Washington State Health Care Authority

Washington Apple Health (Medicaid)

Transhealth Program Billing Guide

July 1, 2024

Washington State Health Care Authority

Disclaimer

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

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

About this guide[1]

This publication takes effective **July 1, 2024,** and supersedes earlier billing guides to this program. Unless otherwise specified, the program(s) in this guide is governed by the rules found in WAC **182-531-1675**.

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

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

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

How can I get HCA Apple Health provider documents?

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

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

Where can I download HCA forms?

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

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[1] This publication is a billing instruction.

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Confidentiality toolkit for providers

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

Copyright disclosure

What has changed?

Subject	Change	Reason for Change
Managed care enrollment	Added information on Apple Health Expansion	HCA is expanding health care coverage to more people effective July 1, 2024.
Integrated Apple Health Foster Care	Added section	Missing from previous guide
Fee-for-service Apple Health Foster Care	Added section	Missing from previous guide
Gender-affirming interventions and treatment (GAT)	Added testosterone testing under fee-for-service and managed care	To clarify this is a covered service. Not a new policy.
EPA Criteria List	Added testosterone testing EPA#870001671 to list	Updated information.

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Program Overview

(Refer to WAC 182-531-1675 [1][a], [d], and [f])

Apple Health Coverage

The Health Care Authority (HCA) covers the services listed in **Coverage** to treat gender dysphoria (also referred to as gender incongruence) under WAC 182-501-0050 and 182-531-0100. These services include life-changing procedures that may not be reversible.

Medical necessity

Under this program, HCA authorizes (see **Authorization**) and pays (see **Payment**) for only medically necessary services. Medical necessity is defined in WAC 182-500-0070 and is determined under WAC 182-501-0165 and limitation extensions in accordance with WAC 182-501-0169.

Clients age 20 and younger

HCA evaluates requests for clients age 20 and younger according to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program described in **Chapter 182-534** WAC. Under the EPSDT program, HCA pays for a service if it is medically necessary, safe, effective, and not experimental.

Additional resources

For resources that may be helpful for providing healthcare services to members of the transgender community, go to the **Transhealth Program** webpage.

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Client Eligibility

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

> **Note:** It is important to always check a client's eligibility prior to providing any services because it affects who pays for the services.

How do I verify a client's eligibility?

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

Verifying eligibility is a two-step process:

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

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

Step 2. **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's **Program benefit packages and scope of services webpage**.

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

- **Online**: Go to **Washington Healthplanfinder** - select the "Apply Now" button. For patients age 65 and older or on Medicare, go to **Washington Connections** select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 1-855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Support (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

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

Yes. Most Apple Health clients are enrolled in one of HCA's MCOs. For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. The MCO is responsible for:

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

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

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

Managed care enrollment

Most Apple Health clients are enrolled in an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may start their first month of MC eligibility in the fee-for-service (FFS) program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination. **Exception**: Apple Health Expansion clients are enrolled in managed care and will not start their first month of eligibility in the FFS program. Providers must check eligibility to determine enrollment for the month of service.

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

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to HCA's **Apply for or renew coverage webpage**, under *How to apply for or renew Apple Health (Medicaid) coverage*.

Clients' options to change plans

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account:** Go to the **Washington Healthplanfinder website**.
- **Available to all Apple Health clients:**
  - Visit the **ProviderOne Client Portal website**:
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.
  - Request a change online at **ProviderOne Contact Us** (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

For online information, direct clients to HCA's **Apple Health Managed Care webpage**.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Apple Health clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the fee-for-service (FFS).

In this situation, each managed care organization (MCO) will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. Examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care Alumni.

Integrated managed care

Clients qualified for managed care enrollment will receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted MCO.

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care's (CC) Apple Health Core Connections Foster Care program receive both medical and behavioral health services from CC.

Clients under this program are:

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

> These clients are identified in ProviderOne as "**Coordinated Care Healthy Options Foster Care**."

The Apple Health Customer Services team can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAS) team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support, and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details,

see HCA's **Mental Health Services Billing Guide**, under *How do providers identify the correct payer*?

Apple Health Expansion

Individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs and who receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contract health plan. For more information, visit Apple Health Expansion.

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) **American Indian/Alaska Native webpage**.

What if a client has third-party liability (TPL)?

If the client has TPL, also known as commercial insurance or private insurance, and the services being requested require prior authorization (PA) from HCA, HCA waives the PA requirement. However, if the commercial or private insurance does not cover the services and HCA is going to be the primary payer, PA is required before services may be provided, regardless of the primary payer. Attach the denied explanation of benefits (EOB) to your PA request.

