

Washington Apple Health (Medicaid)

Enteral Nutrition Billing Guide

October 1, 2016

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 October 1, 2016, 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
Billing and Claim Forms	Effective October 1, 2016, all claims must be filed electronically. See blue box notification.	Policy change to improve efficiency in processing claims

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.

* This publication is a billing instruction.

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Important Changes to Apple Health Effective April 1, 2016

**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 [Early Adopter Region 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 individuals 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 individuals 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
- Individuals 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 an individual 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 be 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
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 COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009
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Beacon Health Options	Beacon Health Options 1-855-228-6502
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Resources Available

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the agency's Resources Available web page.
Finding out about payments, denials, claims processing, or agency-contracted managed care organizations	
Finding agency documents (e.g., billing guides, and fee schedules)	
Private insurance or third-party liability, other than agency-contracted managed care	
Obtaining prior authorization	For all written requests, fax a <i>General Information for Authorization</i> form (HCA 13-835), as well as an <i>Oral Enteral Nutrition Worksheet Prior Authorization Request</i> form (HCA 13-743) to the Enteral Nutrition Program Manager at (866) 668-1214. Both forms must be completely filled out and typed.
Obtaining a limitation extension	For all written requests, fax a <i>General Information for Authorization</i> form (HCA 13-835), as well as a <i>Justification for Use of B9998 Miscellaneous Enteral Nutrition HCPCS Procedure Code and Limitation Extension Request</i> form (HCA 13-745) to the Enteral Nutrition Program Manager at (866) 668-1214. Both forms must be completely filled out and typed.
Finding the nearest Women, Infants, and Children (WIC) clinic	To find the nearest WIC clinic, call (800) 841-1410.

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](#))

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 solutions can be given orally or via feeding tubes. (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 the purpose of evaluating the client’s nutrition and making recommendations regarding the client’s nutrition status or treatment.

Orally administered enteral nutrition products – Enteral nutrition products that a client consumes orally for nutritional support.

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

About this Program

(WAC [182-554-100](#))

What is the purpose of the agency's Enteral Nutrition Program?

The Health Care Authority's (the agency's) Enteral Nutrition Program covers products, equipment, and related supplies that provide medically necessary enteral nutrition to eligible children and tube-fed adults.

- The agency **pays** for tube-delivered products and supplies for eligible children and adults.
- The agency **pays** for oral and tube-delivered enteral nutrition for eligible children age 20 and younger.
- The agency **does not** pay for oral enteral nutrition products for adults age 21 and older.

Client Eligibility

(WAC [182-554-300](#))

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.

Verifying eligibility is a 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**.

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 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.

How do clients receive enteral nutrition products, equipment, and related supplies under the following circumstances?

(WAC [182-554-300](#))

Managed care

Clients who are enrolled in an agency-contracted managed care organization (MCO) must arrange for enteral nutrition products, equipment, and related supplies directly through an agency-contracted MCO. Managed care enrollment will be displayed on the client benefit inquiry screen.

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- 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.

Nursing facilities and adult family homes

Clients are not eligible for oral enteral nutrition products if they reside in a nursing facility, adult family home, assisted living facility, boarding home, or any other residence where the provision of food is included in the daily rate. (WAC [182-554-300\(4\)](#)). As appropriate, the provision of nutrition is the responsibility of the facility. (See chapters [388-76](#), [388-97](#), and [388-78A](#) WAC).

State-owned facilities

For clients who reside in a state-owned facility (i.e., state school, developmental disabilities facility, mental health facility, Western State Hospital, and Eastern State Hospital), enteral nutrition products, equipment, and related supplies are the responsibilities of the state-owned facility.

Hospice

Clients who have elected to use and are eligible to receive the agency's hospice benefit must arrange for enteral nutrition products, equipment, and related supplies directly through their hospice provider.

WIC

Children who qualify for supplemental nutrition from the Women, Infants, and Children (WIC) program must receive supplemental nutrition directly from that program unless the client meets the limited circumstances in WAC [182-554-500\(1\)\(d\)](#).

Note: See the [Scope of Categories of Healthcare Services Table](#) web page for an up-to-date listing of benefit packages.

Provider Requirements

(WAC [182-554-400](#))

Who is eligible to bill for providing enteral nutrition services?

The following providers are eligible to enroll/contract with the agency to provide orally administered enteral nutrition products and tube-delivered enteral nutrition products, equipment, and related supplies:

- Pharmacy providers
- Durable medical equipment (DME) providers

To receive payment for orally administered enteral nutrition products and 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.
- 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.
- Furnish clients with new or used equipment that includes full manufacturer and dealer warranties for at least one year.
- Notify the client's physician if the client has indicated the product is not being used as prescribed and document the notification in the client's file.

