Washington State Health Care Authority

Washington Apple Health (Medicaid)

Mobile Anesthesia for Dental Services Billing Guide

February 1, 2024

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at **askmedicaid@hca.wa.gov**.

About this guide*

This publication takes effect **February 1, 2024**, and supersedes earlier billing guides to this program.

The Health Care Authority is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> 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 HCA's **ProviderOne billing and resource guide** for valuable information to help you conduct business with the Health Care Authority.

You must bill services, equipment, or both, related to any of the programs listed below using the Health Care Authority's Washington Apple Health program-specific billing guides:

- Access to baby and child dentistry (ABCD)
- Orthodontic services
- Oral Health Connection
- Dental Related Services Program

* This publication is a billing instruction.

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How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's **provider alerts webpage**.

To access provider documents, go to HCA's **provider billing guides and fee schedules webpage.**

Confidentiality toolkit for providers

The **Washington State Confidentiality Toolkit for Providers** is a resource for providers required to comply with health care privacy laws.

Where can I download HCA forms?

To download an HCA form, see HCA's **Forms & Publications** webpage. Type only the form number into the Search box (Example: 13-835).

Copyright disclosure

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What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Confidentiality toolkit for providers	Add new resource for health care providers required to comply with health care privacy laws.	New resource
COVID-19 note box	Removed note box referencing COVID-19 webpage	Outdated information, link no longer valid
How do I verify a client's eligibility	Created a new note box to provide updated ways to apply for Apple Health coverage	To keep information current
Mobile anesthesia	Removed note box referencing temporary suspension of prior authorization requirements due to the public health emergency	Outdated information, policy ended May 11, 2023
Anesthesia prior authorization	Removed language in note box "Dental phobia and fear of needles is not specific enough information." Replaced existing note box referencing clients age 21 and older with new note box with specific documentation requirements for prior authorization	Updated criteria Updated criteria for prior authorization including documentation requirements

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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. The Health Care Authority also uses dental definitions found in the current American Dental Association's Current Dental Terminology (CDT®) and the current American Medical Association's Physician's Current Procedural Terminology (CPT®). **Where there is any discrepancy between this section and the current CDT or CPT, this section prevails**.

Adjunctive – A secondary treatment in addition to the primary therapy.

Adult – For the general purposes of HCA's dental program, adult refers to a client 21 years of age and older. (HCA's payment structure changes after age 20 which affects specific program services provided to adults or children).

Ambulatory surgery center (ASC) – Any distinct entity certified by Medicare as an ASC that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

Authorization – An official approval for action taken for/or on behalf of an eligible client. This approval is only valid if the client is eligible on the date of services.

Authorized representative – A person to whom signature authority has been delegated in writing, acting within the limits of their authority.

Billing provider – A provider who bills Medicaid directly and who prescribes or refers items or services through a group, facility, agency, organization, or individual sole proprietor.

Conscious sedation – A drug-induced depression of consciousness during which a client responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, spontaneous ventilation is adequate, and cardiovascular function is maintained.

Current dental terminology (CDT®) – A systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. CDT® is by the Council on Dental Benefit Programs of the American Dental Association (ADA).

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 (AMA).

Deep sedation – A drug-induced depression of consciousness during which a client cannot be easily aroused, ventilatory function may be impaired, but the client responds to repeated or painful stimulation.

Developmental Disabilities Administration (DDA) – The administration within the Department of Social and Health Services (DSHS) responsible for administering and overseeing services and programs for clients with

developmental disabilities, (formerly known as the Division of Developmental Disabilities).

EPSDT – HCA's early and periodic screening, diagnostic, and treatment program for clients age 20 and younger as described in **Chapter 182-534 WAC**.

Facility fee T2035 – The fee paid to the mobile anesthesiologist to cover the services and supplies necessary to render care.

General anesthesia – A drug-induced loss of consciousness during which a client is not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Clients may require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Limited oral evaluation – An evaluation limited to a specific oral health condition or problem. Typically, a client receiving this type of evaluation has a dental emergency, such as trauma or acute infection.