Most providers choose to submit claims to both the TPL and to HCA for reassurance that HCA will cover the co-pay and deductible up to HCA's allowable amount, or in case the TPL denies the service.

For more information on TPL, refer to HCA's **ProviderOne Billing and Resource Guide**.

Provider Requirements

General Requirements

(WAC 182-531-1675[1][e])

Providers should be knowledgeable of gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria, including experience using standards of care that include the **World Professional Association for Transgender Health (WPATH) standards of care**.

Who may provide and bill for transhealth services?

Eligible providers may be found in WAC 182-531-1675 and HCA's **Physician-related services/Health care professional services billing guide**.

Requirements for qualified and licensed behavioral health providers

Licensed behavioral health providers who perform psychosocial evaluations must meet the definition of WAC 182-531-1400(5). The following providers are eligible to perform these evaluations under **Chapter 182-502 WAC:**

- Psychiatrists
- Psychologists
- Psychiatric advanced registered nurse practitioners (ARNP)
- Psychiatric mental health nurse practitioners- board certified (PMHNP-BC)
- Licensed mental health counselors (LMHC)
- Licensed independent clinical social workers (LICSW)
- Licensed advanced social workers (LASW)
- Licensed marriage and family therapists (LMFT)

(Refer to WAC 182-531-1675 [2][b][i])

In addition, qualified and licensed mental health care providers must:

- Be competent in using the *Diagnostic Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) and the *International Classification of Diseases* for diagnostic purposes.
- Be able to recognize and diagnose coexisting mental health conditions and to distinguish these from gender dysphoria.
- Have completed supervised training in psychotherapy or counseling.
- Be knowledgeable of gender-nonconforming identities and expressions and the assessment and treatment of gender dysphoria.

- Have completed continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

(Refer to WAC 182-531-1675 [2][d]**)**

Coverage

Gender-affirming interventions and treatment (GAT)

(WAC 182-531-1675 [1][b])

Medical services covered by HCA include, but are not limited to:

Services covered through fee-for-service (FFS)

The following are covered through FFS:

- Surgical consults
- Hospitalizations and physician services related to procedures performed for gender-affirming surgery
- Hospitalizations and physician services related to postoperative complications of procedures performed for gender-affirming surgery.
- Medically necessary, gender-affirming hair removal.
- Testosterone testing
    - Use CPT® codes 84402, 84403, or 84410 for fee-for-service clients
    - Submit EPA#870001671 in conjunction with one of the following diagnosis codes: F64, F640, F641, F642, F649
    - Managed care clients who have an HCA-contracted managed care organization (MCO), must receive testosterone testing through their MCO.

Services covered through the MCO

The following are covered through the client's HCA-contracted MCO:

- Physician services
- Hormone therapy
- Puberty suppression therapy
- Speech therapy (including voice training)
- Behavioral health services
- Labs
- Pathology
- Radiology
- Testosterone testing

Note: A health care provider with experience prescribing or delivering, or both, gender affirming treatment must review and confirm the appropriateness of any adverse benefit determination. See RCW 74.09.675.

Gender-affirming treatment (GAT)

(Refer to WAC 182-531-1675 [1][c])

GAT to treat gender dysphoria is covered for clients who have a primary diagnosis of gender dysphoria (ICD codes F64.0, F64.1, F64.2 and F64.9) made by a provider who meets the qualifications outlined in Chapter 182-502 WAC. Prior authorization is required.

Hormone therapy

HCA covers hormone therapy for fee-for-service clients for the treatment of gender dysphoria. Providers may bill HCA for hormone therapies using the expedited authorization (EA) process when the EA criteria is met. If the EA criteria is not met, then prior authorization is required. See the Prescription Drug Program Billing Guide and the Expedited Authorization Codes and Criteria Table for details on EA codes. Both are located under the Provider billing guides and fee schedules webpage. Select the Prescription Drug Program heading for more information. The Prescription Drug Program Expedited Authorization Codes and Criteria Table will be listed below the heading.

Note: Expedited authorization (also known as expedited prior authorization) does not override nonpreferred status or prior authorization for brand products with generic equivalents. See the Apple Health Preferred Drug List for preferred products.

Transportation services

(Refer to WAC 182-531-1675 [1][g])

HCA covers transportation services to and from appointments per Chapter 182-546 WAC. For transportation services, please call the transportation broker in your county. All transportation assistance, including lodging, mileage reimbursement and gas vouchers, must be prior authorized by the broker.

