Washington State Health Care Authority

Washington Apple Health (Medicaid)

Expedited Prior Authorization (EPA) List

April 20, 2023

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.

Please see corresponding billing guides for the most current EPA criteria as this list may not be as up to date.

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WHAT IS EXPEDITED PRIOR AUTHORIZATION (EPA)

Expedited prior authorization (EPA) is designed to eliminate the need for written authorization.

The agency establishes authorization criteria, and identifies the criteria with specific codes, and/or situations, enabling providers to use an EPA number in replace of a formal authorization request submission.

To bill the agency for diagnostic conditions, procedures, treatments, and services that meet the EPA criteria, the provider must first determine that the specific criteria is met, then when submitting your bill for payment, enter the appropriate EPA number in the authorization number field.

The agency denies claims submitted without a required EPA/authorization number.

The agency denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the EPA number.

Note: If EPA criteria is not met, the agency requires an official authorization request to be submitted.

EPA Guidelines

The provider must verify medical necessity for the EPA number submitted. The client's medical record documentation must support the medical necessity and be available upon the agency's request. If the agency determines the documentation does not support the EPA criteria requirements, the claim will be denied.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
ACCESS TO BABY AND CHILD DENTISTRY					
See Access to Baby and Child Dentistry	D2941		interim therapeutic restoration - primary dentition	870001379	Interim therapeutic restoration (ITR) will be allowed in lieu of a definitive restoration as follows: • Child must be age 5 or younger or a DDA client through age 12 or younger. • Has current decay • ABCD provider and has completed ITR training • ITR is expected to last a minimum of one year • Allowed for a maximum of 5 teeth per visit • Based on the treating dentist clinical judgement, will be allowed yearly until can be definitively treated or until the client's 6th birthday. Not allowed in conjunction with general anesthesia (D9222, D9223, D9239, or D9243). NOT ALLOWED on the same day as other definitive restorations.
See Access to Baby and Child Dentistry	D2941		interim therapeutic restoration - primary dentition	870001380	Interim therapeutic restoration (ITR) will be allowed in lieu of a definitive restoration as follows: • Child must be age 5 or younger or a DDA client through age 12 or younger • Has current decay • ABCD provider and has completed ITR training • ITR is expected to last a minimum of one year • Allowed for a maximum of five teeth per visit • Based on the treating dentist clinical judgement, will be allowed yearly until can be definitively treated or until the client's 6th birthday. Not allowed in conjunction with general anesthesia (D9222, D9223, D9239, or D9243). D1354 (silver diamine fluoride) is not payable on the same tooth, same visit as ITR. ALLOWED on the same day as definitive treatment if documentation that the child was not able to proceed with complete treatment once started.

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AMBULANCE AND ITA TRANSPORTATION					
See Ambulance and ITA Transportation	A0428		Emergency ground ambulance to a *mental health facility*	870001398	Use when the client has • A *mental health complaint* and is willing to be transported to an alternative destination. The provider must submit an authorization form (HCA 13-680) completed and signed by: ✓ The emergency personnel and the client, OR ✓ The County Medical Program Director
	A0428		Emergency ground ambulance to a *substance use disorder treatment facility*	870001399	Use when the client • Is *incapacitated or gravely disabled by drugs or alcohol* and is willing to be transported to an alternative destination. The provider must submit an authorization form (HCA 13-680) completed and signed by: ✓ The emergency personnel and the client, OR ✓ The County Medical Program Director

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DENTAL-RELATED SERVICES					
See Dental-Related Services	D0150		Comprehensive oral evaluation	870001327	Allowed for established patients who have a documented significant change in health conditions.
See Dental-Related Services This EPA is Ending 5/11/2023	D2335		Resin 4/> surf or w incis an	870001307	Allowed for primary anterior teeth (CDEFGHMNOPQR) when determined medically necessary by a dental practitioner and a more appropriate alternative to a crown. *The agency does not pay for a crown on the same tooth if a restoration has been done within the past 6 months. **Note** - In addition to the EPA # on your claim, you must enter a claim note "Pay per authorization - see EPA information"
See Dental-Related Services	D7280		Exposure of unerupted tooth	870001366	Allowed when client has an active orthodontic treatment plan that has been approved by HCA. Allowed one time per client, per tooth. Provider performing the procedure must keep documentation (in their records) of associated orthodontic treatment plan. If HCA has not approved orthodontic treatment for the client, prior authorization is required.
	D7283		Place device impacted tooth		
See Dental-Related Services	D7971		Excision of pericoronal gingiva	870001310	Allowed when determined to be medically necessary by a dental practitioner for treatment of a newly erupting tooth.
See Dental-Related Services	D9222		Deep anest, 1st 15 min	870001387	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 agency can bill this code.
	D9223		General anesth ea addl 15 min		

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ENTERAL NUTRITION					
See Enteral Nutrition	B4157	BO, BA	Formulas for special disorders of metabolism	870001405 For clients age 20 and under	For clients age 20 and younger who have inherited metabolic disorders only
	B4162	BO, BA	Formulas for inherited disorders of metabolism		
See Enteral Nutrition	B4100		Food thickener oral	870001406 For clients age 1-20	For clients age 1 to 20 with dysphagia documented by video fluoroscopy
See Enteral Nutrition			For urgent one-time, one-month supply	870001407	For a one-month supply (one month equals 30 days) for clients age 20 and younger when: • The client has an **urgent or immediate need** for orally administered nutrition products (e.g. to prevent hospitalization). • The client has or is at risk of growth or nutrient deficits due to a condition that prevents the client from meeting their needs using food, over-the-counter nutrition products, standard infant formula, or standard toddler formula. • The prescriber has completed HCA's Enteral Nutrition Products Prescription and Order (HCA 13-961) form. See Where can I download HCA forms? A dietician must evaluate the client as soon as possible to confirm the prescribed product meets the current nutritional and caloric needs. The prescribing provider must follow-up to id

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See Enteral Nutrition			To treat a growth of nutritional deficiency (when medically necessary) Monthly supply up to 6 months	870001408	For clients age 20 and younger whose primary care physician has determined medical necessity for an orally administered enteral nutrition product. Before starting the oral enteral nutrition product, the next reasonable step care is consultation with a dietitian. This EPA covers a monthly supply for up to 6 months after the client has been evaluated by a dietitian when: • The client has or is at risk of growth or nutrient deficits due to a condition that prevents the client from meeting their needs using food, over-thecounter nutrition products, standard infant formula, or stand toddler formula. Prescribing provider must submit a growth chart with current measurement to the servicing provider (CDC growth charts are available on HCA's website if needed). • The prescriber has completed HCA's Enteral Nutrition Products Prescription and Order (HCA 13-961) form. • The client has completed Dietitian Worksheet – Oral Enteral Nutrition Assessment (HCA 13-109) form from a registered dietitian (RD) that includes all of the following: o Evaluation of the client's nutritional status, including growth and nutrient analysis. o An explanation about why the product is medically necessary as defined in WAC 182-500-0070. o A nutrition care plan that monitors the client's nutrition status and includes a plan for transitioning the client to food or food products, if possible. o Recommendations, as necessary, for the primary care provider to refer the client to other health care providers (for example, gastrointestinal specialists, allergists, speech therapists, occupational therapists, applied behavioral analysis providers, and mental health providers) who will address the client's growth or nutrient deficits.

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See Enteral Nutrition			To treat a medical condition that needs additional formula than WIC allows for medical reasons	870001425	**For clients** eligible for the WIC program, but who have a medical condition requiring additional amounts of an oral enteral nutrition product (formula) than what is allowed by WIC rules. Please note that WIC allows variable amounts of formula based on the client's age. The amount covered by Medicaid must be recalculated as the client grows and will correspond to amounts shown on the WIC table. ✓ Use the information on the *WIC/Medicaid Nutrition Form* (DOH 962-937 March 2014) to calculate the number of additional HCPCS units of the required formula as needed. Bill the additional units ONLY.
See Enteral Nutrition			Therapeutic, non-standard formula not available from WIC	870001426	For clients eligible for the WIC program, who need a therapeutic, non-standard formula that is not available from WIC due to a medical condition.

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HABILITATIVE SERVICES					
For client 21 & older: Additional Benefit Limits with Expedited Prior Authorization					
See Habilitative Services			Botox therapy with Speech therapy	870001328	When the clinical situation is: Part of a botulinum toxin injection protocol when prior authorization for the botulinum toxin treatment has been obtained from the agency. **Limitation**: Six additional units, per client, per calendar year For requesting units beyond the additional benefit limits, see **Requesting a Limitation Extension** in Billing Guide.
See Habilitative Services			Botox therapy with *Physical* therapy	870001329	When the clinical situation is: Part of a botulinum toxin injection protocol when prior authorization for the botulinum toxin treatment has been obtained from the agency. **Limitation**: Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year. For requesting units beyond the additional benefit limits, see **Requesting a Limitation Extension** in Billing Guide.
See Habilitative Services			Botox therapy with *Occupational* therapy		

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HEARING HARDWARE					
See Hearing Hardware	L8615		Coch implant headset replace	870000001	Use EPA 870000001 when billing for cochlear implant device or bone conduction hearing device replacement parts. The following must be met: • The cochlear implant device or bone conduction hearing device is unilateral (bilateral requires PA). • The manufacturer's warranty has expired. • The part is for immediate use (not a back-up part).
	L8616		Coch implant microphone repl		
	L8617		Coch implant trans coil repl		
	L8618		Coch implant tran cable repl		
	L8621		Repl zinc air battery		
	L8622		Repl alkaline battery		
	L8623		Lith ion batt CID non-earlyl		
	L8624		Lith ion batt CID, ear level		
See Hearing Hardware	V5256		Hearing aid, digit, mon, ite	870001552	**Second Hearing Aid** for clients 21 years of age and older, who have tried to adapt with one hearing aid for a period of 90 days, whose auditory screening shows an average hearing of 45 dBHL or greater in both ears and one or more of the following is documented in the client's record. The client is: • Unable to or has difficulty with conducting job duties with only one hearing aid. • Unable to or has difficulty with functioning in the school environment with only one hearing aid. • Unable to live safely in the community with only one hearing aid. Include a brief explanation of why the client's safety is a concern. • Legally blind. If a client has been using one hearing aid for 90 days, and the agency authorizes a second hearing aid, bill for the second hearing aid using a monaural procedure code. Billing a binaural code in conjunction with a monaural code within 5 years is not allowed without prior authorization.
	V5257		Hearing aid, digit, mon, bte		
See Hearing Hardware	V5275		Ear impression	870001599	For annual ear impression, per hearing aid if needed.
See Hearing Hardware	V5011		Hearing aid fitting/checking	870001600	Allowed up to three times per year for additional follow-up visits only after the initial three visits bundled with each new hearing aid are used

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HOME INFUSION THERAPY/PARENTERAL NUTRITION					
See *Home Infusion Therapy and Parenteral Nutrition Program*	A9276, A9277, A9278, A4238, A4239, E2102, E2103		Continuous glucose monitoring (CGM)	870001535	Invoice required. Use for clients: • Age 18 and younger, • Adults with Type 1 diabetes, and • Adults with Type 2 diabetes who are: ✓ Unable to achieve target HbA1C despite adherence to an appropriate glycemic management plan (after six (6) months) of intensive insulin therapy and testing blood glucose 4 or more times per day), ✓ Suffering from one or more severe (blood glucose < 50 mg/dl or symptomatic) episodes of hypoglycemia despite adherence to an appropriate glycemic management plan (intensive insulin therapy; testing blood glucose 4 or more times per day), ✓ Unable to recognize, or communicate about, symptoms of hypoglycemia
See *Home Infusion Therapy and Parenteral Nutrition Program*	A9276, A9277, A9278, A4238, A4239, E2102, E2103		Continuous glucose monitoring (CGM)	870001536	Invoice required. Use for pregnant women of any age with: • Type 1 diabetes • Type 2 diabetes and on insulin prior to pregnancy • Gestational diabetes whose blood glucose is not well controlled (HbA1C above target or experiencing episodes of hyperglycemia or hypoglycemia) during pregnancy and require insulin

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HOSPICE SERVICES					
See Hospice Services				870001409	Children 20 years old or younger - enrolled in hospice with or without concurrent care treatment. Hospice agencies will remain and are responsible for symptom control related to the child's terminal illness. See WAC 182-551-1210 to see what is included in the hospice daily rate.

