Washington State Health Care Authority

Washington Apple Health (Medicaid)

Expedited Prior Authorization (EPA) List

April 7, 2025

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

TABLE OF CONTENTS

What is Expedited Prior Authorization (EPA) 3
Access to Baby and Child Dentistry 4
Applied Behavior Analysis (ABA) 4
Dental-Related Services 6
Enteral Nutrition 7
Habilitative Services 10
Hearing SERVICES 11
Home Infusion Therapy/Parenteral Nutrition 14
Hospice Services 15
Inpatient Hospital Services 16
  Newborn administrative days 16
  inpatient WITHDRAWAL MANAGEMENT 17
Kidney Center Services 19
Maternity Support Services and Infant Case Management 20
Medical Equipment AND Supplies (MES) 21
  Rentals 22
  Rental Manual Wheelchairs 22
  Rental/Purchase Hospital Beds 24
  Low Air Loss Therapy Systems 27
  Noninvasive Bone Growth/Nerve Stimulators 28
  Miscellaneous Durable Medical Equipment 29
  Medical nutrition therapy 30
Mental Health Services 31
  EPA Numbers representing evidence and research based practice 31
EPA for billing inpatient psychiatric services for eligible Apple Health clients without a managed care plan or behavioral health services organization (BHSO) 35

epa for inpatient evaluation and treatment 36
Orthodontic Services 37
Outpatient Rehabilitation 42
    Occupational Therapy and Physical Therapy 42
    Speech Therapy 44
Physician-Related Services/Health Care Professional Services 45
Planned Home Births & Births in Birthing Centers 72
Pregnancy Related Services 73
Prosthetic and Orthotic (P&O) Devices 74
Respiratory Care 78
Sleep centers 79
TransHealth Program 79
Tribal Health Program 82
Vision Hardware for Clients Age 20 and Younger 82

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	D2940		Placement of interim direct restoration	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	D2940		Placement of interim direct restoration	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.
APPLIED BEHAVIOR ANALYSIS (ABA)					
See https://www.hca.wa.gov/billers-	0373T		Adapt bhv tx ea 15 min	870001657	The client has a qualifying diagnosis of autism spectrum disorder or other intellectual/developmental disability for which there is

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules#a					evidence ABA is effective from an ABA Center of Excellence (COE) provider (developmental pediatrician, neurologist, pediatric neurologist, psychiatrist, pediatric psychiatrist, licensed psychologist or other qualified medical provider designated by HCA as a COE). The services are ordered by an ABA COE provider. Short-term, focused ABA services provided in an inpatient setting to stabilize the client's harmful behavior to a level/intensity that promotes discharge to a less restrictive setting. The hospitalization or continued hospitalization occurred because of the client's severe harmful behavior. The client's severe harmful behavior prevents discharge to a less restrictive setting. Meets all other criteria for ABA services in this guide and Chapter 182-531A WAC. Continuation of ongoing ABA services that were provided in another setting prior to hospitalization does not meet criteria for EPA.
See https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules#a	97153		Adaptive behavior tx by tech	870001656	The client has a qualifying diagnosis of autism spectrum disorder or other intellectual/developmental disability for which there is evidence ABA is effective from an ABA Center of Excellence (COE) provider (developmental pediatrician, neurologist, pediatric neurologist, psychiatrist, pediatric psychiatrist, licensed psychologist or other qualified medical provider designated by HCA as a COE). The services are ordered by an ABA COE provider. Short-term, focused ABA services provided in an inpatient setting to stabilize the client's harmful behavior to a level/intensity that promotes discharge to a less restrictive setting.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
					The hospitalization or continued hospitalization occurred because of the client's severe harmful behavior. The client's severe harmful behavior prevents discharge to a less restrictive setting. Meets all other criteria for ABA services in this guide and Chapter 182-531A WAC. Continuation of ongoing ABA services that were provided in another setting prior to hospitalization does not meet criteria for EPA.

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	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 Health Care Authority 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	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		
See Dental-Related Services	D4910		Periodontal maint procedures	870001655	Clients age 21 and older with a diagnosis of diabetes. Provider performing the procedure must keep documentation (in their records) of the client's diabetes diagnosis.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
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 through 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 identify any medical or behavioral issues that require referral for management.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria ***Expedited Prior Authorization Inventory***
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 in 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-the-counter nutrition products, standard infant formula, or standard 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.

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

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
HABILITATIVE SERVICES					
For client 21 & older: Additional Benefit Limits with Expedited Prior Authorization					
See Habilitative Services	92609		Botox therapy with Speech therapy Clients Age 21 and Older	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 Health Care Authority. **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 Clients Age 21 and Older	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 Health Care Authority. **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 Clients Age 21 and Older		
See Habilitative Services	97165 rev code 0434		DSHS OT eval (bed rail assessment) with *Occupational* therapy	870001326	One per client, unless change of residence or condition OT Eval for bedrails is a DSHS program. Use EPA# 870001326 with Rev code 0434 and CPT® code 97165.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
HEARING SERVICES					
See Hearing Services	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 Services	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 HCA 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 Services	V5275		Ear impression	870001599	Limit one per calendar year replacement only, per hearing aid if needed.
See Hearing Services	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.
See Hearing Services	CPT code 69930		**Unilateral** cochlear implant	870000423	Based upon review of evidence provided by HTCC (20130517A—Cochlear Implants: Bilateral vs. Unilateral), HCA considers cochlear

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
			for clients age 20 and younger	Note: For criteria for **bilateral** cochlear implants, see EPA 870001365	implant devices to be medically necessary when the following criteria are met: • Client has bilateral severe to profound sensorineural hearing loss • Client has limited or no benefit from hearing aids • Client has the cognitive ability and willingness to participate in an extensive auditory rehabilitation program • Client has 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 • Client has no other contraindications for surgery • Device is used in accordance with the FDA-approved labeling. Implantation may be performed unilaterally or bilaterally.
See Hearing Services	CPT code 69930		**Bilateral** cochlear implants for clients age 20 and younger	870001365 Note: For **unilateral** cochlear implants, see EPA 870000423	HCA considers cochlear implant devices to be medically necessary when the following criteria are met: • Client has bilateral severe to profound sensorineural hearing loss • Client has limited or no benefit from hearing aids • Client has the cognitive ability and willingness to participate in an extensive auditory rehabilitation program • Client has 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 • Client has no other contraindications for surgery • Device is used in accordance with the FDA-approved labeling.
See Hearing Services	69433 or 69436		Tympanostomy tubes	870001382	Based upon review of evidence provided by HTCC (20151120B—Tympanostomy Tubes in Children), HCA considers tympanostomy tubes for children **age 16 and younger** to be medically necessary when the child 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:

