Washington State Health Care Authority

Washington Apple Health (Medicaid)

Expedited Prior Authorization (EPA) Inventory

February 14, 2018

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.

Clinical Quality and Care Transformation, Authorization Services

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WHAT IS EXPEDITED PRIOR AUTHORIZATION (EPA)

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

Example: The procedure code needed is 90734, after verifying it has an assigned EPA number (870000421 & 870000424) verify which EPA number is appropriate for the age of the client. Then, because both EPA number use the following criteria, verify the client is in **one** of the at-risk groups because of the following:

1) Not routinely recommended for ages 19-21, but may be administered as catch-up vaccination for those who have not received a dose after their 16th birthday
2) Has persistent complement deficiencies
3) Has anatomic or functional asplenia
4) Are at risk during a community outbreak attributable to a vaccine serogroup
5) Infected with human immunodeficiency virus (HIV), if another indication for vaccination exists
6) Is a microbiologist who is routinely exposed to isolates of N. meningitidis
7) Is a freshman entering college who will live in a dormitory

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 ~~last three digits of the~~ EPA number.

The billing provider must document in the client's file how it meets the EPA criteria, and make this information available to the agency upon request. If the agency determines the documentation does not support meeting the criteria the claim will be denied.

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

EPA Guidelines

As stated above, the provider must meet the criteria for the EPA number submitted, and the client's clinical documentation must support 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.

A complete EPA number has 9 digits. The first five or six digits of the EPA number must begin with **87000 or 870000**, and the last three or four digits will be the code assigned to the diagnostic condition, procedure, treatment, or service of that EPA criteria. *If the client does not meet the EPA criteria, a formal authorization request is required to be submitted.*

Note: Certain EPA criteria is also dependent on the diagnosis code. These could require an additional step by using the **Approved Diagnosis Codes by Program** resource. These are specified within the Criteria Description column.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
ACCESS TO BABY AND CHILD DENTISTRY					
See Access to Baby and Child Dentistry	D2941		interim therapeutic restoration - primary dentition	870001379	Interim therapeutic restoration (ITR) will be allowed in lieu of a definitive restoration as follows: • Child must be age 5 or younger • Has current decay • Provider is ABCD certified and has completed ITR training • ITR is expected to last a minimum of 1 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 or on the same day as other definitive restorations.
See Access to Baby and Child Dentistry	D2941		interim therapeutic restoration - primary dentition	870001380	Interim therapeutic restoration (ITR) will be allowed in lieu of a definitive restoration as follows: • Child must be age 5 or younger • Has current decay • Provider is ABCD certified and has completed ITR training • ITR is expected to last a minimum of 1 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. Allowed on same day as definitive treatment if documentation that child was not able to proceed with complete treatment once started.

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AMBULANCE AND ITA TRANSPORTATION					
See Ambulance and ITA Transportation	A0428		Emergency ground ambulance to a *mental health facility*	870001398	Use when the client has **one** of the following conditions: • A *mental health complaint* and is willing to be transported to an alternative destination. • The provider must submit an authorization form (HCA 13-680) completed and signed by: ✓ The emergency personnel and the client, OR ✓ The County Medical Program Director
	A0428		Emergency ground ambulance to a *substance use disorder treatment facility*	870001399	Use when the client has **one** of the following conditions: • Is *incapacitated or gravely disabled by drugs or alcohol* and is willing to be transported to an alternative destination. • The provider must submit an authorization form (HCA 13-680) completed and signed by: ✓ The emergency personnel and the client, OR ✓ The County Medical Program Director
See Ambulance and ITA Transportation	A0426 A0428		Nonemergency transportation services	870001404	Use when the client has **one** of the following conditions: • Altered mental status (i.e. Alzheimer, dementia, or voluntary behavioral health services - not mental health services that fall under the Involuntary Treatment Act) • Bariatric • Bedbound (not able to stand or bear weight unassisted) • Continuous cardiac monitoring • Quadriplegic • Requires a ventilator • Requires continuous oxygen usage en route • Tracheostomy (needed for prolonged respiratory support) An EPA number must accompany the required Physician Certification Statement (PCS). The PCS thoroughly documents the circumstances requiring nonemergency ambulance transportation.

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DENTAL-RELATED SERVICES					
See Dental-Related Services	D0150		Comprehensive oral evaluation - new or established patient	870001327	Allowed for established patients who have a documented significant change in health conditions.
See Dental-Related Services	D1510		Space maintainer - fixed - unilateral	870001410	Allowed for the replacement of an existing lost or broken fixed unilateral space maintainer. Up to two replacements allowed. Prior authorization required for three or more replacements. Medical justification, including a dated photograph or radiograph, must be present in the client record.
See Dental-Related Services	D1515		Space maintainer - fixed - bilateral	870001308	Allowed to replace an existing bilateral fixed space maintainer when teeth 3 & 14 or 19 & 30 have erupted
See Dental-Related Services	D2929		Prefabricated porcelain or ceramic crown, posterior	870001347	Allowed for a client age 12 and younger for a **primary** posterior tooth when determined to be medically necessary by a dental practitioner and **one** of the following conditions are met: • Evidence of extensive caries • Evidence of Class II caries with rampant decay • Treatment of decay requires sedation or general anesthesia. Allowed once every three years; allowed once every two years for clients of DDA. Medical justification (including preoperative x-rays or clinical documentation of findings when unable to take x-rays due to young age) must be present in the client record.
	D2930		Prefabricated stainless steel crown, posterior		

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See Dental-Related Services	D2929		prefabricated porcelain or ceramic crown, anterior	870001348	Allowed for a client age 12 and younger for a **primary** anterior tooth when determined to be medically necessary by a dental practitioner and **one** of the following conditions are met: • Evidence of extensive caries • Evidence of rampant decay • Treatment of decay requires sedation or general anesthesia Allowed once every three years; allowed once every two years for clients of DDA. Medical justification (including preoperative x-rays) must be present in the client record.
	D2930		Prefabricated stainless steel crown, anterior		
See Dental-Related Services	D2335		Resin-based composite - four or more surfaces or involving incisal angle (anterior)	870001307	Allowed for primary anterior teeth (CDEFGHMNOPQR) when determined medically necessary by a dental practitioner and a more appropriate alternative to a crown. *If a bill for a crown on the same tooth is received within six months the amount paid for this treatment will be recouped.
See Dental-Related Services	D2390		Resin-based composite crown, anterior	870001348	Allowed for a client age 12 and younger for a primary anterior tooth when determined to be medically necessary by a dental practitioner and **one** of the following conditions are met: • Evidence of extensive caries • Evidence of rampant decay • Treatment of decay requires sedation or general anesthesia Medical justification must be present in the client record.
See Dental-Related Services	D5110		Maxillary complete denture	870001414	Allowed for initial complete maxillary denture in conjunction with the EPAs for extractions making the client edentulous. (EPA #8700001383, #8700001384, #8700001385, #8700001388, or #8700001413.) For clients residing in an alternate living facility (ALF) or in a nursing facility, group home, or other facility, EPA does not apply. See ***Alternate living facilities or nursing facilities*** for requesting PA.

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See Dental-Related Services	D5120		Mandibular complete denture	870001415	Allowed for initial complete mandibular denture in conjunction with the EPAs for extractions making the client edentulous. (EPA #8700001383, #8700001384, #8700001385, #8700001388, or #8700001413.) For clients residing in an alternate living facility (ALF) or in a nursing facility, group home, or other facility, EPA does not apply. See ***Alternate living facilities or nursing facilities*** for requesting PA.
See Dental-Related Services	D7111, D7140, D7210, D7220, D7230, D7240		Extractions of four or more teeth per arch over a six-month period, resulting in the client becoming edentulous in the maxillary arch or mandibular arch	870001383	Allowed when client is diagnosed with a medical condition that requires radiation to head/neck area
				870001384	Allowed for a client on a transplant list. Has clinical evidence of infected teeth or gums. Extractions are recommended by the transplant surgeon.
				870001385	Allowed for a client requiring joint replacement. Has clinical evidence of infected teeth or gums. Extractions are recommended by the joint replacement physician/surgeon.
				870001388	Allowed for a client requiring heart surgery. Has clinical evidence of infected teeth or gums. Extractions are recommended by the physician/surgeon.
See Dental-Related Services	D7140		Extractions of four or more teeth per arch over a six-month period, resulting in the client becoming edentulous in the maxillary arch or mandibular arch	870001413	Only allowed when making the client edentulous and when determined to be medically necessary by a dental practitioner and **one or all** of the following conditions are met: • Evidence of extensive caries/rampant decay, defined by the agency as widespread caries that affects 67% or greater of the teeth (per arch) and penetrates quickly to the dental pulp • Evidence of generalized periodontal disease (per arch) with bone loss leaving less than 4mm of bone The following medical justification must be present in the client record: • Recent periodontal charting (within that year) (oral surgeons do not need periodontal charting in the client's record) • Current radiographic evidence (x-rays) showing bone loss and of diagnostic quality • Current radiographic evidence (x-rays) showing extensive/rampant caries and of diagnostic quality

