Washington State Health Care Authority

Washington Apple Health (Medicaid)

Medical Equipment and Supplies Billing Guide

January 1, 2020

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

About this guide*

This guide takes effect January 1, 2020, and supersedes earlier billing 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.

Services, equipment, or both related to any of the programs listed below must be billed using the agency's Washington Apple Health program-specific billing guides:

- Medical Nutrition Therapy Billing Guide
- Home Infusion Therapy Billing Guide
- Prosthetic and Orthotic Devices Billing Guide

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

What has changed?

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

* This publication is a billing instruction.

Subject	Change	Reason for Change
What are the general guidelines for wheelchairs?	The *Medical Necessity for Wheelchair Purchase (for home clients only)* form number corrected to HCA 19-0008. Updated throughout guide.	Correct form number.

How can I get agency provider documents?

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

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

Where can I download agency forms?

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

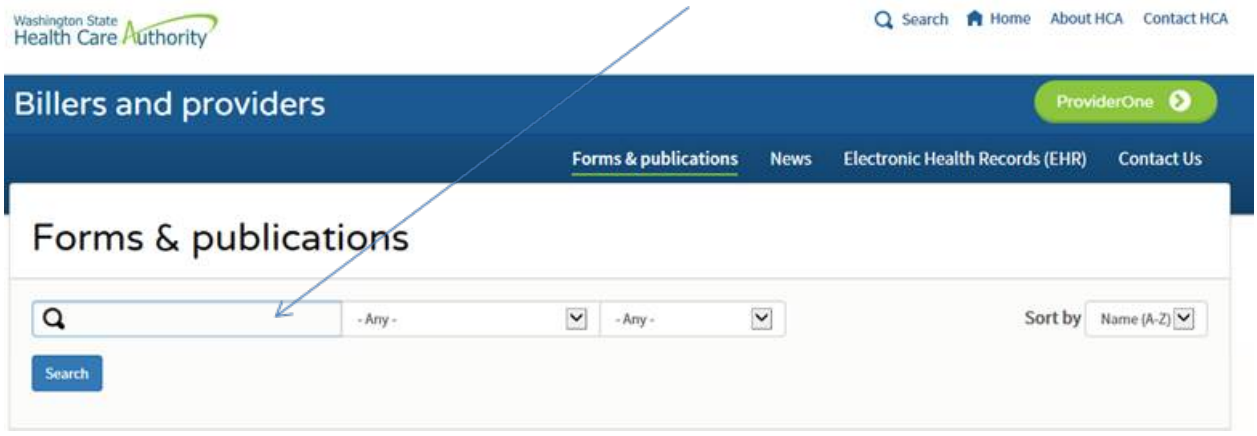

Table of Contents

Resources Available **8**

Definitions **9**

About the Program **13**

What products in general does the medical equipment program cover? 13
What are habilitative services under this program? 15
Billing for habilitative services 15

Client Eligibility **16**

How do I verify a client's eligibility? 16
Are clients enrolled in an agency-contracted managed care organization (MCO) eligible? 17
Managed care enrollment 18
Clients who are not enrolled in an agency-contracted managed care plan for physical health services 19
Integrated managed care (IMC) 20
Integrated Apple Health Foster Care (AHFC) 21
What if a client has third-party liability (TPL)? 22

Provider/Manufacturer Information **23**

What types of medical equipment and related services does the agency pay for? 23
What requirements must providers and suppliers meet? 23
How can equipment/supplies be added to the covered list in this billing guide? 25
How do providers furnish proof of delivery? 25
How does the agency decide whether to rent or purchase equipment? 27

Coverage – Medical Equipment **29**

How long does the agency pay for hospital bed rental? 30
When does the agency purchase a semi-electric hospital bed? 31
What is the purchase limit on mattresses and related equipment? 32
What is the purchase limit for patient lifts/traction equipment/fracture frames/transfer boards? 33
What is the purchase limitation for positioning devices? 33
What is the limit for the purchase of osteogenesis electrical stimulator (bone growth stimulator)? 34
Does the agency cover communication devices/ speech generating devices (SGD) without PA? 35
What limitations does the agency place on ambulatory aids (canes, crutches, walkers, and related supplies)? 37
Miscellaneous medical equipment 37
When does the agency cover the equipment for negative pressure wound therapy for home use? 38

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

Coverage Table – Medical Equipment & Wheelchairs 39

Coverage Table – Legends.....39
Coverage Table 39

Coverage Table –Medical Supplies 57

Coverage Table – Legends.....57
Coverage Table 57

Coverage/Limitations 78

What is covered?.....78

Coverage for Non-CRT Wheelchairs 87

What are the general guidelines for wheelchairs? 87
Does the agency cover the rental or purchase of a manual wheelchair? 88
Does the agency cover power-drive wheelchairs?.....89
What are the guidelines for clients with multiple wheelchairs? 90

Modifications, Accessories, and Repairs for Non-CRT Wheelchairs 91

What are the requirements for modifications, accessories, and repairs to noncomplex rehabilitation technology (CRT) wheelchairs? 91
When does the agency pay for transit option restraints? 92
When does the agency cover non-CRT wheelchair repairs? 92

Clients Residing in a Skilled Nursing Facility 93

What does the per diem rate include for a skilled nursing facility?.....93
Manual and power-drive wheelchairs 93
(WAC 182-543-5700(2)) 93
Speech generating devices (SGD) 94
Specialty beds 95
What does the agency pay for outside the per diem rate?.....95

Exception to Rule 96

What is an exception to rule (ETR)?.....96
How do I request an exception to rule (ETR)? 96

Authorization..... 97

What is authorization? 97
What is prior authorization (PA)?.....97
How do I request prior authorization (PA)? 99
Online direct data entry into ProviderOne 99
Written or Fax 99
How are photos and X-rays submitted for medical and medical equipment requests? 100
What is expedited prior authorization (EPA)?.....101
What is a limitation extension (LE)? 102

EPA Criteria Coding List..... 103

What are the expedited prior authorization (EPA) criteria for equipment rental?.....103

Billing..... 113

What are the general billing requirements? 113
What billing requirements are specific to medical equipment?.....113
How does a provider bill for a managed care client?.....114
How does a provider bill for clients eligible for Medicare and Medicaid? 115
What is included in the rate?.....115
Where can I find the fee schedules for medical equipment and supplies? 116
Where can the agency's required forms be found?.....116
How do I bill claims electronically? 117

Warranty 118

When do I need to make warranty information available? 118
When is the dispensing provider responsible for costs? 118

Resources Available

Topic	Resource Information
Becoming a provider or submitting a change of address or ownership	See the agency's Billers and Providers webpage
Finding out about payments, denials, claims processing, or agency-contracted managed care organizations	
Electronic billing	
Finding agency documents (e.g., Washington Apple Health billing guides, provider notices, and fee schedules)	
Private insurance or third-party liability, other than agency-contracted managed care	
Requesting that equipment/supplies be added to the "covered" list in this billing guide	(800) 562-3022 (phone) (866) 668-1214 (fax)
Requesting prior authorization or a limitation extension	Providers may submit prior authorization requests online through direct data entry into ProviderOne. See the agency's prior authorization webpage for details. Providers may also fax requests to 866-668-1214.
Questions about the payment rate listed in the fee schedule	Cost Reimbursement Analyst Professional Reimbursement PO Box 45510 Olympia, WA 98504-5510 (360) 753-9152 (fax)

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.

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

Digitized speech – (Also referred to as devices with **whole message** speech output) - Words or phrases that have been recorded by a person other than the SGD user for playback upon command of the SGD user.

EPSDT - See WAC 182-500-0005.

Health care Common Procedure Coding System (HCPCS) – A coding system established by the Health Care Financing Administration (HCFA) to define services and procedures. HCFA is now known as the Centers for Medicare and Medicaid Services (CMS). (WAC 182-543-1000)

House Wheelchair – A skilled nursing facility wheelchair that is included in the skilled nursing facility's per-patient-day rate under chapter 74.46 RCW. (WAC 182-543-1000)

Manual Wheelchair – See **Wheelchair – Manual**.

Medical equipment – Includes medical equipment and appliances, and medical supplies. (WAC 182-543-1000)

Medical equipment and appliances - Health care-related items that:

- Are primarily and customarily used to serve a medical purpose;
- Generally are not useful to a person in the absence of illness or injury;
- Can withstand repeated use;
- Can be reusable or removable; and
- Are suitable for use in any setting where normal life activities take place.
- (WAC 182-543-1000)

Medical supplies – Health care-related items that are:

- Consumable, or disposable, or cannot withstand repeated use by more than one person;
- Required to address an individual medical disability, illness, or injury;
- Suitable for use in any setting which is not a medical institution and in which normal life activities take place; and
- Generally not useful to a person in the absence of illness or injury.
  (WAC 182-543-1000)

Personal or comfort item – An item or service that primarily serves the comfort or convenience of the client or caregiver. (WAC 182-543-1000)

Plan of Care (POC) – (Also known as plan of treatment (POT)). A written plan of care that is established and periodically reviewed and signed by both a physician and a home health agency provider that describes the home health care to be provided at the client's residence. (WAC 182-551-2010)

Reusable Supplies – Supplies that are to be used more than once. (WAC 182-543-1000)

Power-Drive Wheelchair – See Wheelchair – Power. (WAC 182-543-1000)

Scooter – A federally-approved, motor-powered vehicle that:

- Has a seat on a long platform.
- Moves on either three or four wheels.
- Is controlled by a steering handle.
- Can be independently driven by a client. (WAC 182-543-1000)

Specialty bed – A pressure reducing support surface, such as foam, air, water, or gel mattress or overlay. (WAC 182-543-1000)

Speech generating device (SGD) - An electronic device or system that compensates for the loss or impairment of a speech function due to a congenital condition, an acquired disability, or a progressive neurological disease. The term includes only that equipment used for the purpose of communication. Formerly known as augmentative communication device (ACD).

Synthesized speech – A technology that translates a user's input into device-generated speech using algorithms representing linguistic rules; synthesized speech is not the prerecorded messages of digitized speech. An SGD that has synthesized speech is not limited to pre-recorded messages but rather can independently create messages as communication needs dictate. (WAC 182-543-1000)

Three- or four-wheeled scooter – A three- or four-wheeled vehicle meeting the definition of scooter (see **scooter**) and has all of the following minimum features:

- Rear drive
- A twenty-four volt system
- Electronic or dynamic braking
- A high to low speed setting
- Tires designed for indoor/outdoor use (WAC 182-543-1000)

Trendelenburg position – A position in which the patient is lying on his or her back on a plane inclined thirty to forty degrees. This position makes the pelvis higher than the head, with the knees flexed and the legs and feet hanging down over the edge of the plane. (WAC 182-543-1000)

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

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

- Standard:

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

- Lightweight:

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

- High strength lightweight:

  - ✓ Is usually made of a composite material
  - ✓ Is capable of being modified.
  - ✓ Accommodates a person weighing up to 250 pounds
  - ✓ Has an extended warranty period of over three years
  - ✓ Accommodates the very active person

- Hemi:

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

- Pediatric:

  Has a narrower seat and shorter depth more suited to pediatric patients, usually adaptable to modifications for a growing child

- Recliner:

  Has an adjustable, reclining back to facilitate weight shifts and provide support to the upper body and head

- Tilt-in-Space:

  Has a positioning system that allows both the seat and back to tilt to a specified angle to reduce shear or allow for unassisted pressure releases

- Heavy Duty:

  Has one of the following:

  - ✓ Specifically manufactured to support a person weighing up to 300 pounds
  - ✓ Accommodating a seat width of up to 22 inches wide (not to be confused with custom manufactured wheelchairs)

- Rigid:
  Is of ultra-lightweight material with a rigid (nonfolding) frame

- Custom Heavy Duty. Is either of the following:

  - ✓ Specifically manufactured to support a person weighing over 300 pounds
  - ✓ Accommodates a seat width of over 22 inches wide (not to be confused with custom manufactured wheelchairs)

- Custom Manufactured Specially Built:

  ✓ Ordered for a specific client from custom measurements
  ✓ Is assembled primarily at the manufacturer's factory

  (WAC 182-543-1000)

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

- Custom power adaptable to:

  ✓ Alternative driving controls
  ✓ Power recline and tilt-in-space systems

- Noncustom power:

  Does not need special positioning or controls and has a standard frame

- Pediatric:

  Has a narrower seat and shorter depth that is more suited to pediatric patients. Pediatric wheelchairs are usually adaptable to modifications for a growing child (WAC 182-543-1000)

About the Program

(WAC 182-543-0500)

What products in general does the medical equipment program cover?

The federal government considers medical equipment and related supplies as services under the Medicaid program. For information about the Habilitative Services benefit, see What are habilitative services under this program?

The agency covers medical equipment and related supplies listed in this billing guide according to agency rules and subject to the limitations and requirements within this guide. The agency pays for medical equipment and related supplies including modifications, accessories, and repairs when they are:

- Within the scope of the client's medical program (see WAC 182-501-0060 and WAC 182-501-0065).
- Medically necessary, as defined in WAC 182-500-0070.
- Prescribed and signed or cosigned by a physician and within the scope of the practitioner's licensure, except for dual-eligible Medicare/Medicaid clients when Medicare is the primary payer and the agency is billed for a copay and/or deductible only.

Note: (Orders that do not require a physician signature/cosignature)

- Supplies and equipment necessary for or ancillary to the administration of pharmaceuticals or monitoring their effectiveness, including glucose monitors, glucose test strips, lancets, insulin pens, needles, syringes, inhalation masks, nebulizers and spacers, may be ordered by nonphysician practitioners (i.e. advanced registered nurse practitioners or physician assistants) within their scope of practice without a physician signature/cosignature.
- Respiratory supplies and equipment necessary for or ancillary to the administration or monitoring of medications including oxygen, such as inhalation masks, nebulizers and spacers, may be ordered by nonphysician practitioners within their scope of practice without a physician signature/cosignature.

Note: If a client is a resident in a skilled nursing facility, a nonphysician practitioner (i.e. advanced registered nurse practitioner or a physician assistant) may order medical equipment and supplies within their scope of practice without a physician signature or cosignature.

If a client is discharged to their home, any order for medical equipment and supplies must be signed or cosigned by a physician.

- Authorized, as required in this billing guide, and in accordance with the following:

  ✓ Chapter 182-501 WAC
  ✓ Chapter 182-502 WAC
  ✓ Chapter 182-543 WAC

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

The agency requires prior authorization (PA) for covered medical equipment related supplies, and related services when the clinical criteria are not met, including the criteria associated with the expedited prior authorization (EPA) process.

The agency evaluates requests requiring PA on a case-by-case basis to determine medical necessity, according to the process found in WAC 182-501-0165.

Note: See Authorization for specific details regarding authorization for the medical equipment program.

The agency bases its determination about which medical equipment services and related supplies require PA or EPA on utilization criteria (see Authorization). The agency considers all of the following when establishing utilization criteria:

- Cost
- The potential for utilization abuse
- A narrow therapeutic indication
- Safety

The agency evaluates a request for any medical equipment item listed under the provisions of WAC 182-501-0160 (see Exception to Rule). When 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.
- Not experimental (see the agency's current Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Billing Guide for more information).

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

What are habilitative services under this program?

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

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

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

Billing for habilitative services

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

Services and equipment related to any of the following programs must be billed using the agency's Washington Apple Health program-specific billing guide:

- Prosthetic and Orthotic Devices
- Complex Rehabilitation Technology (CRT)

Client Eligibility

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

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

How do I verify a client's eligibility?

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

Verifying eligibility is a two-step process:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Managed care enrollment

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

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

Checking eligibility

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

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

Apple Health – Changes for January 1, 2020

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

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

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

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

Clients have a variety of options to change their plan:

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

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

  ✓ Visit the ProviderOne Client Portal website:

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

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

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

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

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

Integrated managed care (IMC)

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

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

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

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

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

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

Integrated managed care regions

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

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

Integrated Apple Health Foster Care (AHFC)

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

Clients under this program are:

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

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

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

Fee-for-service Apple Health Foster Care

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

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

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

Provider/Manufacturer Information

(WAC 182-543-2000)

What types of medical equipment and related services does the agency pay for?

The agency pays qualified providers for medical equipment and related services on a fee-for-service basis as follows:

- Medical equipment providers for medical equipment and related repair services
- Medical equipment dealers, pharmacies, and home health agencies under their national provider identifier (NPI) for medical supplies
- Physicians who provide medical equipment and supplies in the office (the agency may pay separately for medical supplies, subject to the provisions in the agency's resource-based relative value scale fee schedule)
- Out-of-state orthotics and prosthetics providers who meet their state regulations

For more information about medical equipment that requires a face-to-face encounter, see the list of covered items published by the Centers for Medicare and Medicaid Services.

What requirements must providers and suppliers meet?

Providers and suppliers of medical equipment and related services must:

- Meet the general provider requirements in chapter 182-502 WAC.
- Be enrolled with Medicaid and Medicare.
- Have the proper business license.
- Be certified, licensed and/or bonded if required, to perform the services billed to the agency.