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					▪ 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 Hearing Services	69433 or 69436		Tympanostomy tubes	870001654	HCA considers tympanostomy tubes to be medically necessary for clients **age 17 and older** for any of the following indications: • Autophony due to patulous eustachian tube • Barotitis media control • Cholesteatoma • Chronic retraction of tympanic membrane or pars flaccida • Complications of otitis media such as meningitis, facial nerve paralysis, coalescent mastoiditis, or brain abscess • Otitis media with effusion after 3 months or longer and bilateral hearing impairment (defined as 20 dB hearing threshold level or worse in both ears) (tympanostomy tube) • Recurrent episodes of acute otitis media (more than 3 episodes in 6 months or more than 4 episodes in 12 months) (tympanostomy tube) • Severe otalgia in acute otitis media (myringotomy) • To obtain a culture (diagnostic tympanocentesis/myringotomy) of the middle ear fluid prior to beginning or changing antimicrobial therapy (this may be necessary in situations such as otitis media that has failed to respond to appropriate antimicrobial therapy, or for otitis media in individuals or neonates who are immunocompromised)

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
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 • 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

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
HOSPICE SERVICES					
See Hospice Services	Rev codes: 0651, 0652, 0655, 0656			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.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
INPATIENT HOSPITAL SERVICES					
See Inpatient Hospital Services	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622		Newborn deliveries; Early elective delivery or natural delivery **prior to 39 weeks** gestation	870001375	HCA does not pay for early elective deliveries. An early elective delivery is defined in WAC 182-500-0030 as any non-medically necessary induction or cesarean section before 39 weeks gestation. An early elective delivery is considered medically necessary if 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 (WAC 182-533-0400). **This EPA also needs to be used for clients who deliver naturally prior to 39 weeks.**
			Newborn deliveries: 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.**
NEWBORN ADMINISTRATIVE DAYS					
	Rev code 0191		Additional newborn administrative days (i.e., beyond day five)	870001641	HCA pays for additional newborn administrative days (i.e., beyond day five) with expedited prior authorization (EPA) if the days meet the newborn, postpartum parent, medication, and additional services criteria specified in the previous section, and the following additional criteria are met: • The newborn requires ongoing monitoring and does not meet criteria for discharge because the newborn is having difficulty with one or more of the following: o Feeding or sucking, or poor weight gain o Gastrointestinal disturbance (e.g., vomiting, diarrhea, cramping) o Sleep (i.e., falling asleep or maintaining sleep) o Being consoled (e.g., excessive crying or irritability, tremors, hypertonia) • The newborn can receive continuous care from the postpartum parent:

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
					o The newborn has not transferred into the neonatal intensive care unit (NICU) or the pediatric specialty unit for closer monitoring o The postpartum parent is staying at the hospital to provide continuous care
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 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.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					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. HCA requires prior authorization (PA) if the EPA criteria above is not met. HCA may approve more than 14 in-center hemodialysis treatments for up to a 6-month period.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
MATERNITY SUPPORT SERVICES AND INFANT CASE MANAGEMENT					
See Maternity Support Services and Infant Case Management ** To receive reimbursement, tribal programs must use the procedure code and modifier above and one of these additional modifiers based on the client's demographic information. **Client Demographic Addt'l Modifier** **American Indian or Alaska Native UA** **Nonnative person SE**	T1017 with Dx: Z76.2 1 unit = 15 minutes	HD	Targeted case management, each 15 minutes	870001418	EPA is required when an infant's ICM eligibility occurs before age three months. 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.

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.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
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 provider, 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/lancets	870001263	For pregnant people with gestational diabetes, HCA pays for the quantity necessary to support testing as directed by the client's provider. For pregnant people with gestational diabetes, HCA pays for the quantity necessary to support testing as directed by the client's provider, up to 12 months postpartum.
			Blood glucose test strips/lancets for children through age 20	870001265	100 over limit - for children only

RENTALS

What are the expedited prior authorization (EPA) criteria for equipment rental?

Note: The following pertains to expedited prior authorization (EPA) numbers 870000700 – 870000820:

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 provider 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. Rentals in the hospital are included in the Diagnoses Related Group (DRG) payment.
3) HCA 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.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
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 the client totally non-weight bearing or is unable to use other aids for 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 provider, that is less than 6 months.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
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 the client totally non-weight bearing or is unable to use other aids for 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 provider, that is 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 over 250 lbs. 2) Requires a wheelchair to participate in normal daily activities. 3) Has a medical condition that renders the client totally non-weight bearing or is unable to use other aids for 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 provider, that is 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 for 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. 4) Has a length of need, as determined by the prescribing provider, that is less than 6 months.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
RENTAL/PURCHASE HOSPITAL BEDS					
Note (For Rental Manual or Semi-electric Hospital Bed): 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 the 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 provider, a PA for purchase must be requested. 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. Rentals in the hospital are included in the DRG payment. 5) HCA 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). 4) Has a medical condition that necessitates upper body positioning at no less than a 30-degree angle the majority of time the client is in the bed. 5) Has full-time caregivers. 6) Does **not** also have a rental wheelchair.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
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 own bed, and determined to be ineffective in meeting 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 operate the bed controls independently and safely. 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*?

