



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
<b>Out of Area Coverage: Inpatient Within the U.S and U.S. Territories Only</b>	Covered	Covered	Not Covered
<b>Ambulance: Ground</b>	Not Covered	Not Covered	All transportation covered by the HCA. Effective 01/01/18
<b>Ambulance: Air</b>	Not Covered	Not Covered	All transportation covered by the HCA. Effective 01/01/18
<b>Transplants: Organ Donation, Tissue Donation &amp; work-up related to Transplants (Excludes Corneal)</b>	<ul style="list-style-type: none"> <li>•Refer to PA list: <a href="http://www.chpw.org/for-providers/prior-authorization-and-medical-review/">http://www.chpw.org/for-providers/prior-authorization-and-medical-review/</a></li> <li>•Corneal Transplants do not require prior authorization</li> </ul>	<ul style="list-style-type: none"> <li>•Refer to PA list: <a href="http://www.chpw.org/for-providers/prior-authorization-and-medical-review/">http://www.chpw.org/for-providers/prior-authorization-and-medical-review/</a></li> <li>•Corneal Transplants do not require prior authorization</li> </ul>	Not Covered
<b>Prescriptions , Pharmacy, Drugs</b>	Please visit CHPW's searchable formulary ( <a href="http://chpw.org/for-members/pharmacy/apple-health-formulary">http://chpw.org/for-members/pharmacy/apple-health-formulary</a> ) to look up current formulary status of medications	Please visit CHPW's searchable formulary ( <a href="http://chpw.org/for-members/pharmacy/apple-health-formulary">http://chpw.org/for-members/pharmacy/apple-health-formulary</a> ) to look up current formulary status of medications	See Prescriptions, Pharmacy, Covered by HCA only and EXCLUDED (Not Covered by HCA or CHPW) in this grid.
<b>Medical Injectable Drugs, injections</b>	Covered	Covered	See Prescriptions, Pharmacy, Covered by HCA only and EXCLUDED (Not Covered by HCA or CHPW) in this grid.



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<b>Prescriptions, Pharmacy: Medication Assisted Therapy, MAT</b>	Covered	Covered	Not Covered
<b>Prescriptions, Pharmacy COVERED BY HCA ONLY (includes the generic equivalents)</b>	Covered by HCA Only: Please refer to Procedure Tool on CHPW.org - <a href="https://forms.chpw.org/pclt">https://forms.chpw.org/pclt</a>	Covered by HCA Only: Please refer to Procedure Tool on CHPW.org - <a href="https://forms.chpw.org/pclt">https://forms.chpw.org/pclt</a>	Covered by HCA Only



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<b>Prescriptions, pharmacy:</b> <b>EXCLUDED (Not Covered CHPW or HCA):</b> <ul style="list-style-type: none"><li>• Alternative Medicines</li><li>• Herbal medicines</li><li>• Homeopathy</li></ul> <b>For Treatment of:</b> <ul style="list-style-type: none"><li>• Impotence</li><li>• Infertility</li><li>• Sexual Dysfunction</li><li>• Weight loss</li></ul>	NOT Covered by HCA or CHPW: Please refer to Procedure Tool on CHPW.org - <a href="https://forms.chpw.org/pclt">https://forms.chpw.org/pclt</a>	NOT Covered by HCA or CHPW: Please refer to Procedure Tool on CHPW.org - <a href="https://forms.chpw.org/pclt">https://forms.chpw.org/pclt</a>	NOT Covered by HCA or CHPW : Please refer to Procedure Tool on CHPW.org - <a href="https://forms.chpw.org/pclt">https://forms.chpw.org/pclt</a>
Vaccinations, Shots, immunizations, flu	Covered	Covered	Not Covered
Allergy Testing/Serum	Covered	Covered	Not Covered
Surgeries,surgery:	Covered	Covered	Not Covered
Mammogram: Screening	Covered	Covered	Not Covered
Injections: B12 Injections	Covered	Covered	Not Covered



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Vocational Rehabilitation	Not Covered	Not Covered	Not Covered
Wound Care: Outpatient	Covered	Covered	No, Not Covered



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<b>Rehabilitation: Outpatient Physical Therapy, PT</b>	<ul style="list-style-type: none"> <li>• Age 21 and older, the evaluation and reevaluation is limited to 1 per member, per calendar year, not included in 12 visit limit</li> <li>• 12 Visits PT limit per calendar year.</li> <li>• PA is required after 12 visits per calendar year for additional PT services.</li> <li>• PA required for all services performed <b>by a Home Health Agency</b>.</li> </ul>	<ul style="list-style-type: none"> <li>• Age 20 and younger, evaluation and reevaluations are not limited and are not included in the visit limit.</li> <li>• PA required for all services performed <b>by a Home Health Agency</b>.</li> <li>• Age 20 and younger, PA is required after 12 visits per calendar year for additional PT services. - EXCEPTION: This requirement is waived when services are performed in a Neurodevelopment Center of Excellence.</li> <li>• PA is required for any Optometrist performing physical therapy (Orthoptic, Pliooptic Therapy). EXCEPTION: This requirement is waived when services are performed in a Neurodevelopmental Center of Excellence.</li> </ul>	Not Covered



