Washington State
Health Care Authority

Washington Apple Health (Medicaid)

Enteral Nutrition Billing Guide

January 1, 2020

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.

About this guide*

This publication takes effect January 1, 2020, and supersedes earlier guides to this program.

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

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

What has changed?

Subject	Change	Reason for Change
Behavioral Health Organization (BHO)	Removed this section	Effective January 1, 2020, behavioral health services in all regions will be provided under integrated managed care.
Integrated Managed Care Regions	Effective January 1, 2020, integrated managed care is being implemented in the last three regions of the state: • **Great Rivers** (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties) • **Salish** (Clallam, Jefferson, and Kitsap counties) • **Thurston-Mason** (Mason and Thurston counties)	Effective January 1, 2020, HCA completed the move to whole person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as “behavioral health”). This delivery model is called Integrated Managed Care (IMC).

* This publication is a billing instruction.

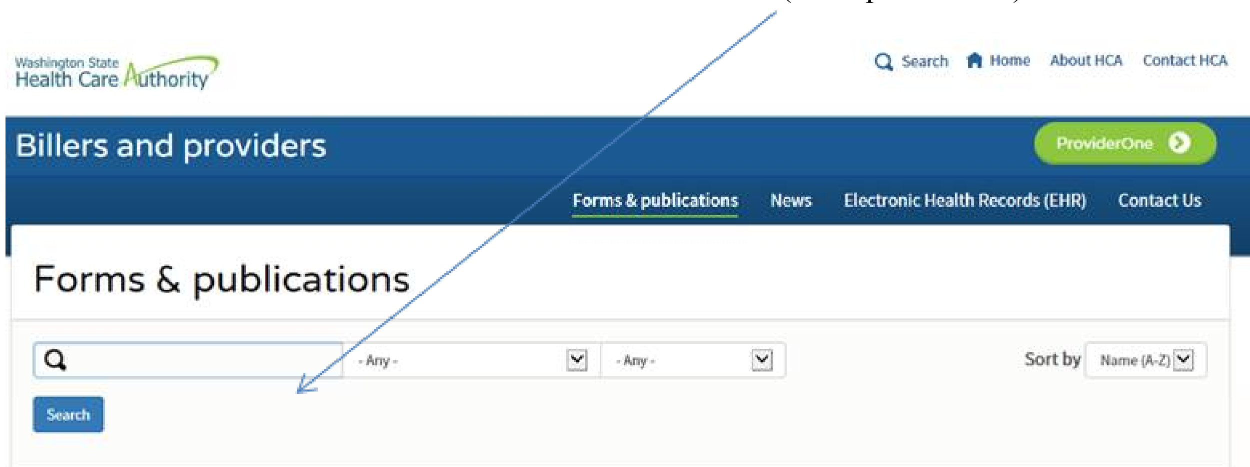
How can I get agency provider documents?

To access provider alerts, go to the agency's provider alerts webpage.

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

Where can I download agency forms?

To download an agency provider form, go to the agency's Forms & publications webpage. Type the HCA form number into the **Search box** as shown below (Example: 13-835).



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Resources Available

Topic	Contact Information
Contacting the Agency Medical Assistance Customer Service Center (MACSC)	See the agency's Billers and Providers webpage
Becoming a provider or submitting a change of address or ownership	
Finding out about payments, denials, claims processing, or Agency managed care organizations	
Electronic billing	
Finding Agency documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Agency managed care	
Finding the nearest Women, Infants, and Children (WIC) clinic	To find the nearest WIC clinic, call 1-800-841-1410 or visit the Department of Health's WIC webpage.

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

Body mass index (BMI) – A number that shows body weight relative to height, and is calculated using inches and pounds, or meters and kilograms. (WAC 182-554-200)

Dietitian (RD) – A dietitian registered with the Academy of Nutrition and Dietetics and certified by the Washington State Department of Health.

Enteral nutrition – The use of medically necessary nutrition products alone, or in combination with traditional food, when a client is unable to consume enough traditional food to meet nutritional requirements. Enteral nutrition may be provided orally or via feeding tube. (WAC 182-554-200)

Enteral nutrition equipment – Durable medical feeding pumps and intravenous (IV) poles used in conjunction with nutrition supplies to dispense formula to a client. (WAC 182-554-200)

Enteral nutrition supplies – The supplies (such as nasogastric, gastrostomy and jejunostomy tubes) necessary to allow nutritional support via the alimentary canal or any route connected to the gastrointestinal system.

Medical nutrition therapy – Face-to-face interactions between a certified registered dietician and a client or the client's guardian for evaluating the client's nutrition and making recommendations regarding the client's nutrition status or treatment.

Orally administered enteral nutrition products – Formulas or solutions that a person consumes orally for nutritional support.

Rental – A monthly or daily rental fee paid for equipment.

About this Program

What is the Enteral Nutrition Program?

(Chapter 182-554 WAC)

The Enteral Nutrition Program covers products, equipment, and supplies related to medically necessary nutrition when a client is unable to consume enough traditional food to meet nutritional requirements. Enteral nutrition may be provided orally or via feeding tube.

Client Eligibility

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

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

Who is eligible for enteral nutrition?

To receive oral or tube-delivered enteral nutrition products, equipment, and related supplies, a person must be eligible for one of the Washington Apple Health programs under WAC 182-501-0060 or be eligible for the Alien Emergency Medical (AEM) program under WAC 182-507-0110.

How do I verify a client's eligibility?

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

Verifying eligibility is a two-step process:

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

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

Step 2. **Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's Program Benefit Packages and Scope of Services webpage.

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

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org

2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)

3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

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

Yes. Most Medicaid-eligible clients are enrolled in one of the agency's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an agency-contracted MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for:

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

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

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

Note: To prevent billing denials, check the client's eligibility **prior** to scheduling services and at the **time of the service**, and make sure proper authorization or referral is obtained from the agency-contracted MCO, if appropriate. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for. However, some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination.

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

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's Get Help Enrolling page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Apple Health – Changes for January 1, 2020

Effective January 1, 2020, the Health Care Authority (HCA) completed the move to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

IMC is implemented in the last three regions of the state:

- **Great Rivers** (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties)
- **Salish** (Clallam, Jefferson, and Kitsap counties)
- **Thurston-Mason** (Mason and Thurston counties)

These last three regions have plan changes, with only Amerigroup, Molina, and United Healthcare remaining. There are changes to the plans available in these last three regions. The only plans that will be in these regions are Amerigroup, Molina, and United Healthcare. If a client is currently enrolled in one of these three health plans, their health plan will not change.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:
  Go to Washington HealthPlanFinder website.