Out-of-state care

(WAC 182-531-1675 [1][h])

Any out-of-state care, including a pre-surgical consultation, must be prior authorized as an out-of-state service per WAC 182-501-0182.

Reversal procedures

(WAC 182-531-1675 [1][i])

HCA does not cover procedures and surgeries related to reversal of gender affirming surgery.

Corrective surgeries for intersex traits

(WAC 182-531-1675 [1][j])

HCA covers corrective or reparative surgeries for people with intersex traits who received surgeries that were performed without the person's consent.

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Authorization

Authorization is HCA's approval for covered services, equipment, or supplies before the services are provided to clients, as a precondition for provider reimbursement. **Prior authorization (PA), expedited prior authorization (EPA), and limitation extensions (LE) are forms of authorization**.

Prior authorization (PA)

What is prior authorization (PA)?

Prior authorization (PA) is the process HCA uses to authorize a service before it is provided to a client. The PA process applies to covered services and is subject to client eligibility and program limitations. TPA does not guarantee payment.

> **Note**: In addition to receiving PA, the client must be on an eligible program. For example, a client on the Family Planning Only program would not be eligible for transhealth surgery.

For examples on how to complete a PA request, see HCA's **Billers, providers, and partners** webpage.

> **Note**: HCA reviews requests for payment for noncovered health care services according to WAC 182-501-0160 as an exception to rule (ETR).

How does HCA determine PA?

HCA reviews PA requests in accordance with WAC 182-501-0165. HCA uses evidence-based medicine to evaluate each request. HCA considers and evaluates all available clinical information and credible evidence relevant to the client's condition. At the time of the request, the provider responsible for the client's diagnosis or treatment must submit credible evidence specifically related to the client's condition. Within 15 days of receiving the request from the client's provider, HCA reviews all evidence submitted and will either:

- Approve the request.
- Deny the request if the requested service is not medically necessary.
- Request the provider to submit additional justifying information within 30 days. When the additional information is received, HCA will approve or deny the request within 5 business days of the receipt of the additional information. If the additional information is not received within 30 days, HCA will deny the requested service.

When HCA denies all or part of a request for a covered service or equipment, HCA sends the client and the provider written notice within 10 business days of the date the information is received that:

- Includes a statement of the action HCA intends to take.
- Includes the specific factual basis for the intended action.
- Includes references to the specific WAC provision upon which the denial is based.
- Is in sufficient detail to enable the recipient to learn why HCA's action was taken.
- Is in sufficient detail to determine what additional or different information might be provided to challenge HCA's determination.
- Includes the client's administrative hearing rights.
- Includes an explanation of the circumstances under which the denied service is continued or reinstated if a hearing is requested.
- Includes example(s) of lesser cost alternatives that permit the affected party to prepare an appropriate response.

Requesting prior authorization (PA)

When a procedure's EPA criteria has not been met or the covered procedure requires PA, providers must request prior authorization from HCA. Procedures that require PA are listed in the fee schedule. HCA does not retrospectively authorize any health care services that require PA after they have been provided except when a client has delayed certification of eligibility.

Online direct data entry into ProviderOne

Providers may submit a prior authorization request by direct data entry into ProviderOne or by submitting the request in writing (see HCA's **prior authorization webpage** for details).

Online submission or fax

If providers chose to submit their PA request online or via fax, the following must be provided:

- The *General Information for Authorization* form, HCA 13-835. See **Where can I download HCA forms?** This form must be page one of the mailed/faxed request and must be typed.
- **Required documentation** to support the request for authorization.

Submit fax PA requests (with forms and documentation) to: (866) 668-1214

Submission of photos and X-rays for medical

Step-by-step instructions are available online.

Required documentation for prior authorization (PA)

(Refer to WAC 182-531-1675[2])

HCA requires PA for all treatments and surgical services to treat gender dysphoria. Surgical services include the initial surgery, modifications to a previous surgery, or complications from a previous surgery. The only exceptions to the PA requirement are mastectomy for gender dysphoria and hair removal in preparation for bottom surgery, which are processed through expedited prior authorization (EPA). If the client does not meet the EPA criteria for mastectomy or hair removal in preparation for bottom surgery, then PA is required. EPA cannot be used for a revision or repair of previous mastectomy; PA is required.