- Provide instructions for use of equipment.
- Furnish to clients only new equipment that includes full manufacturer and dealer warranties.
- Furnish, upon agency request, documentation of proof of delivery (See How do providers furnish proof of delivery?).
- Bill the agency using only the allowed procedure codes published within this billing guide.
- Have a valid prescription. A prescription must meet all of the following:

  ✓ Be written on the agency's *Prescription* form, HCA 13-794 (See Where can I download agency forms?)

  ✓ Be signed or cosigned by a physician. Electronic signatures are acceptable.

Note: (Orders that do not require a physician signature/cosignature)
- Supplies and equipment necessary for or ancillary to the administration of pharmaceuticals or monitoring their effectiveness, including glucose monitors, glucose test strips, lancets, insulin pens, needles, syringes, inhalation masks, nebulizers and spacers, may be ordered by nonphysician practitioners (i.e. advanced registered nurse practitioners or physician assistants) within their scope of practice without a physician signature/cosignature.
- Respiratory supplies and equipment necessary for or ancillary to the administration or monitoring of medications including oxygen, such as inhalation masks, nebulizers and spacers, may be ordered by nonphysician practitioners within their scope of practice without a physician signature/cosignature.

Note: If a client is a resident in a skilled nursing facility, a nonphysician practitioner (i.e. advanced registered nurse practitioner or a physician assistant) may order medical equipment and supplies within their scope of practice without a physician signature or cosignature.

If a client is discharged to their home, any order for medical equipment and supplies must be signed or cosigned by a physician. Electronic signatures are acceptable.

✓ Be written, signed (including the prescriber's credentials), and dated by the prescriber on the same day and before delivery of the supply, equipment, or device. Prescriptions must not be back-dated.

✓ Be no older than one year from the date the prescriber signs the prescription

- ✓ State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity

Note: For dual eligible Medicare/Medicaid clients when Medicare is the primary payer and the agency is being billed for co-pay and/or deductible only, the above does not apply.

How can equipment/supplies be added to the covered list in this billing guide?

(WAC 182-543-2100)

Any interested party, such as a provider, supplier, and manufacturer may request the agency to include new equipment/supplies in this guide.

The request should include credible evidence, including but not limited to:

- Manufacturer's literature.
- Manufacturer's pricing.
- Clinical research/case studies (including FDA approval, if required).
- Proof of the Centers for Medicare and Medicaid Services (CMS) certification, if applicable.
- Any additional information the requester feels would aid the agency in its determination.

Send requests to:

Medical Equipment Program Management Unit
PO Box 45506
Olympia WA 98504-5506

How do providers furnish proof of delivery?

(WAC 182-543-2200)

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

- The agency requires a delivery slip as proof of delivery, and it must meet all of the following:
  - ✓ Be signed and dated by the client or the client's authorized representative (the date of signature must be the date the item was received by the client)

- ✓ Include the client's name and a detailed description of the item(s) delivered, including the quantity and brand name
- ✓ Include the serial number for medical equipment that may require future repairs

- When the provider or supplier submits a claim for payment to the agency, the date of service on the claim must be one of the following:
  - ✓ For a one-time delivery, the date the item was received by the client or authorized representative
  - ✓ For medical equipment for which the agency has established a monthly maximum, on or after the date the item was received by the client or authorized representative

When a provider uses a delivery/shipping service to deliver items which are not fitted to the client, the provider must furnish proof of delivery that the client received the equipment and/or supply, when the agency requests that information.

- If the provider uses a delivery/shipping service, the tracking slip is the proof of delivery.

  The tracking slip must include all of the following:
  - ✓ The client's name or a reference to the client's package(s)
  - ✓ The delivery service package identification number
  - ✓ The delivery address

- If the provider/supplier delivers the product, the proof of delivery is the delivery slip. The delivery slip must include all of the following:
  - ✓ The client's name
  - ✓ The shipping service package identification number
  - ✓ The quantity, detailed description(s), and brand name(s) of the items being shipped
  - ✓ The serial number for medical equipment that may require future repairs

- When billing the agency, do both of the following:

  - ✓ Use the shipping date as the date of service on the claim if the provider uses a delivery/shipping service

  - ✓ Use the actual date of delivery as the date of service on the claim if the provider/supplier does the delivery

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

Providers must obtain PA when required before delivering the item to the client. The item must be delivered to the client before the provider bills the agency.

The agency does not pay for medical equipment furnished to the agency's clients when either of the following applies:

- The medical professional who provides medical justification to the agency for the item provided to the client is an employee of, has a contract with, or has any financial relationship with the provider of the item.

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

How does the agency decide whether to rent or purchase equipment?

(WAC 182-543-2250)

- The agency bases its decision to rent or purchase wheelchairs, medical equipment and supplies on the length of time the client needs the equipment.

- A provider must not bill the agency for the rental or purchase of equipment supplied to the provider at no cost by suppliers/manufacturers.

- The agency purchases **new** medical equipment only.

  - ✓ **A new** medical equipment item that is placed with a client initially as a rental item is considered a new item by the agency at the time of purchase.

  - ✓ **A used** medical equipment item that is placed with a client initially as a rental item must be replaced by the supplier with a new item prior to purchase by the agency.

- The agency requires a dispensing provider to ensure the medical equipment rented to a client is:

  - ✓ In good working order.

  - ✓ Comparable to equipment the provider rents to clients with similar medical equipment needs who are either private pay clients or who have other third-party coverage.

- The agency's minimum rental period for covered medical equipment is one day.

- The agency authorizes rental equipment for a specific period of time. The provider must request authorization from the agency for any extension of the rental period.

- The agency's reimbursement amount for rented medical equipment includes all of the following:

  - ✓ Delivery to the client

  - ✓ Fitting, set-up, and adjustments

  - ✓ Maintenance, repair and/or replacement of the equipment

  - ✓ Return pickup by the provider

- The agency considers rented equipment to be purchased after a 12-month rental unless the equipment is restricted as rental only.

- Medical equipment and related services purchased by the agency for a client are the client's property.

- The agency rents, but does not purchase, certain medical equipment for clients.

- The agency stops paying for any rented equipment effective the date of a client's death. The agency prorates monthly rentals as appropriate.

- For a client who is eligible for both Medicare and Medicaid, the agency pays only the client's coinsurance and deductibles. The agency discontinues paying client's coinsurance and deductibles for rental equipment when either of the following apply:

  - ✓ The reimbursement amount reaches Medicare’s reimbursement cap for the equipment.

  - ✓ Medicare considers the equipment purchased.

The agency does not obtain or pay for insurance coverage against liability, loss and/or damage to rental equipment that a provider supplies to a client.

Coverage – Medical Equipment

(WAC 182-543-3000)

When does the agency cover hospital beds?

The agency covers one hospital bed in a 10-year period, per client, with the following limitations. Prior authorization is required.

- A manual hospital bed as the primary option when the client has full-time caregivers.
- A semi-electric hospital bed only when:
  - ✓ The client's medical need requires the client to be positioned in a way that is not possible in a regular bed and the position cannot be attained through less costly alternatives (e.g., the use of bedside rails, a trapeze, pillows, bolsters, rolled up towels or blankets).
  - ✓ The client's medical condition requires immediate position changes.
  - ✓ The client is able to operate the controls independently.
  - ✓ The client needs to be in the Trendelenburg position.

The agency bases the decision to rent or purchase a manual or semi-electric hospital bed on the length of time the client needs the bed.

How long does the agency pay for hospital bed rental?

The agency pays up to 11 months of continuous rental of a hospital bed in a 12-month period as follows:

- For a manual hospital bed with mattress, with or without bed rails. The client must meet all of the following clinical criteria:

  - ✓ Has a length of need/life expectancy that is 12 months or less
  - ✓ Has a medical condition that requires positioning of the body that cannot be accomplished in a standard bed (reason must be documented in the client's file)
  - ✓ Has tried pillows, bolsters, and/or rolled up blankets/towels in client's own bed, and determined to not be effective in meeting client's positioning needs (nature of ineffectiveness must be documented in the client's file)
  - ✓ Has a medical condition that necessitates upper body positioning at no less than a 30° angle the majority of time the client is in the bed
  - ✓ Does not have full-time caregivers
  - ✓ Does not also have a rental wheelchair

- For a semi-electric hospital bed with mattress, with or without bed rails. The client must meet all of the following clinical criteria:

  - ✓ Has a length of need/life expectancy that is 12 months or less
  - ✓ Has tried pillows, bolsters, and/or rolled up blankets/towels in own bed, and determined ineffective in meeting positioning needs (nature of ineffectiveness must be documented in the client's file)
  - ✓ Has a chronic or terminal condition such as chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), lung cancer or cancer that has metastasized to the lungs, or other pulmonary conditions that cause the need for immediate upper body elevation
  - ✓ Must be able to independently and safely operate the bed controls
  - ✓ Does not have a rental wheelchair

When does the agency purchase a semi-electric hospital bed?

The agency pays for the initial purchase of a semi-electric hospital bed with mattress, with or without bed rails, when all of the following criteria are met. Prior authorization is required.

- The client:

  - ✓ Has a length of need/life expectancy that is twelve months or more.
  - ✓ Has tried positioning devices such as: pillows, bolsters, foam wedges, rolled up blankets/towels in own bed, and been determined ineffective in meeting positioning needs (nature of ineffectiveness must be documented in the client's file).
  - ✓ Must be able to independently and safely operate the bed controls.
  - ✓ Does not also have a rental wheelchair.

-AND-

- Is diagnosed with one of the following:

  - ✓ With quadriplegia
  - ✓ With tetraplegia
  - ✓ With Duchene muscular dystrophy
  - ✓ With amyotrophic lateral sclerosis (ALS), often referred to as Lou Gehrig's disease
  - ✓ As ventilator-dependent
  - ✓ With chronic obstructive pulmonary disease (COPD) or congestive heart failure (CHF) with aspiration risk or shortness of breath that causes the need for an immediate position change of more than thirty degrees

- Requests for PA must be submitted to the agency using the online submission option (see the agency's Prior Authorization webpage for details) or be in writing and accompanied by all of the following:

  - ✓ A completed *General Information for Authorization* form, HCA 13-835, see Where can I download agency forms? (see Authorization for more information)

  - ✓ A *Hospital Bed Evaluation* form, HCA 13-747

- ✓ Documentation of the client's life expectancy, in months and/or years, and the client's diagnosis
  - ➢ The client's date of delivery and serial number of the hospital bed must be submitted prior to payment
- ✓ Be accompanied by written documentation, from the client or caregiver, indicating the client has not been previously provided a hospital bed, purchase or rental

Note: For other forms, see Medicaid Forms.

What is the purchase limit on mattresses and related equipment?

The agency purchases the following mattresses with limits. Prior authorization is required.

Equipment	Limitation
Pressure pad, alternating with pump	One in a five-year period
Dry pressure mattress	One in a five-year period
Gel or gel-like pressure pad for mattress	One in a five-year period
Gel pressure mattress	One in a five-year period
Water pressure pad for mattress	One in a five-year period
Dry pressure pad for mattress	One in a five-year period
Mattress, inner spring	One in a five-year period
Mattress, foam rubber	One in a five-year period

What is the purchase limit for patient lifts/traction equipment/fracture frames/transfer boards?

(WAC 182-543-3100)

The agency covers the purchase of the following patient lifts, traction equipment, fracture frames, and transfer boards with limitations. Prior authorization is not required.

Equipment	Limitation
Patient lift, hydraulic, with seat or sling	One per client in a five-year period
Traction equipment	One per client in a five-year period
Trapeze bars	One per client in a five-year period PA for rental required
Fracture frames	One per client in a five-year period PA for rental required
Transfer board or devices	One per client in a five-year period

What is the purchase limitation for positioning devices?

(WAC 182-543-3200)

The agency covers positioning devices with the following limitations. Prior authorization (PA) is not required.

Equipment	Limitation
Positioning system/supine board (small or large), including padding, straps adjustable armrests, footboard, and support blocks	One per client in a five-year period
Prone stander (infant, child, youth, or adult size). The prone stander must be prescribed by a physician and the client must not be residing in a nursing facility.	One per client in a five-year period
Adjustable standing frame (for child/adult 30 - 68 inches tall), including two padded back support blocks, a chest strap, a pelvic strap, a pair of knee blocks, an abductor, and a pair of foot blocks	One per client in a five-year period
Positioning car seats	One per client, eight years of age and older or four feet nine inches or taller, in a five-year period

What is the limit for the purchase of osteogenesis electrical stimulator (bone growth stimulator)?

(WAC 182-543-3300)

The agency covers noninvasive osteogenesis electrical stimulators, limited to one per client in a five-year period. Prior authorization (PA) is required.

The agency pays for the purchase of non-spinal bone growth stimulators, only when both of the following apply:

- The stimulators have pulsed electromagnetic field (PEMF) simulation
- The client meets **one or more of the following clinical criteria:**
  - ✓ Has a nonunion of a long bone fracture (which includes clavicle, humerus, phalanx, radius, ulna, femur, tibia, fibula, metacarpal & metatarsal) after three months have elapsed since the date of injury without healing
  - ✓

-OR-

  - ✓ Has a failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the last surgery

The agency pays for the purchase of spinal bone growth stimulators, when both of the following apply:

- Prescribed by a neurologist, an orthopedic surgeon, or a neurosurgeon
- The client meets one or more of the following clinical criteria:
  - ✓ Has a failed spinal fusion where a minimum of nine months have elapsed since the last surgery
  - ✓ Is post-op from a multilevel spinal fusion surgery
  - ✓ Is post-op from spinal fusion surgery where there is a history of a previously failed spinal fusion

Does the agency cover communication devices/ speech generating devices (SGD) without PA?

(WAC 182-543-3400)

The agency covers both of the following:

- One artificial larynx, any type, without prior authorization, per client in a five-year period
- One speech generating device (SGD), with prior authorization, per client every two years

The agency pays only for those approved SGDs that have one of the following:

- Digitized speech output, using pre-recorded messages
- Synthesized speech output requiring message formation by spelling and access by physical contact with the device
- Synthesized speech output, permitting multiple methods of message formulation and multiple methods of device access

The agency requires prior authorization (PA) for SGDs and reviews requests on a case-by-case basis. The client must have a severe expressive speech impairment and the client's medical condition warrants the use of a device to replace verbal communication (e.g., to communicate medical information).

Requests to the agency for prior authorization must meet all of the following:

- The request must be submitted to the agency online using the online submission option (see the agency's Prior authorization webpage for details) or be in writing and accompanied by all of the following:
  - ✓ A completed *General Information for Authorization* form, HCA 13-835, see Where can I download agency forms? (WAC 182-543-7000)
  - ✓ A copy of the client's prescription for an evaluation for a SGD
  - ✓ A completed *Speech Language Pathologist (SLP) Evaluation for Speech Generating Devices* form, HCA 15-310

The agency requires, at a minimum, all the following information:

- A detailed description of the client's therapeutic history
- A written assessment by a licensed speech language pathologist (SLP)

- Documentation of all of the following:
  - ✓ The client has reliable and consistent motor response, which can be used to communicate with the help of a SGD.
  - ✓ The client has demonstrated the cognitive and physical abilities to utilize the equipment effectively and independently to communicate.
  - ✓ The client's treatment plan includes a training schedule for the selected device.
- A copy of the prescription for the SGD from the client's treating physician written on an agency *Prescription* form, HCA 13-794, see Where can I download agency forms? (WAC 182-543-2000(2))

The agency may require trial-use rental of a SGD. The agency applies the rental costs for the trial-use to the purchase price.

The agency pays for the repair or modification of a SGD when all of the following are met:

- All warranties are expired
- The cost of the repair or modification is less than 50 percent of the cost of a new SGD and the provider has supporting documentation
- The repair has a warranty **for a minimum of 90 days**

The agency does not pay for devices requested for the purpose of education.

The agency pays for replacement batteries for a SGD in accordance with WAC 182-543-5500(3). The agency does not pay for back-up batteries for a SGD.

For a client who is eligible for both Medicare and Medicaid, a provider must first request coverage of the SGD from Medicare. If Medicare denies the request for coverage, the provider may request the SGD from the agency following the rules within this billing guide.

What limitations does the agency place on ambulatory aids (canes, crutches, walkers, and related supplies)?

(WAC 182-543-3500)

The agency covers the purchase of the following ambulatory aids with the following limitations. Prior authorization is not required.

Ambulatory Aid	Limitation
Canes	One per client in a five-year period
Crutches	One per client in a five-year period
Walkers	One per client in a five-year period

The agency pays for replacement underarm pads for crutches and replacement handgrips and tips for canes, crutches, and walkers. Prior authorization is not required.

Miscellaneous medical equipment

The agency pays for miscellaneous medical equipment as follows:

- Blood glucose monitor (specialized or home) - One in a three-year period. See WAC 182-543-5500(12) for blood monitoring/testing supplies. For continuous glucose monitoring systems including related equipment and supplies, see the prior authorization (PA) criteria in the Home Infusion Billing Guide.
- Continuous passive motion (CPM) machine - Up to ten days' rental and requires PA.
- Lightweight protective helmet/soft shell (including adjustable chin/mouth strap) - Two per 12-month period.
- Lightweight ventilated hard-shell helmet (including unbreakable face bar, woven chin strap with adjustable buckle and snap fastener, and one set of cushion pads for adjusting fit to head circumference) - Two per 12-month period.
- Pneumatic compressor - One in a five-year period.
- Positioning car seat - One in a five-year period.

