

Washington Apple Health (Medicaid)

Sleep Centers Billing Guide

January 1, 2019

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect January 1, 2019. It is a compilation taken from several guides detailing information on Sleep Studies.

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Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

Refer also to the agency's [ProviderOne Billing and Resource Guide](#) for additional information about agency billing.

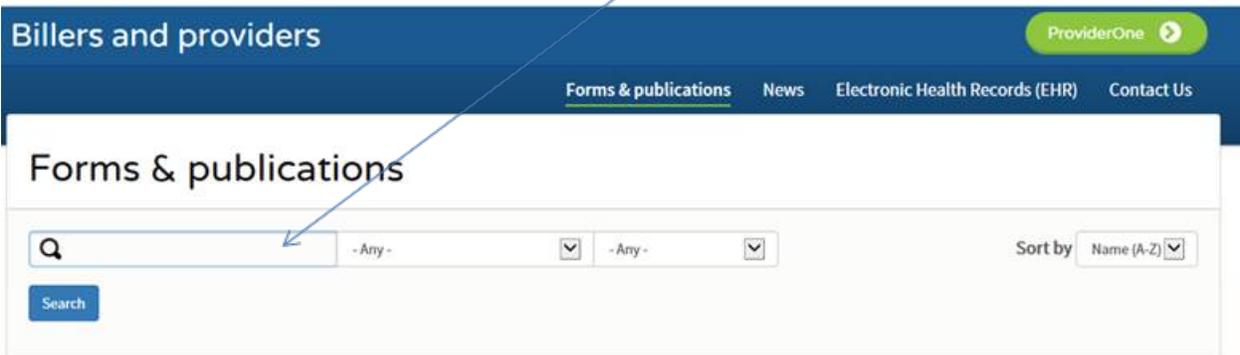
* This publication is a billing instruction.

What has changed?

Subject	Change	Reason for Change
Client Eligibility: BHO, Changes for January 1, 2019, IMC, and Integrated Apple Health Foster Care	Effective January 1, 2019 , some existing integrated managed care regions have new counties and many new regions and counties will be implemented.	Apple Health managed care organizations (MCOs) in certain RSAs will expand their coverage of behavioral health services (mental health and substance use disorder treatment), along with continuing to cover physical health services.
Mandibular Advancement Device	Added coverage for mandibular advancement devices (MAD), including prior authorization information, exclusions, and payment information.	New procedure code
Equipment and supplies	Added codes G0454 and 99446 under prescribing information for medical equipment and supplies and home health services	Updated to align with federal regulations and new WAC
Rental and Purchase of a CPAP device	Added reminder to blue note box that a prescription for CPAP machine must not be older than one year from the date the prescriber signs the prescription.	Clarification

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and provider's webpage, select [Forms & publications](#). Type the HCA form number into the **Search box** as shown below (Example: 13-835).



The screenshot shows the 'Billers and providers' section of the Washington State Health Care Authority website. The 'Forms & publications' sub-section is active. A search bar is present with a magnifying glass icon, a search button, and two dropdown menus set to '- Any -'. A 'Sort by' dropdown is set to 'Name (A-Z)'. A blue arrow points from the top right towards the search bar.

How can I get agency provider documents?

To download and print agency provider notices and billing guides, go to the agency's [Provider billing guides and fee schedules](#) website.

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Resources Available

Topic	Contact Information
<p>How do I obtain prior authorization or a limitation extension?</p>	<p>For all requests for prior authorization or limitation extensions, both these forms are required:</p> <ul style="list-style-type: none"> • A completed, TYPED <i>General Information for Authorization</i> form, HCA 13-835. This request form must be the initial page when you submit your request. <p>See Where can I download agency forms? Fax your request to: 866-668-1214.</p>
<p>How do I check on the status of a request for prior authorization or limitation extension?</p>	<ul style="list-style-type: none"> • Call 800-562-3022 and select the topic • Call 800-562-3022, extension 15471
<p>How do I get answers for billing questions?</p>	<p>Call 800-562-3022 and ask for the billing extension.</p>
<p>How do I obtain information regarding the Sleep Centers and Sleep Medicine Program?</p>	<p>Do one of the following:</p> <ul style="list-style-type: none"> • Contact the Billers and Providers "contact us" webpage • Contact the Sleep Centers and Sleep Medicine program manager at: Division of Health Care Services/CQCT Health Care Authority P.O Box 45506 Olympia, WA 98504-5506
<p>Who do I contact if I have a reimbursement question?</p>	<p>Cost Reimbursement Analyst Professional Reimbursement PO Box 45510 Olympia, WA 98504-5510</p>

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to [Chapter 182-500 WAC](#) for a complete list of definitions for Washington Apple Health.

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.

Apnea – The cessation of airflow for at least ten seconds

Apnea-hypopnea index (AHI) – The average number of episodes of apnea and hypopnea per hour of sleep without the use of a positive airway pressure device. For purposes of this chapter, respiratory effort related arousals (RERAs) are not included in the calculation.

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.

American Academy of Sleep Medicine (AASM) - The only professional society dedicated exclusively to the medical subspecialty of sleep medicine. AASM sets standards and promotes excellence in health care, education, and research. Members specialize in studying, diagnosing, and treating disorders of sleep and daytime alertness such as insomnia, narcolepsy, and obstructive sleep apnea.

Bundled services – Services integral to the major procedures that are included in the fee for the major procedure. Bundled services are not reimbursed separately.

Central sleep apnea (CSA) – Is defined as meeting all the following criteria:

- An apnea-hypopnea index (AHI) greater than or equal to 5.
- Central apneas/hypopneas greater than 50% of the total apneas/hypopneas.
- Central apneas or hypopneas greater than or equal to 5 times per hour.
- Symptoms of either excessive sleepiness or disrupted sleep.

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.

Complex Sleep Apnea (CompSA) – A form of central apnea specifically identified by the persistence or emergence of central apneas or hypopneas, upon exposure to CPAP or a bi-level respiratory assist device without a back-up rate feature, when obstructive events have disappeared. These clients have predominantly obstructive or mixed apneas during the diagnostic sleep study occurring at greater than or equal to five times per hour. With use of a CPAP or bi-level respiratory assist device without a back-up rate feature, the client shows a pattern of apneas and hypopneas that meets the definition of central sleep apnea (CSA).

Continuous positive airway pressure (CPAP)- A single-level device which delivers a constant level of positive air pressure (within a single respiratory cycle) by way of tubing and an interface to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs.

Core provider agreement" or "CPA" - The basic contract the agency holds with providers serving medical assistance clients.

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.

Hypopnea – A temporary reduction of airflow lasting at least ten seconds and accompanied with a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% decrease in oxygen saturation. The AHI is the average number of episodes of apnea and hypopnea per hour of sleep without the use of a positive airway pressure device.

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

- (1) Disclosed and discussed the client's diagnosis
- (2) Offered the client an opportunity to ask questions about the procedure and to request information in writing
- (3) Given the client a copy of the consent form
- (4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257
- (5) Given the client oral information about all of the following:
 - a. The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure
 - b. Alternatives to the procedure including potential risks, benefits, and consequences
 - c. The procedure itself, including potential risks, benefits, and consequences

"Multiple sleep latency test" or "MSLT"

- A sleep disorder diagnostic tool used to measure the time elapsed from the start of a daytime nap period to the first signs of sleep, called sleep latency. The MSLT is used extensively to test for narcolepsy, to distinguish between physical tiredness and true excessive daytime sleepiness, or to assess whether treatments for breathing disorders are working.