> **Note:** Unless otherwise noted, it is a general requirement for the client to be on gender affirming hormone therapy and live in a gender role that is congruent with their gender identity (including non-binary) for a minimum of 12 months preceding all gender-affirming treatment.

General requirements for provider documentation

The provider must include the following documentation with the prior authorization request. The documentation must be signed and dated by the provider and in letter format, except for the surgeon's history and physical and surgical plan. It is also important to include the facility billing national provider identifier (NPI) and the clinic billing NPI when submitting the PA request to help ensure payment.

Psychosocial evaluations. Each comprehensive psychosocial evaluation must:

- Be completed within the past 18 months.
- Be in letter form, and 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.

Primary care provider's documentation. A letter of support from the primary care provider or provider managing the client's gender-affirming hormonal therapy must be completed within the past 18 months and include:

- A medical necessity for surgery and confirmation that the client is adherent with current gender dysphoria treatment; and either:

- Documentation of gender-affirming hormone use for a minimum of 12 continuous months immediately preceding the request for surgery, except for mastectomy or reduction mammoplasty; **or**
- A medical contraindication to gender affirming hormone therapy.

Surgeon's documentation. A clinical note from the surgeon performing the procedure must be completed within the past 12 months preceding surgery and include the:

- Medical history and physical examination
- Medical necessity for surgery
- Surgical plan
- For hysterectomies, a completed *Hysterectomy Consent* form, HCA 13-365.

Breast augmentation

For breast augmentation, submit:

- One comprehensive psychosocial evaluation completed within the past 18 months from a **qualified and licensed behavioral health provider**.
- A letter written within the past 18 months from the provider managing the client's gender affirming hormone therapy.
- The client's history and physical and surgical plan completed within the past 12 months from the surgeon who will perform the surgery.

Mastectomy

If the client meets the EPA criteria required for a mastectomy, use **EPA #870001615** (EPA) for clients age 17 and older. Otherwise, prior authorization is required. The following clinical criteria and documentation must be kept in the client's medical record and made available to HCA upon request:

- One comprehensive psychosocial evaluation completed within 18 months preceding surgery from a **qualified and licensed behavioral health provider** that:
  - Independently confirms the diagnosis of gender dysphoria as defined by the *Diagnostic Statistical Manual of Mental Disorders*.
  - Documents that the client has been evaluated for any coexisting behavioral health conditions and if any are present, the conditions are adequately managed.
- A letter of medical necessity within the past 18 months supporting the request for mastectomy from the primary care provider
- The client's history and physical and surgical plan completed within the past 12 months from the surgeon who will perform the surgery

For clients age 17 and younger, each comprehensive psychosocial evaluation must be performed by a licensed and qualified behavioral health provider who

specializes in adolescent transgender care and meets the qualifications outlined in WAC 182-531-1400.

> **Note:** It is **not** a requirement for the client to be on gender affirming hormone therapy and live in a gender role congruent with their gender identity preceding mastectomy.

Facial feminization

For facial feminization surgery, submit:

- One comprehensive psychosocial evaluation completed within the past 18 months from a **qualified and licensed behavioral health provider**.
- A letter written within the past 18 months from the provider managing the client's gender affirming hormone therapy.
- The client's history and physical (H&P), and the surgical plan completed within the past 12 months by the surgeon who will perform the surgery.
    - The assessment in the H&P must include an objective assessment that identifies the masculine features requiring surgical intervention to treat gender dysphoria for the client.
    - The surgical plan must include a description of how the requested procedures will address the client's masculine features, feminize the face, and treat the client's gender dysphoria. All codes requested must be addressed in the documented surgical plan to determine medical necessity of requested procedures.
- Photos of the client's face (including the neck, if requesting laryngoplasty or tracheal shave) from approximately two feet away, to include views from the front, sides, and with the client looking up and looking down.

Gender-affirming voice surgery

For gender affirming voice surgery, submit:

- A letter of support (within the past 12 months) from a speech language pathologist (SLP) stating the client has completed speech therapy/voice therapy, including the outcome of the therapy.
- A recent (within the past 12 months) history and physical and treatment plan from the otolaryngologist who will perform the procedure.
- Either of the following:
    - A recent (within the past 18 months) letter of medical necessity supporting the request for voice modification procedure from the primary care provider.
    - For voice masculinization, a recent (within the past 18 months) letter from the provider managing the client's gender-affirming hormone therapy.