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

Are providers required to notify clients of their rights (advance directives)?

[\(42 CFR, Subpart I\)](#)

Yes. All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment.
- Make decisions concerning their own medical care.
- Formulate an advance directive for their health care, such as a living will or durable power of attorney.

What records specific to the agency's Enteral Nutrition Program must be kept?

(WAC [182-554-400](#), [182-554-500](#), [182-554-600](#), and [182-554-700](#))

Providers must keep legible, accurate, and complete charts in the client's records to justify the medical necessity of the items provided.

For oral enteral nutrition products

Medical vendors or pharmacies must keep the following in their files:

- A copy of one of the following completed forms:
 - ✓ The *Oral Enteral Nutrition Worksheet Prior Authorization Request* form (HCA [13-743](#)) with the authorization number provided by the agency (the prescription is a part of the form)
- A copy of the WIC denial for clients age 4 and younger, which must state all of the following:
 - ✓ 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 product.
- A copy of the dietician evaluation for clients age 20 and younger who are on an eligible program

Prescribers must keep the following in the client's file:

- A copy of one of the following completed forms:
 - ✓ The *Oral Enteral Nutrition Worksheet Prior Authorization Request* form (HCA [13-743](#))
 - ✓ The *Oral Enteral Nutrition Worksheet Expedited Prior Authorization Request* form (HCA [13-761](#))
- Specific, detailed documentation of reasons why trials of traditional foods did not meet the nutritional needs of the client

- A copy of the dietician evaluation for clients age 20 and younger who are on an eligible program
- Specific, detailed documentation that the WIC products have been tried and failed or that they are contraindicated when the client is eligible for the WIC program but the product being ordered is not on the WIC product list

For tube-delivered enteral nutrition products and supplies

Medical vendors or pharmacies must keep the following in the client's file:

- A copy of the prescription which is signed and dated by the prescriber and lists the client's medical condition and the exact daily caloric amount of medically necessary enteral nutrition product
- A copy of the WIC denial for clients age 4 and younger, which must state all of the following:
 - ✓ 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 product.
- A copy of the dietician evaluation for clients age 20 and younger who are on an eligible program

Prescribers must keep the following in their files:

A copy of the dietician evaluation, for clients age 20 and younger who are enrolled in an eligible agency program

Coverage

(WAC [182-554-500](#))

How does the agency cover enteral nutrition products?

The agency covers orally administered enteral nutrition products for clients age 20 and younger. See [What orally administered enteral nutrition products are covered?](#)

The agency covers tube-delivered enteral nutrition products for any eligible client, regardless of age. See [What tube-delivered enteral nutrition products are covered?](#)

What orally administered enteral nutrition products are covered?

The agency covers orally administered enteral nutrition products for **clients age 20 and younger** as follows:

- The client's nutritional needs cannot be met using traditional foods, baby foods, and other regular grocery products that can be pulverized or blenderized and used to meet the client's caloric and nutritional needs.
- The client is able to manage their feedings independently or who has a caregiver who can manage the feedings.
- The client meets one of the clinical criteria under WAC 182-554-500. See [What are the clinical criteria for a client to receive covered orally administered enteral nutrition products?](#)

What are the clinical criteria for a client to receive covered orally administered enteral nutrition products?

To receive covered orally administered enteral nutrition products, a client must meet the clinical criteria for one of the following conditions.

Acquired immune deficiency syndrome (AIDS)

The client must meet one of the following clinical criteria. The client must:

- Be in a wasting state.
- Have either:
 - ✓ A BMI of less than or equal to 25, or
 - ✓ An unintentional or unexplained weight loss of 5 percent in 1 month, 7.5 percent in 3 months, or 10 percent in 6 months.
- Have a weight-for-length less than or equal to the 5th percentile if the client is age 3 or younger.
- Have a body mass index (BMI) of either:
 - ✓ Less than or equal to the 5th percentile if the client is age 4 through 17.
 - ✓ Less than or equal to 18.5 if the client is age 18 through 20.

Note: The provider must obtain prior authorization (PA) to receive payment.

Amino acid, fatty acid, and carbohydrate metabolic disorder

The client must require, for medical necessity, a specialized nutrition product.

Note: The provider must follow the agency's expedited prior authorization (EPA) process to receive payment.

Cancer

The client must be receiving chemotherapy, radiation therapy, or post-therapy treatment.

Note: The provider must follow the agency's expedited prior authorization (EPA) process to receive payment.

Note: The agency pays for orally administered enteral nutrition products to a maximum of 3 months following the completion of chemotherapy or radiation therapy.