Month – For the purposes of this guide, means 30 days, regardless of the number of days in a specific calendar month.

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

"Obstructive sleep apnea" or "OSA" This syndrome refers to the interruption of breathing during sleep, due to obstructive tissue in the upper airway that collapses into the air passage with respiration

Polysomnogram - The test results from a polysomnography

"Polysomnography" - A multiparametric test that electronically transmits and records specific physical activities while a person sleeps. The recordings become data that are analyzed by a qualified sleep specialist to determine whether or not a person has a sleep disorder.

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.

Registered polysomnographic technologist" or "RPSGT"

- A sleep technologist credentialed by the board of registered polysomnographic technologists to assist sleep specialists in the clinical assessment, physiological monitoring and testing, diagnosis, management, and prevention of sleep-related disorders with the use of various diagnostic and therapeutic tools. These tools include, but are not limited to, polysomnograph, positive airway pressure devices, oximeter, capnograph, actigraph, nocturnal oxygen, screening devices, and questionnaires. To become certified as a registered polysomnographic technologist, a sleep technologist must have the necessary clinical experience, hold CPR certification or its equivalent, adhere to the board of registered polysomnographic technologists standards of conduct, and pass the registered polysomnographic technologist examination for polysomnographic technologists.

Respiratory Effort Related Arousals (RERA)

– These occur when there is a sequence of breaths that lasts at least ten seconds, characterized by increasing respiratory effort or flattening of the nasal pressure waveform, which lead to an arousal from sleep. However, they do not meet the criteria of an apnea or hypopnea. The degree to which RERAs are associated with the same sequelae as apneas and hypopneas is unknown, although clients with only RERAs can be symptomatic in terms of excessive daytime sleepiness.

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

RUL – Also called Reasonable Useful Lifetime.

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

About the Program

(WAC [182-531-1500](#))

What is the purpose of the Sleep Centers and Medicine program?

The purpose of the Sleep Centers and Medicine program is to provide medically necessary diagnostics, equipment, services, and supplies to eligible agency clients who are not enrolled in a managed care plan and reside in:

- A home
- A community residential setting
- A skilled nursing facility

When does the agency pay for sleep center and sleep medicine related care?

The agency pays when it is:

- Prescribed by the client's physician.
- Medically necessary, as defined under WAC [182-500-0070](#).
- Performed by an agency-designated center of excellence (COE) that is an independent diagnostic testing facility, sleep laboratory, or outpatient hospital
- Billed according to this billing guide.
- Provided and used within accepted medical care community standards of practice.

The agency pays when the results are used to:

- Establish a diagnosis of narcolepsy or sleep apnea; or
- Evaluate a client's response to therapy, such as continuous positive airway pressure (CPAP)

Becoming an agency-approved Center of Excellence (COE)

To become an agency-approved COE, a sleep center must send the following documentation to the Health Care Authority, Provider Enrollment, P.O. Box 45510, Olympia, WA 98504-5510:

- A completed Core Provider Agreement
- A copy of the sleep center's current accreditation certificate by the American Academy of Sleep Medicine (AASM)

Note: Sleep centers must request reaccreditation from AASM in time to avoid expiration of COE status with the agency.

At least one physician on staff at the sleep center must be board certified in sleep medicine. If the only physician on staff who is board certified in sleep medicine resigns, the sleep center must ensure another physician on staff at the sleep center obtains board certification or another board certified physician is hired. The sleep center must then send Provider Enrollment a copy of the physician's board certification.

If a certified medical director leaves a COE, the COE status does not transfer with the medical director to another sleep center.

The COE must maintain a record of the physician's order for the sleep study.

Client Eligibility

(WAC [182-540-110\(1\)](#))

Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the agency's [Apple Health managed care page](#) for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Is the client enrolled in an agency-contracted managed care organization (MCO), in a behavioral health organization (BHO), or is the client receiving services through fee-for-service (FFS) Apple Health?

Verifying eligibility is a two-step process:

Step 1. Verify the patient's eligibility for Apple Health. For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's [ProviderOne Billing and Resource Guide](#).

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. Verify service coverage under the Apple Health client's benefit package. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's [Program Benefit Packages and Scope of Services](#) webpage.

Note: Patients who are not Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at:
www.wahealthplanfinder.org
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to:
Washington Healthplanfinder
PO Box 946
Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

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

(WAC [182-531-1500](#))

Yes. Most Medicaid-eligible clients are enrolled in one of the agency's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an agency-contracted MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in [WAC 182-502-0160](#).

Note: To prevent billing denials, check the client's eligibility **prior** to scheduling services and at the **time of the service**, and make sure proper authorization or referral is obtained from the agency-contracted MCO, if appropriate. See the agency's [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility.

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's [Get Help Enrolling](#) page.
- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Behavioral Health Organization (BHO)

The Health Care Authority manages the contracts for behavioral health services (mental health and substance use disorder) for the following four Regional Service Areas (RSAs):

- **Great Rivers:** Includes Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties
- **North Sound:** Includes Island, San Juan, Skagit, Snohomish, and Whatcom counties
- **Salish:** Includes Clallam, Jefferson, and Kitsap counties
- **Thurston-Mason:** Includes Thurston and Mason counties

To view a map and table of the integrated managed care plans available within each region, please see [Changes coming to Washington Apple Health](#). You may also refer to the agency's [Apple Health managed care webpage](#).

See the agency's [Mental Health Services Billing Guide](#) for details.

Apple Health – Changes for January 1, 2019

Effective January 1, 2019, agency-contracted managed care organizations (MCOs) in certain Region Service Areas (RSAs) will expand their coverage of behavioral health services (mental health and substance use disorder treatment), along with continuing to cover physical health services. The RSAs are outlined in the [Integrated Managed Care Regions](#) section.

Apple Health clients who are not enrolled in an agency-contracted MCO for their physical health services (e.g., dual-eligible Medicare-Medicaid clients) will still receive their behavioral health services through one of the agency-contracted MCOs. The MCO will provide only behavioral health services for the client.

Most clients will remain with the same health plan, except in regions where client's plan will no longer be available. HCA will auto-enroll these clients to one of the offered plans.

Clients can change their plan at any time by:

- Visiting the [ProviderOne Client Portal](#).
- Calling Apple Health Customer Service toll-free at 1-800-562-3022. This automated system is available 24 hours a day, 7 days a week.
- Requesting a change online through our secure [Contact us – Apple Health \(Medicaid\) client web form](#). Select the topic “Enroll/Change Health Plans.”

Visiting the [Washington Healthplanfinder](#) (only for clients with a Washington Healthplanfinder account).

Integrated managed care

For clients who live in an integrated managed care region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted MCO. The BHO will not provide behavioral health services in these regions.

Clients living in an integrated managed care region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

American Indian/Alaska Native (AI/AN) clients living in an integrated managed care region of Washington may choose to enroll in one of the agency-contracted MCOs available in that region or they may choose to receive all these services through Apple Health FFS. If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's [American Indian/Alaska Native webpage](#).