Facial or body hair removal

For facial or body hair removal, submit:

- A letter written within the past 18 months from the provider managing the client's gender affirming hormone therapy.
- A letter of medical necessity from the provider treating the client (dermatologist or primary care provider), completed within the past 18 months. The letter must include:
  - A description of the hair removal techniques that have been attempted and failed by body region, along with the medical condition that prevents the client from shaving or using other hair removal techniques. Examples include:
    - Documented folliculitis
    - Documented sensitivity to hair removal techniques
    - Thick male pattern hair growth prohibiting adequate hair removal
  - Photos of requested area to be treated from approximately two feet (include method of hair removal used in the following photo series for documentation):
    - Before hair removal:
      - **Face and neck**: Recommend 8-12 hours of hair growth; include length of time from last hair removal)
      - **Body**: Recommend 1-2 weeks of hair growth to visualize hair distribution, thickness, etc. Genital body region photos are not needed.
    - Immediately after hair removal

    For example: The client may remove the hair before bed for the "immediately after hair removal pictures." Then in the morning, take pictures again to demonstrate the 8- to 12-hour hair growth.

- Letter of medical necessity from the provider who will perform the hair removal that includes the size and location of the area to be treated and the number of expected units needed per body region to complete treatment per area requested. Body regions include:
  - Face/neck
  - Chest
  - Abdomen
  - Axillary (underarm)
  - Arm

- Upper back
- Lower back
- Buttocks
- Inner thigh (swimsuit/bikini area)
- Genital area
- Upper leg
- Lower leg

Hysterectomy and orchiectomy

For hysterectomy and orchiectomy to treat gender dysphoria, submit:

- One comprehensive psychosocial evaluation completed within the past 18 months from a **qualified and licensed behavioral health provider.**
- A letter written within the past 18 months from the provider managing the client's gender affirming hormone therapy.
- The client's history and physical, as well as the surgical plan completed within the past 12 months from the surgeon who will perform the surgery.
- For hysterectomy, a completed *Hysterectomy Consent* form, HCA 13-365.

Note:

- If the requested procedure is required to treat a medical condition (e.g., dysmenorrhea or menorrhagia), the authorization must be obtained through the client's MCO and not through fee-for-service.

- It is a general requirement for the client to be on gender affirming hormone therapy for a minimum of 12 months preceding hysterectomy or orchiectomy. However, it is **not** a requirement for the client to live in a gender role congruent with the client's gender identity for a minimum of 12 months preceding hysterectomy or orchiectomy.

Full-bottom surgery

For full-bottom surgery, submit:

- Two separate psychosocial evaluation completed within the past 18 months, from two separate **qualified and licensed behavioral health providers.**
- A letter written within the past 18 months from the provider managing the client's gender affirming hormone therapy.

- The client's history and physical and the surgical plan completed within the past 12 months by the surgeon who will perform the surgery.

Genital or donor skin site hair removal in preparation for bottom surgery

If the client meets EPA criteria for genital or donor skin site hair removal in preparation for bottom surgery, use **EPA #870001616** for clients age 18 and older. Otherwise, prior authorization is required. Either of the following 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.
- A letter of medical necessity from the provider who will perform the hair removal. The letter must include the surgical consult for bottom surgery that addresses the need for hair removal before gender-affirming surgery.

Prior authorization (PA) for clients age 17 and younger

Clients age 17 and younger must submit the same documentation required for their PA request, except that:

- Each 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**.
- For bottom surgery, HCA requires two separate comprehensive psychosocial evaluations from two behavioral health providers, one of whom must specialize in adolescent transgender care and meet the qualifications outlined in WAC 182-531-1400.

Note for EPSDT: If gender dysphoria treatment is requested or prescribed for clients age 20 and younger under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, HCA evaluates it as a covered service under the EPSDT program's requirement that the service is medically necessary, safe, effective, and not experimental.

Expedited prior authorization (EPA)

What is expedited prior authorization (EPA)?

Expedited prior authorization (EPA) is designed to eliminate the need for written authorization. HCA establishes authorization criteria and identifies the criteria with specific codes, enabling providers to create an EPA number using those codes.

To bill HCA for diagnostic conditions, procedures and services that meet the EPA criteria on the following pages, the provider must **use the 9-digit EPA number**. The first five or six digits of the EPA number must be **87000 or 870000**. The last 3 or 4 digits must be the EPA number assigned to the diagnostic condition, procedure, or service that meets the EPA criteria (see EPA criteria list for numbers). Enter the EPA number on the billing form in the authorization number field, or in the **Authorization** or **Comments** section when billing electronically.

