

Washington Apple Health (Medicaid)

Enteral Nutrition Billing Guide

May 1, 2017

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect May 1, 2017, and supersedes earlier guides to this program.

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

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

What has changed?

Subject	Change	Reason for Change
The entire guide.	The entire guide has been reorganized. Updates have also been made to align with WAC changes filed under WSR 17-08-009.	Clarification and policy updates.

* This publication is a billing instruction.

How can I get agency provider documents?

To access provider alerts, go to the agency's [provider alerts](#) web page.

To access provider documents, go to the agency's [provider billing guides and fee schedules](#) web page.

Where can I download agency forms?

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

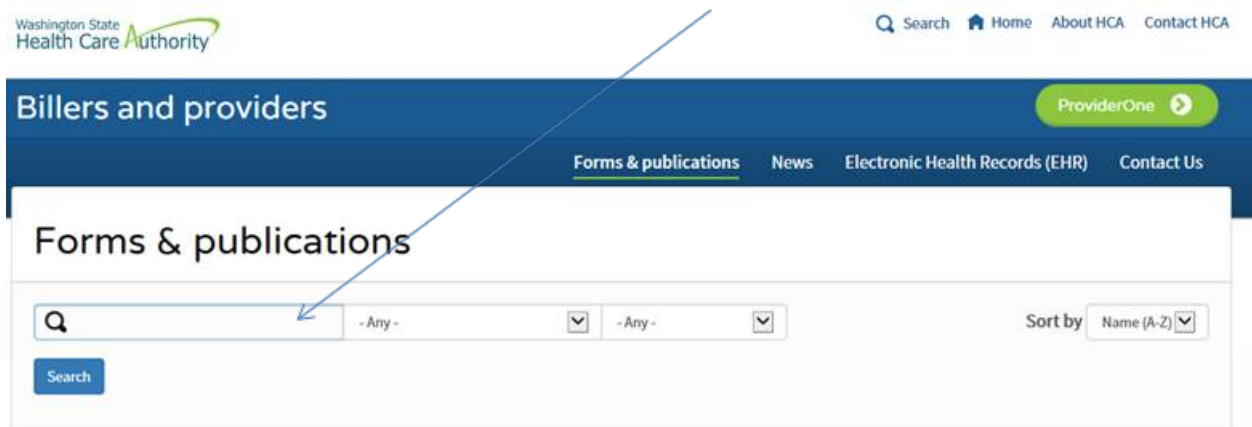


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Resources Available

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. See Where can I download agency forms?
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. See Where can I download agency forms?
Finding the nearest Women, Infants, and Children (WIC) clinic	To find the nearest WIC clinic, call (800) 841-1410 or visit www.doh.wa.gov/youandyourfamily/WIC .

Definitions

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

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

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

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

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

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

Medical nutrition therapy – Face-to-face interactions between a certified registered dietitian 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 – Formulas or solutions that a person consumes orally for nutritional support.

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

About this Program

What is the Enteral Nutrition Program?

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

Client Eligibility

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

Who is eligible for enteral nutrition?

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

Agency-contracted managed care organizations (MCOs)

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 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.

Nursing facilities and adult family homes

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

State-owned facilities

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

Hospice

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

WIC

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

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

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

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.

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

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

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

For additional information, see the agency's [Managed Care](#) web site, under Providers and Billers.

Effective April 1, 2016, important changes to Apple Health

These changes are important to all providers because they may affect who pays 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) provides the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. See the Southwest Washington Provider Fact Sheet on the agency's [Regional Resources](#) web page.

New MCO enrollment policy – earlier enrollment

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

- **New clients** are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health Managed Care.

- **Renewing clients** are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

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

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 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 replace the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the [Mental Health Services 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 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 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 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 are 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) provides 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 are not auto-enrolled, but may opt into CCW. All other eligible clients are 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 choose between CHPW or MHW for behavioral health services, or they are auto-enrolled into one of the two plans. CHPW and MHW 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 receive complex mental health and SUD services from the BHO and managed by DSHS.


Contact Information for Southwest Washington

Beginning on April 1, 2016, there is not 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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Provider Requirements

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

Who is eligible to bill for enteral nutrition services?