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
Note (For Purchase Manual or Semi-electric Hospital Bed): 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) For hospital beds, the date of delivery to the client and serial number of the hospital bed must be submitted prior to payment. 3) It is the vendor's responsibility to determine if the client has not been previously provided a hospital bed, either purchase or rental. 4) 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 like pillows, bolsters, foam wedges, 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 operate the bed controls independently and safely. **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
					4) Written documentation that client has not previously had 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.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
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 Documentation 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.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
MISCELLANEOUS DURABLE MEDICAL EQUIPMENT					
See Medical Equipment & Supplies	E0604	RR	Breast pump, electric	870000800	Unit may be rented for up to 3 months when one of the following conditions directly impacts the ability of the infant to feed from the parent. 1. Prematurity (including multiple gestation); 2. Neurologic disorder; 3. Genetic abnormality; 4. Anatomic or mechanical malformation (e.g., cleft lip or palate); or 5. Congenital malformation requiring surgery (e.g., respiratory, cardiac, gastrointestinal, or central nervous system malformation)
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	For clients age 20 and younger. Limit one set per client during a five-year period. Requires Bed and Pillow Encasements form HCA 13-0052 to be completed and submitted with the claim.
See Medical Equipment & Supplies	A9286		Hygienic item, bed encasement, pillowcases (set of 2) (age 20 and younger)	870001605	For clients age 20 and younger. Limit one set per client during a five-year period. Requires Bed and Pillow Encasements form HCA 13-0052 to be completed and submitted with the claim.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
MEDICAL NUTRITION THERAPY Note: Clients age 20 and younger do not require EPA.					
	97802		Medical nutrition, indiv in	870001644	Clients age 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		

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

MENTAL HEALTH SERVICES

Note: EPA does not apply to out-of-state care.

Allowable CPT® codes to use with evidence-based practices: 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, and 90853.

EPA NUMBERS REPRESENTING EVIDENCE AND RESEARCH 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
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
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
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

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria

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)

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
See Mental Health Services			Inpatient psychiatric hospital involuntary detention 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

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
See [Mental Health Services]()			Inpatient psychiatric hospital voluntary 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 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
EPA FOR INPATIENT EVALUATION AND TREATMENT					
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 there is a change in any of the below: • Legal status • Principal covered diagnosis

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
					• 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 lip and/or palate and craniofacial anomaly cases. Treating provider must be a part of a craniofacial team that includes, but is not limited to, a general or pediatric dentist, orthodontist and an oral maxillofacial surgeon or specialist. 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.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria ***Expedited Prior Authorization Inventory***
See Orthodontic Services	D8030		Limited orthodontic treatment of the adolescent dentition	870000970	Use when billing for cleft lip and/or palate and craniofacial anomaly cases. Treating provider must be a part of a craniofacial team that includes, but is not limited to, a general or pediatric dentist, orthodontist and an oral maxillofacial surgeon or specialist. 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. EPA does not apply for treatment beyond the initial limited treatment. Limitation extension must be submitted to HCA and approved.
See Orthodontic Services	D8670		Limited orthodontic treatment of the adolescent dentition	870000970	Use when billing for cleft lip and/or palate and craniofacial anomaly cases. Treating provider must be a part of a craniofacial team that includes, but is not limited to, a general or pediatric dentist, orthodontist and an oral maxillofacial surgeon or specialist. 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. EPA does not apply for treatment beyond the initial limited treatment. Limitation extension must be submitted to HCA and approved
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 a part of a craniofacial team that includes, but is not limited to, a general or pediatric dentist, orthodontist and an oral maxillofacial surgeon or specialist.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					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. EPA does not apply for treatment beyond the initial comprehensive orthodontic treatment. Limitation extension must be submitted to HCA and approved
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 a part of a craniofacial team that includes, but is not limited to, a general or pediatric dentist, orthodontist and an oral maxillofacial surgeon or specialist. 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. EPA does not apply for treatment beyond the initial limited orthodontic treatment. Limitation extension must be submitted to HCA and approved.
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 a part of a craniofacial team that includes, but is not limited to, a general or pediatric dentist, orthodontist and an oral maxillofacial surgeon or specialist. 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

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
					EPA does not apply for treatment beyond the initial limited orthodontic treatment. Limitation extension must be submitted to HCA and approved.
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 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. • 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. • Cephalometric radiographs (x-rays). 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. • Cephalometric radiographs (x-rays).

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					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. • Cephalometric radiographs (x-rays). Color photographs/IO (intraoral) scans (including five intraoral and three facial views).
See Orthodontic Services	21194		Reconstruct lower jaw 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. • Cephalometric radiographs (x-rays). Color photographs/IO (intraoral) scans (including five intraoral and three facial views).

OUTPATIENT REHABILITATION

ALL CLIENTS 21 AND OLDER & MCS CLIENTS AGES 19-20

additional benefit limits with expedited prior authorization

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
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 When is a limitation extension (LE) required? 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	Brain injury with residual functional deficits within the past 24 months **OR** 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 HCA
				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, hand, 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
		Modifier GO		870001673	Behavioral health condition
	97165, 97166, 97167 97168	Modifier GO	One additional evaluation for a new injury or health condition	870001416	In addition to the one allowed evaluation, when medically necessary
	97161, 97162, 97163	Modifier GP	One additional evaluation for a	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*
			new injury or health condition		
	97165	Modifier GO	DSHS OT eval (bed rail assessment) with *Occupational* therapy	870001326	One per client, unless change of residence or condition OT Eval for bedrails is a DSHS program. Use EPA# with Rev code 0434 and CPT code 97165.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
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	Brain injury with residual cognitive or functional deficits within the past 24 months **OR** 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 HCA
				870000014	New onset muscular-skeletal disorders such as complex fractures which require surgical intervention or surgery 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
PHYSICIAN-RELATED SERVICES/HEALTH CARE PROFESSIONAL SERVICES					
See Physician-Related/ Professional Services	CPT® codes 92928, 92929, 92933, 92934, 92937, 92938, 92941, 92943, and 92944 HCPCS codes C1874, C1875, C9600 C9601, C9602, C9603, C9604, C9605, C9607, C9608		Placement of cardiac stent C codes are Institutional only These procedure codes pay only in OPPS.	870000422	Based upon review of evidence provided by HTCC (20160115B—Cardiac Stents— Re-Review), HCA considers cardiac stents to be medically necessary with the follow criteria: • Drug eluting stents (DES) or bare metal stents (BMS) are indicated for treatment. • For patients being treated for stable angina, cardiac stenting with DES or BMS, with the following conditions: o Angina refractory to optimal medical therapy o Objective evidence of myocardial ischemia When billing for cardiac stents, use one of the following place of service (POS) codes: • 19—Off Campus-Outpatient hospital • 21—Inpatient hospital • 22—On Campus-Outpatient hospital
See Physician-Related/ Professional Services	HCPCS code 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