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See Dental-Related Services	D7280		Surgical access of an unerupted tooth	870001366	Allowed when client is in active orthodontic treatment. Allowed one time per client, per tooth.
	D7283		Placement of device to facilitate eruption of impacted tooth		
See Dental-Related Services	D7472		Removal of torus palantinus	870001411	Allowed for placement of complete denture or partial denture. Medical justification, including a dated photograph or radiograph, must be present in the client record.
See Dental-Related Services	D7473		Removal of torus mandibulus	870001412	Allowed for placement of complete denture or partial denture. Medical justification, including a dated photograph or radiograph, must be present in the client record.
See Dental-Related Services	D7971		Excision of pericoronal gingiva	870001310	Allowed when determined to be medically necessary by a dental practitioner for treatment of a newly erupting tooth.
See Dental-Related Services	D9223		Deep sedation/general anesthesia	870001387	Allowed for clients age 9 through 20 receiving oral surgery services listed in WAC 182-535-1094(1)(f-m) and clients with cleft palate diagnoses. Only anesthesiology providers who have a core provider agreement with the agency can bill this code.

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

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

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RENTAL/PURCHASE HOSPITAL BEDS					
Note: 1) The EPA rental is allowed only one time, per client, per 12-month period. 2) Authorization must be requested for the 12th month of rental at which time the equipment will be considered purchased. The authorization number will be pended for the serial number of the equipment. In such cases, the equipment the client has been using must have been new on or after the start of the rental contract or is documented to be in good working condition. A 1-year warranty will take effect as of the date the equipment is considered purchased if equipment is not new. Otherwise, normal manufacturer warranty will be applied. 3) If length of need is greater than 12 months, as stated by the prescribing physician, a PA for purchase must be requested either in writing or via the toll-free line. 4) If the client is hospitalized or is a resident of a nursing facility and is being discharged to a home setting, rental may not start until the date of discharge. Documentation of the date of discharge must be included in the client's file. Rentals for clients in a skilled nursing facility are included in the nursing facility daily rate, and in the hospital they are included in the DRG payment. 5) The agency does not rent equipment during the time that a request for similar purchased equipment is being assessed, when authorized equipment is on order, or while the client-owned equipment is being repaired and/or modified. The vendor of service is expected to supply the client with an equivalent loaner. 6) Hospital beds **will not** be provided: a. As furniture. b. To replace a client-owned waterbed. c. For a client who does not own a standard bed with mattress, box spring, and frame. d. If the client's standard bed is in an area of the home that is currently inaccessible by the client such as an upstairs bedroom. 7) Only one type of bed rail is allowed with each rental. 8) Mattress may **not** be billed separately.					
See Durable Medical Equipment (DME) & Non-CRT Wheelchairs	E0292, E0310 **OR** E0305	RR	Manual Hospital Bed with mattress with or without bed rails	870000720	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 a medical condition that requires positioning of the body that cannot be accomplished in a standard bed (reason must be documented in the client's file). 3) Has tried pillows, bolsters, and/or rolled up blankets/towels in client's own bed, and determined to not be effective in meeting client's positioning needs (nature of ineffectiveness must be documented in the client's file). *CONTINUED ON NEXT PAGE*

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					4) Has a medical condition that necessitates upper body positioning at no less than a 30-degree angle the majority of time he/she is in the bed. 5) Has full-time caregivers. 6) Does **not** also have a rental wheelchair.
See Durable Medical Equipment (DME) & Non-CRT Wheelchairs	E0294, E0310 **OR** E0305	RR	Semi-Electric Hospital Bed with mattress with or without Bed Rails	870000725	Up to 11 months continuous rental in a 12-month period if **all** of the following criteria are met. The client: 1) Has a length of need/life expectancy that is 12 months or less. 2) Has tried pillows, bolsters, and/or rolled up blankets/towels in client's own bed, and determined to be ineffective in meeting client's positioning needs (nature of ineffectiveness must be documented in the client's file). 3) Has a chronic or terminal condition such as COPD, CHF, lung cancer or cancer that has metastasized to the lungs, or other pulmonary conditions that cause the need for immediate upper body elevation. 4) Must be able to independently and safely operate the bed controls. 5) Does **not** have a rental wheelchair. 6) Has a completed *Hospital Bed Evaluation* form, HCA 13-747. See *Where can I download agency forms*?

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

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					4) Written documentation indicating client has not been previously provided a hospital bed, purchase, or rental (i.e. written statement from client or caregiver) 5) A completed *Hospital Bed Evaluation* form, HCA 13-747. See *Where can I download agency forms*?
LOW AIR LOSS THERAPY SYSTEMS					
Note: The EPA rental is allowed only one time, per client, per 12-month period.					
See Durable Medical Equipment (DME) & Non-CRT Wheelchairs	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 Durable Medical Equipment (DME) & Non-CRT Wheelchairs	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 Durable Medical Equipment (DME) & Non-CRT Wheelchairs	E0277	RR	Low Air Loss Mattress without bed frame	870000740	Initial 30-day rental in a 12-month period upon hospital discharge following a flap surgery.

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See Durable Medical Equipment (DME) & Non-CRT Wheelchairs	E0194	RR	Air Fluidized Flotation System including bed frame	870000750	Initial 30-day rental in a 12-month period upon hospital discharge following a flap surgery. **For all Low Air Loss Therapy Systems the following documentation is required**: 1) *A Low Air-Loss Therapy Systems* form, HCA 13-728 must be completed for each rental segment and signed and dated by nursing staff in facility or client's home. See *Where can I download agency forms*? 2) A new form must be completed for each rental segment. 3) A re-dated prior form will not be accepted. 4) A dated picture must accompany each form.
NONINVASIVE BONE GROWTH/NERVE STIMULATORS					
Note: The EPA rental is allowed only one time, per client, per 12-month period.					
See Durable Medical Equipment (DME) & Non-CRT Wheelchairs	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 Durable Medical Equipment (DME) & Non-CRT Wheelchairs	E0748	NU	Spinal Bone Growth Stimulator	870000770	Allowed for purchase when the prescription is from a neurologist, an orthopedic surgeon, or a neurosurgeon and when **one or more** of the following criteria is met. The client: 1) Has a failed spinal fusion where a minimum of 9 months has elapsed since the last surgery. 2) Is post-op from a multilevel spinal fusion surgery. 3) Is post-op from spinal fusion surgery where there is a history of a previously failed spinal fusion.

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MISCELLANEOUS DURABLE MEDICAL EQUIPMENT					
See Durable Medical Equipment (DME) & Non-CRT Wheelchairs	E0604	RR	Breast pump, electric	870000800	Unit may be rented for the following lengths of time, when **one** of the following criteria is met. The client: 1) Has a maximum of 2 weeks during any 12-month period for engorged breasts, or 2) Has a maximum of 3 weeks during any 12-month period if the client is on a regimen of antibiotics for a breast infection. 3) Has a maximum of 2 months during any 12-month period if the client has a newborn with a cleft palate. 4) Has a maximum of 2 months during any 12-month period if the client meets all of the following: a. Has a hospitalized premature newborn b. Has been discharged from the hospital c. Is taking breast milk to hospital to feed newborn
See Durable Medical Equipment (DME) & Non-CRT Wheelchairs	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 Durable Medical Equipment (DME) & Non-CRT Wheelchairs	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

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EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM					
See Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program	96161		Caregiver/ Maternal depression screening	870001424	Caregiver/Maternal depression screening is required at well-child checkups for caregivers/mothers of infants to age 6 months.
Also in *Physician-Related/Professional Services*	96160, 96161		Caregiver/ Maternal depression screening		• Caregiver/maternal depression screening is required at well-child checkups for caregivers/mothers of infants up to age 6 months. Use procedure code 96161with EPA. • Caregiver/maternal depression screening completed by the caregiver's provider during the 6 months postpartum and billed under the caregiver's ProviderOne ID number. Use procedure code 96160 with EPA.
ENTERAL NUTRITION					
See Enteral Nutrition	B4157	BO, BA	Formulas for special disorders of metabolism	870001405 For clients under age 20	For clients age 20 and younger who have inherited metabolic disorders only, (i.e. amino acid, fatty acid, and carbohydrate metabolic disorders, including phenylketonuria (PKU)). **Documentation required to be completed & kept in the client's file for agency review, upon request:** 1) *Enteral Nutrition Products Prescription form,* HCA 13-961 2) *Metabolic Disorder-Oral Enteral Nutrition EPA Worksheet (Children),* HCA 13-101 See *Where can I download agency forms*?
	B4162	BO, BA	Formulas for inherited disorders of metabolism		

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See Enteral Nutrition	B4100	BO	Food thickener oral For clients under age 1-20	870001406	**Clients age one to 20** For clients with oral, oropharyngeal, and pharyngeal dysphagia. If the client does not meet EPA criteria of a diagnosis of oral, oropharyngeal, and pharyngeal dysphagia, the agency requires prior authorization. • The prescribing provider must complete the following agency forms: ➢ *Thickeners for Children from 1 – 20 years old* – Expedited Prior Authorization (EPA) (HCA 13-112) ➢ *Enteral Nutrition Products Prescription Form* (HCA 13-961) ➢ *Dietitian Worksheet – Oral Enteral Nutrition Assessment* (HCA 13-109) • Durable medical equipment (DME) and pharmacy providers supplying thickeners must retain the completed forms and supporting documentation in the client's file. See *Where can I download agency forms*?
See Enteral Nutrition			For urgent one-time, one-month supply	870001407	**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 the agency's *Enteral Nutrition Products Prescription Form* (HCA 13-961). A dietitian 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. See *Where can I download agency forms*?