- **Available to all Apple Health clients:**

  - ✓ Visit the ProviderOne Client Portal website:

  - ✓ Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

  - ✓ Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

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

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

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Clients who are not enrolled in an agency-contracted managed care plan are automatically enrolled in a BHSO, with the exception of American Indian/Alaska Native clients. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care (IMC)

Clients qualified for managed care enrollment and living in integrated managed care (IMC) regions will receive all physical health services, mental health services, and substance use disorder treatment through their agency-contracted managed care organization (MCO).

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

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

If a client does not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's American Indian/Alaska Native webpage.

For more information about the services available under the FFS program, see the agency's Mental Health Services Billing Guide and the Substance Use Disorder Billing Guide.

For full details on integrated managed care, see the agency's Apple Health managed care webpage and scroll down to "Changes to Apple Health managed care."

Integrated managed care regions

Clients residing in integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency's Apple Health managed care webpage.

Region	Counties	Effective Date
Great Rivers	Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum	January 1, 2020
Salish	Clallam, Jefferson, Kitsap	January 1, 2020
Thurston-Mason	Thurston, Mason	January 1, 2020
North Sound	Island, San Juan, Skagit, Snohomish, and Whatcom	July 1, 2019
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman	January 1, 2019
King	King	January 1, 2019
Pierce	Pierce	January 1, 2019
Spokane	Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties	January 1, 2019
North Central	Grant, Chelan, Douglas, and Okanogan	January 1, 2018 January 1, 2019 (Okanogan)
Southwest	Clark, Skamania, and Klickitat	April 2016 January 1, 2019 (Klickitat)

Integrated Apple Health Foster Care (AHFC)

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

Clients under this program are:

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

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

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact the agency's Foster Care Medical Team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see the agency's Mental Health Services Billing Guide, under *How do providers identify the correct payer*?

How do these clients receive enteral nutrition?

Clients residing in nursing facilities and adult family homes

If a person resides in a nursing facility, adult family home, assisted living facility, boarding home, or any other residence where food is included in the daily rate, oral enteral nutrition products are the responsibility of the facility.

Clients residing in state-owned facilities

If a person resides in a state-owned facility, such as a state school, developmental disabilities facility, or mental health facility, the enteral nutrition products, equipment, and related supplies are the responsibility of the state-owned facility.

Clients who have elected to receive hospice

If a person has elected to receive the agency's hospice benefit, the person must arrange for enteral nutrition products, equipment, and related supplies directly through the hospice benefit.

Clients who qualify for WIC

A child who qualifies for supplemental nutrition from the Women, Infants, and Children (WIC) Program must receive supplemental nutrition directly from that program. However, the child may be eligible for enteral products from the agency if:

- The child's need for a product exceeds WIC's allowed amount
- The product is not available through the WIC Program.

Note: See the Scope of Categories of Healthcare Services Table webpage for an up-to-date listing of benefit packages.

Provider Requirements - General

(WAC 182-554-400)

Who is eligible to bill for enteral nutrition services?

The following providers are eligible to enroll or contract with the agency to provide enteral nutrition products, equipment, and related supplies:

- Pharmacy providers
- Durable medical equipment (DME) providers

What requirements must a provider meet?

To receive payment for orally administered or tube-delivered enteral nutrition products, equipment and related supplies, a provider must meet all the requirements in Chapters 182-501 and 182-502 WAC.

Providers must:

- Provide only services that are within the scope of the provider's license.

- Obtain prior authorization from the agency, if required, before:

  - ✓ Delivery to the client.
  - ✓ Billing the agency.

- Deliver enteral nutritional products in quantities sufficient to meet the client's authorized needs, not to exceed a one-month supply. One month equals 30 days.

- Confirm with the client or the client's caregiver that the next month's delivery of authorized enteral nutrition products is necessary and document the confirmation in the client's file. The agency does not pay for automatic periodic delivery of products.

- Furnish clients with new or used equipment that includes full manufacturer and dealer warranties for at least one year.

- Notify the client's prescribing provider if the client has indicated that the product is not being used as prescribed and document the notification in the client's file.

- Complete the agency's *Enteral Nutrition Products Prescription and Order Form* (HCA #13-961). To be valid, a prescription must:

  - ✓ Be written, dated, and signed (including the prescriber's credentials) by the prescriber on or before the date of delivery of the product, equipment, or related supplies.

  - ✓ Be no older than one year from the date the prescriber signed the prescription.

  - ✓ State the specific item or service requested, the client's diagnosis, and estimated length of need, quantity and units of measure, frequency and directions for use.

- Have proof of delivery.

  - ✓ When a client or the clients' authorized representative receives the product directly from the provider, the provider must furnish the proof of delivery upon agency request. The proof of delivery must:

    - ➢ Be signed and dated by the client or the client's authorized representative. The date of the signature must be the date the client received the item.

    - ➢ Include the client's name and a detailed description of the items delivered, including the quantity and brand name.

  - ✓ When a provider uses a shipping service to deliver items, the provider must furnish proof of delivery upon agency request. The proof of delivery must include:

    - ➢ The client's name or other client identifier.
    - ➢ The delivery service package-identification number.
    - ➢ The delivery address.
    - ➢ The quantity, a detailed description, and brand name of the item being shipped.

- Bill the agency with the following dates of service:

  - ✓ If the provider used a shipping service, the provider must use the shipping date as the date of service.

  - ✓ If the client or the client's authorized representative received the product directly from the provider, the provider must use the date of receipt as the date of service.

Note: The agency does not pay for automatic periodic delivery of products.

Coverage - General

(WAC 182-554-500)

What is covered under the Enteral Nutrition Program?

The agency's Enteral Nutrition Program is **not** a food benefit.

Services covered under the Enteral Nutrition program include:

- Thickeners for clients 20 and younger
- Special formulas for clients with Inherited Metabolic Disorders
- Tube-delivered products for clients regardless of age
- Equipment and Supplies for tube-fed clients
- Oral enteral nutrition products for clients 20 and younger

What is not covered?

(WAC 82-554-800)

The agency does not cover the following:

- Nonmedical equipment, supplies, and related services (for example, back-packs, pouches, bags, baskets, or other carrying containers)

- Orally administered enteral nutrition products for clients age 21 and older

How do I request a noncovered service?

The agency reviews requests for noncovered health care services according to WAC 182-501-0160 as an exception to rule (ETR). To request a noncovered service using the ETR process, send a completed *Oral Enteral Nutrition Exception to Rule (ETR) Request* (HCA #13-864), to the agency.

