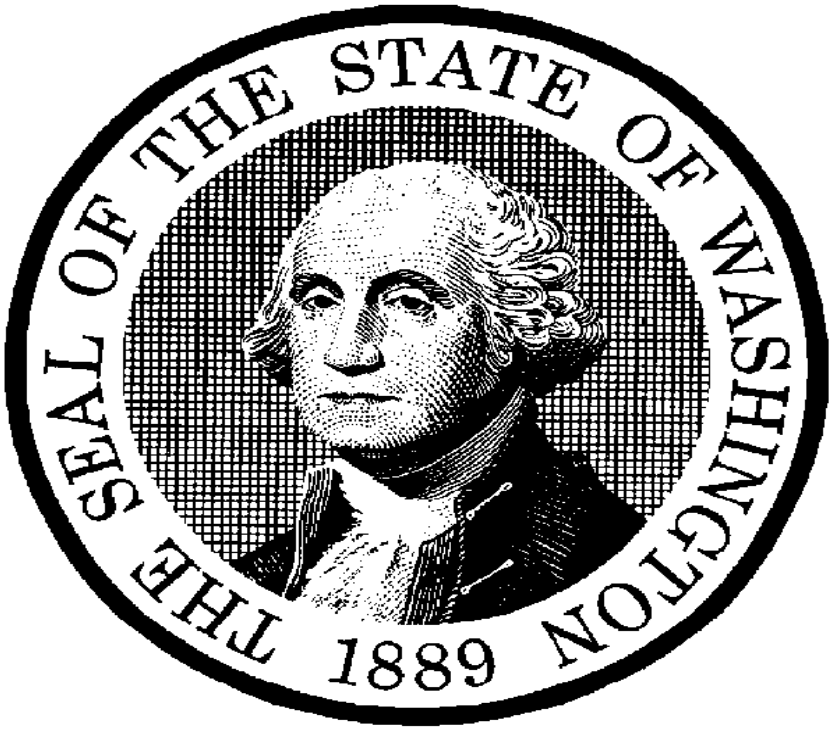
Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

Health and Recovery Services Administration (HRSA)



Home Infusion Therapy/ Parenteral Nutrition Program

Billing Instructions

(Formerly known as Infusion/Enteral/Parenteral)

[Chapter 388-553 WAC]

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About this publication

This publication supersedes all previous Infusion/Enteral/Parenteral Billing Instructions and Numbered Memoranda 01-42 MAA, 02-06 MAA, and 02-53 MAA.

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Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

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Important Contacts

A provider may use HRSA's toll-free lines for questions regarding its program. However, HRSA's response is based solely on the information provided to HRSA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern HRSA's programs. [WAC 388-502-0020(2)].

Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Call the toll-free line:
866.545.0544

Where do I send my claims?

Division of Healthcare Services
PO Box 9247
Olympia WA 98507-9247

Where do I send my request for a limitation extension and/or prior authorization?

Follow the instructions listed in the *Authorization* section in these billing instructions and fax/write to:

360.586.1471 Fax

Division of Healthcare Services
Home Infusion Therapy/Parenteral Nutrition Program Manager
PO Box 45506
Olympia, WA 98506-5506

Who do I contact if I have questions on…

Payments, denials, general questions regarding claims processing, Healthy Options?

Division of Eligibility and Service Delivery 800.562.3022

Private insurance or third party liability, other than Healthy Options?

Division of Healthcare Services
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
800.562.6136

How do I obtain copies of billing instructions or numbered memoranda?

Check out HRSA's web site at: http://maa.dshs.wa.gov, **Provider Publications/Fee Schedule**s link.

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Definitions & Abbreviations

This section defines terms and abbreviations (includes acronyms) used throughout these billing instructions.

Authorization – HRSA official approval for action taken for, or on behalf of, an eligible HRSA client. This approval is only valid if the client is eligible on the date of service.

By Report (BR) – A method of reimbursement for covered items, procedures, and services for which the department has no set maximum allowable fees. HRSA may require the provider to submit a written report to determine reimbursement. [WAC 388-500-0005]

Client – An individual who has been determined eligible to receive medical or health care services under any HRSA program. [WAC 388-500-0005]

Code of Federal Regulations (CFR) – Rules adopted by the federal government. [WAC 388-500-0005]

Community Services Office (CSO) - An office of the department's Economic Services Administration (ESA) that administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement - The basic contract between HRSA and an entity providing services to eligible clients. The Core Provider Agreement outlines and defines terms of participation in medical assistance programs. [WAC 388-500-0005]

Department - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

Disposable Supplies - Supplies that may be used once, or more than once, but cannot be used for an extended period of time. [WAC 388-500-0005]

Durable Medical Equipment (DME) – Equipment that:

(a) Can withstand repeated use;
(b) Is primarily and customarily used to serve a medical purpose;
(c) Generally is not useful to a person in the absence of illness or injury; and
(d) Is appropriate for use in the client's place of residence.

[WAC 388-500-0005]

Duration of Therapy - The estimated span of time that therapy will be needed for a medical problem. [WAC 388-553-200]

Emergency Medical Services – Medical services required by and provided to a patient experiencing an emergency medical condition. [WAC 388-500-0005]

Episode - A continuous period of treatment regardless of the number of therapies involved.