For more information about the services available under the FFS program, see the agency's [Mental Health Services Billing Guide](#) and the [Substance Use Disorder Billing Guide](#).

For full details on integrated managed care, see the agency's [Changes to Apple Health managed care webpage](#).

Integrated managed care regions

Clients who reside in the following integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Specific details, including information about mental health crisis services, is located on the agency's [Apple Health managed care webpage](#).

Existing integrated managed care regions – Expanding January 1, 2019

- **North Central** (Chelan, Douglas, Grant, and Okanogan counties)
The agency expanded this region to include Okanogan county
- **Southwest Washington** (Clark, Klickitat, and Skamania counties)
The agency expanded this region to include Klickitat county

New integrated managed care regions – Effective January 1, 2019

The following new regions are implemented for integrated managed care:

- **Greater Columbia** (Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman counties)
- **King** (King County)
- **Pierce** (Pierce County)
- **Spokane** (Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties)

Integrated Apple Health Foster Care (AHFC)

Effective January 1, 2019, children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington’s (CCW) Apple Health Foster Care program will receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as
“Coordinated Care Healthy Options Foster Care.”

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Administrative Services Organization (BH-ASO). For details, see the agency’s [Mental Health Services Billing Guide](#), under *How do providers identify the correct payer?*

Provider Requirements

What are the general responsibilities of a sleep center/sleep medicine provider?

(WAC [182-531-1500](#))

This section includes general responsibilities for sleep centers and sleep medicine providers. More specific requirements are described in different sections of this guide.

Providers must meet the general provider requirements in chapters [182-502](#) and [182-552](#) WAC and this billing guide.

To be paid for providing sleep studies to eligible clients, the facility must be a Sleep Study Center of Excellence:

- See the agency's approved [COEs for sleep centers](#)
- Be currently accredited by the American Academy of Sleep Medicine (AASM) and continuously meet the accreditation standards of AASM
- Have at least one physician on staff who is board certified in sleep medicine.
- Have at least one registered polysomnographic technologist (RPSGT) in the sleep lab when studies are being performed.

Are providers responsible to verify a client's coverage?

- Providers must verify the client's eligibility in ProviderOne before providing services.
- If ProviderOne indicates the client is enrolled in a managed care plan, contact the client's MCO for all coverage conditions and limits on services. (See [Client Eligibility](#)).
- Bill the agency the usual and customary fee for clients not in managed care and residing at home, in a skilled nursing facility or in a community residential setting.

Note: Also, see [What are the client's rights for health care decisions?](#)

What are the client's rights to health care decisions?

[\(42 CFR §489.102\)](#)

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

Clients have the right to:

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

Coverage

What are the coverage criteria for sleep centers and sleep medicine related services?

This section describes general clinical criteria and policies for sleep centers and sleep medicine services and equipment.

Sleep medicine testing (sleep apnea)

[\(WAC 182-531-1500\)](#)

Sleep studies include polysomnography (PSG), unattended home sleep test (HST), and multiple sleep latency testing (MSLT).

The agency covers attended, full-channel, PSG, MSLT, and HSTs when:

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

Coverage for clients age 18 and older

For clients age 18 and older, the agency covers:

- An unattended home sleep test (HST) performed by an agency-designated COE provider as follows:
 - ✓ Using one of the following HST devices:
 - Type II home sleep monitoring device
 - Type III home sleep monitoring device
 - Type IV home sleep monitoring device that measures at least three channels

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

Coverage for clients age 17 and younger

The agency pays for the following types of sleep studies for clients age 17 and younger who meet one of the indications for medical necessity:

- Full-night, in laboratory PSG
- Split-night, in laboratory PSG

Indications for medical necessity:

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

Note: The agency does not consider chronic insomnia and snoring as medically necessary unless an underlying physiology exists such as loud snoring, awakening with gasping or choking, excessive daytime sleepiness, observed cessation of breathing during sleep, etc.

Note: The agency does not pay for a repeat study when documentation does not indicate medical necessity (e.g., no new clinical documentation indicating the need for a repeat study).

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

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

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

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

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

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

Equipment and Supplies

Prescribing information

To comply with federal regulations, medical equipment and supplies must be cosigned by a physician if ordered by a non-physician provider.

- **Medical supplies and equipment.** If the physician is cosigning the order (that was written by a non-physician practitioner) for medical equipment or supplies, the physician may bill using code **G0454**. For all other information regarding medical equipment, see the agency's [Medical Equipment billing guide](#).
- **For home health services.** If the physician is cosigning the order (that was written by a non-physician practitioner) for home health service, the physician may bill using code **99446**. For more information regarding home health, see the agency's [Home health services billing guide](#).

Bi-level respiratory assist devices (RADs)

The agency covers, without prior authorization (PA), one bi-level respiratory assist device (RAD), with or without a back-up rate feature, per client every five years as long as the following criteria are met:

- The bi-level device has a data card.
- The client has a central or complex sleep apnea or hypoventilation syndrome

[PA](#) is required for Bi-Level RADs if either:

- The client does not meet the required clinical criteria; or
- The agency has purchased a CPAP device or other RAD for the client within the last five years.

Bi-level RAD without the back-up rate feature

For a bi-level RAD without the back-up rate feature, the agency:

- Pays for rental of the device during an initial three month period.

The treating authorized prescriber must:

- ✓ Conduct a face-to-face clinical re-evaluation of the client between day 31 and day 91 of the rental period.
- ✓ In order to continue rental of the device, document the following items in the client's file to show:
 - The progress of the client's relevant symptoms.
 - The client's compliance with using the device.
- Purchases the device after the requirements for the rental are met.

Bi-level RAD with the back-up rate feature

For a bi-level RAD with the back-up rate feature used with a noninvasive interface, the agency:

- Pays for rental of the device during an initial three-month period.

The treating authorized prescriber must:

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- ✓ Conduct a face-to-face clinical re-evaluation of the client between 31 and 91 days of the rental period.
- ✓ In order to continue rental of the device, document the following items in the client's file to show:
 - The progress of the client's relevant symptoms.
 - The client's compliance with using the device.
- Purchases the device after a total of 13 months of rental.

Required clinical criteria

Type of Respiratory Disorder	Type of Device Paid by Agency	Prior Authorization (PA)	Required Clinical Criteria
Central or Complex Sleep Apnea (not due to airway obstruction)	Bi-level RAD device <i>with or without</i> the back-up rate feature	No—when the client’s polysomnogram test meets clinical criteria	The client’s polysomnogram test reveals both: <ul style="list-style-type: none"> • The diagnosis of central sleep apnea (CSA) or complex sleep apnea (CompSA). • Significant improvement of the sleep-associated hypoventilation with the use of a bi-level RAD device with or without the back-up rate feature on the settings that will be prescribed for initial use at home, while breathing the client’s usual FIO₂.
Obstructive Sleep Apnea (OSA)	Bi-level RAD device without the back-up rate feature	No—when all clinical criteria are met	The client meets the clinical criteria for a CPAP. However, the CPAP has been tried and proven ineffective. <p>Ineffective in this case, is defined as documented failure to meet therapeutic goals using a CPAP during either:</p> <ul style="list-style-type: none"> • The titration portion of a facility-based study. • Home use despite optimal therapy (that is, proper mask selection and fitting and appropriate pressure setting).

