



Washington State Department of
Labor & Industries
Crime Victims Compensation Program

Billing Guidelines for Sexual Assault Examinations

Crime Victims Compensation Program



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Throughout this document the term Physician will be used for the following specialties: MD, PA-C, ARNP, RN.

INTRODUCTION

Customer Service is very important to the Department of Labor and Industries and the Crime Victims Compensation Program (CVCP). Our wish is to keep our medical community updated with consistent and accurate information. In support of this effort, the CVCP program is issuing this general billing guide for [sexual assault examinations](#).

CVCP pays for all sexual assault and molestation examinations done for collection of evidence and possible prosecution. [RCW 7.68.170](#) Send these bills to CVCP directly. In this guide, we have listed the codes, our rates, and the forms to use when billing for these exams.

Only when the crime victim files a claim for benefits with CVCP and we have allowed their claim will CVCP consider payment for the treatment of physical injuries sustained during a sexual assault.

[RCW 7.68.130](#)

CVCP repayment rates for these services are in the current [Labor and Industries Medical Aid Rules and Fees Schedules](#).

If you have any questions, please [contact](#) our program:

[Crime Victims Compensation Program](#)

Department of Labor and Industries

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Telephone: 1-800-762-3716

BILLING INFORMATION
SEXUAL ASSAULT EXAMINATION –
HOSPITAL FACILITIES & EMERGENCY DEPARTMENTS
FORM UB04 CMS-1450

FACILITY FEES

Place of Service Code 23 – Emergency Department

Appropriate CPT[®] E/M or CVCP Sexual Assault Exam Local Code for outpatient emergency visit

Codes 99281 through 99285 or
Local Codes 0130C through 0133C

Examples: Revenue Code 450, E/M Code 99283.
Revenue Code 450, Local Code 0130C.

Place of Service Code 22 – Outpatient Hospital

Appropriate CPT[®] E/M or CVCP Sexual Assault Exam Local Code for hospital-based sexual assault clinic visit.

Examples: Revenue Code 510, E/M Code 99202.
Revenue Code 510, Local Code 0131C.

LABORATORY

Examples:

Cultures (multiple sites)

Diagnostic tests

Urine

Serum drug and alcohol screen

CBC

Tests for baselines (HIV, Hep B, Hep C, STDs, pregnancy)

DIAGNOSTICS & RADIOLOGY

Examples:

X-rays

Sonograms

CT Scans

MRIs

INJECTIONS, TAKE-HOME DRUGS, SELF-ADMINISTERED DRUGS & HOSPITAL PHARMACY

All injections, take-home drugs, self-administered drugs and hospital pharmacy filled drugs must be billed separately by **line item detail**.

INJECTIONS, TAKE-HOME DRUGS, SELF-ADMINISTERED DRUGS & HOSPITAL PHARMACY – Continued

Examples:

Sedative medications
Pain medications
Substances related to exam procedure
Vaccines
Antibiotics

As of 03/19/2007, CVCP will cover the following items when billed in conjunction with the initial sexual assault examination provided all other conditions satisfy [RCW 7.68.170](#).

Post coital contraception
Prophylaxis for sexually transmitted diseases
Hepatitis B Immune Globulin
Tetanus Toxoid vaccine
The first three days' supply of a 28-day course of HIV therapy medication

MEDICAL/SURGICAL SUPPLIES

- The cost of the forensic evidence collection kit is bundled into [CVCP's Sexual Assault Exam Local Codes](#).
- Supplies associated with the treatment of physical injuries sustained during a sexual assault **should not be billed** with the initial sexual assault exam billing.

TREATMENT COSTS

Only when no other public or private insurance is available, are we able to consider payment for the cost of treatment and emergency transportation. A police report is required and the victim is to send in a completed [Application for Benefits](#). We can pay only if we approve their claim.