End stage renal disease

The client must be receiving dialysis and be on a fluid restrictive diet to use nutrition bars.

Note: The provider must follow the agency's expedited prior authorization (EPA) process to receive payment.

Decubitus pressure ulcers

The client must have stage 3 or greater decubitus pressure ulcers and an albumin level of 3.2 or below.

Note: The provider must follow the agency's expedited prior authorization (EPA) process to receive a maximum of 3 month's payment.

Failure to thrive, malnutrition, malabsorption

The client's condition must be the result of a stated primary diagnosed disease. The client must meet one of the following clinical criteria. The client must have:

- A disease or medical condition that is organic in nature and not due to cognitive, emotional, or psychological impairment.
- A weight-for-length less than or equal to the 5th percentile if the client is age 2 or younger.
- A BMI of one of the following:
 - ✓ Less than or equal to the 5th percentile if the client is age 3 through 17.
 - ✓ Less than or equal to 18.5, an albumin level of 3.5 or below, and a cholesterol level of 160 or below if the client is age 18 through 20.
 - ✓ Less than or equal to 25, and an unintentional or unexplained weight loss of:
 - 5 percent in 1 month.
 - 7.5 percent in 3 months.
 - 10 percent in 6 months.

Note: The provider must obtain prior authorization (PA) to receive payment.

Medical conditions (e.g., dysphagia) requiring a thickener

For a client **age 1 or older**, the client must:

- Require a thickener to aid in swallowing or currently be transitioning from tube feedings to oral feedings.
- Be evaluated by a speech therapist or an occupational therapist who specializes in dysphagia. The report recommending a thickener must be in the client’s chart in the prescriber’s office.

Note: If prescribing thickeners for a child younger than age 1, providers must request prior authorization on form [HCA 13-011](#). **The PA request must include:**

- Clinical documentation that supports the medical necessity of the request.
- The report recommending a thickener from a speech therapist or occupational therapist who specializes in dysphagia.

If prescribing thickeners for a child older than age one, providers must use the EPA process.

For a client **age 4 and younger**, the client must:

- Have a certified registered dietician (RD) evaluation with recommendations that support the prescriber’s order for oral enteral nutrition products or formulas.
- Have a signed and dated written notification from WIC indicating one of the following:
 - ✓ The client is not eligible for the WIC program.
 - ✓ The client is eligible for the WIC program, but the need for the oral enteral nutrition product or formula exceeds WIC’s allowed amount.
 - ✓ The requested oral enteral nutrition product or formula is not available through the WIC program. Specific, detailed documentation of the tried and failed efforts of similar WIC products or the medical need for alternative products must be in the prescriber’s chart for the child.
- Meet one of the following clinical criteria:
 - ✓ Low birth weight (less than 2500 grams)
 - ✓ A decrease across 2 or more percentile lines on the Centers for Disease Control and Prevention (CDC) growth chart, once a stable growth pattern has been established
 - ✓ Failure to gain weight on 2 successive measurements, despite dietary interventions
 - ✓ Documented specific, clinical factors that place the child at risk for a compromised nutrition or health status

For a client **age 5 through 20**, the client must:

- Have a certified RD evaluation, for eligible clients, with recommendations that support the prescriber's order for oral enteral nutrition products.
- Meet one of the following clinical criteria:
 - ✓ A decrease across 2 or more percentile lines on the CDC growth chart, once a stable growth pattern has been established
 - ✓ Failure to gain weight on 2 successive measurements, despite dietary interventions
 - ✓ Documented specific, clinical factors that place the child at risk for a compromised nutrition or health status

How does a provider request prior authorization for an orally administered enteral nutrition product?

Requests to the agency for prior authorization for orally administered enteral nutrition products must include a completed *Oral Enteral Nutrition Worksheet Prior Authorization Request* form (HCA [13-743](#)).

The *Oral Enteral Nutrition Worksheet PA Request* form (HCA [13-743](#)) must be:

- Completed by the prescribing physician, advanced registered nurse practitioner (ARNP), or physician assistant-certified (PA-C).
- Written, signed (including the prescriber's credentials), and dated by the prescriber on the same day and before delivery of the enteral nutrition product, equipment, or related supply. This form must not be backdated.
- Submitted within 3 months from the date the prescriber signs the prescription.

How does a provider complete the PA request form (HCA 13-743)?