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
<b>Screening, Brief Intervention, Referral and Treatment (SBIRT)</b> <b>IMC also has Mental Health: Brief Intervention Treatment and Substance Use Disorder: Brief Intervention.</b>	Covered, when client is age 18 or older	Not covered for members younger than 17 years of age	Not Covered
Genetic Counseling	Covered.	Covered.	Provider must bill the HCA directly for prenatal genetic counseling provided for MCO clients. HCA Criteria must be met.
Genetic Testing: Non-Prenatal	Covered	Covered	Not Covered
Genetic Testing: Prenatal	Covered	Covered	Not Covered
Allergy Injections	Covered	Covered	Not Covered
Allergy Office Visit	Covered	Covered	Not Covered
Biofeedback Therapy	Covered	Covered	Not Covered
Homeopathy	Not Covered	Not Covered	Not Covered
Hypnotherapy	Not Covered	Not Covered	Not Covered
Naturopathic Physicians (Naturopathy)	Covered	Covered	Not Covered
Osteopathic Manipulative Therapy	Covered	Covered	Not Covered
Ambulance: Facility-To- Facility	Not Covered	Not Covered	All transportation covered by the HCA. Effective 01/01/18



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
Attention Deficit, ADD, ADHD	Covered See Applied Behavior Health Services, ABA	Covered See Applied Behavior Health Services, ABA	Not Covered
Birth Defects And Congenital Anomalies: Office Visits	Covered	Covered	No Covered
Birth Defects And Congenital Anomalies: Surgical Treatment	Covered	Covered	Not Covered
DME: Breast Pumps (Manual)	Covered	Covered	Not Covered
DME: Breast Pumps (Electric)	Covered	Covered	Not Covered
Maternity Support Services	Not Covered	Not Covered	Part of the First Steps Program. Call 1-800-322-2588.
Blood/Blood Component	Covered	Covered	Not Covered
Cardiac Rehabilitation	Covered	Covered	Not Covered
Circumcision: Routine	Not Covered	<ul style="list-style-type: none"> <li>• Effective 02/01/2021</li> <li>• Covered for children under age 18.</li> <li>• Once per lifetime \$200.00 maximum benefit for each child</li> <li>• Provider does not have to be contracted with CHPW; they just need to be willing to bill CHPW and must have a Core Provider Agreement with the Health Care Authority</li> <li>• See CHPW Circumcision Billing Guide for more information.</li> </ul>	Not Covered



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Osteopathic Manipulative Therapy	Covered	Covered	Not Covered
Hearing Aid: Surgically-implanted hearing assistance devices (Cochlear, BAHA)	Adults ages 21 and older, effective 01/01/2024. New and replacement Cochlear implants are now covered.  PA is required.  Replacement parts including batteries are covered.	Children Covered Age 20 & Younger (no changes for 01/01/24)  New and replacement implants are covered. PA is required.  Replacement parts including batteries are covered.	No, Not Covered
Complications from Non-Covered Service	See requirements	See requirements	Not Covered
Cosmetic Services	Not covered	Not Covered	Not Covered
Court Ordered Services	See Mental Health and Substance Use Disorder services	See Mental Health and Substance Use Disorder services	See Mental Health and Substance Use Disorder services
Court Ordered Transportation Services, including ambulance services	Not Covered	Not Covered	All transportation/ambulance covered by the HCA. Effective 01/01/18
Custodial/Convalescent Care	Not Covered	Not Covered	Contact ALTSA (Aging and Long Term Support Administration) <a href="https://www.dshs.wa.gov/altsa">https://www.dshs.wa.gov/altsa</a>



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Dental: Anesthesia for Dental Services In Hospital	<ul style="list-style-type: none"> <li>• CHPW covers the <u>related facility charges</u> for dental services performed under anesthesia.</li> </ul>	<ul style="list-style-type: none"> <li>• CHPW covers the <u>related facility charges</u> for dental services performed under anesthesia.</li> </ul>	<ul style="list-style-type: none"> <li>• HCA covers professional charges for dental care/services provided by a dentist or an oral surgeon</li> </ul> <p><b>EXCEPTION:</b></p> <ul style="list-style-type: none"> <li>• CHPW covers one pre-operative (E/M) visit by the PCP prior to dental services under anesthesia to provide medical clearance.</li> </ul>
Dental: Accidental Services	Covered	Covered	<p>Dental care/services provided by a dentist or an oral surgeon related to emergency, is covered by the HCA.</p> <p>CHPW covers the related facility charges.</p>
Dental: Routine Services	<ul style="list-style-type: none"> <li>• CHPW covers the <u>related facility charges</u> for dental services performed under anesthesia.</li> </ul>	<ul style="list-style-type: none"> <li>• CHPW covers the <u>related facility charges</u> for dental services performed under anesthesia.</li> </ul>	<ul style="list-style-type: none"> <li>• HCA covers professional charges for dental care/services provided by a dentist or an oral surgeon</li> </ul> <p><b>EXCEPTION:</b></p> <ul style="list-style-type: none"> <li>• CHPW covers one pre-operative (E/M) visit by the PCP prior to dental services under anesthesia to provide medical clearance.</li> </ul>



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Dental: Medically Necessary Services	Covered	Covered	Dental care/ <u>services provided by a dentist or an oral surgeon</u> , is covered by the HCA. CHPW covers the related facility charges, when medically necessary.
Developmental Disabilities (see Applied Behavioral Health Services, ABA)	See Applied Behavior Health Services, ABA	See Applied Behavior Health Services, ABA	Not Covered
Dialysis (hemodialysis, peritoneal, renal (kidney failure)	Covered	Covered	Not Covered
DME: Apnea Monitor	Not Covered	Covered	Not Covered
DME: Bra, Bras, Post Surgical	Covered	Covered	Not Covered
DME: Communication Devices	Covered.	Covered.	Not Covered
DME: C-pap/Bi-Pap 3 month rental, auto-Titration	Covered.	Covered.	Not Covered
DME: C-pap/Bi-pap Purchase	Covered.	Covered.	Not Covered
DME, Pharmacy: Diabetic Supplies	Covered	Covered	Not Covered



