Washington State Health Care Authority

Washington Apple Health (Medicaid)

Complex Rehabilitation Technology (CRT) Products & Related Services Billing Guide

January 1, 2017

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, 2017, and supersedes earlier guides to this program.

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> 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
Where can I download agency forms?	Added a new section to help providers more easily find the agency's forms on the new web page.	Clarification
Fee-for-service clients with other primary health insurance to be enrolled into managed care	Added new section regarding changes for some fee-for-service clients.	Policy change
HCPCS code E1028	Added note box saying: "HCPCS code E1028 (Wheelchair accessory, manual swingaway, retractable or removable mounting hardware) must be submitted on one line for correct payment."	Clarification

* This publication is a billing instruction.

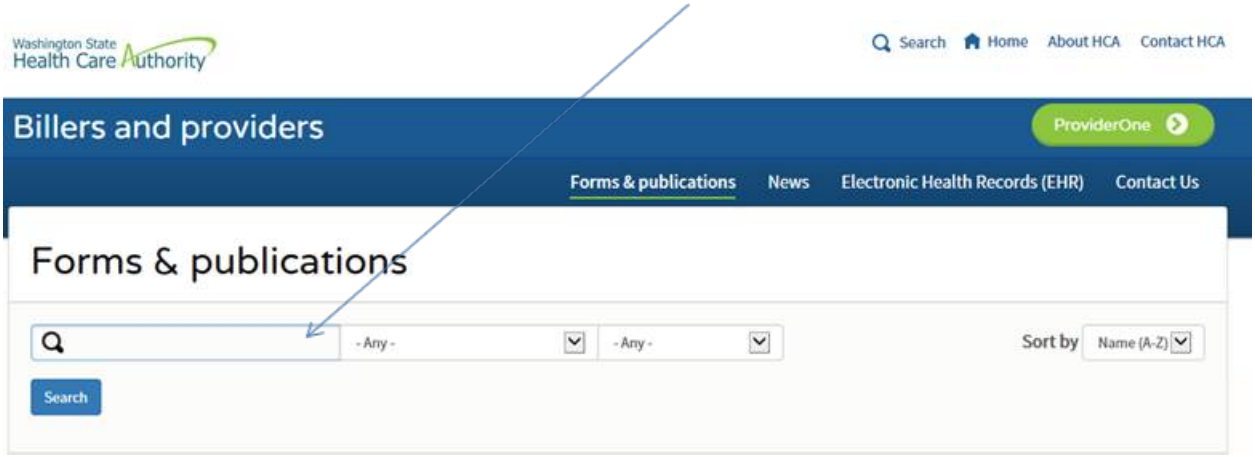
How can I get agency provider documents?

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

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

Where can I download agency forms?

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



Additional resources

For additional resources, see the agency's ProviderOne Resources page.

Table of Contents

Alert! This Table of Contents is automated. Click on a page number to go directly to the page.

Definitions

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

Acquisition cost (AC) – The cost of an item excluding shipping, handling, and any applicable taxes.

Assignment – A process in which a doctor or supplier agrees to accept the Medicare program's payment as payment in full, except for specific deductible and coinsurance amounts required of the patient.

Complex needs patient – A person with a diagnostic or medical condition that results in significant physical or functional needs and capacities. (WAC 182-543-1000)

Complex rehabilitation technology (CRT) – Means wheelchairs and seating systems classified as durable medical equipment within the Medicare program that:

(1) Are individually configured for people to meet their specific and unique medical, physical, and functional needs and capacities for basic activities as medically necessary to prevent hospitalization or institutionalization of a complex needs patient.
(2) Are primarily used to serve a medical purpose and generally not useful to a person in the absence of an illness or injury.
(3) Require certain services to allow for appropriate design, configuration, and use of such item, including patient evaluation and equipment fitting and configuration. (WAC 182-543-1000)

Date of delivery – The date the client actually took physical possession of an item or equipment. (WAC 182-543-1000)

Health care common procedure coding system (HCPCS) – A coding system established by the Centers for Medicare and Medicaid Services (CMS). (WAC 182-543-1000)

Home – For the purposes of this chapter, means location, other than hospital or skilled nursing facility where the client receives care. (WAC 182-543-1000)

Individually configured – A device has a combination of features, adjustments, or modifications specific to complex needs patient that a qualified complex rehabilitation technology supplier provides by measuring, fitting, programming, adjusting, and adapting the device as appropriate so that the device is consistent with an assessment or evaluation of the complex needs patient by a health care professional and consistent with the complex needs patient's medical condition, physical and functional needs and capacities, body size, period of need, and intended use. (WAC 182-543-1000)

Manual wheelchair – See "Wheelchair – Manual."

Medically necessary – See WAC 182-500-0070.

Power-drive wheelchair – See "Wheelchair – Power."

Pricing cluster – A group of manufacturers' list prices for brands/models of DME, medical supplies and nondurable medical equipment that the agency considers when calculating the reimbursement rate for a procedure code that does not have a fee established by Medicare.
(WAC 182-543-1000)

Prior authorization – See WAC 182-500-0085.

Qualified complex rehabilitation technology supplier – A company or entity that:

(1) Is accredited by a recognized accrediting organization as a supplier of CRT.
(2) Meets the supplier and quality standards established for durable medical equipment suppliers under the Medicare program.
(3) For each site that it operates, employs at least one CRT professional, who has been certified by the Rehabilitation Engineering and Assistive Technology Society of North America as an assistive technology professional, to analyze the needs and capacities, and provider training in the use of the selected covered CRT items.
(4) Has the CRT professional physically present for the evaluation and determination of the appropriate individually configured complex rehabilitation technologies for the complex needs patient.
(5) Provides service and repairs by qualified technicians for all CRT products it sells.
(6) Provides written information to the complex needs patient at the time of delivery about how the person may receive service and repair.

(WAC 182-543-1000)

Usual and customary charge – See WAC 182-500-0100.

