

Prior Authorization

[Refer to WAC 388-531-0200]

What is Prior Authorization (PA)?

The prior authorization (PA) process applies to covered services and is subject to client eligibility and program limitations. Bariatric surgery is an example of a covered service that requires PA. PA does not guarantee payment. HRSA reviews requests for payment for noncovered healthcare services according to WAC 388-501-0160 as an Exception to Rule. For Community Inpatient Psychiatric Inpatient authorization, see Section F of HRSA's [Inpatient Hospital Billing Instructions](#).

HRSA's PA requirements are met through the following authorization processes:

- Limitation extensions (LE);
- Written/fax; and
- Expedited prior authorization (EPA).

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

How does HRSA determine PA?

HRSA reviews PA requests in accordance with WAC 388-501-0165. HRSA utilizes evidence-based medicine to evaluate each request. HRSA considers and evaluates all available clinical information and credible evidence relevant to the client's condition. At the time of the request, the provider responsible for the client's diagnosis and/or treatment must submit credible evidence specifically related to the client's condition. Within 15 days of receiving the request from the client's provider, HRSA reviews all evidence submitted and will do one of the following:

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

Current Procedural Terminology[®] 2007 American Medical Association. All Rights Reserved.

(Rev. 06/30/2008)(Eff. 07/01/2008)

- I.1 -

Memo 08-45

**Prior Authorization
Changes are highlighted**

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

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

“Write or Fax” Prior Authorization (PA)

What is “write or fax” PA?

“Write or fax” PA is an authorization process available to providers when a procedure's EPA criteria have not been met or the covered procedure requires PA. Procedures that require PA are listed in the fee schedule. Procedures that are marked with a # sign are noncovered. HRSA does not retrospectively authorize any healthcare services that require PA after they have been provided except when a client has delayed certification of eligibility.

Forms available to request PA include:

- Basic Information Form DSHS 13-756
- Bariatric Surgery Request Form [DSHS 13-785]
- Out of State Medical Services Request Form [DSHS 13-787]
- PET Scan Information Form [DSHS 13-757]
- Oral Enteral Nutrition Worksheet Prior Authorization Request [DSHS 13-743]*
- TYSABRI (Natalizumab) J2323 Request (DSHS #13-832)
- Application for Chest Wall Oscillator (DSHS #13-841)

These forms are available at: <http://www1.dshs.wa.gov/msa/forms/eforms.html>

*See HRSA's Enteral Nutrition Program Billing Instructions for more information.

Be sure to complete all information requested. Requests that are incomplete will be returned to the provider.

Send one of the completed fax forms listed above to:

Health and Recovery Services Administration
Attn: Provider Request/Client Notification Unit
PO Box 45506
Olympia, WA 98504-5506
FAX: 360.586.1471

Limitation Extension (LE)

What is an LE?

LE is an authorization of services beyond the designated benefit limit allowed in Washington Administration Code (WAC) and HRSA's billing instructions.

Note: A request for a limitation extension must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

How do I request a LE authorization?

Some LE authorizations are obtained by using the EPA process. Refer to the EPA section pages I.6-I.11 for criteria. If the EPA process is not applicable, you must request an LE in writing and receive HRSA approval prior to providing the service.

The written request must state all of the following:

1. The name and PIC number of the client;
2. The provider's name, provider number and fax number;
3. Additional service(s) requested;
4. Copy of last prescription and date of last dispense;
5. The primary diagnosis code and CPT code; and
6. Client-specific clinical justification for additional services.

Complete one of the following forms for LEs:

- Basic Information Form (DSHS 13-756); or
- Physical, Occupational, and Speech Therapy Limitation Extension Request Form [DSHS 13-786]

Send or fax your written request for a limitation extension to:

Health and Recovery Services Administration
Provider Request/Client Notification Unit
PO Box 45506
Olympia, WA 98504-5506
FAX: 360.586.1471

Expedited Prior Authorization (EPA)

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

To bill HRSA for diagnostic conditions, procedures and services that meet the EPA criteria on the following pages, the provider must **create a 9-digit EPA number**. The first six digits of the EPA number must be **870000**. The last 3 digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria (see pages I.6-I.11 for codes). Enter the EPA number on the billing form in *the authorization number field*, or in the *Authorization or Comments* section when billing electronically.

