Notice: We launched a new web site. As a result, past versions of the billing guide, such as this one, have broken hyperlinks. Please review the current guide for the correct hyperlinks.
About this guide*

This publication takes effect May 1, 2015, and supersedes earlier guides to this program.

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?

<table>
<thead>
<tr>
<th>Subject</th>
<th>Change</th>
<th>Reason for Change</th>
</tr>
</thead>
<tbody>
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<td>Added HCPCS code E0776 for IV poles</td>
<td>This item has been covered under various miscellaneous codes. Using this code will allow the agency to track usage.</td>
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</tbody>
</table>

How can I get agency provider documents?

To download and print agency provider notices and provider guides, go to the agency’s Provider Publications website.

Additional resources

To download and print agency provider notices and provider guides, see the agency’s Provider Publications website. For additional resources, see the agency’s online list of Resources Available.

* This publication is a billing instruction.
Complex Rehabilitation Technology (CRT)
Products and Related-Services

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**Alert!** The page numbers in this table of contents are “clickable”— hover over on a page number and click to go directly to the page. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks on the left side of the document. (If you don’t see the bookmarks, right click on the document and select Navigation Pane Buttons. Click on the bookmark icon on the left of the document.)
Definitions

This list defines terms and abbreviations, including acronyms, used in this guide. See the agency’s Washington Apple Health Glossary for a more complete list of definitions.

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

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

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

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

(1) Are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities as medically necessary to prevent hospitalization or institutionalization of a complex needs patient.

(2) Are primarily used to serve a medical purpose and generally not useful to a person in the absence of an illness or injury.

(3) Require certain services to allow for appropriate design, configuration, and use of such item, including patient evaluation and equipment fitting and configuration. (WAC 182-543-1000)

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

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

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

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


Medically necessary – See WAC 182-500-0070.
**Power-drive wheelchair** – See “Wheelchair – Power.”

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

**Prior authorization** – See WAC 182-500-0085.

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

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

6. Provides written information to the complex needs patient at the time of delivery about how the individual may receive service and repair. (WAC 182-543-1000)

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

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

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

- **Standard:**
  - Usually is not capable of being modified
  - Accommodates a person weighing up to 250 pounds
  - Has a warranty period of 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
Complex Rehabilitation Technology (CRT) Products and Related Services

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

- **Custom manufactured specially built**:
  - Ordered for a specific client form custom measurements
  - Is assembled primarily at the manufacturer’s facility (WAC 182-543-1000)

- **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.

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

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

- **Heavy duty** meets one of the following:
  - Is specifically manufactured to support a person weighing up to 300 pounds
  - Accommodates a seat width of up to 22” wide (not to be confused with custom manufactured wheelchairs)

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

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

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

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

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

- **Heavy duty** meets one of the following:
  - Is specifically manufactured to support a person weighing up to 300 pounds
  - Accommodates a seat width of up to 22” wide (not to be confused with custom manufactured wheelchairs)

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

What is the purpose of this provider guide?

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

Note: For clients who require a wheelchair but who do not meet the agency’s requirements in this provider guide for an individually configured CRT product, see the agency’s DME/Non-CRT Wheelchairs Provider Guide.

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

(WAC 182-543-0500)

The agency covers complex rehabilitation technology (CRT) products and related services according to agency rules and subject to the limitations and requirements within this guide.

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

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

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

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

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

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

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

The agency evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational as defined by WAC 182-531-0050, under the provisions of WAC 182-501-0165 which relate to medical necessity.
Does the agency follow the National Correct Coding Initiative (NCCI) policy?

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

The agency bases coding policies on the following:

- National and local policies and edits
- Coding guidelines developed by national professional societies
- The analysis and review of standard medical and surgical practices
- Review of current coding practices

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

How can I verify a patient’s eligibility?

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client’s benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

To verify eligibility, follow this two-step process:

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

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

**Step 2.** **Verify service coverage under the Washington Apple Health client’s benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client’s benefit package, see the agency’s *Scope of Categories of Service Table*.