Explanation of Benefits (EOB) – A coded message on the medical assistance Remittance and Status Report that gives detailed information about the claim associated with that report. [WAC 388-500-0005]

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Health and Recovery Services Administration (HRSA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Health Care Payment and Remittance Advice - The Health Care Payment and Remittance Advice is the standard X-12 transaction, number 835, implemented as part of the federal Health Insurance Portability and Accountability Act (HIPAA). The 835 is the HIPAA alternative to the Remittance and Status Report (RA). It is intended for provider use in reconciling claims.

Home Health Agency - An agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence. [WAC 388-551-2010]

Hyperalimentation – See "Parenteral Nutrition." [WAC 388-553-200]

Infusion Therapy – The provision of therapeutic agents or nutritional products to individuals by parenteral infusion for the purpose of improving or sustaining a client's health. [WAC 388-553-200]

Infusion Therapy Provider - An entity or individual who has been authorized by HRSA to provide equipment and supplies for parenteral administration of therapeutic agents to HRSA clients.

Intradialytic Parenteral Nutrition (IDPN) - Intravenous nutrition administered during hemodialysis. IDPN is a form of parenteral nutrition. [WAC 388-553-200]

Internal Control Number (ICN) - A 17-digit number that appears on your *Remittance and Status Report* by the client's name. Each claim is assigned an ICN when it is received by HRSA. The number identifies that claim throughout the claim's history.

Limitation Extension – A process for requesting reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which HRSA routinely reimburses. Limitation extensions require prior authorization. [WAC 388-500-0005]

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-538-050]

Maximum Allowable - The maximum dollar amount HRSA will reimburse a provider for a specific service, supply, or piece of equipment. [WAC 388-500-0005]

Medicaid - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the categorically needy program (CNP) or medically needy program (MNP). [WAC 388-500-0005]

Medical Consultant - A physician employed by the department. [WAC 388-500-0005]

Medical Identification (ID) card – The document that identifies a client's eligibility for a medical program. This card was formerly known as the medical assistance identification (MAID) card or medical coupon.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government health insurance program, for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Nonreusable Supplies – Disposable supplies, which are used once and discarded. [WAC 388-500-0005]

Parenteral Infusion – The introduction of a substance by means other than the gastrointestinal tract, referring particularly to the introduction of substances by intravenous, subcutaneous, intramuscular or intramedullary means. [WAC 388-553-200]

Parenteral Nutrition - The provision of nutritional requirements intravenously. Also known as **Total Parenteral Nutrition (TPN) or Hyperalimentation** [WAC 388-553-200]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each HRSA client consisting of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Permanent Impairment – An impairment that is more than three months in duration.

Plan of Treatment or **Plan of Care** – The written plan of care for a patient which includes, but is not limited to, the physician's order for treatment and visits by the disciplines involved, the certification period, medications, and rationale indicating need for services. [WAC 388-500-0005]

Prior Authorization – A process by which clients or providers must request and receive HRSA approval for certain medical services, equipment, drugs, and supplies, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extensions are forms of prior authorization.
[WAC 388-500-0005]

Prior Authorization Number – An identification number issued to providers who have a signed contract(s) with HRSA.
[WAC 388-500-0005]

Provider - Any person or organization that has a signed contract or core provider agreement with DSHS to provide services to eligible clients. [WAC 388-500-0005]

Provider Number – An identification number issued to providers who have signed contract(s) with HRSA.
[WAC 388-500-0005]

Purchase Only (PO) - A type of purchase used only when either the cost of the item makes purchasing it more cost effective than renting it, or it is a personal item, such as a ventilator mask, appropriate only for a single user.

Remittance And Status Report (RA) - A report produced by MMIS, HRSA's claims processing system that provides detailed information concerning submitted claims and other financial transactions. See also *Health Care Payment and Remittance Advice*. [WAC 388-500-0005]

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

Revised Code of Washington (RCW) - Washington state laws.

Skilled Nursing Facility (SNF) - An institution or part of an institution that is primarily engaged in providing:

- Skilled nursing care and related services for residents who require medical or nursing care;
- Rehabilitation services for injured, disabled or sick clients;
- Health-related care and services to individuals who, because of their mental or physical conditions, require care which can only be provided through institutional facilities and which is not primarily for the care and treatment of mental diseases. (See Section 1919(a) of the Federal Social Security Act for specific requirements.)

Third Party - Any entity that is, or may be, liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
[WAC 388-500-0005]

Total Parenteral Nutrition (TPN) – See "Parenteral Nutrition."
[WAC 388-553-200]

Usual & Customary Fee – The fee that the provider typically charges the general public for the product or service.
[WAC 388-500-0005]

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

About the Program

What is the purpose of the Home Infusion Therapy/ Parenteral Nutrition Program?

[Refer to WAC 388-553-100]

The purpose of the Home Infusion Therapy/Parenteral Nutrition program is to reimburse eligible providers for the supplies and equipment necessary for parenteral infusion of therapeutic agents to medical assistance clients. An eligible client receives this service in a qualified setting to improve or sustain the client's health.

HRSA's Home Infusion Therapy/Parenteral Nutrition program covers:

- Parenteral nutrition [also known as total parenteral nutrition (TPN)]; and
- Home infusion supplies and equipment.

Who is eligible to provide home infusion supplies and equipment and parenteral nutrition solutions?

[Refer to WAC 388-553-400(1)]

Eligible providers of home infusion supplies and equipment and parenteral nutrition solutions must:

- Have a signed Core Provider Agreement with HRSA; and
- Be one of the following provider types:

    - ✓ Pharmacy provider;
    - ✓ Durable medical equipment (DME) provider; or
    - ✓ Infusion therapy provider.