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DME: Incontinent Supplies (briefs, pull-ups, Liners)	<p><b>Covered, adult 20 years of age and older:</b></p> <ul style="list-style-type: none"> <li>• Disposable briefs and pull-up pants (any size) are limited to 150 per month.</li> <li>• Disposable pant liners, shields, guards, pads, and undergarments are limited to 200 per month.</li> </ul>	<p><b>Covered, child age 3 to 20 years of age:</b></p> <ul style="list-style-type: none"> <li>• Disposable briefs and pull-up pants (any size) are limited to: 200 per month.</li> <li>• Disposable pant liners, shields, guards, pads, and undergarments are limited to 200 per month.</li> </ul>	Not Covered
DME: Enteral Therapy Formula	Covered	Covered	Not Covered
DME: Enteral Therapy Pump (Infusion Services)	Covered	Covered	Not Covered
DME: Fracture Frames	Covered	Covered	Not Covered
DME: Hospital Bed	Covered	Covered	Not Covered
DME: Humidifiers	Covered	Covered	Not Covered
DME: Insulin Pump (Infusion Services)	Covered	Covered	Not Covered
DME: Lymphedema Sleeve	Covered	Covered	Not Covered
DME: Nebulizer	Covered	Covered	Not Covered
DME: Oseogen (Bone Growth Stimulator)	Covered	Covered	Not Covered
DME: Oxygen & Related Equipment	Covered	Covered	Not Covered
DME: Prenatal Therapy and Supplies	Covered	Covered	Not Covered
DME: Patient Lifts	Covered.	Covered.	Not Covered



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DME: Suction Pumps	Covered	Covered	Not Covered
DME: Chest Compression Devices	Covered	Covered	Not Covered
DME: Cough Stimulating Devices	Covered	Covered	Not Covered
DME: Wound Vac	Covered	Covered	Not Covered
Medical Nutrition Therapy	Covered	Covered	Not Covered
DME: TENS Unit (Covered under Medicare only)	Not Covered	Not Covered	Not Covered
DME: Trapeze Bars	Covered	Covered	Not Covered
DME: Ventilators And Related Equipment	Covered	Covered	Not Covered
DME: Wheelchairs, Scooters	Covered	Covered	Not Covered
Emergency Room Services	Covered	Covered	Not Covered
Experimental / Investigational Services and Drugs	Refer to PA list	Refer to PA list	Not Covered
Prosthetics, Eye Ball Polishing	Covered	Covered	Not Covered



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Vision:Eye Exam, fitting fees, refractions, visual fields (Routine)	<p><b>Effective 01/01/2023</b></p> <p><b>Age 21 and older:</b></p> <ul style="list-style-type: none"> <li>•Members must obtain routine eye exams from a provider in the VSP Network. Out of Network providers not covered.</li> <li>• Limit one eye exam every 24 months</li> </ul>	<p><b>Age 20 and younger:</b></p> <ul style="list-style-type: none"> <li>•Limit - One eye exam every year.</li> <li>•Members may self refer to contracted providers for routine eye exams</li> <li>•Effective 07/01/21 Contact fitting fees for children are covered in addition to the current eyeglasses fitting fees.</li> <li>•Submit routine vision exams to CHPW, not VSP for children</li> </ul>	<b>Not Covered</b>
Vision: Eye Exam, Medical Condition (diagnose and treat)	<b>Covered</b>	<b>Covered</b>	<b>Not Covered</b>



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<b>Vision: Eyeglasses and eyeglasses adjustments and repair. (Hardware)</b>	<p><b>Age 21 and older:</b> <b>Effective 01/01/23</b></p> <ul style="list-style-type: none"> <li>• Members must obtain eyeglasses from a provider in the VSP Network. Out of Network providers not covered.</li> <li>• One (1) pair of glasses every 24 months for adults aged 21 and older.</li> <li>• Frames must be from the Genesis Collection</li> <li>• Basic lenses single vision, lined bifocal, and lined trifocal are covered.</li> <li>• Other options, tinting, etc. are not covered but available if member wants to pay the cost share.</li> <li>• Contacts are not covered.</li> <li>• Repair of glasses or replacement of lost or stolen glasses is not covered.</li> </ul>	<p><b>Children Age 20 and under:</b></p> <ul style="list-style-type: none"> <li>• Initial eyeglasses for children are not covered by CHPW. Vision Hardware only available through Correctional Industries (CI) Optical. Orders for eyeglasses are submitted by the optical provider to CI Optical.</li> <li>• Effective 07/01/21 Repair and adjustments of eyeglasses (spectacles) for children is not covered by CHPW.</li> </ul>	<p><b>Effective 07/01/21 Repair and adjustment of spectacles for children is covered by Fee for Service (HCA).</b></p>



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Pharmacy, Family Planning: Birth Control, Contraception Emergency and Over The Counter (OTC)	Covered	Covered	Not Covered
Pharmacy, Family Planning: Birth Control, Contraception, Implants, Injections, IUD	Covered	Covered	Member may self-refer to CHPW contracted women's health care providers. If provider is not in network, then services are covered for HCA contracted providers by Fee-for-Service.
Maternity Services, Home Delivery: Outpatient	Covered	Covered	Member may self-refer to CHPW contracted women's health care providers. If provider is not in network without a Plan Referral, then services are covered for HCA contracted providers by Fee-for-Service.
Maternity Services: Inpatient	Covered	Covered	Not Covered
Family Planning: Outpatient (includes observations) preventive, pap tests, mammograms	Covered	Covered	Member may self-refer to CHPW contracted women's health care providers. If provider is not in network, then services are covered for HCA contracted providers by Fee-for-Service.



