

Clinical Policy: HCA/HTCC Clinical Policy Alignment

Reference Number: WA.CP.MP.536

Date of Last Review: 11/25

Effective Date: 01/01/26

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

This policy serves to outline specific services identified as not medically necessary in alignment with Health Care Authority (HCA) and Health Technology Clinical Committee (HTCC) determinations.

Policy/Criteria

- I. It is the policy of Coordinated Care of Washington, Inc., to align with the Health Care Authority (HCA) Billing Guidelines, Health Technology Clinical Committee (HTCC), and WAC 182-501-0070 Noncovered Services.

The following services are considered **not medically necessary**. This list is not exhaustive and additional coverage limitations may apply.

Background

This policy is based on Washington State HCA criteria and HTCC Guidelines.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Service	CPT® Codes	HTCC Review
Extracorporeal Shock Wave Therapy	28890	20170317A
Hip Resurfacing	27299, S2118	20131114B
Hip Surgery for Femoroacetabular Impingement Syndrome	29914, 29915, 29916, 27299, 29999	20191122B
Kyphoplasty, Vertebroplasty, Sacroplasty	22510, 22511, 22512, 22513, 22514, 22515	20250131A
Bronchial Thermoplasty for Asthma	31660, 31661	20160520A
Coronary Artery Calcium Scoring	75571, 0623T, 0624T, 0625T, 0626T	20091120A
Hyaluronic acid (HA)/Platelet-rich plasma (PRP)	J7320, J7321, J7322, J7323, J7324, J7325,	20230721A

Service	CPT® Codes	HTCC Review
	J7326, J7327, J7328, M0076, 0232T	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed.		11/25

References

1. Washington State Health Care Authority. *Physician-Related Services/Health Care Professional Services Billing Guide*. [Physician-Related Services/Health Care Professional Services billing guide](#) Revised October 1, 2025.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise

professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/Enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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