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INPATIENT HOSPITAL SERVICES					
See Inpatient Hospital Services **Also in** *Physician-Related/Professional Services* **And** *Planned Home Births & Births in Birthing Centers*	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622		Obstetrical care; Early elective delivery or natural delivery **prior to 39 weeks** gestation	870001375	Client is under 39 weeks gestation and the mother or fetus has a diagnosis listed in the mother or fetus has a diagnosis listed in the Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation, or mother delivers naturally. An early elective delivery is considered medically necessary if the mother or fetus has a diagnosis listed in the Joint Commission's current table of Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation (WAC 182-533-0400). **This EPA also needs to be used for clients who deliver naturally prior to 39 weeks.**
			Elective delivery or natural delivery at or **over 39 weeks** gestation	870001378	Client is 39 weeks or more gestation. **This applies to both elective and natural deliveries for clients equal to or over 39 weeks gestation.**
INPATIENT WITHDRAWAL MANAGEMENT					
See Inpatient Hospital Services			For acute alcohol withdrawal management use-	870000433	The medical inpatient withdrawal management (previously detox) criteria are listed below. All these criteria must be met: 1. The medical inpatient withdrawal management stay cannot be a scheduled admission due to the acute nature of intoxication and the need for immediate withdrawal management. 2. The stay meets criteria for severity and intensity of illness, and medical necessity standards to qualify as an inpatient admission. 3. The principal diagnosis is related to the use or abuse of alcohol, hypnotic, hallucinogen, stimulant, opioid, or other psychoactive substance. 4. The client is not participating in HCA's Substance-Using Pregnant People (SUPP) Program. 5. The care is provided in a medical unit. 6. This is a medical stay and not a psychiatric stay. The client does not meet medically necessary criteria for inpatient psychiatric care. 7. The hospital is not a DOH-approved withdrawal management (ASAM 3.2 or 3.7) facility. 8. Nonhospital-based withdrawal management is not medically

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					appropriate. 9. The duration of treatment varies with the severity of the patient's illness and the patient's response to treatment **Claims submitted without one of the above EPA numbers will be denied.
See Inpatient Hospital Services			For acute drug withdrawal management use-	870000435	The medical inpatient withdrawal management (previously detox) criteria are listed below. All these criteria must be met: 1. The medical inpatient withdrawal management stay cannot be a scheduled admission due to the acute nature of intoxication and the need for immediate withdrawal management. 2. The stay meets criteria for severity and intensity of illness, and medical necessity standards to qualify as an inpatient admission. 3. The principal diagnosis is related to the use or abuse of alcohol, hypnotic, hallucinogen, stimulant, opioid, or other psychoactive substance. 4. The client is not participating in HCA's Substance-Using Pregnant People (SUPP) Program. 5. The care is provided in a medical unit. 6. This is a medical stay and not a psychiatric stay. The client does not meet medically necessary criteria for inpatient psychiatric care. 7. The hospital is not a DOH-approved withdrawal management (ASAM 3.2 or 3.7) facility. 8. Nonhospital-based withdrawal management is not medically appropriate. 9. The duration of treatment varies with the severity of the patient's illness and the patient's response to treatment **Claims submitted without one of the above EPA numbers will be denied.

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KIDNEY CENTER SERVICES					
See Kidney Center Services	0821		Hemodialysis treatments, more than 14 per month	870001376	To be paid for more than 14 in-center hemodialysis treatments per month, the client's medical records must support the need for additional dialysis treatments as defined by one of the following: • Unable to obtain adequate dialysis as defined by Kt/V > 1.4 with 5 hours three times per week • Refractory Fluid Overload – successive post dialysis weight increases over three runs or more (minimum 4-hour treatment) • Uncontrolled Hypertension as defined by needing 3 blood pressure medications or more and still having a pre-dialysis BP > 140/90 • Heart failure: class III C or worse (defined by New York Heart Association (NYHA) Functional Classification) or history of decompensation with HD < 4x per week (decompensation may include increase in edema, dyspnea, increased diuretic therapy, hospitalizations from heart failure) • Unable to complete run - compromised access – termed treatment early (i.e., clotted line), must meet medical necessity. • Pregnancy • Established on >14 runs per month due to one of the above noted reasons (supportive documentation required) In addition, a signed prescription for additional dialysis by a nephrologist must be in the medical record. The agency requires prior authorization (PA) if the EPA criteria above is not met. The agency may approve more than 14 in-center hemodialysis treatments for up to a 6-month period.

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MATERNITY SUPPORT SERVICES AND INFANT CASE MANAGEMENT					
See Maternity Support Services and Infant Case Management	T1017 with Dx: Z76.2	HD	Targeted case management, each 15 minutes	870001418	Use EPA# 870001418 only when the infant meets all the following criteria: • Infant meets all ICM eligibility as listed in this guide. • An infant's eligibility for ICM begins during the 2nd month of life (see ICM Newborn Calendar). • ICM services are provided during an infant's 2nd month of life. 1 unit = 15 minutes

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MEDICAL EQUIPMENT AND SUPPLIES (MES)					
Note: The following pertains to expedited prior authorization (EPA) numbers 870000851 & 870000852 ONLY: 1. If the medical condition does not meet **all** of the specified criteria, prior authorization must be obtained by submitting a request to the Medical Equipment team (refer to the Resources Available section within the corresponding billing guide). 2. It is the vendor's responsibility to determine whether the client has already used the product allowed with the EPA criteria within the previous 30 days. 3. For extension of authorization beyond the EPA amount allowed, the normal prior authorization process is required. 4. Must have a valid physician prescription as described in WAC 182-543-2000(2)(c) 5. Length of need/life expectancy, as determined by the prescribing physician, and medical justification (including **all** of the specified criteria) must be documented in the client's file. 6. You may bill for only one procedure code, per client, per month.					
See Medical Equipment & Supplies	A4335		Incontinence supply, use for diaper doublers, each (age 3 and older)	870000851	Purchase of 90 per month allowed when the product is: 1. Used for extra absorbency at nighttime only. 2. Prescribed by a physician. 3. Used inside of a brief, diaper, or pull-on.
				870000852	Up to equal amount of diapers/briefs received if **one** of the following criteria for clients is met: 1. Tube fed 2. On diuretics or other medication that causes frequent/large amounts of output 3. Brittle diabetic with blood sugar problems
See Medical Equipment & Supplies	A4927		Additional gloves for clients who live in an assisted living facility	870001262	Will be allowed up to the quantity necessary as directed by the client's physician, not to exceed a total of 400 per month. Allowed for Place of Service 13 (assisted living and adult family home) and 14 (group home).
See Medical Equipment & Supplies	A4253, A4259		Blood glucose test strips and lancets	870001263	For pregnant people with gestational diabetes, HCA pays for the quantity necessary to support testing as directed by the client's physician, up to 60 days postpartum.
			Blood glucose test strips/lancets for children through age 20	870001265	100 over limit - for children only

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RENTALS					
What are the expedited prior authorization (EPA) criteria for equipment rental? **Note:** **The following pertains to expedited prior authorization (EPA) numbers 700 - 820:** 1. If the medical condition does not meet **all** of the specified criteria, prior authorization (PA) must be obtained by submitting a request. 2. It is the vendor's responsibility to determine whether the client has already used the product allowed with the EPA criteria within the allowed time period, or to determine if, the client has already established EPA through another vendor during the specified time period. 3. For extension of authorization beyond the EPA amount allowed, the normal PA process is required. 4. A valid physician prescription is required as described in WAC 182-543-2000(2)(c)) 5. Documentation of the length of need/life expectancy must be kept in the client's file, as determined by the prescribing physician and medical justification (including **all** of the specified criteria).					
RENTAL MANUAL WHEELCHAIRS					
Note (For Rental Manual Wheelchairs): 1) The EPA rental is allowed only one time, per client, per 12-month period. 2) If the client is hospitalized or is a resident of a nursing facility and is being discharged to a home setting, rental may not start until the date of discharge. Documentation of the date of discharge must be included in the client's file. Rentals for clients in a skilled nursing facility are included in the nursing facility daily rate, and in the hospital they are included in the Diagnoses Related Group (DRG) payment. 3) The agency does not rent equipment during the time that a request for similar purchased equipment is being assessed, when authorized equipment is on order, or while the client-owned equipment is being repaired and/or modified. The vendor of service is expected to supply the client with an equivalent loaner. 4) You may bill for only one procedure code, per client, per month. 5) All accessories are included in the reimbursement of the wheelchair rental code. They may not be billed separately.					
See Medical Equipment & Supplies	K0001	RR	Standard manual wheelchair with all styles of arms, footrest, and/or leg-rests	870000700	Up to 2 months continuous rental in a 12-month period if ***all*** of the following criteria are met. The client: 1) Weighs 250 lbs. or less. 2) Requires a wheelchair to participate in normal daily activities. 3) Has a medical condition that renders him/her totally non-weight bearing or is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file). 4) Does ***not*** have a rental hospital bed. 5) Has a length of need, as determined by the prescribing physician, less than 6 months.

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See Medical Equipment & Supplies	K0003	RR	Lightweight manual wheelchair with all styles of arms, footrests, and/or leg-rests	870000705	Up to 2 months continuous rental in a 12-month period if ***all*** of the following criteria are met. The client: 1) Weighs 250 lbs. or less; 2) Can self-propel the lightweight wheelchair and is unable to propel a standard weight wheelchair; 3) Has a medical condition that renders him/her totally non-weight bearing or is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file); 4) Does ***not*** have a rental hospital bed; and 5) Has a length of need, as determined by the prescribing physician, less than 6 months.
See Medical Equipment & Supplies	K0006	RR	Heavy-duty manual wheelchair with all styles of arms, footrests, and/or leg-rests	870000710	Up to 2 months continuous rental in a 12-month period if ***all*** of the following criteria are met. The client: 1) Weighs 250 lbs. or more 2) Requires a wheelchair to participate in normal daily activities. 3) Has a medical condition that renders him/her totally non-weight bearing or is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file). 4) Does ***not*** have a rental hospital bed; and 5) Has a length of need, as determined by the prescribing physician, less than 6 months.
See Medical Equipment & Supplies	E1060	RR	Fully reclining manual wheelchair with detachable arms, desk or full-length and swing-away or elevating leg-rests	870000715	Up to 2 months continuous rental in a 12-month period if ***all*** of the following criteria are met. The client: 1) Requires a wheelchair to participate in normal daily activities and is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file); 2) Has a medical condition that does not allow them to sit upright in a standard or lightweight wheelchair (must be documented); 3) Does ***not*** have a rental hospital bed; and 4) Has a length of need, as determined by the prescribing physician, less than 6 months.

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RENTAL/PURCHASE HOSPITAL BEDS					
Note: 1) The EPA rental is allowed only one time, per client, per 12-month period. 2) Authorization must be requested for the 12th month of rental at which time the equipment will be considered purchased. The authorization number will be pended for the serial number of the equipment. In such cases, the equipment the client has been using must have been new on or after the start of the rental contract or is documented to be in good working condition. A 1-year warranty will take effect as of the date the equipment is considered purchased if equipment is not new. Otherwise, normal manufacturer warranty will be applied. 3) If length of need is greater than 12 months, as stated by the prescribing physician, a PA for purchase must be requested either in writing or via the toll-free line. 4) If the client is hospitalized or is a resident of a nursing facility and is being discharged to a home setting, rental may not start until the date of discharge. Documentation of the date of discharge must be included in the client's file. Rentals for clients in a skilled nursing facility are included in the nursing facility daily rate, and in the hospital they are included in the DRG payment. 5) The agency does not rent equipment during the time that a request for similar purchased equipment is being assessed, when authorized equipment is on order, or while the client-owned equipment is being repaired and/or modified. The vendor of service is expected to supply the client with an equivalent loaner. 6) Hospital beds **will not** be provided: a. As furniture. b. To replace a client-owned waterbed. c. For a client who does not own a standard bed with mattress, box spring, and frame. d. If the client's standard bed is in an area of the home that is currently inaccessible by the client such as an upstairs bedroom. 7) Only one type of bed rail is allowed with each rental. 8) Mattress may **not** be billed separately.					
See Medical Equipment & Supplies	E0292 E0310 E0305	RR	Manual Hospital Bed with mattress with or without bed rails	870000720	The client: 1) Has a length of need/life expectancy that is 12 months or less. 2) Has a medical condition that requires positioning of the body that cannot be accomplished in a standard bed (reason must be documented in the client's file). 3) Has tried pillows, bolsters, and/or rolled up blankets/towels in client's own bed, and determined to not be effective in meeting client's positioning needs (nature of ineffectiveness must be documented in the client's file). *CONTINUED ON NEXT PAGE* 4) Has a medical condition that necessitates upper body positioning at no less than a 30-degree angle the majority of time he/she is in the bed.