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Family Planning: Office Visits	Covered	Covered.	Member may self-refer to CHPW contracted women's health care providers. If provider is not in network, then services are covered for HCA contracted providers by Fee-for-Service.
Family Planning, Maternity: Home Delivery	Covered. Parent must fill out the CHP newborn selection form within 60 days of child's birth to ensure child eligibility.	Covered. Parent must fill out the CHP newborn selection form within 60 days of child's birth to ensure child eligibility.	Member may self-refer to CHPW contracted women's health care providers. If provider is not in network without a Plan Referral, then services are covered for HCA contracted providers by Fee-for-Service.
Family Planning, Maternity: Newborn Care	Covered, However parent must fill out the HP newborn selection form within 60 days of child's birth to ensure child eligibility	Covered, However parent must fill out the HP newborn selection form within 60 days of child's birth to ensure child eligibility	Not Covered
Family Planning: Sterilization for Women(includes tubal ligation)	Covered, must be older than 21 years of age and sign a consent form and wait 30 days after signature. (30 day requirement may be waived in cases of premature delivery or emergency abdominal surgery.)	No, Not Covered	Yes, for member less than 21 years old and those who do not Meet other federal requirements. They must sign a consent form and wait 30 days.
Forensic Exam	Not Covered	Not Covered	Not Covered



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Health Education And Wellness Programs: Asthma Education	Covered	Covered	Not Covered
Health Education And Wellness Programs: Diabetic Education	Covered	Covered	Not Covered
Health Education And Wellness Programs: Nutritional Counseling	Not Covered	Covered	Not Covered
Hearing aids: Non-surgical, hearing hardware	Covered for one or both ears depending on medical necessity. Includes ear mold. Rental of hearing aid (s) for up to 2 months is covered while a client's own hearing aid (s) is being repaired.	Covered	Not Covered
Hearing Exams (audiology)	Covered	Covered	Not Covered
HIV/Aids- Screening	Covered	Covered	Not Covered
Out of Area Coverage: Routine, Preventive Care	Not Covered	Not Covered	Not Covered
Home Health Agency, Home Health Care	Covered	Covered	Not Covered
Home Infusion Therapy	Covered	Covered	Not Covered
Home intrauterine Activity Monitoring (Fetal heart Monitor)	Not Covered	Not Covered	Not Covered
Home Phototherapy Hyperbilirubinemia	Covered	Covered	Not Covered
Hospice Care, Home	Covered	Covered	Not Covered



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Hospital Care: Inpatient Hospice	Covered	Covered	Not Covered
Hospital Care: Inpatient	Covered	Covered	Not Covered
Hospital Care: Outpatient Surgery	Covered	Covered	Not Covered
HPV (Human papilloma Virus) Test	Covered CDC recommendations: Catch-up Vaccine through 26 years of age	Covered CDC recommendations: Adult 27 through 45 years of age	Not Covered
Hyperbaric Oxygen Pressurization	Covered	Covered	Not Covered
Vaccinations, immunizations: meningococcal vaccine	Covered	Covered	Not Covered
Incarcerated Care	Not Covered. Effective 07/01/2017	Not Covered. Effective 07/01/2017.	Covered by Health Care Authority
Infertility, Impotence and Sexual Dysfunction	Not Covered	Not Covered	Not Covered
Interpreter Services: Medical Services (not Mental Health)			For medical encounters and HCA Fair Hearings, refer to the HCA. Interpreter services only covered for administrative issues such as handling member complaints and appeals. Interpreter must be certified with the HCA.
IV Therapy: Outpatient	Covered	Covered	Not Covered
IV Therapy: Home	Covered	Covered	Not Covered



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Learning Disabilities	Not Covered	See Applied Behavior Health Services, ABA	Not Covered
Lymphedema Treatment	Covered	Covered	Not Covered
Mammogram: Diagnostic	Covered	Covered	Not Covered
Manipulation of Spine & Extremities	See osteopathic manipulation and alternative care.	See osteopathic manipulation and alternative care.	See osteopathic manipulation and alternative care.
Mental Health: Inpatient Acute Care Facility Psychiatric Admission (Behavioral Health Unit or Free Standing Hospital)	Covered	Covered	Not Covered
Mental Health: Inpatient Acute Care Professional Services, Counseling, Therapy Services, Individual, Group	Covered. Effective 01/01/2017	Covered. Effective 01/01/2017	Not Covered
Vaccinations, immunizations: Shingles (Herpes Zoster)	ZOSTAVAX - 90736: 60 years of age and older SHINGRIX - 90750: 50 years of age and older	No	Not Covered
Unlisted Codes with Charge more than \$250.00	Covered	Covered	Not Covered
Mental Health: Outpatient Treatment	See specific Mental Health Service.	See specific Mental Health Service.	See specific Mental Health Service.
Methadone Treatment	See Opiate Substitution Treatment Services	See Opiate Substitution Treatment Services	See Opiate Substitution Treatment Services