Example: The 9-digit authorization number for a client with the following criteria would be **870000423**:

- Is 2-years old with prelingual hearing loss; and
- Has a diagnosis of profound sensorineural hearing loss;
- Has stimulable auditory nerves;
- Has cognitive ability to use auditory clues; and
- Willing to undergo an extensive rehabilitation program and is suitable for cochlear implantation with no contraindications for surgery.

870000 = first six digits of all expedited prior authorization numbers. **423**= last three digits of an EPA number indicating that the above criteria is met.

HRSA denies claims submitted without a required EPA number.

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

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

Note: HRSA requires written/fax PA when there is no option to create an EPA number.

Expedited Prior Authorization Guidelines

Documentation

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

Which services require EPA?

HRSA requires EPA for services noted in WAC, HRSA's billing instructions, and/or fee schedules as needing EPA.

You must complete the Oral Enteral Nutrition Worksheet Expedited Prior Authorization Request [DSHS 13-761] for clients who meet EPA criteria for oral enteral nutrition. The completed form must be kept in the client's chart and a copy sent to the pharmacy or medical vendor supplying the oral enteral nutrition product. This form is available at:

<http://www1.dshs.wa.gov/msa/forms/eforms.html>

If the client does not meet the EPA criteria, the Oral Enteral Nutrition Worksheet Expedited Prior Authorization Request form [DSHS 13-761] must be completed and sent to a pharmacy or medical vendor supplying the oral enteral nutrition product.

Washington State
Expedited Prior Authorization Criteria Coding List

Code	Criteria	Code	Criteria
<p>Cochlear Implants CPT: 69930 HCPCS: L8615-L8618, L8621-L8624 Dx.: 389.10-389.18</p>			
423	<p>When one of the following is true:</p> <p>1) Unilateral cochlear implantation for adults (age 18 and older) with post-lingual hearing loss and children (age 12 months-17 years) with prelingual hearing loss when all of the following are true:</p> <p>a) The client has a diagnosis of profound to severe bilateral, sensorineural hearing loss;</p> <p>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;</p> <p>c) The client has the cognitive ability to use auditory clues;</p> <p>d) The client is willing to undergo an extensive rehabilitation program;</p> <p>e) There is an accessible cochlear lumen that is structurally suitable for cochlear implantation;</p> <p>f) Client does not have lesions in the auditory nerve and/or acoustic areas of the central nervous system; and</p>		<p>g) There are no other contraindications to surgery.</p> <p>2) Replacement Parts for Cochlear Implants when all of the following are true:</p> <p>a) HRSA has purchased the implant(s);</p> <p>b) The manufacturer’s warranty has expired;</p> <p>c) The part is for immediate use, not a back-up part; and</p> <p>d) The part is not an external speech processor (these require written/fax authorization).</p>
			<p>Note: Effective for dates of service on and after January 1, 2006, HCPCS code L8619 requires PA.</p>
		<p>Dispensing/Fitting Fees for Glasses CPT: 92340-92342</p>	
615			<p>Glasses (both frames and lenses) – Due to loss or breakage for adults - within 2 years of last dispensing glasses may be replaced when glasses are broken or lost and all of the following are documented in the client’s record:</p> <p>1) Copy of current prescription (less than 18 months old); and</p> <p>2) Date of last dispensing; and</p> <p>3) Both frames and lenses are broken or lost.</p>
			<p>Note: You do not need an EPA # when billing for children or clients with developmental disabilities.</p>