What are the requirements for reimbursement?

[Refer to WAC 388-553-400(2)]

HRSA pays eligible providers for home infusion supplies and equipment and parenteral nutrition solutions only when the providers:

- Are able to provide home infusion therapy within their scope of practice;
- Have evaluated each client in collaboration with the client's physician, pharmacist, or nurse to determine whether home infusion therapy/parenteral nutrition is an appropriate course of action;
- Have determined that the therapies prescribed and the client's needs for care can be safely met;
- Have assessed the client and obtained a written physician order for all solutions and medications administered to the client in the client's residence or in a dialysis center through intravenous, epidural, subcutaneous, or intrathecal routes; and
- Meet the requirements in WAC 388-502-0020, including keeping legible, accurate and complete client charts, and providing the documentation in the client's medical file as listed on pages F.6 and F.7 of this billing instruction.

In order to bill for home infusion therapy/parenteral nutrition, HRSA must first assign you an infusion therapy provider number. See the *Important Contacts* section for information on applying for an Infusion Therapy provider number.

Federally-Qualified Health Centers (FQHCs), Physicians, and Physician Clinics may provide home infusion therapy/parenteral nutrition services in a physician's office or physician clinic, unless the client resides in a nursing facility. Use the appropriate procedure codes from HRSA's *Physicians-Related Services Billing Instructions* when billing for services.

Nursing Facilities: Some services and supplies necessary for the administration of infusion are included in the facility's per diem rate for each client. See the Home Infusion Therapy/Parenteral Nutrition Fee Schedule (Section E) to identify procedure codes that are included in the nursing facility per diem rate. A client's infusion pump, parenteral nutrition pump, insulin pump, solutions, and/or insulin infusion supplies are not included in the nursing facility per diem rate and are paid separately.
[Refer to WAC 388-553-500(6)]

Outpatient Hospital Providers may provide infusion therapy/parenteral nutrition and bill using revenue codes. See HRSA's *Outpatient Hospital Billing Instructions*.

Clients in a State-Owned Facility: Home infusion therapy/parenteral nutrition for HRSA clients in state-owned facilities [state school, developmental disabilities (DD) facilities, mental health facilities, Western State Hospital and Eastern State Hospital] are purchased by the facility through a contract with manufacturers. HRSA does not pay separately for home infusion supplies and equipment or parenteral nutrition solutions for these clients. [Refer to WAC 388-553-500(5)]

Clients who have Elected HRSA's Hospice Benefit: HRSA pays for home infusion/ parenteral nutrition separate from the hospice per diem rate only when both of the following apply:

- The client has a pre-existing diagnosis that requires parenteral support; and
- That pre-existing diagnosis is unrelated to the diagnosis that qualifies the client for hospice.

When billing using a hardcopy 1500 Claim Form, you must enter a "K" indicator in *field 19* to identify that the infusion therapy services were unrelated to the terminal diagnosis. When billing electronically, you must enter a "K" indicator in the "comments" section. [Refer to WAC 388-553-500(5)]

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Client Eligibility

Who is eligible? [Refer to WAC 388-553-300(1)]

Clients presenting DSHS Medical Identification cards with the following identifiers **are eligible** for home infusion therapy/parenteral nutrition:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP-CHIP	CNP-Children's Health Insurance Program
GA-U No Out of State Care	General Assistance – Unemployable
LCP-MNP	Limited Casualty Program – Medically Needy Program

Are clients enrolled in an HRSA managed care plan eligible for home infusion therapy/parenteral nutrition?

[Refer to WAC 388-553-300(2)]

Yes! Clients who are enrolled in an HRSA managed care plan are eligible for Home Infusion Therapy/Parenteral Nutrition. These clients will have an HMO identifier in the HMO column on their DSHS Medical ID cards. Home infusion therapy/parenteral nutrition must be requested through the client's Primary Care Provider (PCP) and be billed directly to the client's managed care plan. See the toll-free telephone number listed on the client's DSHS Medical ID card.

Note: Client's enrollment can change monthly. Prior to serving an HRSA client enrolled in a managed care plan, you must receive approval from the plan in which the client is currently enrolled. The referral must come from a PCP participating in the plan in which the client is currently enrolled.

Newborns of clients enrolled in managed care plans are the responsibility of the plan in which the mother is enrolled for the first 60 days of life. If the mother changes plans, the baby follows the mother.

Primary Care Case Management

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the Primary Care Provider would be in a plan setting. **Please refer to the client's DSHS Medical ID card for the PCCM.**

Coverage

Home Infusion Therapy

All infusion therapy must be medically necessary. The medical necessity for the infusion must be evident in the diagnosis code on the claim. If the diagnosis code does not indicate the medical need for the infusion, DSHS may recoup the payment.

When does DSHS cover infusion therapy in the home?

[Refer to WAC 388-553-300(3)(4)]

DSHS will cover infusion therapy in the home when the client meets the following criteria. The client must:

- Have a written physician order for all solutions and medications administered;
- Be able to manage their infusion in one of the following ways:
  - ✓ Independently;
  - ✓ With a volunteer caregiver who can manage the infusion; or
  - ✓ By choosing to self-direct the infusion with a paid caregiver
  - ✓ (See WAC 388-71-0580);
  - ✓ Be clinically stable and have a condition that does not warrant hospitalization;
  - ✓ Agree to comply with the protocol established by the infusion therapy provider for home infusions. If the client is not able to comply, the client's caregiver may comply;
  - ✓ Consent, if necessary, to receive solutions and medications administered in the home through intravenous, enteral, epidural, subcutaneous, or intrathecal routes. If the client is not able to consent, the client's legal representative may consent.
- Reside in a residence that has adequate accommodations for administering infusion therapy including:
  - ✓ Running water;
  - ✓ Electricity;
  - ✓ Telephone access; and
  - ✓ Receptacles for proper storage and disposal of drugs and drug products.