Example: The 9-digit authorization number for a client with the following criteria would be **870000421**:

- Client is age 11 through 55
- Client is in one of the at-risk groups because the client meets **one** of the following:
  - Has terminal complement component deficiencies
  - Has anatomic or functional asplenia
  - Is a microbiologist who is routinely exposed to isolates of **Neisseria meningitis**
  - Is a freshman entering college who will live in a dormitory

HCA denies claims submitted without a required EPA number.

HCA denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.

The billing provider must document in the client's file how the EPA criteria were met and make this information available to HCA on request. If HCA determines the documentation does not support the criteria being met, the claim will be denied.

Note: HCA requires PA via online submission or fax when there is no option to create an EPA number.

EPA documentation 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 HCA's request. If HCA determines the documentation does not support the EPA criteria requirements, the claim will be denied.

Procedures for which providers may use EPA

(Refer to WAC 182-531-1675 [3])

HCA allows a provider to use the EPA process for the following medically necessary procedures:

Genital or donor skin graft site hair removal

For clients age 18 and older: For genital or donor skin graft site hair removal in preparation for gender-affirming surgery, use **EPA # 870001616**. A maximum of 156 units per year is allowed. After two years, PA is required.

Criteria:

- Primary diagnosis code of: F64.0, F64.1, F64.2, or F64.9
- CPT® codes 17999 (laser), 17380 (electrolysis), and 64999 (nerve block) are only allowed if associated with a primary diagnosis code of F64.0, F64.1, F64.2, or F64.9, and CPT® code 64999 can only be billed in conjunction with CPT® code 17380.
- The client must be age 18 or older to use EPA.
- For clients age 17 and younger, a PA request must be requested.

Documentation requirements:

See **Genital or donor skin site hair removal** for PA.

Mastectomy or reduction mammoplasty

For clients age 17 and older: For bilateral mastectomy or reduction mammoplasty with or without chest reconstruction, use **EPA #870001615**. There is a lifetime limit of one for CPT® codes 19303 and 19318. For example, if the client undergoes reduction mammaplasty and is billed using CPT® code 19318, the client is not eligible for services billed using either CPT® code 19318 or CPT® code 19303 at a later time. EPA cannot be used to revise or repair a previous mastectomy or reduction mammaplasty; PA is required.

Criteria:

- Primary diagnosis code of; F64.0, F64.1, F64.2, or F64.9
- CPT® codes 19303 (mastectomy), 19318 (breast reduction), 19350 (nipple/areola reconstruction), 15877 (suction lipectomy-trunk), 15860 (test vascular flow in flap or graft)
- CPT® codes 19350, 15877, and 15860 are only allowed if associated with either CPT® code 19303 or CPT® code 19318 AND a primary diagnosis code of F64.0, F64.1, F64.2, or F64.9
- The client must be age 17 or older to use EPA.

Documentation requirements:

See **Requirements for provider documentation** section.

Recoupment

(WAC 182-531-1675 [3][e])

HCA may recoup any payment made to a provider for services to treat gender dysphoria if the provider does not follow the EPA process outlined in WAC 182-501-0163 or if the provider does not maintain the required documentation.

Providers must retain supporting documentation for audit purposes. (See WAC 182-502A-0401, Program integrity activities.)

EPA criteria list

A complete EPA number is 9 digits. The first five or six digits of the EPA number must be **87000 or 870000**. The last 3 or 4 digits must be the EPA number assigned to the diagnostic condition, procedure, or service that meets the EPA criteria. If the client does not meet the EPA criteria, prior authorization (PA) is required (see Prior authorization).

EPA Number	Service Name	CPT®/HCPCS/DX	Criteria
870001400	Surgical consultation related to transgender surgery	Dx: F64.0, F64.1, F64.2, and F64.9	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.

870001615	Mastectomies and reduction mammoplasty	CPT® codes: 19303, 19318, 19350 15877, 15860	• 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:
			  • Psychiatrist
			  • Psychologist
			  • Psychiatric advanced registered nurse practitioner (ARNP)
			  • Psychiatric mental health nurse practitioner-board certified (PMHNP-BC)

EPA Number	Service Name	CPT®/HCPCS/DX	Criteria
			• 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.

EPA Number	Service Name	CPT®/HCPCS/DX	Criteria

870001616	Genital electrolysis or donor site hair removal and nerve block	CPT® codes: 17380, 17999, 64999	• CPT® codes 17380, 17999, 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.
			• CPT® code 64999 is only allowed if associated with either 17380 AND a primary diagnosis code of F64.0, F64.1, F64.2, or F64.9.
			• The client must be age 18 or older. For clients age 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 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 PA.