Warranty-period – A guarantee or assurance, according to manufacturers' or provider's guidelines, of set duration from the date of purchase.
(WAC 182-543-1000)

Wheelchair – Manual – A federally-approved, non-motorized wheelchair that is capable of being independently propelled and fits one of the following categories:

- **Standard:**
  - ✓ Usually is not capable of being modified
  - ✓ Accommodates a person weighing up to 250 pounds
  - ✓ Has a warranty period of a least one year

- **Lightweight:**
  - ✓ Composed of lightweight materials
  - ✓ Capable of being modified
  - ✓ Accommodates a person weighing up to 250 pounds
  - ✓ Usually has a warranty period of at least three years

- **High-strength lightweight**:
  - ✓ Is usually made of a composite material
  - ✓ Is capable of being modified
  - ✓ Accommodates a person weighing up to 250 pounds
  - ✓ Has an extended warranty period of over three years

- ✓ Accommodates the very active person

- **Hemi:**
  - ✓ Has a seat-to-floor height lower than 18" to enable an adult to propel the wheelchair with one or both feet
  - ✓ Is identified by its manufacturer as "Hemi" type with specific model numbers that include the "Hemi" description

- **Pediatric:** Has a narrower seat and shorter depth more suited to pediatric patients, usually adaptable to modifications for a growing child.

- **Recliner:** Has an adjustable, reclining back to facilitate weight shifts and provide support to the upper body and head.

- **Tilt-in-space:** Has a positioning system, which allows both the seat and back to tilt to a specified angle to reduce shear or allow for unassisted pressure releases.

- **Heavy duty** meets one of the following:

  - ✓ Is specifically manufactured to support a person weighing up to 300 pounds
  - ✓ Accommodates a seat width of up to 22" wide (not to be confused with custom manufactured wheelchairs)

- **Rigid:** Is an ultra-lightweight material with a rigid (nonfolding) frame.

- **Custom heavy duty** meets one of the following**:**
  - ✓ Is specifically manufactured to support a person weighing over 300 pounds
  - ✓ Accommodates a seat width of over 22" wide (not to be confused with custom manufactured wheelchairs).

- **Custom manufactured specially built:**
  - ✓ Ordered for a specific client form custom measurements
  - ✓ Is assembled primarily at the manufacturer's facility

(WAC 182-543-1000)

Wheelchair – Power – A federally-approved, motorized wheelchair that can be independently driven by a client and fits one of the following categories:

- **Custom power adaptable** to:
  - ✓ Alternative driving controls
  - ✓ Power recline and tilt-in-space systems

- **Non-custom power**: Does not need special positioning or controls and has a standard frame.

- **Pediatric**: Has a narrower seat and shorter depth that is more suited to pediatric patients. Pediatric wheelchairs are usually adaptable to modifications for a growing child.

(WAC 182-543-1000)

About CRT

What is the purpose of the complex rehabilitation technology (CRT) billing guide?

The purpose of this billing guide is to provide billing information for individually configured, complex rehabilitation technology (CRT) products and related services provided to eligible clients with complex needs.

> **Note:** For clients who require a wheelchair but who do not meet the agency's requirements in this billing guide for an individually configured CRT product, see the agency's Durable Medical Equipment (DME)/Non-CRT Wheelchairs Billing Guide.

When does the agency pay for CRT products and related services?

(WAC 182-543-0500)

The agency covers CRT products and related services according to agency rules and subject to the limitations and requirements within this guide.

The agency pays for CRT products and related services including modifications, accessories, and repairs when they are all of the following:

- Covered
- Within the client's medical program scope (see WAC 182-501-0060 and 182-501-0065)
- Medically necessary, as defined in WAC 182-500-0005
- Prescribed by a physician, advanced registered nurse practitioner (ARNP), physician assistant certified (PAC), or naturopathic physician within the scope of his or her licensure, except for dual eligible Medicare/Medicaid clients when Medicare is the primary payer and the agency is billed for a co-pay and/or deductible only
- Authorized, as required in this billing guide, and per the following:
  - ✓ Chapter 182-501 WAC
  - ✓ Chapter 182-502 WAC
  - ✓ Chapter 182-543 WAC

- Provided and used within accepted medical or physical medicine community standards of practice

The agency requires prior authorization (PA) for CRT products and related services. The agency evaluates requests requiring PA on a case-by-case basis to determine medical necessity, according to the process found in WAC 182-501-0165.

Note: See Authorization for specific details regarding authorization for CRT.

The agency evaluates a request for any CRT product or related service listed as noncovered within this billing guide under the provisions of WAC 182-501-0160. When EPSDT applies, the agency evaluates a noncovered product or service according to the process in WAC 182-501-0165 to determine if it is all of the following:

- Medically necessary
- Safe
- Effective
- Not experimental (refer to the agency's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Billing Guide for more information)

The agency evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational as defined by WAC 182-531-0050, under the provisions of WAC 182-501-0165 which relate to medical necessity.

Does the agency follow the National Correct Coding Initiative (NCCI) policy?

Yes. The agency follows the National Correct Coding Initiative (NCCI) policy. The Centers for Medicare and Medicaid Services (CMS) created this policy to promote national correct coding methods. NCCI assists the agency to control improper coding that may lead to inappropriate payment.

The agency bases coding policies on the following:

- The American Medical Association's (AMA) Current Procedural Terminology (CPT®) manual
- National and local policies and edits
- Coding guidelines developed by national professional societies
- The analysis and review of standard medical and surgical practices
- Review of current coding practices

The agency may perform a post-pay review on any claim to ensure compliance with NCCI. NCCI rules are enforced by the ProviderOne payment system.

Client Eligibility

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington 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.

To verify eligibility, follow this two-step process:

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

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

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

Note: Patients who wish to apply for Washington Apple Health can do so 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. When verifying eligibility using ProviderOne, if the client is enrolled in an agency-contracted managed care organization (MCO), managed care enrollment will be displayed on the Client Benefit Inquiry screen. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their MCO by calling the telephone number provided to them.

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 MCO 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 MCO. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

The agency does not pay for complex rehabilitation technology (CRT) products or related services provided to a client who is enrolled in an agency-contracted MCO, but who did not use one of the MCO's participating providers.

What if a client has third-party liability (TPL)?

If the client has TPL coverage (excluding Medicare), prior authorization must be obtained before providing any service requiring prior authorization. For more information on TPL, refer to the agency's ProviderOne Billing and Resource Guide.

Effective January 1, 2017, some fee-for-service clients who have other primary health insurance will be enrolled into managed care

On January 1, 2017, the agency enrolled some fee-for-service Apple Health clients who have other primary health insurance into an agency-contracted managed care organization (MCO).

This change did not affect all fee-for-service Apple Health clients who have other primary health insurance. The agency continues to cover some clients under the fee-for-service Apple Health program, such as dual-eligible clients whose primary insurance is Medicare.

For additional information, see the agency's Managed Care web site, under Providers and Billers.

Effective April 1, 2016, important changes to Apple Health

These changes are important to all providers because they may affect who will pay for services.