Note: DSHS evaluates a request for home infusion therapy supplies and equipment or parenteral nutrition solutions that are not covered or are in excess of the home infusion therapy/parenteral nutrition program's limitations or restrictions, according to WAC 388-501-0165. See the Authorization Section within these billing instructions. [See WAC 388-553-500]

Parenteral Nutrition

All parenteral nutrition must be medically necessary. The medical necessity for the product being supplied must be evident in the diagnosis code on the claim. If the diagnosis code does not indicate the medical need for parenteral nutrition, DSHS may recoup the payment.

When is Parenteral Nutrition covered?

[Refer to WAC 388-553-300(5)]

To receive parenteral nutrition, a client must meet the conditions under Home Infusion Therapy (see page C.1) as follows:

- Have hyperemesis gravidarum or an impairment involving the gastrointestinal tract lasting 3 months or longer, where either of these conditions prevents oral or enteral intake to meet the client's nutritional needs;
- Be unresponsive to medical interventions other than parenteral nutrition; and
- Be unable to maintain weight or strength.

When is Parenteral Nutrition *NOT* covered?

[Refer to WAC 388-553-300(6)]

DSHS does not cover parenteral nutrition program services for a client who has a functioning gastrointestinal tract when the need for parenteral nutrition is due only to:

- A swallowing disorder;
- A gastrointestinal defect that is not permanent unless the client meets the criteria below;
- A psychological disorder (such as depression) that impairs food intake;
- A cognitive disorder (such as dementia) that impairs food intake;
- A physical disorder (such as cardiac or respiratory disease) that impairs food intake;
- A side effect of medication; or
- Renal failure or dialysis, or both.

When does DSHS cover parenteral nutrition for a client who has a condition expected to last less than three months?

[Refer to WAC 388-553-300(7)]

DSHS covers parenteral nutrition for a client whose gastrointestinal impairment is expected to last less than three months when:

- The criteria on page C.1 are met;
- The client has a written physician order that documents the client is unable to receive oral or tube feedings; and
- It is medically necessary for the gastrointestinal tract to be totally nonfunctional for a period of time.

When does DSHS cover Intradialytic Parenteral Nutrition (IDPN) solutions?

[Refer to WAC 388-553-300(8)]

DSHS covers intradialytic parenteral nutrition (IDPN) solutions when:

- The parenteral nutrition is not solely supplemental to deficiencies caused by dialysis; and
- The client meets the criteria on page C.1 (client eligibility) and items a.- c. on page C.2 under "**When is Parenteral Nutrition Covered?"**

What documentation is required to be in the client's medical record and available to DSHS upon request when providing parenteral nutrition to DSHSclients?

See CMS-1500 Claim Form instructions within these billing instructions specific to the *Home Infusion Therapy/Parenteral Nutrition Program*.

> **Note:** DSHS evaluates a request for home infusion therapy supplies and equipment or parenteral nutrition solutions that are not covered or are in excess of the home infusion therapy/parenteral nutrition program's limitations or restrictions, according to WAC 388-501-0165 and WAC 388-501-0169. See the Authorization Section within these billing instructions. [WAC 388-553-500]

Equipment/Supply Limitations

[Refer to WAC 388-553-500(1)(2)(3)(4)(5)(6)]

The home infusion therapy/parenteral nutrition program covers the following equipment and supplies for eligible clients, subject to the limitations and restrictions listed below:

- Home infusion supplies, limited to one month's supply per client, per calendar month;
- Parenteral nutrition (solutions), limited to one month's supply, per client, per calendar month;
- Covered rental of pumps is limited to one type of infusion pump, one type of parenteral pump, and/or one type of insulin pump per client, per calendar month and as follows:
  - ✓ All rent-to-purchase infusion parenteral and/or insulin pumps must be new equipment at the beginning of the rental period;
  - ✓ DSHS covers the rental payment for each type of infusion, parenteral, or insulin pump for up to 12 months. (DSHS considers a pump purchased after 12 months of rental payment.);
  - ✓ DSHS covers only one purchased infusion or parenteral pump, per client in a five-year period;
  - ✓ DSHS covers only one purchased insulin pump, per client in a four-year period.

Note: Covered supplies and equipment that are within the described limitations listed above do not require prior authorization for payment. Requests for supplies and/or equipment that exceed the limitations or restrictions listed in this section require prior authorization and are evaluated on an individual basis.

The following are considered included in DSHS's payment for equipment rentals or purchases:

- Instructions to a client or a caregiver, or both, on the safe and proper use of equipment provided;
- Full service warranty;
- Delivery and pick-up; and
- Set-up, fitting, and adjustments.