Physician-Related Services

Code	Criteria	Code	Criteria
Dispensing/Fitting Fees for Frames Only			
CPT: 92340-92342			
618	<p>Replacement Frames –Due to loss or breakage: For adults - lost or broken frames may be replaced when all of the following are documented in the client’s record:</p> <ol style="list-style-type: none"> 1) No longer covered under the manufacturer’s 1 year warranty; and 2) Copy of current prescription demonstrating the medical necessity for prescription eye wear; (see pg. C.3) and 3) Documentation of broken or lost frames. 		<ol style="list-style-type: none"> 2) The client’s treatment is stabilized; and 3) The lens correction must have a 1.0 or greater diopter change between the sphere or cylinder correction in at least one eye; and 4) The previous and new refraction must be documented in the client record.
	<p>Note: You do not need an EPA # when billing for children or clients with developmental disabilities.</p>	623	<p>Replacement eyeglass lenses – Due to loss or breakage: For adults, lost or broken lenses may be replaced when all of the following are documented in the client’s record:</p> <ol style="list-style-type: none"> 1) Copy of current prescription (prescription is less than 18 months old); and 2) Date of last dispensing (if known); and 3) Documentation of lens damage or loss.
	<p>Note: You do not need an EPA # when billing for children or clients with developmental disabilities.</p>		<p>Note: You do not need an EPA # when billing for children or clients with developmental disabilities.</p>
619	<p>Durable Frames for adults and children - when the following is documented in the client’s record:</p> <ol style="list-style-type: none"> 1) The client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period. 	624	<p>Replacement eyeglass lenses – Due to headaches/blurred vision/difficulty with school or work: For adults and children - within 2 years 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 all of the following are documented in the client’s record:</p> <ol style="list-style-type: none"> 1) The client has symptoms e.g., headaches, blurred vision, difficulty with school or work; and 2) Copy of current prescription (prescription is less than 18 months old for adults); and 3) Date of last dispensing, if known; and 4) Absence of a medical condition that is known to cause temporary visual acuity changes (e.g. diabetes, pregnancy); and
620	<p>Flexible Frames for adults and children - when the following is documented in the client’s record:</p> <ol style="list-style-type: none"> 1) The client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period. 		
Dispensing/Fitting Fees for Lenses Only			
CPT: 92340 - 92342			
622	<p>Replacement eyeglass lenses - Due to eye surgery/effects of prescribed medication/diseases affecting vision: For adults and children - within 2 years of last dispensing when:</p> <ol style="list-style-type: none"> 1) The client has a stable visual condition (see Definition section); and 		

Physician-Related Services

Code	Criteria	Code	Criteria
5)	A refractive change of at least .75 diopter or greater between the sphere or cylinder correction in at least one eye.		
625	High index eyeglass lenses for adults and children when one of the following is documented in the client’s record: 1) A spherical refractive correction of +/- 8.0 diopters or greater; or 2) A cylinder correction of +/- 3.0 diopters or greater.		
Dispensing/Fitting Fees for Contacts			
CPT: 92070, 92310-92317			
621	Replacement Contact Lenses – Due to eye surgery/effects of prescribed medication/diseases affecting vision: For adults - within 1 year of last dispensing when: 1) The client has a stable visual condition (see Definition section); and 2) The client’s treatment is stabilized; and 3) The lens correction has a 1.0 or greater diopter change in at least one eye between the sphere or cylinder correction; and 4) The previous and new refraction are documented in the client record.		
	Note: You do not need an EPA # when billing for children or clients with developmental disabilities.		
627	Replacement Contact Lenses – Due to loss or breakage: For adults - once every 12 months when contact lenses are lost or damaged and the prescription is less than 18 months old. Note: You do not need an EPA # when billing for children or clients with developmental disabilities.		
	Note: You do not need an EPA # when billing for children or clients with developmental disabilities.		
		Hyperbaric Oxygen Therapy	
		CPT: 99183	
		425	When both of the following are true: 1) The diagnosis is 250.70-250.83; and 2) Hyperbaric Oxygen Therapy is being done in combination with conventional diabetic wound care.
		Meningococcal Vaccine	
		CPT: 90734 (Conjugate Vaccine – Menactra®)	
		421	Client is 11 years of age through 55 years of age and meets in one of the “at risk” groups because the client has one of the following: 1) Has terminal complement component deficiencies; 2) Has anatomic or functional asplenia; 3) Is a microbiologist who is routinely exposed to isolates of N. meningitidis; or 4) Is a freshman entering college who will live in a dormitory.
		CPT: 90733 (Polysaccharide vaccine – Menomune®)	
		424	Client meets at least 1 of the 5 criteria for use of the meningococcal vaccine outlined for EPA code 421 (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; or b) Older than 55 years of age. 2) The conjugate vaccine is not available.

Code	Criteria	Code	Criteria
------	----------	------	----------

Orthotics
HCPCS: L3030

780 Foot insert, removable, formed to patient foot.

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 facitis with pain; or
- 5) Pronation.

Note:

- 1) If the medical condition does not meet one of the above specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 800.292.8064.
- 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.

HCPCS: L3310 & L3320

781 Lift, elevation, heel & sole, per inch.

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.

HCPCS: L3334

782 Lift, elevation, heel, per inch

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) Lifts are not covered for less than one (1) inch.
- 2) Lifts are only allowed on one (1) pair of client shoes.
- 3) If the medical condition does not meet one of the above-specified criteria, you must obtain prior authorization by submitting a request in writing to DMM (see *Important Contacts*) or by calling the authorization toll-free number at 800.292.8064.
- 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.