**Note:** Patients who wish to apply for Washington Apple Health can do so in one of the following ways:

1. By visiting the Washington Healthplanfinder’s website at: www.wahealthplanfinder.org
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to: Washington Healthplanfinder PO Box 946 Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.
Are clients enrolled in an agency-contracted managed care organization (MCO) eligible?

Yes! When verifying eligibility using ProviderOne, if the client is enrolled in an agency managed care organization (MCO), managed care enrollment will be displayed on the Client Benefit Inquiry screen. All services must be requested directly through the client’s Primary Care Provider (PCP). Clients can contact their MCO by calling the telephone number provided to them.

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

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

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

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

Are clients enrolled in primary care case management (PCCM) eligible?

For the client who has chosen to obtain care with a PCCM provider, this information will be displayed on the Client Benefit Inquiry screen in ProviderOne. These clients must obtain or be referred for services via a PCCM provider. The PCCM provider is responsible for coordination of care just like the PCP would be in a plan setting.

**Note:** To prevent billing denials, please 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 PCCM provider. See the agency’s ProviderOne Billing and Resource Guide for instructions on how to verify a client’s eligibility.
What if a client has third-party liability (TPL)?

If the client has TPL coverage (excluding Medicare), prior authorization must be obtained before providing any service requiring prior authorization.
Provider/Manufacturer Information

Who is eligible to provide CRT products and related services?

(WAC 182-543-4400)

To be eligible to provide complex rehabilitation technology products (CRT) and related services on a fee-for-service basis to clients, providers must:

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

The client must be evaluated by a licensed health care provider who performs specialty evaluations within that provider’s scope of practice (occupational or physical therapists) and who does not have a financial relationship with the supplier.
What are the agency’s requirements for CRT providers?

CRT providers must:

- Be present at the client’s evaluation to assist in selection of the appropriate CRT product(s) and provide training in the use of the selected items.

- Provide written information to the client at the time of delivery as to how the client may receive services and repairs.

- Provide service and repairs by a qualified technician for all CRT products it sells.

- Meet the general provider requirements in chapter 182-502 WAC.

- Obtain prior authorization before delivering the CRT product to the client.

- Furnish to clients only new CRT products that include full manufacturer and dealer warranties.

- Furnish, upon agency request, documentation of proof of delivery. (See What are the requirements for proof of delivery?)

- Have a valid prescription. To be valid, a prescription must meet all of the following:
  
  ✓ Be written on the agency’s Prescription form, HCA 13-794
  
  ✓ Be written by a physician, advanced registered nurse practitioner (ARNP), physician’s assistant certified (PAC), or naturopathic physician
  
  ✓ Be written, signed (including the prescriber’s credentials), and dated by the prescriber on the same day or before delivery of the supply, equipment, or device (prescriptions must not be back-dated)
  
  ✓ Be no older than one year from the date the prescriber signs the prescription
  
  ✓ State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity

**Note:** The above does not apply to dual eligible Medicare/Medicaid clients when Medicare is the primary payer and the agency is being billed for the copay and/or deductible only.
• Deliver the CRT product to the client before the provider bills the agency.

• Bill the agency using only the allowed procedure codes listed within this provider guide.

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

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

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

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

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

**What are the agency’s requirements for proof of delivery?**

(***WAC 182-543-2200***)

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

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

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

### What are habilitative services under this program?

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

**Effective January 1, 2014,** and applicable to those clients in the expanded population and covered by the Alternative Benefit Plan (ABP) only, the agency will cover CRT used to treat one of the qualifying conditions listed in the agency’s [Habilitative Services Provider 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 Provider Guide](#) in the primary diagnosis field on the claim form.
The agency covers, with prior authorization (PA), the following individually configured, complex rehabilitation technology (CRT) products and related services provided to eligible clients with complex needs.