When the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) applies, the agency evaluates a noncovered service, equipment, or supply according to the process in WAC 182-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 182-534-0100 for EPSDT rules).

> **Note:** The agency evaluates a request for orally administered enteral nutrition products and tube-delivered enteral nutrition products that are not covered or are in excess of the enteral nutrition program limitations or restrictions, in accordance with WAC 182-554-500.

Thickeners

(WAC 182-554-525)

Client eligibility

The agency covers thickeners for clients age 20 and younger with oral, oropharyngeal, and pharyngeal dysphagia. There is no benefit for clients age 21 and older.

> **Note:** If oral, oropharyngeal, and pharyngeal dysphagia is diagnosed without videofluoroscopy, documentation of the findings of the swallow evaluation must be recorded and include information on trials of different food consistencies that lead to the recommendation of a particular dysphagia diet.

Authorization

Clients age one to 20

For clients with oral, oropharyngeal, and pharyngeal dysphagia, use expedited prior authorization (EPA) #870001406 when billing. 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) Form* (HCA #13-112)
  - ✓ *Enteral Nutrition Products Prescription and Order 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.

Clients under age one

- Prior authorization (PA) is required.

> **Note:** The Food and Drug Administration (FDA) and the American Academy of Pediatrics have warned that xanthan gum (e.g. *Simply Thick*) and other gum thickeners are not safe for infants. Providers who feel xanthan gum is the next reasonable step in care must request PA.

- The PA request must include documentation on:
  - ✓ What other strategies were used to address dysphagia and why these strategies were unsuccessful.
  - ✓ Confirmation that the parents or guardians have been advised of the warning and agree that the benefit outweighs the risk.
- For prior authorization, complete the following forms and fax the forms together to the agency at (866) 668-1214:
  - ✓ A typed *General Information for Authorization* (HCA #13-835) form (use this in place of the coversheet for the fax transmission) and
  - ✓ *Thickeners for Babies Less Than One Year – Prior Authorization Request Form* (HCA #13-111);
  - ✓ *Enteral Nutrition Products Prescription and Order Form* (HCA #13-961); and
  - ✓ *Dietitian Worksheet – Oral Enteral Nutrition Assessment* (HCA #13-109).

  (See Where can I download agency forms?)

Product list

DME and pharmacy providers must use the Enteral Nutrition Product Classification List located on the Palmetto GBA website. To view the list, select *Enteral Nutrition* in the *Classification(s)* drop down menu and click *Search*. Providers must use the applicable HCPCS codes in the product list with the appropriate modifier for all enteral nutritional claims. The agency accepts billing for the codes and products listed on the Palmetto GBA Enteral Nutrition Product Classification List only.

The agency denies claims for enteral nutrition products billed without the appropriate modifiers.

Coverage table

Category (HCPCS code)	Modifier	Short Description	One Unit Equals	Policy/Comments
B4100	BO	Food thickener oral	1 oz	Examples: Resource, ThickenUp, Simply Thick, Thick & Easy, and Thick-It. For a client younger than age 1, the provider must request PA. Thickeners are covered for clients one year and older when EPA criteria is met. Use EPA #870001406.

Record keeping

The agency requires DME and pharmacy providers to keep legible, accurate, and complete records to justify the medical necessity of the items provided. See the Record Keeping chart in this guide.

Fee schedule

You can find the current Enteral Nutrition Fee Schedule on the agency's Enteral Nutrition Fee Schedule webpage.

Inherited Metabolic Disorders

(**WAC 182-554-550**)

Client eligibility

The agency covers orally administered enteral nutrition products for clients age 20 and younger with amino acid, fatty acid, and carbohydrate metabolic disorders, including phenylketonuria (PKU).

Authorization

Clients age 20 and younger

Use EPA# 870001405 when billing.

Durable medical equipment (DME) and pharmacy providers must complete and retain the following forms in the client's file:

- *Metabolic Disorders – Oral Enteral Nutrition Expedited Prior Authorization (EPA) Worksheet: Children* (HCA #13-101) form
- *Enteral Nutrition Products Prescription and Order Form* (HCA #13-961)

Clients age 21 and older

To request an exception to rule, DME and pharmacy providers must complete the following forms and fax them together to the agency at (866) 668-1214 for review:

- A typed *General Information for Authorization* (HCA #13-835) form (use this in place of the coversheet for the fax transmission)
- *Metabolic Disorders – Oral Enteral Nutrition Exception to Rule (ETR) Request: Adults* (HCA #13-100)
- *Enteral Nutrition Products Prescription and Order Form* (HCA #13-961)

(See Where can I download agency forms?)

Product list

See Product list.

Coverage table

Category (HCPCS code)	Modifier	Short Description	One Unit Equals	Policy/ Comments
B4157	BO or BA	Ef special metabolic inherit	100 cal	Use EPA #870001405
B4162	BO or BA	Ef ped spec metabolic inherit	100 cal	Use EPA #870001405

Miscellaneous

Prior authorization (PA) is required before billing HCPCS code B9998.

HCPCS Code	Modifier	Short Description	EPA/PA	Part of NH per diem	Policy/ Comments
B9998		Enteral supp not otherwise c	PA	N	Requires PA. Complete form HCA #13-745 and send with typed and completed form HCA #13-835. Invoice for requested item must be submitted for review.

Record keeping

The agency requires DME and pharmacy providers to keep legible, accurate, and complete records to justify the medical necessity of the items provided. See the Record Keeping chart in this guide.

Fee schedule

You can find the current Enteral Nutrition Fee Schedule on the agency's Enteral Nutrition Fee Schedule webpage.

Tube-Delivered Enteral Nutrition

(**WAC 182-554-600**)

Client eligibility

The agency covers tube-delivered enteral nutrition products, equipment, and related supplies, regardless of age, if the client:

- Has a valid prescription under WAC 182-554-400.
- Can manage tube feedings independently or with a caregiver's assistance.
- Has at least one of the following medical conditions:
  - ✓ A disease or condition that impairs the client's ability to ingest sufficient calories and nutrients or restricts calories and nutrients from food from reaching the gastrointestinal tract
  - ✓ A disease or condition of the small bowel that impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength properly proportioned to the client's overall health status

Dual eligible clients

Clients with both Medicare and Medicaid are eligible for some tube-delivered products under Medicare Part B. Medicaid is always the payer of last resort.

Women, Infants, and Children (WIC) and tube-delivered enteral nutrition

If a WIC-eligible tube-fed client can use a standard formula available from WIC, the client must receive the product from WIC. All clients under age 5, including tube-fed clients, must receive products and formulas directly from WIC unless:

- The client is not eligible for the WIC program.
- The client is eligible for the WIC program, but the need for the enteral nutrition product or formula exceeds WIC's allowed amount.