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client's Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. See the Southwest Washington Provider Fact Sheet on the agency's Regional Resources web page**.**

New MCO enrollment policy – earlier enrollment

Beginning April 1, 2016, Washington Apple Health (Medicaid) implemented a new managed care enrollment policy placing clients into an agency-contracted MCO **the same month** they are determined eligible for managed care as a new or renewing client. This policy eliminates a person being placed temporarily in fee-for-service while they are waiting to be enrolled in an MCO or reconnected with a prior MCO.

- **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.

Clients currently in fee-for-service or currently enrolled in an MCO are not affected by this change. Clients in fee-for-service who have a change in the program they are eligible for may be enrolled into Apple Health Managed Care depending on the program. In those cases, this enrollment policy will apply.

How does this policy affect providers?

- 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 new policies.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs will replace the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the Mental Health Billing guide. BHOs use the Access to Care Standards (ACS) for mental health conditions and American Society of Addiction Medicine (ASAM) criteria for SUD conditions to determine client's appropriateness for this level of care.

Fully Integrated Managed Care (FIMC)

Clark and Skamania Counties, also known as SW WA region, is the first region in Washington State to implement the FIMC system. This means that physical health services, all levels of mental health services, and drug and alcohol treatment are coordinated through one managed care plan. Neither the RSN nor the BHO will provide behavioral health services in these counties.

Clients must choose to enroll in either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW). If they do not choose, they are auto-enrolled into one

of the two plans. Each plan is responsible for providing integrated services that include inpatient and outpatient behavioral health services, including all SUD services, inpatient mental health and all levels of outpatient mental health services, as well as providing its own provider credentialing, prior authorization requirements and billing requirements.

Beacon Health Options provides mental health crisis services to the entire population in Southwest Washington. This includes inpatient mental health services that fall under the Involuntary Treatment Act for people who are not eligible for or enrolled in Medicaid, and short-term substance use disorder (SUD) crisis services in the SW WA region. Within their available funding, Beacon has the discretion to provide outpatient or voluntary inpatient mental health services for people who are not eligible for Medicaid. Beacon Health Options is also responsible for managing voluntary psychiatric inpatient hospital admissions for non-Medicaid clients.

In the SW WA region some clients are not enrolled in CHPW or Molina for FIMC, but will remain in Apple Health fee-for-service managed by the agency. These clients include:

- Dual eligible – Medicare/Medicaid
- American Indian/Alaska Native (AI/AN)
- Medically needy
- Clients who have met their spenddown
- Noncitizen pregnant women
- People in Institutions for Mental Diseases (IMD)
- Long-term care residents who are currently in fee-for-service
- Clients who have coverage with another carrier

Since there is no BHO (RSN) in these counties, Medicaid fee-for-service clients receive complex behavioral health services through the Behavioral Health Services Only (BHSO) program managed by MHW and CHPW in SW WA region. These clients choose from CHPW or MHW for behavioral health services offered with the BHSO or will be auto-enrolled into one of the two plans. A BHSO fact sheet is available online.

Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18th birthday

American Indian/Alaska Native (AI/AN) children will **not** be auto-enrolled, but may opt into CCW. All other eligible clients will be auto-enrolled.

AHCC complex mental health and substance use disorder services

AHCC clients who **live in** Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will use the BHO Access to Care Standards to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.

AHCC clients who **live outside** Skamania or Clark County will receive complex mental health and substance use disorder services from the BHO and managed by DSHS.

Contact Information for Southwest Washington

Beginning on April 1, 2016, there will not be an RSN/BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to a person who is not eligible for or enrolled in Medicaid.

If a provider does not know which MCO a client is enrolled in, this information can located by looking up the patient assignment in ProviderOne.

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

MOLINA HEALTHCARE	Molina Healthcare of Washington, Inc. 1-800-869-7165

COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009

Beacon Health Options	Beacon Health Options 1-855-228-6502

Provider/Manufacturer Information

Who is eligible to provide complex rehabilitation technology (CRT) products and related services?

(WAC 182-543-4400)

To be eligible to provide CRT and related services on a fee-for-service basis to clients, providers must:

- Meet the definition of a qualified CRT supplier.
- Employ at each site that a company operates, at least one CRT professional who is certified by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).
- Be enrolled with Medicaid and Medicare.
- Be registered with the appropriate taxonomy number (**332BC3200X**) to bill for CRT and related services.

The client must be evaluated by a licensed health care provider who performs specialty evaluations within that provider's scope of practice (occupational or physical therapists) and who does not have a financial relationship with the supplier.

What are the agency's requirements for CRT providers?

CRT providers must:

- Be present at the client's evaluation to assist in selection of the appropriate CRT product(s) and provide training in the use of the selected items.
- Provide written information to the client at the time of delivery as to how the client may receive services and repairs.
- Provide service and repairs by a qualified technician for all CRT products it sells.

- Meet the general provider requirements in chapter 182-502 WAC.
- Obtain prior authorization before delivering the CRT product to the client.
- Furnish to clients only new CRT products that include full manufacturer and dealer warranties.
- Furnish, upon agency request, documentation of proof of delivery.
  (See What are the agency's requirements for proof of delivery?)
- Have a valid prescription. To be valid, a prescription must meet all of the following:
  - ✓ Be written on the agency's Prescription form, HCA 13-794. See Where can I download agency forms?
  - ✓ Be written by a physician, advanced registered nurse practitioner (ARNP), physician's assistant certified (PAC), or naturopathic physician
  - ✓ Be written, signed (including the prescriber's credentials), and dated by the prescriber on the same day or before delivery of the supply, equipment, or device (prescriptions must not be back-dated)
  - ✓ Be no older than one year from the date the prescriber signs the prescription
  - ✓ State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity

  Note: The above does not apply to dual eligible Medicare/Medicaid clients when Medicare is the primary payer and the agency is being billed for the copay and/or deductible only.
- Deliver the CRT product to the client before the provider bills the agency.
- Bill the agency using only the allowed procedure codes listed within this billing guide.

When does the agency not pay for CRT products or related services?

The agency does not pay for CRT products or related services furnished to eligible clients when:

- The medical professional who provides medical justification to the agency for the item

provided to the client is an employee of, has a contract with, or has any financial relationship with the provider of the item.

- The medical professional who performs a client evaluation is an employee of, has a contract with, or has any financial relationship with a provider of CRT.

- The CRT products or related services have been delivered to a client without PA from the agency.

What are the agency's requirements for proof of delivery?