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Neurodevelopment Therapy	No.	Covered.	Not Covered
Mental Health: Neuropsychological Testing, Also see Psychological Assessment	Covered	Covered	Not Covered
Obesity Services, Weight Reduction and Control Services	Not Covered	Not Covered	Not Covered
Occupational Injuries	Not Covered	Not Covered	Not Covered
Office Visit	Covered	Covered	Not Covered
Orthoptic, Pleoptic Therapy, eye exercises, eye training	Covered	Covered	Not Covered
Out of Area Coverage: Urgent Care Within the U.S and U.S. Territories Only	Covered	Covered	Not Covered
Out Of Area Coverage: Emergency Room, ER Within the U.S and U.S. Territories Only	Covered	Covered	Not Covered
Outpatient Diagnostic and Therapeutic Radiology, Xray, Image	Covered	Covered	Not Covered
Outpatient Diagnostic: Laboratory Services	Covered	Covered	Not Covered



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<b>Outpatient Therapeutic and Diagnostic Radiology Service, Xray, Image</b>	Covered.	Covered.	Not Covered
<b>Pain Clinic: Office Visits</b>	Covered.	Covered.	Not Covered
<b>Pain Clinic: Outpatient Rehabilitation</b>	Covered.	Covered.	Not Covered
<b>Pain Clinic: Treatment (e.g. nerve block, epidural)</b>	Covered.	Covered.	Not Covered
<b>Pain Management</b>	Covered.	Covered.	Not Covered
<b>Hospice Care: Palliative Care</b>	Covered.	Covered.	Not Covered
<b>Pathology Services</b>	Covered	Covered	Not Covered
<b>Physical Exams, Preventive Care, Sports Physicals for ages 6 through 18.</b>	Covered	Covered	Not Covered
<b>PKU (Phenylketonuria) Formula</b>	Covered	Covered	Not Covered
<b>Podiatry (including diabetic foot care)</b>	Age 21 and older	Not Covered	Not Covered
<b>Prescriptions, Pharmacy: Inpatient Drugs</b>	Covered	Covered	Not Covered
<b>DME: Durable Medical Equipment</b>	Covered	Covered	Not Covered
<b>Out of Area: Prescriptions, Pharmacy, Drugs</b>	See requirements	See requirements	Not Covered
<b>Prescriptions, Pharmacy: Outpatient Drugs</b>	Covered	Covered	Not Covered



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Prescriptions, Pharmacy: Mail Order Prescriptions	Not Covered	Not Covered	Not Covered
Prescriptions, Pharmacy: Take Home Drugs	Covered	Covered	Not Covered
Preventive Care, well-child checks, screening colonoscopies, Pap tests, mammograms, bone density testing, Early and periodic screening with diagnosis and treatment (EPSDT)	Covered	Covered	Not Covered
DME: Prosthetics and Orthotics (Prostheses)	Covered	Covered	Not Covered
Pulmonary Rehabilitation	Covered	Covered	Not Covered
Radiation & Chemotherapy	Covered	Covered	Not Covered
Radiation & Chemotherapy: Oral Chemotherapy	Covered	Covered	Not Covered
Radiation & chemotherapy: Injectable And Infused Chemotherapy	Covered	Covered	Not Covered
Rehabilitation: Inpatient	Covered	Covered	Not Covered



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<b>Rehabilitation: Outpatient Occupational Therapy, OT</b>	<ul style="list-style-type: none"> <li>• Age 21 and older, evaluation and reevaluation is limited to 1 per member, per calendar year, not included in 12 visit limit</li> <li>• 12 visit OT limit per calendar year</li> <li>• PA is required for any Optometrist performing occupational therapy (Orthoptic, Pleoptic Therapy).</li> <li>• PA is required after 12 visits per calendar year for additional OT services.</li> <li>• PA required for age 21 and over, for all services <b>performed by a Home Health Agency.</b></li> </ul>	<ul style="list-style-type: none"> <li>• Age 20 and younger, evaluation and reevaluations are not limited and are not included in the visit limit.</li> <li>• PA required for all services performed <b>by a Home Health Agency.</b></li> <li>• Age 20 and younger, PA is required after 12 visits per calendar year for additional OT services. - EXCEPTION: This requirement is waived when services are performed in a Neurodevelopment Center of Excellence.</li> <li>• PA is required for any Optometrist performing occupational therapy (Orthoptic, Pleoptic Therapy). EXCEPTION: This requirement is waived when services are performed in a Neurodevelopmental Center of Excellence.</li> </ul>	Not Covered



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
Rehabilitation: Outpatient Speech Therapy, ST	<ul style="list-style-type: none"> <li>Age 21 and older, evaluation and reevaluation is limited to 1 per member, per calendar year, not included in 12 visit limit.</li> <li>12 visit ST limit per calendar year.</li> <li>PA required for age 21 and over, after 12 Visits ST per calendar year</li> <li>PA required for age 21 and over, for all services <a href="#">performed by a Home Health Agency</a>.</li> </ul>	<p>Effective 01/01/16 for age 20 and under. No unit or hour limit.</p> <p>PA required for all services performed <a href="#">by a Home Health Agency</a>.</p>	Not Covered
Respite Care: Hospice		Covered	Yes
Reversal of Sterilization	Not Covered	Not Covered	Not Covered
Saliva Testing	Not Covered	Not Covered	Not Covered
School Nurse Services	Not Covered	Not Covered	Only for special education students with individual/family special education plan (IFSP). School bills fee-for-service.
Screening Exams: (preventive) Colorectal (colonoscopy)	Covered	Covered	Not Covered
Screening Exams: (preventive)	Covered	Covered	Not Covered