A completed *Oral Enteral Nutrition Worksheet PA Request* form (HCA [13-743](#)) must verify all the following:

- The client meets all the requirements listed in this billing guide

Enteral Nutrition

- The client's physical limitations and expected outcome
- The client's current clinical nutritional status, including the relationship between the client's diagnosis and nutritional need
- For a client age 18 through 20, the client's recent weight loss history, and a comparison of the client's actual weight to ideal body weight and current body mass index (BMI)
- For a client age 18 through 20, the client's growth history and a comparison to expected weight gain must have:
 - ✓ An evaluation of the weight-for-length percentile if the client is age 3 or younger
 - ✓ An evaluation of the BMI if the client is age 4 through 17
- The client's medical condition and the exact daily caloric amount of needed enteral nutrition product
- The reason why the client cannot consume enough traditional food to meet nutritional requirements
- The medical reason the specific enteral nutrition product, equipment, or supply is prescribed
- Documentation explaining why less costly, equally effective products or traditional foods are not appropriate
- The number of days or months the enteral nutrition products, equipment, or necessary supplies are required
- The client's likely expected outcome if enteral nutritional support is not provided

Note: Clients age 20 and younger must be evaluated by a certified RD within 30 days of initiation of enteral nutrition products and periodically (at the discretion of the certified RD) while receiving enteral nutrition products. The certified RD must be a current provider with the agency.

What tube-delivered enteral nutrition products are covered?

(WAC [182-554-600](#))

The agency covers tube-delivered enteral nutrition products, equipment, and related supplies, without prior authorization, for eligible clients regardless of age when the client has a valid prescription. A valid prescription must:

- Be written by a physician, advanced registered nurse practitioner (ARNP), or physician's assistant certified (PA-C).
- Be written, signed (including the prescriber's credentials), and dated by the prescriber on the same day and before delivery of the supply, equipment, or device. Prescriptions must not be back-dated.
- Be submitted within 3 months from the date the prescriber signs the prescription.
- State the specific product requested, diagnosis, estimated length of need (months), and quantity.

What are the clinical criteria for a client to receive covered tube-delivered enteral nutrition products?

To receive covered tube-delivered enteral nutrition products, a client must be able to manage tube feedings independently, or with a caregiver who can manage the feedings.

The client must **also** meet the clinical criteria for one of the following conditions. The client must have:

- A disease or clinical condition that impairs the client's ability to ingest sufficient calories and nutrients from products orally, or does not permit sufficient calories and nutrients from food to reach 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

Are there limitations to how the agency pays for tube-delivered enteral nutrition products?

Yes. The following limitations apply:

- The agency pays for 1 purchased pump, per client, in a 5-year period
- The agency pays for 1 purchased non-disposable intravenous pole, required for enteral nutrition product delivery, per client, per lifetime.
- The agency pays for up to 12 months of rental payments for tube-delivered enteral nutrition equipment. After 12 months of rental, the agency considers the equipment purchased and it becomes the client's property.
- The agency pays for repairs and replacement parts for tube-delivered enteral nutrition equipment, with PA, when the equipment is:
 - ✓ Owned by the client.
 - ✓ Less than 5 years old.
 - ✓ No longer under warranty.

Note: Providers must follow the agency's Expedited Prior Authorization (EPA) process to receive payment.

What does the agency require when requesting enteral nutrition products for WIC program eligible clients?

(WAC [182-554-500](https://www.wa.gov/department-of-social-and-community-development/182-554-500))

Clients who qualify for supplemental nutrition assistance from the Women, Infants, and Children (WIC) program must receive supplemental nutrition assistance through that program. The agency considers requests for enteral nutrition products and supplies for WIC program-eligible clients when all the following are met:

- The vendor:
 - ✓ Receives a completed *Oral Enteral Nutrition Worksheet Expedited Prior Authorization Request* form (HCA [13-761](https://www.wa.gov/department-of-social-and-community-development/13-761)) from the prescriber.

- ✓ Submits an *Oral Enteral Nutrition Worksheet Prior Authorization Request* form (HCA [13-743](#)) to the agency.
- ✓ Receives an order for the enteral nutrition product or supply from the prescriber, for the tube-fed clients.
- A signed and dated written notification from WIC is attached to the request indicating one of the following:
 - ✓ The client is not eligible for the WIC program.
 - ✓ The client is eligible for the WIC program, but the need for the oral enteral nutrition product or formula exceeds WIC's allowed amount.
 - ✓ The requested oral enteral nutrition product or formula is not available through the WIC program. Specific, detailed documentation of the tried and failed efforts of similar WIC products or the medical need for alternative products must be in the prescriber's chart for the child.
- The client meets the Enteral Nutrition Program requirements in this guide.

For clients not eligible for the WIC program, providers must enter an F indicator in the Comments section of the claim form.

Note: For information regarding the WIC program, call (800) 841-1410, or see Department of Health's (DOH's) [WIC-approved formulas](#) list.