Charges associated with the treatment of injuries sustained during a sexual assault:

X-rays (follow-up)
Laboratory (for treatment)
Medical/surgical supplies associated with physical injuries:
 Wound Care
 Dressing
 Sutures
Surgical procedures associated with physical injuries
Follow-up mental health care
Repeat physical exam

BILLING INFORMATION

SEXUAL ASSAULT EXAMINATION – PROFESSIONAL FEES FORM HCFA-1500

Professional fees should be billed on the HCFA-1500 using the Local Codes and descriptions included in the CVCP Fee Schedule for Sexual Assault Examinations, as follows:

Local Code 0130C – Sexual Assault – Vitals Only, No Physical Exam

| | | | |
|----------------------------|------------------------|----------------------------|------------------------|
| MD | MD | RN | RN |
| <u>Non-facility</u> | <u>Facility</u> | <u>Non-facility</u> | <u>Facility</u> |
| \$23.86 | \$23.86 | \$21.47 | \$21.47 |

Local Code 0131C - Sexual Assault Examination Level 1:

Total Time: 15 to 45 minutes face-to-face with patient by medical provider(s). Requires history and physical examination. May also include forensic evidence collection kit, anogenital examination with colposcopic magnification, medical photography.

| | | | | |
|----------------------------|------------------------|----------------------------|------------------------|---------|
| MD | MD | RN | RN | |
| <u>Non-facility</u> | <u>Facility</u> | <u>Non-facility</u> | <u>Facility</u> | |
| \$321.16 | \$226.82 | \$289.04 | \$204.13 | LEVEL 1 |

Local Code 0132C - Sexual Assault Examination Level 2:

Total Time: 46 to 119 minutes face-to-face with patient by medical provider(s). Requires history and physical examination. May also include forensic evidence collection kit, anogenital examination with colposcopic magnification, medical photography.

| | | | | |
|----------------------------|------------------------|----------------------------|------------------------|---------|
| MD | MD | RN | RN | |
| <u>Non-facility</u> | <u>Facility</u> | <u>Non-facility</u> | <u>Facility</u> | |
| \$509.85 | \$399.78 | \$458.86 | \$359.80 | LEVEL 2 |

Local Code 0133C - Sexual Assault Examination Level 3:

Total Time: 120 minutes or more face-to-face with patient by medical provider(s). Requires history and physical examination. May also include forensic evidence collection kit, anogenital examination with colposcopic magnification, medical photography.

| | | | | |
|----------------------------|------------------------|----------------------------|------------------------|---------|
| MD | MD | RN | RN | |
| <u>Non-facility</u> | <u>Facility</u> | <u>Non-facility</u> | <u>Facility</u> | |
| \$567.32 | \$449.66 | \$510.58 | \$404.69 | LEVEL 3 |

REPORTING REQUIREMENTS

All providers who treat a sexual assault victim are required to complete the one-page CVCP [Sexual Assault Exam Report](#). Please attach this report form to your bill. We deny all bills that do not have this report attached. Go to our website to find this form.

www.lni.wa.gov/FormPub/Detail.asp?DocID=2222

FOLLOW-UP VISIT FOR CONTINUATION OF INITIAL EXAM

When billing for a follow-up visit that is a continuation of the initial sexual assault examination, a report supporting that the follow-up visit was for the purpose of gathering evidence, must be included.

MENTAL HEALTH THERAPY

Our program will pay for up to 3 counseling sessions in the event a child victim is unable to complete the physical sexual assault examination, after the exam has been initiated. A maximum of 3 counseling sessions may be authorized for the purpose of desensitizing the victim to the sexual assault examination.

- These counseling sessions are billed with and paid for as part of the sexual assault examination.

DIAGNOSIS CODE BILLING PROCEDURE CODE

V71.5

90806

General provider requirements; who may treat.

(1) Mental health providers must qualify as an approved provider and register with the crime victims compensation program before they are authorized to provide treatment and receive payment in accordance with these rules.

(2) The following providers who are permanently licensed or registered in Washington are eligible to register with this program:

- (a) Psychiatrists;
 - (b) Psychologists;
 - (c) Advanced registered nurse practitioners with a specialty in psychiatric and mental health nursing;
 - (d) Ph.D.s not licensed as psychologists and master level counselors whose degree is in a field of study related to mental health services including, but not limited to, social work, marriage and family therapy or mental health counseling.
- (3) Out-of-state providers must be currently licensed, registered and/or certified within the state in which they practice. Washington requires mental health counselors to have a masters degree to treat Washington crime victim clients.

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FILING A CLAIM

If you need [application](#) forms call: 1-800-762-3716

If the patient does not have an approved claim with CVCP then follow-up treatment and the associated costs will be their responsibility.

After we allow a patient's claim with CVCP, you can bill their public or private insurance, if any, first. Then you can submit your bill to our program for payment. You must attach a copy of their insurance EOB, if any, and bill us using your patient's CVCP claim number.

Who can get help?

- Victims injured in a violent crime in Washington State.
- Survivors of a homicide victim.
- Washington residents injured by an act of terrorism in a foreign country.