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
Sexual Reassignment Surgery, Transgender Surgery, Transsexual Surgery	Not covered	Not Covered	May be covered by HCA
Skilled Nursing Facility, Inpatient, SNF	Covered	Covered	If care is no longer medically necessary and changes to custodial care, fax form to DSHS: <ul style="list-style-type: none"> <li>• Notice of Action – Adult Residential Services Form</li> <li>• FAX to DSHS at 855-635-8305.</li> </ul> Must include the date the client's status changed. <ul style="list-style-type: none"> <li>• Link to form:  <a href="https://www.dshs.wa.gov/fsa/forms">https://www.dshs.wa.gov/fsa/forms</a></li> </ul>
Sleep Study	Covered	Covered.	Not Covered
Smoking, Tobacco, Nicotine Cessation: Services	Covered, Ages 18 and older are covered through Alere Quit-for-Life smoking cessation program. For questions, please call 1-866-784-8454.	Not covered for members younger than 18.	Not Covered
Smoking, Tobacco, Nicotine Cessation: Pharmacy, Prescription, Drugs, Nicotine Replacement	Covered	Covered	Not Covered
Substance Abuse (See Substance Use Disorder)	See Substance Use Disorder	See Substance Use Disorder	See Substance Use Disorder



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
<b>Surgeries, Surgery: Abortion, Spontaneous (miscarriage)</b>	Covered	Covered	Not Covered
<b>Surgeries, surgery: Abortion, Elective termination of pregnancy.</b>	Not covered by Managed Care (MCO)	Not covered by Managed Care (MCO)	Please contact the HCA, Fee for Service for elective termination of pregnancy services.
<b>Surgeries: Ambulatory Surgery (outpatient or same day surgery)</b>	Covered.	Covered.	Not Covered
<b>Surgeries: Bariatric Surgery/ Weight Loss Procedures</b>	Covered	Covered	Not Covered
<b>Surgeries,surgery: Mammoplasty</b>	Covered	Covered	Not Covered
<b>Surgeries: Breast Reduction Surgery (Mammoplasty)</b>	Covered	Covered	Not Covered
<b>Surgeries: Cosmetic or Plastic Surgery. Including tattoo removal, face lifts, ear or body</b>	Not Covered	Not Covered	Not Covered
<b>Surgeries: Eye Surgery (Lasik®)(for vision improvement)</b>	Not Covered	Not Covered	Not Covered
<b>Surgeries: Eye Surgery (laser) (for a medical condition)</b>	Covered	Covered	Not Covered
<b>Surgeries,surgery: Mastectomy</b>	Covered	Covered	Not Covered
<b>Surgeries: Reconstructive, Plastic Surgery and Supplies</b>	Covered	Covered	Not Covered



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
<b>Surgeries,surgery: Skin Tag Removal</b>	Covered	Covered	Not Covered
<b>Surgeries,surgery: Tonsillectomy and Adenolectomy</b>	Covered	Covered	No, Not Covered
<b>Surgeries,surgery: UPP (Uvulopalatopharyngoplasty)</b>	Covered	Covered	No, Not Covered
<b>Surgeries,surgery: Vasectomy</b>	See requirements	Not Covered For members 20 and younger.	Refer to HCA if less than 21 years old and those who do not meet other federal requirements.
<b>Temporomandibular Joint (TMJ) &amp; Myofacial Pain</b>	Covered	Covered	Dental care/services provided by a dentist or an oral surgeon, is covered by the HCA. CHPW covers the related facility charges, when medically necessary.
<b>Transplants: Corneal Transplant</b>	Covered	Covered	Not Covered



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
Habilitative Services	<p><b>Ages 21 and older:</b>            Separate reimbursement for Evaluation and re-evaluation. Not included in 6 hour limit.</p> <ul style="list-style-type: none"> <li>• 6 Hours Occupational Therapy</li> <li>• 6 Hours Physical Therapy</li> <li>• 6 Visits Speech Therapy (Untimed)</li> <li>•PA required for ages 21 and older for more than 6 hours of any therapy service.</li> </ul>	<p><b>Ages 20 and younger, unlimited habilitative services.</b></p>	<b>Not Covered</b>
Transplants: Organ Donation, Tissue Donation, evaluation & work-up related to Transplants (Excludes Corneal)	Covered	Covered	Not Covered
Transplants: Transplant Donor Search	Covered	Covered	Not Covered
Transportation (from and to office visits) home to office or from PCP to specialist.	Not Covered, effective 01/01/18	Not Covered, effective 01/01/18	All transportation/ambulance covered by the HCA. Effective 01/01/18
Urgent Care	Covered	Covered	Not Covered
Prescriptions, Pharmacy: Vitamins	Covered	Covered	Not Covered
Inpatient (All Planned Admissions)	Covered	Covered	Not Covered
Clinical Trials	Covered	Covered	Not Covered



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
<b>Mental Health: Outpatient, Applied Behavioral Analysis, ABA, Autism, ADD,ADHD</b>	Covered	Covered	Not Covered
<b>Mental Health: Outpatient, Electroconvulsive Therapy (ECT)</b>	Covered.	Covered.	Not Covered
<b>Mental Health: Outpatient, Psychiatric evaluations. This is different from IMC Mental Health: Intake Evaluation.</b>	Covered.	Covered.	Not Covered
<b>Mental Health: Brief Intervention Treatment, Individual, Family, Group (in addition to SBIRT)</b>	Covered	Covered	Not Covered
<b>Mental Health: Crisis</b>	Covered	Covered	Not Covered
<b>Mental Health: Outpatient Day Support, Intensive Outpatient (IOP), Partial Hospitalization (PHP) high intensity services</b>	Covered	Covered	Not Covered