When does the agency cover the equipment for negative pressure wound therapy for home use?

The agency covers the purchase of the following wound care devices with limits. Prior authorization (PA) is required. Documentation of tried or considered wound care must be documented on the *Negative Pressure Wound Therapy* form (HCA 13-726).

Equipment	Limitation
Dressing set, electrical pump, stationary or portable	Purchase only
Canister, disposable, used with suction pump	Purchase only Limit of 5 per client every 30 days. Allowed only when billed in conjunction with prior authorized HCPCS code E2402
Electrical pump, stationary or portable	Rental only

Prior authorization requests for purchase must include *Prescription* form (HCA 13-794) and *Negative Pressure Wound Therapy* form (HCA 13-726). See Where can I download agency forms?

Client must show healing within 30 days for continuation of service.

The agency pays for a maximum of 4 months of negative pressure wound therapy beginning when the device was applied during an inpatient stay and prior to discharge into a home setting.

Coverage Table – Medical Equipment & Wheelchairs

Coverage Table – Legends

Status Code Legends	Other Legends
BR = By Report	NF = Nursing Facility
D = Discontinued	EPA = Expedited Prior Authorization
DC = Same/similar covered code in fee schedule	PA = Prior Authorization
DP = Service managed through a different program	RA = Replacement of medical equipment
N = New	NU = New Equipment
P = Policy change	

Coverage Table

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
Beds, mattresses, and related equipment				
	A4640	RA	Alternating pressure pad	Purchase only. Included in NF daily rate.
	A6550		Neg pres wound ther drsg set	Purchase only. PA required.
	A7000	NU	Disposable canister for pump	Limit of 5 per client every 30 days. Allowed only when billed in conjunction with PA HCPCS code E2402.
BR	K0743		Portable home suction pump	PA required
	E0181	NU/RR	Press pad alternating w/ pump	PA required for rental only.
	E0182	NU	Replace pump, alt press pad	Included in NF daily rate.
	E0184	NU	Dry pressure mattress	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0185	NU/RR	Gel pressure mattress pad	Considered purchased after 1 years rental. Limit of 1 per client every 5 years.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
				PA required for rental. Included in NF daily rate.
	E0186	NU/RR	Air pressure mattress	For powered pressure reducing mattress see HCPCS code E0277. Considered purchased after 1 years rental. PA required for rental. Included in NF daily rate.
BR	E0190		Positioning cushion	Purchase only. PA required. Included in NF daily rate.
DC	E0193		Powered air flotation bed	See E0194
	E0194	NU/RR	Air fluidized bed	Considered purchased after 1 years rental. PA or EPA required.
	E0196	NU	Gel pressure mattress	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0197	NU/RR	Air pressure pad for mattres	Considered purchased after 1 years rental. PA required for rental. Included in NF daily rate.
	E0198	NU	Water pressure pad for mattr	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0199	NU	Dry pressure pad for mattres	Limit of 1 per client every 5 years. Included in NF daily rate.
DC	E0255		Hospital bed var ht w/mattr	See HCPCS codes E0292 and E0305 or E0310.
DC	E0256		Hospital bed var ht w/o matt	See HCPCS codes E0293 and E0305 or E0310.
DC	E0260		Hosp bed semi-electr w/matt	See HCPCS codes E0294 and E0305 or E0310.
DC	E0261		Hosp bed semi-electr w/o mat	See HCPCS codes E0295 and E0305 or E0310.
DC	E0265		Hosp bed total electr w/mat	See HCPCS codes E0296 and E0305 or E0310.
DC	E0266		Hosp bed total elec w/o matt	See HCPCS codes E0297 and E0305 or E0310.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	E0271	NU	Mattress innerspring	Limit of 1 per client every 5 years. Replacement only. Included in NF daily rate.
	E0272	NU	Mattress foam rubber	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0277	NU/RR	Powered pres-redu air mattrs	Considered purchased after 1 years rental. PA or EPA required.
	E0290	NU	Hosp bed fx ht w/o rails w/m	
	E0291	NU	Hosp bed fx ht w/o rail w/o	
	E0292	NU/RR	Hosp bed var ht no sr w/matt	Considered purchased after 1 years rental. Limit of 1 per client every 10 years. PA required. Included in NF daily rate.
	E0293	NU/RR	Hosp bed var ht no sr no mat	Considered purchased after 1 years rental. Limited of 1 per client every 10 years. PA required. Included in NF daily rate.
	E0294	NU/RR	Hosp bed semi-elect w/ mattr	Considered purchased after 1 years rental. Limit of 1 per client every 10 years. PA or EPA required. Included in NF daily rate.
	E0295	NU/RR	Hosp bed semi-elect w/o matt	Considered purchased after 1 years rental. Limit of 1 per client every 10 years. PA required. Included in NF daily rate.
	E0300	NU/RR	Enclosed ped crib hosp grade	Considered purchased after 1 years rental. PA required. Included in NF daily rate.
	E0301	NU	Hd hosp bed, 350-600 lbs	PA required
DC	E0302		Ex hd hosp bed > 600 lbs	See E0304

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	E0303	NU/RR	Hosp bed hvy dty xtra wide	Considered purchased after 1 years rental. Limit of 1 per client every 10 years. PA required. Included in NF daily rate.
	E0304	NU/RR	Hosp bed xtra hvy dty x wide	Considered purchased after 1 years rental. Limit of 1 per client every 10 years. PA required. Included in NF daily rate.
	E0305	NU/RR	Rails bed side half length	Considered purchased after 1 years rental. Limit of 1 per client every 10 years. Rental requires PA or EPA. Included in NF daily rate.
	E0310	NU/RR	Rails bed side full length	Considered purchased after 1 years rental. Limit of 1 per client every 10 years. Rental requires PA or EPA. Included in NF daily rate.
	E0316	NU	Bed safety enclosure	PA required. Included in NF daily rate.
	E0328		Ped hospital bed, manual	Purchase only. Limit of 1 per client every 10 years. PA required. Included in NF daily rate.
	E0329		Ped hospital bed semi/elect	Purchase only. Limit of 1 per client every 10 years. PA required. Included in NF daily rate.
	E0371	NU/RR	Nonpower mattress overlay	Considered purchased after 1 years rental. PA or EPA required.
	E0372	NU/RR	Powered air mattress overlay	Considered purchased after 1 years rental. PA or EPA required.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	E0373	NU/RR	Nonpowered pressure mattress	Considered purchased after 1 years rental. PA or EPA required.
	E2402	RR	Neg press wound therapy pump	Rental only. PA required.
Other patient room equipment				
	E0621	NU	Patient lift sling or seat	Included in NF daily rate.
	E0630	NU/RR	Patient lift hydraulic	Considered purchased after 1 years rental. Limit of 1 per client every 5 years. Includes bath. PA required for rental. Included in NF daily rate.
	E0635	NU/RR	Patient lift electric	Considered purchased after 1 year rental. PA required for rental. Included in NF daily rate.
DC	E0636		Pt support & positioning sys	See E0635
DC	E0830		Ambulatory traction device	
	E0840	NU	Tract frame attach headboard	
DC	E0849		Cervical pneum trac equip	
	E0850	NU	Traction stand free standing	Limit of 1 per client every 5 years. Included in NF daily rate.
DC	E0855		Cervical traction equipment	
DC	E0856		Cervic collar w air bladders	
	E0860	NU	Tract equip cervical tract	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0870	NU	Tract frame attach footboard	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0880	NU	Trac stand free stand extrem	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0890	NU	Traction frame attach pelvic	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0900	NU	Trac stand free stand pelvic	Limit of 1 per client every 5 years. Included in NF daily rate.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	E0910	NU/RR	Trapeze bar attached to bed	Considered purchased after 1 years rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.
	E0911	NU/RR	Hd trapeze bar attach to bed	Considered purchased after 1 years rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.
	E0912	NU/RR	Hd trapeze bar free standing	Considered purchased after 1 year rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.
	E0920	NU/RR	Fracture frame attached to b	Considered purchased after 1 years rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.
	E0930	NU/RR	Fracture frame free standing	Considered purchased after 1 years rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.
	E0940	NU/RR	Trapeze bar free standing	Considered purchased after 1 years rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.
	E0941	NU/RR	Gravity assisted traction de	Considered purchased after 1 years rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	E0946	NU/RR	Fracture frame dual w cross	Considered purchased after 1 years rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.
	E0947	NU	Fracture frame attachmnts pe	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0948	NU	Fracture frame attachmnts ce	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0705	NU	Transfer device	Limit of 1 per client every 5 years. Included in NF daily rate.
Positioning devices				
	E0637	NU/RR	Combination sit to stand sys	Considered purchased after 1 years rental. PA required. Included in NF daily rate.
	E0638	NU	Standing frame sys	Limit of 1 per client every 5 years. PA required. Included in NF daily rate.
	E0639	NU	Moveable patient lift system	Limit of 1 per client every 5 years. PA required. Included in NF daily rate.
DC	E0641		Multi-position stnd fram sys	See E0637
DC	E0642		Dynamic standing frame	See E0637
Noninvasive bone growth/nerve stimulators				
	E0740	NU/RR	Non-implant pelv flr e-stim	Considered purchased after 1 years rental. PA required. Included in NF daily rate.
	E0747	NU	Elec osteogen stim not spine	Limit of 1 per client every 5 years. PA or EPA is required.
	E0748	NU	Elec osteogen stim spinal	Limit of 1 per client every 5 years. PA or EPA is required.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
DP	E0749		Elec osteogen stim implanted	See Physician-related Services/Health Care Professional Services Billing Guide
	E0760	NU	Osteogen ultrasound stimltor	Limit of 1 per client every 5 years. PA or EPA is required.
DP	E0762		Trans elec jt stim dev sys	See Physician-related Services/Health Care Professional Services Billing Guide
DP	E0765		Nerve stimulator for tx n&v	See Physician-related Services/Health Care Professional Services Billing Guide
Communication devices				
	E2500	NU	Sgd digitized pre-rec <=8min	PA required.
	E2502	NU	Sgd prerec msg >8min <=20min	PA required.
	E2504	NU	Sgd prerec msg>20min <=40min	PA required.
	E2506	NU	Sgd prerec msg > 40 min	PA required.
	E2508	NU	Sgd spelling phys contact	PA required.
	E2510		Sgd w multi methods msg/accs	Purchase only. PA required.
	E2512	NU	Sgd accessory, mounting sys	PA required.
BR	E2599		Sgd accessory noc	Purchase only. PA required.
	L8500		Artificial larynx	Purchase only. Limit of 1 per client every 5 years.
Ambulatory aids				
	A4635		Underarm crutch pad	Purchase only. Included in NF daily rate.
	A4636	NU	Handgrip for cane etc	Included in NF daily rate.
	A4637	NU	Repl tip cane/crutch/walker	Included in NF daily rate.
	E0100	NU	Cane adjust/fixed with tip	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0105	NU	Cane adjust/fixed quad/3 pro	Limit of 1 per client every 5 years. Included in NF daily rate.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	E0110	NU	Crutch forearm pair	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0111	NU	Crutch forearm each	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0112	NU	Crutch underarm pair wood	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0113	NU	Crutch underarm each wood	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0114	NU	Crutch underarm pair no wood	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0116	NU	Crutch underarm each no wood	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0117	NU	Underarm springassist crutch	PA required.
DC	E8000		Posterior gait trainer	See HCPCS code E8001.
BR	E8001		Upright gait trainer	Purchase only. PA required. Included in NF daily rate.
DC	E8002		Anterior gait trainer	See HCPCS code E8001.
	E0130	NU	Walker rigid adjust/fixed ht	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0135	NU	Walker folding adjust/fixed	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0140	NU	Walker w trunk support	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0141	NU	Rigid wheeled walker adj/fix	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0143	NU	Walker folding wheeled w/o s	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0144	NU	Enclosed walker w rear seat	Limit of 1 per client every 5 years. Included in NF daily rate.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	E0147	NU	Walker variable wheel resist	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0148	NU	Heavyduty walker no wheels	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0149	NU	Heavy duty wheeled walker	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0153	NU	Forearm crutch platform atta	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0154	NU	Walker platform attachment	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0155	NU	Walker wheel attachment,pair	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0156	NU	Walker seat attachment	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0157	NU	Walker crutch attachment	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0158	NU	Walker leg extenders set of4	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0159	NU	Brake for wheeled walker	Included in NF daily rate.
			Bathroom equipment	
	E0163	NU/RR	Commode chair with fixed arm	PA required. Use form HCA 13-872
	E0165	NU/RR	Commode chair with detacharm	PA required. Use form HCA 13-872
	E0167		Commode chair pail or pan	PA required. Use form HCA 13-872
	E0168	NU/RR	Heavyduty/wide commode chair	PA required. Use form HCA 13-872
	E0175		Commode chair foot rest	PA required
	E0240		Bath/shower chair	PA required. Use form HCA 13-872
	E0241		Bath tub wall rail	PA required. Use form HCA 13-872
	E0243		Toilet rail	PA required.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
				Use form HCA 13-872
	E0244		Toilet seat raised	PA required. Use form HCA 13-872
	E0245		Tub stool or bench	PA required. Use form HCA 13-872
	E0247		Trans bench w/wo comm open	PA required. Use form HCA 13-872
	E0248		Hdtrans bench w/wo comm open	PA required. Use form HCA 13-872
	E0700		Safety equipment	Purchase only. Included in NF daily rate.
Blood monitoring				
	A4660		Sphyg/bp app w cuff and stet	PA required
	A4663		Dialysis blood pressure cuff	PA required
	A4670		Automatic bp monitor, dial	PA required
	A9275		Disp home glucose monitor	Purchase only.
	E0607	NU	Blood glucose monitor home	Limit of 1 per client, per 3 years.
	E2100	NU	Bld glucose monitor w voice	Limit of 1 per client, per 3 years. PA required.
	E2101	NU	Bld glucose monitor w lance	
Miscellaneous medical equipment				
	A8000	NU	Soft protect helmet prefab	Limit of 1 per client, per year.
	A8001	NU	Hard protect helmet prefab	Limit of 1 per client, per year.
BR	A8002	NU	Soft protect helmet custom	Limit of 1 per client, per year. PA required.
BR	A8003	NU	Hard protect helmet custom	Limit of 1 per client, per year. PA required.
BR	A8004	NU	Repl soft interface, helmet	Not allowed in addition to HCPCS codes A8000 – A8003.
	E0202	RR	Phototherapy light w/ photom	Rental only. Includes all supplies. Limit of 5 days of rental per client, per 12- month period.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	E0602	NU	Manual breast pump	Purchase only. Limit of 1 per client per lifetime. Not allowed in combination with E0603 or E0604.
	E0603	NU	Electric breast pump	Purchase only. Limit of 1 per client per lifetime. Not allowed in combination with HCPCS codes E0604 or E0602. PA required.
	E0604	RR	Hosp grade elec breast pump	Rental only. If client received a kit during hospitalization, an additional kit is not covered. PA or EPA is required.
	E0650	NU/RR	Pneuma compresor non-segment	Considered purchased after 1 years rental. Limit of 1 per client every 5 years. Rental requires PA or EPA is required. Included in NF daily rate.
	E0655	NU	Pneumatic appliance half arm	
	E0660	NU	Pneumatic appliance full leg	
	E0665	NU	Pneumatic appliance full arm	
	E0666	NU	Pneumatic appliance half leg	
	E0935	RR	Cont pas motion exercise dev	Rental allowed for maximum of 10 days. Limits = per knee. PA or EPA is required.
	E0936	RR	Cpm device, other than knee	PA required
BR	E1399	NU	Durable medical equipment mi	Purchase only. PA required.
	E2000	RR	Gastric suction pump hme mdl	Rental only. PA required.
	K0606		Aed garment w elec analysis	PA required
	K0607		Repl batt for aed	
	K0608		Repl garment for aed	
	K0609		Repl electrode for aed	
	K0739		Repair/svc dme non-oxygen eq	For client-owned equipment only. PA required.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	T5001	NU/RR	Position seat spec orth need	Limit of 1 per client every 5 years. PA required for rental and for clients age 6 and younger. Included in NF daily rate.
Other charges for medical equipment services				
BR	A6549		Compression garments	PA required – use form HCA 13-871
	A7048		Vacuum collection drainage unit, including all supplies	Limit 4 per month
	E0486		Oral device/appliance	See Sleep Center Provider Guide
	E1399	NU/RR	Durable medical equipment mi	Provide complete description including copy of manufacturer's product information price catalog with request for authorization. PA required.
Manual wheelchairs (covered HCPCS codes) (For CRT Wheelchairs - see Complex Rehabilitation Technology Billing Guide)				
	E1028	NU	W/c manual swingaway	PA required HCPCS code E1028 must be submitted on one line for correct payment.
	E1031	NU	Rollabout chair with casters	PA required
	E1060	RR	Wheelchair detachable arms	EPA required
	K0001	NU/RR	Standard wheelchair	EPA required for rental only
	K0002	NU/RR	Stnd hemi (low seat) whlchr	PA required for rental only.
	K0003	NU/RR	Lightweight wheelchair	PA required for rental only
	K0004	NU	High strength ltwt whlchr	PA required
	K0006	NU/RR	Heavy duty wheelchair	PA required
BR	K0108	NU	W/c component-accessory nos	PA required
Manual wheelchairs (noncovered HCPCS codes)				
DC	E1050		Whelchr fxd full length arms	See HCPCS codes K0003 and E1226.
DC	E1070		Wheelchair detachable foot r	See HCPCS codes K0003 and E1226.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
DC	E1083		Hemi-wheelchair fixed arms	See HCPCS code K0002 and K0003.
DC	E1084		Hemi-wheelchair detachable a	See HCPCS code K0002 and K0003.
DC	E1085		Hemi-wheelchair fixed arms	See HCPCS code K0002 and K0003.
DC	E1086		Hemi-wheelchair detachable a	See HCPCS code K0002 and K0003.
DC	E1087		Wheelchair lightwt fixed arm	See HCPCS code K0004.
DC	E1088		Wheelchair lightweight det a	See HCPCS code K0004.
DC	E1089		Wheelchair lightwt fixed arm	See HCPCS code K0004.
DC	E1090		Wheelchair lightweight det a	See HCPCS code K0004.
DC	E1092		Wheelchair wide w/ leg rests	See HCPCS code K0007.
DC	E1093		Wheelchair wide w/ foot rest	See HCPCS code K0007.
DC	E1100		Whchr s-recl fxd arm leg res	See HCPCS code K0003 and E1226.
DC	E1130		Whlchr stand fxd arm ft rest	See HCPCS code K0001.
DC	E1140		Wheelchair standard detach a	See HCPCS code K0001.
DC	E1150		Wheelchair standard w/ leg r	See HCPCS code K0001.
DC	E1160		Wheelchair fixed arms	
DC	E1170		Whlchr ampu fxd arm leg rest	See HCPCS code K0001 – K0005.
DC	E1171		Wheelchair amputee w/o leg r	See HCPCS code K0001 – K0005.
DC	E1172		Wheelchair amputee detach ar	See HCPCS code K0001 – K0005.
DC	E1180		Wheelchair amputee w/ foot r	See HCPCS code K0001 – K0005.
DC	E1190		Wheelchair amputee w/ leg re	See HCPCS code K0001 – K0005.
DC	E1195		Wheelchair amputee heavy dut	See HCPCS code K0007.
DC	E1200		Wheelchair amputee fixed arm	See HCPCS code K0001 – K0005.
DC	E1221		Wheelchair spec size w foot	See HCPCS code K0001 – K0014.
DC	E1222		Wheelchair spec size w/ leg	See HCPCS code K0001 – K0014.
DC	E1223		Wheelchair spec size w foot	See HCPCS code K0001 – K0014.
DC	E1224		Wheelchair spec size w/ leg	See HCPCS code K0001 – K0014.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
DC	E1240		Whchr litwt det arm leg rest	See HCPCS code K0003 or K0004.
DC	E1250		Wheelchair lightwt fixed arm	See HCPCS code K0003 or K0004.
DC	E1260		Wheelchair lightwt foot rest	See HCPCS code K0003 or K0004.
DC	E1270		Wheelchair lightweight leg r	See HCPCS code K0003 or K0004.
DC	E1280		Whchr h-duty det arm leg res	See HCPCS code K0007.
DC	E1285		Wheelchair heavy duty fixed	See HCPCS code K0007.
DC	E1290		Wheelchair hvy duty detach a	See HCPCS code K0007.
DC	E1295		Wheelchair heavy duty fixed	See HCPCS code K0007.
Power-operated vehicles (covered HCPCS codes)				
	K0800	NU	Pov group 1 std up to 300lbs	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396. PA required.
	K0801	NU	Pov group 1 hd 301-450 lbs	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396. PA required.
	K0802	NU	Pov group 1 vhd 451-600 lbs	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396. PA required.
	K0806	NU	Pov group 2 std up to 300lbs	Not allowed in combination with HCPCS codes E1228, E1297,