Mobile anesthesiologist – An anesthesiologist, dental anesthesiologist, or a qualified professional permitted under WAC 246-817 to provide conscious sedation with parenteral or multiple oral agents, deep sedation, or general anesthesia in an office setting other than their own. This provider may only deliver anesthesia services at the time of treatment, while a separate provider renders dental services.

National Provider Identification (NPI) – A unique, 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS).

Standard of care – What reasonable and prudent practitioners would do in the same or similar circumstances.

Servicing provider – A provider who does not bill Medicaid directly and who prescribes or refers items or services through a group, facility, agency, organization, or individual sole proprietor.

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About the Program

What is the purpose of the mobile anesthesia program?

The purpose of the mobile anesthesia program is to increase access to dental treatment for pediatric, Medicaid clients aged 0-20 and developmentally disabled clients of all ages, who require behavior management by allowing mobile (traveling) anesthesiologists to provide anesthesia services in a dental office setting that otherwise would not have the equipment and qualifications to provide moderate or deep sedation.

Who is eligible to become an HCA-contracted mobile anesthesia services provider?

To become credentialed to provide mobile anesthesia services with HCA's Apple Health dental programs, you must have a current, signed Core Provider Agreement (CPA) with HCA as well as a separate, current Mobile Anesthesia contract. Please contact HCA's Contracts sections by email at contracts@hca.wa.gov for more information.

The following providers are eligible to enroll with the Health Care Authority to furnish and bill for mobile anesthesia services provided to eligible clients:

- Persons currently licensed by the state of Washington to:
  - Practice anesthesia by any of the following:
    - Providing conscious sedation with parenteral or multiple oral agents, deep sedation, or general anesthesia as an anesthesiologist, dental anesthesiologist, or qualified professional under chapter 246-817 WAC.
    - Providing conscious sedation with parenteral or multiple oral agents as a dentist with a conscious sedation permit issued by the Department of Health (DOH) that is current at the time the billed service is provided.
    - Providing deep sedation or general anesthesia as a dentist with a general anesthesia permit issued by DOH that is current at the time the billed service is provided.
    - Providing anesthesia services in a mobile setting as an anesthesiologist, dental anesthesiologist, or qualified professional who holds a current mobile anesthesia contract with the Health Care Authority.

Note: Mobile anesthesiologists must be a separate provider than the provider delivering treatment.

- Border area providers of dental-related services who are qualified in their states to provide these services.

Note: The Health Care Authority pays licensed providers participating in the Health Care Authority's Dental-Related Services program for only those services that are within their scope of practice. (WAC 182-535-1070(2))

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Client Eligibility

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 HCA will not pay for.

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 HCA'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 HCA's Program Benefit Packages and Scope of Services webpage.

Note: To determine if the client has the DDA indicator, see the ProviderOne Billing and Resource Guide.

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

- **Online**: Go to Washington Healthplanfinder - select the "Apply Now" button. For patients age 65 and older or on Medicare, go to Washington Connections select the "Apply Now" button.
- **Mobile app:** Download the WAPlanfinder app – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 1-855-627-9604 (TTY).

- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Support (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

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

Yes. Dental-related services, including surgical services with a dental-related diagnosis, for eligible clients enrolled in a Health Care Authority-contracted managed care organization (MCO), are covered under Washington Apple Health fee-for-service. Mobile anesthesiologists bill the Health Care Authority directly for all dental-related services provided to eligible MCO clients including the T2035 facility fee.

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Coverage

When does HCA pay for covered mobile anesthesia services?

Subject to coverage limitations and client-age requirements identified for a specific service, the Health Care Authority pays for mobile anesthesia services and procedures when the services are all of the following:

- Part of the client's benefit package.
- Within the scope of an eligible client's Washington Apple Health program.
- Medically necessary.
- Meet the Health Care Authority's authorization requirements, if any.
- Documented in the client's record per chapter 182-502 WAC and meet the Department of Health's (DOH) requirements in WAC 246-817-305 and WAC 246-817-310.
- Within accepted dental or medical practice standards.
- Consistent with a diagnosis of dental disease or dental condition.
- Reasonable in amount and duration of care, treatment, or service.
- Listed as covered in this billing guide.