(WAC 182-543-2200)

When a provider delivers an item directly to the client or the client's authorized representative, the provider must furnish the proof of delivery when the agency requests that information. All of the following apply:

- The proof of delivery must:
  - ✓ Be signed and dated by the client or the client's authorized representative (the date of signature must be the date the item was received by the client).
  - ✓ Include the client's name and a detailed description of the item(s) delivered, including the quantity and brand name.
  - ✓ For CRT products that may require future repairs, include the serial number.
  - ✓ When the provider or supplier submits a claim for payment to the agency, the date of service on the claim must be the date the item was received by the client or authorized representative.

- When billing the agency, use the actual date of delivery as the date of service on the claim if the provider/supplier does the delivery.

Note: A provider must not use a delivery/shipping service to deliver items which must be fitted to the client.

What are habilitative services under this program?

Habilitative services are those medically necessary services provided to help a client partially or fully attain or maintain developmental age-appropriate skills that were not fully acquired due to a congenital, genetic, or early-acquired health condition. Such services are required to maximize the client's ability to function in his or her environment.

Applicable to those clients in the expanded population and covered by the Alternative Benefit Plan (ABP) only, the agency will cover CRT used to treat one of the qualifying conditions listed in the agency's Habilitative Services Billing Guide, under *Client Eligibility*.

All other program requirements are applicable to a habilitative service and should be followed unless otherwise directed (e.g., prior authorization).

Billing for habilitative services

Habilitative services must be billed using one of the qualifying diagnosis codes listed in the agency's *Habilitative Services Billing Guide* in the primary diagnosis field on the claim.

CRT Coverage Table

The agency covers, **with prior authorization (PA)**, the following individually configured, complex rehabilitation technology (CRT) products and related services provided to eligible clients with complex needs.

Reminder: see CRT Fee Schedule for payment requirements.

Code Status Indicator	HCPCS Code	Modifier	Short Description	Policy/ Comments
Wheelchairs – Manual				
	K0004	NU	High strength ltwt whlchr	
	K0005	NU	Ultralightweight wheelchair	
	K0006	NU	Heavy duty wheelchair	
	K0007	NU	Extra heavy duty wheelchair	
	K0009	NU	Other manual wheelchair/base	
	K0195	NU	Elevating leg rests, pair	
	E1161	NU	Manual adult wc w tiltinspac	
	E1225	NU	Manual semi-reclining back	
	E1226	NU	Manual fully reclining back	
	E1227	NU	Wheelchair spec sz spec ht a	
	E1228	NU	Wheelchair spec sz spec ht b	
	E1229	NU	Pediatric wheelchair nos	
	E1231	NU	Rigid ped w/c tilt-in-space	
	E1232	NU	Folding ped wc tilt-in-space	
	E1233	NU	Rig ped wc tltnspc w/o seat	
	E1234	NU	Fld ped wc tltnspc w/o seat	
	E1235	NU	Rigid ped wc adjustable	
	E1236	NU	Folding ped wc adjustable	
	E1237	NU	Rgd ped wc adjstabl w/o seat	
	E1238	NU	Fld ped wc adjstabl w/o seat	
BR	E1239	NU	Ped power wheelchair nos	

Legend

Code Status Indicator
BR = By report
NC = Not Covered

Modifier
NU = Purchase

Note: Billing provision limited to a one-month supply. One month equals 30 days.

Code Status	HCPCS Code	Modifier	Short Description	Policy/ Comments
Wheelchairs – Power				
	K0813	NU	Pwc gp 1 std port seat/back	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340–E2343, E2381–E2396 K0056, E0978, E2366, K0099, K0051, K0052, E0995, K0037, K0040–K0045, K0052, K0015, K0019, K0020, E0981 & E0982
	K0814	NU	Pwc gp 1 std port cap chair	
	K0815	NU	Pwc gp 1 std seat/back	
	K0816	NU	Pwc gp 1 std cap chair	
	K0820	NU	Pwc gp 2 std port seat/back	
	K0821	NU	Pwc gp 2 std port cap chair	
	K0822	NU	Pwc gp 2 std seat/back	
	K0823	NU	Pwc gp 2 std cap chair	
	K0824	NU	Pwc gp 2 hd seat/back	
	K0825	NU	Pwc gp 2 hd cap chair	
	K0826	NU	Pwc gp 2 vhd seat/back	
	K0827	NU	Pwc gp vhd cap chair	
	K0828	NU	Pwc gp 2 xtra hd seat/back	
	K0829	NU	Pwc gp 2 xtra hd cap chair	
	K0830	NU	Pwc gp2 std seat elevate s/b	
	K0831	NU	Pwc gp2 std seat elevate cap	
	K0835	NU	Pwc gp2 std sing pow opt s/b	
	K0836	NU	Pwc gp2 std sing pow opt cap	
	K0837	NU	Pwc gp 2 hd sing pow opt s/b	
	K0838	NU	Pwc gp 2 hd sing pow opt cap	
	K0839	NU	Pwc gp2 vhd sing pow opt s/b	
	K0840	NU	Pwc gp2 xhd sing pow opt s/b	
	K0841	NU	Pwc gp2 std mult pow opt s/b	
	K0842	NU	Pwc gp2 std mult pow opt cap	
	K0843	NU	Pwc gp2 hd mult pow opt s/b	
	K0848	NU	Pwc gp 3 std seat/back	
	K0849	NU	Pwc gp 3 std cap chair	
	K0850	NU	Pwc gp 3 hd seat/back	
	K0851	NU	Pwc gp 3 hd cap chair	
	K0852	NU	Pwc gp 3 vhd seat/back	

Legend

Code Status Indicator
BR = By report
NC = Not Covered

Modifier
NU = Purchase

Note: Billing provision limited to a one-month supply. One month equals 30 days.