Benefits cannot be paid to someone:

- Injured while participating in a felony.
- Injured while confined in jail, prison, or institutionalized
- Who incited, provoked or consented to the crime.
- Who is unwilling to provide reasonable cooperation to law enforcement.

What are the requirements?

- Notify law enforcement of the crime within 1 year or within 1 year of when a report could have reasonably been made.
- CVCP must receive the application
 - Within two years of reporting the crime to law enforcement
 - Within two years of your eighteenth birthday if you were a minor at the time of the crime.
 - Within five years from reporting the crime to law enforcement with good cause.
- You need to use benefits available from all other public and private insurance first.
- You must reimburse CVCP if you receive an insurance settlement or proceeds from a lawsuit based on the crime.

What benefits may be available if your claim is allowed?

- Payment of medical, dental, and mental health counseling bills.
- Partial payment of lost wages.
- Partial payment of funeral costs.
- Modification to homes and vehicles to accommodate permanent injuries.
- Limited pension payment to the spouse or child of a deceased victim.
- Counseling for family members of sexual assault victims and homicide victims.

All benefits listed have maximum dollar limits set by law. Property losses are not covered.

PLACE OF SERVICE CODES

| | |
|----|--|
| 00 | NOT SUPPLIED |
| 01 | PHARMACY |
| 03 | SCHOOL |
| 04 | HOMELESS SHELTER |
| 05 | INDIAN HEALTH SERVICE FREE-STANDING FACILITY |
| 06 | INDIAN HEALTH SERVICE PROVIDER-BASED FACILITY |
| 07 | TRIBAL 638 FREE-STANDING FACILITY |
| 08 | TRIBAL 638 PROVIDER-BASED FACILITY |
| 11 | OFFICE |
| 12 | HOME |
| 13 | ASSISTED LIVING FACILITY |
| 14 | GROUP HOME |
| 15 | MOBILE UNIT |
| 20 | URGENT CARE FACILITY |
| 21 | INPATIENT HOSPITAL |
| 22 | OUTPATIENT HOSPITAL |
| 23 | EMERGENCY ROOM - HOSPITAL |
| 24 | AMBULATORY SURGICAL CENTER |
| 25 | BIRTHING CENTER |
| 26 | MILITARY TREATMENT FACILITY |
| 31 | SKILLED NURSING FACILITY |
| 32 | NURSING FACILITY |
| 33 | CUSTODIAL CARE FACILITY |
| 34 | HOSPICE |
| 41 | AMBULANCE (LAND) |
| 42 | AMBULANCE (AIR OR WATER) |
| 49 | INDEPENDENT CLINIC |
| 50 | FEDERALLY QUALIFIED HEALTH CENTER |
| 51 | INPATIENT PSYCHIATRIC FACILITY |
| 52 | PSYCHIATRIC FACILITY, PARTIAL HOSPITALIZATION |
| 53 | COMMUNITY MENTAL HEALTH CENTER |
| 54 | INTERMEDIATE CARE FACILITY/MENTALLY RETARDED |
| 55 | RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY |
| 56 | PSYCHIATRIC RESIDENTIAL TREATMENT CENTER |
| 57 | NON-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY |
| 60 | MASS IMMUNIZATION CENTER |
| 61 | COMPREHENSIVE INPATIENT REHABILITATION FACILITY |
| 62 | COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY |
| 65 | END STAGE RENAL DISEASE TREATMENT FACILITY |
| 71 | STATE OR LOCAL PUBLIC HEALTH CLINIC |
| 72 | RURAL HEALTH CLINIC |
| 81 | INDEPENDENT LABORATORY |
| 99 | OTHER UNLISTED FACILITY |