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

- Pharmacy providers
- Durable medical equipment (DME) providers

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

Providers must:

- Provide only services that are within the scope of the provider's license.
- Obtain prior authorization from the agency, if required, before:
 - ✓ Delivery to the client.
 - ✓ Billing the agency.
- Deliver enteral nutritional products in quantities sufficient to meet the client's authorized needs, not to exceed a one-month supply.
- Confirm with the client or the client's caregiver that the next month's delivery of authorized enteral nutrition products is necessary and document the confirmation in the client's file. The agency does not pay for automatic periodic delivery of products.
- Furnish clients with new or used equipment that includes full manufacturer and dealer warranties for at least one year.
- Notify the client's prescribing provider if the client has indicated that the product is not being used as prescribed and document the notification in the client's file.

- Complete the agency's *Enteral Nutrition Products Prescription* form (HCA 13-961). To be valid, a prescription must:
 - ✓ Be written, dated, and signed (including the prescriber's credentials) by the prescriber on or before the date of delivery of the product, equipment, or related supplies.
 - ✓ Be no older than one year from the date the prescriber signed the prescription.
 - ✓ State the specific item or service requested, the client's diagnosis, and estimated length of need, quantity and units of measure, frequency and directions for use.
- Have proof of delivery.
 - ✓ When a client or the clients' authorized representative receives the product directly from the provider, the provider must furnish the proof of delivery upon agency request. The proof of delivery must:
 - Be signed and dated by the client or the client's authorized representative. The date of the signature must be the date the client received the item.
 - Include the client's name and a detailed description of the items delivered, including the quantity and brand name.
 - ✓ When a provider uses a shipping service to deliver items, the provider must furnish proof of delivery upon agency request. The proof of delivery must include:
 - The client's name or other client identifier.
 - The delivery service package identification number.
 - The delivery address.
 - The quantity, a detailed description, and brand name of the item being shipped.
- Bill the agency with the following dates of service:
 - ✓ If the provider used a shipping service, the provider must use the shipping date as the date of service.
 - ✓ If the client or the client's authorized representative received the product directly from the provider, the provider must use the date of receipt as the date of service.

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

Coverage

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

What is covered under the Enteral Nutrition Program?

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

Services covered under the Enteral Nutrition program include:

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

What is not covered?

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

The agency does not cover the following:

- Nonmedical equipment, supplies, and related services (for example, back-packs, pouches, bags, baskets, or other carrying containers)
- Orally administered enteral nutrition products for clients age 21 and older

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, see [Where can I download agency forms?](#)) to the agency. See the agency's [Resources Available](#).

For clients with inherited metabolic disorders to request an exception to rule, see these [instructions](#) for additional information.

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 WAC [182-501-0165](#) to determine if it is medically necessary, safe, effective, and not experimental (see WAC [182-534-0100](#) for EPSDT rules).

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

Thickeners

[\(WAC 182-554-525\)](#)

Client Eligibility

The agency covers thickeners for clients age 20 and younger with dysphagia documented by videofluoroscopy. If the client is under age one, prior authorization (PA) is required. There is no benefit for clients 21 years and older.

Authorization

Clients age one to 20.

- Use EPA [#870001406](#). If client does not meet EPA, PA is required.
- Durable medical equipment (DME) and pharmacy providers supplying thickeners for with dysphagia documented by videofluoroscopy that requires a thickener, the prescribing provider must complete the *Thickeners for Children – Expedited Prior Authorization (EPA)* form (HCA 13-112).

Clients under age one.

- Prior authorization (PA) is required.
- The Food and Drug Administration (FDA) and the American Academy of Pediatrics have warned that xantham gum (e.g. *Simply Thick*) and other gum thickeners are not safe for infants. Providers who feel xantham gum is the next reasonable step in care must request PA.
- The PA request must include documentation on:
 - What other strategies were used to address dysphagia and why these strategies were unsuccessful.
 - Confirmation that the parents or guardians have been advised of the warning and agree that the benefit outweighs the risk.
- For authorization, use the *Thickeners for Babies Less Than One Year – Prior Authorization (PA) Request* form (HCA 13-111) and fax to 866-668-1214 along with the *General Information for Authorization* form (HCA13-835) as coversheet.