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					5) Has full-time caregivers. 6) Does **not** also have a rental wheelchair.
See Medical Equipment & Supplies	E0294 E0310 E0305	RR	Semi-electric hospital bed with mattress with or without bed rails	870000725	Up to 11 months continuous rental in a 12-month period if **all** of the following criteria are met. The client: 1) Has a length of need/life expectancy that is 12 months or less. 2) Has tried pillows, bolsters, and/or rolled up blankets/towels in client's own bed, and determined to be ineffective in meeting client's positioning needs (nature of ineffectiveness must be documented in the client's file). 3) Has a chronic or terminal condition such as COPD, CHF, lung cancer or cancer that has metastasized to the lungs, or other pulmonary conditions that cause the need for immediate upper body elevation. 4) Must be able to independently and safely operate the bed controls. 5) Does **not** have a rental wheelchair. 6) Has a completed *Hospital Bed Evaluation* form, HCA 13-747. See *Where can I download agency forms*?

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Note: 1) The EPA criteria is to be used only for an initial purchase per client, per lifetime. It is not to be used for a replacement or if EPA rental has been used within the previous 24 months. 2) It is the vendors' responsibility to determine if the client has not been previously provided a hospital bed, either purchase or rental. 3) Hospital beds **will not** be covered: a. As furniture b. To replace a client-owned waterbed c. For a client who does not own a standard bed with mattress, box spring and frame d. If the client's standard bed is in an area of the home that is currently inaccessible by the client such as an upstairs bedroom					
See Medical Equipment & Supplies	E0294	NU	Semi-electric hospital bed with mattress with or without bed rails	870000726	Initial purchase if **all** of the following criteria are met. The client: 1. Has a length of need/life expectancy that is 12 months or more. 2. Has tried positioning devices such as: pillows, bolsters, foam wedges, and/or rolled up blankets/towels in own bed, and been determined ineffective in meeting positioning needs (nature of ineffectiveness must be documented in the client's file). 3. Has one of the following diagnoses: a. Quadriplegia b. Tetraplegia c. Duchenne's M.D. d. ALS e. Ventilator dependent f. COPD or CHF with aspiration risk or shortness of breath that causes the need for an immediate position change of more than 30 degrees 4. Must be able to independently and safely operate the bed controls. **Documentation Required:** 1) Life expectancy, in months and/or years 2) Client diagnosis including ICD code 3) Date of delivery and serial number *CONTINUED ON NEXT PAGE*

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					4) Written documentation indicating client has not been previously provided a hospital bed, purchase, or rental (i.e. written statement from client or caregiver) 5) A completed *Hospital Bed Evaluation* form, HCA 13-747. See *Where can I download agency forms*?
LOW AIR LOSS THERAPY SYSTEMS					
Note: The EPA rental is allowed only one time, per client, per 12-month period.					
See Medical Equipment & Supplies	E0371 E0372	RR	Low air loss mattress overlay	870000730	Initial 30-day rental followed by one additional 30-day rental in a 12-month period if **all** of the following criteria are met. The client: 1) Is bed-confined 20 hours per day during rental of therapy system. 2) Has at least one stage 3 decubitus ulcer on trunk of body. 3) Has acceptable turning and repositioning schedule. 4) Has timely labs (every 30 days). 5) Has appropriate nutritional program to heal ulcers.
See Medical Equipment & Supplies	E0277 E0373	RR	Low air loss mattress without bed frame	870000735	Initial 30-day rental followed by an additional 30-day rental in a 12-month period if **all** of the following criteria are met. The client: 1) Is bed-confined 20 hours per day during rental of therapy system. 2) Has multiple stage 3/4 decubitus ulcers or one stage 3/4 with multiple stage 2 decubitus ulcers on trunk of body. 3) Has ulcers on more than one turning side. 4) Has acceptable turning and repositioning schedule. 5) Has timely labs (every 30 days). 6) Has appropriate nutritional program to heal ulcers.
See Medical Equipment & Supplies	E0277 E0373	RR	Low air loss mattress without bed frame	870000740	Initial 30-day rental in a 12-month period upon hospital discharge following a flap surgery.

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See Medical Equipment & Supplies	E0194	RR	Air fluidized flotation system including bed frame	870000750	Initial 30-day rental in a 12-month period upon hospital discharge following a flap surgery. **For all Low Air Loss Therapy Systems the following documentation is required**: 1) *A Low Air-Loss Therapy Systems* form, HCA 13-728 must be completed for each rental segment and signed and dated by nursing staff in facility or client's home. See *Where can I download agency forms*? 2) A new form must be completed for each rental segment. 3) A re-dated prior form will not be accepted. 4) A dated picture must accompany each form.
NONINVASIVE BONE GROWTH/NERVE STIMULATORS					
Note: The EPA rental is allowed only one time, per client, per 12-month period.					
See Medical Equipment & Supplies	E0747 E0760	NU	Non-spinal bone growth stimulator	870000765	Allowed **only** for purchase of brands that have pulsed electromagnetic field simulation (PEMF) when **one or more** of the following criteria is met. The client: 1) Has a nonunion of a long bone fracture (which includes clavicle, humerus, phalanges, radius, ulna, femur, tibia, fibula, metacarpal and metatarsal) after 6 months has elapsed since the date of injury without healing. 2) Has a failed fusion of a joint other than in the spine where a minimum of 6 months has elapsed since the last surgery.
See Medical Equipment & Supplies	E0748	NU	Spinal bone growth stimulator	870000770	Allowed for purchase when the prescription is from a neurologist, an orthopedic surgeon, or a neurosurgeon and when **one or more** of the following criteria is met. The client: 1) Has a failed spinal fusion where a minimum of 9 months has elapsed since the last surgery. 2) Is post-op from a multilevel spinal fusion surgery. 3) Is post-op from spinal fusion surgery where there is a history of a previously failed spinal fusion.

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MISCELLANEOUS DURABLE MEDICAL EQUIPMENT					
See Medical Equipment & Supplies	E0604	RR	Breast pump, electric	870000800	Unit may be rented for the following lengths of time, when **one** of the following criteria is met. The client: 1) Has a maximum of 2 weeks during any 12-month period for engorged breasts, or 2) Has a maximum of 3 weeks during any 12-month period if the client is on a regimen of antibiotics for a breast infection. 3) Has a maximum of 2 months during any 12-month period if the client has a newborn with a cleft palate. 4) Has a maximum of 2 months during any 12-month period if the client meets all of the following: a. Has a hospitalized premature newborn b. Has been discharged from the hospital c. Is taking breast milk to hospital to feed newborn
See Medical Equipment & Supplies	E0935	RR	Continuous passive motion system (CPM)	870000810	Up to 10 days rental during any 12-month period, upon hospital discharge, when the client is diagnosed with **one** of the following: 1) Frozen joints 2) Intra-articular tibia plateau fracture 3) Anterior cruciate ligament injury 4) Total knee replacement
See Medical Equipment & Supplies	E0650	RR	Extremity pump	870000820	Up to 2 months rental during a 12-month period for treatment of severe edema. Purchase of the equipment should be requested and rental not allowed when equipment has been determined to be all of the following: 1) Medically effective 2) Medically necessary 3) A long-term, permanent need
See Medical Equipment & Supplies	A9286		Hygienic item, bed encasement, mattress (twin) age 20 and younger	870001604	See *Bed and Pillow Encasements* form HCA 13-0052. See **Where can I download HCA forms**?
See Medical Equipment & Supplies	A9286		Hygienic item, bed encasement, pillowcases (set of	870001605	See *Bed and Pillow Encasements* form HCA 13-0052. See **Where can I download HCA forms**?

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
			2) age 20 and younger.		
MEDICAL NUTRITION THERAPY					
www.hca.wa.gov/assets/billers-and-providers/Medical-nutrition-ther-bg-20230317.pdf https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules	97802		Medical nutrition, indiv in	870001644	Clients aged 21 and older must have one of the following medical conditions: • Body mass index (BMI) of 30 kg/m2 or higher • Cardiovascular risk factors (hypertension, dyslipidemia, congestive heart failure) • Diabetes mellitus • Chronic kidney disease
	97803		Medical nutrition, indiv subseq		
	97804		Medical nutrition, group		

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MENTAL HEALTH SERVICES			
EPA NUMBERS REPRESENTING EVIDENCE-BASED PRACTICE			
See Mental Health Services	**Training Entity**	**Treatment Family**	**EPA number**
	Acceptance and Commitment Therapy (ACT) for children with anxiety	CBT for Anxiety	870001555
	Acceptance and Commitment Therapy (ACT) for children with depression	CBT for Depression	870001566
	Adlerian Play Therapy	Parent Behavioral Therapy	870001572
	Attachment and Biobehavioral Catch-up (ABC)	Infant Mental Health	870001632
	Attachment-Based Family Therapy	CBT for Depression	870001566
	Barkley Model	ADHD	870001563
	Being Brave	CBT for Anxiety	870001555
	Blues Program	CBT for Depression	870001571
	Brief PMTO	Parent Behavioral Therapy	870001572
	Brief Strategic Family Therapy (BSFT)	Parent Behavioral Therapy	870001582
	Child Behavioral Therapy (Individual)	Parent Behavioral Therapy	870001572
	Child Life and Attention Skills (CLAS)	ADHD	870001633
	Child Parent Relationship Therapy	Parent Behavioral Therapy	870001572
	Child-Parent Psychotherapy	Infant Mental Health	870001597
	Classroom-based intervention for war exposed children	CBT for Trauma	870001589
	Coaching Our Acting-Out Children: Heightening Essential Skills (COACHES)	ADHD	870001634
	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	CBT for Trauma	870001590
	Cognitive Behavioral Therapy (CBT) for Psychosis	CBT for first episode psychosis	870001635
	Collaborative Assessment and Management of Suicidality (CAMS)	Significant Mood Disorders and Self Harm	870001636
	Communication Method Program (COMET)	Parent Behavioral Therapy	870001572
	Confident Kids	CBT for Anxiety	870001555
	Cool Kids	CBT for Anxiety	870001556
	Coping Cat	CBT for Anxiety	870001557
	Coping Cat/Koala book-based model	CBT for Anxiety	870001558
	Coping Koala	CBT for Anxiety	870001559
	Coping Power Program	Parent Behavioral Therapy	870001572
	Coping With Depression – Adolescents	CBT for Depression	870001567

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria	*Expedited Prior Authorization Inventory*
See Mental Health Services	Dialectical Therapy (DBT) Therapy (DBT) for adolescent self-harming behavior				Significant Mood Disorders and Self Harm	870001585
	Effective Child Therapy/ Society of Clinical Child and Adolescent Psychology				CBT for Anxiety	870001555
	Effective Child Therapy / Society of Clinical Child and Adolescent Psychology				CBT for Depression	870001566
	Enhanced Behavioral Family Intervention				Parent Behavioral Therapy	870001572
	Enhancing Resiliency Among Students Experiencing Stress (ERASE-Stress)				CBT for Trauma	870001591
	Exposure-Response Prevention (ERP) for youth with obsessive-compulsive disorder (OCD)				CBT for OCD	870001637
	Eye Movement Desensitization and Reprocessing (EMDR)				CBT for Trauma	870001598
	Family-Based Treatment (FBT) for eating disorders				Eating Disorders	870001638
	First Step to Success				Parent Behavioral Therapy	870001572
	Functional Family Therapy				Adolescent family systems	870001639
	Get Lost Mr. Scary Program				CBT for Anxiety	870001555
	Group Mind-Body Skills				CBT for Trauma	870001588
	Harborview CBT+ Learning Collaborative				CBT for Anxiety	870001555
	Harborview CBT+ Learning Collaborative				CBT for Depression	870001566
	Harborview CBT+ Learning Collaborative				CBT for Trauma	870001588
	Harborview CBT+ Learning Collaborative				Parent Behavioral Therapy	870001572
	Harborview CBT+ Learning Collaborative				ADHD	870001617
	Helping Noncompliant Child				Parent Behavioral Therapy	870001573
	Incredible Years Basic				Parent Behavioral Therapy	870001574
	Incredible Years: Parent training + Child training				Parent Behavioral Therapy	870001575
	Individual-based IPT (12 sessions)				Interpersonal Psychotherapy for Depression	870001618
	Infant-Parent Psychotherapy (IPP)				Infant Mental Health	870001619
	Integrated behavior therapy for selective mutism				CBT for Anxiety	870001555
	Interpersonal Psychotherapy Adolescent Skills Training (IPT-AST)				Interpersonal Psychotherapy for Depression	870001620
	Kids Club & Moms Empowerment				CBT for Trauma	870001588
	Managing and Adapting Practice (MAP)				CBT for Anxiety	870001560
	Managing and Adapting Practice (MAP)				CBT for Depression	870001568
	Managing and Adapting Practice (MAP)				CBT for Trauma	870001593