Code Status	HCPCS Code	Modifier	Short Description	Policy/ Comments
	K0853	NU	Pwc gp 3 vhd cap chair	
	K0854	NU	Pwc gp 3 xhd seat/back	
	K0855	NU	Pwc gp 3 xhd cap chair	
	K0856	NU	Pwc gp3 std sing pow opt s/b	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340–E2343, E2381–E2396 K0056, E0978, E2366, K0099, K0051, K0052, E0995, K0037, K0040–K0045, K0052, K0015, K0019, K0020, E0981 & E0982
	K0857	NU	Pwc gp3 std sing pow opt cap	
	K0858	NU	Pwc gp3 hd sing pow opt s/b	
	K0859	NU	Pwc gp3 hd sing pow opt cap	
	K0860	NU	Pwc gp3 vhd sing pow opt s/b	
	K0861	NU	Pwc gp3 vhd sing pow opt s/b	
	K0862	NU	Pwc gp3 hd mult pow opt s/b	
	K0863	NU	Pwc gp3 vhd mult pow opt s/b	
BR	K0890	NU	Pwc gp5 ped sing pow opt s/b	
BR	K0891	NU	Pwc gp5 ped mult pow opt s/b	
BR	K0898	NU	Power wheelchair noc	
	E0950	NU	Tray	
	E0951	NU	Loop heel	
	E0952	NU	Toe loop/holder, each	
	E0955	NU	Cushioned headrest	
	E0956	NU	W/c lateral trunk/hip support	
	E0957	NU	W/c medial thigh support	
	E0958	NU	Whlchr att- conv 1 arm drive	
	E0960	NU	W/c shoulder harness/straps	
	E0961	NU	Wheelchair brake extension	
	E0966	NU	Wheelchair head rest extensi	
	E0967	NU	Manual wc hand rim w project	
	E0971	NU	Wheelchair anti-tipping devi	
	E0973	NU	W/ch access det adj armrest	
	E0974	NU	W/ch access anti-rollback	
	E0978	NU	W/c acc,saf belt pelv strap	
	E0980	NU	Wheelchair safety vest	
	E0981	NU	Seat upholstery, replacement	
	E0982	NU	Back upholstery, replacement	

Legend

Code Status Indicator
BR = By report
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Modifier
NU = Purchase

Note: Billing provision limited to a one-month supply. One month equals 30 days.

Code Status	HCPCS Code	Modifier	Short Description	Policy/ Comments
	E0983	NU	Add pwr joystick	
	E0984	NU	Add pwr tiller	
	E0985	NU	W/c seat lift mechanism	
	E0986	NU	Man w/c push-rim pow assist	
	E0990	NU	Wheelchair elevating leg res	
	E0992	NU	Wheelchair solid seat insert	
	E0994	NU	Wheelchair arm rest	
	E0995	NU	Wheelchair calf rest	
	E1002	NU	Pwr seat tilt	
	E1003	NU	Pwr seat recline	
	E1004	NU	Pwr seat recline mech	
	E1005	NU	Pwr seat recline pwr	
	E1006	NU	Pwr seat combo w/o shear	
	E1007	NU	Pwr seat combo w/shear	
	E1008	NU	Pwr seat combo pwr shear	
NC	E1009	NU	Add mech leg elevation	
	E1010	NU	Add pwr leg elevation	
BR	E1011	NU	Ped wc modify width adjust	
	E1012	NU	Ctr mount pwr elev leg rest	
	E1014	NU	Reclining back add ped w/c	
	E1015	NU	Shock absorber for man w/c	
	E1016	NU	Shock absorber for power w/c	
	E1017	NU	Hd shck absrbr for hd man wc	
	E1018	NU	Hd shck absrbr for hd pwr w/c	
	E1028		Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory.	
	E1030	NU	W/c vent tray gimbaled	

Legend

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Modifier
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Note: Billing provision limited to a one-month supply. One month equals 30 days.

Code Status	HCPCS Code	Modifier	Short Description	Policy/ Comments
Wheelchairs - Accessories				
	E2201	NU	Man w/ch acc seat w>=20"<24"	
	E2202	NU	Seat width 24-27 in	
	E2203	NU	Frame depth 20 to less than 22 in	
	E2204	NU	Frame depth 22 to 25 in	
	E2205	NU	Manual wc accessory, handrim	
	E2206	NU	Complete wheel lock assembly	
	E2207	NU	Crutch and cane holder	
	E2208	NU	Cylinder tank carrier	
	E2209	NU	Arm trough each	
	E2210	NU	Wheelchair bearings	
	E2211	NU	Pneumatic propulsion tire	
	E2212	NU	Pneumatic prop tire tube	
	E2213	NU	Pneumatic prop tire insert	
	E2214	NU	Pneumatic caster tire each	
	E2215	NU	Pneumatic caster tire tube	
	E2216	NU	Foam filled propulsion tire	
	E2217	NU	Foam filled caster tire each	
	E2218	NU	Foam propulsion tire each	
	E2219	NU	Foam caster tire any size ea	
	E2220	NU	Solid propulsion tire each	
	E2221	NU	Solid caster tire each	
	E2222	NU	Solid caster integrated whl	
	E2224	NU	Propulsion whl excludes tire	
	E2225	NU	Caster wheel excludes tire	
	E2226	NU	Caster fork replacement only	
	E2227	NU	Gear reduction drive wheel	
	E2231	NU	Solid seat support base	
	E2291	NU	Planar back for ped size wc	
	E2292	NU	Planar seat for ped size wc	
	E2293	NU	Contour back for ped size wc	
	E2294	NU	Contour seat for ped size wc	

Legend

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Code Status	HCPCS Code	Modifier	Short Description	Policy/ Comments
NC	E2295	NU	Ped dynamic seating frame	
BR	E2300	NU	Pwr seat elevation sys	
BR	E2301	NU	Pwr standing	
	E2310	NU	Electro connect btw control	
	E2311	NU	Electro connect btw 2 sys	
	E2312	NU	Mini-prop remote joystick	
	E2313	NU	Pwc harness, expand control	
	E2321	NU	Hand interface joystick	
	E2322	NU	Mult mech switches	
	E2323	NU	Special joystick handle	
	E2324	NU	Chin cup interface	
	E2325	NU	Sip and puff interface	
	E2326	NU	Breath tube kit	
	E2327	NU	Head control interface mech	
	E2328	NU	Head/extremity control inter	
	E2329	NU	Head control nonproportional	
	E2330	NU	Head control proximity switc	
NC	E2331	NU	Attendant control	
	E2340	NU	W/c wdth 20-23 in seat frame	
	E2341	NU	W/c wdth 24-27 in seat frame	
	E2342	NU	W/c dpth 20-21 in seat frame	
	E2343	NU	W/c dpth 22-25 in seat frame	
	E2351	NU	Electronic sgd interface	
BR	E2358	NU	Gr 34 nonsealed leadacid	
	E2359	NU	Gr34 sealed leadacid battery	
	E2360	NU	22nf nonsealed leadacid	
	E2361	NU	22nf sealed leadacid battery	
	E2363	NU	Gr24 sealed leadacid battery	
	E2365	NU	U1 sealed leadacid battery	
	E2366	NU	Battery charger, single mode	
	E2367	NU	Battery charger, dual mode	
	E2368	NU	Pwr wc drivewheel motor repl	

