT Code	Brief Description	Limits
95860	Needle EMG; one extremity with or without related paraspinal areas	<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.
95861	two extremities...	
95863	three extremities...	
95864	four extremities...	
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).

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Miscellaneous Services
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Nerve Conduction Study (NCS):

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

TB Treatment Services: The E&M codes 99201-99215 are for office visits only, and must be billed by 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

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, DSHS will deny the E&M code.

Ultraviolet Phototherapy

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

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Collagen Implants

DSHS 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.

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, DSHS will deny the E&M code.

Artificial Disc Replacement

As a result of the Health Technology Assessment Reviews, for dates of service on and after January 1, 2010:

- DSHS will require prior authorization for **cervical** disc replacement CPT codes 22856 and 22861 (refer to Section I). The basis for coverage/noncoverage is as follows:
 - ✓ Clients must meet the following Federal Drug Administration (FDA)-approved indications for use and not have any contra-indications. FDA approval is device-specific, but includes:
 - Skeletally mature patient.
 - Reconstruction of a disc following single-level discectomy for intractable symptomatic cervical disc disease (radiculopathy or myelopathy) confirmed by patient findings and imaging.
 - ✓ Clients cannot have any of the following FDA general contra-indications:
 - Infection - active systemic or at the site of implantation.
 - Any allergy or sensitivity to implant materials.
 - Certain bone and spine diseases (e.g., severe spondylosis or marked cervical instability).
 - ✓ Non FDA-approved uses are noncovered.
- DSHS will require prior authorization for **lumbar** disc replacement CPT codes 22857, 22862, and 22865 (refer to Section I).

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Cochlear Implant Services [Refer to WAC 388-531-0200(4) (c)]

Bilateral cochlear implants require prior approval and may be approved for pre-lingual children. Unilateral cochlear implantation (CPT code 69930) requires EPA (see section I). If a client does not meet the EPA criteria or you are requesting bilateral cochlear implantation for pre-lingual children, PA is required.

Effective for dates of services on and after January 1, 2010, DSHS will cover replacement parts for cochlear devices through the DSHS/HRSA Hearing Aids and Services Program *only*. DSHS payments will be made only to those vendors with a current core provider agreement that supply replacement parts for cochlear implants and BAHA.

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

- Vagus nerve stimulation (CPT codes 61885, 61886, 61888 and 64573) requires prior authorization (refer to Section I - 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.
- DSHS does not pay for VNS and related procedures for a diagnosis of Depression (CPT 64550-64565, 64590-64595, 95970, 95974, and 95975).

Osseointegrated Implants

- Insertion **or replacement** of osseointegrated implants (CPT codes 69714-69718) requires prior authorization (refer to Section I - Prior Authorization).
- The procedure can be performed in an inpatient hospital setting or outpatient hospital setting.

Effective for dates of services on and after January 1, 2010, DSHS will cover replacement parts for bone-anchored hearing aids (BAHA) through the DSHS/HRSA Hearing Aids and Services Program *only*. DSHS payments will be made only to those vendors with a current core provider agreement that supply replacement parts for cochlear implants and BAHA.

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 and 174-174.9
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

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Miscellaneous Services
Changes are Highlighted

Outpatient Cardiac Rehabilitation

Eligible programs:

- CNP;
- Children's Health;
- LCP-MNP (only clients 20 years of age and younger);
- GAU; and
- GAU-ADATSA.

DSHS 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.

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.

DSHS **does not** cover procedure code 93797 or **G0423**.

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Outpatient Cardiac Rehabilitation

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Physician-Related Services

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.

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

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

- DSHS pays for up to 6 hours of diabetic education/diabetic management per client, per calendar year.
- Certified diabetic education providers must be approved by the Department of Health (DOH). Contact the number provided below to receive a list of DOH approved diabetic education providers.
- All physicians, ARNP's, clinics, hospitals, and Federally Qualified Health Centers are eligible to apply to be a diabetes education provider. The Diabetes Control Program (DCP) at DOH develops the application criteria and evaluates all applications for this program.
- A minimum of 30 minutes of education/management must be provided per session.
- Diabetes education may be provided in a group or individual setting, or a combination of both, depending on the client's needs.

Note: DSHS does not reimburse for diabetes education if those services are an expected part of another program provided to the client (e.g. school-based health services or adult day health services).

For more information on becoming a diabetes education provider and to obtain an application, write or call:

Diabetes Prevention and Control Program
Department of Health
PO Box 47855
111 Israel Rd SE
Tumwater, WA 98501
1-253- 395-6758

Note: DSHS is still in the process of writing the Diabetic Education Billing Instructions. Please refer to memo 05-41 until the new billing instructions are published.

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 DSHS clients who have been diagnosed with diabetes or asthma. These visits are limited to groups of two or more clients and are payable only to physicians or advanced registered nurse practitioners (ARNPs). However, participation from other professional staff, including physician assistants, physical therapists, nurses, and nutritionists is encouraged.

Program Requirements

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

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- G.16 - Genetic Counseling and Genetic Testing

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Out-of-State Hospital Admissions

Changes are Highlighted

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: DSHS pays only for the time that a client spends in the group clinical visit.

Other Limitations:

DSHS 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.

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.

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Genetic Counseling and Genetic Testing

DSHS 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 253-395-6742.

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

DSHS 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.

DSHS 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 DSHS 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 DSHS 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 Assistant – Unemployable (GAU) program. For these clients, DSHS 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.

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- G.18 - Genetic Counseling and Genetic Testing

Memo 09-87

Out-of-State Hospital Admissions

Changes are Highlighted

Reproductive Health Services

How does DSHS define reproductive health services?

[WAC 388-532-001]

DSHS 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 DSHS for reproductive health services provided to eligible clients, physicians, and advanced registered nurse practitioners (ARNPs) 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 *DSHS-Approved Family Planning Providers Billing Instructions* for more information on how to become a DSHS-approved family planning provider and more information on the Family Planning Only program. Clients enrolled in a DSHS managed care organization may self refer outside their plan for abortions.

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- H.1 -

Reproductive Health Services

Memo 09-87

Changes are highlighted

Who is eligible? [Refer to WAC 388-532-100(1)]

DSHS covers limited, medically necessary reproductive health services for clients presenting DSHS Medical Identification (ID) cards with one of the following identifiers:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP – CHIP	CNP – Children’s Health Insurance Program
GAU No Out of State Care	General Assistance Unemployable
General Assistance	ADATSA
LCP-MNP	Limited Casualty Program-Medically Needy Program

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:

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

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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:** DSHS 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: DSHS does not pay for preventive health exams for clients 21 years of age and older.