- The requested product or formula, or the equivalent, is not available through the WIC program.

Authorization

The agency covers tube-delivered enteral nutrition products without prior authorization for eligible clients living in their homes and other residential settings, but not for clients in inpatient settings.

The prescribing provider must complete an *Enteral Nutrition Products Prescription and Order Form* (HCA #13-961). (See Where can I download agency forms?) The DME and pharmacy provider must keep this completed form in the client's file.

For clients age 4 years and younger, the Department of Health's *WIC/Medicaid Nutrition Form* (DOH 962-937 March 2014) must also be completed.

Product list

See Product list.

Coverage table

Category (HCPCS code)	Modifier	Short Description	One Unit Equals
B4102	BA	Ef adult fluids and electro	500 ml
B4103	BA	Ef ped fluid and electrolyte	500 ml
B4149	BA	Ef blenderized foods	100 cal
B4150	BA	Ef complet w/intact nutrient	100 cal
B4152	BA	Ef calorie dense>/=1.5kcal	100 cal
B4153	BA	Ef hydrolyzed/amino acids	100 cal
B4154	BA	Ef spec metabolic noninherit	100 cal
B4155	BA	Ef incomplete/modular	100 cal
B4157	BA	Ef special metabolic inherit	100 cal
B4158	BA	Ef ped complete intact nut	100 cal
B4159	BA	Ef ped complete soy based	100 cal
B4160	BA	Ef ped caloric dense>/=0.7kc	100 cal
B4161	BA	Ef ped hydrolyzed/amino acid	100 cal
B4162	BA	Ef ped specmetabolic inherit	100 cal

Miscellaneous

Prior authorization (PA) is required before billing HCPCS code B9998.

HCPCS Code	Modifier	Short Description	EPA/PA	Part of NH per diem	Policy/ Comments
B9998		Enteral supp not otherwise c	PA	N	Requires PA. Complete HCA #13-745 form and send with typed and completed HCA #13-835 form as the cover sheet. To be reimbursed, you must submit the invoice for the requested item.

Record keeping

The agency requires DME and pharmacy providers to keep legible, accurate, and complete records to justify the medical necessity of the items provided. See the Record Keeping chart in this guide.

Fee schedule

You can find the current Enteral Nutrition Fee Schedule on the agency's Enteral Nutrition Fee Schedule webpage.

Enteral Equipment and Related Supplies for Tube-Delivered Enteral Nutrition

(WAC 182-554-700)

Client eligibility

The agency covers medically necessary enteral feeding supply kits, tubing, and the rental, purchase, and repair of pumps and IV poles for all eligible clients regardless of age according to the limits listed in the coverage tables in this section.

Authorization

Providers must obtain authorization for enteral equipment and supplies when noted on the coverage tables in this section.

To exceed the specified limits, providers request a Limitation Extension (LE). To request an LE, providers must complete the following forms and fax them to the agency at (866) 668-1214:

- A typed *General Information for Authorization* (HCA #13-835) form (use this in place of the coversheet for the fax transmission)
- *Enteral Equipment and Supplies Limitation Extension (LE) and Exception to Rule (ETR) Request Form* (HCA #13-115)
- *Enteral Nutrition Products Prescription and Order Form* (HCA #13-961)

(See Where can I download agency forms?)

Rescinding authorization

The agency may rescind authorization for prescribed equipment if the equipment was not delivered to the client before the client:

- Loses medical eligibility.
- Becomes covered by a hospice agency and the equipment is used in the treatment of the terminal diagnosis or related condition(s).
- Enrolls in or becomes eligible for an agency-contracted MCO.
- Dies.

Coverage

- The following are included in the agency's reimbursement for equipment rentals or purchases:

  - ✓ Instructions to the client, caregiver, or both, on the safe and proper use of equipment provided
  - ✓ Full service warranty
  - ✓ Delivery and pick-up
  - ✓ Fitting and adjustments

- If changes in circumstances occur during the rental period, such as death or ineligibility, the agency will terminate reimbursement effective on the date of the change in circumstances.

- Providers may not bill for simultaneous rental(s) and purchase of the same item at any time.

- The agency will pay up to an additional three months of pump rental while a client-owned pump is being repaired.

- The agency will **not** reimburse providers for equipment that was supplied to them **at no cost** through suppliers/manufacturers or items that have been returned by clients.

- Rent-to-purchase equipment may be new or used at the beginning of the rental period.

> **Note:** Covered items that are not part of the nursing facility per diem may be billed separately to the agency.

Enteral supply kits

To request a limitation extension to exceed specified limits, see Authorization.

- Do not bill more than one supply kit code per day. No modifier is needed when billing for enteral supply kits or enteral tubing.
- Enteral supply kits include all the necessary supplies for the client to administer enteral nutrition.
- If billing for a span of dates, the number of units must match the number of days billed.

Coverage table – enteral supply kits

HCPCS Code	Short Description	EPA/PA	Part of NH per diem	Policy/ Comments
B4034	Enter feed supkit syr by day		N	Maximum # of units - 1 per client, per day
B4035	Enteral feed supp pump per d		N	Maximum # of units - 1 per client, per day
B4036	Enteral feed sup kit grav by		N	Maximum # of units - 1 per client, per day

Enteral tubing

The total number of allowed tubes includes any tubes provided as part of the replacement kit. To request a limitation extension to exceed specified limits, see Authorization.

Coverage table – enteral tubing

HCPCS Code	Short Description	EPA/PA	Part of NH per diem	Policy/ Comments
B4081	Enteral ng tubing w/ stylet		N	Maximum # of units - 3 per client, per 30 days
B4082	Enteral ng tubing w/o stylet		N	Maximum # of units - 3 per client, per 30 days
B4083	Enteral stomach tube levine		N	Maximum # of units - 1 per client, per 30 days

HCPCS Code	Short Description	EPA/PA	Part of NH per diem	Policy/ Comments
B4087	Gastro/jejuno tube, std		N	Maximum # of units - 5 per client, per 30 days **Note:** Use this code when billing for extension tubing.
B4088	Gastro/jejuno tube, low-pro		N	Max # of units - 1 per client, every 2 months

Enteral repairs

Repairs to a client-owned pump require **authorization** from the agency. Providers may request authorization after the repairs have begun.

Submit a typed *General Information for Authorization* (HCA #13-835) form (use this in place of the coversheet for the fax transmission to the agency along with an invoice for the repairs that separates parts from labor charges. (See Where can I download agency forms?)