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
				E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396. PA required.
	K0807	NU	Pov group 2 hd 301-450 lbs	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396. PA required.
	K0808	NU	Pov group 2 vhd 451-600 lbs	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396. PA required.
BR	K0812	NU	Power operated vehicle noc	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396. PA required.
Cushions				
	E2601	NU	Gen w/c cushion wdth < 22 in	PA required
	E2602	NU	Gen w/c cushion wdth >=22 in	PA required
	E2603	NU	Skin protect wc cus wd <22in	PA required
	E2604	NU	Skin protect wc cus wd>=22in	PA required
	E2605	NU	Position wc cush wdth <22 in	PA required
	E2606	NU	Position wc cush wdth>=22 in	PA required
	E2607	NU	Skin pro/pos wc cus wd <22in	PA required

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	E2608	NU	Skin pro/pos wc cus wd>=22in	PA required
	E2622	NU	Adj skin pro w/c cus wd<22in	PA required
	E2623	NU	Adj skin pro wc cus wd>=22in	PA required
	E2624	NU	Adj skin pro/pos cus<22in	PA required
	E2625	NU	Adj skin pro/pos wc cus>=22	PA required
Armrests and parts				
	E0994	NU	Wheelchair arm rest	PA required
	K0019	NU	Arm pad repl, each	PA required
Lower extremity positioning (leg rests, etc.)				
	E0951	NU	Loop heel	PA required
	E0952	NU	Toe loop/holder, each	PA required
	E0995	NU	Wc calf rest, pad replacemnt	PA required
	K0038	NU	Leg strap each	PA required
	K0039	NU	Leg strap h style each	PA required
	K0041	NU	Large size footplate each	PA required
	K0195	NU	Elevating whlchair leg rests	PA required
Seat and positioning				
	E0950	NU	Tray	PA required
	E0960	NU	W/c shoulder harness/straps	PA required
	E0978	NU	W/c acc,saf belt pelv strap	PA required
	E0980	NU	Wheelchair safety vest	PA required
	E0981	NU	Seat upholstery, replacement	PA required
	E0982	NU	Back upholstery, replacement	PA required
	E0992	NU	Wheelchair solid seat insert	PA required
	E2231	NU	Solid seat support base	PA required
BR	E2291	NU	Planar back for ped size wc	PA required
BR	E2292	NU	Planar seat for ped size wc	PA required
BR	E2293	NU	Contour back for ped size wc	PA required
BR	E2294	NU	Contour seat for ped size wc	PA required
	E2611	NU	Gen use back cush wdth <22in	PA required
	E2612	NU	Gen use back cush wdth>=22in	PA required
	E2613	NU	Position back cush wd <22in	PA required
	E2614	NU	Position back cush wd>=22in	PA required
	E2615	NU	Pos back post/lat wdth <22in	PA required
	E2616	NU	Pos back post/lat wdth>=22in	PA required
Hand rims, wheel, and tires (includes parts)				
	E0967	NU	Man wc rim/projection rep ea	PA required

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	E2211	NU	Pneumatic propulsion tire	PA required
	E2212	NU	Pneumatic prop tire tube	PA required
	E2213	NU	Pneumatic prop tire insert	PA required
	E2214	NU	Pneumatic caster tire each	PA required
	E2215	NU	Pneumatic caster tire tube	PA required
	E2216	NU	Foam filled propulsion tire	PA required
	E2217	NU	Foam filled caster tire each	PA required
	E2218	NU	Foam propulsion tire each	PA required
	E2219	NU	Foam caster tire any size ea	PA required
	E2220	NU	Solid propuls tire, repl, ea	PA required
	E2221	NU	Solid caster tire repl, each	PA required
	E2222	NU	Solid caster integ whl, repl	PA required
	E2224	NU	Propulsion whl excl tire rep	PA required
	E2225	NU	Caster wheel excludes tire	PA required
	E2226	NU	Caster fork replacement only	PA required
	K0065	NU	Spoke protectors	PA required
	K0069	NU	Rr whl compl sol tire rep ea	PA required
	K0070	NU	Rr whl compl pne tire rep ea	PA required
	K0071	NU	Fr cstr comp pne tire rep ea	PA required
	K0072	NU	Fr cstr semi-pne tire rep ea	PA required
	K0073	NU	Caster pin lock each	PA required
	K0077	NU	Fr cstr asmb sol tire rep ea	PA required
Other accessories				
	E0776	NU/RR	Iv pole	PA required
	E0961	NU	Wheelchair brake extension	Changed from pair to each with new description. PA required.
	E0971	NU	Wheelchair anti-tipping devi	PA required
	E0973	NU	W/ch access det adj armrest	PA required
	E1029	NU	W/c vent tray fixed	PA required
	E1030	NU	W/c vent tray gimbaled	PA required
	E2207	NU	Crutch and cane holder	PA required
	E2208	NU	Cylinder tank carrier	PA required
	K0105	NU	Iv hanger	PA required
Miscellaneous repair only				
	E2210	NU	Pwc acc, lith-based battery	PA required
	E2619	NU	Replace cover w/c seat cush	PA required

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

Coverage Table –Medical Supplies

Coverage Table – Legends

Status Code Indicator
DC = Same/similar covered code in fee schedule
DP = Service managed through a different program
KS = Noninsulin dependent

Modifiers
KX = Insulin dependent
RA = Replacement equipment
RB = Replacement as part of repair
RR = Equipment rental

Other Legends
NF = Nursing Facility
PA = Prior Authorization
*Not allowed in combination with any other disposable diaper or pant, or rental reusable diaper or pant.

Coverage Table

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
			Syringes and needles	
	A4206		1 cc sterile syringe&needle	Included in NF daily rate
	A4207		2 cc sterile syringe&needle	Included in NF daily rate
	A4208		3 cc sterile syringe&needle	Included in NF daily rate
	A4209		5+ cc sterile syringe&needle	Included in NF daily rate
	A4210		Nonneedle injection device	Included in NF daily rate
	A4213		20+ cc syringe only	Included in NF daily rate
	A4215		Sterile needle	Included in NF daily rate
	A4322		Irrigation syringe	Not allowed in combination with code A4320, A4355. Included in NF daily rate.
			Blood monitoring/testing supplies	
	A4233		Alkalin batt for glucose mon	Limit 1 every 3 months
	A4234		J-cell batt for glucose mon	Limit 1 every 3 months
	A4235		Lithium batt for glucose mon	Limit 1 every 3 months
	A4236		Silvr oxide batt glucose mon	
	A4253	KX/KS	Blood glucose/reagent strips	Included in NF daily rate.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
				1 unit billed = 1 box of 50 strips (e.g. 1 unit = 50, 2 units = 100 strips; 3 units = 150 strips, etc.) Limits: 100/month for insulin dependent; 100/3 months noninsulin dependent; for children age 20 and younger insulin dependent, 300 test strips and 300 lancets per month (medical equipment providers must submit claims with EPA 870001265); Pharmacy POS providers must use EPA 85000000265 and must bill according to POS instructions – see the Prescription Drug Program Billing Guide
	A4255		Glucose monitor platforms	
	A4256		Calibrator solution/chips	Included in NF daily rate.
	A4258		Lancet device each	1 allowed per client, per 6 months. Included in NF daily rate.
	A4259	KX/KS	Lancets per box	Included in NF daily rate. 1 unit = 1 box of 100 lancets (e.g. 1 unit = 100; 2 units = 200; 3 units = 300; etc.) Limits: 100/month for insulin dependent; 100/3 months noninsulin dependent; for children age 20 and younger insulin dependent, 300 test strips and 300 lancets per month (medical equipment providers must submit claims with EPA 870001265); Pharmacy

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
				POS providers must use EPA 85000000265 and must bill according to POS instructions – see the Prescription Drug Program Billing Guide
Antiseptics and germicides				
	A4244		Alcohol or peroxide per pint	Max of 1 pint allowed per client, per 6 months. Included in NF daily rate.
	A4245		Alcohol wipes per box	Max of 1 box allowed per client, per month. Included in NF daily rate.
	A4246		Betadine/phisohex solution	Max of 1 pint allowed per client, per month. Included in NF daily rate.
	A4247		Betadine/iodine swabs/wipes	Max of 1 box allowed per client, per month. Included in NF daily rate.
BR	A4248		Chlorhexidine antisept	Max of 1 box allowed per client, per month. Included in NF daily rate.
Bandages, dressings, and tapes (Unless needed for the first 6 weeks of post-surgery, all bandages, dressings, and tapes are included in the NF daily rate.)				
BR	A4649		Surgical supplies	PA required
	A6010		Collagen based wound filler	PA required
	A6011		Collagen gel/paste wound fil	PA required
	A6021		Collagen dressing <=16 sq in	
	A6022		Collagen drsg>16<=48 sq in	
	A6023		Collagen dressing >48 sq in	PA required
	A6024		Collagen dsg wound filler	
	A6025		Silicone gel sheet, each	
	A6154		Wound pouch each	
	A6196		Alginate dressing <=16 sq in	
	A6197		Alginate drsg >16 <=48 sq in	
	A6198		Alginate dressing > 48 sq in	
	A6199		Alginate drsg wound filler	
	A6203		Composite drsg <= 16 sq in	
	A6204		Composite drsg >16<=48 sq in	
	A6205		Composite drsg > 48 sq in	
	A6206		Contact layer <= 16 sq in	

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	A6207		Contact layer >16<= 48 sq in	
	A6208		Contact layer > 48 sq in	
	A6209		Foam drsg <=16 sq in w/o bdr	
	A6210		Foam drg >16<=48 sq in w/o b	
	A6211		Foam drg > 48 sq in w/o brdr	
	A6212		Foam drg <=16 sq in w/border	
	A6213		Foam drg >16<=48 sq in w/bdr	
	A6214		Foam drg > 48 sq in w/border	
	A6215		Foam dressing wound filler	
	A6216		Non-sterile gauze<=16 sq in	
	A6217		Non-sterile gauze>16<=48 sq	
	A6218		Non-sterile gauze > 48 sq in	
	A6219		Gauze <= 16 sq in w/border	
	A6220		Gauze >16 <=48 sq in w/bordr	
	A6221		Gauze > 48 sq in w/border	
	A6222		Gauze <=16 in no w/sal w/o b	
	A6223		Gauze >16<=48 no w/sal w/o b	
	A6224		Gauze > 48 in no w/sal w/o b	
	A6229		Gauze >16<=48 sq in watr/sal	
	A6230		Gauze > 48 sq in water/salne	
	A6231		Hydrogel dsg<=16 sq in	
	A6232		Hydrogel dsg>16<=48 sq in	
	A6233		Hydrogel dressing >48 sq in	
	A6234		Hydrocolld drg <=16 w/o bdr	
	A6235		Hydrocolld drg >16<=48 w/o b	
	A6236		Hydrocolld drg > 48 in w/o b	
	A6237		Hydrocolld drg <=16 in w/bdr	
	A6238		Hydrocolld drg >16<=48 w/bdr	
	A6240		Hydrocolld drg filler paste	
	A6241		Hydrocolloid drg filler dry	
	A6242		Hydrogel drg <=16 in w/o bdr	
	A6243		Hydrogel drg >16<=48 w/o bdr	
	A6244		Hydrogel drg >48 in w/o bdr	
	A6245		Hydrogel drg <= 16 in w/bdr	
	A6246		Hydrogel drg >16<=48 in w/b	

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	A6247		Hydrogel drg > 48 sq in w/b	
	A6248		Hydrogel drsg gel filler	
	A6251		Absorpt drg <=16 sq in w/o b	
	A6252		Absorpt drg >16 <=48 w/o bdr	
	A6253		Absorpt drg > 48 sq in w/o b	
	A6254		Absorpt drg <=16 sq in w/bdr	
	A6255		Absorpt drg >16<=48 in w/bdr	
	A6256		Absorpt drg > 48 sq in w/bdr	
	A6257		Transparent film <= 16 sq in	
	A6258		Transparent film >16<=48 in	
	A6259		Transparent film > 48 sq in	
	A6260		Wound cleanser any type/size	
BR	A6261		Wound filler gel/paste /oz	PA required
	A6262		Wound filler dry form / gram	PA required
	A6266		Impreg gauze no h20/sal/yard	
	A6402		Sterile gauze <= 16 sq in	
	A6403		Sterile gauze>16 <= 48 sq in	
	A6404		Sterile gauze > 48 sq in	
	A6407		Packing strips, non-impreg	
	A6441		Pad band w>=3" <5"/yd	
	A6442		Conform band n/s w<3"/yd	
	A6443		Conform band n/s w>=3"<5"/yd	
	A6444		Conform band n/s w>=5"/yd	
	A6445		Conform band s w <3"/yd	
	A6446		Conform band s w>=3" <5"/yd	
	A6447		Conform band s w >=5"/yd	
	A6448		Lt compres band <3"/yd	
	A6449		Lt compres band >=3" <5"/yd	
	A6450		Lt compres band >=5"/yd	
	A6451		Mod compres band w>=3"<5"/yd	
	A6452		High compres band w>=3"<5"yd	
	A6453		Self-adher band w <3"/yd	
	A6454		Self-adher band w>=3" <5"/yd	
	A6455		Self-adher band >=5"/yd	
	A6456		Zinc paste band w >=3"<5"/yd	