- **FDA-approved prescription contraception method**
(see DSHS's *Prescription Drug Program Billing Instructions*);
- **OTC contraceptives, drugs, and supplies**
(see DSHS's *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.

(See page H.23 for instructions)

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.

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- H.3 -

Reproductive Health Services

Memo 09-87

Changes are highlighted

Services for Women (continued)

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

Note: For HIV testing use CPT® 86703. **DSHS 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 DSHS/HRSA [HRSA-Approved Family Planning Providers Billing Instructions](#) for details.
- **Implanon (HCPCS code J7307)**

DSHS 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 and send in an invoice with your billing.

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

Services for Men

DSHS 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 DSHS's *Prescription Drug Program Billing Instructions*);
- **Sterilization procedures when:**
 - ✓ Requested by the client; and
 - ✓ Performed in an appropriate setting for the procedure.

(See page H.23 for instructions)

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 *Billing* section specifics.

Note: DSHS 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 postpregnancy coverage by DSHS. **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 Medical ID card stating *FAMILY PLANNING ONLY*. If her pregnancy ends for any reason other than delivery, she **must** notify the CSO to receive the Family Planning Only Medical ID card.

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

To be paid by DSHS 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.

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Memo 09-87

**Family Planning Only
Changes are highlighted**

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 Definitions 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).

DSHS 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 DSHS's *Prescription Drug Program Billing Instructions* for requirements)
- **OTC contraceptives, drugs, and supplies**
(see DSHS's *Prescription Drug Program Billing Instructions*)
- **Sterilization** procedures that meet the requirements of DSHS's *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.

- **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.

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Family Planning Only
Changes are highlighted

- **Education** for FDA-approved contraceptives, natural family planning, and abstinence.
- **Implanon (CPT code J7307)**

DSHS 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 and send in an invoice with your billing.

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

What drugs and supplies are paid under the Family Planning Only program?

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

Absorbable Sulfonamides
Anaerobic antiprotozoal – antibacterial agents
Antibiotics, misc. other
Antifungal Agents
Antifungal Antibiotics
Cephalosporins – 1st generation
Cephalosporins – 2nd generation
Cephalosporins – 3rd generation
Condoms
Contraceptives, injectables
Contraceptives, intravaginal
Contraceptives, intravaginal, systemic
Contraceptives, transdermal
Diaphragms/cervical caps
Intrauterine devices
Macrolides

Nitrofurans Derivatives
Oral contraceptives
Quinolones
Tetracyclines
Vaginal Antibiotics
Vaginal antifungals
Vaginal lubricant preparations
Vaginal Sulfonamides

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Family Planning Only
Changes are highlighted

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's DSHS Medical ID card says *Family Planning Only* 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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Inpatient Services: DSHS 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 DSHS of the circumstances and conditions that caused the need for the inpatient services in order for DSHS 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 DSHS Division of Medical Management at 360-586-1471.

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

Fee Schedule: DSHS 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

DSHS 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. DSHS 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.

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

Providers who are in the same clinic who **do not** have the same group provider number **must not** bill DSHS 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 DSHS for maternity services until all care is completed.

Unbundling Obstetrical Care

In the situations described below, providers may not be able to bill DSHS 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 DSHS may have paid another provider for some of the client’s OB care, or a provider may have been paid by another insurance carrier for some of the client’s OB care.

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

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

- OR -

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

In this case, the provider may actually perform all of the components of the global OB package in a short time. DSHS 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 field 19 of the CMS-1500 claim form.

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 DSHS managed care organization for the remainder of her pregnancy. DSHS 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.

DSHS 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.

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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, DSHS 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 DSHS using the date of the last antepartum visit in the "to and from" fields.

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

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

When billing for antepartum care, **do not bill** using CPT E&M codes for the first three visits, then CPT code 59425 for visits four through six, and then CPT code 59426 for visits seven and on. These CPT codes are used to bill only the **total** number of times 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 DSHS 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 DSHS 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 DSHS 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 DSHS 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 DSHS for the antepartum care using the antepartum care only codes, along with CPT code 59430 (postpartum care only).

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

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

Additional Monitoring for High-Risk Conditions

When providing **additional monitoring** for high-risk conditions in excess of the CPT guidelines for normal antepartum visits, bill using E&M codes **99211-99215 with modifier UA**. The office visits may be billed in addition to the global fee **only after** exceeding the CPT guidelines for normal antepartum care.

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.**

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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 DSHS for the hospital admission or for labor management. These services are included in the global OB package.

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

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

In addition to the hospital admission, DSHS 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: DSHS 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, DSHS 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: DSHS **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 DSHS 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 DSHS- assigned provider number 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), DSHS pays the consulting physician for the consultation as follows:

- If the consulting physician does not perform the cesarean section, bill DSHS the appropriate consultation code.

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- If the consulting physician performs the cesarean section and does the consultation **two or more days prior to the date of surgery**, bill DSHS the appropriate **consultation code with modifier 57** (e.g. 99241-57).

DSHS 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** DSHS 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). DSHS does not pay providers for a consultation with a normal pregnancy diagnosis code (e.g. V22.0-V22.2).

DSHS 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

- DSHS 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.
- DSHS 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.
- 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 DSHS's current *Births in Birthing Centers Billing Instructions*. For deliveries in a home birth setting, refer to DSHS's current *Planned Home Births Billing Instructions*.

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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, call DSHS's Family Services Section at 360.725.1655 (see Important Contacts section).

HIV/AIDS Counseling/Testing

DSHS 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. DSHS 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.

DSHS 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.

DSHS 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 DSHS for Maternity Services” is included on the following pages.

**Billing HRSA 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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**Billing HRSA 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	Admit code with modifier TH and the prolonged services code(s) must be billed on the same claim form.

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.

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Sterilization

What is sterilization? [Refer to WAC 388-531-1550(1)]

Sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing. This includes vasectomies and tubal ligations.

Note: DSHS does **not** pay for hysterectomies performed solely for the purpose of sterilization.

What are DSHS's payment requirements for sterilizations?

[Refer to WAC 388-531-1550(2)]

DSHS covers sterilization when all of the following apply:

- The client has **voluntarily** given informed consent;
- The client is at least 18 years of age at the time consent is signed;
- The client is a mentally competent individual; and
- At least 30 days, but not more than 180 days, have passed between the date the client gave informed consent and the date of the sterilization.

Note: DSHS pays providers for sterilizations for managed care clients 18 through 20 years of age under the fee-for-service system. All other managed care clients must obtain their sterilization services from their managed care provider.