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See Enteral Nutrition			To treat a growth of nutritional deficiency (when medically necessary) Monthly supply up to 6 months	870001408	**For clients age 20 and younger,** whose primary care physician has determined medical necessity for an orally administered enteral nutrition product. Before starting the oral enteral nutrition product, the next reasonable step 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 risk of growth or nutrient deficits due to a condition that prevents the client from meeting their needs using food, over-the-counter nutrition product, 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 at the HCA website if needed). ➢ The prescriber has completed the agency's *Enteral Nutrition Products Prescription Form* (HCA 13-961). ➢ The client has a completed *Dietitian Worksheet – Oral Enteral Nutrition Assessment* (HCA 13-109) form from a registered dietitian (RD) that includes all of the following: ✓ Evaluation of the client's nutritional status, including growth and nutrient analysis. ✓ An explanation about why the product is medically necessary as defined in WAC 182-500-0070. ✓ 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. ✓ 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. See *Where can I download agency forms*?

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

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
HABILITATIVE SERVICES					
For client 21 & older: Additional Benefit Limits with Expedited Prior Authorization					
See Habilitative Services	92609	GN	Botox therapy with Speech therapy	870001328	When the clinical situation is: Part of a botulinum toxin injection protocol when prior authorization for the botulinum toxin treatment has been obtained from the agency. **Limitation**: Six additional units, per client, per calendar year For requesting units beyond the additional benefit limits, see **Requesting a Limitation Extension** in Billing Guide.
See Habilitative Services	G0151	GP	Botox therapy with *Physical* therapy	870001329	When the clinical situation is: Part of a botulinum toxin injection protocol when prior authorization for the botulinum toxin treatment has been obtained from the agency. **Limitation**: Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year. For requesting units beyond the additional benefit limits, see **Requesting a Limitation Extension** in Billing Guide.
See Habilitative Services	G0152	GO	Botox therapy with *Occupational* therapy		
HEARING HARDWARE					
See Hearing Hardware	L8615 L8616 L8617 L8618 L8621 L8622 L8623 L8624			870000001	For cochlear implant and bone conduction (Baha®) replacement parts, the following expedited prior authorization (EPA) criteria must be met: • The cochlear implant or bone conduction (Baha®) is unilateral (bilateral requires PA). • The manufacturer's warranty has expired. • The part is for immediate use (not a back-up part).
HOSPICE SERVICES					
See Hospice Services				870001409	Children 20 years old or younger - enrolled in hospice with or without concurrent care treatment. Hospice agencies will remain and are responsible for symptom control related to the child's terminal illness. See WAC 182-551-1210 to see what is included in the hospice daily rate.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
INPATIENT HOSPITAL SERVICES					
See Inpatient Hospital Services **Also in** *Physician-Related/Professional Services* **And** *Planned Home Births & Births in Birthing Centers*	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622		Obstetrical care; Early elective delivery or natural delivery **prior to** 39 weeks gestation	870001375	Client is under 39 weeks gestation and the mother or fetus has a diagnosis listed in the mother or fetus has a diagnosis listed in the Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation, or mother delivers naturally. An early elective delivery is considered medically necessary if the mother or fetus has a diagnosis listed in the Joint Commission's current table of Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation (WAC 182-533-0400). **This EPA also needs to be used for clients who deliver naturally prior to 39 weeks.**
			Elective delivery or natural delivery at or **over** 39 weeks gestation	870001378	Client is 39 weeks or more gestation.
MEDICAL INPATIENT DETOXIFICATION (MID) SERVICES					
See Inpatient Hospital Services			Room & Board - Semi-private Two Bed (Medical or General) Acute alcohol detoxification use	870000433	**3 days for acute alcohol detoxification** **All** of these MID criteria must be met: 1. The MID stay cannot be a scheduled admission due to the acute nature of intoxication and the need for immediate detoxification. 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 listed in the agency's Approved Diagnosis Codes by Program webpage for Inpatient Hospital Services. 4. The client is not participating in the agency's Chemical-Using Pregnant (CUP) Women Program. 5. The care is provided in a medical unit, not a detoxification unit. *CONTINUED ON NEXT PAGE*

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					6. This is a medical stay and not a psychiatric stay. The client does not meet medically necessary criteria for inpatient psychiatric care, and an approval from the DBHR designee or Behavioral Health Organization (BHO) is not appropriate. 7. The hospital is not a DBHR-approved detoxification facility. 8. Nonhospital based detoxification is not medically appropriate
See Inpatient Hospital Services			Room & Board - Semi-private Two Bed (Medical or General) Acute drug detoxification use	870000435	**5 days for acute drug detoxification** **All** of these MID criteria must be met: 1. The MID stay cannot be a scheduled admission due to the acute nature of intoxication and the need for immediate detoxification. 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 listed in the agency's Approved Diagnosis Codes by Program webpage for Inpatient Hospital Services. 4. The client is not participating in the agency's Chemical-Using Pregnant (CUP) Women Program. 5. The care is provided in a medical unit, not a detoxification unit. 6. This is a medical stay and not a psychiatric stay. The client does not meet medically necessary criteria for inpatient psychiatric care, and an approval from the DBHR designee or Behavioral Health Organization (BHO) is not appropriate. 7. The hospital is not a DBHR-approved detoxification facility. 8. Nonhospital based detoxification is not medically appropriate

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

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	T1017 with Dx Z76.2			870001418	An EPA is required when an infant's ICM eligibility occurs prior to the 3rd month of age. To be eligible for ICM, the infant must: • Be covered under categorically needy (CN), medically needy (MN), alternative benefit plan (ABP), or state-funded medical programs with Washington Apple Health • Meet the age requirement for ICM, which is the day after the maternity cycle ends, through the last day of the month of the infant's first birthday • Reside with at least one **parent* who needs assistance accessing medical, social, educational, or other services to meet the infant's basic health and safety needs *For the purposes of ICM, a *parent* is any person who resides with an infant, provides the infant's day-to-day care, and is one or more of the following: ✓ The infant's natural or adoptive parent ✓ A person other than a foster parent who has been granted legal custody of the infant ✓ A person who is legally obligated to support the infant • Not be receiving any case management services funded through Title XIX Medicaid that duplicate ICM services • Infant meets **all** ICM eligibility as defined above. • An infant's eligibility for ICM begins during the 2nd month of life, (see ICM Newborn Calendar). • ICM services are provided during the infant's 2nd month of life. • No more than two units may be billed to complete the ICM Screening Tool (HCA 13-658) form. For dates of service prior to October 1, 2017, contact the ICM Program Manager found in the Maternity Support Billing Guide.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
MENTAL HEALTH SERVICES					
NEUROPSYCHOLOGICAL TESTING of clients **age 16 and older**, in an outpatient or inpatient setting.					
Note: If the client does not meet the expedited prior authorization (EPA) criteria listed in this guide and this table, the agency requires prior authorization (PA) for the testing. Additionally, the agency no longer requires providers who bill for neuropsychological testing to be board-certified; however, upon request, providers must be able to furnish credentials that demonstrate their expertise. Refer to Neuropsychological Testing within the Mental Health Billing Guide.					
The agency pays only "qualified" providers for administering neuropsychological testing to eligible agency clients. To be "qualified," providers must be both of the following: • Currently licensed in Washington State to practice psychology or clinical neuropsychology • One of the following: ✓ Board-certified in clinical neuropsychology by the American Board of Clinical Neuropsychology ✓ Have adequate education, training, and experience as defined by having completed all of the following: ➢ A doctoral degree in psychology from an accredited university training program ➢ An internship, or its equivalent, in a clinically relevant area of professional psychology ➢ The equivalent of two full-time years of experience and specialized training, at least one of which is at the post-doctoral level, in the study and practice of clinical neuropsychology and related neurosciences (these two years must include supervision by a clinical neuropsychologist)					
This section describes *four groups* of criteria that apply to billing in certain circumstances. Up to 15 units for any of these codes combined in a calendar year. For outpatient or non-PM&R inpatient settings, criteria in *any one of groups 1-4* must be met.					
See Mental Health Services	96118		Neuropsych testing by psych/phys	870001207	To assist with rehabilitation efforts and manage outcomes in inpatient physical medicine and rehabilitation (PM&R) patients, criteria in *Group 1* must be met. **Group 1** **All** of the following must be met: • The patient to be evaluated has, or is suspected to have, an acquired injury to the brain as a result of traumatic brain injury, stroke, multiple sclerosis, aneurysm, anoxia, hypoxia, dementia, neoplasm, or chemotherapy. • The patient is age 16 or older. • The patient was functioning normally (was able to attend school, work competitively, or live independently) prior to the brain disorder. *CONTINUED ON NEXT PAGE*
	96119		Neuropsych testing by tech		