Repairs or nonroutine service may not exceed 50 percent of the purchase price.

Coverage table – enteral repairs

HCPCS Code	Modifier	Short Description	Authorization Required	Part of NH per diem	Policy/ Comments
E1399		Durable medical equipment mi	Y	N	Detailed invoice required
B9002	RR	Enter nutr inf pump any type	Y	N	The agency will pay up to 3 months rental while client-owned pump is being repaired.
K0739		Repair/svc dme non-oxygen eq	Y	N	Repairs or non-routine service not to exceed 50 percent of purchase price, if the equipment is less than 5 years old. Separate parts from labor and indicate number of units (e.g. 15 minutes) requested.

Pumps and poles

- The agency considers poles and pumps purchased after 12-months rental.
- Pumps may be new or used equipment at the beginning of rental period.
- Providers must use the procedure codes listed in the agency's fee schedule along with the appropriate modifier for all poles and pumps.

Coverage table – pumps and poles

HCPCS Code	Modifier	Short Description	EPA/PA	Part of NH per diem	Policy/ Comments
E0776	NU	Iv pole		Y	Maximum # of units - 1 per client, per lifetime
E0776	RR	Iv pole		Y	Maximum # of units - 1 per month, not to exceed 12 months
B9002	RR	Enter nutr inf pump any type		N	Maximum # of units - 1 per month, not to exceed 12 months

Payment

(WAC 182-554-900)

What is included in the agency's payment?

The agency determines reimbursement for covered enteral nutrition equipment and necessary supplies according to the set fee schedule, and evaluates and updates the maximum allowable fees for enteral nutrition products, equipment, and related supplies at least once per year.

The agency's payment for covered enteral nutrition products, equipment, and related supplies include all the following:

- Any adjustments or modifications to the equipment required within three months of the date of delivery (not applicable to adjustments required because of changes in the client's medical condition)
- Instructions to the client, caregiver, or both, on the safe and proper use of equipment provided
- Full service warranty

- Delivery and pick-up
- Fitting and adjustments

If changes in circumstance occur during the rental period, such as death or ineligibility, the agency discontinues payment effective on the date of the change in circumstance.
The agency does not pay for simultaneous rental and purchase of any item.

The agency does not reimburse providers for equipment that is supplied to them at no cost through suppliers or manufacturers.

The provider who furnishes enteral nutrition equipment to a client is responsible for any costs incurred to have equipment repaired by another provider if:

- Any equipment that the agency considers purchased requires repair during the applicable warranty period.
- The provider refuses or cannot fulfill the warranty.
- The client still needs the equipment. If the rental equipment must be replaced during the warranty period, the agency recoups fifty percent of the total amount previously paid toward rental and eventual purchase of the equipment delivered to the client if:
- The provider is unwilling or unable to fulfill the warranty.
- The client still needs the equipment.

Noncovered equipment and supplies
(WAC 182-554-800)

Noncovered medical equipment, supplies and related services include backpacks, pouches, bags, baskets or other carrying container.

For a product that needs an unspecified code, prior authorization is required. To request prior authorization, fax the following completed forms to the agency at (866) 668-1214:

- A typed *General Information for Authorization* (HCA #13-835) form (use this in place of the coversheet for the fax transmission) and
- *Justification for Miscellaneous Enteral Nutrition Procedure Code (B9998)* (HCA #13-745) form

(See Where can I download agency forms?)

Miscellaneous

Prior authorization (PA) is required before billing HCPCS code B9998.

HCPCS Code	Short Description	Authorization Required	Part of NH per diem	Policy/ Comments
B9998	Enteral supp not otherwise c	Yes	N	Use form HCA #13-745 *Justification for Miscellaneous Enteral Nutrition Procedure Code (B9998)*. Include invoice for Rates determination.

Record keeping

The agency requires DME and pharmacy providers to keep legible, accurate, and complete records to justify the medical necessity of the items provided. See the Record Keeping chart in this guide.

Fee schedule

You can find the current Enteral Nutrition Fee Schedule on the agency's Enteral Nutrition Fee Schedule webpage.

Oral Enteral Nutrition

(WAC 182-554-500)

Overview of new requirements

Oral enteral nutrition is a medical benefit for treating medical conditions when no equally effective, less costly alternative is available to treat the client's condition. It is not a food benefit, such as the Basic Food in Washington and WIC.

When commercially available products are prescribed to correct documented nutritional or growth deficiencies, they should be used for the shortest amount of time possible before transitioning to a diet of traditional food or food products with ingredients that can be purchased for the client as grocery products. These include:

- Over-the-counter nutrition products
- Standard infant formulas
- Standard toddler formulas

The provider who prescribes a product covered by the oral enteral nutrition benefit must refer the client for services of other health care professionals whenever needed. Clients receiving the oral enteral products must address the medical issues causing inadequate diet and nutrition. These other providers may include:

- Primary care providers
- Dietitians
- Gastroenterology specialists
- Allergists
- Developmental pediatricians
- Applied Behavior Analysis (ABA) and mental health providers
- Speech and occupational therapists

Client eligibility

Oral enteral nutrition is a covered benefit for clients 20 years of age and younger.

There is no oral enteral nutrition benefit for clients 21 and older. Providers may request an exception to rule (ETR) by completing the *Oral Enteral Nutrition Exception to Rule Request* (HCA #13-864) form and faxing the request to the agency at (866) 668-1214.

Women, Infants, Children (WIC), and Oral Enteral Nutrition

- All clients under age five who qualify for supplemental nutrition from the Women, Infants, and Children (WIC) nutrition program must receive products and formulas directly from that program.

- The agency may cover orally administered enteral nutrition products for a client under age 5 if the client is:

  - ✓ Not eligible for the WIC program.
  - ✓ Eligible for the WIC program, but the client's need for an oral enteral nutrition product or formula exceeds the amount allowed by WIC rules.
  - ✓ Eligible for the WIC program, but a medically necessary product or formula is not available through the WIC program.

Provider requirements

Prescribing providers

The health care provider who prescribes an oral enteral nutrition product is attesting that a client has or is at risk of growth or nutrient deficits due to a condition that prevents the client from meeting nutritional needs using food, over-the-counter nutrition products, standard infant formula, or standard toddler formula.

If "failure to thrive" or "feeding difficulties" is diagnosed, the underlying medical or behavioral cause must be identified and addressed. Prescribing providers are responsible for referring clients who are prescribed oral enteral nutrition products paid for by the agency to speech or occupational therapists, applied behavioral analysis (ABA) providers, mental health providers, or other medical providers such as allergists, developmental pediatricians or gastroenterologists to address comorbid conditions related to inadequate intake of regular food when indicated.