DSHS pays providers (e.g., hospitals, anesthesiologists, surgeons, and other attending providers) for a sterilization procedure only when the completed federally approved Sterilization Consent Form, DSHS 13-364, is attached to the claim. Click link to download the DSHS 13-364 http://www1.dshs.wa.gov/pdf/ms/forms/13_364.pdf. DSHS does not accept any other forms attached to the claim. DSHS pays after the procedure is completed.

DSHS pays providers for epidural anesthesia in excess of the six-hour limit for deliveries if sterilization procedures are performed in conjunction with, or immediately following, a delivery. DSHS determines total billable units by:

- Adding the time for the sterilization procedure to the time for the delivery; and
- Determining the total billable units by adding together the delivery base anesthesia units (BAUs), the delivery time, and the sterilization time.

Do not bill the BAUs for the sterilization procedure separately.

Additional Requirements for Sterilization of Mentally Incompetent or Institutionalized Clients

Providers must meet the following additional consent requirements before DSHS will pay the provider for the sterilization of a mentally incompetent or institutionalized client. DSHS requires both of the following to be attached to the claim form:

- Court orders that include the following:
 - ✓ A statement that the client is to be sterilized; **and**
 - ✓ The name of the client's legal guardian, who will be giving consent for the sterilization.
- Sterilization Consent Form [DSHS 13-364] signed by the client's legal guardian.

When does DSHS waive the 30-day waiting period?

[WAC 388-531-1550(3) and (4)]

DSHS does not require the 30-day waiting period, but does require at least a 72 hour waiting period, for sterilization in the following circumstances:

- At the time of premature delivery, the client gave consent at least 30 days before the *expected* date of delivery. The expected date of delivery must be documented on the consent form.
- For emergency abdominal surgery, the nature of the emergency must be described on the consent form.

DSHS waives the 30-day consent waiting period for sterilization when the client requests that sterilization be performed at the time of delivery, **and** completes a Sterilization Consent Form [DSHS 13-364]. One of the following circumstances must apply:

- The client became eligible for Medical Assistance during the last month of pregnancy (**CMS-1500 Claim Form field 19: "NOT ELIGIBLE 30 DAYS BEFORE DELIVERY"**); or
- The client did not obtain medical care until the last month of pregnancy (**CMS-1500 Claim Form field 19: "NO MEDICAL CARE 30 DAYS BEFORE DELIVERY"**); or
- The client was a substance abuser during pregnancy, but is not using alcohol or illegal drugs at the time of delivery. (**CMS-1500 Claim Form field 19: "NO SUBSTANCE ABUSE AT TIME OF DELIVERY."**)

The provider must note on the CMS-1500 Claim Form in field 19 or on the backup documentation, which of the above waiver condition(s) has been met. Required language is shown in parenthesis above. Providers who bill electronically must indicate this information in the *Comments* field.

When does DSHS *not* accept a signed Sterilization Consent Form? [Refer to WAC 388-531-1550(5) and (6)]

DSHS does not accept informed consent obtained when the client is in any of the following conditions:

- In labor or childbirth;
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or other substances that affect the client's state of awareness.

Why do I need a DSHS-approved Sterilization Consent Form?

Federal regulations prohibit payment for sterilization procedures until a federally approved and accurately completed Sterilization Consent Form [DSHS 13-364] is received. To comply with this requirement, surgeons, anesthesiologists, and assistant surgeons as well as the facility in which the surgery is being performed must obtain a copy of a completed Sterilization Consent Form [DSHS 13-364] to attach to their claim.

Providers must use Sterilization Consent Form [DSHS 13-364] in order for DSHS to pay your claim. DSHS does not accept any other form.

To **download** DSHS forms, visit: <http://www1.dshs.wa.gov/msa/forms/eforms.html>
Scroll down to form number 13-364.

To **have a hard copy sent** to you, contact:
DSHS Forms Management Phone: 360.664.6047 or Fax: 360.664.6186

Include in the request:

- Form number and name;
- Quantity desired;
- Provider name and your office name; and
- Full mailing address.

DSHS will deny a claim for a procedure received without the Sterilization Consent Form [DSHS 13-364]. DSHS will deny a claim with an incomplete or improperly completed Sterilization Consent Form. Submit the claim and completed Sterilization Consent Form [DSHS 13-364] to:

**DSHS-HRSA
PO Box 9248
Olympia WA 98507-9248**

If you are submitting your sterilization claim form electronically, be sure to indicate in the comments section that you are sending in a hard copy of the Sterilization Consent Form [DSHS 13-364] is being sent. Then send in the form with the electronic claims ICN.

Who completes the Sterilization Consent Form?

- Sections I, II, and III of the Sterilization Consent Form are completed by the client, interpreter (if needed), and the physician/clinic representative more than 30 days, but less than 180 days, prior to date of sterilization. If less than 30 days, refer to page F.2: "When does DSHS waive the 30 day waiting period?" and/or section IV of the Sterilization Consent Form.
- The bottom right portion (section IV) of the Sterilization Consent Form is completed shortly before, on, or after the surgery date by the physician who performed the surgery.
- If sections I, II, and III of the initial Sterilization Consent Form are completed by one physician or group, and a different physician or group performed the surgery:
 - ✓ The physician performing the surgery completes another Sterilization Consent Form filling in section IV; and
 - ✓ The client signs and dates lines (7) and (8) of Section I. The client's date of signature can be the date of surgery or after. It does not have to be the date of the procedure.

Submit both Sterilization Consent Forms with your claim.

Frequently Asked Questions on Billing Sterilizations

1. If I provide sterilization services to Family Planning Only clients along with a secondary surgical intervention, such as lysis of adhesions, will I be paid?

The scope of coverage for Family Planning Only clients is limited to contraceptive intervention only. DSHS does not pay for any other medical services unless they are medically necessary in order for the client to safely, effectively and successfully use or continue to use their chosen birth control method.

Only claims submitted with diagnosis codes in the V25 series (excluding V25.3) will be processed for possible payment. All other diagnosis codes are noncovered and will not be paid.

Note: Remember to submit all sterilization claims with the **completed**, federally approved Sterilization Consent Form.

2. If I provide sterilization services to a Medicaid, full scope of care client along with a secondary surgical intervention, such as lysis of adhesions or Cesarean Section delivery, how do I bill?

CNP clients have full scope of care and are eligible for more than contraceptive intervention only. Submit the claim with a completed, federally approved Sterilization Consent Form for payment.

If the provider does not have the consent form or it wasn't completed properly or the client was sterilized prior to the 30 days waiting period (client doesn't meet the criteria for DSHS to waive the 30 day waiting period) then the sterilization line on the claim will be denied and the other line items on the claim will be processed for possible payment.

How to Complete the Sterilization Consent Form

- All information on the Sterilization Consent Form [DSHS 13-364] must be legible.
- All blanks on the Sterilization Consent Form [DSHS 13-364] must be completed *except* race, ethnicity, and interpreter’s statement (unless needed).
- DSHS does not accept “stamped” or electronic signatures.