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					• The patient has potential to return to important areas of role functioning (e.g., work, school, or independent living). • Testing will be used only in conjunction with functionally based rehabilitation, not "cognitive" rehabilitation.
NEUROPSYCHOLOGICAL TESTING of clients **age 16 and older**, in an outpatient or inpatient setting.					
See Mental Health Services	96118		Neuropsych testing by psych/phys	870001207	**Group 2** The client is suspected to have a diagnosis of dementia or multiple sclerosis based on **one** of the following: • Client or family complaints • A head CT (computed tomography scan) • A mental status examination or other medical examination This suspected diagnosis is not confirmed or able to be differentiated from the following: • Normal aging • Mild concussion • Depression • Focal neurological impairments A firm diagnosis would change the medical treatment plan, clinical management, or aid important client or family decisions.
	96119		Neuropsych testing by tech		
				870001207	**Group 3** The client is undergoing brain surgery for epilepsy, a tumor, or Parkinson's disease, and neuropsychological testing may help with **either** of the following: • Guide the surgeon in the goal of sparing healthy brain tissue and sites that are critical to some major function such as language • Identify poor candidates for neurological surgery due to dementia (e.g., in cases where deep brain stimulation implants are being considered to manage intractable tumors)

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
NEUROPSYCHOLOGICAL TESTING of clients **age 16 and older**, in an outpatient or inpatient setting.					
See Mental Health Services	96118		Neuropsych testing by psych/phys	870001207	**Group 4** The client is being considered for surgery (e.g., a lung transplant), and neuropsychological testing may help identify if the client is a poor candidate for surgery (e.g., in cases where cognitive impairment from chronic hypoxia or other risk factors make it unlikely that the person can accurately follow a rigorous post-transplant protocol to prevent organ rejection).
	96119		Neuropsych testing by tech		
PSYCHOLOGICAL TESTING					
See Mental Health Services	96101	UC	Psychological testing by psych/phys	870001315	Up to 7 hours for clients age 20 and younger for whom psychological testing is required to determine a definitive diagnosis for autism spectrum disorder and service is provided at a Center of Excellence. This EPA code is only available to psychologists, psychiatrists and qualified COEs. Providers must bill with a UC modifier.
EPA billing requirements for evidence and research-based practices					
Note: Evidence-based medicine, evidence-based practice, research-based practice, and evidence-based health care (collectively "EBPs") include programs such as cognitive behavioral therapy (CBT) and the Positive Parenting Program (Triple P). The agency is required by law to collect data on EBPs in Washington State. Providers who provide these services to clients under age 21 should include the appropriate EPA number from the following table when billing for EBP.					
See Mental Health Services				870001318	Positive Parenting Program (Triple P) (Level 2)
				870001319	Positive Parenting Program (Triple P) (Level 3)
				870001330	Parent-Child Interaction Therapy (PCIT)
				870001331	Cognitive Behavioral Therapy (CBT)+ for Behaviors, Anxiety and Depression
				870001332	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
				870001333	Bonding and Attachment via the Theraplay model (Promising Practice)
				870001334	Cognitive Behavioral Therapy (CBT)
				870001335	Strengthening Families Program
				870001401	Positive Parenting Program (Triple P) (Level 4)

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
Note: The following CPT codes may be used for inpatient professional services provided to an MCO client during a BHO-authorized admission to place of service 21 or 51:					
See Mental Health Services **Also in** *Physician-Related/Professional Services*	90785, 90791, 90792, 90832, 90838, 90845, 90846, 90847, 90849, 90853, 90870, 96101, 96111, 96116, 96118, 96119, 99221-99223, 99231-99233, 99251-99255, 99238, 99239		Inpatient professional services provided to a non-FIMC-enrolled MCO client when the admission was authorized by the BHO	870001369	**All** of the following conditions must be met: ❖ The client is enrolled in an MCO ❖ The client's inpatient hospital (POS 21, 51) admission was paid for by the BHO ❖ The client's primary diagnosis is in the psychiatric range for ICD diagnosis codes ❖ The services are provided by a psychiatrist, psychologist, or psychiatric ARNP

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
NONDURABLE MEDICAL SUPPLIES AND EQUIPMENT (MSE)					
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 DME team (refer to the Resources Available section within the corresponding billing guide). 2. It is the vendor's responsibility to determine whether the client has already used the product allowed with the EPA criteria within the previous 30 days. 3. For extension of authorization beyond the EPA amount allowed, the normal prior authorization process is required. 4. Must have a valid physician prescription as described in WAC 182-543-2000(2)(c) 5. Length of need/life expectancy, as determined by the prescribing physician, and medical justification (including **all** of the specified criteria) must be documented in the client's file. 6. You may bill for only one procedure code, per client, per month.					
See Nondurable Medical Supplies and Equipment (MSE)	A4335		Incontinence supply, use for diaper doublers, each (age 3 & up)	870000851	Purchase of 90 per month allowed when **all** of the following criteria are met: a) Product is used for extra absorbency at nighttime only b) When prescribed by a physician
				870000852	Up to equal amount of diapers/briefs received if **one** of the following criteria for clients is met: a) Tube fed b) On diuretics or other medication that causes frequent/large amounts of output c) Brittle diabetic with blood sugar problems
See Nondurable Medical Supplies and Equipment (MSE)	A4927		Additional gloves for clients who live in an assisted living facility	870001262	Will be allowed up to the quantity necessary as directed by the client's physician, not to exceed a total of 400 per month. Allowed for Place of Service 13 (assisted living and adult family home) and 14 (group home).
See Nondurable Medical Supplies and Equipment (MSE)	A4253 A4259		Blood glucose test strips and lancets for pregnant women with gestational diabetes	870001263	Up to the quantity necessary to support testing as directed by their physician, up to 60 days post delivery
			300 test strips and 300 lancets per month for children through age 20	870001265	100 over limit - for children only