Note: The Health Care Authority may require second opinions and consultations before authorizing any procedure.

Mobile Anesthesia

The Health Care Authority:

- Requires the provider's current Department of Health (DOH) anesthesia permit to be on file with the Health Care Authority.
- Covers office-based oral or parenteral conscious sedation, deep sedation, or general anesthesia.

To review maximum allowable fees, see the Health Care Authority's Fee Schedule.

Anesthesia prior authorization

CDT® Code	Description	Ages	PA?
D9222	deep sedation/general anesthesia – first 15 minutes	Age 8 and younger, age 9 through 20 with diagnosis of cleft palate, or any age clients of DDA	N
D9222	deep sedation/general anesthesia – first 15 minutes	Age 9 through 20 without diagnosis of cleft palate and age 21 and older. See EPA #870001387	Y*
D9223	deep sedation/general anesthesia – additional 15 – minute increments	Age 8 and younger, age 9 through 20 with diagnosis of cleft palate, or any age clients of DDA	N
D9223	deep sedation/general anesthesia – additional 15 – minute increments	Age 9 through 20 without diagnosis of cleft palate and age 21 and older. See EPA #870001387	Y*
D9248	non-intravenous conscious sedation (this includes non-IV minimal and moderate sedation)	Age 20 and younger Any age clients of DDA	N
D9248	non-intravenous conscious sedation (this includes non-IV minimal and moderate sedation)	Age 21 and older	Y

CDT® Code	Description	Ages	PA?
D9239	intravenous moderate (conscious) sedation/analgesia – first 15 minutes	Age 20 and younger Any age clients of DDA	N
D9239	intravenous moderate (conscious) sedation/analgesia – first 15 minutes	Age 21 and older	Y
D9243	intravenous moderate (conscious) sedation/analgesia – additional 15-minute increments	Age 20 and younger Any age clients of DDA	N
D9243	intravenous moderate (conscious) sedation/analgesia – additional 15-minute increments	Age 21 and older	Y

Note: Letters of medical necessity for anesthesia must clearly describe the medical need for anesthesia and what has been tried and failed.

Note: For clients age 21 and older, HCA considers all requests for prior authorization for other conditions which general anesthesia or conscious sedation is medically necessary, as defined in WAC 182-500-0070.

Documentation required for prior authorization:

- Current (within the past 12 months) x-rays (radiographs)
- Relevant treatment plan
- Letter that clearly describes the medical necessity of performing the dental procedure with sedation

The Health Care Authority:

- Requires providers of oral or parenteral conscious sedation, deep sedation, or general anesthesia to meet:
  - The prevailing standard of care.
  - The provider's professional organizational guidelines.
  - The requirements in chapter 246-817 WAC.
  - Relevant DOH medical, dental, or nursing anesthesia regulations.
- Pays for anesthesia services according to WAC 182-535-1400(5).

Note: CDT® code D9920 Behavior Management is not billable in in conjunction with CDT® codes D9222, D9223, D9239, D9243, or T2035 in any setting.

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Authorization

Prior authorization (PA) and expedited prior authorization (EPA) numbers do not override the client's eligibility or program limitations. Not all categories of eligibility receive all services.

General information about authorization

For services that require PA, the Health Care Authority uses the payment determination process described in WAC 182-501-0165.

Authorization of a service indicates only that the specific service is medically necessary. Authorization does not guarantee payment.

The authorization is valid for 6 to 12 months as indicated in the Health Care Authority's authorization letter and only if the client is eligible for covered services on the date of service.

When do I need to get prior authorization?

Authorization must take place **before** the service is provided.

In an acute emergency, the Health Care Authority **may** authorize the service after it is provided when the Health Care Authority receives justification of medical necessity. This justification must be received by the Health Care Authority within seven business days of the emergency service.

When does the Health Care Authority deny a prior authorization request?

The Health Care Authority denies a PA request for a service when the requested service:

- Is covered by another state agency program.
- Is covered by an entity outside HCA.
- Fails to meet the program criteria, limitations, or restrictions in this billing guide.

How do I obtain prior authorization?

Providers may submit a prior authorization request by direct data entry into ProviderOne or fax (see the Health Care Authority's prior authorization webpage for details).