When does the agency pay for medical nutrition therapy?

The agency pays for medical nutrition therapy when it is provided by a certified registered 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 pays for oral enteral nutrition for clients on Medicare Part B when the client meets the criteria in this billing guide.

It is not necessary to submit a Medicare denial.

When 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](#).

What is not covered?

(WAC [182-554-800](#))

The agency does not cover the following:

- Nonmedical equipment, supplies, and related services, including but not limited to, backpacks, pouches, bags, baskets, or other carrying containers
- Orally administered enteral nutrition products for clients age 21 and older

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 Fax/Written Request Basic Information form (HCA [13-756](#)) to the agency. See the agency's [Resources Available](#).

Refer to the agency's [ProviderOne Billing and Resource Guide](#) for information regarding noncovered services and billing for a Fee-For-Service client.

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

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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: Orally administered enteral nutrition products do not include medical foods in the form of a pill or capsule.

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's limitations or restrictions, in accordance with WAC [182-554-500](#).

Coverage Table

What is the policy for the rental or purchase of equipment?

- All 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.
- Repairs to a client-owned pump require **authorization** that may be obtained after the repairs have been started. Submit a completed *Fax/Written Request Basic Information* form (HCA [13-756](#)) along with an invoice for the repairs that separates parts from labor charges.
- Repairs or non-routine service may not exceed 50 percent of the purchase price.
- 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 exceed specified limitations, a Limitation Extension (LE) request must be submitted. See [Resources Available](#) for more information.

- 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.

HCPCS Code	Short Description	EPA/PA	Part of NH per diem	Policy/Comments
B4034	Enteral Feeding Supply Kit; syringe (bolus only)		N	Maximum # of units - 1 per client, per day
B4035	Enteral Feeding Supply Kit; pump fed, per day		N	Maximum # of units - 1 per client, per day
B4036	Enteral Feeding Supply Kit; gravity fed		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.

HCPCS Code	Short Description	EPA/PA	Part of NH per diem	Policy/Comments
B4081	Nasogastric tubing with stylet (each)		N	Max # of units - 3 per client, per 30 days
B4082	Nasogastric tubing without stylet (each)		N	Max # of units - 3 per client, per 30 days
B4083	Stomach tube – Levine type (each)		N	Max # of units - 1 per client, per 30 days
B4087	Gastrostomy/jejunostomy tube, standard, any material, any type, each		N	Max # of units - 5 per client, per 30 days Note: Use this code when billing for extension tubing.
B4088	Gastrostomy/jejunostomy tube, low-profile, any material, any type, each		N	Max # of units - 1 per client, every 2 months

Enteral repairs

HCPCS Code	Modifier	Short Description	Authorization Required	Part of NH per diem	Policy/ Comments
E1399		Repair parts for enteral equipment. Only client-owned pumps less than five years old and no longer under warranty will be allowed replacement parts.	Y	N	Detailed invoice required
B9002	RR	Loaner pump	Y	N	The agency will pay up to 3 months rental while client-owned pump is being repaired.
K0739		Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes.	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

- Poles and pumps are considered purchased after 12-months rental.
- Pumps may be new or used equipment at the beginning of rental period.

HCPCS Code	Modifier	Short Description	EPA/PA	Part of NH per diem	Policy/ Comments
E0776	NU	IV pole. Purchase. Nondisposable. Modifier required.		Y	Max # of units - 1 per client, per lifetime
E0776	RR	IV pole. Rental. Nondisposable. Modifier required.		Y	Max # of units - 1 per month, not to exceed 12 months
B9002	RR	Enteral nutrition infusion pump with alarm		N	Max # of units - 1 per month, not to exceed 12 months

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		NOC for enteral supplies	PA	N	Purchase & Max # of units to be determined by the agency. Backpacks are not covered.

How is HCPCS code B9998 submitted to the agency for miscellaneous enteral nutrition charges?

To submit charges and receive payment for miscellaneous enteral nutrition HCPCS code B9998, submit a fully completed *Justification for Use of B9998 Miscellaneous Enteral Nutrition Procedure Code and Limitation Extension Request* form (HCA [13-745](#)). This form must be submitted to the agency's Enteral Nutrition Program Manager before submitting the claim to the agency.

Note: Do not submit claims using HCPCS code B9998 until an authorization number has been received from the agency indicating that the bill has been reviewed and the payable amount has been determined.

Include all the following supporting documentation on the HCA 13-745 form:

- Agency name and National Provider Identifier (NPI)
- Date of service
- Explanation of client-specific medical necessity
- Invoice
- Name of piece of equipment
- Name of primary piece of equipment and whether the equipment is rented or owned
- Prescription
- ProviderOne client ID

Prior Authorization

What is 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.**

Note: See the agency's [ProviderOne Billing and Resource Guide](#) for more information on requesting authorization.