Type of Respiratory Disorder	Type of Device Paid by Agency	Prior Authorization (PA)	Required Clinical Criteria
Hypoventilation Syndrome	Bi-level RAD device without the back-up rate feature	No—when all the clinical criteria are met.	<p>The client meets one of these three sets of clinical criteria:</p> <ul style="list-style-type: none"> • An initial arterial blood gas PaCO₂, done while awake and breathing the client's prescribed FIO₂, \geq to 45 mm Hg. <p style="text-align: center;">-AND-</p> <p>Spirometry shows an FEV₁/FVC \geq to 70% and an FEV₁ \geq 50% of predicted.</p> <p style="text-align: center;">-OR-</p> <ul style="list-style-type: none"> • An arterial blood gas PaCO₂, done during sleep or immediately upon awakening, and breathing the client's prescribed FIO₂, shows the client's PaCO₂ worsened \geq to 7 mm Hg compared to the original result. <p style="text-align: center;">-OR-</p> <ul style="list-style-type: none"> • A facility-based PSG demonstrates oxygen saturation \leq 88% for \geq to 5 continuous minutes of nocturnal recording time (minimum recording time of 2 hours) that is not caused by obstructive upper airway events—that is, AHI less than 5.

Replacement of bi-level RAD equipment and supplies

- PA is required for the replacement of a bi-level RAD device if the client has had the device for less than five years.
- After five years, the client's authorized prescriber must conduct a face-to-face evaluation documenting that the client continues to use and benefit from the bi-level RAD device. A new polysomnogram (PSG) (sleep test), trial period, or PA is not required.
- The agency pays for replacement supplies for a bi-level RAD device, as identified in the [Coverage Table](#).
- For specific details about items covered, see the [Coverage Table](#).

Continuous positive airway pressure (CPAP) and supplies

WAC [182-552-0400](#)

Clinical criteria

The agency covers, without prior authorization (PA), one continuous positive airway pressure (CPAP) device including related supplies, per client, every five years, provided the following criteria are met:

- The client is diagnosed with obstructive sleep apnea using a clinical evaluation and a positive attended polysomnogram (PSG) performed in a sleep laboratory or performed during an unattended home sleep study.

Notes: The agency does not pay for a CPAP device when the client is diagnosed with upper airway resistance syndrome (UARS).

- CPAP is the least costly, most effective treatment modality.
- The CPAP device has a data card and is FDA approved.
- The item requested is not included in any other reimbursement methodology such as the diagnosis-related group (DRG).

Additional criteria for clients age 13 and older

- The client's polysomnogram demonstrates an apnea-hypopnea index (AHI) ≥ 15 events per hour with a minimum of 30 events.

-OR-

- The client's PSG demonstrates the AHI is ≥ 5 and ≤ 14 events per hour with a minimum of 10 events and clinical documentation of one of the following:
 - ✓ Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia.
 - ✓ Hypertension, ischemic heart disease, or history of stroke.

Additional criteria for clients age 12 and younger

Clinical criteria must include:

- A documented diagnosis of obstructive sleep apnea (OSA).
- A PSG that demonstrates an apnea index (AI) or apnea-hypopnea index (AHI) ≥ 1 and one of the following:
 - ✓ Adenotonsillectomy has been unsuccessful in relieving OSA
 - ✓ Adenotonsillar tissue is minimal
 - ✓ Adenotonsillectomy is inappropriate based on OSA being attributable to another underlying cause (such as craniofacial anomaly or obesity) or adenotonsillectomy is contraindicated
 - ✓ The client's family does not wish to pursue surgical intervention

Note: The AHI is calculated on the average number of events per hour. If the AHI is calculated based on less than two hours of sleep or recording time, the total number of recorded events used to calculate the AHI must be at least the number of events that would have been required in a two-hour period (that is, must reach at least 30 events without symptoms or at least 10 events with symptoms).

Use of RAD instead of CPAP

If a client meets the criteria for CPAP, but a CPAP device has been tried and proven ineffective, the agency will cover a bi-level RAD without the back-up.

Ineffective, in this case, means documented failure to meet therapeutic goals using a CPAP during either:

- The titration portion of a facility-based study.
- Home use despite optimal therapy (that is, proper mask selection and fitting and appropriate pressure setting).

Prior authorization for a CPAP device

[PA](#) is required for a CPAP device if either:

- The client does not meet the required [clinical criteria](#).
- The agency has purchased either a CPAP or a bi-level RAD device for the client within the last five years.

Rental and purchase of a CPAP device

After the initial three-month rental period for a CPAP device, the agency will consider purchasing this device for the client.

Note: The provider must submit a purchase request to the agency. A prescription for CPAP machines must not be older than 1 year from the date the prescriber signs the prescription. The following documentation of clinical benefit must be recorded in the client's file:

- A face-to-face clinical re-evaluation of the client by the authorized prescriber, which documents that symptoms of obstructive sleep apnea are improved.
- A review of objective evidence by the authorized prescriber of the client's adherence* to use of the CPAP device.

*Adherence is defined as use of the CPAP device ≥ 4 hours per night on 70% of nights during a consecutive 30-day period anytime during the first 3 months of initial usage.

For specific details about CPAP-related covered items, see the [Coverage Table](#)

Replacement of CPAP equipment and supplies

- PA is required for the replacement of a CPAP device if the client has had the device for less than five years.
- After five years, the client's treating authorized prescriber must conduct a face-to-face evaluation documenting that the client continues to use and benefit from the CPAP device. A new PSG (sleep test), trial period, or PA is not required.
- The agency pays for replacement supplies for a CPAP device, as identified in the [Coverage Table](#).

Mandibular Advancement Devices (Oral Appliances)

CPAP is considered the first line standard of treatment for sleep apnea and should be the first choice for sleep physicians for adult clients with sleep-disordered breathing and daytime sleepiness with mild to moderate obstructive sleep apnea. Sleep physicians should consider oral appliances rather than no treatment for adults intolerant of CPAP or for whom CPAP is contraindicated.

Clinical Criteria

The agency pays for one custom-made (procedure code E0486) mandibular advancement device (MAD), per client age 21 and older, every five years when the following criteria (established by the federal Centers for Medicare & Medicaid Services (CMS) for Medicare and the American Academy of Sleep Medicine (AASM)) are met:

- A face-to-face evaluation with a sleep medicine physician prior to sleep testing is completed in an agency-designated center of excellence (COE)
- Sleep testing criteria for CPAP is met
 - ✓ AHI or RDI \geq 15 per hour with minimum of 30 events **OR**
 - ✓ The AHI or RDI \geq 5 and \leq 14 events per hour with minimum of 10 events and documentation of:
 - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,
 - Hypertension, ischemic heart disease, or history of stroke; or,
 - ✓ If the AHI $>$ 30 or the RDI $>$ 30 and meets either of the following criteria:

- The beneficiary is not able to tolerate a positive airway pressure (PAP) device; or,
- The treating physician determines that the use of a CPAP device is contraindicated.
- The client has tried and failed the use of CPAP. Documentation of at least a 6-month trial period describing why CPAP failed, or reason explaining why CPAP is not the appropriate treatment
- Device is ordered by treating provider post review of sleep study
- The device is provided and billed for by a licensed dentist (DDS or DMD) that meet one of the following criteria:
 - ✓ Certification in dental sleep medicine by a nonprofit organization, such as the American Board of Dental Sleep Medicine (ABDSM);
 - ✓ Designation as the dental director of a dental sleep medicine facility accredited by a non-profit organization, such as the American Academy of Dental Sleep Medicine (AADSM); or
 - ✓ Recognized continuing education in dental sleep medicine provided by a dental sleep medicine focused nonprofit organization or accredited dental school within the last 2 years
- The device must be titrated in a sleep center by a qualified provider who has experience in titrating the MAD
- The client must have their own teeth (no dentures or partials)

Prior Authorization

Prior authorization is required.