(See [Where can I download agency forms?](#))

Product List

DME and pharmacy providers 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 accepts billing for only the codes and products listed on the Noridian Enteral Nutrition Product Classification List.

Note: Providers must use the appropriate modifier when billing the agency for these codes.

DME and pharmacy providers must bill the HCPCS code in the product list with the appropriate modifier for all enteral nutrition products. The agency denies claims for enteral nutrition products without modifiers.

Coverage Table for Thickeners

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

Record Keeping, Billing, Reimbursement and Post-pay Audit

The agency requires DME and pharmacy providers to keep legible, accurate, and complete records to justify the medical necessity of the items provided. This includes:

- A copy of the *Enteral Nutrition Products Prescription form* (HCA 13-961) that is signed and dated by the prescribing provider and lists the client’s medical condition and the exact daily amount of thickener product prescribed.
- A copy of the *Thickeners for Children – Expedited Prior Authorization (EPA)* form (HCA 13-112), or the *Thickeners for Babies Less Than One Year – Prior Authorization (PA) Request* form (HCA 13-111).
- A copy of the dietitian evaluation for clients age 20 and younger.

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

Inherited Metabolic Disorders

[\(WAC 182-554-550\)](#)

Client Eligibility

The agency covers orally administered enteral nutrition products for clients age 20 and younger with amino acid, fatty acid, and carbohydrate metabolic disorders, including phenylketonuria (PKU), by expedited prior authorization (EPA). Clients age 21 and older can request an exception to rule (ETR) under [WAC 182-501-0160](#).

Authorization

Clients age 20 and younger

- Durable medical equipment (DME) and pharmacy providers supplying these products must use EPA #[870001405](#).
- A complete *Metabolic Disorders – Expedited Prior Authorization (EPA) Worksheet: Children* form (HCA 13-101) for clinical criteria must be retained in the client's records.

Clients age 21 and older

- DME and pharmacy providers must use the [exception to rule process](#) for clients age 21 and older. For authorization, use the *Metabolic Disorders – Exception to Rule Requests: Adults* form (HCA 13-100) and fax to 866-668-1214 along with the *General Information for Authorization* form (HCA13-835) as coversheet.

(See [Where can I download agency forms?](#))

Product List

DME and pharmacy providers 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 provider must use the appropriate modifier when billing the agency for these codes.

DME and pharmacy providers must bill the HCPCS code in the product list with the appropriate modifier for all enteral nutrition products. The agency denies claims for enteral nutrition products without modifiers.

Coverage Table for Inherited Metabolic Disorders

Category (HCPCS code)	Description	One Unit Equals	Policy/Comments
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	Use EPA #870001405
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	Use EPA #870001405

Miscellaneous

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

HCPCS Code	Modifier	Short Description	EPA/PA	Part of NH per diem	Policy/Comments
B9998		NOC for enteral supplies	PA	N	Requires PA. Complete form HCA 13-745 and send with typed and completed form HCA 13-835. Invoice for requested item must be submitted for review.

Record Keeping, Billing, Reimbursement and Post-pay Audit

The agency requires DME and pharmacy providers to keep legible, accurate, and complete records to justify the medical necessity of the items provided. This includes:

- A copy of the *Enteral Nutrition Products Prescription form* (HCA 13-961) that is signed and dated by the prescribing provider and lists the client's medical condition and the exact daily amount of product prescribed. This prescription must be renewed annually at a minimum.
- A copy of *Metabolic Disorders – Expedited Prior Authorization (EPA) Worksheet: Children* form (HCA 13-101), or the *Metabolic Disorders – Exception to Rule Requests: Adults* form (HCA 13-100).

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

Tube-Delivered Enteral Nutrition

(WAC 182-554-600)

Client Eligibility

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

- Meets [general eligibility criteria \(WAC 182-554-300\)](#).
- Has a valid prescription according to *Enteral Nutrition Products Prescription* form (HCA 13-961) under [WAC 182-554-400](#). The provider must submit the form within three months of the date the prescriber signed the prescription. (See [Where can I download agency forms?](#))
- Can manage tube feedings independently or with a caregiver's assistance.
- Has a disease or condition that impairs the client's ability to ingest sufficient calories and nutrients or restricts calories and nutrients from food from reaching the gastrointestinal tract.
- Has a disease or condition of the small bowel that impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength properly proportioned to the client's overall health status.