Legend

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Code Status	HCPCS Code	Modifier	Short Description	Policy/ Comments
	E2369	NU	Pwr wc drivewheel gear repl	
	E2370	NU	Pwr wc dr wh motor/gear comb	
	E2371	NU	Gr27 sealed leadacid battery	
	E2372	NU	Gr27 non-sealed leadacid	
	E2373	NU	Hand/chin ctrl spec joystick	
	E2374	NU	Hand/chin ctrl std joystick	
	E2375	NU	Non-expandable controller	
	E2376	NU	Expandable controller, repl	
	E2377	NU	Expandable controller, initl	
	E2378	NU	Pw actuator replacement	
	E2381	NU	Pneum drive wheel tire	
	E2382	NU	Tube, pneum wheel drive tire	
	E2383	NU	Insert, pneum wheel drive	
	E2384	NU	Pneumatic caster tire	
	E2385	NU	Tube, pneumatic caster tire	
	E2386	NU	Foam filled drive wheel tire	
	E2387	NU	Foam filled caster tire	
	E2388	NU	Foam drive wheel tire	
	E2389	NU	Foam caster tire	
	E2390	NU	Solid drive wheel tire	
	E2391	NU	Solid caster tire	
	E2392	NU	Solid caster tire, integrate	
	E2394	NU	Drive wheel excludes tire	
	E2395	NU	Caster wheel excludes tire	
	E2396	NU	Caster fork	
	K0015	NU	Detach non-adjus hght armrest	
	K0017	NU	Detach adjust armrest base	
	K0018	NU	Detach adjust armrst upper	
	K0019	NU	Arm pad each	
	K0020	NU	Fixed adjust armrest pair	
	K0037	NU	High mount flip-up footrest	
	K0038	NU	Leg strap each	

Legend

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Modifier
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Code Status	HCPCS Code	Modifier	Short Description	Policy/ Comments
	K0039	NU	Leg strap h style each	
	K0040	NU	Adjustable angle footplate	
	K0041	NU	Large size footplate each	
	K0042	NU	Standard size footplate each	
	K0043	NU	Ftrst lower extension tube	
	K0044	NU	Ftrst upper hanger bracket	
	K0045	NU	Footrest complete assembly	
	K0046	NU	Elevat legrst low extension	
	K0047	NU	Elevat legrst up hangr brack	
	K0050	NU	Ratchet assembly	
	K0051	NU	Cam relese assem ftrst/lgrst	
	K0052	NU	Swingaway detach footrest	
	K0053	NU	Elevate footrest articulate	
	K0056	NU	Seat ht <17 or >=21 ltwt wc	
	K0065	NU	Spoke protectors	
	K0069	NU	Rear whl complete solid tire	
	K0070	NU	Rear whl compl pneum tire	
	K0071	NU	Front castr compl pneum tire	
	K0072	NU	Frnt cstr cmpl sem-pneum tir	
	K0073	NU	Caster pin lock each	
	K0077	NU	Front caster assem complete	
	K0098	NU	Drive belt power wheelchair	
	K0105	NU	Iv hanger	
	K0108	NU	W/c component-accessory nos	
	K0733	NU	12-24hr sealed lead acid	
NC	K0868	NU	Pwc gp 4 std seat/back	
NC	K0869	NU	Pwc gp 4 std cap chair	
NC	K0870	NU	Pwc gp 4 hd seat/back	
NC	K0871	NU	Pwc gp 4 vhd seat/back	
NC	K0877	NU	Pwc gp4 std sing pow opt s/b	
NC	K0878	NU	Pwc gp4 std sing pow opt cap	
NC	K0879	NU	Pwc gp4 hd sing pow opt s/b	

Legend

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Code Status	HCPCS Code	Modifier	Short Description	Policy/ Comments
NC	K0880	NU	Pwc gp4 vhd sing pow opt s/b	
NC	K0884	NU	Pwc gp4 std mult pow opt s/b	
NC	K0885	NU	Pwc gp4 std mult pow opt cap	
NC	K0886	NU	Pwc gp4 hd mult pow s/b	
Equipment, Replacement, Repair				
	K0739	NU	Repair/svc dme non-oxygen eq	
	E0776	NU, RR	IV Pole	
Wheelchairs - Cushion				
	E2601	NU	Gen w/c cushion wdth < 22 in	
	E2602	NU	Gen w/c cushion wdth >=22 in	
	E2603	NU	Skin protect wc cus wd <22in	
	E2604	NU	Skin protect wc cus wd>=22in	
	E2605	NU	Position wc cush wdth <22 in	
	E2606	NU	Position wc cush wdth>=22 in	
	E2607	NU	Skin pro/pos wc cus wd <22in	
	E2608	NU	Skin pro/pos wc cus wd>=22in	
	E2609	NU	Custom fabricate w/c cushion	
NC	E2610	NU	Powered w/c cushion	
	E2611	NU	Gen use back cush wdth <22in	
	E2612	NU	Gen use back cush wdth>=22in	
	E2613	NU	Position back cush wd <22in	
	E2614	NU	Position back cush wd>=22in	
	E2615	NU	Pos back post/lat wdth <22in	
	E2616	NU	Pos back post/lat wdth>=22in	
	E2617	NU	Custom fab w/c back cushion	Includes hardware
	E2619	NU	Replace cover w/c seat cush	
	E2620	NU	Wc planar back cush wd <22in	
	E2621	NU	Wc planar back cush wd>=22in	
	E2622	NU	Adj skin pro w/c cus wd<22in	
	E2623	NU	Adj skin pro wc cus wd>=22in	
	E2624	NU	Adj skin pro/pos cus<22in	
	E2625	NU	Adj skin pro/pos wc cus>=22	

Legend

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Note: Billing provision limited to a one-month supply. One month equals 30 days.

Code Status	HCPCS Code	Modifier	Short Description	Policy/ Comments
Wheelchairs - Modifications				
	E1297	NU	Wheelchair special seat dept	
	E1298	NU	Wheelchair spec seat depth/w	

Legend

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Authorization

When a service requires authorization, the provider must properly request authorization in accordance with the agency's rules, this billing guide, and any related provider notices.

When authorization is not properly requested, the agency rejects and returns the request to the provider for further action. The rejection of the request is not a denial of service.

Note: The agency's authorization of service(s) does not guarantee payment.