Home Infusion Therapy/ Parental Nutrition Program Coverage Table

Infusion Therapy Equipment and Supplies

Procedure Code	Modifier	Description	NH Per Diem?	Policy/Comments
• **Reimbursement is limited to a one-month's supply.**				
A4220		Refill kit for implantable infusion pump.	Y	Limited to 1 kit, per client, per month.
A4221		Supplies for maintenance of drug infusion catheter, per week;	Y	(List drug(s) separately) (includes dressings for the catheter site and flush solutions not directly related to drug infusion). The catheter site may be a peripheral intravenous line, a peripherally inserted central catheter (PICC), a centrally inserted intravenous line with either an external or subcutaneous port, or an epidural catheter. Procedure code A4221 also includes all cannulas, needles, dressings, and infusion supplies(excluding the insulin reservoir) related to continuous subcutaneous insulin infusion via external insulin infusion pump (E0784). **1 unit = 1 week**
A4222		Supplies for external drug infusion pump, per cassette or bag (List drug(s) separately).	Y	Procedure code A4222 includes the cassette or bag, diluting solutions, tubing, and other administration supplies, port cap changes, compounding charges and preparation charges.

Infusion Therapy Equipment and Supplies (continued)				
Procedure Code	**Modifier**	**Description**	**NH Per Diem?**	**Policy/Comments**
A4223		Infusion supplies not used with external infusion pump, per cassette or bag (list drug(s) separately).	Y	Procedure code A4223 includes supplies such as diluents, IV tubing or administration sets, supplies and materials for compounding and/or administering of gravity bags or premix/commercial bags that can be run by gravity and not with an external pump. **Examples of therapies:** Antibiotic therapies (e.g., vancomycin, tobramycin, and penicillin) that may be dispensed in gravity bags without the need for an external pump. Not allowed in combination with procedure code A4222. You must submit an invoice for payment.
Antiseptics & Germicides **Reimbursement is limited to a one-month's supply.**				
Procedure Code	**Modifier**	**Description**	**NH Per Diem?**	**Policy/Comments**
A4245		Alcohol wipes, per box. .	Y	1 box per client, per month. Not allowed in combination with A4244
A4246		Betadine or Phisohex solution, per pint.	Y	1 pint per client, per month. Not allowed in combination with A4247.
A4247		Betadine or iodine swabs/wipes, per box of 100.	Y	1 box per client, per month. Not allowed in combination with A42464
E0776-	NU	IV pole.	Y	**Purchase.**
E0776	RR	IV pole.	Y	**Rental per month**. **1 unit = 1 month**

Infusion Pumps

- **Bill only one type of infusion pump code, per month.**
- **DSHS does not reimburse for a rental and a purchase of the same item simultaneously per client.**
- **Infusion pumps are considered purchased after 12 months' rental.**
- **Rent-to-purchase infusion pumps must be new equipment at beginning of rental period.**
- **Modifier is required when billing.**
- **Purchase is limited to one pump, per client, per five years.**

Procedure Code	Modifier	Description	NH Per Diem?	Policy/Comments
E0779	NU	Ambulatory infusion pump, mechanical, reusable, for infusion 8 hours or greater.	N	**Purchase.**
E0779	RR	Ambulatory infusion pump, mechanical, reusable, for infusion 8 hours or greater.	N	**Rental per month.**
E0780	NU	Ambulatory infusion pump, mechanical, reusable, for infusion less than 8 hours.	N	**Purchase.**
E0781	NU	Ambulatory infusion pump, single or multiple channel, electric or battery operated, with administrative equipment, worn by patient.	N	**Purchase.**
E0781	RR	Ambulatory infusion pump, single or multiple channel, electric or battery operated, with administrative equipment, worn by patient.	N	**Rental per month.**
E0791	NU	Parenteral infusion pump, stationary, single or multi-channel.	N	**Purchase.**
E0791	RR	Parenteral infusion pump, stationary, single or multi-channel.	N	**Rental per month.**

Parenteral Nutrition Infusion Pumps

- **DSHS reimburses for only one type of parenteral nutrition pump, per month.**
- **DSHS does not reimburse for a rental and a purchase of the same item simultaneously per client.**
- **Rent-to-purchase parenteral pumps must be new equipment at beginning of rental period.**
- **Parenteral Nutrition pumps are considered purchased after 12 months' rental.**
- **Modifier is required when billing.**
- **Purchase is limited to one pump, per client, per 5 years.**

Procedure Code	Modifier	Description	NH Per Diem?	Policy/Comments
B9004	NU	Parenteral nutrition infusion pump, portable.	N	**Purchase.**
B9004	RR	Parenteral nutrition infusion pump, portable.	N	**Rental per month. 1 unit = 1 month.**
B9006	NU	Parenteral nutrition infusion pump, stationary.	N	**Purchase.**
B9006	RR	Parenteral nutrition infusion pump, stationary.	N	**Rental per month. 1 unit = 1 month**

Parenteral Nutrition Solutions

When using half units of parenteral solutions, DSHS will reimburse for 1 unit every other day, otherwise allowed once per day. In the event an odd number of days of therapy are delivered, you may round the last day of therapy to the closest unit. (**Example: If you are delivering 250 ml of 50% dextrose for 21 consecutive days, you may bill for 11 units of parenteral solution.)**