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
ORTHODONTIC SERVICES					
Note: Providers must correctly indicate the appliance date on **all** orthodontic treatment claims.					
See Orthodontic Services	D8660		Cleft palate pre-orthodontic treatment visit	870000970	Use when billing for cleft palate and craniofacial anomaly cases. Billable only by the treating orthodontic provider. Includes preparation of comprehensive diagnostic records (additional photos, study casts, cephalometric examination film, and panoramic film), formation of diagnosis and treatment plan from such records, and formal case conference. Treating provider **must** be an orthodontist **and either be** a member of a recognized craniofacial team **or** approved by the agency's Dental Consultant to provide this service. Medically necessary ICD diagnosis codes must be documented in the client's record**.** See the agency's Approved Diagnosis Codes by Program web page for Orthodontic Services.
See Orthodontic Services	D8020		Limited orthodontic treatment of the transitional dentition for cleft palate	870001402	Use when billing for cleft palate and craniofacial anomaly cases. For the **initial placement** when the appliance placement date and the date of service *are the same*. Includes first three months of treatment and appliance(s).
				870001403	Use when billing for cleft palate and craniofacial anomaly cases. For each **subsequent three-month** period when the appliance placement date and the date of service *are different*. The agency reimburses a maximum of three follow-up visits.
					Note: **To receive reimbursement for each subsequent three-month period:** • The provider must examine the client in the provider's office at least once during the three-month period. **However, the agency prefers that the client be seen every eight to ten weeks, or as medically necessary.* • Continuing treatment must be billed after each three-month interval. • Document the actual service dates in the client's record.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Orthodontic Services	D8030		Limited orthodontic treatment of the adolescent dentition for cleft palate	870000970	Use when billing for cleft palate and craniofacial anomaly cases. For the **initial placement** when the date of service and the appliance placement date *are the same*. Includes first three months of treatment and appliances.
				870000970	Use when billing for cleft palate and craniofacial anomaly cases. For each **subsequent three-month period** when the appliance placement date and the date of service *are different*. The agency reimburses a maximum of eight follow-up visits.
					Note: **To receive reimbursement for each subsequent three-month period:** • The provider must examine the client in the provider's office at least once during the three-month period. **However, the agency prefers that the client be seen every eight to ten weeks, or as medically necessary.* • Continuing treatment must be billed after each three-month interval. • Document the actual service dates in the client's record.
See Orthodontic Services	D8060		Interceptive orthodontic treatment of the transitional dentition for cleft palate	870000980	Use when billing for cleft palate and craniofacial anomaly cases. Payable only once per client. The maximum allowance includes all professional fees, laboratory costs, and required follow-up. No allowance for lost or broken appliance.
See Orthodontic Services	D8080		Comprehensive orthodontic treatment of the adolescent dentition for cleft palate	870000990	Use when billing for cleft palate and craniofacial anomaly cases. For the **initial placement** when the date of service and the appliance placement date *are the same*. Includes first six months of treatment and appliances.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Orthodontic Services	D8080		Comprehensive orthodontic treatment of the adolescent dentition for cleft palate	870000990	Use when billing for cleft palate and craniofacial anomaly cases. For each **subsequent three-month period** when the appliance placement date and the date of service *are different*. The agency reimburses a maximum of eight follow-up visits. **Note:** **To receive reimbursement for each subsequent three-month period:** • The provider must examine the client in the provider's office at least once during the three-month period, with the first three-month interval beginning six months after the initial appliance placement. **However, the agency prefers that the client be seen every eight to ten weeks, or as medically necessary.* • Continuing treatment must be billed after each three-month interval. • Document the actual service dates in the client's record.
OUTPATIENT HOSPITAL SERVICES					
See Outpatient Hospital Services **Also in** *Physician-Related/Professional Services, and Vision Hardware for Clients Age 20 and Younger*	92134		Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral, retina	870000051	Limited 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.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Outpatient Hospital Services **Also in** *Physician-Related/Professional Services*	77080, 77081		Bone mineral density testing with dual x-ray absorptiometry (DXA) - **initial screening**	870001363 For **repeat** testing, see EPA 870001364	Bone mineral density testing with dual x-ray absorptiometry (DXA) is a covered benefit with the following conditions: *Asymptomatic women* • Women 65 years of age and older or • Women 64 years of age and younger with equivalent ten year fracture risk to women age 65 as calculated by FRAX (Fracture Risk Assessment) tool or other validated scoring tool. *Men or women* • Long term glucocorticoids (i.e. current or past exposure to glucocorticoids for more than 3 months) **or** • Androgen deprivation or other conditions known to be associated with low bone mass
See Outpatient Hospital Services **Also in** *Physician-Related/Professional Services*	77080, 77081		Bone mineral density testing with dual x-ray absorptiometry (DXA) - **repeat test**	870001364 For **initial** testing, see EPA 870001363	Repeat bone mineral density testing with dual x-ray absorptiometry (DXA) is a covered benefit when the client meets **one** of the following: • T-score** > -1.5, 15 years to next screening test • T-score -1.5 to -1.99, 5 years to next screening test • T-score ≤ -2.0, 1 year to next screening test **Or** Use of medication associated with low bone mass or presence of a condition known to be associated with low bone mass.
See Outpatient Hospital Services **Also in** *Physician-Related/Professional Services*	84402, 84403		Testosterone testing	870001368	For males age 19 and older and at least **one** of the following conditions are met: • Suspected or known primary hypogonadism • Suspected or known secondary hypogonadism with organ causes such as: ✓ Pituitary disorder ✓ Suprasellar tumor ✓ Medications suspected to cause hypogonadism ✓ HIV with weight loss ✓ Osteoporosis • Monitoring of testosterone therapy

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

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
ALL CLIENTS 21 AND OLDER & MCS CLIENTS AGES 19-20 additional benefit limits with expedited prior authorization					
SPEECH THERAPY					**When client's diagnosis is:**
See Outpatient Rehabilitation	Six additional units, per client, per calendar year. See **Requesting a Limitation Extension** in the Outpatient Rehabilitation Billing Guide for requesting units beyond the additional benefit limits -or- if the client's diagnosis is not listed in this table. **NOTE: Speech therapy claims require modifier GN**			870000007	Speech deficit which requires a speech generating device
				870000008	Lymphedema
				870000009	Brain injury **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 the agency
				870000012	Spinal cord injury resulting in paraplegia or quadriplegia within the past 24 months
				870000013	Major joint surgery – partial or total replacement only
				870000014	New onset muscular-skeletal disorders such as complex fractures which require surgical intervention or surgeries involving spine or extremities (e.g., arm, shoulder, leg, foot, knee, or hip)
				870000015	Acute, open, or chronic non-healing wounds **OR** Burns - 2nd or 3rd degree only
				870000016	New onset neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre)) **OR** Reflex sympathetic dystrophy
				870000017	Speech deficit due to injury or surgery to face, head, or neck
See Outpatient Rehabilitation	97166	GO	DSHS OT eval (personal care for children)	870001343	One per client, unless change of residence or condition.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
PHYSICIAN-RELATED SERVICES/HEALTH CARE PROFESSIONAL SERVICES					
See Physician-Related/ Professional Services	C1874, C1875, C9601, C9602, C9603, C9604, C9605, C9606, C9607, C9608 - - - - - - 92980, 92981		Placement of Cardiac Drug Eluting or Bare Metal Stent and Device C codes are Institutional only **Bare Metal**	870000422	Either drug eluting or bare metal cardiac stents are covered when cardiac stents are indicated for treatment when medically necessary. For patients being treated for stable angina, cardiac stents are a covered benefit with the following conditions: 1) Angina refractory to optimal medical therapy, and 2) Objective evidence of myocardial ischemia
See Physician-Related/ Professional Services	J2796		Injection, Romiplostim, 10 Microgram	870001300	**All of the following must apply**: 1) Documented diagnosis of Idiopathic Thrombocytopenic Purpura (ITP) 2) Patient must be at least 18 years of age 3) Inadequate response (reduction in bleeding) to: a. Immunoglobulin treatment b. Corticosteroid treatment **or** c. Splenectomy
See Physician-Related/ Professional Services	J0129		Orencia (abatacept)	870001321	Treatment of rheumatoid arthritis when prescribed by a rheumatologist in patients who have tried and failed one or more DMARDs. Dose is subcutaneous injection once weekly. IV dosing is up to 1000mg dose to start, repeated at week 2 and 4, then maintenance up to 1000mg every 4 weeks.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	90733, 90734		Meningococcal Vaccine (Conjugate Vaccine - Menactra®)	870000421	Client is age 11 through 55 and is in one of the at-risk groups because the client meets **one** of the following: 1) Not routinely recommended for ages 19-21, but may be administered as catch-up vaccination for those who have not received a dose after their 16th birthday 2) Has persistent complement deficiencies 3) Has anatomic or functional asplenia 4) Are at risk during a community outbreak attributable to a vaccine serogroup 5) Infected with human immunodeficiency virus (HIV), if another indication for vaccination exists 6) Is a microbiologist who is routinely exposed to isolates of N. meningitidis 7) Is a freshman entering college who will live in a dormitory **Note:** For clients age 11 through 20, see EPA 870000424 (below), or the agency's *EPSDT Billing Guide.*
	90733		Meningococcal Vaccine (Polysaccharide vaccine – Menomune®)	870000424	Client must meet at least 1 of the 5 criteria for use of the meningococcal vaccine outlined for EPA 870000421 (CPT code 90734) **and one of the following is true**: 1) The client is one of the following: a) 2 years of age through 10 years of age b) Older than 55 years of age 2) The conjugate vaccine is not available.
See Physician-Related/ Professional Services	G0297		Low dose CT for lung cancer screen	870001362	The client must meet **all** of the following criteria: • Is age 55-80, **and** • Has a history of smoking 30 packs a year and still smokes, **or** • Has a history of smoking 30 packs a year and has quit smoking in the last 15 years