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	A6457		Tubular dressing	
BR	A6501		Compres burngarment bodysuit	PA required
BR	A6502		Compres burngarment chinstrp	PA required
BR	A6503		Compres burngarment facehood	PA required
BR	A6504		Cmprsburngarment glove-wrist	PA required
BR	A6505		Cmprsburngarment glove-elbow	PA required
BR	A6506		Cmprsburngrmnt glove-axilla	PA required
BR	A6507		Cmprs burngarment foot-knee	PA required
BR	A6508		Cmprs burngarment foot-thigh	PA required
BR	A6509		Compres burn garment jacket	PA required
BR	A6510		Compres burn garment leotard	PA required
BR	A6511		Compres burn garment panty	PA required
BR	A6512		Compres burn garment, noc	PA required
BR	A6513		Compress burn mask face/neck	PA required
	S8431		Compression bandage	
	T5999		Supply, nos	PA required
Tapes				
	A4450		Non-waterproof tape	Unless needed for the first 6 weeks of post-surgery, all bandages, dressings, and tapes are included in the NF daily rate.)
	A4452		Waterproof tape	
	A4461		Surgicl dress hold non-reuse	
	A4463		Surgical dress holder reuse	
	A4465		Non-elastic extremity binder	
Ostomy supplies (Note: Items in this category are not taxable)				
	A4361		Ostomy face plate	Max of 10 allowed per client, per month. Not allowed in combination with codes A4375, A4376, A4379, or A4380.
	A4362		Solid skin barrier	For ostomy only.
	A4363		Ostomy clamp, replacement	
	A4364		Adhesive, liquid or equal	Max of 4 allowed per client, per month. For ostomy or catheter.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	A4366		Ostomy vent	
	A4367		Ostomy belt	Max of 2 allowed per client every 6 months.
	A4368		Ostomy filter	Not allowed in combination with code A4418, A4419, A4423, A4424, A4425, or A4427.
	A4369		Skin barrier liquid per oz	
	A4371		Skin barrier powder per oz	
	A4372		Skin barrier solid 4x4 equiv	
	A4373		Skin barrier with flange	
	A4375		Drainable plastic pch w fcpl	Max of 10 allowed per month, per client. Not allowed in combination with code A4361, A4377, or A4378.
	A4376		Drainable rubber pch w fcplt	Max of 10 allowed per month, per client. Not allowed in combination with code A4361, A4377, or A4378.
	A4377		Drainable plstic pch w/o fp	Max of 10 allowed per month, per client. Not allowed in combination with code A4375, A4376, or A4378.
	A4378		Drainable rubber pch w/o fp	Max of 10 allowed per month, per client. Not allowed in combination with code A4375, A4376, or A4377.
	A4379		Urinary plastic pouch w fcpl	Max of 10 allowed per month, per client. Not allowed in combination with code A4361, A4381, A4382, or A4383.
	A4380		Urinary rubber pouch w fcplt	Max of 10 allowed per month, per client. Not allowed in combination with code A4361, A4381, A4382, or A4383.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	A4381		Urinary plastic pouch w/o fp	Max of 10 allowed per month, per client. Not allowed in combination with code A4379, A4380, A4382, or A4383.
	A4382		Urinary hvy plstc pch w/o fp	Max of 10 allowed per month, per client. Not allowed in combination with code A4379, A4380, A4381, A4383.
	A4383		Urinary rubber pouch w/o fp	Max of 10 allowed per client per month. Not allowed in combination with code A4379, A4380, A4381, A4382.
	A4384		Ostomy faceplt/silicone ring	
	A4385		Ost skn barrier sld ext wear	
	A4387		Ost clsd pouch w att st barr	Max of 30 allowed per client, per month.
	A4388		Drainable pch w ex wear barr	Max of 10 allowed per client, per month.
	A4389		Drainable pch w st wear barr	Max of 10 allowed per client, per month.
	A4390		Drainable pch ex wear convex	Max of 10 allowed per client, per month.
	A4391		Urinary pouch w ex wear barr	Max of 10 allowed per client, per month.
	A4392		Urinary pouch w st wear barr	Max of 10 allowed per client, per month.
	A4393		Urine pch w ex wear bar conv	Max of 10 allowed per client, per month.
	A4394		Ostomy pouch liq deodorant	
	A4395		Ostomy pouch solid deodorant	
	A4396		Peristomal hernia supprt blt	
	A4397		Irrigation supply sleeve	Max of 1 allowed per client, per month.
	A4398		Ostomy irrigation bag	Max of 2 allowed per client, every 6 months.
	A4399		Ostomy irrig cone/cath w brs	Max of 2 allowed per client, every 6 months.
	A4400		Ostomy irrigation set	Max of 2 allowed per client, every 6 months.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	A4404		Ostomy ring each	Max of 10 allowed per client, per month.
	A4405		Nonpectin based ostomy paste	
	A4406		Pectin based ostomy paste	
	A4407		Ext wear ost skn barr <=4sq"	
	A4408		Ext wear ost skn barr >4sq"	
	A4409		Ost skn barr convex <=4 sq i	
	A4410		Ost skn barr extnd >4 sq	
	A4411		Ost skn barr extnd =4sq	
	A4412		Ost pouch drain high output	Max of 10 allowed per client, every 30 days.
	A4413		2 pc drainable ost pouch	Max of 10 allowed per client, per month.
	A4414		Ost sknbar w/o conv<=4 sq in	
	A4415		Ost skn barr w/o conv >4 sqi	
	A4416		Ost pch clsd w barrier/filtr	Max of 30 allowed per client, per month. Not allowed in combination with A4368.
	A4417		Ost pch w bar/bltinconv/fltr	Max of 30 allowed per client, per month. Not allowed in combination with A4368.
	A4418		Ost pch clsd w/o bar w filtr	Max of 30 allowed per client, per month. Not allowed in combination with A4368.
	A4419		Ost pch for bar w flange/flt	Max of 30 allowed per client, per month. Not allowed in combination with A4368.
	A4421		Ostomy supply misc	PA required
	A4422		Ost pouch absorbent material	
	A4423		Ost pch for bar w lk fl/fltr	Max of 30 allowed per client, per month. Not allowed in combination with A4368.
	A4424		Ost pch drain w bar & filter	Max of 10 allowed per client, per month. Not allowed in combination with A4368.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	A4425		Ost pch drain for barrier fl	Max of 10 allowed per client, per month. Not allowed in combination with A4368.
	A4426		Ost pch drain 2 piece system	Max of 10 allowed per client, per month.
	A4427		Ost pch drain/barr lk flng/f	Max of 10 allowed per client, per month. Not allowed in combination with A4368.
	A4428		Urine ost pouch w faucet/tap	Max of 10 allowed per client, per month.
	A4429		Urine ost pouch w bltinconv	Max of 10 allowed per client, per month.
	A4430		Ost urine pch w b/bltin conv	Max of 10 allowed per client, per month.
	A4431		Ost pch urine w barrier/tapv	Max of 10 allowed per client, per month.
	A4432		Os pch urine w bar/fange/tap	Max of 10 allowed per client, per month.
	A4433		Urine ost pch bar w lock fln	Max of 10 allowed per client, per month.
	A4434		Ost pch urine w lock flng/ft	Max of 10 allowed per client, per month.
	A4435		1pc ost pch drain hgh output	Max of 10 allowed per client, per month.
	A4455		Adhesive remover per ounce	Max of 3 allowed per client, per month.
	A5051		Pouch clsd w barr attached	Max of 60 allowed per client, per month.
	A5052		Clsd ostomy pouch w/o barr	Max of 60 allowed per client, per month.
	A5053		Clsd ostomy pouch faceplate	Max of 60 allowed per client, per month.
	A5054		Clsd ostomy pouch w/flange	Max of 60 allowed per client, per month.
	A5055		Stoma cap	Max of 30 allowed per client, per month.
	A5061		Pouch drainable w barrier at	Max of 20 allowed per client, per month.
	A5062		Drnble ostomy pouch w/o barr	Max of 20 allowed per client, per month.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	A5063		Drain ostomy pouch w/flange	Max of 20 allowed per client, per month.
	A5071		Urinary pouch w/barrier	Max of 20 allowed per client, per month.
	A5072		Urinary pouch w/o barrier	Max of 20 allowed per client, per month.
	A5073		Urinary pouch on barr w/flng	Max of 20 allowed per client, per month.
	A5081		Stoma plug or seal, any type	Max of 30 allowed per client, per month.
	A5082		Continent stoma catheter	Max of 1 allowed per client, per month.
	A5083		Stoma absorptive cover	See code A6219.
	A5093		Ostomy accessory convex inse	Max of 10 allowed per client, per month.
	A5120		Skin barrier, wipe or swab	For ostomy only
	A5121		Solid skin barrier 6x6	For ostomy only
	A5122		Solid skin barrier 8x8	For ostomy only
	A5126		Disk/foam pad +or- adhesive	Max of 10 allowed per client, per month.
Urological supplies				
	A4310		Insert tray w/o bag/cath	Max of 60 per client, per month. Not allowed in combination with A4311, A4312, A4313, A4314, A4315, A4316, A4353, or A4354. Included in NF daily rate.
	A4311		Catheter w/o bag 2-way latex	Max of 3 allowed per client, per month. Not allowed in combination with code A4310, A4314, or A4338. Included in NF daily rate.
	A4312		Cath w/o bag 2-way silicone	Max of 3 allowed per client, per month. Not allowed in combination with code A4310, A4315, or A4344. Included in NF daily rate.
	A4313		Catheter w/bag 3-way	Max of 3 allowed per client, per month. Not allowed in combination

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
				with code A4310, A4316, or A4346. Included in NF daily rate.
	A4314		Cath w/drainage 2-way latex	Max of 3 allowed per client, per month. Not allowed in combination with code A4310, A4311, A4338, A4354, or A4357. Included in NF daily rate.
	A4315		Cath w/drainage 2-way silcne	Max of 3 allowed per client, per month. Not allowed in combination with code A4310, A4312, A4344, A4354, or A4357. Included in NF daily rate.
	A4316		Cath w/drainage 3-way	Max of 3 allowed per client, per month. Not allowed in combination with code A4310, A4313, A4346, A4354, or A4357. Included in NF daily rate.
	A4320		Irrigation tray	Max of 30 allowed per client, per month. Not allowed in combination with code A4322 or A4355. Included in NF daily rate.
	A4326		Male external catheter	Max of 60 allowed per client, per month. Included in NF daily rate.
	A4327		Fem urinary collect dev cup	Included in NF daily rate
	A4328		Fem urinary collect pouch	Included in NF daily rate
	A4330		Stool collection pouch	Included in NF daily rate
	A4331		Extension drainage tubing	Included in NF daily rate Not allowed in combination with code A4354, A5105, A5113, or A5114.
	A4332		Lube sterile packet	Included in NF daily rate
	A4333		Urinary cath anchor device	Included in NF daily rate
	A4334		Urinary cath leg strap	Included in NF daily rate

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	A4335		Incontinence supply	Included in NF daily rate (age 3 and older.) EPA required.
	A4336		Urethral insert	PA required
	A4338		Indwelling catheter latex	Max of 3 allowed per client, per month. Not allowed in combination with code A4311 or A4314. Included in NF daily rate.
	A4340		Indwelling catheter special	Max of 3 allowed per client, per month. Included in NF daily rate.
	A4344		Cath indw foley 2 way silicn	Max of 3 allowed per client, per month. Not allowed in combination with code A4312 or A4315. Included in NF daily rate.
	A4346		Cath indw foley 3 way	Max of 3 allowed per client, per month. Not allowed in combination with code A4313 or A4316. Included in NF daily rate.
	A4349		Disposable male external cat	Max of 60 allowed per client, per month. Included in NF daily rate.
	A4351		Straight tip urine catheter	Max of 120 allowed per client, per month. Not allowed in combination with code A4352 or A4353.
	A4352		Coude tip urinary catheter	Max of 120 allowed per client, per month. Not allowed in combination with code A4351 or A4353.
	A4353		Intermittent urinary cath	PA required. Not allowed in combination with A4310, A4351, A4352, or A4354.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
				Includes sterile no touch catheter systems. Included in NF daily rate.
	A4354		Cath insertion tray w/bag	PA required. Not allowed in combination with A4310, A4314, A4315, A4316, A4353, A4357, A4358, and A5112. Included in NF daily rate.
	A4355		Bladder irrigation tubing	Max of 30 allowed per client, per month. Not allowed in combination with A4320 and A4322. Included in NF daily rate.
	A4356		Ext ureth clmp or compr dvc	Max of 2 allowed per client, per year. Included in NF daily rate.
	A4357		Bedside drainage bag	Max of 2 allowed per client, per month. Not allowed in combination with code A4314-A4316 or A4354. Included in NF daily rate.
	A4358		Urinary leg or abdomen bag	Max of 2 allowed per client, per month. Not allowed in combination with code A5113, A5114, A4354, or A5105. Included in NF daily rate.
	A4360		Disposable ext urethral dev	Max of 2 allowed per client, per month.
	A4402		Lubricant per ounce	Included in NF daily rate. For insertion of urinary catheters.
	A4456		Adhesive remover, wipes	Max of 50 wipes allowed per client, per month.
	A4520		Incontinence garment anytype	PA required. Included in NF daily rate.
	A5056		1 pc ost pouch w filter	
	A5057		1 pc ost pou w built-in conv	
	A5102		Bedside drain btl w/wo tube	Max of 2 allowed per client, per 6 months. Included in NF daily rate.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	A5105		Urinary suspensory	Max of 2 allowed per client, per month. Not allowed in combination with code A4358, A5112, A5113, or A5114. Included in NF daily rate.
	A5112		Urinary leg bag	Max of 1 allowed per client, per month. Not allowed in combination with code A4354, A5105, A5113, or A5114. Included in NF daily rate.
	A5113	RA	Latex leg strap	Not allowed in combination with code A4358, A5105, or A5112. Included in NF daily rate.
	A5114	RA	Foam/fabric leg strap	Not allowed in combination with code A4358, A5105, or A5112. Included in NF daily rate.
	T4521		Adult size brief/diaper sm	Medical exceptions to max quantity or age limitations require PA. Max of 200 diapers purchased per client, per month. For clients age 20 and older. Recommended for waist sizes 24" – 32." Included in NF daily rate.
	T4522		Adult size brief/diaper med	Medical exceptions to max quantity or age limitations require PA. Max of 200 diapers purchased per client, per month. For clients age 20 and older. Recommended for waist sizes 32" – 44." Included in NF daily rate.
	T4523		Adult size brief/diaper lg	Medical exceptions to max quantity or age limitations require PA. Max of 200 diapers purchased per client, per month. For clients age 20

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
				and older. Recommended for waist sizes 45" – 58." Included in NF daily rate.
	T4524		Adult size brief/diaper xl	Medical exceptions to max quantity or age limitations require PA. Max of 200 diapers purchased per client, per month. For clients age 20 and older. Recommended for waist sizes 56" – 64." Included in NF daily rate.
	T4525	59 (To designate daytime use only)	Adult size pull-on sm	Medical exceptions to max quantity or age limitations require PA. Max of 200 pull-ons for clients age 6 through 20, per month. Max of 150 allowed for clients age 20 and older, per month. Included in NF daily rate.
	T4526	59 (To designate daytime use only)	Adult size pull-on med	Medical exceptions to max quantity or age limitations require PA. Max of 200 pull-ons for clients age 6 through 20, per month. Max of 150 allowed for clients age 20 and older, per month. Recommended for waist sizes 32" – 44." Included in NF daily rate.
	T4527	59 (To designate daytime use only)	Adult size pull-on lg	Medical exceptions to max quantity or age limitations require PA. Max of 200 pull-ons for clients age 6 through 20, per month. Max of 150 allowed for clients age 20 and older, per month. Recommended for waist sizes 45" – 58." Included in NF daily rate.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	T4528	59 (To designate daytime use only)	Adult size pull-on xl	Medical exceptions to max quantity or age limitations require PA. Max of 200 pull-ons for clients age 6 through 20, per month. Max of 150 allowed for clients age 20 and older, per month. Recommended for waist sizes 56" – 64." Included in NF daily rate.
	T4529		Ped size brief/diaper sm/med	Medical exceptions to max quantity or age limit require PA. For clients age 3-20. Recommended for waist sizes 13" – 19" Max of 200 diapers purchased per client, per month. Included in NF daily rate.
	T4530	59 (To designate daytime use only)	Ped size brief/diaper lg	Medical exceptions to max quantity or age limit require PA. For clients age 3-20. Max of 200 diapers purchased per client, per month. Included in NF daily rate.
	T4531	59 (To designate daytime use only)	Ped size pull-on sm/med	Medical exceptions to max quantity or age limit require PA. For clients age 3-20. Max of 200 diapers purchased per client, per month. Included in NF daily rate.
	T4532	59 (To designate daytime use only)	Ped size pull-on lg	Medical exceptions to max quantity or age limit require PA. For clients age 3-20. Max of 200 pull-ons, per client, per month. Included in NF daily rate.
	T4533	59	Youth size brief/diaper	For clients age 6-20. Recommended for waist sizes 18" – 26"