The Health Care Authority may request additional information as follows:

- Additional x-rays (radiographs).
- Photographs.
- Second opinions and/or consultations.
- Arch/quadrant designation:

Code	Area
00	Entire oral cavity
01	Maxillary arch
02	Mandibular arch
10	Upper right quadrant
20	Upper left quadrant
30	Lower left quadrant
40	Lower right quadrant

- Any other information requested by the Health Care Authority.

Note: The Health Care Authority requires a provider who is requesting prior authorization to submit sufficient, current (within the past 12 months), objective, clinical information to establish medical necessity.

Note: All images must include both of the following:

- The date the images were taken.
- The client's name and date of birth or their ProviderOne Client ID number.

Note: For information on obtaining Health Care Authority forms, see the Health Care Authority's Forms & Publications webpage.

How do I submit a PA request?

For information on submitting prior authorization requests to the Health Care Authority, see Requesting Prior Authorization in the Health Care Authority's ProviderOne billing and resource guide or the Health Care Authority's prior authorization webpage.

How to submit a PA request, without x-rays (radiographs) or photos: For procedures that do not require x-rays (radiographs) or photos, submit by direct data entry (DDE) in the ProviderOne portal or fax the PA request to the Health Care Authority at: (866) 668-1214.

How to submit a PA request, with x-rays (radiographs) or photos: Pick one of following options for submitting x-rays (radiographs) or photos to the Health Care Authority:

- Submit request through ProviderOne by direct data entry and attach x-rays (radiographs) or photos to the PA request.
- Use the FastLook™ and FastAttach™ services provided by National Electronic Attachment, Inc. (NEA). You may register with NEA by visiting www.nea-fast.com and entering "FastWDSHS" in the blue promotion code box. Contact NEA at 1-800-782-5150, ext. 2, with any questions.

  When choosing this option, you can fax your request to the Health Care Authority and indicate the NEA# in the NEA field on the PA Request Form or in the comments if submitting request through Direct Data Entry. There is a cost associated which will be explained by the NEA services.

Note: The Health Care Authority does not accept any documentation on CDs, thumb drives, or any device that requires downloading on state equipment.

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What is expedited prior authorization (EPA)?

Expedited Prior Authorization (EPA) eliminates the need for prior authorization for selected procedure codes.

To use an EPA:

- Enter the EPA number on the claim form when billing the Health Care Authority.
- When requested, provide documentation showing the client's condition meets all the EPA criteria.

Prior authorization is required when a situation does not meet all the EPA criteria for selected dental procedure codes. See the Health Care Authority's Prior Authorization webpage for details.

It is the provider's responsibility to determine if a client has already received the service allowed with the EPA criteria. If the client already received the service, a PA request is required to provide the service again or to provide additional services. For claim inquiries, or to check for service limitations, contact the Medical Assistance Customer Service Center (MACSC):

- Phone: 1-800-562-3022
- Online: https://fortress.wa.gov/hca/p1contactus/

Note: By entering an EPA number on your claim, you attest that all the EPA criteria are met and can be verified by documentation in the client's record. These services are subject to post payment review and audit by the Health Care Authority or its designee.

The Health Care Authority may recoup any payment made to a provider if the provider did not follow the required EPA process and if not all of the specified criteria were met.

EPA code list

EPA#	CDT® Code	Description	Criteria
870001387	D9222	deep sedation/general anesthesia– first 15-minute increments	Allowed for clients age 9 through 20 receiving oral surgery services listed in WAC 182-535-1094(1)(f-l) and clients with cleft palate diagnoses. Only anesthesiology providers who have a core provider agreement with the Health Care Authority can bill this code.
870001387	D9223	deep sedation/general anesthesia– additional 15-minute increments	Allowed for clients age 9 through 20 receiving oral surgery services listed in WAC 182-535-1094(1)(f-l) and clients with cleft palate diagnoses. Only anesthesiology providers who have a core provider agreement with the Health Care Authority can bill this code.

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Billing

All claims must be submitted electronically to the Health Care Authority, 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 Health Care Authority's Paper claim billing resource.

What are the general billing requirements?