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
					o Corticosteroid treatment o Splenectomy
See Physician-Related/ Professional Services	HCPCS code 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.
See Physician-Related/ Professional Services	CPT code 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 HCA allows diagnosis code Z87.891 as primary diagnosis.
See Physician-Related/ Professional Services	CPT codes 70540, 70542, 70543		Magnetic Resonance Imaging (MRI) of the sinus for rhinosinusitis	870001422	Based upon review of the evidence provided by HTCC (20150515A—Imaging for Rhinosinusitis), HCA considers imaging of the sinus with computed tomography (CT) for rhinosinusitis to be medically necessary when **one of the following** is true: • The client is experiencing the following "red flags:" o Swelling of orbit o Altered mental status o Neurological findings o Signs of meningeal irritation o Severe headache o Signs of intracranial complication, including, but not limited to: ▪ Meningitis ▪ Intracerebral abscess ▪ Cavernous sinus thrombosis

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					o Involvement of nearby structures, including, but not limited to periorbital cellulitis • Two of the following persistent symptom for more than 12 weeks AND medical therapy has failed: o Facial pain-pressure-fullness o Mucopurulent drainage o Nasal obstruction (congestion) o Decreased sense of smell • Needed for surgical planning. HCA considers magnetic resonance imaging (MRI) of the sinus to be medically necessary when the criteria in this section are met AND the client is younger than age 21 or is pregnant.
	CPT codes 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
	CPT codes 70450, 70460, 70470, 70486, 70487, and 70488		Sinus Computed Tomography (CT) for rhinosinusitis	870001423	Based upon review of the evidence provided by HTCC (20150515A—Imaging for Rhinosinusitis), HCA considers imaging of the sinus with computed tomography (CT) for rhinosinusitis to be medically necessary when **one of the following** is true: • The client is experiencing the following “red flags:” o Swelling of orbit o Altered mental status o Neurological findings o Signs of meningeal irritation o Severe headache

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					o Signs of intracranial complication, including, but not limited to: ▪ Meningitis ▪ Intracerebral abscess ▪ Cavernous sinus thrombosis o Involvement of nearby structures, including, but not limited to periorbital cellulitis • Two of the following persistent symptom for more than 12 weeks AND medical therapy has failed: o Facial pain-pressure-fullness o Mucopurulent drainage o Nasal obstruction (congestion) o Decreased sense of smell • Needed for surgical planning.
See Physician-Related/ Professional Services	CPT codes 77080, 77081		Initial bone mineral density testing with dual x-ray absorptiometry (DXA)	870001363 For *repeat* testing see EPA 870001364	Asymptomatic persons assigned female at birth The client must meet one 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 The client must meet one 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

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
					Other conditions known to be associated with low bone mass including, but not limited to: • Patients receiving ARIMIDEX • Bariatric surgery • Celiac disease • Cushing Syndrome Based upon review of evidence provided by HTCC (20141121A—Screening and Monitoring Tests for Osteopenia/Osteoporosis)
See Physician-Related/ Professional Services	CPT codes 77080, 77081		Repeat bone mineral density testing with dual x-ray absorptiometry (DXA)	870001364 For *initial* testing see EPA 870001363	The client must meet 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 • Use of medication associated with low bone mass or presence of a condition known to be associated with low bone mass ** "T-Score" refers to the result of a DXA scan compared to a reference population Based upon review of evidence provided by HTCC (20141121A—Screening and Monitoring Tests for Osteopenia/Osteoporosis) Note: - Once treatment for osteoporosis has begun, HCA does not consider serial monitoring with DXA to be medically necessary. - HCA does not consider monitoring osteoporosis with DXA to be medically necessary when it is due to the development of a fragility fracture only.
See Physician-Related/ Professional Services	CPT code 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
	CPT code 81599		Gene expression profile (breast) genomic testing - *Endopredict*	870001420	

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
	CPT code 81520		Gene expression profile (breast cancer) *Prosigna*	870001545	Based upon review of the evidence provided by HTCC (20180316A—Gene Expression Profile Testing of Cancer Tissue), HCA considers gene expression profile testing to be medically necessary for breast or prostate cancer when the criteria in the following EPAs are met: #870001386, #870001420, #870001545, #870001546, #870001547, #870001548, #870001549, #870001550, and #870001551. HCA considers only the listed tests as medically necessary.
	CPT code 81521		Gene expression profile (breast cancer) *MammaPrint*	870001546	
See Physician-Related/ Professional Services	CPT code 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 Based upon review of the evidence provided by HTCC (20180316A—Gene Expression Profile Testing of Cancer Tissue), HCA considers gene expression profile testing to be medically necessary for breast or prostate cancer when the criteria in the following EPAs are met: #870001386, #870001420, #870001545, #870001546, #870001547, #870001548, #870001549, #870001550, and #870001551. HCA considers only the listed tests as medically necessary.
	CPT code 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 Based upon review of the evidence provided by HTCC (20180316A—Gene Expression Profile Testing of Cancer Tissue), HCA considers gene expression profile testing to be medically necessary for breast or prostate cancer when the criteria in the following EPAs are met: #870001386, #870001420, #870001545, #870001546, #870001547,