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria	*Expedited Prior Authorization Inventory*
See Mental Health Services	Managing and Adapting Practice (MAP)				Parent Behavioral Therapy	870001576
	Modularized Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct (MATCH-ADTC)				CBT for Anxiety	870001561
	Modularized Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct (MATCH-ADTC)				CBT for Depression	870001569
	Modularized Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct (MATCH-ADTC)				CBT for Trauma	870001594
	Modularized Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct (MATCH-ADTC)				Parent Behavioral Therapy	870001577
	Multimodal Therapy (MMT) for children with ADHD				ADHD	870001565
	Multimodal therapy (MMT) for children with disruptive behavior				Parent Behavioral Therapy	870001572
	Multisystemic Therapy (MST) for youth with serious emotional disturbance (SED)				Mood disorders; Adolescent Family Systems	870001586
	Narrative Exposure Therapy (KID-NET)				CBT for Trauma	870001592
	National Child Traumatic Stress Network Learning Collaboratives				Infant Mental Health	870001621
	Neurofeedback Training				ADHD	870001622
	New Forest Parenting Program (NFPP)				ADHD	870001564
	Oregon Social Learning Program (OSLO)				Parent Behavioral Therapy	870001572
	Organizational Skills Training (OST)				ADHD	870001623
	Parent cognitive behavioral therapy (CBT) for children with anxiety				CBT for Anxiety	870001562
	Parent Management Training (PMT)				Parent Behavioral Therapy	870001572
	Parent Management Training Oregon (PMTO)				Parent Behavioral Therapy	870001579
	Parent-Child Interaction Therapy (PCIT)				Parent Behavioral Therapy	870001578
	Plan My Life (PML)				ADHD	870001624
	Primary and Secondary Control Enhancement (PASCET)				CBT for Depression	870001566
	Problem Solving Skills Training				Parent Behavioral Therapy	870001572
	Prolonged Exposure for Adolescents (PE-A)				CBT for Trauma	870001588
	Promoting First Relationships (PFR)				Infant Mental Health	870001625
	Research Units in Behavioral Intervention (RUBI)				Parent Behavioral Therapy	870001572
	Risk Reduction through Family Therapy (RRFT)				CBT for Trauma	870001588
	Seattle Children's Eating Disorder Clinic				Eating Disorders	870001626
	Seattle Children's OCD-Intensive Outpatient Program (OCD-IOP)				CBT for OCD	870001627
	Social Learning Parent Training (Hanf model)				Parent Behavioral Therapy	870001572
	STAY				Parent Behavioral Therapy	870001572

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See Mental Health Services	Stop Now and Plan (SNAP)				Parent Behavioral Therapy	870001572
	Strategies to Enhance Positive Parenting (STEPP)				ADHD	870001628
	Support for Students Exposed to Trauma (SSET)				CBT for Trauma	870001588
	Supporting Teens' Autonomy Daily (STAND)				ADHD	870001629
	Take Action Program				CBT for Anxiety	870001555
	Taming Sneaky Fears				CBT for Anxiety	870001555
	Teaching Recovery Techniques (TRT)				CBT for Trauma	870001588
	The CALM Program				CBT for Anxiety	870001555
	The Reach Institute (CATIE trainings)				CBT for Trauma	870001588
	The Reach Institute (CATIE trainings)				Parent Behavioral Therapy	870001572
	The Reach Institute (CATIE trainings)				CBT for Anxiety	870001555
	The Reach Institute (CATIE trainings)				CBT for Depression	870001566
	Theraplay				Infant Mental Health	870001630
	Timid to Tiger				CBT for Anxiety	870001555
	Trauma Affect Regulation: Guide for Education and Therapy (TARGET)				CBT for Trauma	870001588
	Trauma Focused CBT for children				CBT for Trauma	870001595
	Triple P Precursor				Parent Behavioral Therapy	870001572
	Triple P Precursor Parenting Program: Level 4, Group				Parent Behavioral Therapy	870001580
	Triple-P Positive Parenting Program: Level 4, Individual				Parent Behavioral Therapy	870001581
	Tuning Into Kids				Parent Behavioral Therapy	870001572
	Turtle Program				CBT for Anxiety	870001555
	University of Washington Certificate in EBP in Children's Behavioral Health				CBT for Trauma	870001588
	University of Washington Certificate in EBP in Children's Behavioral Health				Parent Behavioral Therapy	870001572
	University of Washington Certificate in EBP in Children's Behavioral Health				CBT for Anxiety	870001555
	University of Washington Certificate in EBP in Children's Behavioral Health				CBT for Depression	870001566
	University of Washington First Episode Psychosis/CBT for Psychosis Program				CBT for First Episode Psychosis	870001631
	University of Washington MA in Applied Child and Adolescent Psychology				Parent Behavioral Therapy	870001572

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See Mental Health Services	University of Washington MA in Applied Child and Adolescent Psychology				CBT for Anxiety	870001555
	University of Washington Certificate in EBP in Children's Behavioral Health				CBT for Depression	870001566
	University of Washington First Episode Psychosis/CBT for Psychosis Program				CBT for Psychosis	870001631
	University of Washington MA in Applied Child and Adolescent Psychology				Parent Behavioral Therapy	870001572
	University of Washington MA in Applied Child and Adolescent Psychology				CBT for Anxiety	870001555
	University of Washington MA in Applied Child and Adolescent Psychology				CBT for Depression	870001566
	University of Washington MA in Applied Child and Adolescent Psychology				CBT for Trauma	870001588
EPA FOR BILLING INPATIENT PSYCHIATRIC SERVICES FOR ELIGIBLE APPLE HEALTH CLIENTS WITHOUT A MANAGED CARE PLAN OR BEHAVIORAL HEALTH SERVICES ORGANIZATION (BHSO)						
See Mental Health Services	**Involuntary** Treatment Act Admissions for Apple Health clients without a managed care plan			870001610	Use this EPA when the patient is detained under the Involuntary Treatment Act (ITA) in chapters 71.05 and 71.34 RCW Inpatient psychiatric care for all fee-for-service Apple Health clients (see Services requiring EPA) must be all the following: • Medically necessary (as defined in WAC 182-500-0070) • Admissions where psychiatric needs are the focus of treatment • Less restrictive placements are not available • Approved (ordered) by the professional in charge of the hospital or hospital unit Services provided in a psychiatric hospital shall have psychiatric diagnosis and be in APR DRG 740-760, 770, and 772-776 A new authorization or EPA must be used when there is a change in any of the below: • Legal status • Principal covered diagnosis • Hospital of service	

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See Mental Health Services	**Voluntary** Admissions for Apple Health clients without a managed care plan			870001611	Use this EPA when the patient agrees to admission for treatment. Inpatient psychiatric care for all fee-for-service Apple Health clients (see **Services requiring EPA**) must be all of the following: • Medically necessary (as defined in **WAC 182-500-0070**) • Admissions where psychiatric needs are the focus of treatment • Less restrictive placements are not available • Approved (ordered) by the professional in charge of the hospital or hospital unit Services provided in a psychiatric hospital shall have psychiatric diagnosis and be in APR DRG 740-760, 770, and 772-776 A new authorization or EPA must be used when there is a change in any of the below: • Legal status • Principal covered diagnosis • Hospital of service
See Mental Health Services	**Voluntary** Admissions for Apple Health clients without a managed care plan			870001612	Use this EPA when the patient agrees to admission for treatment. Evaluation and Treatment inpatient residential care for all fee-for-service Apple Health clients (see Services requiring EPA) must be all of the following: • Medically necessary (as defined in WAC 182-500-0070) • Admissions where psychiatric needs are the focus of treatment and not have an acute medical condition • Less restrictive placements are not available • Approved (ordered) by the professional in charge of the facility Services provided in an evaluation and treatment centers shall have psychiatric diagnosis and be in APR DRG 740-760, 770, and 772-776 A new authorization or EPA must be used when

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					there is a change in any of the below: • Legal status • Principal covered diagnosis • Place of service
See Mental Health Services	**Involuntary** Admissions for Apple Health clients without a managed care plan			870001613	Use this EPA when the patient has been **detained through the Involuntary Treatment Act.** Evaluation and Treatment inpatient residential care for all fee-for-service Apple Health clients (see Services requiring EPA) must be all of the following: • Medically necessary (as defined in WAC 182-500-0070) • Admissions where psychiatric needs are the focus of treatment and not have an acute medical condition • Less restrictive placements are not available • Approved (ordered) by the professional in charge of the facility Services provided in an evaluation and treatment centers shall have psychiatric diagnosis and be in APR DRG 740-760, 770, and 772-776 A new authorization or EPA must be used when there is a change in any of the below: • Legal status • Principal covered diagnosis • Place of service
ORTHODONTIC SERVICES					
Note: Providers must correctly indicate the appliance date on **all** orthodontic treatment claims.					
See Orthodontic Services	D8660		Pre-orthodontic treatment visit	870000970	Use when billing for cleft palate and craniofacial anomaly cases. Treating provider **must** be an orthodontist **and either be** a member of a recognized craniofacial team **or** approved by the agency's Dental Consultant to provide this service. Medically necessary ICD diagnosis codes associated with cleft palate, cleft uvula or cleft lip must be documented in the client's record. ICD

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					diagnosis codes associated with craniofacial anomalies per WAC 182-535A-0040 need to be documented to use EPA.
See Orthodontic Services	D8030		Limited orthodontic treatment of the adolescent dentition	870000970	Use when billing for cleft palate and craniofacial anomaly cases. Treating provider **must** be an orthodontist **and** be either a member of a recognized craniofacial team or approved by HCA's Dental Consultant to provide this service. Medically necessary ICD diagnosis codes associated with cleft palate, cleft uvula or cleft lip must be documented in the client's record. ICD diagnosis codes associated with craniofacial anomalies per WAC **182-535A-0040** need to be documented to use EPA. Limitations apply. EPA does not override the limitations/requirements for limited treatment. See **limited orthodontic treatment**
See Orthodontic Services	D8670		Limited orthodontic treatment of the adolescent dentition	870000970	Use when billing for cleft palate and craniofacial anomaly cases. Treating provider must be an orthodontist and either be a member of a recognized craniofacial team or approved by HCA's Dental Consultant to provide this service. Medically necessary ICD diagnosis codes associated with cleft palate, cleft uvula or cleft lip must be documented in the client's record. ICD diagnosis codes associated with craniofacial anomalies per WAC 182-535A-0040 need to be documented to use EPA. Limitations apply. EPA does not override the limitations/requirements for limited treatment. See limited orthodontic treatment.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Orthodontic Services	D8080 D8670		Comprehensive orthodontic treatment of the adolescent dentition	870000990	Use when billing for cleft lip and/or palate and craniofacial anomaly cases. Treating provider **must** be an orthodontist **and be either** a member of a recognized craniofacial team or approved by HCA's Dental Consultant to provide this service. Medically necessary ICD diagnosis codes associated with cleft lip and palate, cleft palate or cleft lip must be documented in the client's record. ICD diagnosis codes associated with craniofacial anomalies per WAC 182- 535A-0040 need to be documented to use EPA. Limitations apply. EPA does not override the limitations/requirements for comprehensive treatment. See comprehensive orthodontic treatment. Limitations apply. EPA does not override the limitations/requirements for comprehensive treatment. See **comprehensive orthodontic treatment**.
See Orthodontic Services	D7280		Surgical access of an unerupted permanent tooth	870001366	Allowed when client has an active orthodontic treatment plan that has been approved by HCA. Allowed one time per client, per tooth. Provider performing the procedure must keep documentation (in their records) of associated orthodontic treatment plan. If HCA has not approved orthodontic treatment for the client, a prior authorization is required.
	D7283		Placement of device to facilitate eruption of impacted permanent tooth	870001366	Allowed when client has an active orthodontic treatment plan that has been approved by HCA. Allowed one time per client, per tooth. Provider performing the procedure must keep documentation (in their records) of associated orthodontic treatment plan. If HCA has not approved orthodontic treatment for the client, a prior authorization is required.
See Orthodontic Services	D8020		Limited orthodontic treatment of the transitional dentition	870001402	Use when billing for cleft lip and/or palate and craniofacial anomaly cases. Treating provider **must** be an orthodontist **and either be** a member of a recognized craniofacial team or approved by HCA's Dental Consultant to provide this service. Medically necessary ICD diagnosis codes associated with cleft lip and