EPA Number	Service Name	CPT®/HCPCS/DX	Criteria
870001671	Testosterone testing	CPT® codes: 84402, 84403, 84410	• Use EPA for fee-for-service clients - In conjunction with diagnosis codes F64, F640, F641, F642, F649 • Managed care clients must receive testosterone testing through their HCA-contracted managed care organization (MCO)

Payment

Payment for gender-affirming interventions and treatment

Clients covered under an MCO

Payment for gender affirming hormone therapy, speech therapy, and behavioral health services to treat gender dysphoria is the responsibility of the client's MCO.

Clients covered under fee-for-service

Payment for other gender-affirming treatment, including electrolysis and post-operative complications, if required, to treatment gender dysphoria are the responsibility of the Medicaid fee-for-service program. These services require prior authorization (PA). See **Required documentation for prior authorization (PA)**?

HCA pays for consultations related to gender-affirming treatment/surgery and associated electrolysis or laser hair removal required for gender reassignment surgery (GRS). These consultations are paid for by HCA through fee-for-service. To ensure payment, bill HCA directly for this consultative visit using an expedited prior authorization (EPA) number. See EPA #**870001400** for details.

> **Note:** When billing Medicaid fee-for-service for complications related to GRS, providers must add "SCI=TC" in the *Comments* filed on the claim.

Fee schedule

For maximum allowable fees associated with procedure codes billable for transhealth services, see HCA's **Transhealth program fee schedule**.

Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information, see HCA's **ProviderOne Billing and Resource Guide** webpage and scroll down to *Paperless billing at HCA*. For providers approved to bill paper claims, visit the same webpage and scroll down to *Paper Claim Billing Resource*.

What are the general billing requirements?

Providers must follow HCA **ProviderOne Billing and Resource Guide**.

These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments.
- What fee to bill HCA for eligible clients.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- Billing for clients eligible for both Medicare and Medicaid.
- Third-party liability.
- Record keeping requirements.

Billing for multiple services

If multiples of the same procedures are performed on the same day, providers must bill with the appropriate modifier (if applicable) and must bill all the services on the same claim to be considered for payment.

Billing for outpatient hospital services in hospital-based clinics

HCA requires clinics to bill for outpatient services in one of the following ways:

- If the Department of Health (DOH) has not designated the clinic as a hospital-based entity, the clinic must submit to HCA an electronic professional claim containing both:
    - The facility and the professional fees in the *Submitted Charges* field.
    - The place of service (POS) 11 (office setting) in the *Place of Service* field.

  Medicare and Medicaid policy prohibit the hospital from billing a facility fee in this circumstance. HCA will reimburse the clinic the nonfacility setting fee. This single claim comprises the total payment for the services rendered

- If DOH has designated the clinic as a hospital-based entity, for HCA to reimburse the clinic and the associated hospital for services provided to clients eligible for Washington Apple Health (Medicaid), the following must happen:
    - The clinic must submit to HCA a professional electronic claim containing both:
        - The professional fees in the *Submitted Charges* field.
        - POS 22 (outpatient setting) in the *Place of Service* field.
    - The hospital must submit to HCA an electronic institutional claim with the facility fees the *Total Claim Charge* field.

  These two billings comprise the total payment for the services rendered.

In the circumstances described above, clinics must follow instructions in this billing guide related to office setting and outpatient services.

How do I resolve issues with gender indicator when billing for transgender clients?

For gender to procedure mismatch: for transgender female with male genitalia

For a transgender client, providers must include an additional diagnosis on the claim that indicates the client is transgender (F64.0, F64.1, F64.2 and F64.9). On a professional claim, diagnosis may be in any diagnosis field on the claim. On an institutional claim, the diagnosis may be in any other diagnosis field. Use of the additional diagnosis allows the gender-specific procedures to be processed through HCA's claims system. Without the additional diagnosis code, the claim may be denied.

> **Example situation**:
>
> A client self-identifies as a female but still has male specific body parts. This client then gets a routine prostate exam. This bill would deny for a male-only procedure being billed on a female client. However, if a diagnosis such as gender identity disorder was listed as the additional diagnosis, the claim would then be processed for payment.

In these circumstances, providers must bill the diagnosis (F64.0, F64.1, F64.2 and F64.9) as additional on the professional claim or as other on the institutional claim. If a claim is denied for a gender mismatch, see **How does the provider notify HCA of a date of birth or gender mismatch**? On an institutional claim, the "Patient reason for visit" diagnosis may not be used.