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	70540, 70542, 70543		Magnetic Resonance Imaging (MRI) of the sinus for rhinosinusitis	870001422	Criteria for sinus MRI listed below **AND** less than 18 years of age OR pregnant. • *Red Flags, OR • Persistent Symptoms longer than 12 weeks AND failure of medical therapy, OR • Surgical planning. Repeat scanning is not covered except for Red Flags or surgical planning. *See **Imaging for rhinosinusitis** in the Billing Guide for a listing of Red Flags.
	70450, 70460, 70470, 70486, 70487, 70488		Sinus Computed Tomography (CT) for rhinosinusitis	870001423	
See Physician-Related/ Professional Services **Also in** *Outpatient Hospital Services*	77080, 77081		Bone mineral density testing with dual x-ray absorptiometry (DXA) - initial screening	870001363	**Initial** bone mineral density testing with dual x-ray absorptiometry (DXA) is a covered benefit with the following conditions: *Asymptomatic women* • Women 65 years of age and older or • Women 64 years of age and younger with equivalent ten year fracture risk to women age 65 as calculated by FRAX (Fracture Risk Assessment) tool or other validated scoring tool. *Men or women* • Long term glucocorticoids (i.e. current or past exposure to glucocorticoids for more than 3 months) **or** Androgen deprivation or other conditions known to be associated with low bone mass
				870001364	**Repeat** bone mineral density testing with dual x-ray absorptiometry (DXA) is a covered benefit when the client meets **one** of the following: • T-score** > -1.5, 15 years to next screening test • T-score -1.5 to -1.99, 5 years to next screening test • T-score ≤ -2.0, 1 year to next screening test **Or** Use of medication associated with low bone mass or presence of a condition known to be associated with low bone mass.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	81507, 81420		Noninvasive prenatal diagnosis of fetal aneuploidy (NIPT)	870001344	The agency considers NIPT for serum marker screening for fetal aneuploidy to be medically necessary in women with high-risk singleton pregnancies, who have had genetic counseling, **when one or more of the following are met**: • Pregnant woman is age 35 years or older at the time of delivery • History of a prior pregnancy with a trisomy or aneuploidy • Family history of aneuploidy (first degree relatives or multiple generations affected) • Positive first or second trimester standard biomarker screening test for aneuploidy, including sequential, or integrated screen, or a positive quadruple screen • Parental balanced Robertsonian translocation with increased risk for fetal T13 or T21 • Findings indicating an increased risk of aneuploidy
See Physician-Related/ Professional Services	81519		Oncology (breast) genomic testing - *Oncotype*	870001386	*Oncology genomic (breast) is conducted by two companies (Endopredict and Oncotype).* **All** of the following conditions must be met: • The test is performed within 6 months of the diagnosis • Node negative (micrometastases less than 2mm in size are considered node negative) • Hormone receptor positive (ER-positive or PR-positive) • Tumor size .6-1.0 cm with moderate/poor differentiation or unfavorable features (ie, angiolymphatic invasion, high nuclear grade, high histologic grade) OR tumor size >1 cm • Unilateral disease • Her-2 negative • Patient will be treated with adjuvant endocrine therapy • The test result will help the patient make decisions about chemotherapy when chemotherapy is a therapeutic option
	81519	QP	Oncology (breast) genomic testing - *Endopredict*	870001420	

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services **Also in** *Outpatient Hospital Services*	84402, 84403, 84410		Testosterone testing	870001368	For males age 19 and older and **at least one** of the following conditions are met: • Suspected or known primary hypogonadism • Suspected or known secondary hypogonadism with organ causes such as: ✓ Pituitary disorder ✓ Suprasellar tumor ✓ Medications suspected to cause hypogonadism ✓ HIV with weight loss ✓ Osteoporosis • Monitoring of testosterone therapy
See Physician-Related/ Professional Services	86480, 86481		Targeted TB testing with interferon-gamma release assays	870001325	Targeted TB testing with interferon-gamma release assays may be considered medically necessary for clients **five years of age and older** for **any** of the following conditions: • History of positive tuberculin skin test or previous treatment for TB disease • History of vaccination with BCG (Bacille Calmette-Guerin) • Recent immigrants (within 5 years) from countries that have a high prevalence of tuberculosis • Residents and employees of high-risk congregate settings (homeless shelters, correctional facilities, substance abuse treatment facilities) • Clients with an abnormal CXR consistent with old or active TB • Clients undergoing evaluation or receiving TNF alpha antagonist treatment for rheumatoid arthritis, psoriatic arthritis, or inflammatory bowel disease • Exposure less than two years before the evaluation **AND** • Client in agreement to remain in compliance with treatment for latent tuberculosis infection if found to have a positive test. The tuberculin skin test is the preferred method of testing for children under the age of 5.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	87625		HPV genotyping	870001381	For females age 30 and older, when the following conditions are met: • Pap negative and HPV positive • Pap no EC/TZ and HPV positive
See Physician-Related/ Professional Services **Also in** *Vision Hardware for Clients Age 20 and Younger*	92014, 92015		Visual Exam/Refraction (Optometrists/ Ophthalmologists only)	870000610	**Eye Exam/Refraction - Due to loss or breakage**: For adults within 2 years of last exam when no medical indication exists and **both** of the following are documented in the client's record: 1) Glasses are broken or lost or contacts that are lost or damaged 2) Last exam was at least 18 months ago **Note**: EPA # is not required when billing for children or clients with developmental disabilities.
See Physician-Related/ Professional Services **Also in** *Outpatient Hospital, and Vision Hardware for Clients Age 20, and Younger*	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.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	77301, 77338, 77370, G6015, G6016		Intensity modlat'd radiation therapy (IMRT) **Dx code:** C61, or in the agency's Approved Diagnosis Codes by Program	870001313 **By diagnosis**	• Head and neck cancers (See the agency's Approved Diagnosis Codes by Program web page for Physician-Related Services/Health Care Professionals for this EPA number). • Prostate cancer (Dx: C61) **Note: All other diagnoses not in the EPA list require prior authorization.**
				870001374 **For sparing adjacent critical structures**	To meet EPA criteria, clinical documentation must state which critical structure is to be spared. For example: "Critical structure spared is bladder." IMRT is considered medically necessary when there is a concern about damage to surrounding critical structures with the use of external beam or 3D conformal radiation therapy. The critical structure spared (for example: bladder) should be documented in the note. The adjacent critical structure EPA applies to the following cancers*: ➢ Anal cancer ➢ Anaplastic thyroid cancer ➢ Brain tumors in close proximity to critical structures ➢ Esophageal cancer where dose exceeds 50 Gy ➢ Gallbladder cancer where dose exceeds 50 Gy ➢ Head and neck cancer excluding T1 and T2 glottic cancer ➢ Left breast cancer if the lesion is in close proximity to the heart or other cardiovascular structures ➢ Lung cancer if the lesion is in close proximity to the heart or other critical structures ➢ Pancreatic cancer where dose exceeds 50 Gy ➢ Postoperative radiation to pelvis for endometrial cancer ➢ Prostate cancer ***If not listed, please submit for prior authorization review.**