The agency may recoup any payment made to a provider if the agency later determines that the service was not properly authorized. See WAC 182-502-0100(1)(c).

Is authorization required for complex rehabilitation technology (CRT)?

(WAC 182-543-7100)

Yes. The agency requires complex rehabilitation technology (CRT) providers to obtain prior authorization (PA) for CRT products and related services and deliver the CRT product or related service to the client before billing the agency.

What documentation is required for requesting PA?

Requests for PA must include all of the following completed forms:

- General Information for Authorization form, HCA 13-835 (see WAC 182-543-7000 Authorization)
- Medical Necessity for Wheelchair Purchase (for home clients only) form, HCA 13-727 or Medical Necessity for Wheelchair Purchase for Nursing Facility Clients form, HCA 13-729 from the client's physician or therapist
- The agency's Prescription form, HCA 13-794. For nursing facility clients, a copy of the telephone order, signed by the physician, for the wheelchair assessment is required in place of the prescription form

See Where can I download agency forms?

Facility or therapist letterhead must be used for any documentation that does not appear on an agency form.

Note: For more information on requesting authorization, see the Prior Authorization chapter of agency's ProviderOne Billing and Resource Guide.

When the agency receives the initial request for PA, the prescription(s) (or telephone order) for those CRT products or related services must not be older than three months from the date the agency receives the request.

The agency requires certain information from providers in order to prior authorize the purchase of CRT. This information includes, but is not limited to, the following:

- The manufacturer's name
- The equipment model and serial number
- A detailed description of the item
- Any modifications required, including the CRT product or accessory number as shown in the manufacturer's catalog

For PA requests, the agency requires the prescribing provider to furnish patient-specific justification for base equipment and each requested line item accessory or modification as identified by the manufacturer as a separate charge. The agency does not accept general standards of care or industry standards for generalized equipment as justification.

The agency considers requests for new CRT products or services that do not have assigned healthcare common procedure coding system (HCPCS) codes, and are not listed in this billing guide. These items require PA.

The provider must furnish all of the following information to the agency to establish medical necessity:

- A detailed description of the item(s) or service(s) to be provided
- The cost or charge for the item(s)
- A copy of the manufacturer's invoice, price-list or catalog with the product description for the item(s) being provided
- A detailed explanation of how the requested item(s) differs from an already existing code description

The agency does not pay for the purchase or repair of CRT that duplicates equipment the client already owns. If the provider believes the purchase or repair of CRT is not duplicative, the provider must request PA and submit the following to the agency, as appropriate:

- Why the existing equipment no longer meets the client's medical needs
- Why the existing equipment could not be repaired or modified to meet those medical needs
- Upon request, documentation showing how the client's condition met the criteria for PA

A provider may resubmit a request for PA for a CRT product or service that the agency has denied. The agency requires the provider to include new documentation that is relevant to the request.

Submitting photos and x-rays for CRT requests

For submitting photos and x-rays for CRT requests, use the FastLook™ and FastAttach® services provided by Medical Electronic Attachment, Inc. (MEA).

You may register with MEA as follows:

- Go to MEA's website
- Select Register (on the menu bar next to the NEA logo)
- Choose the "I am a NEW client" option
- Enter "FastWDSHS" in the "Have a FastAttach® promotion code?" box

Contact MEA toll-free at (800) 782-5150, ext. 2, with any questions. When this option is chosen, you can fax your request to the agency and indicate the MEA# in the *MEA* field (box 18) on the PA Request Form.

Note: There is an associated cost, which will be explained by the MEA services.

If you choose to mail your requests, the agency requires you to:

1. Place photos or x-rays in a large envelope

2. Attach the PA request form and any other additional pages to the envelope

3. Put the client's name, ProviderOne ID#, and the program section the request is for on the envelope

4. Place in a larger envelope for mailing. Multiple sets of requests can be mailed together.

5. Mail to the agency

Reimbursement

What is the agency's reimbursement policy for complex rehabilitation technology (CRT)?

(WAC 182-543-9000(1))

The agency pays for complex rehabilitation technology products, repairs, and related services provided on a fee-for-service (FFS) basis, which meet the conditions in WAC 182-502-0100, as follows:

- To agency-enrolled qualified complex rehabilitation technology (CRT) suppliers under their national provider identifier (NPI) numbers, subject to the limitations found within this billing guide
- When billed with the appropriate taxonomy number for CRT and related services (**332BC3200X**)
- In accordance with the health care common procedure coding system (HCPCS) guidelines for product classification and code assignation

> **Note:** The agency is the payer of last resort for clients with Medicare or third-party insurance.

The agency's maximum payment for CRT and related services is the lesser of either of the following:

- Providers' usual and customary charges
- Established rates, except as provided in How do I bill for clients eligible for Medicare and Medicaid?

What resources does the agency use in setting maximum allowable fees for CRT?

(WAC 182-543-9000(2) and (3))

The agency sets, evaluates, and updates the maximum allowable fees for CRT and related services at least once yearly using available published information including, but not limited to, the following:

- Commercial data bases

- Manufacturers' catalogs
- Medicare fee schedules
- Wholesale prices

The agency may adopt policies, procedure codes, and/or rates that are inconsistent with those set by Medicare if the agency determines that such actions are necessary.

What is included in the rate for CRT?

(WAC 182-543-9000(8))

The agency's payment rate for covered CRT products and related services includes all of the following:

- Any adjustments or modifications to the equipment required within three months of the date of delivery, or are covered under the manufacturer's warranty (this does not apply to adjustments required because of changes in the client's medical condition)
- Any pick-up and/or delivery fees or associated costs (e.g., mileage, travel time, gas, etc.)
- Telephone calls
- Shipping, handling, and/or postage
- Routine maintenance of CRT products including:
  - ✓ Testing
  - ✓ Cleaning
  - ✓ Regulating
  - ✓ Assessing the client's equipment
- Fitting and/or set-up
- Instruction to the client or client's caregiver in the appropriate use of the equipment, device, and/or supplies

What is the payment methodology for CRT?

(WAC 182-543-9250)

- The agency reimburses a CRT provider for purchased CRT products based on the assigned health care common procedure coding system (HCPCS) code. The agency requires providers to make sure the specific brand and model of CRT products dispensed are coded according to the Centers for Medicare and Medicaid Services' (CMS) pricing,

data analysis, and coding (PDAC) web site.