EOB CODES MOST COMMONLY USED FOR SEXUAL ASSAULT BILLS

- 003 Initial office visit payable one time only same claimant/provider/diagnosis.
- 016 Thank you. Your effort to complete this bill correctly has been appreciated.
- 037 Crime Victims responsible for payment of this bill. Reimburse payments made by other sources.
- 043 Denied. Procedure code missing from bill.
- 045 Denied. Type service/procedure code is invalid. Refer to current fee schedule for valid code.
- 101 Denied as duplicate. If not a duplicate, submit an adjustment request with documentation.
- 113 When billing "unlisted procedure" code specific description of service must be on the bill.
- 120 Denied. The date of service is required. Submit bill only when service has been completed.
- 124 Denied. The beginning/ending service date is missing or invalid.
- 202 Charges must be submitted on a HCFA-1500 for processing.
- 220 Denied. Bill not submitted in timely manner. Patient is not responsible for this charge.
- 245 Denied. Please rebill these services on an outpatient bill.
- 246 Denied. Procedure and or modifier code is incorrect for service described on bill.
- 304 Denied. This service is not authorized.
- 309 Charges previously paid for this date. If this is not a duplicate submit adjustment to old bill.
- 326 Denied. This service or drug is not allowed for treatment of Crime Victim injuries.
- 328 Denied. Claimant age and/or sex invalid for this procedure or diagnosis.
- 331 Please refer to the billing instructions provided by Labor & Industries.
- 350 Report is required when this procedure and/or modifier code is billed. No report was received.
- 360 Circumstances do not clearly warrant additional charge beyond usual charge for basic services.
- 386 Payment not made on this bill. This service(s) is duplicated on another bill in process.
- 389 Procedure code changed to more closely reflect service indicated.
- 390 Denied. A report is required when billing for this service or procedure.
- 417 Denied. These services need to be rebilled under the appropriate claim number.
- 447 Denied. This supply/service is "bundled" into another procedure.
- 522 Denied. A facility fee may not be billed in conjunction with procedure code(s) 99170, 57452, or 46600.
- 525 Denied. Per CVC policy 2.00 a max of 3 counseling sessions may be authorized for a rape exam.
- 526 Denied. Rape exam follow up and treatment charges are not payable under rape exam claim number.

EOB CODES MOST COMMONLY USED FOR SEXUAL ASSAULT BILLS (continued)

- 527 Denied. Dept can pay only those services used for gathering evidence as part of a rape examination.
- 543 Denied. Mental health services payable only for desensitizing/preparing pt for rape exam procedure.
- 573 Denied. Services were done in emergency room. Time is not a factor when services provided in emergency room.
- 579 The Crime Victims Act prohibits payment for treatment of an offender.
- 583 Denied. No claim has been received by the Department for this injury and this isn't a rape exam
- 592 Denied. Documentation shows sexual assault exam performed in emergency room. Please rebill with appropriate place of service and E/M codes.
- 702 Proc billed not allowed in combination w/other code billed for this DOS. Refer to current fee schedule.
- 715 Denied. CVC is not responsible for payment when services provided are solely for the purpose of evaluation of treatment needs.
- 717 Denied. Physical exam and/or forensic evidence collection was not performed.
- 718 Denied. Exams of drug endangered children are not payable under a rape exam claim.
- 723 CVCP is not responsible for payment when the crime occurred while the victim was confined or incarcerated. See RCW 7.68.070 (3) (C).
- 728 Denied. Please rebill using appropriate sexual assault exam code 0130C through 0133C with one-page CVCP report form attached.
- 749 Avoid possible bill denial. Please submit future bills with completed one-page CVCP sexual assault report form attached.
- 773 Denied. Please itemize pharmacy/take home drugs and rebill.
- 775 Denied. Report submitted is incomplete or level of service billed does not match report information.
- 785 Procedure code 1040M not payable as part of sexual assault exam. Rebill with regular CVC claim number.
- 831 Denied. Service is payable under a different procedure code. Refer to fee schedule & rebill.
- 837 Denied. The date of service does not correspond to the supporting document's date of service.
- 870 Denied. Date of service on bill does not match the review date or report date.
- 918 Report/documentation submitted does not justify the code and/or fee billed.
- 935 Denied. This is a duplicate charge.
- 961 Denied. This is not a Washington State Crime Victim injury.
- 963 This deduction is taken for payment(s) made in error.
- 997 Refer to the accompanying explanation of benefits code listed for this service.
- A97 Denied. Dept accepts only hospital types of bill 131 through 134 on HCFA-1450 (UB92).
- B15 Place of service was changed to reflect actual site of service.
- P17 Service was paid on a more recent invoice sent to the department.

FREQUENTLY ASKED QUESTIONS

Q: When CVC denies billing for report, do you mean police report?

A: No, we need a completed one-page CVC Sexual Assault Exam Report form attached to the billing for each examiner of a sexual assault victim.

Q: If a provider admits a rape victim and it becomes an inpatient stay will CVC pay?

A: No. The provider must separate out the initial sexual assault exam charges and bill CVC separately. The patient can file an application with CVC and billings for treatment will be considered if the claim is allowed and after all private and public insurances have been billed.