Is prior authorization required for enteral nutrition?

(WAC [182-554-700](#))

Providers must obtain authorization for covered orally administered enteral nutrition products, tube-delivered enteral equipment, and related supplies. This is required in chapter [182-554](#) WAC, published agency billing guides, or when the clinical criteria required in this billing guide are not met.

- Providers must submit a written request to the agency for PA as specified in WAC [182-554-500\(2\)](#).

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

- 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.
- Upon request, a provider must provide documentation to the agency showing how the client's condition met the criteria for PA.
 - ✓ Authorization requirements in this guide are not a denial of service for the client.
 - ✓ When an oral enteral nutrition product or tube-delivered enteral nutrition equipment or related supply requires authorization, the provider must properly request authorization in accordance with the agency's rules and this billing guide.

Enteral Nutrition

- ✓ When authorization is not properly requested, the agency rejects and returns the request to the provider for further action. The agency does not consider the rejection of the request to be a denial of service.
- ✓ Agency authorization does not necessarily guarantee payment.
- The agency evaluates requests for authorization for covered enteral nutrition products, equipment, and related-supplies that exceed limitations in this chapter on a case-by-case basis under WAC [182-501-0169](#).
- The agency may recoup any payment made to a provider if the agency later determines that the service was not properly authorized or did not meet the EPA criteria. See WAC [182-502-0100](#)(1)(c).
- ✓ If a fee-for-service client enrolls in an agency-contracted MCO before the agency completes the purchase or rental of prescribed enteral nutrition products, necessary equipment, and supplies:
 - The agency rescinds authorization for the purchase or rental.
 - The agency stops paying for any equipment on the last day of the month preceding the month in which the client becomes enrolled in the managed care plan.
 - The agency-contracted MCO determines the client's continuing need for the equipment and is then responsible for the client.
- ✓ The agency rescinds any 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).
 - Becomes eligible for an agency-contracted managed care plan.
 - Dies.

How do I request authorization for an emergency fill?

In emergency situations, providers may deliver a maximum 3-day supply of enteral nutrition products that require PA without an authorization number for a maximum of a 3-day supply. However, to receive payment, the provider must fax justification for the request to the agency no later than the following working day after the fill.

What is expedited prior authorization (EPA)?

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

To bill the agency for enteral nutritional products and supplies that meet the EPA criteria on the following pages, the vendor must create a nine-digit EPA number using the following criteria:

The first 4 or 5 digits of the EPA number must be **8700 or 87000**. The last 3 or 4 digits document the product description and conditions that make up the EPA criteria.

EPA numbers begin with 87000.

Example
 Nutritional bars for a client:

- Age 21 and younger
- With a diagnosis of end stage renal disease
- On dialysis and on a fluid restricted diet with an albumin of 3.2 or less

The EPA code number is 1110; add these 4 digits.

The EPA number = 870001110.

- For EPA, a provider must establish that the client’s condition meets the clinically appropriate EPA criteria outlined in this billing guide. The appropriate EPA number must be used when the provider bills the agency.
- For each EPA number, there must be a completed *Oral Enteral Nutrition Worksheet Expedited Prior Authorization Request* form (HCA [13-761](#)) in the client’s file.
- Specific, detailed documentation explaining why trials of traditional foods did not meet the nutritional needs of the client must be in the prescriber’s files. This information may be obtained from a family member or caregiver.

- Documentation showing how the client's condition met the criteria for PA or EPA must be provided to the agency upon request.

Providers must request PA from the agency when a situation does not meet the EPA criteria for a selected HCPCS code. Providers must fax a request to the agency Enteral Nutrition Program Manager (see [Resources Available](#)).

Expedited Prior Authorization guidelines:

- A. Medical justification (criteria)** - Medical justification must come from the client's prescriber with an appropriately completed *Oral Enteral Nutrition Worksheet Expedited Prior Authorization Request* form (HCA [13-761](#)). The vendor must use this form when using the EPA process. The client must meet the exact criteria in order for providers to use an EPA number. Specific, detailed documentation explaining why trials of traditional foods did not meet the nutritional needs of the client must be in the vendor's files. If the client does not continue to meet the criteria, but needs an oral enteral nutrition product, providers must send in an appropriately completed *Oral Enteral Nutrition Worksheet Prior Authorization Request* form (HCA [13-743](#)).
- B. Documentation** - The billing vendor **must keep** the completed *Oral Enteral Nutrition Worksheet Expedited Prior Authorization Request* form (HCA [13-761](#)) in the client's file. Upon request, a vendor must provide specific, detailed documentation to the agency showing how the client's condition met the criteria for EPA. Vendors must keep documentation on file for six years (see WAC [182-502-0020](#)).