- **Reimbursement is limited to a one-month's supply.**

Procedure Code	Modifier	Description	NH Per Diem?	Policy/Comments
B4164		Parenteral nutrition solution; carbohydrates (dextrose), 50% or less (500 ml = 1 unit) home mix.	N	***Not allowed in combination with B4189, B4193, B4197, B4199, B5000, B5100, and B5200.***
B4168		Parenteral nutrition solution; amino acid, 3.5% (500 ml = 1 unit) home mix.	N	***Not allowed in combination with B4189, B4193, B4197, B4199, B5000, B5100, and B5200.***
B4172		Parenteral nutrition solution; amino acid, 5.5% through 7% (500 ml = 1 unit) – home mix.	N	***Not allowed in combination with B4189, B4193, B4197, B4199, B5000, B5100, and B5200.***
B4176		Parenteral nutrition solution; amino acid, 7% through 8.5% (500 ml = 1 unit) – home mix.	N	***Not allowed in combination with B4189, B4193, B4197, B4199, B5000, B5100, and B5200.***

Parenteral Nutrition Solution (continued)				
Procedure Code	**Modifier**	**Description**	**NH Per Diem?**	**Policy/Comments**
B4178		Parenteral nutrition solution; amino acid greater than 8.5% (500 ml = 1 unit) - home mix.	N	***Not allowed in combination with B4189, B4193, B4197, B4199, B5000, B5100, and B5200.***
B4180		Parenteral nutrition solution; carbohydrates (dextrose) greater than 50% (500 ml = 1 unit) = home mix.	N	***Not allowed in combination with B4189, B4193, B4197, B4199, B5000, B5100, and B5200.***
B4185		Parenteral nutrition solution, per 10 grams, lipids	N	~~***Effective 01/01/06.***~~
B4189		Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 10 to 51 grams of protein – premix.	N	
B4193		Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 grams of protein – premix.	N	
B4197		Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 74 to 100 grams of protein – premix.	N	

Parenteral Nutrition Solution (continued)				
Procedure Code	**Modifier**	**Description**	**NH Per Diem?**	**Policy/Comments**
B4199		Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, over 100 grams of protein – premix.	N	
B4216		Parenteral nutrition; additives (vitamins, trace elements, heparin, electrolytes) – home mix, per day.	N	***Not allowed in combination with B4189, B4193, B4197, B4199, B5000, B5100, and B5200.***
B5000		Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal – amirosyn RF, nephramine, renamine – premix.	N	
B5100		Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic – freamine HBC, hepatmine - premix.	N	
B5200		Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress - branch chain amino acids - premix.	N	

Parenteral Nutrition Supplies

- **Parenteral Nutrition Kits are considered "all-inclusive" items necessary to administer therapy.**
- **Reimbursement is limited to a one-month's supply.**

Procedure Code	Modifier	Description	NH Per Diem?	Policy/Comments
B4220		Parenteral nutrition supply kit; premix,	N	**Per day.** **1 unit = 1 day.** ***Not allowed in combination with B4222***
B4222		Parenteral nutrition supply kit; home mix,	N	**Per day.** **1 unit = 1 day**. ***Not allowed in combination with B4220***
B4224		Parenteral nutrition administration kit, per day.	N	**Per day. 1 unit = 1 day**

Insulin Infusion Pumps

- **Covered for Type I Diabetes only. Type II Diabetes requires prior authorization.**
- **Modifier is required when billing**

Procedure Code	Modifier	Description	NH Per Diem?	Policy/Comments
E0784	NU	External ambulatory infusion pump, insulin, includes case.	N	**1 per client, per 4 years. Purchase.**
E0784	RR	External ambulatory infusion pump, insulin.	N	**Rental per month**. **1 unit = 1 month**. Maximum of 12 months' rental allowed.

Insulin Infusion Supplies

- **Reimbursement is limited to a one-month's supply.**

Procedure Code	Modifier	Description	NH Per Diem?	Policy/Comments
A4230		Infusion set for external insulin pump, non-needle cannula type.	N	**2 boxes per client, per month. 1 unit = 1 box of 10.**
A4231		Infusion set for external insulin pump, needle type.	N	**2 boxes per client, per month. 1 unit = 1 box.**
A4232		Syringe with needle for external insulin pump, sterile, 3 cc.	N	**2 boxes per client, per 1 month. 1 unit = 1 box of 10.**
K0601		Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt.	N	10 per client per 6 months.
K0602		Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt.	N	10 per client per 6 months.
K0603		Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt.	N	9 per client per 3 months.
K0604		Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt	N	
K0605		Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt	N	

Miscellaneous Infusion Supplies				
• **Reimbursement is** limited **to a one-month's supply.**				
Procedure Code	**Modifier**	**Description**	**NH Per Diem?**	**Policy/Comments**
A4927**		Gloves, nonsterile, per box of 100 gloves.	Y	**1 unit = 1 box of 100 gloves.** **Limit = 2 units per client, per month** **Prior Authorization is required for units exceeding 2 units per client, per month.** **Effective August 1, 2009.**
A4930**		Gloves, sterile, per pair.	Y	**Limit 30 pair per client, per month.** **Effective August 1, 2009**
B9999		No other code for parenteral supplies.	N/A	**Requires prior authorization. See instructions on page D.1 Authorization**
~~E1340~~		~~Repair or nonroutine service, for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes.~~	~~N~~	~~**Must submit invoice with claim.**~~ **Replaced with K0739 January 1, 2010.**
E1399		Equipment repair, parts.	N	**Requires prior authorization. See instructions on page D.1 Authorization**
E1399		10 quart chemotherapy waste container.	Y	**Requires prior authorization. See instructions on page D.1 Authorization**
K0739		Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes.	N	**Prior authorization is required.** **Must submit invoice with claim that separates labor costs from other costs.**

****** DSHS allows additional non-sterile gloves per client, per month, if the client resides in an assisted living facility (these facilities are identified by code 13 in the "Place of Service" box on the claim form). DSHS allows additional gloves up to the quantity necessary as directed by the client's physician, not to exceed a total of 400 per month (4 units), with the use of Expedited Prior Authorization (EPA) number 870001262.