HCPCS: L3000

784 Foot insert, removable, molded to patient model, "UCB" type, Berkeley Shell, each

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; or
- 3) For ankle stability as required due to an existing medical condition such as hypotonia, Cerebral Palsy, etc.

Code	Criteria	Code	Criteria
------	----------	------	----------

Note:

- 1) If the medical condition does not meet one of the above-specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 800.292.8064.
- 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.
- 3) If the client only medically requires one orthotic, right or left, prior authorization must be obtained.

HCPCS: L3215 or L3219

785 Orthopedic footwear, woman's or man's shoes, oxford.

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; or
- 4) To accommodate clubfoot.

Note:

HRSA does not allow orthopedic footwear for the following reasons:

- 1) To accommodate L3030 orthotics;
- 2) Bunions;
- 3) Hammer toes;
- 4) Size difference (mismatched shoes); or
- 5) Abnormal sized foot.

**Reduction Mammoplasties/
Mastectomy for Gynecomastia**

CPT: 19318, 19300

DX: 611.1 and 611.9 only

241 A female with a diagnosis for *hypertrophy of the breast* with:

- 1) Photographs in client's chart, *and*
- 2) Documented medical necessity including:
 - a) Back, neck, and/or shoulder pain for a minimum of one year, directly attributable to macromastia, *and*
 - b) Conservative treatment not effective; *and*
- 3) Abnormally large breasts in relation to body size with shoulder grooves, *and*
- 4) Within 20% of ideal body weight, *and*
- 5) Verification of minimum removal of 500 grams of tissue from each breast.

242 A male with a diagnosis for **gynecomastia**:

- 1) Pictures in clients' chart, *and*
- 2) Persistent tenderness and pain, *and*
- 3) If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than one year.

**Other Reduction Mammoplasties/
Mastectomy for Gynecomastia for a Male or
Female with Diagnosis of 611.1 Or 611.9**

CPT: 19300 and 19318

250 Reduction mammoplasty or mastectomy, not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.

Physician-Related Services

Code	Criteria	Code	Criteria
Blepharoplasties		Neuropsychological Testing	
CPT: 15822, 15823, and 67901-67908,		CPT: 96118 and 96119	
630	Blepharoplasty for noncosmetic reasons when <i>both</i> of the following are true: <ol style="list-style-type: none"> 1) The excess upper eyelid skin impairs the vision by blocking the superior visual field; 2) On a central visual field test, the vision is blocked to within 10 degrees of central fixation. 	1207	Refer to Section E for criteria.
Strabismus Surgery		Laboratory Testing	
CPT: 67311-67340		CPT: 83900, 83909, 88384, and 88385	
DX: 378.22		1209 Limited to 15 donor screenings when both of the following criteria is met: <ol style="list-style-type: none"> 1) The client is undergoing or has had a hematopoietic cell transplant; and 2) The transplant is being done at an HRSA-approved Center of Excellence. 	
631	Strabismus surgery for clients 18 years of age and older when <i>both</i> of the following are true: <ol style="list-style-type: none"> 1) The client has double vision (esotropia), ICD-9-CM diagnosis code 378.22; and 2) It is not done for cosmetic reasons. 		
Visual Exam/Refraction (Optometrists/Ophthalmologists only)			
CPT: 92014-92015			
610	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: <ol style="list-style-type: none"> 1) Glasses that are broken or lost or contacts that are lost or damaged; and 2) Last exam was at least 18 months ago. 		
<div style="border: 1px solid black; background-color: #e0f0ff; padding: 5px;"> <p>Note: You do not need an EPA # when billing for children or clients with developmental disabilities.</p> </div>			

HRSA-Approved Centers of Excellence (COE)

[Refer to WAC 388-531-0650]

The following services must be performed in an HRSA-approved Center of Excellence (COE) and **do not require prior authorization (PA)**. See the next page for a list of COEs.

- Organ/bone marrow/peripheral stem cell transplants. HRSA pays for organ procurement fees and donor searches. For donor searches, CPT codes 86812-86822 are limited to a maximum of 15 tests total for human leukocyte antigens (HLA) typing per client, per lifetime. HRSA requires PA for more than 15 tests. When billing for these donor services, you must bill using the recipient's PIC code. To bill for donor services, use the appropriate V59 series diagnosis code as the principal diagnosis code. For example, if you are billing a radiological exam on a potential donor for a kidney transplant, bill V59.4 for the kidney donor and use V70.8 as a secondary diagnosis-examination of a potential donor. Refer to WAC 388-531-1750, 388-550-1900, 388-550-2100, and 388-550-2200.