The *Oral Enteral Nutrition Worksheet Expedited Prior Authorization Request* form (HCA [13-761](#)) must be filled out in its entirety. The client must meet the exact criteria in order for the vendor to use an EPA number. To continue to use this form when the allowed time period ends, the prescriber must complete a new form, and the vendor must verify the EPA criteria are still met. The client must continue to meet the exact criteria in order for the vendor to use an EPA number. If the criteria are not met, a completed *Oral Enteral Nutrition Worksheet Prior Authorization Request* form (HCA [13-743](#)) must be submitted.

Note: To ensure program compliance, the agency conducts post-payment reviews. See WAC [182-502-0100](#).

**Washington State
Expedited Prior Authorization Criteria Coding List**

Procedure Code	EPA Code 8700	Description	Criteria
Enteral Nutrition Products			
B9998	1110	NOC for enteral supplies	Nutritional bars are authorized for clients: <ul style="list-style-type: none"> • With diagnosis of end stage renal disease • On dialysis • On fluid restrictive diets • With an albumin level of 3.2 or less
Medical Conditions			
Use the appropriate procedure code for the service being provided	1100	End stage renal disease Dx N18.6	The client must be receiving dialysis. Note: Clients receiving dialysis must be on a fluid restrictive diet to use nutrition bars. When billing for nutrition bars, use EPA # 870001110.
Use the appropriate procedure code for the service being provided	1101	Cancer(s) See the agency's Approved Diagnosis Codes by Program	The client must be currently receiving chemotherapy, or radiation therapy or both. Providers may also use this code to bill for the post therapy phase (up to 3 months following the completion of chemotherapy or radiation therapy).
Use the appropriate procedure code for the service being provided	1102	Decubitus Pressure Ulcer(s) See the agency's Approved Diagnosis Codes by Program	The client must have: <ul style="list-style-type: none"> • Stage 3 or greater decubitus pressure ulcer(s) • An albumin level of 3.2 or less EPA may be used for 3 months only.

Note: EPA codes are valid for children age 20 and younger only. The program does not cover enteral nutrition for adults age 21 and older.

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ProcedureCode	EPA Code 8700	Description	Criteria
Use the appropriate procedure code for the service being provided	1103	<p>Amino Acid, Fatty Acid, and Carbohydrate Metabolic Disorders</p> <p>See the agency's Approved Diagnosis Codes by Program</p>	The client must require a specialized oral enteral nutrition product.
Use the appropriate procedure code for the service being provided	1104	<p>Medical Condition Requiring Thickeners (HCPCS Code: B4100) for Dysphagia</p> <p>Dx R13.0, R13.11, R13.12, R13.13, R13.14, R13.19</p>	<p>The client must:</p> <ul style="list-style-type: none"> • Require a thickener to aid in swallowing or be currently transitioning from tube feedings to oral feedings. • Have been evaluated by a speech therapist, or an occupational therapist that specializes in dysphagia (the report must be in the client's chart in the prescriber's office recommending a thickener). <p>Note: If the client is age 1 through 20 and requires only a thickener, an evaluation by a dietician is not required.</p> <p>For a client younger than age 1, the provider must request PA. See PA requirements under medical conditions requiring a thickener.</p>

Note: EPA codes are valid for children age 20 and younger only. The program does not cover enteral nutrition for adults age 21 and older.

ProcedureCode	EPA Code 8700	Description	Criteria
Age Requirements			
Use the appropriate procedure code for the service being provided	1106	Children age 4 or younger (younger than age 5)	<p>Client must have:</p> <ul style="list-style-type: none"> • A certified RD evaluation with recommendations (which support the prescriber’s order) for medically necessary, oral enteral nutrition products or formulas. • A signed and dated written notification from WIC indicating one of the following: <ul style="list-style-type: none"> ✓ Client is not eligible for the WIC program ✓ Client is eligible for the WIC program, but the need for the oral enteral nutrition product or formula exceeds WIC’s allowed amount ✓ The requested oral enteral nutrition product or formula is not available through the WIC program. (Specific, detailed documentation of the tried and failed efforts of similar WIC products, or the medical need for alternative products, must be in the prescriber’s chart for the child) <p>The client must meet one of the following criteria:</p> <ul style="list-style-type: none"> • Low birth weight (less than 2500 grams) • A decrease across 2 or more percentile lines on the CDC growth chart, once a stable growth pattern has been established • Failure to gain weight on 2 successive measurements, despite dietary interventions • Documented specific, clinical factors that place the child at risk for a compromised nutrition and/or health status

Note: EPA codes are valid for children age 20 and younger only. The program does not cover enteral nutrition for adults age 21 and older.