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
		(To designate daytime use only)		Max of 200 diapers purchased per client, per month. Included in NF daily rate.
	T4534	59 (To designate daytime use only)	Youth size pull-on	Medical exceptions to max quantity or age limit require PA. For clients age 6-20. Recommended for waist sizes 17" – 26" Max of 200 pull-ons purchased per client, per month. Included in NF daily rate.
	T4535	59 (To designate daytime use only)	Disposable liner/shield/pad	Medical exceptions to max quantity require PA. Not to be used inside any other product. For clients age 3 and older. Max of 200 pieces allowed per client, per month. Included in NF daily rate.
	T4536	NU	Reusable pull-on any size	For clients age 3 and older. Max of 4 per client, per year. Included in NF daily rate.
	T4536	RR	Reusable pull-on any size	For clients age 3 and older. Max of 150 allowed per client, per month. Included in NF daily rate.
	T4537	NU	Reusable underpad bed size	Limit 42 per year. Not allowed in combination with code T4541, T4542, or T4537 (RR).
	T4537	RR	Reusable underpad bed size	Limit 90 per month. Not allowed in combination with code T4541, T4542, or T4537 (NU). Included in NF daily rate.
	T4538	RR	Diaper serv reusable diaper	Medical exceptions to max quantity or age limit require PA. For clients age 3 and older. Max of 200 diapers allowed per

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
				client, per month. Included in NF daily rate.
	T4539	NU	Reuse diaper/brief any size	Medical exceptions to max quantity or age limit require PA. For clients age 3 and older. Max of 36 diapers allowed per client, per month. Included in NF daily rate.
	T4541		Large disposable underpad	For use on the client's bed only. Requires a minimum underpad size of 810 square inches. Max of 180 pieces allowed per client, per month. Not allowed in combination with code T4537 (NU) or T4537 (RR). Included in NF daily rate.
	T4543		Adult disp brief/diap abv xl	For clients age 20 and older. Recommended for waist sizes 65" – 84" Max of 200 pieces purchased per client, per month. Included in NF daily rate.
	T4544	59 (To designate daytime use only)	Adlt disp und/pull on abv xl	For clients age 6 and older. Recommended for waist sizes 65" and over. Max of 200 allowed for clients age 6 to 19, per month. Max of 150 allowed per clients age 20 and older, per month. Included in NF daily rate.
Braces, belts, and supportive devices				
	A4467		Belt strap sleev grmnt cover	
	A4565		Slings	Max of 2 allowed per client, per year. Included in NF daily rate.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	A4570		Splint	Max of 1 allowed per client per year. Included in NF daily rate.
	E0942		Cervical head harness/halter	Max of 1 allowed per client per year. Included in NF daily rate.
	E0944		Pelvic belt/harness/boot	Max of 1 allowed per client per year. Not allowed for use during pregnancy. Included in NF daily rate.
	E0945		Belt/harness extremity	Max of 1 allowed per client per year. Not allowed for use during pregnancy. Included in NF daily rate.
Decubitus care products				
	E0188		Synthetic sheepskin pad	Max of 1 allowed per client per year. Included in NF daily rate.
	E0189		Lambswool sheepskin pad	Max of 1 allowed per client per year. Included in NF daily rate.
	E0191		Protector heel or elbow	Max of 4 allowed per client per year. Included in NF daily rate.
Miscellaneous supplies				
	A4561		Pessary rubber, any type	See Physician-related Services/Healthcare Professional Services Billing Guide
	A4562		Pessary, non rubber,any type	See Physician-related Services/Healthcare Professional Services Billing Guide
	A4927		Non-sterile gloves	Quantities exceeding 2 units per month require PA. One unit = 100 gloves. Included in NF daily rate and in home health care rate.

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments
	A4930		Sterile, gloves per pair	Max of 30 per client, per month. Included in NF daily rate and in home health care rate.
	A6410		Sterile eye pad	Max of 20 allowed per client, per month. Included in NF daily rate.
	A6411		Non-sterile eye pad	Max of 1 allowed per client, per month. Included in NF daily rate.
	T5999		Supply, nos	PA required
	S8265		Haberman feeder	

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

Coverage/Limitations

(WAC 182-543-5500)

What is covered?

The agency covers the following nondurable medical supplies and equipment (MSE) and related services. Prior authorization is not required.

- Antiseptics and germicides:
  - ✓ Alcohol (isopropyl) or peroxide (hydrogen) - 1 pint per month
  - ✓ Alcohol wipes (box of 200) - 1 box per month
  - ✓ Betadine or phisoHex solution - 1 pint per month
  - ✓ Betadine or iodine swabs/wipes (box of 100) - 1 box per month
- Bandages, dressings, and tapes
- Blood monitoring/testing supplies:
  - ✓ Replacement battery of any type, used with a client-owned, medically necessary home or specialized blood glucose monitor - 1 in a 3-month period
  - ✓ Spring-powered device for lancet - 1 in a 6-month period
  - ✓ Diabetic test strips as follows:
    - ➢ For children, age 20 and younger, as follows:
      - ▪ Insulin dependent, 300 test strips and 300 lancets per client, per month (medical equipment providers must submit claims with EPA 870001265; Pharmacy POS providers must use EPA 85000000265 and must bill according to POS instructions – see the Prescription Drug Program Billing Guide)
      - ▪ For noninsulin dependent, 100 test strips and 100 lancets per client, per month

- For adults age 21 and older:
  - Insulin dependent, 100 test strips and 100 lancets per client, per month
  - For noninsulin dependent , 100 test strips and 100 lancets per client, every 3 months

✓ See WAC 182-543-5500(12) for blood glucose monitors.

- Decubitus care products:

✓ Cushion (gel, sacroiliac, or accuback) and cushion cover (any size) - 1 per 12-month period

✓ Synthetic or lamb's wool sheepskin pad - 1 per 12-month period

✓ Heel or elbow protectors - 4 per 12-month period

- Ostomy supplies:

✓ Adhesive for ostomy or catheter: cement; powder; liquid (e.g., spray or brush) or paste (any composition, e.g., silicone or latex) - 4 total ounces per month

✓ Adhesive or non-adhesive disk or foam pad for ostomy pouches - 10 per month

✓ Adhesive remover or solvent - 3 ounces per month

✓ Adhesive remover wipes, 50 per box - 1 box per month

✓ Closed pouch, with or without attached barrier, with a 1- or 2-piece flange, or for use on a faceplate - 60 per month

✓ Closed ostomy pouch with attached standard wear barrier, with built-in 1-piece convexity - 30 per month

✓ Continent plug for continent stoma - 30 per month

✓ Continent device for continent stoma - 1 per month

✓ Drainable ostomy pouch, with or without attached barrier, or with 1- or 2-piece flange - 20 per month

✓ Drainable ostomy pouch with attached standard or extended wear barrier, with or without built-in 1-piece convexity - 20 per month

- ✓ Drainable ostomy pouch for use on a plastic or rubber faceplate (only 1 type of faceplate allowed) - 10 per month
- ✓ Drainable urinary pouch for use with a plastic, heavy plastic, or rubber faceplate (only 1 type of faceplate allowed) - 10 per month
- ✓ Irrigation bag - 2 every 6 months
- ✓ Irrigation cone and catheter, including brush - 2 every 6 months
- ✓ Irrigation supply, sleeve - 1 per month
- ✓ Ostomy belt (adjustable) for appliance - 2 every 6 months
- ✓ Ostomy convex insert - 10 per month
- ✓ Ostomy ring - 10 per month
- ✓ Stoma cap - 30 per month
- ✓ Ostomy faceplate - 10 per month. The agency does not pay for either of the following when billed in combination with an ostomy faceplate with:
  - ➢ Drainable pouches with plastic face plate attached.
  - ➢ Drainable pouches with rubber face plate.

- Syringes and needles
- Urological supplies - diapers and related supplies:
  - ✓ The standards and specifications in this section apply to all disposable incontinence products (e.g., briefs, diapers, pull-up pants, underpads for beds, liners, shields, guards, pads, and undergarments)
  - ✓ All of the following apply to all disposable incontinence products:
    - ➢ All materials used in the construction of the product must be safe for the client's skin and harmless if ingested
    - ➢ Adhesives and glues used in the construction of the product must not be water-soluble and must form continuous seals at the edges of the absorbent core to minimize leakage
    - ➢ The padding must provide uniform protection

- The product must be hypoallergenic
- The product must meet the flammability requirements of both federal law and industry standards
- All products are covered for client personal use only

✓ In addition, diapers must:

- Be hourglass shaped with formed leg contours.
- Have an absorbent filler core that is at least one-half inch from the elastic leg gathers.
- Have leg gathers that consist of at least 3 strands of elasticized materials.
- Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials.
- Have a back sheet that is moisture impervious and is at least 1.00 mm thick, designed to protect clothing and linens.
- Have a top sheet that resists moisture returning to the skin.
- Have an inner lining that is made of soft, absorbent material.
- Have either a continuous waistband, or side panels with a tear-away feature, or refastenable tapes, as follows:
  - For child diapers, at least 2 tapes, 1 on each side
  - The tape adhesive must release from the back sheet without tearing, and permit a minimum of 3 fastening/unfastening cycles

✓ In addition pull-up pants and briefs must meet the following specifications:

- Be made like regular underwear with an:
  - Elastic waist.
  - Have at least 4 tapes, 2 on each side or 2 large tapes, one on each side.
- Have an absorbent core filler that is at least one-half inch from the elastic leg gathers
- Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling

- Have leg gathers that consist of at least 3 strands of elasticized materials
- Have a back sheet that is:
  - Moisture impervious, is at least 1.00 mm thick.
  - Designed to protect clothing and linens.
- Have an inner lining made of soft, absorbent material.
- Have a top sheet that resists moisture returning to the skin.

✓ In addition, underpads are covered only when used for clients with incontinence, and only when used for protection on a client's bed, and must meet the following specifications:

- Have an absorbent layer that is at least one and one-half inches from the edge of the underpad.
- Be manufactured with a waterproof backing material.
- Be able to withstand temperatures not to exceed 140 degrees Fahrenheit.
- Have a covering or facing sheet that is made of nonwoven, porous materials that have a high degree of permeability, allowing fluids to pass through and into the absorbent filler. The patient contact surface must be soft and durable.
- Have filler material that is highly absorbent. It must be heavy weight fluff filler or the equivalent.
- Have 4-ply, nonwoven facing, sealed on all 4 sides.

✓ In addition liners, shields, guards, pads, and undergarments are covered for incontinence only and must meet the following specifications:

- Have channels to direct fluid throughout the absorbent area, and leg gathers to assist in controlling leakage, and/or be contoured to permit a more comfortable fit.
- Have a waterproof backing designed to protect clothing and linens.
- Have an inner liner that resists moisture returning to the skin.

- Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials.
- Have pressure-sensitive tapes on the reverse side to fasten to underwear.
- For undergarments only, be contoured for a good fit, have at least 3 elastic leg gathers, and may be belted or unbelted.

✓ The agency pays for urological products when they are used alone. The following are examples of products in which the agency does not pay for when used in combination with:

- Disposable diapers.
- Disposable pull-up pants and briefs.
- Disposable liners, shields, guards, pads, and undergarments.
- Rented reusable diapers (e.g., from a diaper service).
- Rented reusable briefs (e.g., from a diaper service) or pull-up pants.

✓ The agency approves a client's use of a combination of products only when the client uses different products for daytime and nighttime use.

Example: Pull-up pants for daytime use and disposable diapers for nighttime use. The total quantity of all products in this section used in combination cannot exceed the monthly limitation for the product with the highest limit.

Note: Bill for only one size of diapers or pull-up pants per month. The agency does not pay for multiple sizes.

✓ Purchased disposable diapers (any size) are limited to 200 per month for clients age 3 and older.

- Reusable cloth diapers (any size) are limited to:
  - Purchased - 36 per year.
  - Rented - 200 per month.

✓ Disposable briefs and pull-up pants (any size) are limited to:

- 200 per month for a child age 3 to 20.
- 150 per month for an adult age 21 and older.

✓ Reusable briefs, washable protective underwear, or pull-up pants (any size) are limited to:

- Purchased - 4 per year.
- Rented - 150 per month.

- ✓ Disposable pant liners, shields, guards, pads, and undergarments are limited to 200 per month.

- ✓ Underpads for beds are limited to:

  - ➢ Disposable (any size) - 180 per month.
  - ➢ Purchased, reusable (large) - 42 per year.
  - ➢ Rented, reusable (large) - 90 per month.

Note: When billing the agency for incontinence products, the claim must be for a single date of service with at least 30 days in between claims.

Example: DOS 5/15/19-5/15/19 for the first claim, the next claim needs to be at least 6/14/19-6/14/19 (30 days in between DOS). If you are billing for a limit that is over the allowed amount, and you have authorization from HCA to exceed the limit, bill on two separate lines. One claim line for the allowed amount and one claim line for the exceeded limit. The claim line to exceed the limit must include the authorization number.

- ✓ Urological supplies - urinary retention:

  - ➢ Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube - 2 per month. The agency does not pay for these when billed in combination with any of the following:

    - ▪ With extension drainage tubing for use with urinary leg bag or urostomy pouch (any type, any length), with connector/adapter.

    - ▪ With an insertion tray with drainage bag, and with or without catheter.

  - ➢ Bedside drainage bottle, with or without tubing - 2 per 6 month period.

  - ➢ Extension drainage tubing (any type, any length), with connector/adapter, for use with urinary leg bag or urostomy pouch. The agency does not pay for these when billed in combination with a vinyl urinary leg bag, with or without tube.

  - ➢ External urethral clamp or compression device (not be used for catheter clamp) - 2 per 12-month period.

  - ➢ Indwelling catheters (any type) - 3 per month.

  - ➢ Insertion trays:

- Without drainage bag and catheter - 60 per month. The agency does not pay for these when billed in combination with other insertion trays that include drainage bag, catheters, and/or individual lubricant packets.

- With indwelling catheters - 3 per month - The agency does not pay for these when billed in combination with other insertion trays without drainage bag and/or indwelling catheter; individual indwelling catheters; and/or individual lubricant packets.

- Irrigation syringe (bulb or piston) - The agency does not pay for these when billed in combination with irrigation tray or tubing.

- Irrigation tray with syringe (bulb or piston) - 30 per month. The agency does not pay for these when billed in combination with an irrigation syringe (bulb or piston), or irrigation tubing set.

- Irrigation tubing set - 30 per month - The agency does not pay for these when billed in combination with an irrigation tray or an irrigation syringe (bulb or piston).

- Leg straps (latex foam and fabric) - Replacement only.

- Male external catheter, specialty type, or with adhesive coating or adhesive strip - 60 per month.

- Urinary suspensory with or without leg bag, with or without tube - 2 per month. The agency does not pay for these when billed in combination with:

  - Latex urinary.
  - Leg bag.
  - Urinary suspensory.
  - Without a leg bag.
  - Extension drainage tubing.
  - Leg strap.

- Urinary leg bag, vinyl, with or without tube - 2 per month - The agency does not pay for these when billed in combination with drainage bag and without catheter.

- Urinary leg bag, latex - 1 per month - The agency does not pay for these when billed in combination with or without catheter.

- Miscellaneous supplies:
  - ✓ Eye patch (adhesive wound cover) - 1 box of 20.
  - ✓ Sterile gloves – 30 pair, per client, per month.

- Miscellaneous MSE:
  - ✓ Bilirubin light or light pad - 5 day rental per 12-month period for at-home newborns with jaundice.

Coverage for Non-CRT Wheelchairs

(WAC 182-543-4000)

The agency covers, with prior authorization (PA), manual and power-drive wheelchairs for clients who reside at home.

> **Note:** For clients with complex needs and who require an individually configured complex rehabilitation technology (CRT) product, see the agency's Complex Rehabilitation Technology Billing Guide.

What are the general guidelines for wheelchairs?

For manual or power-drive wheelchairs for clients who reside at home, requests for PA must include all of the following completed forms:

- *General Information for Authorization* form, HCA 13-835, see Where can I download agency forms? (WAC 182-543-7000 Authorization)
- *Medical Necessity for Wheelchair Purchase (for home clients only)* form, HCA 19-0008 from the client's physician or therapist
- The agency's *Prescription* form, HCA 13-794

The agency does not pay for manual or power-drive wheelchairs that have been delivered to a client without PA from the agency, as described in this billing guide.

When the agency determines that a wheelchair is medically necessary, according to the process found in WAC 182-501-0165, for 6 months or less, the agency rents a wheelchair for clients who live at home.

> **Note:** For clients that do not live at home, see Clients Residing in a Skilled Nursing Facility.

Does the agency cover the rental or purchase of a manual wheelchair?

(WAC 182-543-4100)

The agency covers the rental or purchase of a manual wheelchair for clients who reside at home and are nonambulatory or who have limited mobility and requires a wheelchair to participate in normal daily activities.

> **Note:** For clients that do not live at home, see Clients Residing in a Skilled Nursing Facility.