Note: Use of V70.8 as a principal diagnosis will cause the line to be denied.

Note: As required by federal law, organ transplants and services related to an organ transplant procedure are not covered under the AEM program.

- Inpatient Chronic Pain Management. Refer to 388-531-0700 and 388-550-2400; or
- Sleep studies (CPT codes 95805, 95807-95811). Refer to WAC 388-531-1500 and 388-550-6350.

Bariatric Surgery must be performed in an HRSA-approved hospital and **requires PA**.

Effective for dates of service on and after July 1, 2008, providers must bill with their approved COE facility provider number using the following billing guidelines:

- Electronic billers (837p) must put the COE approved facility provider number in the Comments field of the electronic claim.
- Paper billers must put the COE approved facility provider number in field 32 on the CMS-1500 claim form.

HRSA-Approved Organ Transplant Centers of Excellence (COE) [*Refer to WAC 388-531-1750 and WAC 388-550-1900 - WAC 388-550-2200]

APPROVED TRANSPLANT HOSPITALS	ORGAN(S)	CPT CODE
Children's Hospital & Regional Medical Center/Seattle	Bone Marrow (BMT) (autologous & allogenic)	38230, 38240-38242
	Peripheral Stem Cell Transplant (PSC-T)	38205-38206, 38240-38242
	Heart	33940, 33944, 33945
	Liver	47133, 47135-47136, 47140, 47141 or 47142, 47143-47147
	Kidney	50323, 50325, 50327, 50328, 50329, 50300, 50320 or 50547, 50360, 50365, 50380
	Small Bowel	44135 or 44136, 44715, 44720 and/or 44721, 44132 or 44133
Dorenbacher Children's Hospital/Portland NW Marrow Transplant Program (PSC-T only)	BMT	38230, 38240-38242
	PSC-T	38205-38206, 38240-38242
Good Samaritan Hospital Medical/Puyallup	PSC-T	38205-38206, 38240-38242
Inland NW Blood Center/Sacred Heart	PSC-T	38205-38206, 38240-38242
Legacy Good Samaritan Hospital and Medical Center/Portland (Northwest Marrow Transplant Program)	BMT	38230, 38240-38242
	PSC-T	38205-38206, 38240-38242
Mary Bridge Children's Hospital and Health Center/Tacoma	PSC-T (autologous only)	38206, 38241
Oregon Health Sciences University (OHSU) and Hospital/Portland	Heart	33945, 33944, 33940
	Liver	47135-47136, 47143-47147, 47140, 47141 or 47142
	Kidney	50323 or 50325, 50327-50239, 50300, 50320 or 50547, 50360, 50365, 50380
	Pancreas	48160, 48551, 48552, 48550, 48554
Providence Portland Medical Center/Portland	PSC-T (autologous only)	38206, 38241
Providence St. Peter Hospital/Olympia	PSC-T	38206, 38240-38242

Current Procedural Terminology® 2007 American Medical Association. All Rights Reserved.

(Rev. 06/30/2008)(Eff. 07/01/2008)

Physician-Related Services

APPROVED TRANSPLANT HOSPITALS	ORGAN(S)	CPT CODE
Sacred Heart Medical Center/Spokane	PSC-T	38205-38206, 38240-38242
	Kidney	50323 or 50325, 50327-50329, 50300, 50320 or 50547, 50360, 50365, 50380
	Heart	33945, 33944, 33940
	Heart/Lung(s)	33935, 33933, 33930
	Lung	32851-32854, 32855 or 32856, 32850
Seattle Cancer Care Alliance/Seattle	BMT	38230, 38240-38242
	PSC-T	38205-38206, 38240-38242
St. Joseph's Medical Center/Tacoma	BMT (autologous only)	38230, 38241
	PSC-T	38205-38206, 38240-38242
Swedish Medical Center/Seattle	Kidney	50360, 50365, 50380, 50323 or 50325, 50327, 50328, 50329, 50300, 50320 or 50547
	PSC-T	38205, 38206, 38240-38241
University of Washington Medical Center/Seattle	BMT	38230, 38240-38241
	PSC-T	38205, 38206, 38240-38241
	Heart	33945, 33944, 33940
	Heart/Lung(s)	33935, 33933, 33930
	Lung	32851-32854, 32855 or 32856, 32850
	Kidney	50360, 50365, 50380, 50323 or 50325, 50327-50329, 50300, 50320 or 50547
	Liver	47135 or 47136, 47143, 47144 or 47145, 47146, 47147, 47133, 47140, 47141 or 47142
	Pancreas	48160, 48554, 48551, 48552, 48550
Virginia Mason Medical Center/Seattle	Kidney	50360, 50365, 50380, 50323 or 50325, 50327, 50328, 50329, 50300, 50320 or 50547
	Pancreas	48160, 48554, 48551, 48552, 48550
	BMT	38230, 38240-38241
	PSC-T	38205, 38206, 38240-38241