The following numbers correspond to those listed on the Sterilization Consent Form [DSHS 13-364]:

Section I: Consent to Sterilization	
Item	Instructions
1. Physician or Clinic:	Must be name of physician, ARNP, or clinic that gave client required information regarding sterilization. This may be different than performing physician if another physician takes over. <i>Examples: Clinic – ABC Clinic. Physician – Either doctor’s name, or doctor on call at ABC Clinic.</i>
2. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
3. Month/Day/Year:	Must be client's birth date.
4. Individual to be sterilized:	Must be client's first and last name. Must be same name as Items #7, #12, and #18 on Sterilization Consent Form [DSHS 13-364].
5. Physician:	Can be group of physician or ARNP names, clinic names, or physician or ARNP on call at the clinic. This doesn’t have to be the same name signed on Item # 22.
6. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
7. Signature:	Client signature. Must be client's first and last name. Must be same name as Items #4, #12, and #18 on Sterilization Consent Form [DSHS 13-364]. Must be signed in ink.

Item	Instructions
8. Month/Day/Year:	<p>Date of consent. Must be date that client was initially counseled regarding sterilization.</p> <p>Must be more than 30 days, but less than 180 days, prior to date of sterilization (Item # 19). Note: This is true even of shorter months such as February.</p> <p>The first day of the 30 day wait period begins the day after the client signs and dates the consent form, line #8.</p> <p>Example: If the consent form was signed on 2/2/2005, the client has met the 30-day wait period on 3/5/2005.</p> <p>If less than 30 days, refer to "When does DSHS waive the 30 day waiting period?" and section IV of Sterilization Consent Form [DSHS 13-364].</p>

Section II: Interpreter's Statement

Item	Instructions
9. Language:	Must specify language into which sterilization information statement has been translated.
10. Interpreter:	<p>Must be interpreter's name.</p> <p>Must be interpreter's original signature in ink.</p>
11. Date:	Must be date of interpreter's statement.

Section III: Statement of Person Obtaining Consent

Item	Instructions
12. Name of individual:	<p>Must be client's first and last name.</p> <p>Must be same name as Items #4, #7, and #18 on Sterilization Consent Form.</p>
13. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
14. Signature of person obtaining consent:	Must be first and last name signed in ink.
15. Date:	Date consent was obtained.
16. Facility:	Must be full name of clinic or physician obtaining consent. Initials are acceptable.
17. Address:	Must be physical address of physician's clinic or office obtaining consent.

Section IV: Physician's Statement	
Item	Instructions
18. Name of individual to be sterilized:	Must be client's first and last name. Must be same name as Items #4, #7, and #12 on Sterilization Consent Form [DSHS 13-364].
19. Date of sterilization:	Must be more than 30 days, but less than 180 days, from client's signed consent date listed in Item #8. If less than 30 days, refer to "When does DSHS waive the 30 day waiting period?" and section IV of the Sterilization Consent Form [DSHS 13-364].
20. Specify type of operation:	Indicate type of sterilization procedure. Examples: Bilateral tubal ligation or vasectomy.
21. Expected date of delivery:	When premature delivery box is checked, this date must be <i>expected</i> date of delivery. Do not use actual date of delivery.
22. Physician:	Physician's or ARNP's signature. Must be physician or ARNP who actually performed sterilization procedure. Must be signed in ink. Name must be the same name as on the claim submitted for payment.
23. Date:	Date of physician's or ARNP's signature. Must be completed either shortly before, on, or after the sterilization procedure.
24. Physician's printed name	Please print physician's or ARNP's name signed on Item #22.

How to Complete the Sterilization Consent Form for a Client Age 18-20

1. Use Sterilization Consent Form [DSHS 13-364].
2. Cross out "**age 21**" in the following three places on the form and write in "**18**":
 - a. Section I: Consent to Sterilization: "**I am at least 21...**"
 - b. Section III: Statement of Person Obtaining Consent: "**To the best of my knowledge... is at least 21...**"
 - c. Section IV: Physician's Statement: "**To the best of my knowledge... is at least 21...**"



SAMPLE STERILIZATION CONSENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from
 (1) Dr. Tim Lu
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) tubal ligation The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 years of age and was born on (3) August 1, 1971
Month Day Year

I (4) Jane Doe hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) Dr. Tim Lu
Physician

by a method called (6) tubal ligation My consent
Specify type of operation

expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) August 20, 2001
Signature Month Day Year

You are requested to supply the following information, but it is not required. *Race and ethnicity designation (please check):*

- American Indian or Alaska Native
- Black (not of Hispanic origin)
- Hispanic
- Asian or Pacific Islander
- White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in (9) _____ language and explained

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter Date

DSHS 13-364 (Rev. 12/2002)

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) Jane Doe signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation.

(13) tubal ligation the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) August 20, 2001
Signature of person obtaining consent Date

(16) US Clinic
Facility

(17) PO Box 123, Anywhere, WA 98000
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) Jane Doe (19) October 1, 2001
Name of individual to be sterilized Date of sterilization operation

I explained to him/her the nature of the sterilization operation

(20) tubal ligation The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- Premature delivery
- Individual's expected date of delivery (21) _____
- Emergency abdominal surgery (describe circumstances)

(22) _____ (23) October 1, 2001
Physician's Signature Date

(24) Dr. Tim Lu
Physician's Printed Name



STERILIZATION CONSENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from
 (1) Dr. Tim Lu
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) tubal ligation The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 18 years of age and was born on (3) August 1, 1984
Month Day Year

I (4) Jane Doe hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) Dr. Tim Lu
Physician

by a method called (6) tubal ligation My consent
Specify type of operation

expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) August 20, 2001
Signature Month Day Year

You are requested to supply the following information, but it is not required. Race and ethnicity designation (please check):

- American Indian or Alaska Native
- Black (not of Hispanic origin)
- Asian or Pacific Islander
- Hispanic
- White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in (9) _____ language and explained

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter Date

DSHS 13-364 (Rev. 12/2002)

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) Jane Doe signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation.

(13) tubal ligation the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 18 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) August 20, 2001
Signature of person obtaining consent Date

(16) US Clinic
Facility

(17) PO Box 123, Anywhere, WA 98000
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) Jane Doe (19) October 1, 2001
Name of individual to be sterilized Date of sterilization operation

I explained to him/her the nature of the sterilization operation

(20) tubal ligation The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 18 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- Premature delivery
- Individual's expected date of delivery (21) _____
- Emergency abdominal surgery (describe circumstances)

(22) _____ (23) October 1, 2001
Physician's Signature Date

(24) Dr. Tim Lu
Physician's Printed Name

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 DSHS-approved consent form to attach to their claim.
- **ALL** hysterectomy procedures require a properly completed DSHS-approved consent form, regardless of the client's age or the ICD-9-CM diagnosis.
- Submit the claim and completed DSHS-approved consent form to the:

**DSHS-HRSA
PO BOX 9248
OLYMPIA WA 98507-9248**

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.