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	19318, 19300		Reduction Mammoplasties/ Mastectomy for Gynecomastia **Dx codes:** N62, N64.9, or L13.9	870000241	A female with a diagnosis for **hypertrophy of the breast** with: 1) Photographs in client's chart 2) Documented medical necessity including: a) Back, neck, and/or shoulder pain for a minimum of one year, directly attributable to macromastia b) Conservative treatment not effective 3) Abnormally large breasts in relation to body size with shoulder grooves 4) Within 20% of ideal body weight, and 5) Verification of minimum removal of 500 grams of tissue from each breast
				870000242	A male with a diagnosis for **gynecomastia** with: 1) Pictures in clients' chart 2) Persistent tenderness and pain 3) If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than one year
See Physician-Related/ Professional Services	Q4116		Alloderm	870001342	**All** of the following must be met: • It is medically necessary • The client has a diagnosis of breast cancer • The servicing provider is either a general surgeon or a plastic surgeon
See Physician-Related/ Professional Services	15822, 15823, 67901, 67902, 67903, 67904, 67905, 67906, 67907, 67908		Blepharoplasties	870000630	Blepharoplasty for non-cosmetic reasons when **both** of the following are true: 1) The excess upper eyelid skin impairs the vision by blocking the superior visual field, and 2) On a central visual field test, the vision is blocked to within 10 degrees of central fixation.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	58150, 58152, 58180, 58200, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58545, 58546, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573,		Hysterectomies for Cancer	870001302	Client must have a diagnosis of cancer requiring a hysterectomy as part of the treatment plan. See the agency's Approved Diagnosis Codes by Program web page for Physician-Related Services/Health Care Professionals for this EPA number.
			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) See the agency's Approved Diagnosis Codes by Program web page for Physician-Related Services/Health Care Professionals for this EPA number.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	62320, 62322, 62324, 62326		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 interoperatively or postoperatively for pain control. Otherwise, an authorization request must be submitted through Qualis Health.
See Physician-Related/ Professional Services	69930		**Unilateral** cochlear implant for clients age 20 and younger	870000423 Note: For criteria for bilateral cochlear implants, see EPA 870001365	The agency pays for cochlear implantation only when the products come from a vendor with a *Core Provider Agreement* with the agency, there are *no other contraindications to surgery*, and **one** of the following must be true: **Unilateral** cochlear implantation for clients age 18 through 20 with post-lingual hearing loss and clients (12 months-17 years old) with pre-lingual hearing loss when all of the following are true: a) The client has a diagnosis of profound to severe bilateral, sensorineural hearing loss b) The client has stimulable auditory nerves but has limited benefit from appropriately fitted hearing aids (e.g., fail to meet age-appropriate auditory milestones in the best-aided condition for young children, or score of less than ten or equal to 40% correct in the best-aided condition on recorded open-set sentence recognition tests c) The client has the cognitive ability to use auditory clues d) The client is willing to undergo an extensive rehabilitation program e) There is an accessible cochlear lumen that is structurally suitable for cochlear implantation f) The client does not have lesions in the auditory nerve and/or acoustic areas of the central nervous system **Note:** See the agency's Hearing Hardware for Clients 20 Years of Age and Younger Billing Guide for replacement parts for cochlear implants.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	69930	50	**Bilateral** cochlear implants for clients age 20 and younger	870001365 Note: For **unilateral** cochlear implants, see EPA 870000423	The client must: • Be age 12 months through 20 years old • Have bilateral severe to profound sensorineural hearing loss. See qualifying diagnoses as listed in the agency's Approved Diagnosis Codes by Program web page for Physician-Related Services/Health Care Professionals for this EPA number. • Be limited or no benefit from hearing aids • Have cognitive ability and willingness to participate in an extensive auditory rehabilitation program • Have freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system • Have no other contraindications for surgery • Use device in accordance with the FDA approved labeling
See Physician-Related/ Professional Services	67311, 67312, 67314, 67316, 67318, 67320, 67331, 67332, 67334, 67335, 67340		Strabismus Surgery **Dx Code:** H53.2	870000631	Strabismus surgery for clients 18 years of age and older when **both** of the following are true: 1) The client has a strabismus-related double vision (diplopia), Dx H53.2, and 2) It is not done for cosmetic reasons
See Physician-Related/ Professional Services	91200		Transient elastograph	870001350	**All** of the following must be met: • Baseline detectable HCV RNA viral load • Chronic hepatitis C virus infection and BMI < 30 • Both APRI (AST to platelet ratio index) and FibroSURE™ tests have been completed with the following results: ➢ FibroSURE™ < 0.49 and APRI > 1.5 **or** ➢ 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	69433, 69436		Tympanostomy tubes	870001382	The client is age 16 or younger and is: Diagnosed **with acute otitis media (AOM) and the client**: • Has complications or is immunocompromised or is at risk for infection **OR** • Has had 3 episodes of AOM in the last 6 months with one occurring in the last 6 months **and** • Has the presence of effusion at the time of assessment for surgical candidacy **OR** The client is diagnosed with **otitis media with effusion (OME) and the client has**: • An effusion for 3 months or greater and there is documented hearing loss **OR** • A disproportionate risk from the effects of hearing loss, such as those with speech delay, underlying sensory-neuro hearing loss or cognitive disorders
See Physician-Related/ Professional Services	F64.1, F64.2		Surgical consultation related to transgender surgery	870001400	**All** of 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
See Physician-Related/ Professional Services	99183, G0277		Hyperbaric Oxygen Therapy (Note: G0277 is for institutional only)	870000425	**All** of the following must be true: • The diagnosis must be listed in the agency's Approved Diagnosis Codes by Program web page for Physician-Related Services/Health Care Professionals for this EPA number. • Patient has type 1 or type 2 diabetes and has a lower extremity wound that is due to diabetes • Patient has a wound classified as Wagner grade 3 or higher • Hyperbaric oxygen therapy is being done in combination with conventional diabetic wound care

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	95250, 95251		Continuous Glucose Monitoring (CGM)	870001312	**Allowed only for clients 18 years of age and younger** for the in-home use of professional or diagnostic CGM for a 72-hour period. The client must: • Have diabetes mellitus (DM). • Be insulin dependent. • Have had one or more severe episodes of hypoglycemia (blood glucose less than or equal to 50 mg/dl) *requiring assistance from another person, or complicated by a hypoglycemia-induced seizure. The CGM must be: • Ordered by a pediatrician. • Provided by an FDA-approved CGM device. Verification with self-monitoring of blood glucose (SMBG) is needed prior to adjusting insulin. Do not use the CGM results to adjust insulin. **Limit**: 2 monitoring periods of 72 hours each, per client, every 12 months. ***Requiring assistance** means that the client does not recognize the symptoms of hypoglycemia and/or is unable to respond appropriately.
See Physician-Related/ Professional Services	99211, 99212, 99213, 99214, 99231, 99232, 99233, 99241, 99242, 99243, 99251, 99252, 99253	GQ	Teledermatology	870001419	**MISSING HEADER** • The teledermatology is associated with an office visit between the eligible client and the referring health care provider. • The teledermatology can be done in person or via synchronous 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.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	99492, G0512		Initial psychiatric collaborative care management	870001427	To be used to initiate new episode of care when **less than** a 6 month lapse in services: • Provider has identified a need for a new episode of care for an eligible condition • There has been less than 6 months since the client has received any CoCM services
See Physician-Related/ Professional Services	99493, 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 **Also in** *Inpatient Hospital Services* **And** *Planned Home Births & Births in Birthing Centers*	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622		Obstetrical care; Early elective delivery or natural delivery **prior to** 39 weeks gestation	870001375	Client is **under** 39 weeks gestation and the mother or fetus has a diagnosis listed in the mother or fetus has a diagnosis listed in the Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation, or mother delivers naturally. An early elective delivery is considered medically necessary if the mother or fetus has a diagnosis listed in the Joint Commission's current table of Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation (WAC 182-533-0400). **This EPA also needs to be used for clients who deliver naturally prior to 39 weeks.**
			Elective delivery or natural delivery at or **over** 39 weeks gestation	870001378	Client is 39 weeks or **more** gestation.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Physician-Related/ Professional Services	96160, 96161		Caregiver/ Maternal depression screening	870001424	• Caregiver/maternal depression screening is required at well-child checkups for caregivers/mothers of infants up to age 6 months. Use procedure code 96161with EPA. • Caregiver/maternal depression screening completed by the caregiver's provider during the 6 months postpartum and billed under the caregiver's ProviderOne ID number. Use procedure code 96160 with EPA.
Also in *Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program*	96161		Caregiver/ Maternal depression screening		Caregiver/Maternal depression screening is required at well-child checkups for caregivers/mothers of infants to age 6 months.
See Physician-Related/ Professional Services	97110		Orthoptic/pleoptic training	870001371	Documented diagnosis of convergence insufficiency, convergence excess, or binocular dysfunction, with a secondary diagnosis of traumatic brain injury (TBI). (Dx: *H50.411* **or** *H50.412* with secondary Dx of TBI)
	97112			870001372	Documented diagnosis of convergence insufficiency, convergence excess, or binocular dysfunction, with a secondary diagnosis of traumatic brain injury (TBI). (Dx: *H51.12* with secondary dx of TBI)
	97530			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 **Also in** *Mental Health Services*			Professional services provided to an MCO client during the BHO authorized admission	870001369	**All** of the following conditions must be met: • The client's inpatient hospital (POS 21, 51) admission was authorized by the BHO • The client's primary diagnosis is in the psychiatric range. See qualifying diagnoses as listed in the agency's Approved Diagnosis Codes by Program web page for Physician-Related Services/Health Care Professionals for this EPA number. • The services are provided by a psychiatrist, psychologist, or psychiatric ARNP

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
PLANNED HOME BIRTHS & BIRTHS IN BIRTHING CENTERS					
See Planned Home Births & Births in Birthing Centers	90371, J0290, J1364, J2540, S0077		EPA criteria for drugs not billable by licensed midwives	870000690	To use an EPA to bill procedure codes 90371, J2540, S0077, J0290, J1364, the licensed midwife must meet **all** of the following: • Obtained physician or standing orders for the administration of the drug listed as **not billable by a licensed midwife**. • Placed the physician or standing orders in the client's file. • Will provide a copy of the physician or standing orders to the agency upon request. See **Coverage Table** within this Billing Guide
See Planned Home Births & Births in Birthing Centers **Also in** *Inpatient Hospital Services* **And** *Physician-Related/Professional Services*	59400, 59409, 59410		Obstetrical care; Early elective delivery or natural delivery **prior to** 39 weeks gestation	870001375	Client is under 39 weeks gestation and the mother or fetus has a diagnosis listed in the mother or fetus has a diagnosis listed in the Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation, or mother delivers naturally. An early elective delivery is considered medically necessary if the mother or fetus has a diagnosis listed in the Joint Commission's current table of Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation (WAC 182-533-0400). **This EPA also needs to be used for clients who deliver naturally prior to 39 weeks.**
			Elective delivery or natural delivery at or **over** 39 weeks gestation	870001378	Client is 39 weeks or more gestation.