The agency determines the type of manual wheelchair for a client residing at home as follows:

- A standard wheelchair if the client's medical condition requires the client to have a wheelchair to participate in normal daily activities

- A standard lightweight wheelchair if the client's medical condition does not allow the client to use standard weight wheelchair because of one of the following:

  - ✓ The client cannot self-propel a standard weight wheelchair.
  - ✓ Custom modifications cannot be provided on a standard weight wheelchair

- A high-strength lightweight wheelchair for a client who meets one of the following:

  - ✓ Whose medical condition doesn't allow the client to self-propel a lightweight or standard weight wheelchair

  - ✓ Requires custom modifications that cannot be provided on a standard weight or lightweight wheelchair

- A heavy duty wheelchair for a client who requires a specifically manufactured wheelchair designed to meet one of the following:

  - ✓ Support a person weighing 300 pounds and over

  - ✓ Accommodate a seat width up to 22 inches wide (not to be confused with custom heavy-duty wheelchairs)

- A custom heavy-duty wheelchair for a client who requires a specifically manufactured wheelchair designed to meet one of the following:

  - ✓ Support a person weighing 300 pounds and over

  - ✓ Accommodate a seat width over 22 inches wide

- A rigid wheelchair for a client who meets all of the following:

  ✓ Has a medical condition that involves severe upper extremity weakness
  ✓ Has a high level of activity
  ✓ Is unable to self-propel any of the above types of wheelchairs

- A custom manufactured wheelchair for a client with a medical condition requiring wheelchair customization that cannot be obtained on any of the categories of wheelchairs listed in this billing guide.

- Pediatric wheelchairs/positioning strollers having a narrower seat and shorter depths more suited to pediatric patients, usually adaptable to modifications for a growing child.

Does the agency cover power-drive wheelchairs?

(WAC 182-543-4200 (1)(2))

The agency covers power-drive wheelchairs when the prescribing physician certifies that all of the following clinical criteria are met:

- The client can independently and safely operate a power-drive wheelchair

- The client's medical condition negates his or her ability to self-propel any of the wheelchairs listed in the manual wheelchair category

- A power-drive wheelchair will do one of the following:

  ✓ Provide the client the only means of independent mobility
  ✓ Enable a child to achieve age-appropriate independence and developmental milestones

Note: All of the following additional information is required for a three or four-wheeled power-drive scooter/power-operated vehicle (POV):

- The prescribing physician certifies that the client's condition is stable.
- The client is unlikely to require a standard power-drive wheelchair within the next two years.

What are the guidelines for clients with multiple wheelchairs?

(WAC 182-543-4200(3)-(6))

When the agency approves a power-drive wheelchair for a client who already has a manual wheelchair, the power-drive wheelchair becomes the client's primary chair, unless the client meets the criteria for dual wheelchairs.

The agency pays to maintain only the client's primary wheelchair, unless the agency approves both a manual wheelchair and a power-drive wheelchair for a noninstitutionalized client.

The agency pays for one manual wheelchair and one power-drive wheelchair for noninstitutionalized clients only when one of the following circumstances applies:

- The architecture of the client's home is completely unsuitable for a power-drive wheelchair, such as narrow hallways, narrow doorways, steps at the entryway, and insufficient turning radius

- The architecture of the client's home bathroom is such that power-drive wheelchair access is not possible, and the client needs a manual wheelchair to safely and successfully complete bathroom activities and maintain personal cleanliness

- The client has a power-drive wheelchair, but also requires a manual wheelchair because the power-drive wheelchair cannot be transported to meet the client's community, workplace, or educational activities. In this case, the manual wheelchair would allow the caregiver to transport the client in a standard automobile or van. The agency requires the client's situation to meet both of the following conditions:

  - ✓ The client's activities that require the second wheelchair must be located farther than one-fourth of a mile from the client's home.

  - ✓ Cabulance, public buses, or personal transit are not available, practical, or possible for financial or other reasons.

Note: When the agency approves both a manual wheelchair and a power-drive wheelchair for a noninstitutionalized client who meets one of the criteria for dual wheelchairs, the agency will pay to maintain both wheelchairs.

Modifications, Accessories, and Repairs for Non-CRT Wheelchairs

(WAC 182-543-4300)

What are the requirements for modifications, accessories, and repairs to noncomplex rehabilitation technology (CRT) wheelchairs?

The agency covers wheelchair accessories and modifications that are specifically identified by the manufacturer as separate line item charges. Prior authorization is required. To receive payment, providers must submit all of the following to the agency:

- A completed *General Information for Authorization* form, HCA 13-835, see Where can I download agency forms? (WAC 182-543-7000 Authorization)
- A completed *Prescription* form, HCA 13-794
- A completed *Medical Necessity for Wheelchair Purchase (for home clients only)* form, HCA 19-0008
- The make, model, and serial number of the wheelchair to be modified
- The modification requested
- Any specific information regarding the client's medical condition that necessitates the modification

Note: The date on the *Medical Necessity for Wheelchair Purchase (for home clients only)* form, HCA 19-0008, must not be dated prior to the date on the *Prescription* form, HCA 13-794.

Note: All wheelchairs and wheelchair rentals require prior authorization. Rental rates are monthly unless otherwise indicated.

DC = Same/similar covered code in fee schedule
DP = Service managed through a different program
N = New
P = Policy change
PA = Prior Authorization Required

When does the agency pay for transit option restraints?

The agency pays for transit option restraints only when used for client-owned vehicles.

When does the agency cover non-CRT wheelchair repairs?

The agency covers non-CRT wheelchair repairs. Prior authorization is required. To receive payment, providers must submit all of the following to the agency:

- *General Information for Authorization* form, HCA 13-835, see Where can I download agency forms? (see Authorization for more information)
- A completed *Medical Necessity for Wheelchair Purchase (for home clients only)* form, HCA 19-0008
- The make, model, and serial number of the wheelchair to be repaired
- The repair requested

Note: PA is required for the repair and modification of client-owned equipment.

Note: All wheelchairs and wheelchair rentals require prior authorization. Rental rates are monthly unless otherwise indicated.

DC = Same/similar covered code in fee schedule
DP = Service managed through a different program
N = New
P = Policy change
PA = Prior Authorization Required

Clients Residing in a Skilled Nursing Facility

(WAC 182-543-5700)

What does the per diem rate include for a skilled nursing facility?

The agency's skilled nursing facility per diem rate, established in chapter 74.46 RCW, chapter 388-96 WAC, and chapter 388-97 WAC, includes any reusable and disposable medical supplies that may be required for a skilled nursing facility client, unless otherwise specified within this billing guide.

The agency pays for the following covered medical equipment and related supplies outside of the skilled nursing facility per diem rate, subject to the limitations in this billing guide:

- Wheelchairs
- Speech generating devices (SGD)
- Specialty beds

Manual and power-drive wheelchairs

(WAC 182-543-5700(2))

The agency pays for one manual or one power-drive wheelchair for clients who reside in a skilled nursing facility, with prior authorization (PA), according to the requirements in WAC 182-543-4100, WAC 182-543-4200, and WAC 182-543-4300.

Requests for PA must meet all of the following:

- Be for the exclusive full-time use of a skilled nursing facility resident
- Not be included in the skilled nursing facility's per diem rate
- Include a completed *General Information for Authorization* form, HCA 13-835; see Where can I download agency forms?
- Include a copy of the telephone order, signed by the physician, for the wheelchair assessment
- Include a completed *Medical Necessity for Wheelchair Purchase for Nursing Facility Clients* form, HCA 19-0006

The agency pays for wheelchair accessories and modifications that are specifically identified by the manufacturer as separate line item charges, with prior authorization (PA). To receive payment, providers must submit all of the following to the agency:

- A completed *Prescription* form, HCA 13-794, see Where can I download agency forms?
- A completed *Medical Necessity for Wheelchair Purchase for Nursing Facility Clients* form, HCA 19-0006. The date on form 19-0006 must not be prior to the date on the *Prescription* form, HCA 13-794 (see Authorization for more information)
- The make, model, and serial number of the wheelchair to be modified
- The modification requested.
- Specific information regarding the client's medical condition that necessitates modification to the wheelchair

The agency pays for wheelchair repairs, with PA. To receive payment, providers must submit all of the following to the agency:

- A completed *Medical Necessity for Wheelchair Purchase for Nursing Facility (NF) Clients* form, HCA 19-0006. See WAC 182-543-7000, Authorization
- The make, model, and serial number of the wheelchair to be repaired
- The repair requested

PA is required for the repair and modification of client-owned equipment.

The skilled nursing facility must provide a house wheelchair as part of the per diem rate, when the client resides in a skilled nursing facility.

When the client is eligible for both Medicare and Medicaid and is residing in a skilled nursing facility in lieu of hospitalization, the agency does not reimburse for medical equipment and related supplies, prosthetics, orthotics, medical supplies, related services, and related repairs and labor charges under fee-for-service (FFS).

Speech generating devices (SGD)

(WAC 182-543-5700(2))

The agency pays for the purchase and repair of a speech generating device (SGD), with PA. The agency pays for replacement batteries for SGDs in accordance with WAC 182-543-5500(3).

Specialty beds

(WAC 182-543-5700(2))

The agency pays for the purchase or rental of a specialty bed (a heavy-duty bariatric bed is not a specialty bed) when both of the following apply. Prior authorization is required.

- The specialty bed is intended to help the client heal.
- The client's nutrition and laboratory values are within normal limits.

The agency considers decubitus care products to be included in the skilled nursing facility per diem rate and does not reimburse for these separately. (See Warranty for more information.)

What does the agency pay for outside the per diem rate?

(WAC 182-543-5700(13))

The agency pays for the following medical supplies for a client in a skilled nursing facility outside the skilled nursing facility per diem rate:

- Medical supplies or services that replace all or parts of the function of a permanently impaired or malfunctioning internal body organ

  This includes, but is not limited to the following:

  - ✓ Colostomy and other ostomy bags and necessary supplies. (see WAC 388-97-1060(3), nursing homes/quality of care)
  - ✓ Urinary retention catheters, tubes, and bags, excluding irrigation supplies.
- Supplies for intermittent catheterization programs, for the following purposes:
  - ✓ Long term treatment of atonic bladder with a large capacity
  - ✓ Short term management for temporary bladder atony
- Surgical dressings required as a result of a surgical procedure, for up to six weeks post-surgery

Exception to Rule

What is an exception to rule (ETR)?

The agency evaluates a request for any medical equipment, related supplies, and related services under the provisions of WAC 182-501-0160.

When 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.
- Not experimental (see to the agency's current Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Billing Guide for more information).

How do I request an exception to rule (ETR)?

Requests for ETR may be submitted online through direct data entry into the ProviderOne system or in writing to the fax number located on the agency's form and include all of the following:

- A completed *General Information for Authorization*, HCA 13-835 form, see Where can I download agency forms?

- A completed *Prescription*, HCA 13-794, form

A letter explaining how the client's situation meets the provisions of WAC 182-501-0160.

Authorization

What is authorization?

(WAC 182-543-7000)

Authorization 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. **Prior authorization (PA), expedited prior authorization (EPA) and limitation extensions (LE) are forms of authorization.**

The agency requires providers to obtain authorization for covered medical equipment and related supplies as follows:

- As described in this billing guide
- As described in chapter 182-501 WAC, chapter 182-502 WAC, and chapter 182-543 WAC
- When the clinical criteria required in this billing guide are not met

What is prior authorization (PA)?

(WAC 182-543-7100)

The agency requires providers to obtain PA for certain items and services before delivering that item or service to the client, except for dual-eligible Medicare/Medicaid clients when Medicare is the primary payer. The item or service must also be delivered to the client before the provider bills the agency.

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

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

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

When the agency receives the initial request for PA, the prescription(s) for those items or services must not be older than six months from the date the agency receives the request.

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

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

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

The agency considers requests for new medical equipment and related supplies that do not have assigned health care common procedure coding system (HCPCS) codes, and are not listed in this billing guide. These items require PA.

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

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

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

- Why the existing equipment no longer meets the client's medical needs

OR

- Why the existing equipment could not be repaired or modified to meet those medical needs

AND

- Upon request, documentation showing how the client's condition met the criteria for PA or EPA

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

How do I request prior authorization (PA)?

When a procedure's EPA criteria has not been met or the covered procedure requires PA, providers must request prior authorization from the agency. Procedures that require PA are listed in the fee schedule. The agency does not retrospectively authorize any health care services that require PA after they have been provided except when a client has delayed certification of eligibility.

Online direct data entry into ProviderOne

Providers may submit a prior authorization request by direct data entry into ProviderOne or by submitting the request in writing (see the agency's prior authorization webpage for details).

Written or Fax

If providers choose to submit a written or faxed PA request, the following must be provided:

- The *General Information for Authorization* form, HCA 13-835. See Where can I download agency forms? This form must be page one of the mailed/faxed request and must be typed.
- The program form. This form must be attached to the request.
- Charts and justification to support the request for authorization.

Submit written or faxed PA requests (with forms and documentation) to:

- **By Fax:** (866) 668-1214
- **By Mail:**
  Authorization Services Office
  PO Box 45535
  Olympia, WA 98504-5535

All requests for PA must be accompanied by a completed *General Information for Authorization* form, HCA 13-835 in addition to any program specific agency forms as required within this section. See Where can I download agency forms?

> **Note:** Applicable forms may be downloaded from the agency's Billers and Providers webpage.

For expedited prior authorization (EPA), a client must meet the clinically appropriate EPA criteria outlined within this billing guide. The appropriate EPA number must be used when the provider bills the agency (see What is expedited prior authorization (EPA)?).

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

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

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

Authorization requirements in this billing guide are not a denial of service to the client. The agency may recoup any payment made to a provider if the agency later determines that the service was not properly authorized or did not meet the EPA criteria. See WAC 182-502-0100(1)(c).

How are photos and X-rays submitted for medical and medical equipment requests?

For submitting photos and X-rays for medical and medical equipment PA requests, use the FastLook™ and FastAttach™ services provided by Vyne Medical.

Register with Vyne Medical through their website.

Contact Vyne Medical at 865-293-4111 with any questions.

When this option is chosen, fax the request to the agency and indicate the MEA# in box 18 on the *General Information for Authorization* (HCA 13-835) form. **There is an associated cost, which will be explained by the MEA services.**

> **Note:** See the agency ProviderOne Billing and Resource Guide and review the Prior Authorization (PA) chapter for more information on requesting authorization.

What is expedited prior authorization (EPA)?

(WAC 182-543-7300)

The expedited prior authorization (EPA) process is designed to eliminate the need for written or telephone requests for prior authorization for selected medical equipment procedure codes.

The agency requires a provider to create an authorization number for EPA for selected medical equipment procedure codes. The process and criteria used to create the authorization number is explained within this billing guide. The authorization number must be used when the provider bills the agency.

Upon request, a provider must provide documentation to the agency showing how the client's condition met the criteria for EPA.

Prior authorization is required when a situation does not meet the EPA criteria for medical equipment procedure codes. See the agency's Prior authorization webpage for details.

The agency may recoup any payment made to a provider if the provider did not follow the required expedited authorization process and criteria.

To bill the agency for medical equipment that meets the EPA criteria on the following pages, the vendor must create a 9-digit EPA number. The first five or six digits of the EPA number will be 870000 or 87000**.** The last three or four digits is the specific code which meets the EPA criteria. HIPAA 5010 does not allow multiple authorization (prior/expedited) numbers per claim. If billing an electronic claim, enter the EPA at the claim level in the *Prior Authorization* section.

Vendors are reminded that EPA numbers are only for those products listed on the following pages. EPA numbers are not valid for:

- Other medical equipment requiring PA.
- Products for which the documented medical condition does not meet ***all*** of the specified criteria.
- Over-limitation requests.

Providers must request prior authorization when a situation does not meet the criteria for a selected medical equipment code. See the agency's Prior authorization webpage for details.

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

.

What is a limitation extension (LE)?

(WAC 182-543-7200)

The agency limits the amount, frequency, or duration of certain covered ME, and related supplies, and reimburses up to the stated limit without requiring prior authorization (PA).

Certain covered items have limitations on quantity and frequency. These limits are designed to avoid the need for PA for items normally considered medically necessary and for quantities sufficient for a thirty-day supply for one client.

The agency requires a provider to request PA for a limitation extension (LE) in order to exceed the stated limits for ME, and medical supplies. See the agency's Prior authorization webpage for details.

The agency evaluates requests for LE under the provisions of WAC 182-501-0169.

EPA Criteria Coding List

What are the expedited prior authorization (EPA) criteria for equipment rental?

Note: The following pertains to expedited prior authorization (EPA) numbers 700 - 820:

1. If the medical condition does not meet **all** of the specified criteria, prior authorization (PA) must be obtained. See the agency's Prior authorization webpage for details.

2. It is the vendor's responsibility to determine whether the client has already used the product allowed with the EPA criteria within the allowed time period, or to determine if, the client has already established EPA through another vendor during the specified time period.

3. For extension of authorization beyond the EPA amount allowed, the normal PA process is required.

4. A valid physician prescription is required as described in WAC 182-543-2000(2)(c))

5. Documentation of the length of need/life expectancy must be kept in the client's file, as determined by the prescribing physician and medical justification (including **all** of the specified criteria).