- **RU-486 Abortion Drug**

DSHS 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 DSHS 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 DSHS, facility fees are payable only for surgical abortions. Do not bill facility fee charges for drug-induced abortions not requiring surgical intervention. DSHS 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 DSHS managed care organization can self refer for abortions.

Contracted facility fee payment includes all room charges, equipment, supplies, and drugs (including anesthesia, 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. DSHS 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 DSHS's [Inpatient Hospital Billing Instructions](#).

DSHS'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.

How does DSHS determine PA?

DSHS reviews PA requests in accordance with WAC 388-501-0165. DSHS utilizes evidence-based medicine to evaluate each request. DSHS 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, DSHS reviews all evidence submitted and will do one of the following:

- Approve the request;
- Deny the request if the requested service is not medically necessary; or
- Request the provider to submit additional justifying information within 30 days. When the additional information is received, DSHS 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, DSHS will deny the requested service.

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(Rev. 12/31/2009)(Eff. 01/01/2010)

- I.1 -

Memo 09-87

**Prior Authorization
Changes are Highlighted**

When DSHS denies all or part of a request for a covered service or equipment, DSHS 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.

“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. DSHS does not retrospectively authorize any healthcare services that require PA after they have been provided except when a client has delayed certification of eligibility.

Forms available to request PA include:

- Basic Information Form [DSHS 13-756]
- Bariatric Surgery Request Form [DSHS 13-785]
- Out of State Medical Services Request Form [DSHS 13-787]
- PET Scan Information Form [DSHS 13-757]
- Oral Enteral Nutrition Worksheet Prior Authorization Request [DSHS 13-743]*
- TYSABRI (Natalizumab) J2323 Request [DSHS #13-832]
- Application for Chest Wall Oscillator [DSHS #13-841]

These forms are available at: <http://www1.dshs.wa.gov/msa/forms/eforms.html>

*See DSHS's Enteral Nutrition Program Billing Instructions for more information.

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Memo 09-87

**Prior Authorization
Changes are Highlighted**

Be sure to complete all information requested. Requests that are incomplete will be returned to the provider.

Send one of the completed fax forms listed above to:

Health and Recovery Services Administration
Attn: Provider Request/Client Notification Unit
PO Box 45506
Olympia, WA 98504-5506
FAX: 1-360-586-1471

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 DSHS's 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 I.6-I.11 for criteria. If the EPA process is not applicable, an LE must be requested in writing and receive DSHS approval prior to providing the service.

The written request must state all of the following:

1. The name and PIC number of the client;
2. The provider's name, provider number 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.

Complete one of the following forms for LEs:

- Basic Information Form, DSHS 13-756; or
- Physical, Occupational, and Speech Therapy Limitation Extension Request Form, DSHS 13-786.

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Memo 09-87

**Prior Authorization
Changes are Highlighted**

Send or fax your written request for a limitation extension to:

DSHS-Health and Recovery Services Administration
Provider Request/Client Notification Unit
PO Box 45506
Olympia, WA 98504-5506
FAX: 1-360-586-1471

Expedited Prior Authorization (EPA)

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

To bill DSHS 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 **87000 or 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 I.6-I.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.

DSHS denies claims submitted without a required EPA number.

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

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

Which services require EPA?

DSHS requires EPA for services noted in WAC, DSHS's billing instructions, and/or fee schedules as needing EPA.

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

Code	Criteria	Code	Criteria
<p>Cochlear Implants CPT: 69930 Dx.: 389.10-389.18</p> <p>DSHS will only reimburse for cochlear implantation when the products come from a vendor with a Core Provider Agreement with DSHS.</p> <p>Note: Bilateral cochlear implantation requires prior authorization.</p>		<p>f) Client does not have lesions in the auditory nerve and/or acoustic areas of the central nervous system; and</p> <p>g) There are no other contraindications to surgery.</p> <p>Note: Replacement parts for cochlear implants have been moved to the Hearing Aids & Services Program. Refer to the DSHS/HRSA Hearing Aids & Services Billing Instructions for more information.</p>	
423	<p>When one of the following is true:</p> <p>1) Unilateral cochlear implantation for adults (age 18 and older) with post-lingual hearing loss and children (age 12 months-17 years) with prelingual hearing loss when all of the following are true:</p> <p>a) The client has a diagnosis of profound to severe bilateral, sensorineural hearing loss;</p> <p>b) The client has stimulable auditory nerves but has limited benefit from appropriately fitted hearing aids (e.g., fail to meet age-appropriate auditory milestones in the best-aided condition for young children, or score of less than ten or equal to 40% correct in the best-aided condition on recorded open-set sentence recognition tests;</p> <p>c) The client has the cognitive ability to use auditory clues;</p> <p>d) The client is willing to undergo an extensive rehabilitation program;</p> <p>e) There is an accessible cochlear lumen that is structurally suitable for cochlear implantation;</p>	<p>Dispensing/Fitting Fees for Glasses CPT: 92340-92342</p> <p>615 Glasses (both frames and lenses) – Due to loss or breakage for adults - within 2 years of last dispensing glasses may be replaced when glasses are broken or lost and all of the following are documented in the client’s record:</p> <p>1) Copy of current prescription (less than 18 months old); and</p> <p>2) Date of last dispensing; and</p> <p>3) Both frames and lenses are broken or lost.</p> <p>Note: You do not need an EPA # when billing for children or clients with developmental disabilities.</p>	<p>Dispensing/Fitting Fees for Frames Only CPT: 92340-92342</p> <p>618 Replacement Frames –Due to loss or breakage: For adults - lost or broken frames may be replaced when all of the following are documented in the client’s record:</p> <p>1) No longer covered under the manufacturer’s 1 year warranty; and</p>