Q. Can I bill for an individual counseling session?

A. Yes. In the event a child victim is unable to complete the physical sexual assault examination, after the examination has been initiated, a maximum of three counseling sessions may be authorized for the purpose of desensitizing the victim to the medical examination procedure. These counseling sessions should be billed separately under the therapist's individual provider # using procedure code 90806 and paid as part of the rape examination under diagnosis code V71.5.

Q. What services should we expect to see billed in conjunction with a sexual assault examination?

A. If an alleged victim receives a complete examination in an ER setting, the hospital will bill for costs related to that examination, including an initial ER visit.

If an alleged assault does not include life threatening injuries when a victim presents at an ER and the hospital has a sexual assault clinic associated with it, a screening exam is performed in the ER and the victim is referred to the clinic for a complete sexual assault examination. A forensic exam may be billed subsequent to the ER visit. The forensic exam must be for gathering of evidence and can occur anywhere from the same day to several weeks after the ER exam. A separate, completed one-page sexual assault report form is required for both the ER screening exam and the subsequent sexual assault examination.

Q. Is CVC responsible for payment of both the physical examination AND the social services provided on the day of the physical examination?

A. No, the social services part is not included in the physical exam.

GENERAL CPT[®] INFORMATION

Current Procedural Terminology, Fourth Edition (CPT[®]) is a systematic listing and coding of procedures and services performed by physicians. Each procedure or service is identified with a five-digit code. The use of CPT[®] codes simplifies the reporting of services. With this coding and recording system, the procedure or service rendered by the physician is accurately identified.

Inclusion of a descriptor and its associated specific five-digit identifying code number in CPT[®] is generally based upon the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations. Inclusion in CPT[®] does not represent endorsement by the American Medical Association of any particular diagnostic or therapeutic procedure. Inclusion or exclusion of a procedure does not imply any health insurance coverage or reimbursement policy.

Requests to Update CPT[®]

The effectiveness of CPT[®] is dependent upon constant updating to reflect changes in medical practice. This can only be accomplished through the interest and timely suggestions of practicing physicians, medical specialty societies, state medical associations, and other organizations and agencies. Accordingly, the American Medical Association welcomes correspondence, inquiries, and suggestions concerning old and new procedures, as well as other matters such as codes and indices.

For suggestions concerning the introduction of new procedures, or the coding, deleting, or revising of procedures contained in CPT[®], correspondence requesting an application for coding change should be directed to:

CPT[®] Editorial Research & Development
American Medical Association
515 North State Street
Chicago, Illinois 60610

All proposed additions to, or modifications of, CPT[®] will be by decision of the CPT[®] Editorial Panel after consultation with appropriate medical specialty societies.

DOCUMENTATION

The following are the basic principles of documentation. They apply to all types of medical and surgical services in all settings.

1. The medical record should be first and foremost a tool of clinical care and communication.
2. The medical record should be complete and legible.
3. The documentation of each patient encounter should include or provide reference to:

The chief complaint and/or reason for the encounter and, as appropriate, relevant history, examination findings and prior diagnostic test results:

- assessment, clinical impression or diagnosis;
 - plan for care; and
 - date legible identity of the health care professional.
4. If not specifically documented, the reason for the encounter and/or chief complaint and the rationale for ordering diagnostic and other ancillary services should be able to be easily inferred.
 5. To the greatest extent possible, past and present diagnoses and conditions, including those in the prenatal and intrapartum period that affect the newborn, should be accessible to the treating and/or consulting physician.
 6. Appropriate health risk factors should be identified.
 7. The patient's progress, response to and changes in treatment, planned follow-up care and instructions, and diagnosis should be documented.
 8. The CPT[®] and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record and be at a level sufficient for a clinical peer to determine whether services have been accurately coded.
 9. The confidentiality of the medical record should be fully maintained consistent with the requirements of medical ethics and of law.

RESOURCES

Current Procedure Terminology CPT®, American Medical Association, Chicago Illinois, 2007

Principals of CPT® Coding, American Medical Association, Chicago Illinois, 1999

Documentation – The Basics, American Medical Association web site, June 19, 1999, www.ama-assn.org/emupdate/mso292.rtf

Bulletin 98-01 - Crime Victims Compensation Program, State of Washington, Department of Labor and Industries

[RCW 7.68](#)

[RCW 7.68.170](#)

[RCW 7.68.130](#)

[WAC 296-31-030](#)

*Other formats for persons with disabilities are available on request.
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