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					palate, cleft palate or cleft lip must be documented in the client's record. ICD diagnosis codes associated with craniofacial anomalies per WAC 182-535A-0040 need to be documented to use EPA. Limitations apply. EPA does not override the limitations/requirements for limited treatment. See limited orthodontic treatment.
See Orthodontic Services	D8670		Limited orthodontic treatment of the transitional dentition	870001403	Use when billing for cleft lip and/or palate and craniofacial anomaly cases. Treating provider **must** be an orthodontist **and either be** a member of a recognized craniofacial team or approved by HCA's Dental Consultant to provide this service. Medically necessary ICD diagnosis codes associated with cleft lip and palate, cleft palate or cleft lip must be documented in the client's record. ICD diagnosis codes associated with craniofacial anomalies per WAC 182- 535A-0040 need to be documented to use EPA. Limitations apply. EPA does not override the limitations/requirements for limited treatment. See limited orthodontic treatment
See Orthodontic Services	21077, 21079, 21080, 21081, 21082, 21083, 21084, 21085, 21086, 21087, 21088, 21089		Prepare face/oral prosthesis Appropriate diagnosis code M26220, M2603, M2602, M26213	870001539	Use when billing for orthognathic surgery. There must be an approval in the system for full comprehensive orthodontic treatment for the client, plus all of the following in the client's record: • A treatment plan, including expected surgical intervention Current Procedural Terminology (CPT) codes. • Documentation that the commitment letter from the surgeon was included in the request for full comprehensive orthodontic treatment. • Cephalometric radiographs (x-rays). Color photographs/IO (intraoral) scans (including five intraoral and three facial views).
See Orthodontic Services	21141, 21142, 21143, 21145, 21146, 21147, 21150,		Reconstruct midface lefort Appropriate diagnosis code M26220, M2603, M2602, M26213	870001539	Use when billing for orthognathic surgery in **an outpatient or inpatient setting.** There must be an approval in the system for full comprehensive orthodontic treatment for the client, plus all of the following in the client's record: • A treatment plan, including expected surgical intervention Current Procedural Terminology (CPT®) codes.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					• Documentation that the commitment letter from the surgeon was included in the request for full comprehensive orthodontic treatment. • Cephalometric radiographs (xrays). Color photographs/IO (intraoral) scans (including five intraoral and three facial views).
See Orthodontic Services	21193, 21195, 21196, 21198, 21199		Reconstruct lower jaw Appropriate diagnosis code M26220, M2603, M2602, M26213	870001539	Use when billing for orthognathic surgery in an **outpatient or inpatient** setting. There must be an approval in the system for full comprehensive orthodontic treatment for the client, plus all of the following in the client's record: • A treatment plan, including expected surgical intervention Current Procedural Terminology (CPT®) codes. • Documentation that the commitment letter from the surgeon was included in the request for full comprehensive orthodontic treatment. • Cephalometric radiographs (xrays). Color photographs/IO (intraoral) scans (including five intraoral and three facial views).
See Orthodontic Services	21151, 21154, 21155, 21159, 21160		Reconstruct midface lefort Appropriate diagnosis code M26220, M2603, M2602, M26213	870001539	Use when billing for orthognathic surgery in **an inpatient hospital** setting; NOT an outpatient setting. There must be an approval in the system for full comprehensive orthodontic treatment for the client, plus all of the following in the client's record: • A treatment plan, including expected surgical intervention Current Procedural Terminology (CPT®) codes. • Documentation that the commitment letter from the surgeon was included in the request for full comprehensive orthodontic treatment. • Cephalometric radiographs (xrays). Color photographs/IO (intraoral) scans (including five intraoral and three facial views).
See Orthodontic Services	21194		Reconstruct lower jaw Appropriate diagnosis code	870001539	Use when billing for orthognathic surgery in **an inpatient hospital** setting; NOT an outpatient setting. There must be an approval in the system for full comprehensive orthodontic treatment for the client, plus all of the following in the client's record:

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
			M26220, M2603, M2602, M26213		• A treatment plan, including expected surgical intervention Current Procedural Terminology (CPT®) codes. • Documentation that the commitment letter from the surgeon was included in the request for full comprehensive orthodontic treatment. • Cephalometric radiographs (x-rays). Color photographs/IO (intraoral) scans (including five intraoral and three facial views).

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*

OUTPATIENT REHABILITATION					
ALL CLIENTS 21 AND OLDER & MCS CLIENTS AGES 19-20 additional benefit limits with expedited prior authorization					
OCCUPATIONAL THERAPY AND PHYSICAL THERAPY					**When client's diagnosis is:**
See Outpatient Rehabilitation	Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year See **Requesting a Limitation Extension** in the Outpatient Rehabilitation Billing Guide for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table. **NOTE: Physical therapy claims require modifier GP,** and **Occupational therapy claims require modifier GO**			870000008	Lymphedema
				870000009	Cerebral vascular accident, with residual functional deficits within the past 24 months
				870000010	Swallowing deficits due to injury or surgery to face, head, or neck
				870000011	As part of a botulinum toxin injection protocol when botulinum toxin is prior authorized by the agency
				870000012	Spinal cord injury resulting in paraplegia or quadriplegia within the past 24 months
				870000013	Major joint surgery – partial or total replacement only
				870000014	New onset muscular-skeletal disorders such as complex fractures which require surgical intervention or surgeries involving spine or extremities (e.g., arm, shoulder, leg, foot, knee, or hip)
				870000015	Acute, open, or chronic non-healing wounds **OR** Burns - 2nd or 3rd degree only
				870000016	New onset neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre) **OR** Reflex sympathetic dystrophy
	97165, 97166, 97167	GO	One additional evaluation for a new injury or health condition	870001416	In addition to the one allowed evaluation, when medically necessary *Occupational therapy
	97161, 97162, 97163	GP	One additional evaluation for a new injury or health condition	870001417	In addition to the one allowed evaluation, when medically necessary, when it is ordered by the client's primary care provider or orthopedic surgeon

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
ALL CLIENTS 21 AND OLDER & MCS CLIENTS AGES 19-20 additional benefit limits with expedited prior authorization					
SPEECH THERAPY					**When client's diagnosis is:**
See Outpatient Rehabilitation	Six additional units, per client, per calendar year. See **Requesting a Limitation Extension** in the Outpatient Rehabilitation Billing Guide for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table. **NOTE: Speech therapy claims require modifier GN**			870000007	Speech deficit which requires a speech generating device
				870000009	Cerebral vascular accident, with residual functional deficits within the past 24 months
				870000010	Swallowing deficits due to injury or surgery to face, head, or neck
				870000011	As part of a botulinum toxin injection protocol when botulinum toxin is prior authorized by the agency
				870000014	New onset muscular-skeletal disorders such as complex fractures which require surgical intervention or surgeries involving the vault, base of the skull, face, cervical column, larynx, or trachea
				870000015	Burns of internal organs such as nasal oral mucosa or upper airway **OR** Burns of the face, head, and neck – 2nd or 3rd degree only.
				870000016	New onset neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre))
				870000017	Speech deficit due to injury or surgery to face, head, or neck

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
PHYSICIAN-RELATED SERVICES/HEALTH CARE PROFESSIONAL SERVICES					
See Physician-Related/ Professional Services	C1874, C1875, C9601, C9602, C9603, C9604, C9605, C9606, C9607, C9608		Placement of Cardiac Drug Eluting or Bare Metal Stent and Device C codes are Institutional only	870000422	Either drug eluting or bare metal cardiac stents are **covered** when cardiac stents are indicated for treatment when medically necessary. For patients being treated for stable angina, cardiac stents are a **covered benefit with the following conditions**: 1) Angina refractory to optimal medical therapy, and 2) Objective evidence of myocardial ischemia
See Physician-Related/ Professional Services	J2796		Injection, Romiplostim, 10 Microgram	870001300	**All the following must apply:** • Documented diagnosis of Idiopathic Thrombocytopenic Purpura (ITP) • Patient must be at least 18 years of age • Inadequate response (reduction in bleeding) to one of the following: o Immunoglobulin treatment o Corticosteroid treatment o Splenectomy
See Physician-Related/ Professional Services	J0129		Orencia (abatacept)	870001321	Treatment of rheumatoid arthritis when prescribed by a rheumatologist in patients who have tried and failed one or more DMARDs. Dose is subcutaneous injection once weekly. IV dosing is up to 1000mg dose to start, repeated at week 2 and 4, then maintenance up to 1000mg every 4 weeks.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	71271		Low dose CT for lung cancer screen	870001362	The client must meet **all** of the following criteria: • Is age 50-80 • Has a history of smoking 20 packs a year and either of the following: • still smokes • has quit smoking in the last 15 years
See Physician-Related/ Professional Services	70540, 70542, 70543		Magnetic Resonance Imaging (MRI) of the sinus for rhinosinusitis	870001422	Criteria for sinus MRI listed below **AND** client is younger than age 21 OR pregnant. • *Red Flags, OR • Two of the listed *Persistent Symptoms longer than 12 weeks AND failure of medical therapy, OR • Surgical planning. HCA does not consider repeat scanning to be medically necessary except for Red Flags or Surgical Planning.
	70540, 70542, 70543		Magnetic Resonance Imaging (MRI) orbit	870001553	Evaluation of one of the following: • Suspected or known infection • A mass or other structural abnormality
	70450, 70460, 70470, 70486, 70487, and 70488		Sinus Computed Tomography (CT) for rhinosinusitis	870001423	• *Red Flags OR • Two of the listed persistent symptoms longer than 12 weeks AND failure of medical therapy; OR • Surgical planning. Repeat scanning is not covered except for *Red Flags* or *surgical planning*. *For a listing of Red Flags, see **Imaging for Rhinosinusitis** found in the Physician-Related/Professional Services Billing Guide.

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See Physician-Related/ Professional Services	77080, 77081		Bone mineral density testing with dual x-ray absorptiometry (DXA) - initial screening	870001363 For *repeat* testing see EPA 870001364	Bone mineral density testing with dual x-ray absorptiometry (DXA) is a covered benefit with the following conditions: **Asymptomatic persons assigned female at birth** Either of the following: • 65 years of age and older • 64 years of age and younger with equivalent 10-year fracture risk to individuals age 65 as calculated by FRAX (Fracture Risk Assessment) tool or other validated scoring tool **Any individual** Either of the following: • Long term glucocorticoids (i.e., current or past exposure to glucocorticoids for more than 3 months) • Androgen deprivation or other conditions known to be associated with low bone mass
See Physician-Related/ Professional Services	77080, 77081		Bone mineral density testing with dual x-ray absorptiometry (DXA) - repeat test	870001364 For *initial* testing see EPA 870001363	**Repeat** bone mineral density testing with dual x-ray absorptiometry (DXA) is a covered benefit when the client meets **one** of the following: • T-score** > -1.5, 15 years to next screening test • T-score -1.5 to -1.99, 5 years to next screening test • T-score ≤ -2.0, 1 year to next screening test **Or** • Use of medication associated with low bone mass or presence of a condition known to be associated with low bone mass.
See Physician-Related/ Professional Services	90734		Meningococcal Vaccine 90734 (Conjugate Vaccine – Menactra®)	870000421	Client is age 19 through 55 and is in one of the at-risk groups because the client meets one of the following: • Not routinely recommended for ages 19-21, but may be administered as catch-up vaccination for those who have not received a dose after their 16th birthday • Has persistent complement deficiencies • Has anatomic or functional asplenia • Are at risk during a community outbreak attributable to a vaccine serogroup • Infected with human immunodeficiency virus (HIV), if another indication for vaccination exists • Is a microbiologist who is routinely exposed to isolates of N. meningitidis • Is a freshman entering college who will live in a dormitory

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	81507, 81420		Noninvasive prenatal diagnosis of fetal aneuploidy (NIPT)	870001344	The agency considers NIPT for serum marker screening for fetal aneuploidy to be medically necessary in women with high-risk singleton pregnancies, who have had genetic counseling, **when one or more of the following are met**: • Pregnant woman is age 35 years or older at the time of delivery • History of a prior pregnancy with a trisomy or aneuploidy • Family history of aneuploidy (first degree relatives or multiple generations affected) • Positive first or second trimester standard biomarker screening test for aneuploidy, including sequential, or integrated screen, or a positive quadruple screen • Parental balanced Robertsonian translocation with increased risk for fetal T13 or T21 • Findings indicating an increased risk of aneuploidy
See Physician-Related/ Professional Services	81519		Gene expression profile (breast cancer) – *Oncotype Dx*	870001386	Breast cancer gene expression testing is covered when ***all*** of the following conditions are met: • Stage 1 or 2 cancer • Estrogen receptor positive and Human Epidermal growth factor Receptor 2 (HER2-NEU) negative • Lymph node negative or 1-3 lymph node(s) positive • The test result will help the patient and provider make decisions about chemotherapy or hormone therapy
	81599		Gene expression profile (breast) genomic testing - *Endopredict*	870001420	
	81520		Gene expression profile (breast cancer) *Prosigna*	870001545	
	81521		Gene expression profile (breast cancer) *MammaPrint*	870001546	