Providers must follow the Health Care Authority's ProviderOne billing and resource guide. These billing requirements include:

- What time limits exist 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.
- What standards to use for record keeping.

Note: If an ICD diagnosis code is entered on the dental billing and it is an invalid diagnosis code, the claim will be denied.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the Health Care Authority's Billers, providers, and partners 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.

Medical providers billing for mobile anesthesia

Mobile anesthesia providers designated as a "medical" provider (taxonomy beginning with 20 or 36), must submit a professional claim or an 837P HIPPA compliant transaction (or CMS 1500 claim form).

Dental providers billing for mobile anesthesia

Mobile anesthesia providers designated as a "dental" provider (taxonomy beginning with 12), must submit a dental claim or an 837D HIPPA compliant transaction (or ADA dental claim form).

Billing for anesthesia

Billing time for anesthesia begins when the anesthesiologist or certified registered nurse anesthetist (CRNA) starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (e.g., when the patient can be safely placed under post-operative supervision).

- Bill for general anesthesia as follows:
  - Bill one unit of CDT® code D9222 for the first 15-minute increment
  - Billing one or more units of CDT® code D9223 for each additional 15-minute increment

> **Note**: Maximum number of units (21 total – 1 unit for CDT® code D9222 and up to 20 units for CDT® code D9223).

- Bill for intravenous conscious sedation/analgesia as follows:
  - Bill one unit of CDT® code D9239 for the first 15-minute increment
  - Bill one or more units of CDT® code D9243 for each additional 15-minute increment

> **Example**: You are billing for 60 minutes of deep sedation (CDT® codes D9222/D9223), complete the claim as follows:
>
> - Claim line one – D9222 one unit (first 15 minutes)
>
> - Claim line two – D9223 three units (additional 45 minutes)
>
> In ProviderOne, there is a box in which the provider submits how many **units** of anesthesia were delivered for that visit. You must put **units** in this box even though the direction (in parenthesis) next to the box says to enter in minutes. The direction on the screen in parenthesis is wrong. Please enter **units** in the box.

- Both medical and dental mobile anesthesia providers will need to bill using CDT® codes for sedation.

Billing for dental facility fee

Mobile anesthesia providers must use the 5-digit Healthcare Common Procedure Coding System (HCPCS) procedure code T2035 when submitting claims for a dental facility fee using the appropriate claim submission method.

HCA will pay a single facility fee, T2035, which includes the services and supplies necessary for a mobile anesthesiologist to render care in a dental office setting. Payment is made according to the applicable anesthesia procedure codes in addition to the facility fee once per client, per day. The dental facility fee, T2035, will be paid no more than once per client, per day. The dental facility fee T2035 is only payable in a dental office setting and not in a facility or ASC setting.

Billing for clients with commercial insurance as primary

Medical mobile anesthesia providers that bill on a professional claim for a client that has a primary commercial health insurance plan are required to bill the client's commercial insurance prior to Apple Health (HCA). If the private insurance has denied the service, providers should include a Claim Adjustment Reason Code (CARC) on the HCA claim that matches the denial reason given by the commercial insurance carrier. The 96 CARC, for noncovered service(s), tells the ProviderOne system the primary insurance does not cover the service(s).

Dental mobile anesthesia providers that bill on a dental claim for a client that has a primary commercial dental insurance are required to bill the client's commercial insurance prior to Apple Health (HCA). If the private insurance does not cover the service(s) or has denied the service(s), providers should include the appropriate CARC that matches the denial reason given by the commercial insurance carrier.

For further assistance with claims that involve a primary commercial insurance, providers can complete an HCA **Contact Us** request by following these instructions:

- Open **Contact Us**
- Select Provider
- Fill out all required fields
- From the Select Topic dropdown menu, choose Private Commercial Insurance
- Select the appropriate sub-topic

**In the Other Comments box, include the HCA Client ID with your request.*

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Fee Schedules

Where can I find dental fee schedules?

For CDT®/dental codes – see the Health Care Authority's Dental fee schedule.

For dental oral surgery codes, see the Health Care Authority's Physician-related/professional services fee schedule.

> **Note**: Bill the Health Care Authority your usual and customary charge.