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
					#870001548, #870001549, #870001550, and #870001551. HCA considers only the listed tests as medically necessary.
See Physician-Related/ Professional Services	CPT code 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) • Test result will help inform treatment decision between definitive therapy (surgery or radiation) and conservative management Based upon review of the evidence provided by HTCC (20180316A—Gene Expression Profile Testing of Cancer Tissue), HCA considers gene expression profile testing to be medically necessary for breast or prostate cancer when the criteria in the following EPAs are met: #870001386, #870001420, #870001545, #870001546, #870001547, #870001548, #870001549, #870001550, and #870001551. HCA considers only the listed tests as medically necessary.
	CPT code 81541		Gene Expression profile (prostate cancer) *Prolaris*	870001550	
See Physician-Related/ Professional Services	CPT code 81479		Gene Expression profile (prostate cancer) *Decipher prostate cancer classifier assay*	870001551	Is covered if both of the following are true: • The client is post radical prostatectomy. • The test result will help the client decide between active surveillance and adjuvant radiotherapy. Based upon review of the evidence provided by HTCC (20180316A—Gene Expression Profile Testing of Cancer Tissue), HCA considers gene expression profile testing to be medically necessary for breast or prostate cancer when the criteria in the following EPAs are met: #870001386, #870001420, #870001545, #870001546, #870001547, #870001548, #870001549, #870001550, and #870001551. HCA considers only the listed tests as medically necessary.
See Physician-Related/ Professional Services	CPT code 81546		mRNA gene analysis (thyroid nodules)	870001642	All the following must be met: • Clients with one or more thyroid nodules with a history or characteristics suggesting malignancy such as: o Nodule growth over time o Family history of thyroid cancer

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
					o Hoarseness, difficulty swallowing or breathing o History of exposure to ionizing radiation o Hard nodule compared with rest of gland consistency o Presence of cervical adenopathy • Have an indeterminate follicular pathology on fine needle aspiration Covered once per client, per lifetime. A second test may be requested through the PA process for a second, unrelated thyroid nodule with indeterminate pathology. Per NCCN guidelines for diagnosis of thyroid cancer, HCA considers molecular gene analysis of thyroid nodules that have been determined as "inconclusive" after fine needle aspiration to be medically necessary when the criteria in EPA #870001642 is met.
See Physician-Related/ Professional Services	CPT code 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	CPT code 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.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	CPT code 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 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	CPT code 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,

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					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	CPT code 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 • 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	CPT code 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	CPT codes 84402, 84403, 84410		Testosterone testing	870001368	Based upon review of evidence provided by HTCC (20150320A—Testosterone Testing), HCA considers testosterone testing to be medically necessary for clients assigned male at birth who are age 18 and older when **at least one** of the following conditions are met:

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					• Suspected or known primary hypogonadism • Suspected or known secondary hypogonadism with an organic cause, such as one of the following: o Pituitary disorders o Suprasellar tumor o Medications suspected to cause hypogonadism o HIV with weight loss o Osteoporosis • Physical signs of hypogonadism • The following symptoms of sexual dysfunction (all three criteria from European male aging study): o Poor morning erection o Low sexual desire o Erectile dysfunction • Monitoring of testosterone therapy
See Physician-Related/ Professional Services	CPT codes 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 • Breast cancer in person assigned male at birth

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					• 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	CPT codes 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: • Glasses are broken or lost or contacts that are lost or damaged • 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	CPT code 92134		Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral, retina.	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 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. 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	CPT code 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

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
					• 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	CPT codes 77301 77338 77370 G6015 G6016		Intensity modulated radiation therapy (IMRT)	870001374 **For sparing adjacent critical structures**	• Any cancer that would require radiation to focus on the head/neck/chest/abdomen/pelvic area • Document in the clinical notes which critical structure is being spared
See Physician-Related/ Professional Services	CPT codes 19318, 19300		Reduction Mammoplasties/ Mastectomy for Gynecomastia **Dx codes:** N62, N64.9, or L13.9	870000241	A client assigned female at birth with a diagnosis for **hypertrophy of the breast** with: • Photographs in client's chart • Documented medical necessity including: o Back, neck, and/or shoulder pain for a minimum of 1 year, directly attributable to macromastia o Conservative treatment not effective • Abnormally large breasts in relation to body size with shoulder grooves • Within 20% of ideal body weight, and • Verification of minimum removal of 500 grams of tissue from each breast
See Physician-Related/ Professional Services	CPT codes 19318, 19300		Reduction Mammoplasties/ Mastectomy for Gynecomastia **Dx codes:** N62, N64.9, or L13.9	870000242	A client assigned male at birth with a diagnosis for **gynecomastia** with: • Pictures in clients' chart • Persistent tenderness and pain • 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	CPT code Q4116		Alloderm	870001342	Alloderm (HCPCS Q4116) may be billed only when related to a diagnosis of breast cancer and when services are provided by a general surgeon or a plastic surgeon.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	CPT codes 15822, 15823, 67901, 67902, 67903, 67904, 67906, 67908		Blepharoplasties	870000630	HCA considers blepharoplasty or blepharoptosis surgery to be medically necessary when **all** the following clinical criteria are met: • The client's excess upper eyelid skin is blocking the superior visual field. • The blocked vision is within 10 degrees of central fixation using a central visual field test

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
See Physician-Related/ Professional Services	58150, 58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58542, 58543, 58544, 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) *CPT code 58210 not included w/ EPA 870001303

Billing Guide Connection	**Codes**	**Modifier**	**Description**	**EPA #**	**EPA Criteria**
See [Physician-Related/ Professional Services]	CPT codes 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]	CPT codes 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: • The client has a strabismus-related double vision (diplopia) and • It is not done for cosmetic reasons
See [Physician-Related/ Professional Services]	CPT code 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

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	CPT code 99183 HCPCS code G0277		Hyperbaric Oxygen Therapy (Note: G0277 is for institutional only)	870000425	Hyperbaric oxygen therapy may be considered **medically necessary** for treatment of the following conditions in the inpatient or outpatient hospital setting: • Decompression sickness • Acute carbon monoxide poisoning • Acute cyanide poisoning • Acute gas or air embolism • Gas gangrene (clostridial myositis and myonecrosis) • Progressive necrotizing soft tissue infections • Acute traumatic ischemia secondary to crush injuries o For prevention of loss of function or for limb salvage o Used in combination with standard medical and surgical management • Late radiation tissue injury • Prevention of osteoradionecrosis following tooth extraction in a previously radiated field • Refractory osteomyelitis o Unresponsive to standard medical and surgical management • Compromised flaps and skin grafts o For prevention of loss of function or for limb salvage • Non-healing diabetic wounds of the lower extremities o Patient has type 1 or type 2 diabetes and has a lower extremity wound that is due to diabetes o Patient has a wound classified as Wagner grade 3 or higher o Patient has failed an adequate course of standard wound therapy The following are considered not medically necessary: • Thermal burns • Acute and chronic sensorineural hearing loss • Cluster and migraine headaches • Multiple sclerosis • Cerebral palsy • Traumatic and chronic brain injury • Arterial, venous or pressure ulcers