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	81599		Gene expression profile (breast cancer) *Mammostrat*	870001547	Breast cancer gene expression testing is covered when all of the following conditions are met: • Stage 1 or 2 cancer • The test result will help the patient make decisions about hormone therapy
	81518		Gene expression profile (breast cancer) *Breast Cancer Index*	870001548	The client must be all the following: • HR+ • Lymph node negative (LN-) or lymph node positive (LN+) with 1-3 positive nodes • Early stage (stage 1-2) • Distant recurrence free • Considering hormone/endocrine therapy
See Physician-Related/ Professional Services	0047U		Gene Expression profile (prostate cancer) *Oncotype DX prostate cancer assay*	870001549	Prostate cancer gene expression is covered when the following conditions are met: • low and favorable intermediate risk disease as defined by National Comprehensive Cancer Network (NCCN) and • The test result will help inform treatment decision between definitive therapy (surgery or radiation) and conservative management
	81541		Gene Expression profile (prostate cancer) *Prolaris*	870001550	
See Physician-Related/ Professional Services	81479		Gene Expression profile (prostate cancer) *Decipher prostate cancer classifier assay*	870001551	Is covered if both of the following are true: • is post radical prostatectomy and • the test result will help the client decide between active surveillance and adjuvant radiotherapy
See Physician-Related/ Professional Services	81546		mRNA gene analysis (thyroid nodules)	870001642	Patients with one or more thyroid nodules with a history or characteristics suggesting malignancy such as: • Nodule growth over time • Family history of thyroid cancer • Hoarseness, difficulty swallowing or breathing • History of exposure to ionizing radiation • Hard nodule compared with rest of gland consistency • Presence of cervical adenopathy Have an indeterminate follicular pathology on fine needle aspiration

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					Once per patient lifetime. A second test may be requested through the PA process for a second, unrelated thyroid nodule with indeterminate pathology.
See Physician-Related/ Professional Services	81418		Gene sequence analysis panel	870001645	Covered only for determining eligibility for medication therapy if required or recommended in the FDA labelling for that medication, in Table One of the FDA Table of Pharmacogenetic Associations. These tests have unproven clinical utility for decisions regarding medications when not required in the FDA labeling (e.g., psychiatric, anticoagulant, opioids).
See Physician-Related/ Professional Services	81441		Gene sequence analysis panel	870001646	Client must: • Be clinically diagnosed with IBMFS and used for diagnostic, not screening purposes • Have a history of unexplained cytopenias • Have a family history of similar cytopenias, AA, MDS/AML, or clinical stigmata of the IBMFSs • Have a prenatal diagnosis of an at-risk fetus, after confirmation of variant(s) in the parent(s). Must not be used for carrier testing unless one partner is a known carrier.
See Physician-Related/ Professional Services	81449		Targeted genomic sequence analysis panel	870001647	Covered as diagnostic test only if one of the following are true: • The requested testing is a companion diagnostic test per the FDA label for the member's cancer type and specific treatments being considered • At least five tumor markers included in the panel individually meet criteria for the tumor type based on one of the following: o All criteria are met from a test specific guideline if one is available

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					o An oncology therapy FDA label requires results from the tumor marker test to use the therapy effectively or safely for the member's cancer type o NCCN guidelines include the tumor marker test in the management algorithm for that particular cancer type and all other requirements are met (e.g., specific pathology findings, staging); however, the tumor marker must be explicitly included in the guidelines and not simply included in a footnote as an intervention that "may be considered"
See Physician-Related/ Professional Services	81451		Targeted genomic sequence analysis panel	870001648	Covered as diagnostic test only if one of the following are true: • The requested testing is a companion diagnostic test per the FDA label for the member's cancer type and specific treatments being considered • At least five tumor markers included in the panel individually meet criteria for the tumor type based on one of the following: o All criteria are met from a test specific guideline if one is available o An oncology therapy FDA label requires results from the tumor marker test to use the therapy effectively or safely for the member's cancer type o NCCN guidelines include the tumor marker test in the management algorithm for that particular cancer type and all other requirements are met (e.g., specific pathology findings, staging); however, the tumor marker must be explicitly included in the guidelines and not simply included in a footnote as an intervention that "may be considered"
See Physician-Related/ Professional Services	81456		Targeted genomic sequence analysis panel	870001649	Covered as diagnostic test only if one of the following are true: • The requested testing is a companion diagnostic test per the FDA label for the member's cancer type and specific treatments being considered

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					• At least five tumor markers included in the panel individually meet criteria for the tumor type based on one of the following: o All criteria are met from a test specific guideline if one is available o An oncology therapy FDA label requires results from the tumor marker test to use the therapy effectively or safely for the member's cancer type o NCCN guidelines include the tumor marker test in the management algorithm for that particular cancer type and all other requirements are met (e.g., specific pathology findings, staging); however, the tumor marker must be explicitly included in the guidelines and not simply included in a footnote as an intervention that "may be considered"
See Physician-Related/ Professional Services	87467		Targeted genomic sequence analysis panel	870001650	Both of the following must be true: • Client has a confirmed diagnosis of Hepatitis B Virus infection based on positive HBsAg, Anti-HBs antibody, or Anti-core antigen (anti-HBc) antibody test • The result must be used to monitor response to treatment
See Physician-Related/ Professional Services	84402, 84403, 84410		Testosterone testing	870001368	Covered: For clients assigned male at birth age 19 and older when at least one of the following conditions are met: o Suspected or known primary hypogonadism o Suspected or known secondary hypogonadism with organ causes such as: ♣ Pituitary disorder ♣ Suprasellar tumor ♣ Medications suspected to cause hypogonadism ♣ HIV with weight loss

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					♣ Osteoporosis o Monitoring of testosterone therapy As part of the treatment for gender dysphoria when a client has a diagnosis of gender dysphoria and is being treated with one of the following: o Hormone replacement therapy o Hormone suppression therapy
See Physician-Related/ Professional Services	81162, 81163, 81164, 81165, 81166, 81167, 81212, 81215, 81216, 81217		BRCA Genetic Testing	870001603	Client must be *one* of the following: • Of any age with a *known* pathogenic gene variant in a cancer susceptibility gene or with a blood relative with a *known* gene variant in a cancer susceptibility gene • Diagnosed at any age with *any* of the following: o Ovarian cancer o Pancreatic cancer o Metastatic prostate cancer o Breast cancer or a high grade (Gleason score > 7) prostate cancer and of Ashkenazi Jewish ancestry • With a breast cancer diagnosis meeting any of the following: o Breast cancer diagnosed < age 50 o Triple negative breast cancer diagnosed age < age 60 o Two breast cancer primaries o Breast cancer at any age *and* both of the following: □ One or more close blood relatives* with *any* of the following: □ Breast cancer < age 50 □ Male breast cancer □ Pancreatic cancer □ High grade or metastatic prostate cancer □ Two or more close blood relatives* with breast cancer at any age *First-, second-, and third-degree relatives
See Physician-Related/ Professional Services	86480, 86481		Targeted TB testing with interferon-gamma release assays	870001325	Targeted TB testing with interferon-gamma release assays may be considered medically necessary for clients **five years of age and older** for **any** of the following conditions: • History of positive tuberculin skin test or previous treatment for TB disease • History of vaccination with BCG (Bacille Calmette-Guerin) • Recent immigrants (within 5 years) from countries that have a high prevalence of tuberculosis

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					• Residents and employees of high-risk congregate settings (homeless shelters, correctional facilities, substance abuse treatment facilities) • Clients with an abnormal CXR consistent with old or active TB • Clients undergoing evaluation or receiving TNF alpha antagonist treatment for rheumatoid arthritis, psoriatic arthritis, or inflammatory bowel disease • Exposure less than two years before the evaluation **AND** • Client in agreement to remain in compliance with treatment for latent tuberculosis infection if found to have a positive test. The tuberculin skin test is the preferred method of testing for children under the age of 5.
See Physician-Related/ Professional Services	87625		HPV genotyping	870001381	For clients with cervix age 30 and older, when the following conditions are met: • Pap negative and HPV positive • Pap no EC/TZ and HPV positive
See Physician-Related/ Professional Services **Also in** *Vision Hardware for Clients Age 20 and Younger*	92014, 92015		Visual Exam/Refraction (Optometrists/ Ophthalmologists only)	870000610	**Eye Exam/Refraction - Due to loss or breakage**: For adults within 2 years of last exam when no medical indication exists, and **both** of the following are documented in the client's record: 1) Glasses are broken or lost or contacts that are lost or damaged 2) Last exam was at least 18 months ago **Note**: EPA # is not required when billing for children or clients with developmental disabilities.
See Physician-Related/ Professional Services	92134		Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and	870000051	Limit to 12 per calendar year. The client must meet **both** of the following criteria: • The client is undergoing active treatment (intraocular injections, laser or incisional surgery) for conditions such as cystoid macular edema (CME); choroidal neovascular membrane (CNVM) from any source (active macular degeneration (AMD) in particular); diabetic retinopathy or macular edema; retinal vascular occlusions; epiretinal

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			report, unilateral or bilateral, retina.		membrane; vitromacular traction; macular holes; unstable glaucoma; multiple sclerosis with visual symptoms; optic neuritis; optic disc drusen; optic atrophy; eye toxicity or side-effects related to medication use; papilledema or pseudopapilledema • There is documentation in the client's record describing the medical circumstance and explaining the need for more frequent services.
See Physician-Related/ Professional Services	92025		Corneal topography	870001609	Limited to two tests per calendar year. Client has one of the following diagnoses: • Central corneal ulcer • Corneal dystrophy, bullous keratopathy, and complications of transplanted cornea • Diagnosing and monitoring disease progression in keratoconus or Terrien's marginal degeneration • Difficult fitting of contact lens • Post-traumatic corneal scarring • Pre- and post-penetrating keratoplasty and post kerato-refractive surgery for irregular astigmatism • Pterygium or pseudo pterygium
See Physician-Related/ Professional Services	77301 77338 77370 G6015 G6016		Intensity modulated radiation therapy (IMRT)	870001374 **For sparing adjacent critical structures**	To meet EPA criteria, any cancer that would require radiation to focus on the head/neck/chest/abdomen/pelvic area would meet the EPA criteria. It would require clinical documentation that states which critical structure is spared. For example: "Critical structure spared is bladder."
See Physician-Related/ Professional Services	19318, 19300		Reduction Mammoplasties/ Mastectomy for Gynecomastia **Dx codes:** N62, N64.9, or L13.9	870000241 Click here for men	A client assigned female at birth with a diagnosis for **hypertrophy of the breast** with: 1) Photographs in client's chart 2) Documented medical necessity including: a) Back, neck, and/or shoulder pain for a minimum of one year, directly attributable to macromastia b) Conservative treatment not effective 3) Abnormally large breasts in relation to body size with shoulder grooves

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					4) Within 20% of ideal body weight, and 5) Verification of minimum removal of 500 grams of tissue from each breast
See Physician-Related/ Professional Services	19318, 19300		Reduction Mammoplasties/ Mastectomy for Gynecomastia **Dx codes:** N62, N64.9, or L13.9	870000242 Click here for women	A client assigned male at birth with a diagnosis for gynecomastia with: 1) • Pictures in clients' chart 2) • Persistent tenderness and pain 3) • If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than 1 year
See Physician-Related/ Professional Services	Q4116		Alloderm	870001342	**All** of the following must be met: • It is medically necessary • The client has a diagnosis of breast cancer • The servicing provider is either a general surgeon or a plastic surgeon
See Physician-Related/ Professional Services	15822, 15823, 67901, 67902, 67903, 67904, 67906, 67908		Blepharoplasties	870000630	Blepharoplasty for non-cosmetic reasons when **both** of the following are true: 1) The excess upper eyelid skin impairs the vision by blocking the superior visual field, and 2) On a central visual field test, the vision is blocked to within 10 degrees of central fixation.
See Physician-Related/ Professional Services	59899	U3	Intrauterine balloon	870001614	To treat postpartum hemorrhage Dx: 072, 072.0, 072.1, 072.2, 072.3