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Physician-Related Services

Code	Criteria	Code	Criteria
	2) Copy of current prescription demonstrating the medical necessity for prescription eye wear; (see pg. C.3) and 3) Documentation of broken or lost frames. <div style="border: 1px solid black; background-color: #e0f0ff; padding: 5px; margin: 5px 0;"> Note: You do not need an EPA # when billing for children or clients with developmental disabilities. </div>		
619	Durable Frames for adults and children - when the following is documented in the client's record: 1) The client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period.	623	Replacement eyeglass lenses – Due to loss or breakage: For adults, lost or broken lenses may be replaced when all of the following are documented in the client's record: 1) Copy of current prescription (prescription is less than 18 months old); and 2) Date of last dispensing (if known); and 3) Documentation of lens damage or loss. <div style="border: 1px solid black; background-color: #e0f0ff; padding: 5px; margin: 5px 0;"> Note: You do not need an EPA # when billing for children or clients with developmental disabilities. </div>
620	Flexible Frames for adults and children - when the following is documented in the client's record: 1) The client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period.	624	Replacement eyeglass lenses – Due to headaches/blurred vision/difficulty with school or work: For adults and children - within 2 years of last dispensing, for refractive changes (provider error is the responsibility of the provider to warranty their work and replace the lens at no charge) when all of the following are documented in the client's record: 1) The client has symptoms e.g., headaches, blurred vision, difficulty with school or work; and 2) Copy of current prescription (prescription is less than 18 months old for adults); and 3) Date of last dispensing, if known; and 4) Absence of a medical condition that is known to cause temporary visual acuity changes (e.g. diabetes, pregnancy); and 5) A refractive change of at least .75 diopter or greater between the sphere or cylinder correction in at least one eye.
Dispensing/Fitting Fees for Lenses Only CPT: 92340 - 92342			
622	Replacement eyeglass lenses - Due to eye surgery/effects of prescribed medication/diseases affecting vision: For adults and children - within 2 years of last dispensing when: 1) The client has a stable visual condition (see Definition section); and 2) The client's treatment is stabilized; and 3) The lens correction must have a 1.0 or greater diopter change between the sphere or cylinder correction in at least one eye; and 4) The previous and new refraction must be documented in the client record.		

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Physician-Related Services

Code	Criteria	Code	Criteria
625	<p>High index eyeglass lenses for adults and children when one of the following is documented in the client’s record:</p> <ol style="list-style-type: none"> 1) A spherical refractive correction of +\ - 8.0 diopters or greater; or 2) A cylinder correction of +\ - 3.0 diopters or greater. 		
<p>Dispensing/Fitting Fees for Contacts CPT: 92070, 92310-92317</p>		<p>Hyperbaric Oxygen Therapy CPT: 99183 (C1300 is billed for the outpatient facility charge.)</p> <p>425 When both of the following are true:</p> <ol style="list-style-type: none"> 1) The diagnosis is 250.70-250.83; and 2) Hyperbaric Oxygen Therapy is being done in combination with conventional diabetic wound care. 	
621	<p>Replacement Contact Lenses – Due to eye surgery/effects of prescribed medication/diseases affecting vision: For adults - within 1 year of last dispensing when:</p> <ol style="list-style-type: none"> 1) The client has a stable visual condition (see Definition section); and 2) The client’s treatment is stabilized; and 3) The lens correction has a 1.0 or greater diopter change in at least one eye between the sphere or cylinder correction; and 4) The previous and new refraction are documented in the client record. 	<p>Meningococcal Vaccine CPT: 90734 (Conjugate Vaccine – Menactra®)</p> <p>421 Client is 11 years of age through 55 years of age 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. <p>CPT: 90733 (Polysaccharide vaccine – Menomune®)</p>	
	<p>Note: You do not need an EPA # when billing for children or clients with developmental disabilities.</p>	<p>424 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:</p> <ol style="list-style-type: none"> 1) The client is one of the following: <ol style="list-style-type: none"> 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. 	
627	<p>Replacement Contact Lenses – Due to loss or breakage: For adults - once every 12 months when contact lenses are lost or damaged and the prescription is less than 18 months old.</p>		
	<p>Note: You do not need an EPA # when billing for children or clients with developmental disabilities.</p>		

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Code	Criteria	Code	Criteria
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Orthotics

HCPCS: L3030

780 Foot insert, removable, formed to patient foot.

One (1) pair allowed in a 12-month period if one of the following criteria is met:

- 1) Severe arthritis with pain;
- 2) Flat feet or pes planus with pain;
- 3) Valgus or varus deformity with pain;
- 4) Plantar fasciitis with pain; or
- 5) Pronation.

Note:

- 1) If the medical condition does not meet one of the above specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 800.292.8064.
- 2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.

HCPCS: L3310 & L3320

781 Lift, elevation, heel & sole, per inch.

Allowed for as many inches as required (has to be at least one inch), for a client with a leg length discrepancy, on one shoe per 12-month period.

HCPCS: L3334

782 Lift, elevation, heel, per inch

Allowed for as many inches as required (has to be at least one inch), for a client with a leg length discrepancy, on one shoe per 12-month period.

Note:

- 1) Lifts are not covered for less than one (1) inch.
- 2) Lifts are only allowed on one (1) pair of client shoes.
- 3) If the medical condition does not meet one of the above-specified criteria, you must obtain prior authorization by submitting a request in writing to DMM (see *Important Contacts*) or by calling the authorization toll-free number at 800.292.8064.
- 4) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.

HCPCS: L3000

784 Foot insert, removable, molded to patient model, "UCB" type, Berkeley Shell, each

Purchase of one (1) pair per 12-month period for a client 16 years of age or younger allowed if any of the following criteria are met:

- 1) Required to prevent or correct pronation;
- 2) Required to promote proper foot alignment due to pronation; or
- 3) For ankle stability as required due to an existing medical condition such as hypotonia, Cerebral Palsy, etc.

Code	Criteria	Code	Criteria
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Note:

- 1) If the medical condition does not meet one of the above-specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
- 2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.
- 3) If the client only medically requires one orthotic, right or left, prior authorization must be obtained.

HCPCS: L3215 or L3219

785 Orthopedic footwear, woman's or man's shoes, oxford.

Purchase of one (1) pair per 12-month period allowed if any of the following criteria are met:

- 1) When one or both shoes are attached to a brace;
- 2) When one or both shoes are required to accommodate a brace with the exception of L3030 foot inserts;
- 3) To accommodate a partial foot prosthesis; or
- 4) To accommodate clubfoot.

Note:

DSHS does not allow orthopedic footwear for the following reasons:

- 1) To accommodate L3030 orthotics;
- 2) Bunions;
- 3) Hammer toes;
- 4) Size difference (mismatched shoes); or
- 5) Abnormal sized foot.

**Reduction Mammoplasties/
Mastectomy for Gynecomastia**

CPT: 19318, 19300

DX: 611.1 and 611.9 only

241 A female with a diagnosis for *hypertrophy of the breast* with:

- 1) Photographs in client's chart, *and*
- 2) Documented medical necessity including:
 - a) Back, neck, and/or shoulder pain for a minimum of one year, directly attributable to macromastia, *and*
 - b) Conservative treatment not effective; *and*
- 3) Abnormally large breasts in relation to body size with shoulder grooves, *and*
- 4) Within 20% of ideal body weight, *and*
- 5) Verification of minimum removal of 500 grams of tissue from each breast.