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

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Prosthetic and Orthotic (P&O) Devices	L3000		Foot insert, removable, molded to patient model, "UCB" type, Berkeley Shell, each	870000784	Purchase of one (1) pair per 12-month period for a client 16 years of age or younger allowed if any of the following criteria are met: 1) Required to prevent or correct pronation 2) Required to promote proper foot alignment due to pronation 3) For ankle stability as required due to an existing medical condition such as hypotonia, Cerebral Palsy, etc. Note: 1) If the medical condition does not meet the criteria specified above, you must obtain prior authorization. 2) This EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the EPA has been used for the client within 12 months prior to the provider's proposed date of service. 3) If the client only medically requires one orthotic, right or left, prior authorization must be obtained.
See Prosthetic and Orthotic (P&O) Devices	L3215, L3219		Orthopedic footwear, woman's or man's shoes, oxford	870000785	Purchase of one (1) pair per 12-month period allowed if any of the following criteria are met: 1) When one or both shoes are attached to a brace 2) When one or both shoes are required to accommodate a brace with the exception of L3030 foot inserts 3) To accommodate a partial foot prosthesis 4) To accommodate club foot **Note**: 1) The agency does not allow orthopedic footwear for the following reasons: a. To accommodate L3030 orthotics b. Bunions c. Hammer toes d. Size difference (mismatched shoes) e. Abnormal sized foot 2) The agency only allows the following manufacturers of orthopedic footwear: a. Acor b. Alden Shoe Company *CONTINUED ON NEXT PAGE*

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
					c. Jerry Miller d. Markell e. P.W. Minor f. Walkin-Comfort g. Hanger h. Answer 2 i. Keeping Pace 3) If the medical condition does not meet one of the criteria specified above, you must obtain prior authorization. 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: 1) Client is 16 years of age and younger 2) Required due to a medical condition causing crouched gait **Note**: 1) If the medical condition does not meet one of the criteria specified above, you must obtain prior authorization. 2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Prosthetic and Orthotic (P&O) Devices	L5681, L5683		Addition to lower extremity, below knee/above knee, socket insert, suction suspension with or without locking mechanism	870000787	Initial purchase of one (1) L5683 and L5681 per initial, lower extremity prosthesis (one to wash, one to wear) allowed per 12-month period if any of the following criteria are met: 1) Short residual limb 2) Diabetic 3) History of skin problems/open sores on stump **Note**: 1) If the medical condition does not meet one of the criteria specified above, you must obtain prior authorization. 2) This EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the EPA has been used for the client within 12 months prior to the provider's proposed date of service. 3) EPA is for initial purchase only. It is not to be used for replacements of existing products.
RESPIRATORY CARE					
See Respiratory Care	E0465, E0466	RR, U2	Home Ventilator (invasive and non-invasive)	870000000	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. **All** of the following criteria must be met in order to use this EPA: • The client must be under the age of 18 and currently using a pressure support ventilator. • The client must be able to take spontaneous breaths. • There must be a physician order for the pressure support setting, and the client must be utilizing the ventilator in the pressure support mode.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Respiratory Care	E0445	SC	Enhanced Oximeter **(Do not bill with A0445 NU)**	870000006	With **all** of the following features: • Alarms for heart rate and oxygen saturation • Adjustable alarm volume • Memory for download • Internal rechargeable battery Client must be age 17 and younger, in the home, and meet the clinical criteria for an *Oximeter* found below: **Clinical criteria for standard oximeters** • The agency covers the purchase of standard oximeters, without PA, for clients age 17 or younger in the home when the client: ✓ Has chronic lung disease and is on supplemental oxygen. ✓ Has a compromised or artificial airway. ✓ Has chronic lung disease requiring a ventilator or a bi-level RAD. • PA is needed for purchasing standard oximeters for clients 18 years or older. **Clinical criteria for enhanced oximeters** • The agency covers the purchase of enhanced oximeters, without PA, for clients age 17 or younger in the home when both: ✓ The criteria for a standard oximeter are met. ✓ The EPA criteria are met. • The agency covers the purchase of enhanced oximeters, with PA, for: ✓ Clients age 18 and older ✓ Clients age 17 and younger who do not meet clinical criteria. **Purchase limit of 1 per client, every 3 years.**

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Respiratory Care	E0424	RR	Portable gaseous oxygen systems **(Do not bill with A4615 - A4620, E0439, E0441 - E0444, E1390, E1392)**	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.
	E0431	RR	Portable gaseous oxygen systems **(Do not bill with A4615 - A4620, E0434, E0441 - E0444, K0738**		
	E0434	RR	Portable gaseous oxygen systems **(Do not bill with A4615 - A4620, E0431, E0441 - E0444, E1392, K0738)**		
	E0439	RR	Portable gaseous oxygen systems **(Do not bill with A4615 - A4620, E0424, E0441 - E0444, E1390, E1392)**		

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
See Respiratory Care	E1390	RR	Portable gaseous oxygen systems **(Do not bill with A4615 - A4620, E0424, E0439, E0441 - E0444)**	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.
	E1392	RR	Portable gaseous oxygen systems **(Do not bill with A4615 - A4620, E0424, E0431, E0434, E0439, E0441 - E0444)**		
	K0738	RR	Portable gaseous oxygen systems **(Do not bill with A4615 - A4620, E0431, E0434, E0441 - E0444)**		
See Respiratory Care	E0570	NU	Nebulizer with compressor **(Do not bill with A4619, A4217, A7007, A7010, A7012, A7014, A7018, E0500)**	870000900	Use this EPA for clients who do **not** meet the clinical criteria (see **Coverage Criteria** in this Billing Guide), but who have a diagnosis of acute bronchiolitis, or acute bronchitis requiring the administration of nebulized medications.

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
STERILIZATION					
See Sterilization	58565		Hysteroscopy bi tube occlusion w/perm implants		Hysteroscopic Sterilization (ESSURE®) Only providers on the agency-approved hystereoscopic sterilization providers list may bill, and be paid for hysteroscopic sterilizations.
	A4264		Intratubal occlusion device		**Note: Code A4264 must be billed with 58565**
TRIBAL HEALTH PROGRAM					
See Tribal Health Program	T1015		Dental services, Client is AI/AN	870001305	Facilities must follow the agency's Washington Apple Health program-specific billing guide and do **all** of the following: • Bill a dental (837D/ADA) claim; • Bill with the appropriate billing taxonomy - 122300000X; • Add HCPCS code T1015 (the amount billed for HCPCS code T1015 is not relevant as it does not affect payment); and • Bill with an American Indian/Alaska Native (AI/AN) or non-native EPA number at document level (if the dental service requires further authorization, use the dental authorization number on the claim line for the service that requires further authorization).
See Tribal Health Program	T1015		Dental services, Client is non-native	870001306	
See Tribal Health Program **Place of Service** 05, 06, 07, 08 / **Provider Type** 01, 02, 03, 04, 05, 09, 10, 12	H0030		Alcohol and/or drug hotline	870001349	Either: (1) client has elective exemption from Medicaid Managed Care under 42 U.S.C.1396u-2 (e.g., client is AI/AN); or (2) client is a Clinical Family Member. Crisis Services, Day Support, Medication Monitoring, Peer Support, Stabilization services, Therapeutic psych-education
	H2011		Crisis interven svc, 15 min		
Provider Type 04, 05, 06, 09, 10, 12	H2012		Behav hlth day treat, per hr (Day Support)		
Provider Type 01, 02, 03, 04, 05, 06, 09, 10, 12	H0033		Oral med adm direct observe		
	H0034		Med trng & support per 15min (Meds Monitoring)		
Provider Type 06, 14	H0038		Self-help/peer svc per 15min		

Billing Guide Connection		Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
	Provider Type 01, 02, 03, 04, 05, 09, 10, 12	S9484		Crisis intervention per hour	870001349	Either: (1) client has elective exemption from Medicaid Managed Care under 42 U.S.C.1396u-2 (e.g., client is AI/AN); or (2) client is a Clinical Family Member. Crisis Services, Day Support, Medication Monitoring, Peer Support, Stabilization services, Therapeutic psych-education
	Provider Type 01, 02, 03, 04, 05, 06, 09, 10, 12	H0025		Alcohol and/or drug preventi		
		H2027		Psychoed svc, per 15 min		
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.
				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.
				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.
				Replacement due to headaches/ blurred vision/difficulty with school or work	870000624	Within one year of last dispensing, for refractive changes (provider error is the responsibility of the provider to warranty their work and replace the lens at no charge) when the provider documents all the following in the client's record: • The client has symptoms e.g., headaches, blurred vision, difficulty with school or work. • Copy of current prescription • Date of last dispensing, if known • Absence of a medical condition that is known to cause temporary visual acuity changes (e.g. diabetes, pregnancy) • A refractive change of at least .75 diopter or greater between the sphere or cylinder correction in at least one eye

Billing Guide Connection	Codes	Modifier	Description	EPA #	EPA Criteria *Expedited Prior Authorization Inventory*
			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
See Vision Hardware for Clients Age 20 and Younger **Also in** *Outpatient Hospital, and Physician-Related/Professional Services*	92134		Cptr ophth dx img post segment	870000051	Limited 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.