Authorization

Written/fax authorization does not override the client's eligibility or program limitations. Not all categories of eligibility receive all services. For example: Infusion pumps are not covered under the Family Planning Only program.

Written/Fax Authorization

What is written/fax authorization?

Written or fax authorization is a paper authorization process available to providers. It is used for Limitation Extension requests (see below) and for services noted in Washington Administrative Code (WAC) and billing instructions as needing prior authorization.

For the Home Infusion Therapy/Parenteral Nutrition Program, you must obtain written/fax authorization for:

- Miscellaneous parenteral therapy supplies (**procedure code B9999**). See page C.14 for further details "Justification for use of Miscellaneous Parenteral Supply Procedure Code (B9999). To request prior authorization, fax a completed DSHS 13-721 form to request prior authorization to 1- 360 - 586-1471.

- Equipment repairs, parts, and 10 quart chemotherapy waste containers require prior authorization (**procedure code E1399)**. To request prior authorization, Fax a completed DSHS 12-756 form to 1-360-586-1471.

- Limitation Extensions - See page D.2.

To download the forms above, go to: http://www1.dshs.wa.gov/msa/forms/eforms.html

How do I obtain written/fax authorization?

Authorization may be obtained by sending a request, along with any required forms, to:

HRSA – Medical Request Coordinator
Medical and Enteral Authorization Unit
PO Box 45506
Olympia, WA 98504-5506
Fax 1-360-586-1471

Limitation Extension

What is a Limitation Extension?

Limitation extension (LE) is authorization for cases when HRSA determines that it is medically necessary to provide more units of service than allowed in HRSA's WAC and billing instructions.

How do I get LE authorization?

LE authorization may be obtained by using the written/fax authorization process.

Your request must include the following:

1. Name of agency and provider number;
2. Client's name and PIC number;
3. Procedure code and description of supply needed;
4. Copy of the original prescription; and
5. Explanation of client-specific medical necessity to exceed limitation.

Fax a completed DSHS 13-756 form to request prior authorization to (360) 586-1471.

Authorization may be obtained by sending a request, along with any required forms, to:

HRSA – Medical Request Coordinator
Medical and Enteral Authorization Unit
PO Box 45506
Olympia, WA 98504-5506
Fax 1-360-586-1471

Miscellaneous Parenteral Supply Procedure Code B9999

Miscellaneous procedure code B9999 requires prior authorization. In order to be reimbursed for B9999, you must **first** complete the attached DSHS 13-721 form and fax the form to HRSA for review and approval. Keep a copy of your request in the client's file.

To download this form, go to: http://www1.dshs.wa.gov/msa/forms/eforms.html

Do not submit claims using HCPCS code B9999 **until you have received an authorization number from HRSA** indicating that your bill has been reviewed and approved.

Include the following supporting documentation with your fax for approval:

- Agency name and provider number;
- Client PIC;
- Date of service;
- Name of primary piece of equipment and whether the equipment is rented or owned;
- Invoice;
- Prescription; and
- Explanation of client-specific medical necessity.

Make copies of the attached form and mail/fax to:

HRSA – Medical Request Coordinator
Medical and Enteral Authorization Unit
PO Box 45506
Olympia, WA 98504-5506
Fax 1-360-586-1471

To download the **Justification for Use of Miscellaneous Parenteral Supply Procedure Code (B9999)** form, DSHS 13-721, go to http://www1.dshs.wa.gov/msa/forms/eforms.html.

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Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- HRSA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. HRSA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in HRSA's billing instructions.

- HRSA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders HRSA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- HRSA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to HRSA's satisfaction that there are other extenuating circumstances.

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[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill HRSA for the service.

- Providers may **resubmit, modify, or adjust** any timely initial claim, **except** prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

> **Note:** HRSA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The time-periods do not apply to overpayments that the provider must refund to DSHS. After the time-periods, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ HRSA does not pay the claim.

What fee should I bill HRSA for eligible clients?

Bill HRSA your usual and customary fee**.**

> **Exception:** If billing Medicare Part B crossover claims, bill the amount submitted to Medicare.

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM name in field 17 on the 1500 Claim Form; and
- Enter the seven-digit, HRSA-assigned identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill HRSA, the claim will be denied.

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

If a client is eligible for both Medicare and Medicaid (otherwise known as "dual-eligible"), **you must <u>first</u> submit a claim to Medicare and accept assignment within Medicare's time limitations**. HRSA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill HRSA within six months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, HRSA requires the provider to meet HRSA's initial 365-day requirement for initial claim (see page K.1).
- Codes billed to HRSA must match codes billed to Medicare when billed as a Medicare Part B crossover claim.

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to HRSA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your HRSA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill HRSA directly.

- If Medicare has made payment, and there is a balance due from HRSA, you must submit a 1500 Claim Form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do not submit paid lines with denied lines. This could cause a delay in payment or a denial.

- If Medicare denies services, but HRSA covers them, you must bill on a 1500 Claim Form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment or a denial.

- If Medicare denies a service that requires prior authorization by HRSA, HRSA will waive the prior authorization requirement but will still require authorization. Authorization or denial of your request will be based upon medical necessity.