242 A male with a diagnosis for **gynecomastia**:

- 1) Pictures in clients' chart, *and*
- 2) Persistent tenderness and pain, *and*
- 3) If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than one year.

**Other Reduction Mammoplasties/
Mastectomy for Gynecomastia for a Male or
Female with Diagnosis of 611.1 Or 611.9**

CPT®: 19300 and 19318

250 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

Code	Criteria	Code	Criteria
Blepharoplasties		Neuropsychological Testing	
CPT: 15822, 15823, and 67901-67908,		CPT: 96118 and 96119	
630	Blepharoplasty for noncosmetic reasons when <i>both</i> of the following are true: <ol style="list-style-type: none"> 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. 	1207	Refer to Section E for criteria.
Strabismus Surgery		Laboratory Testing	
CPT: 67311-67340		CPT: 83900, 83909, 88384, and 88385	
DX: 368.2		1209 Limited to 15 donor screenings when both of the following criteria is met: <ol style="list-style-type: none"> 1) The client is undergoing or has had a hematopoietic cell transplant; and 2) The transplant is being done at a DSHS-approved Center of Excellence. 	
631	Strabismus surgery for clients 18 years of age and older when <i>both</i> of the following are true: <ol style="list-style-type: none"> 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. 	Injection, Romiplostim, 10 Micrograms	
Visual Exam/Refraction (Optometrists/Ophthalmologists only)		HCPCS: J2796	
CPT: 92014-92015		1300 All of the following must apply: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> a. Immunoglobulin treatment; and b. Corticosteroid treatment; or c. Splenectomy. 	
610	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: <ol style="list-style-type: none"> 1) Glasses that are broken or lost or contacts that are lost or damaged; and 2) Last exam was at least 18 months ago. 		
<div style="border: 1px solid black; background-color: #e0f0ff; padding: 5px;"> <p>Note: You do not need an EPA # when billing for children or clients with developmental disabilities.</p> </div>			

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DSHS-Approved Centers of Excellence (COE)

[Refer to WAC 388-531-0650]

DSHS pays for medically necessary transplant procedures only for eligible DSHS 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.

DSHS covers the following transplant procedures when the transplant procedures are performed in a hospital designated by DSHS 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.

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

DSHS 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. DSHS requires PA for more than 15 tests. Use the recipients PIC code 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.

DSHS does not pay for experimental transplant procedures. In addition, DSHS 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.

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(Rev. 12/31/2009)(Eff. 01/01/2010)

- I.12 -

Memo 09-87

Centers of Excellence
Changes are Highlighted

Physician-Related Services

DSHS 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 DSHS-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 DSHS-approved hospital and **requires PA**.

Providers must bill with their approved COE facility provider number using the following billing guidelines:

- Electronic billers (837p) must put the COE approved facility provider number in the Comments field of the electronic claim.
- Paper billers must put the COE approved facility provider number in field 32 on the CMS-1500 claim form.

Note: When private insurance or Medicare has paid as primary insurance and you are billing DSHS as secondary insurance, DSHS does not require PA or that the transplant, sleep study, or bariatric surgery be done in a Center of Excellence or DSHS-approved hospital.

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

To view the DSHS-Approved Centers of Excellence list for both Sleep Study and Transplant Centers of Excellence visit DSHS on line at: <http://hrsa.dshs.wa.gov/HospitalPymt/>

DSHS-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 DSHS sleep center's provider number where the sleep study/polysomnogram or multiple sleep latency testing was performed. (Refer to previous page for appropriate location of DSHS-approved sleep center.) Enter the COE provider number in box 32 on the CMS-1500 Claim Form. When billing electronically, note the COE provider number 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 provider number in field 32. When billing electronically, note the COE provider number in the *Comments* section.

Sleep Center Physician Consultations and Referral for Cognitive Behavioral Therapy (CBT)

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

DSHS 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.

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

DSHS 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

DSHS 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 DSHS a completed “Bariatric Surgery Request” form, DSHS # 13-785, to:

DSHS-Health and Recovery Services Administration
 Attn: Medical Request Coordinator
 PO Box 45506
 Olympia, WA 98504-5506
 FAX: 1-360-586-1471

DSHS 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

For dates of service on and after January 1, 2010, DSHS 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 DSHS.

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

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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, **DSHS**'s fee schedule amounts are established using three relative value unit (RVU) components: work, practice expense, and malpractice expense. **DSHS** uses two levels of practice expense components to determine the fee schedule amounts for reimbursing professional services. This may result in two RBRVS maximum allowable fees for a procedure code. These are:

- **Facility setting maximum allowable fees (FS Fee)** - Paid when the provider performs the services in a facility setting (e.g., a hospital or ambulatory surgery center) and the cost of the resources are the responsibility of the facility; or
- **Nonfacility setting maximum allowable fees (NFS Fee)** - Paid when the provider performs the service in a nonfacility setting (e.g., office or clinic) and typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the service performed.

Some services, by nature of their description, are performed only in certain settings and have only one maximum allowable fee per code. Examples of these services include:

- Evaluation and management (E&M) codes which specify the site-of-service (SOS) within the description of the procedure codes (e.g., initial hospital care); and
- Major surgical procedures that are generally performed only in hospital settings.

How does the SOS payment policy affect provider payments?

Providers billing professional services are paid at one of two maximum allowable fees, depending on where the service is performed.

Does **DSHS** pay providers differently for services performed in facility and nonfacility settings?

Yes. When a provider performs a professional service in a facility setting, **DSHS** makes two payments - one to the performing provider and another to the facility. The payment to the provider (FS Fee) includes the provider's professional services only. A separate payment is made directly to the facility where the service took place, which includes payment for necessary resources. The FS Fee excludes the allowance for resources that are included in the payment to the facility. Paying the lower FS Fee to the performing provider when the facility is also paid eliminates duplicate payment for resources.

When a provider performs a professional service in a nonfacility setting, **DSHS** 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 **DSHS** also makes a payment to a facility. In most cases, **DSHS** 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

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Physician-Related Services

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: Reminder: all claims submitted to **DSHS** must include the appropriate Medicare **two-digit place of service code**. Claims with single-digit place of service codes will be denied.

Due to Medicare’s consolidated billing requirements, **DSHS** 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 **DSHS** 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, **DSHS** 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

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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: Reminder: All claims submitted to **DSHS** must include the appropriate Medicare **two-digit place of service code**. Claims with single-digit place of service codes will be denied.