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
<b>Mental Health:</b> <b>Family Treatment</b>	Covered	Covered	Not Covered
<b>Mental Health:</b> <b>Freestanding Evaluation and Treatment</b>	Covered	Covered	Not Covered
<b>Mental Health:</b> <b>Group Treatment Services</b>	Covered	Covered	Not Covered
<b>Mental Health:</b> <b>High Intensity Outpatient Treatment (intensive services)</b>	Covered	Covered	Not Covered
<b>Mental Health:</b> <b>Individual Treatment Services</b>	Covered	Covered	Not Covered
<b>Mental Health:</b> <b>Intake Evaluation</b>	Covered	Covered	Not Covered
<b>Mental Health:</b> <b>Medication Management</b>	Covered	Covered	Not Covered
<b>Mental Health:</b> <b>Medication Monitoring</b>	Covered	Covered	Not Covered
<b>Mental Health:</b> <b>Inpatient Residential Setting</b>	Covered	Covered	Not Covered
<b>Mental Health:</b> <b>Inpatient Rehabilitation Facility</b>	Covered	Covered	Not Covered
<b>Mental Health:</b> <b>Peer Support (Community Support Services)</b>	Covered	Covered	Not Covered



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
<b>Mental Health:</b> Psychological Assessment Neuropsychological Testing	Covered	Covered	Not Covered
<b>Mental Health:</b> Psychological Assessment Psychological Testing	Covered	Covered	Not Covered
<b>Mental Health:</b> Rehabilitation Case Management (Community Support Services)	Covered	Covered	Not Covered
<b>Mental Health:</b> Special Population Evaluation	Covered	Covered	Not Covered
<b>Mental Health:</b> Stabilization Services (Crisis)	Covered	Covered	Not Covered
<b>Mental Health:</b> Therapeutic Psychoeducation (Education)	Covered	Covered	Not Covered
<b>Mental Health:</b> Care Coordination Services	Covered	Covered	Not Covered
<b>Mental Health:</b> Child and Family Team Meetings	Covered	Covered	Not Covered
<b>Mental Health:</b> Co-occurring Treatment	Covered	Covered	Not Covered



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
<b>Mental Health: Engagement and Outreach (Community Support Services)</b>	Covered	Covered	Not Covered
<b>Mental Health: Housing and Recovery through Peer Services (HARPS)</b>	Covered	Covered	Not Covered
<b>Mental Health: Interpreter Services</b>	Covered	Covered	Not Covered
<b>Mental Health: Court Ordered Involuntary Treatment Investigation, Court Ordered Involuntary Commitment (Crisis)</b>	Covered	Covered	These services for members on the CHPW plan FIMCBD/FHB, are covered by the HCA.
<b>Mental Health: Clubhouse</b>	Covered	Covered	Not Covered
<b>Mental Health: Request for Services Not Crisis</b>	Covered	Covered	Not Covered
<b>Mental Health: Respite Care</b>	Covered	Covered	Not Covered
<b>Mental Health: Supported Employment</b>	Covered	Covered	Not Covered
<b>Mental Health: Court Ordered Testimony for Involuntary Treatment Services</b>	Covered	Covered	Not Covered



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
<b>Mental Health:</b> Evidence Based Practice Children's Mental Health	No	Covered	Not Covered
Mental Health: Court Ordered Jail Services Community Transition	Covered	Covered	Not Covered
Mental Health: Court Ordered Offender Re-Entry Community Safety Program (ORCSP)	Covered	Covered	Not Covered
Mental Health: WA-PACT	Covered	Covered	Not Covered
Mental Health: Wraparound Services intensive services, WISE	NO for over age 21.	Covered	Not Covered
Mental Health: Inpatient Acute Care Facility Psychiatric Admission (Behavioral Health Unit or Free Standing Hospital)	Covered	Covered	Not Covered
Mental Health: Inpatient Acute Care Professional Services, Counseling, Therapy Services, Individual, Group	Covered. Covered by CHPW, effective 01/01/2017.	Covered. Covered by CHPW, effective 01/01/2017.	Not Covered



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
<b>Mental Health: Outpatient, Repetitive Transcranial Magnetic Stimulation, rTMS</b>	Covered.	Covered.	Not Covered
<b>Mental Health: Out of Area Coverage: Within the U.S and U.S. Territories Only</b>	Covered	Covered	Not Covered
<b>Substance Use Disorder (SUD): Assessment (initial)</b>	Covered	Covered	Not Covered
<b>Substance Use Disorder: Outpatient Case Management (Community Support Service)</b>	Covered	Covered	Not Covered
<b>Substance Use Disorder: Opiate Substitution Treatment Services</b>	Covered	Covered	Not Covered
<b>Substance Use Disorder: Outpatient, Brief Outpatient Treatment - Individual, Family, Group</b>	Covered	Covered	Not Covered
<b>Substance Use Disorder: Outpatient Intensive Outpatient Treatment - Individual, Family, Group</b>	Covered	Covered	Not Covered



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
<b>Substance Use Disorder (SUD): Inpatient Intensive Short Term Residential Facility</b>	Covered	Covered	Not Covered
<b>Substance Use Disorder (SUD): Inpatient Intensive Short Term Residential Professional Services</b>	Covered	Covered	Not Covered
<b>Substance Use Disorder (SUD): Inpatient Long Term Residential Facility</b>	Covered	Covered	Not Covered
<b>Substance Use Disorder (SUD): Inpatient Long Term Residential Professional Services</b>	Covered	Covered	Not Covered
<b>Substance Use Disorder (SUD): Inpatient Recovery House Residential Facility</b>	Covered	Covered	Not Covered
<b>Substance Use Disorder (SUD): Inpatient Recovery House Residential Professional Services</b>	Covered	Covered	Not Covered