Exclusions

Prefabricated (procedure code E0485) appliances are not considered medically necessary due to insufficient evidence and are not covered. This includes:

- Oral occlusal appliances for temporomandibular joint disorder (TMJ)
- Tongue retaining devices used to treat OSA and/or snoring
- All oral appliances used only to treat snoring without a diagnosis of OSA
- Oral appliances used to treat other dental conditions

- Oral appliances that require repeated fitting and/or adjustments, beyond the first 90-days, in order to maintain fit and/or effectiveness

Billing

MAD are considered medical equipment and are subject to the same claims and billing as other medical equipment. To ensure correct payment of a claim for the creation of a MAD:

- The claim must be billed by the dental office or lab using the taxonomy 332B00000X
- The dentist or dental practice must be enrolled with the agency as a medical equipment provider
- The dentist or dental practice must be an approved provider for the fabrication of MAD

Dentists who have a provider agreement as a medical equipment provider can become an approved provider for MAD by submitting proof of the qualifications listed in the [clinical criteria section](#) to the Sleep Study Program Manager at providerenrollment@hca.wa.gov.

Payment

The agency's payment for MAD is bundled and includes time, labor, material, professional services fabricating, fitting and adjusting, and professional services. Procedure code E0486 is allowed once during the first 90 days following placement of the device.

After the first 90 days, if the device needs repair, bill using procedure code KO739. The agency pays for a replacement after 5 years, or when lost, stolen, or damaged beyond repair.

Pulse Oximetry

(WAC [182-552-0900](#))

Under very limited, specific circumstances, the agency will cover oximetry for sleep disorders.

Clinical criteria for standard oximeters

- The agency covers the purchase of standard oximeters, without PA, for clients age 17 or younger in the home when the client:
 - ✓ Has chronic lung disease and is on supplemental oxygen.
 - ✓ Has a compromised or artificial airway.
 - ✓ Has chronic lung disease requiring a ventilator or a bi-level RAD.

- [PA](#) is needed for purchasing standard oximeters for clients age 18 or older.

Clinical criteria for enhanced oximeters

- The agency covers the purchase of enhanced oximeters, without PA, for clients age 17 or younger in the home when both:
 - ✓ The criteria for a standard oximeter are met.
 - ✓ The EPA criteria are met.

Note: See [EPA Criteria](#) for more details.

- The agency covers the purchase of enhanced oximeters, [with PA](#), for:
 - ✓ Clients age 18 and older
 - ✓ Clients age 17 and younger who do not meet clinical criteria.

For specific details about items covered, see [Miscellaneous](#) in the Coverage Table.

Coverage Table for Equipment and Supplies

The agency covers supplies and related equipment for sleep disorders as identified in the table below.

Bill With:	Taxonomy 332BX2000X
Do Not Bill With:	Any procedure code listed in the Do Not Bill With column of the fee schedule is AT NO TIME allowed in combination with the primary code located in the Hospital Common Coding System (HCPCS) Code column.
Maximum Allowance:	Rentals are calculated on a 30-day basis unless otherwise indicated. In those instances where rental is required before purchase, the rental price is applied towards the purchase price.
Rentals:	From and to dates are required on all rental billings. (1 month equals 30 days.)

Notes: Providers must monitor the amount of supplies and accessories a client is actually using and assure the client has nearly exhausted the supply on hand before dispensing any additional items.

For **policy requirements**, including clinical criteria, for different types of equipment and supplies, see [Coverage Criteria](#). For an **explanation of PA**, including EPA and limitation extension, see [Authorization](#).

Continuous positive airway pressure system (CPAP) coverage table

Code Status Indicator	HCPCS Code	Modifier	Description	Do Not Bill With	EPA/PA?	Policy/Comments
	E0601	RR NU RA	Continuous airway pressure (CPAP) device	E0470 E0471 E0472		<p>Requires results of sleep study performed in an agency-approved sleep center. No PA is required for rental or purchase if criteria are met. (For more about criteria, see CPAP in Clinical Criteria.)</p> <p>Rental limit: 1 unit per month, maximum of 3-months mandatory rental.</p> <p>Limit includes 3-month rental. If criteria met, submit for purchase.</p> <p>Purchase limit: 1 unit per client, every 5 years.</p> <p>Purchase price is amount allowed after 3 months mandatory rental.</p> <p>Use of RA modifier – the RA modifier allows for the replacement of a CPAP at the end of the 5-year limit when the machine is no longer functional or cost effective to repair. This eliminates the 3-month rental requirement for this situation.</p>
NC	E0605		Vaporizer, Room Type			

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Code Status Indicator	HCPCS Code	Modifier	Description	Do Not Bill With	EPA/PA?	Policy/Comments
	A7027		Combination oral/nasal mask, used with continuous positive airway pressure device, each		PA	
	A7028		Oral cushion for combination oral/nasal mask, replacement only, each		PA	
	A7029		Nasal pillows for combination oral/nasal mask, replacement only, pair		PA	
	A7030	NU	Full face mask, used with positive airway pressure device, each	A7031		Limit: 1 every 6 months. (Cushion, pillows, and interface can be replaced every 3 months.)
	A7031	NU	Face mask interface, replacement for full face mask, each	A7030		Limit: 1 every 3 months, not ordered within 3 months of A7030
	A7032	NU	Cushion for use on nasal mask interface, replacement only, each	A7033 A7034		Limit: 1 every 3 months, not ordered within 3 months of A7034
	A7033	NU	Pillow for use on nasal cannula type interface, replacement only, pair	A7032 A7034		Limit: 1 pair every 3 months, not ordered within 3 months of A7034

Sleep Centers

Code Status Indicator	HCPCS Code	Modifier	Description	Do Not Bill With	EPA/PA?	Policy/Comments
	A7034	NU	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap	A7032 A7033		Limit: 1 every 6 months. (Cushion and pillows can be replaced every 3 months.)
	A7035	NU	Headgear used with positive airway pressure device			Limit: 1 every 6 months.
	A7036	NU	Chinstrap used with positive airway pressure device			Limit: 1 every 6 months.
	A4604	NU	Tubing with integrated heating element for use with positive airway pressure device	A7010 A7037		Limit: 1 every 6 months
	A7037	NU	Tubing used with positive airway pressure device	A7010 A4604		Limit: 1 every 6 months.
	A7038	NU	Filter, disposable, used with positive airway pressure device			Limit: 2 every 30 days.
	A7039	NU	Filter, non-disposable, used with positive airway pressure device			Limit: 1 every 6 months.