RENTAL MANUAL WHEELCHAIRS				
Codes	**Modifier**	**EPA Code**	**Description**	**Criteria**
K0001	RR	700	Standard manual wheelchair with all styles of arms, footrest and/or leg rests	Up to 2 months continuous rental in a 12-month period if ***all*** of the following criteria are met. The client: 1) Weights 250 lbs. or less. 2) Requires a wheelchair to participate in normal daily activities. 3) Has a medical condition that renders the client totally non-weight bearing or is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file). 4) Does ***not*** have a rental hospital bed. 5) Has a length of need, as determined by the prescribing physician that is less than 6 months.
K0003	RR	705	Lightweight manual wheelchair with all styles of arms, footrests and/or leg rests	Up to 2 months continuous rental in a 12-month period if ***all*** of the following criteria are met. The client: 1) Weights 250 lbs. or less. 2) Can self-propel the lightweight wheelchair and is unable to propel a standard weight wheelchair. 3) Has a medical condition that renders the client totally non-weight bearing or is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file). 4) Does ***not*** have a rental hospital bed. 5) Has a length of need, as determined by the prescribing physician that is less than 6 months.
K0006	RR	710	Heavy-duty manual wheelchair with all styles of arms, footrests, and/or leg rests	Up to 2 months continuous rental in a 12-month period if ***all*** of the following criteria are met. The client: 1) Weights over 250 lbs. 2) Requires a wheelchair to participate in normal daily activities. 3) Has a medical condition that renders the client totally non-weight bearing or is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file). 4) Does ***not*** have a rental hospital bed. 5) Has a length of need, as determined by the prescribing physician that is less than 6 months

RENTAL MANUAL WHEELCHAIRS				
Codes	**Modifier**	**EPA Code**	**Description**	**Criteria**
E1060	RR	715	Fully reclining manual wheelchair with detachable arms, desk or full-length and swing-away or elevating leg rests	Up to 2 months continuous rental in a 12-month period if ***all*** of the following criteria are met. The client: 1) Requires a wheelchair to participate in normal daily activities and is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file). 2) Has a medical conditions that does not allow them to sit upright in a standard or lightweight wheelchair (must be documented). 3) Does ***not*** have a rental hospital bed. 4) Has a length of need, as determined by the prescribing physician that is less than 6 months.

Note for Rental Manual Wheelchairs

1) The EPA rental is allowed only one time, per client, per 12-month period.

2) If the client is hospitalized or is a resident of a nursing facility and is being discharged to a home setting, rental may not start until the date of discharge. Documentation of the date of discharge must be included in the client's file. Rentals for clients in a skilled nursing facility are included in the nursing facility daily rate. Rentals in the hospital are included in the Diagnoses Related Group (DRG) payment.

3) The agency does not rent equipment during the time that a request for similar purchased equipment is being assessed, when authorized equipment is on order or while the client-owned equipment is being repaired and/or modified. The vendor of service is expected to supply the client with an equivalent loaner.

4) You may bill for only one procedure code, per client, per month.

5) All accessories are included in the reimbursement of the wheelchair rental code. They may not be billed separately.

RENTAL/PURCHASE HOSPITAL BEDS				
Codes	**Modifier**	**EPA Code**	**Description**	**Criteria**
E0292 E0310 E0305	RR	720	Manual hospital bed with mattress with or without bed rails	The client: 1) Has a length of need/life expectancy that is 12 months or less. 2) Has a medical conditional that requires positioning of the body that cannot be accomplished in a standard bed (reason must be documented in the client's file). 3) Has tried pillows, bolsters, and/or rolled up blankets/towels in client's own bed, and determined to not be effective in meeting client's positioning needs (nature of ineffectiveness must be documented in the client's file). 4) Has a medical condition that necessitates upper body positioning at no less than a 30-degree angle the majority of time the client is in the bed. 5) Has full-time caregivers. 6) Does ***not*** also have a rental wheelchair.
E0294 E0310 E0305	RR	725	Semi-electric hospital bed with mattress with or without bed rails	Up to 11 months continuous rental in a 12-month period if ***all*** of the following criteria are met. The client: 1) Has a length of need/life expectancy that is 12 months or less. 2) Has tried pillows, bolsters, and/or rolled up blankets/towels in own bed, and determined ineffective in meeting positioning needs (nature of ineffectiveness must be documented in the client's file). 3) Has a chronic or terminal condition such as COPD, CHF, lung cancer or cancer that has metastasized to the lungs, or other pulmonary conditions that cause the need for immediate upper body elevation. 4) Must be able to independently and safely operate the bed controls. 5) Does ***not*** have a rental wheelchair. 6) Has a completed *Hospital Bed Evaluation* form, HCA 13-747. See Where can I download agency forms?

Note for rental of manual or semi-electric hospital bed:

1) The EPA rental is allowed only one time, per client, per 12-month period.

2) Authorization must be requested for the 12th month of rental, at which time the equipment will be considered purchased. The authorization number will be pended for the serial number of the equipment. In such cases, the equipment the client has been using must have been new on or after the start of the rental contract or is documented to be in good working condition. A 1-year warranty will take effect as of the date the equipment is considered purchased if equipment is not new. Otherwise, normal manufacturer warranty will be applied.

3) If length of need is greater than 12 months, as stated by the prescribing physician, a PA for purchase must be requested.

4) If the client is hospitalized or is a resident of a nursing facility and is being discharged to a home setting, rental may not start until the date of discharge. Documentation of the date of discharge must be included in the client's file. Rentals for clients in a skilled nursing facility are included in the nursing facility daily rate. Rentals in the hospital are included in the DRG payment.

5) The agency does not rent equipment during the time that a request for similar purchased equipment is being assessed, when authorized equipment is on order or while the client-owned equipment is being repaired and/or modified. The vendor o service is expected to supply the client with an equivalent loaner.

6) Hospital beds *will not* be provided:

   a) As furniture.
   b) To replace a client-owned waterbed.
   c) For a client who does not own a standard bed with mattress, box spring, and frame.
   d) If the client's standard bed is in an area of the home that is currently inaccessible by the client such as an upstairs bedroom.

7) Only one type of bed rail is allowed with each rental.

8) Mattress may *not* be billed separately.

Codes	Modifier	EPA Code	Description	Criteria
E0294	NU	726	Semi-electric hospital bed with mattress with or without bed rails	Initial purchase if ***all*** of the following criteria are met. The client: 1) Has a length of need/life expectancy that is 12 months or more. 2) Has tried positioning devices such as pillows, bolsters, foam wedges and/or rolled up blankets/towels in own bed, and been determined ineffective in meeting positioning needs (nature of ineffectiveness must be documented in the client's file). 3) Has of one of the following diagnoses: a. Quadriplegia b. Tetraplegia c. Duchenne's M.D. d. ALS e. Ventilator dependent f. COPD or CHF with aspiration risk or shortness of breath that causes the need for immediate position change or more than 30 degrees. 4) Must be able to independently and safely operate the bed controls. **Documentation Required:** 1) Life expectancy, in months and/or years. 2) Client diagnosis including ICD code. 3) Date of delivery and serial number. 4) Written documentation indicating client has not been previously provided a hospital bed, purchase, or rental (i.e. written statement from client or caregiver). 5) A completed *Hospital Bed Evaluation* form, HCA 13-747. See Where can I download agency forms?

Note for purchase of manual or semi-electric hospital bed:

The EPA criteria is to be used only for an initial purchase per client, per lifetime. It is not to be used for a replacement or if EPA rental has been used within the previous 24 months.

1) It is the vendor's responsibility to determine if the client has not been previously provided a hospital bed, either purchase or rental.
2) Hospital beds ***will not*** be covered:
   a. As furniture
   b. To replace a client-owned waterbed
   c. For a client who does not own a standard bed with mattress, box spring and frame
   d. If the client's standard bed is in an area of the home that is currently inaccessible by the client such as an upstairs bedroom.

LOW AIR LOSS THERAPY SYSTEMS				
Codes	**Modifier**	**EPA Code**	**Description**	**Criteria**
E0371 E0372	RR	730	Low air loss mattress overlay	Initial 30-day rental followed by one additional 30-day rental in a 12-month period if ***all*** of the following criteria are met. The client: 1) Is bed-confined 20 hours per day during rental of therapy system. 2) Has at least one stage 3 decubitus ulcer on trunk of body. 3) Has acceptable turning and repositioning schedule. 4) Has timely labs (every 30 days). 5) Has appropriate nutritional program to heal ulcers.
E0277 E0373	RR	735	Low air loss mattress without bed frame	Initial 30-day rental followed by an additional 30 days rental in a 12-month period if ***all*** of the following criteria are met. The client: 1) Is bed-confined 20 hours per day during rental of therapy system. 2) Has multiple stage 3/4 decubitus ulcers or one stage 3/4 with multiple stage 2 decubitus ulcers on trunk of body. 3) Has ulcers on more than one turning side. 4) Has acceptable turning and repositioning schedule. 5) Has timely labs (every 30 days). 6) Has appropriate nutritional program to heal ulcers.
		740	Low air loss mattress without bed frame	Initial 30-day rental in a 12-month period upon hospital discharge following a flap surgery.
E0194	RR	750	Air fluidized flotation system including bed frame	Initial 30-day rental in a 12-month period upon hospital discharge following a flap surgery. **For All Low Air Loss Therapy Systems Documentation Required:** 1) A *Low Air-Loss Therapy Systems* form, HCA 13-728, must be completed for each rental segment and signed and dated by nursing staff in facility or client's home. See Where can I download agency forms? 2) A new form must be completed for each rental segment. 3) A re-dated prior form will not be accepted. 4) A dated picture must accompany each form.

Note: The EPA rental is allowed only one time, per client, per 12-month period.

NONINVASIVE BONE GROWTH/NERVE STIMULATORS				
Codes	**Modifier**	**EPA Code**	**Description**	**Criteria**
E0747 E0760	NU	765	Non-spinal bone growth stimulator	Allowed ***only*** for purchase of brands that have pulsed electromagnetic field simulation (PEMF) when one or more of the following criteria is met. The client: 1) Has a nonunion of a long bone fracture (which includes clavicle, humerus, phalanges, radius, ulna, femur, tibia, fibula, metacarpal and metatarsal) after 6 months has elapsed since the date of injury without healing. 2) Has a failed fusion of a joint other than in the spine where a minimum of 6 months has elapsed since the last surgery.
E0748	NU	770	Spinal bone growth stimulator	Allowed for purchase when the prescription is from a neurologist, an orthopedic surgeon, or a neurosurgeon and when one or more of the following criteria is met. The client: 1) Has a failed spinal fusion where a minimum of 9 months has elapsed since the last surgery. 2) Is post-op from a multilevel spinal fusion surgery. 3) Is post-op from spinal fusion surgery where there is a history of a previously failed spinal fusion.

Note: The EPA rental is allowed only one time, per client, per 12-month period.

MISCELLANEOUS MEDICAL EQUIPMENT				
Codes	**Modifier**	**EPA Code**	**Description**	**Criteria**
E0604	RR	800	Breast pump, electric	Unit may be rented for the following lengths of time and when the criteria are met. The client: 1) Has a maximum of 2 weeks during any 12-month period for engorged breasts. 2) Has a maximum of 3 weeks during any 12-month period if the client is on a regimen of antibiotics for a breast infection. 3) Has a maximum of 2 months during any 12-month period if the client has a newborn with a cleft palate. 4) Has a maximum of 2 months during any 12-month period if the client meets ***all*** of the following: a. Has a hospitalized premature newborn. b. Has been discharged from the hospital. c. Is taking breast milk to hospital to feed newborn.
E0935	RR	810	Continuous passive motion system (CPM)	Up to 10 days rental during any 12-month period, upon hospital discharge, when the client is diagnosed with one of the following: 1) Frozen joints 2) Intra-articular tibia plateau fracture 3) Anterior cruciate ligament injury 4) Total knee replacement
E0650	RR	820	Extremity pump	Up to 2 months rental during a 12-month period for treatment of severe edema. Purchase of the equipment should be requested and rental not allowed when equipment has been determined to be all of the following: 1) Medically effective 2) Medically necessary 3) A long-term, permanent need

Codes	Modifier	EPA Code	Description	Criteria
A4253 A4259		1263	Blood glucose test strips/lancets	For pregnant people with gestational diabetes, the agency pays for the quantity necessary to support testing as directed by the client's physician, up to 60 days postpartum.
		1265	Blood glucose test strips/lancets for children through age 20	100 over limit – for children only
A4927		1262	Additional gloves for clients who live in an assisted living facility	Will be allowed up to the quantity necessary as directed by the client's physician, not to exceed a total of 400 per month. Allowed for Place of Service 13 (assisted living and adult family home) and 14 (group home).
A4335		851	Incontinence supply, use for diaper doublers, each (age 3 and older)	Purchase of 90 per month allowed when the product is both: 1) Used for extra absorbency at nighttime only. 2) Prescribed by a physician.
		852	Incontinence supply, use for diaper doublers, each (age 3 and older)	Up to equal amount of diapers/briefs received if ***one*** of the following criteria for clients is met: 1) Tube fed 2) On diuretics or other medication that causes frequent/large amounts of output 3) Brittle diabetic with blood sugar problems

Billing

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

What are the general billing requirements?

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

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

What billing requirements are specific to medical equipment?

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

The agency does not pay a medical equipment provider for medical supplies used in conjunction with a physician office visit. The agency pays for these supplies when it is appropriate. See the agency's current Physician-Related Services/Health Care Professional Services Billing Guide.

How does a provider bill for a managed care client?

(WAC 182-543-8100)

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

- The agency stops paying for any rented equipment on the last day of the month preceding the month in which the client becomes enrolled in the MCO.

- The MCO determines the client's continuing need for the equipment and is responsible for paying the provider.
- A client may become an MCO enrollee before the agency completes the purchase of the prescribed medical equipment. The agency considers the purchase complete when the product is delivered and the agency is notified of the serial number. If the client becomes an MCO enrollee before the agency completes the purchase, the following occur:

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

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

  - ✓ The MCO's applicable reimbursement policies apply to the purchase or rental of the equipment.

- A client may be disenrolled from an MCO and placed into fee-for-service before the MCO completes the purchase of prescribed medical equipment.

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

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

  - ✓ The agency's applicable reimbursement policies apply to the purchase or rental of the equipment.

How does a provider bill for clients eligible for Medicare and Medicaid?

(WAC 182-543-8200)

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

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

What is included in the rate?

(WAC 182-543-9000(8))

The agency's payment rate for purchased or rented covered medical equipment, related supplies, and related services include:

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

- Fitting and/or set-up.
- Instruction to the client or client's caregiver in the appropriate use of the equipment, device, and/or supplies.

Where can I find the fee schedules for medical equipment and supplies?

See the agency's fee schedule.

Where can the agency's required forms be found?

The following forms can be downloaded from the agency's forms webpage:

- *Negative Pressure Wound Therapy* form, HCA 13-726
- *Medical Necessity for Wheelchair Purchase (for home client only)* form, HCA 19-0008
- *Low Air-Loss Therapy Systems* form, HCA 13-728
- *Medical Necessity for Wheelchair Purchase for Nursing Facilities (NF) Clients* form, HCA 19-0006
- *Hospital Bed Evaluation* form, HCA 13-747
- *Bathroom Equipment* form, HCA 13-872
- *Compression Garments* form, HCA 13-871
- *Speech Language Pathologist (SLP) Evaluation for Speech Generating Devices* form, HCA 15-310

How do I bill claims electronically?

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

The following claim instructions relate to medical equipment providers:

Name	Entry
Place of Service	These are the only appropriate code(s) for this billing guide: **Code** **To Be Used For** 12 Client's residence 13 Assisted living facility 14 Group home 32 Nursing facility 31 Skilled nursing facility 99 Other

Warranty

When do I need to make warranty information available?

(WAC 182-543-9000(13))

You must make all of the following warranty information available to the agency upon request:

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

When is the dispensing provider responsible for costs?

(WAC 182-543-9000(14))

The dispensing provider who furnishes the equipment, supply or device to a client is responsible for any costs incurred to have a different provider repair the equipment when all of the following apply:

- Any equipment that the agency considers purchased requires repair during the applicable warranty period.
- The provider refuses or is unable to fulfill the warranty.
- The equipment, supply or device continues to be medically necessary.

If the rental equipment, supply, or device must be replaced during the warranty period, the agency recoups 50% of the total amount previously paid toward rental and eventual purchase of the equipment, supply or device delivered to the client when both of the following occur:

- The provider is unwilling or unable to fulfill the warranty.
- The equipment, supply or device continues to be medically necessary.

MINIMUM WARRANTY PERIODS	
Wheelchair Frames (Purchased New) and Wheelchair Parts	**Warranty**
Powerdrive **(depending on model)**	1 year - lifetime
Ultralight	Lifetime
Active Duty Lightweight **(depending on model)**	5 years - lifetime
All Others	1 year
Electrical Components	**Warranty**
All electrical components whether new or replacement parts including batteries	6 months - 1 year
Medical Equipment	**Warranty**
All other medical equipment not specified above (excludes disposable/non-reusable supplies)	1 year