Dual eligible clients

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

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

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

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

Authorization

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

Product List

DME and pharmacy providers must use the [Enteral Nutrition Product Classification List](#) located on the Noridian website. Providers must use the applicable HCPCS codes for all enteral nutritional. The agency accepts 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.

DME and Pharmacy providers must bill the HCPCS code in the product list with the appropriate modifier for all enteral nutrition products. Without the appropriate modifier, the claim will be denied.

Coverage Table for Tube-Feeding Products

Category (HCPCS code)	Description	One Unit Equals
B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit	500 ml
B4103	Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit	500 ml
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

Enteral Nutrition

Category (HCPCS code)	Description	One Unit Equals
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
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

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	Requires PA. Complete form HCA 13-745 and send with typed and completed form HCA 13-835. Invoice for requested item must be submitted for reimbursement.

Record Keeping, Billing, Reimbursement and Post-Pay Audit

The agency requires DME and pharmacy providers to keep legible, accurate, and complete records to justify the medical necessity of the items provided. This includes:

- A copy of the *Enteral Nutrition Products Prescription form* (HCA 13-961) that is signed and dated by the prescribing provider and lists the client's medical condition and the exact daily caloric amount of medically necessary enteral nutrition product.
- For clients age 4 and younger, WIC forms documenting that:
 - The client is not eligible for WIC program services.
 - The client is eligible for WIC program services, but nutrition needs exceed the WIC program's maximum per calendar month allotment.
 - The WIC program cannot provide the prescribed or similar product.
- A copy of a dietitian evaluation for clients age 20 and younger (*Dietitian Worksheet – Oral Enteral Nutrition Assessment* form, HCA 13-109)
 - The client must have at least an annual dietitian consultation to assess growth and nutrient needs.

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

Enteral Equipment and Related Supplies

(WAC 182-554-700)

Client Eligibility

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

Authorization

Providers must obtain authorization for enteral equipment and supplies when noted on the coverage table.

To exceed specified limitations, submit a Limitation Extension (LE) request. Use the *Enteral Equipment and Supplies Limitation Extension Request* form (HCA 13-115). (See [Where can I download agency forms?](#))

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

Coverage

- The following are included in the agency's reimbursement for equipment rentals or purchases:
 - Instructions to the client, caregiver, or both, on the safe and proper use of equipment provided
 - Full service warranty
 - Delivery and pick-up
 - Fitting and adjustments
- If changes in circumstances occur during the rental period, such as death or ineligibility, the agency will terminate reimbursement effective on the date of the change in circumstances.

Enteral Nutrition

- Providers may not bill for simultaneous rental(s) and purchase of the same item at any time.
- The agency will pay up to an additional three months of pump rental while a client-owned pump is being repaired.
- The agency will **not** reimburse providers for equipment that was supplied to them **at no cost** through suppliers/manufacturers or items that have been returned by clients.
- Rent-to-purchase equipment may be new or used at the beginning of the rental period.

Enteral supply kits

To exceed specified limitations, providers must submit a limitation extension (LE) request. Use the *Enteral Equipment and Supplies Limitation Extension Request* form (HCA 13-115). (See [Where can I download agency forms?](#))

- 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. To exceed specified limitations, a limitation extension (LE) request must be submitted. Use the *Enteral Equipment and Supplies Limitation Extension Request* form (HCA 13-115).

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

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), see [Where can I download agency forms?](#) along with an invoice for the repairs that separates parts from labor charges.

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

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

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

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

Noncovered equipment and supplies ([WAC 182-554-800](#))

Noncovered medical equipment, supplies and related services include backpacks, pouches, bags, baskets or other carrying container. When early, periodic screening, diagnosis and treatment (EPSDT) applies, the agency evaluates a request for a noncovered service under [WAC 182-501-0165](#). See [WAC 182-534-0100](#) for EPSDT rules.

For a product that needs an unspecified code, prior authorization is required. Submit the *Justification for Miscellaneous Enteral Nutrition Procedure Code B9998* form (HCA 13-745) with the authorization request.