Current Procedural Terminology® 2007 American Medical Association. All Rights Reserved.

(Rev. 06/30/2008)(Eff. 07/01/2008)

- I.14 -

Memo 08-45

Centers of Excellence
Changes are highlighted

HRSA-Approved Sleep Study Centers

[Refer to WAC 388-531-1500 and 388-550-6350]

HRSA Approved Sleep Centers	Location
ARMC Sleep Disorder Center	Auburn Regional Medical Center - Auburn, WA
Center for Sleep Medicine	Mid Columbia Medical Center - Dalles, OR
Forks Community Hospital	Forks, WA
Harrison Medical Center Sleep Disorders Center	Harrison Medical Center - Bremerton, WA
Highline Sleep Disorders Center	Highline Medical Center - Burien, WA
Holy Family Sleep Center	Holy Family Hospital -Spokane, WA
Kathryn S. Dement Sleep Disorders Center	St. Mary's Medical Center - Walla Walla, WA
KGH Columbia Sleep Lab	Kennewick, WA.
Lourdes Sleep Lab	Lourdes Health Network Pasco, WA
Multicare Sleep Disorders Center	Tacoma General Hospital/ or Mary Bridge Children's Hospital and Health Center- Tacoma, WA
North Olympic Sleep Center	Silverdale, WA
Olympic Medical Center—Sleep Center	Olympic Medical Center Port Angeles, WA
Peace Health	St. John's Medical Center Longview, WA
Providence Sleep Health Institute	Providence Everett Medical Center - Everett, WA.
Public Hospital District No. 2 of Snohomish Co.	Stevens Sleep Center Edmonds, WA
Richland Sleep Disorders Center	Richland, WA
Sleep Center at Valley Medical Center	Valley Medical Center Renton, WA
Sleep Center for Southwest Washington	Providence St. Peter - Olympia, WA
Sleep Disorder Clinic Legacy Good Samaritan Hospital and Medical Center	Legacy Good Samaritan Hospital and Medical Center - Portland, OR
Sleep Disorders Center Virginia Mason Medical Center	Virginia Mason Medical Center - Seattle, WA
Sleep Disorders Program Center	Children's Hospital and Regional Medical Center- Bellevue, WA

Current Procedural Terminology® 2007 American Medical Association. All Rights Reserved.

(Rev. 06/30/2008)(Eff. 07/01/2008)

- I.15 -

Memo 08-45

Sleep Study Centers
Changes are highlighted

Physician-Related Services

HRSA Approved Sleep Centers	Location
St. Anthony’s Sleep Disorders Center	Gig Harbor, WA
St. Clare Sleep Related Breathing Disorders Laboratory	St. Clare Hospital - Tacoma, WA
St. Frances Sleep Disorder Center	St. Frances Hospital – Federal Way, WA
St. Joseph Regional Medical Center Sleep Lab	St. Joseph Regional Medical Center - Lewiston, ID
The Sleep Institute of Spokane	Sacred Heart Medical Center or 104 W. 5 th Suite 400 W - Spokane, WA
Tri-State Memorial Hospital Sleep Diagnostic Services	Tri-State Memorial Hospital Inc. - Clarkston, WA
United General Hospital	United General Hospital – Sedro Wooley, WA
UW Medicine Sleep Disorders Center at Harborview	Harborview Medical Center - Seattle, WA
Vancouver Sleep Disorders Center	Vancouver Neurology - Vancouver, WA
Whidbey General Hospital Sleep Disorders Clinic	Oak Harbor

Providers must:

- Use CPT codes 95805 and 95807-95811 for sleep study services.
- Enter the approved HRSA sleep center’s provider number where the sleep study/polysomnogram or multiple sleep latency testing was performed. (Refer to previous page for appropriate location of HRSA-approved sleep center.) Enter the COE provider number in box 32 on the 1500 Claim Form. When billing electronically, note the COE provider number in the *Comments* section.
- Obtain an ENT consult for children younger than 10 years of age prior to study.
- Sleep studies are limited to rule out obstructive sleep apnea or narcolepsy.