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See Physician-Related/ Professional Services	58150, 58152, 58180, 58200, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58545, 58546, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573		Hysterectomies for Cancer	870001302	Client must have a diagnosis of cancer requiring a hysterectomy as part of the treatment plan.
			Hysterectomies - Complications and Trauma	870001303	Client must have a complication related to a procedure or trauma (e.g., post procedure complications; postpartum hemorrhaging requiring a hysterectomy; trauma requiring a hysterectomy)

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See Physician-Related/ Professional Services	62320, 62321, 62322, 62323, 62324, 62325, and 62327		Interoperative or postoperative pain control using a spinal injection or infusion	870001351	These CPT® codes may be billed with this EPA when they are done intraoperatively or postoperatively for pain control.
See Physician-Related/ Professional Services	69930		**Unilateral** cochlear implant for clients age 20 and younger	870000423 Note: For criteria for bilateral cochlear implants, see EPA 870001365	The agency pays for cochlear implantation only when the products come from a vendor with a *Core Provider Agreement* with the agency, there are *no other contraindications to surgery*, and **one** of the following must be true: **Unilateral** cochlear implantation for clients age 18 through 20 with post-lingual hearing loss and clients (12 months-17 years old) with pre-lingual hearing loss when all of the following are true: a) The client has a diagnosis of profound to severe bilateral, sensorineural hearing loss b) The client has stimulable auditory nerves but has limited benefit from appropriately fitted hearing aids (e.g., fail to meet age-appropriate auditory milestones in the best-aided condition for young children, or score of less than ten or equal to 40% correct in the best-aided condition on recorded open-set sentence recognition tests c) The client has the cognitive ability to use auditory clues d) The client is willing to undergo an extensive rehabilitation program e) There is an accessible cochlear lumen that is structurally suitable for cochlear implantation f) The client does not have lesions in the auditory nerve and/or acoustic areas of the central nervous system **Note:** See the agency's Hearing Hardware for Clients 20 Years of Age and Younger Billing Guide for replacement parts for cochlear implants.

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See Physician-Related/ Professional Services	69930	50	**Bilateral** cochlear implants for clients age 20 and younger	870001365 Note: For **unilateral** cochlear implants, see EPA 870000423	The client must: • Be age 12 months through 20 years old • Have bilateral severe to profound sensorineural hearing loss. • Be limited or no benefit from hearing aids • Have cognitive ability and willingness to participate in an extensive auditory rehabilitation program • Have freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system • Have no other contraindications for surgery • Use device in accordance with the FDA approved labeling
See Physician-Related/ Professional Services	67311, 67312, 67314, 37316, 67318, 67320, 67331, 67332, 67334, 67335, 67340		Strabismus Surgery **Dx Code:** H53.2	870000631	Strabismus surgery for clients 18 years of age and older when **both** of the following are true: 1) The client has a strabismus-related double vision (diplopia), Dx H53.2, and 2) It is not done for cosmetic reasons
See Physician-Related/ Professional Services	91200		Transient elastograph	870001350	**All** of the following must be met: • Baseline detectable HCV RNA viral load • Chronic hepatitis C virus infection and BMI < 30 • Both APRI (AST to platelet ratio index) and FibroSURE™ tests have been completed with the following results: ➢ FibroSURE™ < 0.49 and APRI > 1.5 ➢ FibroSURE™> 0.49 and APRI < 1.5

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See Physician-Related/ Professional Services	69433 or 69436		Tympanostomy tubes	870001382	The client is age 16 or younger and is diagnosed with one of the following: • **Acute otitis media (AOM)** and the client has either of the following: o Complications, is immunocompromised, or is at risk for infection o Both of the following are true: ♣ Has had 3 episodes of AOM in the last 6 months with one occurring in the last 6 months ♣ Has the presence of effusion at the time of assessment for surgical candidacy • **Otitis media with effusion (OME)** and the client has one of the following: o An effusion for 3 months or greater and there is documented hearing loss o A disproportionate risk ♣ For persistent effusion based on anatomic abnormalities ♣ From the effects of hearing loss, such as those with speech delay, underlying sensory-neuro hearing loss or cognitive disorders
See Physician-Related/ Professional Services	99183, G0277		Hyperbaric Oxygen Therapy (Note: G0277 is for institutional only)	870000425	**All** of the following must be true: • Patient has type 1 or type 2 diabetes and has a lower extremity wound that is due to diabetes • Patient has a wound classified as Wagner grade 3 or higher • Hyperbaric oxygen therapy is being done in combination with conventional diabetic wound care
See Physician-Related/ Professional Services	96160 96161		Caregiver/ Birthing parent depression screening	870001424	• Caregiver/birthing parent depression screening is required at well-child checkups for caregivers/birthing parents of infants up to age 6 months. Use CPT® code 96161 with EPA. • Caregiver/birthing parent depression screening completed by the caregiver's provider during the 6 months postpartum and billed under the caregiver's ProviderOne ID number. Use CPT® code 96160 with EPA.

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See Physician-Related/ Professional Services	95250		Professional or diagnostic continuous glucose monitoring (CGM)	870001312	**Allowed** for the in-home use of professional or diagnostic CGM for a 72-hour period. The client must meet the following criteria: • Have a diagnosis of type 1 diabetes and not own a personal CGM device **OR** • Have a diagnosis of type 2 diabetes **AND** is on insulin or other injectable hypoglycemic agents **AND** has frequent hypoglycemic episodes or hypoglycemic unawareness **OR** • Suspected to have primary islet cell hypertrophy or persistent hyperinsulinemia hypoglycemia of infancy The CGM must be both of the following: • Ordered by a provider • Provided by an FDA-approved CGM device **Limit**: 2 monitoring periods of at least 72 hours, per client, every 12 months.
See Physician-Related/ Professional Services	99241-99243, 99251-99253-99211-99214, 99231-99233.	**GQ**	Teledermatology	870001419	All the following must be met: • The teledermatology is associated with an office visit between the eligible client and the referring health care provider. • The teledermatology is asynchronous telemedicine and the service results in a documented care plan, which is communicated back to the referring provider. • The transmission of protected health information is HIPPA compliant. • Written informed consent is obtained from the client that store and forward technology will be used and who the consulting provider is. • GQ modifier required.
See Physician-Related/ Professional Services	CPT® code: 99492 HCPCS code: G0512, G2214		Initial psychiatric collaborative care management	870001427	To be used to initiate new episode of care when **less than** a 6-month lapse in services: • Provider has identified a need for a new episode of care for an eligible condition • There has been less than 6 months since the client has received any CoCM services
See Physician-Related/ Professional Services	CPT® code: 99493		Subsequent psychiatric	870001428	To be used to continue the episode of care **after** 6th month when: • Identified need to continue CoCM episode of care past initial 6 months

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
	HCPCS code: G0512		collaborative care management		• Client continues to improve as evidenced by improved score from a validated clinical rating scale • Targeted goals have not been met • Patient continues to actively participate in care
See Physician-Related/ Professional Services **Also in** *Inpatient Hospital Services* **And** *Planned Home Births & Births in Birthing Centers*	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622		Early elective delivery or natural delivery **prior to** 39 weeks gestation	870001375	Client is **under** 39 weeks gestation and the mother or fetus has a diagnosis listed in the mother or fetus has a diagnosis listed in the Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation, or mother delivers naturally. An early elective delivery is considered medically necessary if the mother or fetus has a diagnosis listed in the Joint Commission's current table of Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation (WAC 182-533-0400). **This EPA also needs to be used for clients who deliver naturally prior to 39 weeks.**
			Elective delivery or natural delivery **at** or **over** 39 weeks gestation	870001378	Client is 39 weeks gestation or over 39 weeks gestation
See Physician-Related/ Professional Services	97110 92065		Orthoptic/pleoptic training	870001371	Documented diagnosis of convergence insufficiency, convergence excess, or binocular dysfunction, with a secondary diagnosis of traumatic brain injury (TBI). (Dx: *H50.411* **or** *H50.412* with secondary dx of TBI)
	97112 92065			870001372	Documented diagnosis of convergence insufficiency, convergence excess, or binocular dysfunction, with a secondary diagnosis of traumatic brain injury (TBI). (Dx: *H51.12* with secondary dx of TBI)
	97530 92065			870001373	Documented diagnosis of convergence insufficiency, convergence excess, or binocular dysfunction, with a secondary diagnosis of traumatic brain injury (TBI). (Dx: *H53.30* with secondary dx of TBI)
See Physician-Related/ Professional Services	99201, 99202, 99203, 99204,		Enhanced medication for opioid use	870001537	**All** of the following criteria must apply: The client must have an opioid use disorder diagnosis code listed on the claim.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
	99205, 99211, 99212, 99213, 99214, 99215, 99251, 99252, 99253, 99254, 99255		disorder provider rate		The provider meets all of the following criteria: • Has a DATA 2000 Waiver. • Currently uses the waiver to prescribe medication for opioid use disorder to clients with opioid use disorder. • Bills for treating a client with a qualifying diagnosis for opioid use disorder. • Provides opioid-related counseling during the visit. • *HCA reimburses the enhancement once per client, per day.
See Physician-Related/ Professional Services	61885, 61886, 64553, 64568, C1822* L8679* L8680* L8682* L8683* L8685* L8686* L8687* L8688*		Vagus nerve stimulation (VNS)	870001554	For management of epileptic seizures for clients that meet all the following criteria: • Adult or child (age 4 or older) • Seizure disorder is refractory to medical treatment, defined as adequate trials of at least three appropriate but different anti-epileptic medications. • Surgical treatment is not recommended or has failed. *These Outpatient Prospective Payment System (OPPS) codes are listed here for providers billing for services using institutional claims. These codes pay as they are set up in OPPS only.
See Physician-Related/ Professional Services	99453, 99454, 99457, 99458, 99091		Remote patient monitoring	870001640	• **Client-specific criteria**. The client must exhibit at least one of the following risk factors in each category: o Health care utilization: ♣ Two or more hospitalizations in the prior 12-month period ♣ Four or more emergency department admissions in the prior 12-month period o Other risk factors that present challenges to optimal care: ♣ Limited or absent informal support systems ♣ Living alone or being home alone for extended periods of time ♣ A history of care access challenges

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					♣ A history of consistently missed appointments with health care providers • **Device-specific criteria**. The device must have both of the following: o Capability to directly transmit patient data to provider o Internet connection and capability to use monitoring tools • **Disease-specific criteria**. In addition to meeting the previously defined general criteria, the client must have a qualifying diagnosis of congestive heart failure, chronic obstructive pulmonary disease, or hypertension. o Congestive heart failure (CHF): RPM to identify early signs or symptoms of decompensation ♣ New York Heart Association (NYHA) class I-IV chronic, symptomatic heart failure; must be in stable condition and on optimized therapy o Chronic obstructive pulmonary disease (COPD): RPM for the purpose of monitoring COPD symptoms and health status Clinical diagnosis of moderate to very severe (GOLD II–IV) COPD o Hypertension (HTN): RPM for the purpose of management of uncomplicated HTN ♣ Client has been diagnosed with stage 1 or 2 HTN. The following are the documentation requirements: • Informed consent
See Physician-Related/ Professional Services	46601, 46607		Diagnostic anoscopy and biopsy	870001651	HCA considers high-resolution anoscopy (HRA) to be medically necessary when either of the following conditions are met: • HRA is used for diagnosis of a suspicious anal lesion in an individual with abnormal anal physical findings. • HRA guidance is used for biopsy and ablation of high-grade anal intraepithelial neoplasia. HCA considers HRA to be experimental and investigational when used for the following purposes and therefore deems it as not medically necessary: • When used for screening of asymptomatic persons. • When used for surveillance after treatment of anal squamous cell carcinoma.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
PLANNED HOME BIRTHS & BIRTHS IN BIRTHING CENTERS					
See Planned Home Births & Births in Birthing Centers	90371, J2540, S0077, J0290, J1364		EPA criteria for drugs not billable by licensed midwives	870000690	To use an EPA to bill procedure codes 90371, J2540, S0077, J0290, J1364, the licensed midwife must meet **all** of the following: • Obtained physician or standing orders for the administration of the drug listed as **not billable by a licensed midwife**. • Placed the physician or standing orders in the client's file. • Will provide a copy of the physician or standing orders to the agency upon request. See **Coverage Table** within this Billing Guide
See Planned Home Births & Births in Birthing Centers **Also in** *Inpatient Hospital Services* **And** *Physician-Related/Professional Services*	59400, 59409, 59410		Natural delivery before 39 weeks	870001375	Client is under 39 weeks gestation and the birthing parent or fetus has a diagnosis listed in the Joint Commission's current table of Conditions possibly justifying elective delivery prior to 39 weeks gestation, or client delivers naturally
			Elective delivery or natural delivery at or over 39 weeks gestation	870001378	Client is 39 weeks gestation or over 39 weeks gestation