(See [Where can I download agency forms?](#))

Miscellaneous

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

HCPCS Code	Short Description	Authorization Required	Part of NH per diem	Policy/ Comments
B9998	NOC for enteral supplies	Yes	N	Use form HCA 13-745 Justification for use of B9998. Include invoice for Rates determination.

Modifiers

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

- **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.

Record Keeping, Billing, Reimbursement and Post-pay Audit

The agency requires DME and pharmacy providers to keep legible, accurate, and complete records to justify the medical necessity of the items provided. This includes:

- A copy of the *Enteral Nutrition Products Prescription form* (HCA 13-961) that is signed and dated by the prescribing provider and lists the client's medical condition and the exact daily amount of product prescribed. This prescription must be renewed annually at a minimum.
- A copy of the *Enteral Equipment and Supplies Limitation Extension Request form* (HCA 13-115).

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

Oral Enteral Nutrition

(WAC 182-554-500)

Overview of new requirements

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

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

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

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

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

Providers should share a plan for the client and caregivers to transition to traditional food or food products with all relevant healthcare professionals involved in the client's care. After six months, the agency requires prior authorization and documentation of ongoing medical necessity for all ongoing prescriptions for orally administered nutrition products.

Client Eligibility

Oral enteral nutrition is a covered benefit for clients 20 years of age and younger. There is no oral enteral nutrition benefit for clients 21 and older. Clients age 21 and older can request an exception to rule (ETR) under [WAC 182-501-0160](#). Use the *Oral Enteral Nutrition Prior Authorization Request* form (HCA 13-110).

Women, Infants and Children (WIC) and oral enteral nutrition

- All clients under age five who qualify for supplemental nutrition from the Women, Infants, and Children (WIC) nutrition program must receive products and formulas directly from that program.
- The agency may cover orally administered enteral nutrition products for a client under age five if the client is:
 - Not eligible for the WIC program.
 - Eligible for the WIC program, but the client's need for an oral enteral nutrition product or formula exceeds the amount allowed by WIC rules.
 - Eligible for the WIC program, but a medically necessary product or formula is not available through the WIC program.

Authorization

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

When using EPA, it is the responsibility of the prescribing provider to ensure that the client meets all eligibility criteria. Responsibility for accuracy and documentation of medical necessity involves the prescribing provider as well as the DME or pharmacy provider. Completed the *Oral Enteral Nutrition Worksheet for Expedited Prior Authorization (EPA) Request* form (HCA 13 114) signed by the prescribing provider, must be available for review. When required, the *Dietitian Worksheet – Oral Enteral Nutrition Assessment* form (HCA 13-109) and consultation notes, [growth charts](#) and the prescription form, must be retained. The records are subject to post pay review according to WAC [182-502-0100](#). (See [Where can I download agency forms?](#))

- Use EPA # 870001407 for clients age 20 and younger when:
 - The client has an urgent or immediate need for orally administered nutrition products (e.g. to prevent hospitalization).
 - The client has or is at risk of growth or nutrient deficits due to a condition that prevents the client from meeting their needs using food, over-the-counter nutrition products, standard infant formula, or standard toddler formula.

- The prescriber has completed the agency's *Enteral Nutrition Products Prescription* form (HCA 13-961).
- A dietitian must evaluate the client as soon as possible to confirm the prescribed product meets the current nutritional and caloric needs. The prescribing provider must follow-up to identify any medical or behavioral issues that require referral for management.
- Use EPA #870001408 for clients age 20 and younger whose primary care physician has determined medical necessity for an orally administered enteral nutrition product. Before starting the oral enteral nutrition product, the next reasonable step care is consultation with a dietitian. This EPA covers a monthly supply for up to 6 months after the client has been evaluated by a dietitian when:
 - The client has or is risk of growth or nutrient deficits due to a condition that prevents the client from meeting their needs using food, over-the-counter nutrition product, standard infant formula, or standard toddler formula. Prescribing provider must submit a growth chart with current measurement to the servicing provider (CDC [growth charts](#) are available at the HCA website if needed).
 - The prescriber has completed the agency's *Enteral Nutrition Products Prescription* form (HCA 13-961).
 - The client has a nutrition assessment (*Dietitian Worksheet – Oral Enteral Nutrition Assessment* form, HCA 13-109) from a registered dietitian (RD) that includes all of the following:
 - ✓ Evaluation of the client's nutritional status, including growth and nutrient analysis.
 - ✓ An explanation about why the product is medically necessary as defined in [WAC 182-500-0070](#).
 - ✓ A nutrition care plan that monitors the client's nutrition status, and includes a plan for transitioning the client to food or food products, if possible.
 - ✓ Recommendations, as necessary, for the primary care provider to refer the client to other health care providers (for example, gastrointestinal specialists, allergists, speech therapists, occupational therapists, applied behavioral analysis providers, and mental health providers) who will address the client's growth or nutrient deficits.
- If a client requires orally administered enteral nutrition products for longer than six months, the DME or pharmacy provider must obtain PA from the agency. The request for PA must include all of the following:
 - Documentation of the client's diagnosis that supports the client's need for the orally administered enteral nutrition product.