The following is a list of approved diagnoses for sleep studies:

327.10	327.20	327.27	780.51
327.11	327.21	327.42	780.53
327.12	327.23	327.51	780.54
327.14	327.26	347.00-347.11	780.57

Note: When billing on a paper 1500 claim form, note the COE provider number in field 32. When billing electronically, note the COE provider number in the *Comments* section.

Sleep Center Physician Consultations and Referral for Cognitive Behavioral Therapy (CBT)

HRSA requires a sleep consultation with a physician who is Board Certified in Sleep Medicine at an HRSA-approved Sleep Center for any eligible client receiving more than six months of continuous nightly use of any of the following insomnia drugs:

- Generic Zolpidem, Ambien[®], Ambien CR[®]
- Sonata[®]
- Lunesta[®]
- Rozerem[®]

Continuous nightly use of the above insomnia drugs may be necessary for some clients, but it may not be appropriate for others. HRSA covers the following drugs without prior authorization within the following limits:

Drug	Limitations
Rozerem [®]	30 tablets/30 days for maximum of 90 days of continuous use
Generic Zolpidem, Ambien [®] , Ambien CR [®] , Sonata [®] , and Lunesta [®]	30 tablets/30 days for first fill, then 10 tablets/30 days

DSHS will send a letter to the prescribing provider and the client when a sleep consultation is required, and a referral for cognitive behavioral therapy (CBT) may be recommended.

HRSA-Approved Inpatient Pain Program

[WAC 388-531-0700 and 388-550-2400]

- HRSA covers inpatient chronic pain management services only when the services are obtained through a HRSA-approved chronic pain facility.
- A client qualifies for inpatient chronic pain management services when all of the following apply:
 - ✓ The client has had chronic pain for at least three consecutive months and has not improved with conservative treatment, including tests and therapies;
 - ✓ At least six months have passed since a previous surgical procedure was done in relation to the pain problem; and
 - ✓ Clients with active substance abuse must have completed a detoxification program, if appropriate, and must be free from drugs or alcohol for six months.
- For chronic pain management, HRSA limits coverage to only one inpatient hospital stay per a client's lifetime, up to a maximum of 21 days.
- HRSA pays for only the chronic pain management services and procedures that are listed in fee schedule.
- HRSA pays for inpatient pain services at the following facility:

DSHS-Approved Inpatient Pain Clinic
--

St. Joseph Hospital & Health Care Center, Tacoma
--

Note: HRSA encourages any providers with a structured inpatient pain program that would like to be included as a HRSA-approved facility to send their program criteria and credentials to:

Health and Recovery Services Administration
PO Box 45506
Olympia WA 98504-5506

HRSA-Approved Bariatric Hospitals and Their Associated Clinics [WAC 388-531-1600 and 388-550-2301]

HRSA Approved Bariatric Hospital and Associated Clinics	Location
University of Washington Medical Center, University of Washington Specialty Surgery Center	Seattle, WA
Oregon Health Science University, OHSU Surgery Center	Portland, OR
Sacred Heart Medical Center, Rockwood Bariatric Specialists	Spokane, WA

HRSA covers medically necessary bariatric surgery in an approved hospital with a bariatric surgery program in accordance with WAC 388-531-1600. Prior authorization is required. To begin the authorization process, providers should fax HRSA a completed “Bariatric Surgery Request form [DSHS # 13-785] to:

Health and Recovery Services Administration
 Attn: Medical Request Coordinator
 PO Box 45506
 Olympia, WA 98504-5506
 FAX: 360.586.1471

Clients enrolled in a managed care organization (MCO) are eligible for bariatric surgery under fee-for-service when prior authorized. Clients enrolled in an MCO who have had their surgery prior authorized by HRSA and who have complications following bariatric surgery are covered fee-for-service for these complications 365 days from the date of the HRSA-approved bariatric surgery. HRSA requires prior authorization (PA) for these services.

This page intentionally left blank.