Dietitians

Consulting dietitians must conduct a complete nutrition assessment to assure the prescribed product is appropriate for the client's nutritional diagnosis. The dietitian must develop an individual diet plan so the client or caregivers will be able to prepare foods using grocery items that meet the client's nutrient and caloric needs. They will assist the client with a transition to food and food products, grocery items available commercially, and homemade shakes and smoothies.

Dietitians, as essential partners in the client's health care team, should recommend to the prescribing provider if their assessment indicates a problem that could be addressed by other health care providers, such as speech or occupational therapists, ABA providers, mental health providers, or other medical providers such as allergists, developmental pediatricians or gastroenterologists.

DME and pharmacy providers (servicing and billing providers)

DME and pharmacy providers are eligible to enroll or contract with the agency to provide orally administered enteral nutrition products.

The DME or pharmacy provider should assure that the prescribing provider and dietitian have fully completed the forms that indicate the client meets EPA criteria, and have accurately identified and calculated the amount of product prescribed.

To receive payment for orally administered enteral nutrition products, a provider must:

- Provide only those services that are within the scope of the provider's license.
- Obtain prior authorization from the agency, if required, before delivery to the client and before billing the agency.
- Deliver enteral nutritional products in quantities sufficient to meet the client's authorized needs, not to exceed a one-month supply. One month equals 30 days.
- Confirm with the client or the client's caregiver that the next month's delivery of authorized orally administered enteral nutrition products is necessary and document the confirmation in the client's file. The agency does not pay for automatic periodic delivery of products.
- Notify the client's physician if the client has indicated the enteral nutrition product is not being used as prescribed, and document the notification in the client's file.
- Bill electronically according to the general billing requirements found in the agency's ProviderOne Billing and Resource Guide.
- Bill using the appropriate modifiers.

Authorization

All orally administered enteral nutrition products require either EPA or PA.

Expedited prior authorization

When using EPA, it is the responsibility of the prescribing provider to ensure that the client meets all eligibility criteria.

The prescribing provider as well as the DME or pharmacy provider are responsible for the accuracy and documentation of medical necessity. A completed *Oral Enteral Nutrition Products for Clients 20 years of Age and Younger – Expedited Prior Authorization (EPA) Worksheet* form (HCA #13-114) signed by the prescribing provider must be kept in the client's file and made available to the agency upon request.

When required, the *Dietitian Worksheet – Oral Enteral Nutrition Assessment* (HCA #13-109) form, consultation notes, growth charts, and the prescription form must be retained in the client's file. This document is subject to post-pay review by the agency under WAC 182-502-0100. (See Where can I download agency forms?)

To facilitate getting medically necessary oral enteral nutrition products, use one of the following expedited prior authorization numbers:

- **EPA #870001407** for urgent one-time, one-month supply; one month equals 30 days.
- **EPA #870001408** when medically necessary to treat a growth of nutritional deficiency. Monthly supply up to 6 months
- **EPA #870001425** for children on WIC who need additional formula than WIC allows for medical reasons
- **EPA #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
- **EPA #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 and Order 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.

- **EPA #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 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 on the agency's website if needed).

  - ✓ The prescriber has completed the agency's *Enteral Nutrition Products Prescription and Order 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.

- **EPA #870001425** for clients eligible for the WIC program, but who have a medical condition requiring additional amounts of an oral enteral nutrition product than what is allowed by WIC rules. Please note that WIC allows variable amounts of formula based on the client's age. The amount covered by Medicaid must be recalculated as the client grows and will correspond to amounts shown on the WIC table.

  Use the information on the *WIC/Medicaid Nutrition Form* (DOH 962-937 March 2014) to calculate the number of additional HCPCS units of the required formula as needed. Bill the additional units ONLY.

- **EPA #870001426** for clients eligible for the WIC program, but who need a therapeutic, non-standard formula that is not available from WIC due to a medical condition.

Prior authorization

- If a client requires more than 6 months to transition to a diet of traditional food or food products (which can be purchased for the client as grocery products), prior authorization (PA) is required.

- If a client requires orally administered enteral nutrition products for longer than six months, the DME or pharmacy provider must obtain PA from the agency. The request for PA must include all of the following:

  - ✓ Documentation of the client's diagnosis that supports the client's need for the orally administered enteral nutrition product

  - ✓ The client's nutrition care plan, including steps to transition the client to food or food products, if possible, or document why the client cannot transition to food or food products. Any updates from subsequent RD reevaluations must be included.

  - ✓ Updates to the client's growth chart

  - ✓ Progress notes documenting regular follow up and weight checks how the prescribed product is treating the client's growth or nutrient deficits, or is necessary to maintain the client's growth or nutrient status

  - ✓ Referrals, if necessary, to other health care providers treating related medical or mental health conditions

  - ✓ Documentation of any communication the treating provider has had with other providers directly or indirectly treating the client's growth or nutrient deficits while the client is receiving orally administered enteral nutrition products

Product list

See Product list.

Coverage table

Category (HCPCS code)	Modifier	Short Description	One Unit Equals
B4102	BO	Ef adult fluids and electro	500 ml
B4103	BO	Ef ped fluid and electrolyte	500 ml
B4149	BO	Ef blenderized foods	100 cal
B4150	BO	Ef complet w/intact nutrient	100 cal
B4152	BO	Ef calorie dense>/=1.5kcal	100 cal
B4153	BO	Ef hydrolyzed/amino acids	100 cal
B4154	BO	Ef spec metabolic noninherit	100 cal
B4155	BO	Ef incomplete/modular	100 cal
B4158	BO	Ef ped complete intact nut	100 cal
B4159	BO	Ef ped complete soy based	100 cal
B4160	BO	Ef ped caloric dense>/=0.7kc	100 cal
B4161	BO	Ef ped hydrolyzed/amino acid	100 cal

Miscellaneous

Prior authorization (PA) is required before billing HCPCS code B9998.

HCPCS Code	Modifier	Short Description	EPA/PA	Part of NH per diem	Policy/ Comments
B9998		Enteral supp not otherwise c	PA	N	

Record keeping

The agency requires DME and pharmacy providers to keep legible, accurate, and complete records to justify the medical necessity of the items provided. See the Record Keeping chart in this guide.

Does the agency pay for medical nutrition therapy?

The agency pays for medical nutrition therapy when it is provided by a dietician with an agency provider number, for clients age 20 and younger who are in an eligible program, when the client is referred by an EPSDT provider.