Note:

✓ Medicare/Medicaid billing claims must be received by HRSA within six (6) months of the Medicare EOMB paid date.
✓ A Medicare Remittance Notice or EOMB must be attached to each claim.

Payment Methodology – Part B

- MMIS compares HRSA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no HRSA allowed amount, HRSA uses Medicare's allowed amount.)

- Medicare's payment is deducted from the amount selected above.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds HRSA's allowable.

- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to HRSA's maximum allowable.

HRSA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. HRSA *can* pay these costs to the provider on behalf of the client when:

1) The provider **accepts** assignment; and

2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

Third-Party Liability

The Health and Recovery Services Administration (HRSA) is required by federal regulation to determine the liability of third-party resources that are available to HRSA clients. All resources available to the client that are applicable to the costs of medical care must be used. Once the applicable resources are applied, HRSA may make payment on the balance if the third-party payment is less than the allowed amount.

To be eligible for HRSA programs, a client must assign his/her insurance rights to the state in conformance with federal requirements.

It is the provider's responsibility to bill HRSA appropriately after pursuing any potentially liable third-party resource when:

- Health insurance is indicated on the client's DSHS Medical ID card; or
- There is a possible casualty claim; or
- You believe insurance is available.

> If you would like assistance in identifying an insurance carrier, call the Third-Party Resource Program at 800.562.6136, or refer to the TPL Carrier Code List on HRSA's web site at http://maa.dshs.wa.gov.

Exception:

Due to federal requirements, the following services will **not** be denied for third-party coverage **unless** the TPL code is **HM, HI, or HO:**

- ✓ Outpatient preventative pediatric care;
- ✓ Outpatient maternity-related services; and
- ✓ Accident related claims, if the third party benefits are not available to pay the claims at the time they are filed, per 42 CFR 433.139(c).

Indicate all available insurance information on the claim form. HRSA pays the claim and pursues the third-party insurance.

You must pursue collection from the subscriber when the client is not the subscriber and the insurance company makes a benefit payment to the subscriber. Under these circumstances, the client is under no obligation to pay unless he/she is the insurance subscriber.

Although the billing time limit for HRSA is 365 days, an insurance carrier's time limit on billing allowances may be different. It is your responsibility to meet the insurance carrier's requirement relating to billing time limits prior to any payment by HRSA.

Note: If you receive payment from HRSA in excess of the amount due, you may refund the excess to the Office of Financial Recovery, or you may submit an adjustment request to HRSA to withhold money from future checks. A copy of the appropriate HRSA Remittance and Status Report showing the original payment and copy of the insurance EOB, if available, should be attached to either the check or the adjustment request, whenever possible.

Mail refund checks to:

Office of Financial Recovery - Med
PO Box 45862
Olympia WA 98504-5862

What records must be kept in the client's file?

Specific to Home Infusion Therapy/Parenteral Nutrition Program
[WAC 388-553-400]

- For a client receiving infusion therapy, the file must contain:

  - ✓ A copy of the written prescription for the therapy;
  - ✓ The client's age, height, and weight;
  - ✓ The medical necessity for the specific home infusion service;

- For a client receiving parenteral nutrition, the file must contain:

  - ✓ All the information listed above;
  - ✓ Oral or enteral feeding trials and outcomes, if applicable;
  - ✓ Duration of gastrointestinal impairment; and
  - ✓ The monitoring and reviewing of the client's lab values:

    - ➢ At the initiation of therapy;
    - ➢ At least once per month; and
    - ➢ When the client and/or the client's lab results are unstable.

General for all providers [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Pertinent medical history;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, **for at least six years from the date of service** or more if required by federal or state law or regulation.

A provider may contact HRSA with questions regarding its programs. However, HRSA's response is based solely on the information provided to HRSA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern HRSA's programs.
(Refer to WAC 388-502-0020[2])

Fee Schedule

You may view **HRSA's Home Infusion Therapy/Parental Nutrition Program Fee Schedule** on-line at http://maa.dshs.wa.gov/RBRVS/Index.html

Completing the 1500 Claim Form

Attention! On November 1, 2006, HRSA now accepts the new 1500 Claim Form (version 08/05).

- **As of April 1, 2007**, HRSA will no longer accept the old HCFA-1500 claim form.

Note: HRSA encourages providers to make use of electronic billing options. For information about electronic billing, refer to the *Important Contacts* section.

Refer to HRSA's current *General Information Booklet* for instructions on completing the 1500 Claim Form. You may download this booklet from HRSA's website at: http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html or request a paper copy from the Department of Printing (see *Important Contacts* section).

The following 1500 Claim Form instructions relate to *Home Infusion Therapy/Parenteral Nutrition Program Billing Instructions*. Click the link above to view general 1500 Claim Form instructions.

HRSA requires HRSA-approved Family Planning providers to list the National Drug Code (NDC) number **on all drug claims** and the amount of drug given to the client in Box 19 of the 1500 Claim Form, or in the *Comments* section of the electronic 1500 Claim Form, when billing for an unlisted contraceptive identified by an EPA number.

For questions regarding claims information, call HRSA toll-free:

800.562.3022

Field No.	Name	Field Required	Entry
24B.	**Place of Service**	Yes	Enter the following code: **Code** — **To Be Used For** 12 — Client's residence 32 — Nursing facility (formerly ICF) 31 — Nursing facility(formerly SNF) 33 — Custodial care facility 65 — End Stage Renal Disease Treatment Facility

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