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services **Note:** For personal, long-term CGM supplies, see HCA's Home Infusion Therapy/Parenteral Nutrition Program Billing Guide for policy.	CPT codes 95249 and 95250		Professional or diagnostic continuous glucose monitoring (CGM)	870001312	Services are subject to the following limitations: • Two per client every 12 months • Billable no sooner than every 30 days HCA considers professional or diagnostic continuous glucose monitoring (CGM) to be medically necessary when: • The client meets **any of the following** criteria: o Has a diagnosis of type 1 diabetes and does not own a personal CGM device **-OR-** o Has a diagnosis of type 2 diabetes and **both of the following**: ● Is on insulin or other injectable hypoglycemic agents ● Has frequent hypoglycemic episodes or hypoglycemic unawareness **-OR-** o Is suspected to have primary islet cell hypertrophy or persistent hyperinsulinemia hypoglycemia of infancy **-AND-** • The CGM meets **all the following** criteria: o Is used for no more than 72 hours o Is ordered by an appropriately licensed provider o Is provided by an FDA-approved CGM device
See Physician-Related/ Professional Services *Note: Effective for dates of service on and after November 1, 2024, this EPA will end. Providers who would like to provide services via store and forward may do so under E-consults. Dermatologists may provide this consultative service or provide services directly to clients in-person or via telemedicine. See*	CPT codes 99211-99214, 99231-99233, 99241-99243, 99252-99253.	**GQ modifier required**	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.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
HCA's Telemedicine Policy Billing Guide for more information.					
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 there has been 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 HCPCS code: G0512		Subsequent psychiatric collaborative care management	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 • 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	CPT codes 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)
	CPT codes 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)
	CPT codes 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	99202, 99203, 99204, 99205, 99211, 99212, 99213,		Enhanced reimbursement rate for medication for opioid use disorder	870001537	HCA considers MOUD to be medically necessary when **all the following** are met: • The client has an opioid use disorder diagnosis listed on the claim. **AND** • The provider: o Bills for treating a client with a qualifying diagnosis for opioid use disorder.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
	99214, 99215, 99251, 99252, 99253, 99254, 99255				**AND** o Provides opioid-related counseling during the visit. One enhanced reimbursement rate, per client, per day is allowed. HCA does not pay the enhanced reimbursement if the client receives services for opioid use disorder through an opioid treatment program facility licensed by the Department of Health.
See Physician-Related/ Professional Services	CPT codes 61885, 61886, 64553, 64568 HCPCS codes C1767* C1778* C1822* L8679* L8680* L8682* L8683* L8685* L8686* L8687* L8688*		Vagal nerve stimulation (VNS)	870001554	Based on review of evidence provided by HTCC (20200515B—Vagal Nerve Stimulation for Epilepsy and Depression—Re-Review), HCA considers vagal nerve stimulation (VNS) for epilepsy to be medically necessary for adults and children (**age 4 and older**) when all the following conditions are met: • 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. HCA does not consider VNS for treatment of depression or transcutaneous VNS to be medically necessary. *These Outpatient Prospective Payment System (OPPS) procedure codes are listed for providers billing for services using institutional claims. These procedure codes pay only in OPPS. See the fee schedule.
See Physician-Related/ Professional Services	CPT codes 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

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
					♣ Living alone or being home alone for extended periods of time ♣ A history of care access challenges ♣ 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 An 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]	CPT codes 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.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
					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.
See Physician-Related/ Professional Services	CPT® codes: 62350, 62362, 62351, 62360, and 62361 HCPCS codes: C1772* C1889* C1891* C2626* E0782* E0783* E0785* and E0786*		Implantable infusion pumps or implantable drug delivery systems *These Outpatient Prospective Payment System (OPPS) procedure codes are listed for providers billing for services using institutional claims. These procedure codes pay only in OPPS	870001674	Based upon review of evidence provided by HTCC (20080815A—Implantable Drug Delivery System for Chronic Noncancer Pain), HCA considers implantable drug delivery systems (infusion pump or IDDS) to be medically necessary for cancer pain or spasticity. HCA does not consider implantable drug delivery systems to be medically necessary for the treatment of chronic, noncancer-related pain.
See Physician-Related/ Professional Services	CPT® codes: 51715 and 95028 HCPCS codes: L8603, L8604,		Periurethral collagen bulking agents	870001675	HCA considers periurethral collagen bulking agents to be medically necessary when all the following are present: • The client has a diagnosis of intrinsic (urethral) sphincter deficiency (ISD) or stress urinary incontinence (SUI). • The client has shown no incontinence improvement through other noninvasive treatment for at least 12 months (e.g., Kegel exercises, biofeedback, or pharmacotherapies).