Sleep Centers

Code Status Indicator	HCPCS Code	Modifier	Description	Do Not Bill With	EPA/PA?	Policy/Comments
NC	A7044		Oral interface, used with positive airway pressure device, each			
NC	A7045		Exhalation port (with or without swivel) used with accessories for positive airway devices, replacement only			
	A7046	NU	Water chamber for humidifier, used with positive airway pressure device, replacement, each			Limit: 1 every 6 months.
NC	A7047		Oral interface used with respiratory suction pump, each			
	E0561		Humidifier, nonheated, used with positive airway pressure device			
	E0562	NU	Humidifier, heated, used with positive airway pressure device			Purchase only. Limit: 1 per 5 years.

Respiratory Assist Devices Coverage

Code Status Indicator	HCPCS Code	Modifier	Description	Do Not Bill With	EPA/PA	Policy/Comments
	E0470	RR NU RA	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	E0601 E0471 E0472	PA**	<p>(Example: BiPAP S)</p> <p>**PA is necessary only if the client does not meet the Medicare clinical criteria; or if a CPAP machine (E0601), or a BiPAP machine (E0470) has been purchased within the last 5 years.</p> <p>Requires results of sleep study performed in an agency-approved sleep center when prescribed for sleep apnea.</p> <p>Purchase required after maximum of 3 months mandatory rental. Client compliance and effectiveness must be documented prior to purchase. Purchase price is amount allowed after 3 months mandatory rental.</p> <p>Limit includes 3-month rental. If criteria are met, submit for a purchase.</p> <p>Purchase limit: 1 unit per client, every 5 years.</p> <p>RA modifier allows for the replacement of a BiPAP at the end of the five (5) year limit when the machine is no longer functional or cost effective to repair. This eliminates the 3-month rental requirement for this situation.</p>

Sleep Centers

Code Status Indicator	HCPCS Code	Modifier	Description	Do Not Bill With	EPA/PA?	Policy/Comments
	E0471	RR RA	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	A4611- A4613 A4616- A4618 E0470 E0472 E0601	PA	<p>PA is necessary only if a CPAP machine (E0601), or a BiPAP machine (E0470) has been purchased within the last 5 years, or if the clinical criteria are not met. (For more about criteria, see Bi-Level Respiratory Assist Devices in Coverage Criteria.)</p> <p>Monthly Rental only. Deemed purchased after 13 months of rental</p> <p>Purchase Limit: 1 per client every 5 years.</p> <p>Use of RA modifier – the RA modifier allows for the replacement of E0471 at the end of the five (5) year limit when the machine is no longer functional or cost effective to repair. This eliminates the 13 month rental requirement.</p>

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Code Status Indicator	HCPCS Code	Modifier	Description	Do Not Bill With	EPA/PA?	Policy/Comments
	E0486	NU	Custom fabricated oral appliance for OSA	E0470 E0471 E0472 E0601	PA	Limit = 1 per client every 5 years PA required Purchase only Clients age 21 and older
	K0739		Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes		PA	

Miscellaneous

Code Status Indicator	HCPCS Code	Modifier	Description	Do Not Bill With	EPA/PA?	Policy/Comments
	E0445	NU	Oximeter device for measuring blood oxygen levels non-invasively	E0445S C	PA	Standard oximeter. PA required for clients age 18 and older. PA not required for clients age 17 and younger who meet clinical criteria. Purchase limit - 1 in a 24 month period per client, regardless of age.
	E0445	SC	Oximeter device for measuring blood oxygen levels non-invasively	E0445N U	PA/ EPA**	Enhanced oximeter PA required for clients 18 years and older; or for clients under 18 who do not meet clinical criteria. (For more details, see Oximeters in Coverage Criteria.) **EPA required for clients who are 17 years and younger and meet clinical criteria. (See the EPA Criteria Table .) Limit = 1 per client every 36 months.
	E1399		Replacement cable for enhanced oximeter		PA	Limit= 2 per client per year.

Sleep Centers

Code Status Indicator	HCPCS Code	Modifier	Description	Do Not Bill With	EPA/PA?	Policy/Comments
	A4606	NU	Oxygen probe for use with oximeter device, replacement	A4606R A		NU = Nondisposable probe Limit = 1 per client every 180 days.
	A4606	RA	Oxygen probe for use with oximeter device, replacement	A4606N U		RA = Disposable probe Limit = 4 per client every 30 days.
	E1399	RB	Durable medical equipment, miscellaneous		PA	For equipment without an assigned HCPCS code. RB = <i>Only</i> for parts used in the repair of client-owned equipment. (See Is PA required for repairs to client-owned equipment? in Reimbursement.)

For more information on respiratory related DME, see the [Respiratory Care Billing Guide](#)

Authorization

(WAC [182-552-1300](#))

What are the general authorization requirements?

- The agency requires providers to obtain authorization for covered sleep medicine services and equipment as required in:
 - ✓ Chapters [182-531](#), [182-501](#) and [182-502](#) WAC.
 - ✓ Published agency billing guides.
 - ✓ Situations where the required clinical criteria are not met.
- When a service requires authorization, the provider must properly request authorization, under the agency's rules and billing guides.
 - ✓ When authorization is not properly requested, the agency rejects and returns the request to the provider for further action.
 - ✓ The agency does not consider the rejection of a request to be a denial of service.
- The agency's authorization of service(s) does not necessarily guarantee payment.
- The agency evaluates requests for authorization of covered sleep medicine services, equipment and supplies that exceed limitations in this chapter on a case-by-case basis under WAC [182-501-0169](#).
- The agency may recoup any payment made to a provider if the agency later determines that the service was not properly authorized, or did not meet the expedited prior authorization (EPA) criteria. (See WAC [182-502-0100](#)(1)(c)).

Notes: For submitting claims with authorization numbers, see [Billing with Authorization](#) in this guide. For more detailed information on requesting authorization, see the agency's [ProviderOne Billing and Resource Guide](#).

What is prior authorization (PA)?

(WACs [182-552-1325](#))

Prior authorization (PA) is the agency's approval for certain medical services, equipment, or supplies **before** being provided to clients (except when the items and services are covered by a third-party payer.) PA is a precondition for provider reimbursement. The item or service must be delivered to the client **before** the provider bills the agency.

What are the criteria for PA?

- With PA, the agency may consider covering new items/equipment that do not have assigned healthcare common procedure coding system (HCPCS) codes, and are not listed in the agency's published issuances.

For these, the provider must furnish all of the following information to the agency to establish medical necessity:

- ✓ A detailed description of the item(s) or service(s) to be provided
 - ✓ The cost or charge for the item(s)
 - ✓ A copy of the manufacturer's invoice, price list or catalog with the product description for the item(s) being provided
 - ✓ A detailed explanation of how the requested item(s) differs from an already existing code description
- In addition, for PA requests, the agency requires the prescribing provider to furnish **client-specific** justification for respiratory care.

The agency does not accept general standards of care or industry standards for generalized equipment as justification.

- When the agency receives the initial request for PA, the prescription(s) for those items or services must **not** be older than three months from the date the agency receives the request.
- The agency does not pay for the purchase, rental, or repair of equipment that duplicates equipment clients already own or rent.