> **Note:** All clients age 20 and younger and on an eligible program must be evaluated by a certified registered dietician who has a signed core provider agreement with the agency, within 30 days of initiation of enteral nutrition products, and periodically (at the discretion of the certified registered dietician) while receiving enteral nutrition products. See Provider Requirements. (See WAC 182-554-500(3).

For more information, see the agency's Medical Nutrition Therapy Medicaid Billing Guide.

Does the agency pay for oral enteral nutrition products for clients who are receiving Medicare part B benefits?

Yes. The agency may pay for oral enteral nutrition through exception to rule for clients on Medicare Part B. The agency reviews requests for noncovered health care services according to WAC 182-501-0160 as an exception to rule (ETR).

The agency does not require a provider to submit a Medicare denial for the client when providing oral enteral nutrition products to these clients.

Does the agency pay for enteral nutrition products used in combination with parenteral nutrition?

The agency pays for both enteral and parenteral nutrition and supplies while a client is being transitioned from parenteral to enteral nutrition. See the agency's Home Infusion Therapy and Parenteral Nutrition Medicaid Billing Guide.

Authorization

(WAC 182-554-700)

Prior authorization (PA)

PA is the agency's approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Expedited prior authorization (EPA) and limitation extensions (LE) are forms of PA.**

Providers may now submit prior authorization (PA) requests online through direct data entry into ProviderOne. See the agency's Prior authorization webpage for details.

> **Note:** See the agency's ProviderOne Billing and Resource Guide for more Information on requesting authorization.

Providers must obtain authorization for all covered orally administered enteral nutrition products, tube-delivered enteral equipment, and related supplies.

- Authorization does not guarantee payment.
- Authorization requirements are not a denial of service.
- Providers must submit a written request to the agency for when required in this billing guide.

> **Note:** The agency does not cover orally administered enteral nutrition for clients age 21 and older.

- Upon request, a provider must provide documentation to the agency showing how the client's condition met the criteria for PA or EPA.
- PA is required for orally administered enteral nutrition products, and tube-delivered enteral equipment, replacement parts, and related supplies.
- The provider must submit a request form for PA on the *Oral Enteral Nutrition Prior Authorization Request for Clients 20 Years of Age or Less* (HCA #13-110) form. This form must be:
  - ✓ Complete, with all fields filled in.
  - ✓ Completed by the prescribing physician, advanced registered nurse practitioner, or physician assistant.

- ✓ Written, dated, and signed (including the prescriber's credentials) by the prescriber on the same day, and before the date of delivery. The agency does not accept backdated forms.
- ✓ Submitted within three months of the date the prescriber signed the prescription.

Expedited prior authorization (EPA)

EPA is a process to eliminate the need to fax requests for prior authorization for selected Healthcare Common Procedure Coding System (HCPCS) codes.

Providers must establish that the client's condition meets the clinically appropriate expedited prior authorization (EPA) criteria outlined in this billing guide. The appropriate EPA number must be used when the provider bills the agency.

Enteral Nutrition Forms

(***Read this Billing Guide completely for full information***)

Authorization	Required Forms	Notes
Oral enteral products		
For urgent one-time, one-month supply One month equals 30 days. **Use EPA# 870001407**	**HCA #13-961** *Enteral Nutrition Products Prescription and Order Form* **HCA #13-114** *Oral Enteral Nutrition Products for Clients 20 Years of Age and Younger – Expedited Prior Authorization (EPA) Worksheet*	Keep completed forms in the client's file for agency review, upon request. No WIC/Medicaid Nutrition form required due to the urgent nature of the need for the oral enteral product.
To treat a growth of nutritional deficiency (when medically necessary) Monthly supply up to 6 months. **Use EPA# 870001408**	**HCA #13-961** *Enteral Nutrition Products Prescription and Order Form* **HCA #13-109** *Dietitian Worksheet – Oral Enteral Nutrition Assessment* **HCA #13-114** *Oral Enteral Nutrition Products for Clients 20 Years of Age and Younger – Expedited Prior Authorization (EPA) Worksheet* **DOH 962-937** *WIC/Medicaid Nutrition Form* if client is age 4 years or younger	Keep completed forms in the client's file for agency review, upon request.
Prior authorization request when medically necessary and client cannot be transitioned to homemade product or food after 6 months of EPA.	**HCA #13-835** *General Information for Authorization* (This form must be typed and must be the coversheet for the fax transmission.) **HCA #13-961** *Enteral Nutrition Products Prescription and Order Form* **HCA #13-109** *Dietitian Worksheet – Oral Enteral Nutrition Assessment* **HCA #13-110** *Oral Enteral Nutrition Prior Authorization Request for Clients 20 Years of age or Less* **DOH 962-937** *WIC/Medicaid Nutrition Form* if client is age 4 years or younger	Fax completed forms to the agency for clinical review.

Authorization	Required Forms	Notes
Oral enteral products (cont.)		
Exception to Rule (ETR)	**HCA #13-835** *General Information for Authorization* (This form must be typed and must be the coversheet for the fax transmission.) **HCA #13-961** *Enteral Nutrition Products Prescription and Order Form* **HCA #13-864** *Oral Enteral Nutrition Exception to Rule (ETR) Request*	Fax completed forms and any additional documentation to HCA for clinical review.
Formulas for inherited disorders of metabolism		
Clients under age 20 **Use EPA #870001405**	**HCA #13-961** *Enteral Nutrition Products Prescription and Order Form* **HCA #13-101** *Metabolic Disorders-Oral Enteral Nutrition Expedited Prior Authorization (EPA) Worksheet: Children*	For clients age 20 and younger who have inherited metabolic disorders only. Keep completed forms in the client's file for agency review, upon request.
Clients age 12 and older Exception to Rule (ETR)	**HCA #13-835** *General Information for Authorization* (This form must be typed and must be the coversheet for the fax transmission.) **HCA #13-961** *Enteral Nutrition Products Prescription and Order Form* **HCA #13-100** *Metabolic Disorders-Oral Enteral Nutrition Exception to Rule (ETR) Request: Adults*	For clients age 21 and older with inherited metabolic disorders only. Fax completed forms and any additional documentation to the agency for clinical review.
Thickeners		
For clients age 1-20 **Use EPA #870001406**	**HCA #13-961** *Enteral Nutrition Products Prescription and Order Form* **HCA #13-109** *Dietitian Worksheet – Oral Enteral Nutrition Assessment* **HCA #13-112** *Thickeners for Children from 1-20 years old Expedited Prior Authorization (EPA) Form*	Keep completed forms in the client's file for agency review, upon request.