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
	and L8606 DX codes: N36.42 N36.43 and N39.3				• A pre-treatment skin test was completed with the collagen bulking agent and the client has no evidence of hypersensitivity.
	CPT® codes 99424, 99425, 99437, and 99491		Physician supervision of **principal care** management services	870001676	HCA considers physician supervision of principle care management services to be medically necessary as follows: For physician supervision of principal care management services, all the following must be met: • One complex chronic condition is expected to last at least 3 months, and places the client at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death. • The complex chronic condition requires development, monitoring, or revision of the disease-specific care plan. • The condition requires frequent adjustments in the medication regimen, or the management of the condition is unusually complex due to comorbidities, or both. • Ongoing communication and care coordination between relevant practitioners furnishing care is provided by the billing provider. • The first 30 minutes are personally provided by a provider, per calendar month.
	CPT® codes 99424, 99425, 99437, and 99491		Physician supervision of **chronic care** management services	870001677	HCA considers physician supervision of chronic care management services to be medically necessary as follows: For physician supervision of chronic care management services, all the following must be met: • Two of more chronic conditions are expected to last at least 12 months, or until the death of the client.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					• The chronic conditions place the client at significant risk of death, acute exacerbation/decompensation, or functional decline. • Comprehensive care plan has been established, implemented, revised, or monitored. • The first 30 minutes are personally provided by a provider, per calendar month.
See [Physician-Related/ Professional Services]()	Neurosurgery: CPT codes 61796, 61797, 61798, 61799, 61800, 63620, and 63621 Radiation: CPT codes 77371, 77372, 77373, 77432, and 77435		Stereotactic radiation surgery (SRS)	870001658	Based on review of the evidence provided by HTCC (20230623A—Stereotactic Radiation Surgery and Stereotactic Body Radiation Therapy), HCA considers stereotactic radiation surgery (SRS) to be medically necessary for the treatment of central nervous system (CNS) and metastatic tumors when all the following are met: • Patient functional status score from one of the following is greater than or equal to o Client **Karnofsky** score is greater than or equal to **50** o Eastern Cooperative Oncology Group **(ECOG)** is less than or equal to **2** • Evaluation includes multidisciplinary team analysis including a surgical specialist and radiation oncologist input and is documented in the chart.
See [Physician-Related/ Professional Services]()	CPT codes 32701, 77370, 77373, 77435		Stereotactic body radiation therapy (SBRT) for **Spine and Paraspinal Cancer**	870001661	In addition to each EPA requirement listed, the evaluation, which includes the multidisciplinary team analysis, including a surgical specialist's and radiation oncologist's input, must be in the client's chart.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
					The following conditions must be present: primary and secondary tumors involving spine parenchyma, meninges/dura, or immediately adjacent bony structures
See Physician-Related/ Professional Services	CPT codes 32701, 77370, 77373, 77435		Stereotactic body radiation therapy (SBRT) for **Located Prostate Cancer**	870001662	In addition to each EPA requirement listed, the evaluation, which includes the multidisciplinary team analysis, including a surgical specialist's and radiation oncologist's input, must be in the client's chart. The following conditions must be present: very low, low, and intermediate risk prostate cancer, as defined by NCCN based on stage, Gleason score, and PSA level
See Physician-Related/ Professional Services	CPT codes 32701, 77370, 77373, 77435		Stereotactic body radiation therapy (SBRT) for **Non-Small Cell Lung Cancer (NSCLC)**	870001663	In addition to each EPA requirement listed, the evaluation, which includes the multidisciplinary team analysis, including a surgical specialist's and radiation oncologist's input, must be in the client's chart. When **all** the following conditions have been met: • Stage I and Stage II (node negative) • Tumor is deemed to be unresectable or patient is deemed too high risk or declines operative intervention.
See Physician-Related/ Professional Services	CPT codes 32701, 77370, 77373, 77435		Stereotactic body radiation therapy (SBRT) for **Small Cell Lung Cancer (SCLC)**	870001664	In addition to each EPA requirement listed, the evaluation, which includes the multidisciplinary team analysis, including a surgical specialist's and radiation oncologist's input, must be in the client's chart. When the following conditions have been met: • Operative intervention declined **AND** • Stage I and Stage II (node negative) and **at least one** of the following: o Tumor is deemed to be unresectable o Client is deemed too high risk for surgery

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
See Physician-Related/ Professional Services	CPT codes 32701, 77370, 77373, 77435		Stereotactic body radiation therapy (SBRT) for **Pancreatic Adenocarcinoma**	870001665	In addition to each EPA requirement listed, the evaluation, which includes the multidisciplinary team analysis, including a surgical specialist's and radiation oncologist's input, must be in the client's chart. When the following conditions have been met: • Operative intervention declined **AND** • Non-metastatic disease and is either deemed not a candidate for induction chemotherapy or has already undergone induction chemotherapy and **at least one** of the following: o Tumor is deemed to be unresectable o Client is deemed too high risk for surgery
See Physician-Related/ Professional Services	CPT codes 32701, 77370, 77373, 77435		Stereotactic body radiation therapy (SBRT) for **Oligometastatic disease**	870001666	In addition to each EPA requirement listed, the evaluation, which includes the multidisciplinary team analysis, including a surgical specialist's and radiation oncologist's input, must be in the client's chart. When **all** the following conditions have been met: • Five or fewer total metastatic lesions (maximum 3 per organ) • Controlled primary tumor • Life expectancy greater than 6 months
See Physician-Related/ Professional Services	CPT codes 32701, 77370, 77373, 77435		Stereotactic body radiation therapy (SBRT) for **Hepatocellular carcinoma**	870001667	In addition to each EPA requirement listed, the evaluation, which includes the multidisciplinary team analysis, including a surgical specialist's and radiation oncologist's input, must be in the client's chart. When **all** the following conditions have been met: • Liver confined disease • Five or fewer lesions • Life expectancy greater than 6 months

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	CPT codes 32701, 77370, 77373, 77435		Stereotactic body radiation therapy (SBRT) for **Cholangiocarcinoma**	870001668	In addition to each EPA requirement listed, the evaluation, which includes the multidisciplinary team analysis, including a surgical specialist's and radiation oncologist's input, must be in the client's chart. When the following conditions are met: • Non-metastatic disease **AND** • **At least one** of the following is met: o Tumor is deemed to be unresectable. o Client is deemed too high risk for surgery. o Operative intervention declined
See Physician-Related/ Professional Services	CPT codes 32701, 77370, 77373, 77435		Stereotactic body radiation therapy (SBRT) for **Renal**	870001669	In addition to each EPA requirement listed, the evaluation, which includes the multidisciplinary team analysis, including a surgical specialist's and radiation oncologist's input, must be in the client's chart. When the following conditions are met: • Non-metastatic disease **AND** • **At least one** of the following is met: o Tumor is deemed to be unresectable. o Client is deemed too high risk for surgery. o Operative intervention declined
See Physician-Related/ Professional Services	CPT codes 31647, 31651, 31648, 31649		Endobronchial valves placement for severe emphysema	870001678	HCA considers endobronchial valve (EBV) placement for severe emphysema to be medically necessary when dyspnea is poorly controlled, and all the following are true: • Forced expiratory volume (FEV1) is less than 50% of the predicted value