Note: Providers should encourage transgender clients to update their gender listed on their Washington Apple Health account by contacting HCA's Medical Eligibility Determination Services (MEDS) toll free 855-623-9357.

ProviderOne gender indicator does not match claim gender indicator

Such as when a client presents as a female, but ProviderOne has the male gender indicator in file. The provider should check the client's gender in ProviderOne when verifying coverage. If a mismatch is found, the provider should encourage the client to update the gender field to their preferred gender. The client can do this by calling HCA's Medical Eligibility Determination Section toll-free 1-855-623-9357.

How does the provider notify HCA of a date of birth or gender mismatch?

If a provider finds that there is a discrepancy with a client's date of birth or gender, send a secured email to mmishelp@hca.wa.gov. Include the following information in the email:

- TCN #
- A comment that the client is transgender
- ProviderOne client ID
- Client's name
- Date of birth
- Gender at birth
- Gender identified as at the time service provided

How does a client update their gender field?

- Clients who applied through the Healthplanfinder must call HCA's Medical Eligibility Determination Section toll free 1-855-623-9357.
- Clients who applied through the Community Service Office (CSO) must call toll-free 1-877-501-2233 or report online at Washington Connection.

Any Washington Apple Health client can call and choose a gender. Clients should be aware other state agencies, such as the Department of Licensing, have different requirements.

How does a client update or change their name?

Before making a name change, the client should first obtain a name change with Social Security. If the client's name does not match the client's name in Social

Security, the system will generate an error, and this could affect the client's coverage.

- Clients who applied through the Healthplanfinder must call toll-free 1-855-623-9357.
- Clients who applied through the Community Service Office (CSO) must call toll-free 1-877-501-2233 or report online at **Washington Connection**.

If providers have any concerns or question regarding the policy with this benefit, please contact HCA by email at **transhealth@hca.wa.gov**.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's **Billers, providers, and partners** webpage.

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

Submitting professional services for Medicare crossovers

For services paid for, and/or applied to the deductible, by Medicare:

- Medicare should forward the claim to HCA. If the claim is not received by HCA, please resolve that issue prior to resubmitting the claim.
- Mark "Yes" for the question, "Is this a Medicare Crossover Claim?" in the electronic claim.
- See the **ProviderOne Billing and Resource Guide** and the **Fact Sheets** webpage to get more information about submitting Medicare payment information electronically and to find out when paper backup must be attached.
- Do not indicate any payment made by Medicare in the Other Payer Information section of the clam. Enter only payments made by non-Medicare, third-party payers (e.g., Blue Cross) in this section and attach the Explanation of Benefits (EOB).

> **Note**: If Medicare allowed/paid on some services and denied other services, the allowed/paid services must be billed on a different claim than the denied services. **Exception**: When billing crossover claims for Indian Health Services, follow the instructions in HCA's **Tribal Health Program Billing Guide**.

Requirements for the provider-generated EOMB to process a crossover claim

Header level information on the EOMB must include all the following:

- Medicare as the clearly identified payer
- The Medicare claim paid or process date
- The client's name (if not in the column level)
- Medicare Reason codes
- Text in font size 12 or greater

Column level labels on the EOMB for the CMS-1500 claim form (version 02/12) must include all the following:

- The client's name
- Date of service
- Number of service units (whole number) (NOS)
- Procedure Code (PROC)
- Modifiers (MODS)
- Billed amount
- Allowed amount
- Deductible
- Amount paid by Medicare (PROV PD)
- Medicare Adjustment Reason codes and Remark codes
- Text that is font size 12

Utilization review

Utilization Review (UR) is a concurrent, prospective, and/or retrospective (including post-pay and pre-pay) formal evaluation of a client's documented medical care to assure that the health care services provided are proper and necessary and are of good quality. The review considers the appropriateness of the place of care, level of care, and the duration, frequency, or quantity of health care services provided in relation to the condition(s) being treated.

HCA uses **InterQual: Evidence-Based Clinical Criteria** as a guideline in the utilization review process.

- Concurrent UR is performed during a client's course of care.
- Prospective UR is performed prior to the provision of health care services.
- Retrospective UR is performed following the provision of health care services and includes both post-payment and pre-payment review.
- Post-payment retrospective UR is performed after health care services are provided and paid.
- Pre-payment retrospective UR is performed after health care services are provided but prior to payment.