Authorization	Required Forms	Notes
Thickeners (cont.)		
Prior authorization required for clients under age 1	**HCA #13-835** *General Information for Authorization* (This form must be typed and must be the coversheet for the fax transmission.) **HCA #13-961** *Enteral Nutrition Products Prescription and Order Form* **HCA #13-109** *Dietitian Worksheet – Oral Enteral Nutrition Assessment* **HCA #13-111** *Thickeners for Babies Less than One Year – Prior Authorization Request Form*	Fax completed forms and any additional documentation to the agency for clinical review.
Tube delivered products		
No PA or EPA if clients meet criteria in WAC 182-554-600.	**HCA #13-961** *Enteral Nutrition Products Prescription and Order Form* **DOH 962-937** *WIC/Medicaid Nutrition Form* if client is age 4 years or younger	Keep completed forms in the client's file for agency review, upon request.
Equipment and supplies for tube delivered products		
No PA or EPA required unless the client's needs exceeds published limits.	**HCA #13-961** *Enteral Nutrition Products Prescription and Order Form*	Keep completed forms in the client's file for agency review, upon request.
Limitation Extension (LE)	**HCA #13-835** *General Information for Authorization* (use this form as the coversheet for the fax transmission) **HCA #13-961** *Enteral Nutrition Products Prescription and Order Form* **HCA #13-115** *Enteral Equipment and Supplies Limitation Extension (LE) and Exception to Rule (ETR) Request Form*	Fax completed forms and any additional documentation to the agency for clinical review.
Request for B9998 - miscellaneous enteral nutrition product.	**HCA #13-835** *General Information for Authorization* (use this form as the coversheet for the fax transmission) **HCA #13-961** *Enteral Nutrition Products Prescription and Order Form* **HCA #13-745** *Justification for Miscellaneous Enteral Nutrition Procedure Code (B9998)*	Fax completed forms and any additional documentation to the agency for clinical review. Invoice for requested item must be submitted for reimbursement.

Modifiers

Note: Providers must use the procedure codes listed in the product list along with the appropriate modifier for all enteral nutrition products. The agency denies claims for enteral nutrition products without modifiers.

Modifier BA

Use Modifier **BA** for medically necessary, **tube-delivered enteral nutrition products and supplies**, not orally administered nutrition.

Modifier BO

Use Modifier **BO** for medically necessary, **orally administered enteral nutrition products**, not nutrition administered by external tube.

Note: Medicare Part B covers enteral nutrition products for clients who are tube-fed. Enteral nutrition products appropriately billed with a 'BO' modifier will not require a Medicare denial and can be billed directly to the agency. Providers must use the procedure codes listed in the agency's fee schedule along with the appropriate modifier for all poles and pumps.

Modifier NU

Use Modifier **NU** to indicate that the provider is billing the agency for newly purchased equipment.

Modifier RR

Use Modifier **RR** to indicate that the provider is billing the agency for rental equipment.

Billing

All claims must be submitted electronically to the agency, except under limited circumstances.
For more information about this policy change, see Paperless Billing at HCA.
For providers approved to bill paper claims, see the agency's Paper Claim Billing Resource.

What are the general billing requirements?

Providers must follow the agency's ProviderOne Billing and Resource Guide. These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
- How to bill for clients eligible for both Medicare and Medicaid
- How to handle third-party liability claims
- What standards to use for record keeping

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims are found on the agency's Billers, providers, and partners webpage, under Webinars.

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

Record Keeping

The agency requires DME and pharmacy providers to keep legible, accurate, and complete records to justify the medical necessity of the items provided. (See WAC 182-502-0020 Health care record requirements.)

Product	Retain in the Client's File
Thickeners	• A copy of the *Enteral Nutrition Products Prescription and Order Form* (HCA #13-961), signed and dated by the prescribing provider, listing the client's medical condition and the exact daily amount of thickener product prescribed • A copy of the *Thickeners for Children from 1-20 years old Expedited Prior Authorization (EPA) Form* (HCA #13-112) form, or the *Thickeners for Babies Less than One Year – Prior Authorization Request Form* (HCA #13-111) form • A copy of the *Dietitian Worksheet – Oral Enteral Nutrition Assessment* (HCA #13-109) form for clients age 20 and younger
Inherited Metabolic Disorders	• A copy of the *Enteral Nutrition Products Prescription and Order Form* (HCA #13-961), signed and dated by the prescribing provider, listing the client's medical condition and the exact daily amount of product prescribed. At a minimum, this prescription must be renewed annually. • A copy of *Metabolic Disorders-Oral Enteral Nutrition Expedited Prior Authorization (EPA) Worksheet: Children* (HCA #13-101) form, or the *Metabolic Disorders-Oral Enteral Nutrition Exception to Rule (ETR) Request: Adults* (HCA #13-100) form

Product	Retain in the Client's File
Tube-Delivered Enteral Nutrition	• A copy of the *Enteral Nutrition Products Prescription and Order Form* (HCA #13-961) that is signed and dated by the prescribing provider and lists the client's medical condition and the exact daily caloric amount of medically necessary enteral nutrition product. • For clients age 4 and younger, WIC forms documenting that: ✓ The client is not eligible for WIC program services. ✓ The client is eligible for WIC program services, but nutrition needs exceed the WIC program's maximum per calendar month allotment. ✓ The WIC program cannot provide the prescribed or similar product.
Enteral equipment and related supplies	• A copy of the *Enteral Nutrition Products Prescription and Order Form* (HCA #13-961), signed and dated by the prescribing provider, listing the client's medical condition and the exact daily amount of product prescribed. At a minimum, this prescription must be renewed annually. • A copy of the *Enteral Equipment and Supplies Limitation Extension (LE) and Exception to Rule (ETR) Request Form* (HCA #13-115) form.

Product	Retain in the Client's File
Oral Enteral Nutrition	• A completed *Oral Enteral Nutrition Products for Clients 20 Years of Age and Younger – Expedited Prior Authorization (EPA) Worksheet* (HCA #13-114) form. The client must meet the exact criteria in order for the vendor to use an EPA number. • Associated documentation Upon request, a vendor must provide specific, detailed documentation to the agency showing how the client's condition met the criteria for EPA. DME and Pharmacy providers must keep documentation on file for six years (see WAC 182-502-0020). Per RCW 74.09.200 and 74.09.290 and WAC 182-502-0020 the forms that must be maintained in the patient's records for 6 years and must be produced in an audit include but are not limited to: • A copy of the completed *Enteral Nutrition Products Prescription and order Form* (HCA #13-961). • A copy of the proof of delivery. • A copy of the dietitian's nutrition assessment(s) signed WIC forms. • Other appropriate HCA signed forms.