ProcedureCode	EPA Code 8700	Description	Criteria
Age Requirements (continued)			
Use the appropriate procedure code for the service being provided	1107	Children age 5 through 20	<p>Client must have a certified RD evaluation with recommendations (which support the prescriber’s order) for medically necessary, oral enteral nutrition products</p> <p>The client must meet one of the following criteria:</p> <ul style="list-style-type: none"> • A decrease across 2 or more percentile lines on the CDC growth chart, once a stable growth pattern has been established • Failure to gain weight on 2 successive measurements, despite dietary interventions • Documented specific, clinical factors that place the child at risk for a compromised nutrition and/or health status

Note: EPA codes are valid for children age 20 and younger only. The program does not cover enteral nutrition for adults age 21 and older.

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.

All enteral nutrition products must have documented justification for medical necessity in the client's file, which must be made available for review by the agency. Claims for reimbursement of nutrition products must be billed with the ICD diagnosis code(s). See the agency's [Approved Diagnosis Codes by Program](#) for enteral nutrition.

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.

Product List

How is the enteral nutrition product classification list used?

Vendors must use the [Enteral Nutrition Product Classification List](#) located on the Noridian website. Providers must use the applicable HCPCS codes for all enteral nutritional claims. The agency will accept billing for **only** the codes and products listed on the Noridian Enteral Nutrition Product Classification List.

Note: The appropriate [modifier](#) must be used when billing the agency for these codes.

Billing must be limited to a one-month supply.

Providers must bill the procedure codes in the product list with the appropriate modifier for all enteral nutrition products. The agency denies claims for enteral nutrition products without modifiers. For a modifier list with descriptions, see [Modifiers](#).

Category (HCPCS code)	Description	One Unit Equals	Policy/Comments
B4100	Food thickener administered orally per ounce	1 oz	<p>Thickeners may be covered when EPA criteria is met. Use EPA # 870001104. Includes Resource ThickenUp, Simply Thick, Thick & Easy, and Thick-It.</p> <p>Covered for clients age 1 through 20 only.</p> <p>Note: If the client is age 1 through 20 and requires only a thickener, an evaluation by a dietician is not required.</p> <p>For a client younger than age 1, the provider must request PA. See PA requirements under medical conditions requiring a thickener.</p>

Enteral Nutrition

Category (HCPCS code)	Description	One Unit Equals	Policy/Comments
B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit	500 ml	If orally administered, covered for clients age 20 and younger only
B4103	Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit	500 ml	If orally administered, covered for clients age 20 and younger only
B4149	Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber.	100 cal	
B4150	Enteral formula consisting of semi-synthetic intact protein/protein isolates.	100 cal	
B4152	Intact protein/protein isolates (calorically dense).	100 cal	
B4153	Hydrolyzed protein/amino acids.	100 cal	
B4154	Defined formula for special metabolic need.	100 cal	
B4155	Modular components.	100 cal	
B4157	Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber.	100 cal	
B4158	Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron.	100 cal	

Enteral Nutrition

Category (HCPCS code)	Description	One Unit Equals	Policy/Comments
B4159	Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron.	100 cal	
B4160	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber.	100 cal	
B4161	Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber.	100 cal	
B4162	Enteral formula, for pediatrics, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber.	100 cal	
B9998	NOC for enteral supplies		<p>Nutritional bars may be covered when EPA criteria is met. Use EPA # 870001110.</p> <p>Bars are covered for clients age 20 and younger only. One bar equals one unit.</p>
<p>Note: The following are examples of products that are not reimbursed by the agency: puddings, cookies, cereals, health shakes, broths, Resource® Ice Cream Plus, etc.</p>			

Payment

What is included in the agency's payment?

(WAC [182-554-900](#))

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.

Where can I find the fee schedule?

You can find the current Enteral Nutrition Fee Schedule on the agency's [Enteral Nutrition Fee Schedule](#) web page.

Billing and Claim Forms

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](#).

This billing guide still contains information about billing paper claims.

This information will be updated effective January 1, 2017.

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 is the CMS-1500 claim form completed?

Instructions on how to bill professional claims and crossover claims electronically can be found on the agency's Billers and Providers web page, under Webinars. See [Medical provider workshop](#). Also, see Appendix I of the agency's [ProviderOne Billing and Resource Guide](#) for general instructions on completing the CMS-1500 claim form.