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					• Residual volume is greater than 150% • Total lung capacity is greater than or equal to 100% • Targeted lobe shows little to no collateral ventilation • Client's activities of daily living are markedly restricted despite maximal medical management Prior to EBV placement, the client must: • Complete a pulmonary rehabilitation program • Be abstinent from smoking of any kind for four consecutive months before the initial evaluation HCA does not consider placement of EBV to be medically necessary when the following criteria are present: Disseminated malignancy or other severe progressive disease • Severe pulmonary hypertension • Other chronic respiratory diseases such as pulmonary fibrosis The client must have a primary diagnosis of J43.0, J43.1, J43.2, J43.8. J43.9, J93.8, J93.81, J93.82, J93.83, or J93.9.
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	The licensed midwife must meet all the following EPA criteria: • 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 • Upon request, provides a copy of the physician or standing orders to HCA This EPA number is **only** for the procedure codes listed in the fee schedule as "not billable by a licensed midwife."
See Planned Home Births & Births in Birthing Centers			Natural delivery before 39 weeks	870001375	Natural delivery before 39 weeks.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
	59400, 59409, 59410		Elective delivery or natural delivery at or over 39 weeks gestation	870001378	Elective delivery or natural delivery at or over 39 weeks gestation
PREGNANCY RELATED SERVICES					
See Pregnancy-related services billing guide: https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules#p	81507, 81420		Noninvasive prenatal diagnosis of fetal aneuploidy (NIPT)	870001344	HCA considers NIPT for serum marker screening for fetal aneuploidy to be medically necessary in pregnant clients with high-risk singleton pregnancies, who have had genetic counseling, when one or more of the following are met: • Pregnant client 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 Pregnancy-related services billing guide: https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules#p	59899	U3	Intrauterine balloon	870001614	To treat postpartum hemorrhage Dx: O72, O72.0, O72.1, O72.2, O72.3

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Pregnancy-related services billing guide: https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules#p	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622		Early elective delivery or natural delivery **prior to** 39 weeks gestation	870001375	HCA does not reimburse for early elective deliveries. An early elective delivery is defined in WAC 182-500-0030 as any nonmedically necessary induction or cesarean section before 39 weeks gestation. 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. **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
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: • Severe arthritis with pain • Flat feet or pes planus with pain • Valgus or varus deformity with pain • Plantar fasciitis with pain • Pronation **Note**: 1. 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). 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.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
See Prosthetic and Orthotic (P&O) Devices	L3334		Lift, elevation, heel and sole, 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 EPA # 870000782. 2. If the medical condition does not meet the criteria specified above, you must obtain prior authorization by submitting a request in writing to the medical equipment authorization section (see Resources Available and HCA's prior authorization webpage). 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.
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: • Required to prevent or correct pronation • Required to promote proper foot alignment due to pronation • 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 one of the criteria specified above, you must obtain prior authorization by submitting a request in writing to medical equipment authorization unit (see Resources Available and HCA's prior authorization webpage). 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,	870000785	Purchase of one (1) pair per 12-month period allowed if any of the following criteria are met:

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
			woman's or man's shoes, oxford		• 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: 1. HCA does not allow orthopedic footwear for the following reasons: •To accommodate L3030 orthotics • Bunions • Hammer toes • Size difference (mismatched shoes) • Abnormal sized foot 2. HCA allows only the following manufacturers of orthopedic footwear: • Acor • Alden Shoe Company • Answer 2 • Apis Footwear • Billy • 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 3. If the medical condition does not meet one of the criteria specified above, you must obtain prior authorization by submitting a request in

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria
					writing to the medical equipment authorization unit (see Resources Available, and HCA's prior authorization webpage). 4. 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: • Client is **16 years of age and younger** • 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 by submitting a request in writing to the medical equipment authorization unit (see Resources Available, and HCA's prior authorization webpage). 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.
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: • Short residual limb • Diabetic • 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 by submitting a request in writing to medical equipment authorization unit (see Resources Available and HCA's prior authorization webpage). 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.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
RESPIRATORY CARE					
See Respiratory Care	E0465, E0466	RR U2	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)	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 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	E1390, E1392	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 [Sleep Centers]	E0445	SC	Enhanced Oximeter **(Do not bill with E0445 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. **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

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					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 (APRN) • Psychiatric mental health nurse practitioner-board certified (PMHNP-BC) • Licensed mental health counselor • Licensed mental health counselor associate • Licensed independent clinical social worker • Licensed independent social worker associate • Licensed advanced social worker • Licensed advanced social worker associate • Licensed marriage and family therapist • Licensed marriage and family therapist associate • The comprehensive behavioral health assessment must: • Independently confirm the diagnosis of gender dysphoria as defined by the Diagnostic Statistical Manual of Mental Disorders. • Document that the client has been assessed for any coexisting behavioral health conditions and if any are present, the conditions are adequately managed. • For clients age 17, the biopsychosocial behavioral health assessment 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**

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
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, 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.
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 Transhealth https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules	84402, 84403, 84410 DX: F64, F640,		Testosterone testing	870001671	• 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)

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
	F641, F642, F649				
TRIBAL HEALTH PROGRAM					
See Tribal Health Program	T1015	Service modality POS	Dental services, Client is an IHS beneficiary AI/AN	870001305	Client is an IHS beneficiary AI/AN For services provided by a Tribal FQHC Affiliate, add HCPCS code T2025
See Tribal Health Program	T1015	Service modality POS	Dental services, Client is **not** an IHS beneficiary AI/AN	870001306	Client is not an IHS beneficiary AI/AN For services provided by a Tribal FQHC Affiliate, add HCPCS code T2025
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 in the client's record that 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 ages 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 *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 lenses
			Replacement due to headaches/	870000624	Within one year of last dispensing, for refractive changes (provider error is the responsibility of the provider to warranty their work and

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			blurred vision/difficulty with school or work		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
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

Back to Top