- If providers believe the purchase, rental or repair of equipment is not duplicative, they may request PA by submitting the following to the agency:
 - ✓ Reasons the existing equipment no longer meets the client's medical needs
 - ✓ Reasons the existing equipment could not be repaired or modified to meet the client's medical needs
 - ✓ Upon request, documentation showing how the client's condition meets the criteria for PA
- A provider may resubmit a request for PA for an item or service that the agency has denied. The agency requires the provider to include new documentation that is relevant to the request

What is the PA process?

For PA, a provider must submit a written request to the agency.

- Providers make written PA requests by submitting:
 - ✓ A completed *General Information for Authorization*, (HCA 13-835) form.
 - ✓ A prescription.
 - ✓ Any other required documentation.
- To prior authorize the purchase or rental of equipment, providers also must provide the information that includes, but is not limited to:
 - ✓ The manufacturer's name.
 - ✓ The equipment model and serial number.
 - ✓ A detailed description of the item.
 - ✓ Any modifications required, including the product or accessory number as shown in the manufacturer's catalog.

(See WAC [182-501-0165](#).)

(See [Where can I download agency forms?](#))

Is PA required for repairs to client-owned equipment?

To be paid for a repair of client-owned equipment, the provider must submit a PA request for repairs and must include:

- A manufacturer pricing sheet showing manufacturer's list or suggested retail price (MSRP); or a manufacturer invoice showing the acquisition cost (AC) of the repair, identifying and itemizing the parts.
- A completed *General Information for Authorization* (HCA 13-835) form showing, by line, the HCPCS codes being requested with corresponding billed charges. See [Where can I download agency forms?](#)
- A statement on company letterhead indicating that the equipment or parts are no longer covered by warranty.
- The serial number of the equipment being repaired.

If the equipment did not come with a serial number or the number is no longer legible or on the equipment, the provider must:

- ✓ Assign a new number.
- ✓ Attach it to the equipment.
- ✓ Include this information on company letterhead.
- Specific labor code (K0739).
- Actual labor time used for repairs.

What is expedited prior authorization (EPA)?

(WACs [182-552-1300](#) and [182-552-1375](#))

The expedited prior authorization (EPA) process eliminates the need for written requests for PA of selected respiratory care procedure codes. Services requiring EPA are identified in the [EPA Criteria Table](#).

What are the EPA criteria?

- For EPA, a provider must document how the EPA criteria are met and have supporting medical documentation. The provider must include all documentation in the client's file, available to the agency on request.
- The provider must use the appropriate EPA number and process when billing the agency.
- When a situation does not meet the EPA criteria for selected respiratory care procedure codes, a written request for PA is required.
- The agency may recoup any payment made to a provider if the provider did not follow the EPA criteria and process.

What is the EPA process?

Providers must create a 9-digit EPA number for selected respiratory care procedure codes:

- The first five or six digits of the EPA number must be 870000.
- The last three or four digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria. (See the [EPA Criteria Table](#).)

Example: In billing E0445 for an enhanced oximeter, the EPA number would be **870000900**. (**870000** = first six digits of all EPA numbers; **900** = last three digits of an EPA number, indicating the clinical criteria and the equipment you are billing.)

Note: When the client's situation does not meet published criteria, authorization is necessary.

Expedited prior authorization (EPA) criteria table

EPA 870000+ Last 3 digits below	Criteria	HCPCS Code	Modifier	Do Not Bill With
006	<p>Enhanced Oximeter</p> <p>With all of the following features:</p> <ul style="list-style-type: none"> • Alarms for heart rate and oxygen saturation • Adjustable alarm volume • Memory for download • Internal rechargeable battery <p>Client must be age 17 and younger, in the home, and meet the clinical criteria for an Oximeter.</p> <p>Purchase limit of 1 per client, every 3 years.</p>	E0445	SC	E0445 NU

What is a limitation extension (LE)?

(WAC [182-552-1300](#) and [182-552-1350](#))

A limitation extension (LE) is the agency's method for the provider to furnish more units than are typically allowed.

The agency limits the amount, frequency, or duration of certain covered respiratory care, and pays up to the stated limit without requiring PA. (Limits are based on what is normally considered medically necessary, for quantities sufficient for a 30-day supply for one client.)

What are the LE criteria?

- The provider must request PA for an LE to exceed the stated limits for respiratory care equipment and supplies using the required process.
- The provider must provide justification that the additional units of service are medically necessary.
- The agency evaluates LE requests on a case-by-case basis under WAC [182-501-0169](#).

Note: LEs do not override the client's eligibility or program limitations. Not all categories of eligibility can receive all services. For example: Kidney dialysis is excluded under the Family Planning Only Program.

What is the LE process?

The provider requests an LE by using a written/fax authorization process. All PA requests must be accompanied by:

- A completed *General Information for Authorization* (HCA 13-835) form.
- A completed *Oxygen and Respiratory Authorization Request* (HCA 15-298) form.
- A prescription.
- Any other required documentation.

See [Where can I download agency forms?](#)

Billing

All claims must be submitted electronically to the agency, except under limited circumstances. For more information about this policy change, see [Paperless Billing at HCA](#). For providers approved to bill paper claims, see the agency's [Paper Claim Billing Resource](#).

What are the general billing requirements?

Providers must follow the agency's [ProviderOne Billing and Resource Guide](#). These billing requirements include:

- Time limits for submitting and resubmitting claims and adjustments.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- How to bill for clients eligible for both Medicare and Medicaid.
- How to handle third-party liability claims.
- Standards for record keeping.

Billing with authorization numbers

- Refer to the [ProviderOne Billing and Resource Guide](#) for instructions on how to add authorization numbers to electronic claims.
- With HIPAA implementation, multiple authorization (prior or expedited) numbers may be submitted on a claim when billing electronically. The authorization number must be placed in the correct data field of the claim. **Do not put authorization numbers in the comment field, as they cannot be processed.**

Is information available to bill for clients eligible for both Medicare and Medicaid?

For more information on billing Medicare/Medicaid crossover claims, see the agency's [ProviderOne Billing and Resource Guide](#).

Note: When Medicare has paid as primary insurance and you are billing the agency as the secondary payer, the agency does not require PA for services.

How does the agency handle third-party liability coverage?

If the client has third-party liability (TPL) coverage for a service requiring authorization by the agency, and the TPL payer denies payment for that service, authorization must be obtained through the agency. A denial from the TPL payer must be submitted with the request.

If the TPL payer is paying for the service, no authorization through the agency is required.

(For more information, see [Authorization](#). For more information on TPL coverage, see the agency's [ProviderOne Billing and Resource Guide](#).)

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's [Billers and Providers](#) webpage, under [Webinars](#).

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the [HIPAA Electronic Data Interchange \(EDI\)](#) webpage.