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, **DSHS** identifies procedure codes that may require prior authorization. However, this list may not be all-inclusive. Prior authorization, limitations, or requirements detailed in **DSHS/HRSA** billing instructions and Washington Administrative Code (WAC) remain applicable.
- Section L contains rate setting methodology and unit rounding instructions for injectable drug codes.
- Many of the **DSHS/HRSA** fee schedules are available for download in Excel format at the **DSHS/HRSA** website at <http://hrsa.dshs.wa.gov>. To view a current fee schedule, click **Provider Publications/Fee Schedules**, then **Accept**, then **Fee Schedules**.

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Medical Supplies and Equipment

General Payment Policies

- DSHS 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.5).
- 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). DSHS pays providers separately for only those MSE listed beginning on page K.5.
- DSHS 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 DSHS upon request. **DO NOT send in an invoice with a claim** for MSE under \$50.00 unless requested by DSHS.
- 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: To request prior authorization for MSE, write or fax:

DSHS-Health and Recovery Services Administration
DME Program Management Unit
PO Box 45506
Olympia, WA 98504-5506
1-360-586-5299 (fax)

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. DSHS 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

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

Physician-Related Services

HCPCS Code	Brief Description
A4649	Surgical supply; miscellaneous
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 dose 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: DSHS does not pay providers for L8603 and L8606 if the implants are done outside the physician's office.

DSHS 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

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

DSHS follows Medicare's drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, DSHS prices the drug at 84% of the Average Wholesale Price (AWP). DSHS updates the rates each time Medicare's rate is updated, up to once per quarter. Unlike Medicare, the DSHS 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, DSHS 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, DSHS multiplies the amount by 0.84 to arrive at the fee schedule maximum allowance.

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).
- DSHS follows Medicare's drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, DSHS 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.
- DSHS follows Medicare's drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, DSHS 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, DSHS 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 DSHS'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, DSHS 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 DSHS'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 DSHS for a drug using an unlisted drug code, providers must report the National Drug Code (NDC) of the drug administered. DSHS uses the NDC when unlisted drug codes are billed to appropriately price the claim. 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.

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 "Comment" section of the claim.

For claims billed using a paper CMS-1500 Claim Form, list the required information in field 19 of the claim form.

See Section C of these billing instructions for more detailed information on NDC billing. An invoice is required when billing.

Note: If there is an assigned HCPCS code for the administered drug, providers **must bill** DSHS using the appropriate HCPCS code. **DO NOT** bill using an unlisted drug code for a drug that has an assigned HCPCS code. DSHS 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 DSHS's web site at:

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

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Memo 09-87

Injectable Drug Codes
Changes are Highlighted

CPT/HCPCS Modifiers

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

Italics indicate additional DSHS 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 DSHS/HRSA 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.

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Memo 09-87

CPT/HCPCS Modifiers
Changes are Highlighted

- 32: **Mandated Services:** *For informational purposes only; no extra allowance is allowed.*
- 47: **Anesthesia By Surgeon:** *Not covered by DSHS.*
- 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 DSHS/HRSA maximum allowable, whichever is less.

For surgical procedures that are typically performed on one side of the body, but performed bilaterally in a specific case, payment is 150% of the global surgery fee for the procedure.

- 51: **Multiple Procedures:** *When multiple surgeries are performed at the same operative session, total payment is equal to the sum of the following: 100% of the highest value procedure; 50% of the global fee for each of the second through fifth procedures. More than five procedures require submission of documentation and individual review to determine the payment amount.*
- 52: **Reduced Services:** Under certain circumstances, a service or procedure is partially reduced at the physician's discretion. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of the modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. *Using this modifier does not reduce the allowance to the provider. Note: Modifier 52 may be used with computerized tomography procedure codes for a limited study or a follow-up study.*
- 53: **Discontinued Procedure:** Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.

Use of modifier 53 is allowed for all surgical procedures. Modifier 53 is a payment modifier when used with CPT code 45378 and HCPCS codes G0105 and G0121 only. It is "information only" for all other surgical procedures.

54, 55, 56 – Providers providing less than the global surgical package should use modifiers 54, 55, & 56. *These modifiers are designed to ensure that the sum of all allowances for all practitioners who furnished parts of the services included in a global surgery fee do not exceed the total amount of the payment that would have been paid to a single practitioner under the global fee for the procedure. The payment policy pays each physician directly for that portion of the global surgery services provided to the client. The breakdown is as follows:*

- 54: **Surgical Care Only:** When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number. *A specific percentage of the global surgical payment in the fee schedule is made for the surgical procedure only.*
- 55: **Postoperative Management Only:** When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier 55 to the usual procedure number. *A specific percentage of the global surgical payment in the fee schedule is made for the surgical procedure only.*
- 56: **Preoperative Management Only:** When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by adding the modifier 56 to the usual procedure number. *A specific percentage of the global surgical payment in the fee schedule is made for the surgical procedure only.*
- 57: **Decision for Surgery:** An evaluation and management (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

- 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 provider number and must bill on the same claim form as the physician/surgeon. 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 provider number must be entered in the performing number field on the 1500 Claim Form or electronic claim record. The reference lab must be CLIA-certified.*

- 91: **Repeat Clinical Diagnostic Laboratory Test** performed on the same day to obtain subsequent report test value(s). *Modifier 91 must be used when repeat tests are performed on the same day, by the same provider to obtain reportable test values with separate specimens taken at different times, only when it is necessary to obtain multiple results in the course of treatment. When billing for a repeat test, use modifier 91 with the appropriate procedure code.*
- 99: **Multiple Modifiers:** Under certain circumstances, two or more modifiers may be necessary to completely describe a service. *Modifier 99 must be used when two or more modifiers affect pricing. All applicable modifiers must be listed in the modifier field of the HIPAA transaction (field 24D of CMS-1500). Modifier 99 must be the first modifier listed on the claim.*
- 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. *HRSA 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. *HRSA 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 HRSA is required if services are performed in a hospital setting.*
- TG **Complex/high level of care.**

Physician-Related 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 HRSA.***

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 general billing requirement in DSHS's [General Information Booklet](http://hrsa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html) (<http://hrsa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html>).

These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims;
- What fee to bill DSHS for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCPM) 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 to be considered for payment.

Completing the CMS-1500 Claim Form

Refer to DSHS's current *General Information Booklet* for instructions on completing the CMS-1500 Claim Form.

You may download this booklet from DSHS's website at:

<http://hrsa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html>.

Instructions Specific to Physicians

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 DSHS 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 DSHS. If the claim is not received by DSHS, 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 DSHS's current *Tribal Health Program Billing Instructions*.

What Does DSHS 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.