- The agency sets, evaluates and updates the maximum allowable fees at least once yearly for CRT using the lesser of:
  - ✓ Current Medicare fees
  - ✓ A pricing cluster
  - ✓ On a by-report basis

- The agency establishes the payment rates for purchased CRT products based on pricing clusters.
  - ✓ A pricing cluster is based on a specific HCPCS code.
  - ✓ The agency's pricing cluster is made up of all the brands/models for which the agency obtains pricing information. However, the agency may limit the number of brands/models included in the pricing cluster. The agency considers all of the following when establishing the pricing cluster:
    - ➢ A client's medical needs
    - ➢ Product quality
    - ➢ Introduction, substitution or discontinuation of certain brands/models
    - ➢ Cost
  - ✓ When establishing the fee for CRT products in a pricing cluster, the maximum allowable fee is the median amount of available manufacturers' list prices for all brands/models as noted in the pricing cluster.

- The agency evaluates by-report (BR) items, procedures, or services for medical necessity, appropriateness and payment value on a case-by-case basis. The agency calculates the payment rate for these items at a percentage of the manufacturer's suggested retail price (MSRP) as of January 31st of the base year, or a percentage of the wholesale acquisition cost (AC) from the manufacturer's invoice.

- The agency uses the following percentages:
  - ✓ For add-on CRT accessories and parts, 84% of MSRP or 140% of AC
  - ✓ For up-charge modifications, seating systems, back and seat cushions, 80% of MSRP or 140% of AC
  - ✓ For CRT manual wheelchair base, 85% of MSRP or 140% of AC
  - ✓ For CRT power-drive wheelchair base, 85% of MSRP or 140% of AC

- The agency may adopt policies, procedures, and/or rates that are inconsistent with those set by Medicare if the agency determines that such actions are necessary.

- The agency does not pay for DME and related supplies, related services, and related repairs and labor charges under fee-for-service (FFS) when the client is any of the following:

  - ✓ An inpatient hospital client
  - ✓ Eligible for both Medicare and Medicaid, and is staying in a skilled nursing facility in lieu of hospitalization
  - ✓ Terminally ill and receiving hospice care
  - ✓ Enrolled in a risk-based managed care organization (MCO) that includes coverage for such items and/or services

- The agency rescinds any purchase order for a prescribed item if the equipment was not delivered to the client before the client:

  - ✓ Dies
  - ✓ Loses medical eligibility
  - ✓ Becomes covered by a hospice agency
  - ✓ Becomes covered by an agency-contracted MCO

- A provider may incur extra costs for customized equipment that may not be easily resold. In these cases, for purchase orders rescinded, the agency may pay the provider an amount it considers appropriate to help defray these extra costs. The agency requires the provider to submit justification sufficient to support such a claim.

Warranty

What warranty information should I keep?

(WAC 182-543-9000(9))

Complex rehabilitation technology (CRT) providers must make the following warranty information available to the agency upon request:

- Date of purchase
- Applicable serial number
- Model number or other unique identifier of the equipment
- Warranty period, available to the agency upon request

When is the dispensing provider responsible for costs?

(WAC 182-543-9000(10))

The dispensing provider who furnishes the CRT product to a client is responsible for any costs incurred to have a different provider repair the CRT product when the following apply:

- Any CRT product that the agency considers purchased requires repair during the applicable warranty period
- The provider refuses or is unable to fulfill the warranty
- The CRT product continues to be medically necessary

MINIMUM WARRANTY PERIODS	
Wheelchair Frames (Purchased New) and Wheelchair Parts	**Warranty**
Powerdrive *(depending on model)*	One (1) year - lifetime
Ultralight	Lifetime
Active Duty Lightweight *(depending on model)*	Five (5) years - lifetime
All Others	One (1) year
Electrical Components	**Warranty**
All electrical components whether new or replacement parts including batteries	Six (6) months - 1 year

Billing

Effective for claims billed on and after October 1, 2016
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 all of the following:

- 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

What billing requirements are specific to complex rehabilitation technology (CRT)?

A provider must not bill the agency for the purchase of CRT products supplied to the provider at no cost by suppliers or manufacturers.

Note: HCPCS code E1028 (wheelchair accessory, manual swingaway, retractable or removable mounting hardware) must be submitted on one line for correct payment.

How do I bill for a managed care client?

(WAC 182-543-8100)

If a fee-for-service (FFS) client enrolls in an agency-contracted managed care organization (MCO), all of the following apply:

- The agency-contracted MCO determines the client's continuing need for the CRT products and related services and is responsible for paying the provider.

- A client may become an MCO enrollee before the agency completes the purchase of prescribed CRT. The agency considers the purchase complete when the product is delivered and the agency is notified of the serial number. If the client becomes an MCO enrollee before the agency completes the purchase:

  - ✓ The agency rescinds the agency's authorization with the vendor until the MCO's primary care provider (PCP) evaluates the client.

  - ✓ Then the agency requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary as defined in WAC 182-500-0070.

  - ✓ Then the MCO's applicable reimbursement policies apply to the purchase of the equipment.

- A client may be disenrolled from an MCO and placed into FFS before the MCO completes the purchase of prescribed CRT products and related services.

  - ✓ The agency rescinds the MCO's authorization with the vendor until the client's PCP evaluates the client.

  - ✓ Then the agency requires the PCP to write a new prescription if the PCP determines the CRT product is still medically necessary as defined in WAC 182-500-0070.

  - ✓ The agency's applicable reimbursement policies apply to the purchase of the CRT product.

How do I bill for clients eligible for Medicare and Medicaid?

(WAC 182-543-8200)

If a client is eligible for both Medicare and Medicaid, all the following apply:

- The agency requires a provider to accept Medicare assignment before any Medicaid reimbursement.
- In accordance with WAC 182-502-0110(3):
  - ✓ If the service provided is covered by Medicare and Medicaid, the agency pays the deductible and coinsurance up to Medicare's allowed amount or the agency's allowed amount, whichever is less.
  - ✓ If the service provided is covered by Medicare but is not covered by the agency, the agency pays only the deductible and/or coinsurance up to Medicare's allowed amount.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's Billers and Providers web page, 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) web page.

The following claim instructions relate to CRT providers:

Field	Entry	
Place of Service	These are the only appropriate code(s) for this billing guide:	
	Code	**To Be Used For**
	12	Client's residence
	13	Assisted living facility
	32	Nursing facility
	31	Skilled nursing facility
	99	Other

Where can I find the CRT fee schedule?

Maximum allowable fees may be found in the agency's CRT Fee Schedule.

Note: Bill the agency your usual and customary charge.