The following claim instructions relate to Respiratory Care:

Name	Entry														
Prior Authorization Number	When applicable. If the service or hardware being billed requires prior authorization, enter the assigned number.														
Place of Service	<p>These are the only appropriate codes for this program:</p> <table data-bbox="673 1459 1263 1711"> <thead> <tr> <th data-bbox="673 1459 860 1497">Facility Type</th> <th data-bbox="925 1459 1144 1497">To Be Used For</th> </tr> </thead> <tbody> <tr> <td data-bbox="738 1497 771 1528">12</td> <td data-bbox="925 1497 1263 1528">Home (client's residence)</td> </tr> <tr> <td data-bbox="738 1528 771 1560">13</td> <td data-bbox="925 1528 1218 1560">Assisted living facility</td> </tr> <tr> <td data-bbox="738 1560 771 1591">14</td> <td data-bbox="925 1560 1088 1591">Group home</td> </tr> <tr> <td data-bbox="738 1591 771 1623">31</td> <td data-bbox="925 1591 1226 1623">Skilled nursing facility</td> </tr> <tr> <td data-bbox="738 1623 771 1654">32</td> <td data-bbox="925 1623 1128 1654">Nursing facility</td> </tr> <tr> <td data-bbox="738 1654 771 1686">99</td> <td data-bbox="925 1654 998 1686">Other</td> </tr> </tbody> </table>	Facility Type	To Be Used For	12	Home (client's residence)	13	Assisted living facility	14	Group home	31	Skilled nursing facility	32	Nursing facility	99	Other
Facility Type	To Be Used For														
12	Home (client's residence)														
13	Assisted living facility														
14	Group home														
31	Skilled nursing facility														
32	Nursing facility														
99	Other														

Name	Entry
Units	For multiple quantities of supplies, enter the number of items dispensed and all of the dates or dates spanned that the supplies were used. Unless the procedure code description specifically indicates pack, cans, bottles, or other quantity, the each is each single item.

Billing for Services

- Refer to the Sleep Medicine [fee schedule](#)
- Enter the approved agency sleep center’s NPI where the sleep study/polysomnogram or multiple sleep latency testing was performed. Refer to [Sleep Centers of Excellence](#) for appropriate location of agency-approved sleep center. Complete claims as follows:
 - ✓ Providers must bill with their approved COE facility NPI in the Claim Note section of the electronic claim.
 - ✓ For billing professional Direct Data Entry (DDE) claims through the ProviderOne Portal, click the “Other Claim Info” tab and open the Service Facility section under Claim Information. Enter the COE NPI in the Provider NPI field.
 - ✓ For billing 837P HIPAA-compliant claims, see the ProviderOne 5010 companion guides on the [HIPAA Electronic Data Interchange \(EDI\)](#) webpage.
- Limit sleep studies to ruling out obstructive sleep apnea or narcolepsy.

When private insurance or Medicare has paid as primary insurance and the provider is billing the agency as secondary insurance, the agency does not require PA or that the sleep study be done in a Center of Excellence.

Billing for Supplies

When a provider bills for supplies that are limited to a specific number per day, the provider needs to bill a span of dates that matches the number of units billed. For example, if a supply has a limit of three per day, and the provider wants to bill for a 10-day supply, the provider would need to bill for a span of dates that covers 10 days and the units billed should be 30.

- When a provider bills for a monthly rental, the provider must bill 30 days at a time unless any of these situations occur:
 - ✓ It is a short-term rental (less than a month).
 - ✓ There is a break in service or eligibility for the client.
 - ✓ It is the last month the provider supplies the equipment to the client, and the client did not have the equipment for 30 days.

Examples of correcting billing are:

- The first month and day the client gets service is February 1, and the provider will be continuing to bill for the rental. The provider should bill for February, 2/1/2011 – 3/2/2011 (non-leap year); and then for March, 3/3/2011 – 4/1/2011; for April, 4/2/2011 – 5/1/2011; and for May, 5/2/2011 – 5/31/2011.
 - The first month and day the client gets service is October 15 and the provider will be continuing to bill for the rental. The provider should bill for October, 10/15/2011 – 11/13/11; and then for November, 11/14/11 – 12/13/11.
- When a provider bills for supplies that have no limit or are limited to a specific number of units in a month, the provider should bill using just the date the supplies were provided.

PLEASE NOTE: NOT FOLLOWING THESE INSTRUCTIONS MAY RESULT IN DENIAL OF YOUR CLAIM.

Add-on codes

The agency will not pay for procedure codes defined in the current CPT® manual as “add-on codes” when these codes are billed alone or with an invalid primary procedure code.

Note: The agency has instituted claims edits requiring that “add-on” procedure codes be billed with a correct primary procedure.

By report

Services with a by-report (BR) indicator in the fee schedule with billed charges of \$1,100 or greater require a detailed report in order to be paid. Attach the report to the claim. For billed charges under \$1,100, DO NOT attach a report to the claim for services with a BR indicator in the fee schedule, unless requested by the agency. The agency pays for medically necessary services on the basis of usual and customary charges or the maximum allowable fee established by the agency, whichever is lower according to WAC 182-502-0100.

Codes for unlisted procedures

(CPT code XXX99)

Providers must bill using the appropriate procedure code. The agency does not pay for procedures when they are judged to be less-than-effective (i.e., an experimental procedure), as reported in peer-reviewed literature (see WAC 182-501-0165). If providers bill for a procedure using a code for an unlisted procedure, it is the provider’s responsibility to know whether the procedure is effective, safe, and evidence-based. The agency requires this for all its programs, as outlined in WAC 182-501-0050. If a provider does not verify the agency’s coverage policy before performing a procedure, the agency may not pay for the procedure.

Diagnosis codes

The agency requires valid and complete ICD diagnosis codes. When billing the agency, use the highest level of specificity (6th or 7th digits when applicable) or the services will be denied. The agency does not cover the following diagnosis codes when billed as the primary diagnosis:

- V00-Y99 codes (Supplementary Classification)
- Most codes in Z00-Z99 (factors influencing health status and contact with health services)

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

Discontinued codes

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

National correct coding initiative

The agency continues to follow the [National Correct Coding Initiative \(NCCI\) policy](#). The Centers for Medicare and Medicaid Services (CMS) created this policy to promote national correct coding methods. NCCI assists the agency to control improper coding that may lead to inappropriate payment. The agency bases coding policies on the following:

- The American Medical Association's (AMA) Current Procedural Terminology (CPT) manual
- National and local policies and edits
- Coding guidelines developed by national professional societies
- The analysis and review of standard medical and surgical practices
- Review of current coding practices

Procedure code selection must be consistent with the current CPT guidelines, introduction, and instructions on how to use the CPT coding book. Providers must comply with the coding guidelines that are within each section (e.g., E/M services, radiology, etc.) of the current CPT book.

Medically Unlikely Edits (MUEs)

Medically unlikely edits (MUEs) are part of the NCCI policy. MUEs are the maximum unit of service per HCPC or CPT code that can be reported by a provider under most circumstances for the same patient on the same date of service. Items billed above the established number of units are automatically denied as a "Medically Unlikely Edit." Not all HCPCS or CPT codes are assigned an MUE. The agency follows the CMS MUEs for all codes. The agency may have units of service edits that are more restrictive than MUEs.

Note: The agency may have units of service edits that are more restrictive than MUEs.

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

Procedure codes

The agency uses the following types of procedure codes within this billing guide:

- Current Procedure Terminology (CPT®)
- 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 agency-covered services. **Due to copyright restrictions, the agency publishes only the official short CPT descriptions. To view the full CPT description, refer to a current CPT manual.**