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
<b>Substance Use Disorder: Withdrawal Management</b>	Covered	Covered	Not Covered
<b>Substance Use Disorder (SUD): Inpatient Acute Withdrawal Management, Detoxification</b>	Covered	Covered	Not Covered
<b>Substance Use Disorder: Alcohol Information School Drug Information School</b>	Covered	Covered	Not Covered
<b>Substance Use Disorder: Interim Services</b>	Covered	Covered	Not Covered
<b>Substance Use Disorder: Recovery Support (Community Support Service)</b>	Covered	Covered	Not Covered
<b>Substance Use Disorder: Court Ordered Involuntary Commitment (Crisis)</b>	Covered	Covered	These services for members on the CHPW plan FIMCBD/FHB, are covered by the HCA.
<b>Substance Use Disorder: Sobering Services</b>	Covered	Covered	Not Covered
<b>Substance Use Disorder: Pregnant, Post Partum or Parenting (PPW) Women's Housing Support Services</b>	Covered	Covered	Not Covered
<b>Substance Use Disorder: Crisis</b>	Covered	Covered	Not Covered



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
Substance Use Disorder: Brief Intervention (in addition to SBIRT)	Covered	Covered	No, Not Covered
Substance Use Disorder (SUD):Inpatient Rehabilitation	Covered	Covered	Not Covered
Substance Use Disorder (SUD):Inpatient Residential	Covered	Covered	Not Covered
Substance Use Disorder: Medication Management	Covered	Covered	Not Covered
Substance Use Disorder: Medication Monitoring	Covered	Covered	Not Covered
Substance Use Disorder: Request for Services, Not Crisis	Covered	Covered	Not Covered
Substance Use Disorder: Out of Area Coverage: Within the U.S and U.S. Territories Only	Covered	Covered	Not Covered
Vaccinations, immunizations: HPV (Human papilloma virus) Vaccine GARDASIL® HPV	Covered. Ages 19 through 26	Covered. Ages 9 through 18.	Not Covered
Injections: Hydroxyprogesterone Caproate (Makena)	Pharmacy Benefit Only	Pharmacy Benefit Only	Not Covered
Surgeries,surgery: Tympanostomy Tubes for age 16 and under	Covered	Covered	Not Covered



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
<b>Surgeries,surgery: Extracorporeal Membrane Oxygenation</b>	Covered	Covered	Not Covered
Telehealth, Telemedicine, TelePsych (medical services, mental health, substance use disorder)	Covered	Covered	Not Covered
Private Duty Nursing (for children)	Not covered for ages 18 and older	Covered ages 17 or younger	Private Duty Nursing for ages 18 and older, refer to the HCA.
<b>Dental: Facility Charges ONLY</b>	Covered	Covered	<ul style="list-style-type: none"> <li>• <u>HCA covers professional charges for dental care/services provided by a dentist or an oral surgeon</u></li> </ul> <p><b>EXCEPTION:</b></p> <ul style="list-style-type: none"> <li>• CHPW covers one pre-operative (E/M) visit by the PCP prior to dental services under anesthesia to provide medical clearance.</li> </ul>



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
Breathalyzer Tests	<p><b>Limit:</b> 4 tests per client per year 6 tests per client, per year for clients with alcohol use disorder</p>	<p><b>Limit:</b> 4 tests per client per year 6 tests per client, per year for clients with alcohol use disorder</p>	
Mental health assessments for young children	Not Covered	<ul style="list-style-type: none"> <li>• Ages 0 to under age 6</li> <li>• Limit to 5 sessions</li> <li>• Travel related benefit is postponed by the HCA until 07/01/22 and is not available at this time.</li> </ul>	Not Covered
ABCD dental/mouth matters, Access to Baby and Child Dentistry/Mouth Matters	Not Covered	<ul style="list-style-type: none"> <li>• Ages 0 to under age 6</li> <li>• Ages 0 to under age 13 with disabilities (indicator on Provider One) </li> <li>• Limited to one visit per day, per family, up to two visits per child in a 12- month period, per provider or clinic.</li> </ul>	Not Covered
Cognitive impairment care planning: Assessment of and care planning for patients with cognitive impairment like dementia, including Alzheimer's disease, at any stage of impairment.	<ul style="list-style-type: none"> <li>• Limited to once every 180 days.</li> <li>• CHPW follows the same coding rules that are published by Medicare. The HCA follows these same Medicare rules.</li> </ul>	Not Covered.	Not Covered



Benefit or Service	Adults Covered Age +20 unless otherwise specified	Children Covered Age 20 & Younger unless otherwise specified	Medicaid coverage through the HCA
Alternative Care •Chiropractor •Acupuncture •Massage Therapy	CHPW Value Add Benefit •Providers must be licensed in the State of WA. •Open network •No authorization or referral required •Adults and children •20 visit <u>combined limit</u> of Alternative Care services.	<b>Chiropractors:</b> •E & M code limit 1 per year •Spinal Manipulation •X-rays •Not covered: Massage Therapy and Physical Therapy  <b>Acupuncture:</b> •E & M code limit 1 per year •Acupuncture needle treatment with or without electrical stimulation.  <b>Massage Therapy</b> •E & M codes not covered •30 minutes – 1 visit	
Intensive Behavioral Supportive Supervision, IBSS	<b>18 years of age or older</b> <b>Prior Authorization Required</b>		