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
PROSTHETIC AND ORTHOTIC (P&O) DEVICES					
See Prosthetic and Orthotic (P&O) Devices	L3030		Foot insert, removable, formed to patient foot	870000780	One (1) pair allowed in a 12-month period if **one** of the following criteria is met: 1) Severe arthritis with pain 2) Flat feet or pes planus with pain 3) Valgus or varus deformity with pain 4) Plantar fasciitis with pain 5) Pronation **Note**: 1) If the medical condition does not meet one of the criteria specified above, you must obtain prior authorization. 2) This EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the EPA has been used for the client within 12 months prior to the provider's proposed date of service.
See Prosthetic and Orthotic (P&O) Devices	L3310, L3320		Lift, elevation, heel & sole, per inch	870000781	For a client with a leg length discrepancy, allowed for as many inches as required (must be at least one inch), on one shoe per 12-month period.
See Prosthetic and Orthotic (P&O) Devices	L3334		Lift, elevation, heel, per inch	870000782	Allowed for as many inches as required (has to be at least one inch), for a client with a leg length discrepancy, on one shoe per 12-month period. **Note**: 1) Lift is covered per inch, for no less than one (1) inch, for one shoe. **For example**: It is medically necessary for a client to have a two (2) inch lift for the left heel. Bill two units of L3334 using this EPA (870000782). 2) If the medical condition does not meet the criteria specified above, you must obtain prior authorization. 3) This EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the EPA has been used for the client within 12 months prior to the provider's proposed date of service.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Prosthetic and Orthotic (P&O) Devices	L3000		Foot insert, removable, molded to patient model, "UCB" type, Berkeley Shell, each	870000784	Purchase of one (1) pair per 12-month period for a client 16 years of age or younger allowed if any of the following criteria are met: 1) Required to prevent or correct pronation 2) Required to promote proper foot alignment due to pronation 3) For ankle stability as required due to an existing medical condition such as hypotonia, Cerebral Palsy, etc. Note: 1) If the medical condition does not meet the criteria specified above, you must obtain prior authorization. 2) This EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the EPA has been used for the client within 12 months prior to the provider's proposed date of service. 3) If the client only medically requires one orthotic, right or left, prior authorization must be obtained.
See Prosthetic and Orthotic (P&O) Devices	L3215, L3219		Orthopedic footwear, woman's or man's shoes, oxford	870000785	Purchase of one (1) pair per 12-month period allowed if any of the following criteria are met: • When one or both shoes are attached to a brace • When one or both shoes are required to accommodate a brace with the exception of L3030 foot inserts • To accommodate a partial foot prosthesis • To accommodate club foot Note: HCA does not allow orthopedic footwear for the following reasons: • To accommodate L3030 orthotics • Bunions • Hammer toes • Size difference (mismatched shoes) • Abnormal sized foot HCA allows only the following manufacturers of orthopedic footwear: • Acor • Alden Shoe Company • Answer 2 • Apis Footwear • Billy

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					• Hanger • Hatchbacks • Ikiki • Jerry Miller • Keeping Pace • Markell • New Balance – XW options • Nike: • Blazer, Flex Advance, and Fly Ease styles have unique velcro or zipper closures that work well with AFOs. • Air Monarch style is deep with XW options. • P.W. Minor • Walkin-Comfort If the medical condition does not meet one of the criteria specified above, you must obtain prior authorization by submitting a request in writing to the medical equipment authorization unit (see Resources Available, and HCA's prior authorization webpage). EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.
See Prosthetic and Orthotic (P&O) Devices	L1945		AFO, molded to patient model, plastic, rigid anterior tibial section (floor reaction)	870000786	Purchase of one per limb allowed per 12-month period if all of the following criteria are met: 1) Client is 16 years of age and younger 2) Required due to a medical condition causing crouched gait **Note**: 1) If the medical condition does not meet one of the criteria specified above, you must obtain prior authorization. 2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Prosthetic and Orthotic (P&O) Devices	L5681, L5683		Addition to lower extremity, below knee/above knee, socket insert, suction suspension with or without locking mechanism	870000787	Initial purchase of one (1) L5683 and L5681 per initial, lower extremity prosthesis (one to wash, one to wear) allowed per 12-month period if any of the following criteria are met: 1) Short residual limb 2) Diabetic 3) History of skin problems/open sores on stump **Note**: 1) If the medical condition does not meet one of the criteria specified above, you must obtain prior authorization. 2) This EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the EPA has been used for the client within 12 months prior to the provider's proposed date of service. 3) EPA is for initial purchase only. It is not to be used for replacements of existing products.

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RESPIRATORY CARE					
See Respiratory Care	E0465, E0466	RR U2	Home Ventilator (invasive and non-invasive)	870000000	Home Ventilator (invasive and non-invasive) – Includes primary and secondary or backup ventilator for chronic respiratory failure. • If the client has *no clinical potential for weaning*, the EPA is valid for *12 months*. • If the client has the *potential to be weaned*, then the EPA is valid for *6 months*.
See Respiratory Care	E0570	NU	Nebulizer with compressor **(Do not bill with A4619, A4217, A7007, A7010, A7012, A7014, A7018, E0500)**	870000900	Use this EPA for clients who do **not** meet the clinical criteria (in Does HCA cover nebulizers and related compressors?), but who have a diagnosis of acute bronchiolitis, or acute bronchitis requiring the administration of nebulized medications.
See Respiratory Care	E0445	SC	Enhanced Oximeter **(Do not bill with A0445 NU)**	870000006	Enhanced Oximeter With all the following features: • Alarms for heart rate and oxygen saturation • Adjustable alarm volume • Memory for download • Internal rechargeable battery Client must be age 17 and younger, in the home, and meet the clinical criteria for standard oximeters. See Does HCA cover oximeters? Purchase limit of 1 per client, every 3 years.
See Respiratory Care		RR		870000052	Restart 36-month oxygen capped rental when meeting **one** of the following criteria: • The initial provider is no longer providing oxygen equipment or services. • The initial provider's Core Provider Agreement with the agency is terminated or expires. • The client moves to an area that is not part of the provider's service area. (This applies to Medicaid-only clients.) • The client moves into a permanent residential setting. • A pediatric client is transferred to an adult provider.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
SLEEP CENTERS					
See Respiratory Care	E0445	SC	Enhanced Oximeter **(Do not bill with A0445 NU)**	870000006	With **all** of the following features: • Alarms for heart rate and oxygen saturation • Adjustable alarm volume • Memory for download • Internal rechargeable battery Client must be age 17 and younger, in the home, and meet the clinical criteria for standard oximeters. See Does HCA cover oximeters? **Purchase limit of 1 per client, every 3 years.**
TRANSHEALTH PROGRAM					
See Transhealth https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules	19303, 19318, 19350, 15877, 15860		Mastectomies and reduction mammoplasty	870001615	• CPT® codes 19350, 15877, and 15860 are only allowed if associated with either 19303 or 19318 AND a primary diagnosis code of F64.0, F64.1, F64.2, or F64.9 • Primary diagnosis code must be one of the following: F64.0, F64.1, F64.2, or F64.9 • The client must be age 17 or older to use EPA. • The following clinical criteria and documentation must be kept in the client's medical record and made available to HCA upon request: • Documentation from the surgeon of the client's medical history and physical examination(s) performed within the twelve months before surgery that includes the medical necessity for surgery and the surgical plan. • A letter of support from the primary care provider signed and dated within the last 12 months that includes documentation of medical necessity for surgery and confirmation that the client is adherent with current gender dysphoria treatment. • One comprehensive psychosocial evaluation. The letter from the mental health provider must be signed and dated within the last 18 months and from a qualified licensed mental health professional as defined in WAC 182-531-1400 (5) who is an eligible provider under chapter 182-502:

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					• Psychiatrist • Psychologist • Psychiatric advanced registered nurse practitioner (ARNP) • Psychiatric mental health nurse practitioner-board certified (PMHNP-BC) • Licensed mental health counselor (LMHC) • Licensed independent clinical social worker (LICSW) • Licensed advanced social worker (LASW) • Licensed marriage and family therapist (LMFT) The comprehensive psychosocial evaluation must: • Independently confirm the diagnosis of gender dysphoria as defined by the Diagnostic Statistical Manual of Mental Disorders. • Document that the client has been evaluated for any coexisting behavioral health conditions and if any are present, the conditions are adequately managed. It is a not a requirement that the client has been on gender affirming hormone therapy and/or lived in a gender role that is congruent with the client's gender identity for a minimum of 12 months preceding surgery for a mastectomy. For clients age 17, the comprehensive psychosocial evaluation must be performed by a behavioral health provider who specializes in adolescent transgender care and meets the qualifications outlined in WAC 182-531-1400. This EPA can only be used once per lifetime.
See Transhealth https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules	17380, 17999, 64999		Genital electrolysis or donor site hair removal and nerve block	870001616	• CPT codes 17380 and 64999 only with diagnosis F64.0, F64.1, F64.2, or F64.9 • Clients must be age 18 and older for genital or donor site hair removal in preparation for gender affirming surgery. • Primary diagnosis code must be one of the following: F64.0, F64.1, F64.2, or F64.9

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					• CPT code 64999 is only allowed if associated with either 17380 AND a primary diagnosis of F64.0, F64.1, F64.2, or F64.9 • The client must be age 18 or older. For clients aged 17 and younger, a PA request must be submitted • The following documentation must be kept in the client's medical record and made available to HCA upon request. A letter of medical necessity from the treating surgeon. The letter must include the size and location of the area to be treated and expected date of the planned genital surgery; or A letter of medical necessity from the provider who will perform the hair removal. The letter must include the surgical consult for the bottom surgery that addresses the need for hair removal before gender-affirming surgery • Maximum of 156 units for CPT code 17380 per year This EPA can only be used for two years per client; additional services would require prior authorization.
See Transhealth https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules	Dx: F64.0, F64.1, F64.2 and F64.9		Surgical consultation related to transgender surgery	870001400	All the following must be met: • Client has gender dysphoria diagnosis • Appointment is done as a consultation to discuss possible transgender related surgery including hair removal by electrolysis or laser Note: This EPA is strictly for surgical consultation and no other transhealth services.
See					
TRIBAL HEALTH PROGRAM					
See Tribal Health Program	T1015		Dental services, Client is AI/AN	870001305	Client is an IHS beneficiary AI/AN
See Tribal Health Program	T1015		Dental services, Client is non-HIS beneficiary AI/AN	870001306	Client is not an IHS beneficiary AI/AN

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VISION HARDWARE FOR CLIENTS AGE 20 AND YOUNGER					
See Vision Hardware for Clients Age 20 and Younger	92340, 92341, 92342		Durable Frames	870000619	When the provider documents one of the following in the client's record: • The client has a diagnosed medical condition that contributes to broken eyeglass frames. • Lost or broken glasses
			Flexible Frames	870000620	When the provider documents one of the following in the client's record: • The client has a diagnosed medical condition that contributes to broken eyeglass frames. • Reasons that the standard CI Optical frame is not suitable for the client, (e.g. client age five or younger) • Lost or broken glasses
			Replacement due to eye surgery/effects of prescribed medication/ diseases affecting vision	870000622	Within one year of last dispensing when: • The client has a stable visual condition (see the billing guide for *Definitions*). • The client's treatment is stabilized. • The lens correction has a 1.0 or greater diopter change between the sphere or cylinder correction in at least one eye. • The provider documents the previous and new refractions in the client record. • Lost or broken glasses
			Replacement due to headaches/ blurred vision/difficulty with school or work	870000624	Within one year of last dispensing, for refractive changes (provider error is the responsibility of the provider to warranty their work and replace the lens at no charge) when the provider documents **all** the following in the client's record: • The client has symptoms e.g., headaches, blurred vision, difficulty with school or work. • Copy of current prescription • Date of last dispensing, if known • Absence of a medical condition that is known to cause temporary visual acuity changes (e.g. diabetes, pregnancy) • A refractive change of at least .75 diopter or greater between the sphere or cylinder correction in at least one eye

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See Vision Hardware for Clients Age 20 and Younger	92340, 92341, 92342		High index eyeglass lenses	870000625	When the provider documents **one** of the following in the client's record: • A spherical refractive correction of +\- 6.0 diopters or greater • A cylinder correction of +\- 3.0 diopters or greater

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