- The client’s nutrition care plan, including steps to transition the client to food or food products, if possible, or document why the client cannot transition to food or food products. Any updates from subsequent RD reevaluations must be included.
- Updates to the client’s growth chart.
- Progress notes documenting regular follow up and weight checks how the prescribed product is treating the client’s growth or nutrient deficits, or is necessary to maintain the client’s growth or nutrient status.
- Referrals, if necessary, to other health care providers treating related medical or mental health conditions.
- Documentation of any communication the treating provider has had with other providers directly or indirectly treating the client’s growth or nutrient deficits while the client is receiving orally administered enteral nutrition products.

Provider Requirements

Prescribing providers

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

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

Dietitians

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

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

DME and pharmacy providers (servicing and billing providers)

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

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

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

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

Coverage Table for Oral Enteral Nutrition

Category (HCPCS code)	Description	One Unit Equals
B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit	500 ml
B4103	Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit	500 ml
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
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
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

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	

Recordkeeping, Billing, Requirement, and Post-pay Audit

To allow for post-pay audit, the following expedited prior authorization is required.

Documentation - The DME or pharmacy provider **must keep** The *Oral Enteral Nutrition Worksheet for Expedited Prior Authorization Request (EPA)* form (HCA 13-114) and associated documentation 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. DME and Pharmacy providers must keep documentation on file for six years (see WAC 182-502-0020).

The provider must completely fill out the *Oral Enteral Nutrition Worksheet for Expedited Prior Authorization Request (EPA)* form (HCA 13-114). 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 client does not meet the criteria, the provider must submit a completed *Oral Enteral Nutrition Prior Authorization Request* form (HCA 13-110) must be submitted.

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

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.

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

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](#).

Authorization

Prior authorization (PA)

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

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.

Providers must obtain authorization for all 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 client does not meet the clinical criteria required in this billing guide.

- Authorization does not guarantee payment.
- Authorization requirements are not a denial of service.
- 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.

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

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

Expedited prior authorization (EPA)

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

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

Rescinding authorization

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

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

Product List

Enteral nutrition product classification list

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 accepts billing for **only** the codes and products listed on the Noridian Enteral Nutrition Product Classification List.

Payment

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

What is included in the agency's payment?

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

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

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

If changes in circumstance occur during the rental period, such as death or ineligibility, the agency discontinues payment effective on the date of the change in circumstance.

The agency does not pay for simultaneous rental and purchase of any item.

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

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

- Any equipment that the agency considers purchased requires repair during the applicable warranty period.
- The provider refuses or cannot fulfill the warranty.

- The client still needs the equipment. If the rental equipment must be replaced during the warranty period, the agency recoups fifty percent of the total amount previously paid toward rental and eventual purchase of the equipment delivered to the client if:
- The provider is unwilling or unable to fulfill the warranty.
- The client still needs the equipment.

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

Effective for claims billed on and after October 1, 2016

All claims must be submitted electronically to the agency, except under limited circumstances.

For more information about this policy change, see [Paperless Billing at HCA](#).

For providers approved to bill paper claims, see the agency's [Paper Claim Billing Resource](#).

What are the general billing requirements?

Providers must follow the agency's [ProviderOne Billing and Resource Guide](#). These billing requirements include:

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

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims are found on the agency's [Billers and Providers](#) web page, under [Webinars](#).

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the [HIPAA Electronic Data Interchange \(EDI\)](#) web page.