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<th>Code Status</th>
<th>HCPCS Code</th>
<th>Modifier</th>
<th>Short Description</th>
<th>Policy/Comments</th>
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**Note:** Billing provision limited to a one-month supply. One month equals 30 days.
### Complex Rehabilitation Technology (CRT) Products and Related-Services

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

<table>
<thead>
<tr>
<th>Code Status</th>
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## Complex Rehabilitation Technology (CRT)
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<td>E2361</td>
<td>NU</td>
<td>22nf sealed leadacid battery</td>
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<td></td>
<td>E2363</td>
<td>NU</td>
<td>Gr24 sealed leadacid battery</td>
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<td></td>
<td>E2365</td>
<td>NU</td>
<td>U1 sealed leadacid battery</td>
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<td></td>
<td>E2366</td>
<td>NU</td>
<td>Battery charger, single mode</td>
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<td></td>
<td>E2367</td>
<td>NU</td>
<td>Battery charger, dual mode</td>
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<td></td>
<td>E2368</td>
<td>NU</td>
<td>Pwr wc drivewheel motor repl</td>
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<td></td>
<td>E2369</td>
<td>NU</td>
<td>Pwr wc drivewheel gear repl</td>
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<td>E2370</td>
<td>NU</td>
<td>Pwr wc dr wh motor/gear comb</td>
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<td>E2371</td>
<td>NU</td>
<td>Gr27 sealed leadacid battery</td>
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<td>E2372</td>
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<td>E2373</td>
<td>NU</td>
<td>Hand/chin ctrl spec joystick</td>
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<td></td>
<td>E2374</td>
<td>NU</td>
<td>Hand/chin ctrl std joystick</td>
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<td>E2375</td>
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<td>Non-expandable controller</td>
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<td>E2376</td>
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<td>Expandable controller, repl</td>
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<td>E2377</td>
<td>NU</td>
<td>Expandable controller, initl</td>
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<td></td>
<td>E2382</td>
<td>NU</td>
<td>Tube, pneumatic drive tire</td>
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<td>E2383</td>
<td>NU</td>
<td>Insert, pneumatic drive tire</td>
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<td>E2384</td>
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<td>E2385</td>
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<td>Tube, pneumatic caster tire</td>
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<td>E2386</td>
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<td>Foam filled drive wheel tire</td>
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<td>E2387</td>
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<td>Foam filled caster tire</td>
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<td>E2389</td>
<td>NU</td>
<td>Foam caster tire</td>
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**Note:** Billing provision limited to a one-month supply. One month equals 30 days.

NC = Not covered  N= New  BR = By Report  NU = Purchase
### Products and Related Services

<table>
<thead>
<tr>
<th>Code</th>
<th>HCPCS Code</th>
<th>Modifier</th>
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<th>Policy/Comments</th>
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<td>Solid drive wheel tire</td>
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<td>E2391</td>
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<tr>
<td>E2392</td>
<td>NU</td>
<td>Solid caster tire, integrate</td>
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<td></td>
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<tr>
<td>E2394</td>
<td>NU</td>
<td>Drive wheel excludes tire</td>
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<td></td>
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<tr>
<td>E2395</td>
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<td>Caster wheel excludes tire</td>
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<tr>
<td>E2396</td>
<td>NU</td>
<td>Caster fork</td>
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</tr>
<tr>
<td>K0015</td>
<td>NU</td>
<td>Detach non-adjustable height armrest</td>
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<tr>
<td>K0017</td>
<td>NU</td>
<td>Detach adjustable armrest base</td>
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<td>K0018</td>
<td>NU</td>
<td>Detach adjustable armrest upper</td>
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<tr>
<td>K0019</td>
<td>NU</td>
<td>Arm pad each</td>
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<tr>
<td>K0020</td>
<td>NU</td>
<td>Fixed adjustable armrest pair</td>
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<td>K0037</td>
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<td>High mount flip-up footrest</td>
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<td>K0038</td>
<td>NU</td>
<td>Leg strap each</td>
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<tr>
<td>K0039</td>
<td>NU</td>
<td>Leg strap height style each</td>
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<td>K0040</td>
<td>NU</td>
<td>Adjustable angle footplate</td>
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<td>K0041</td>
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<td>Large size footplate each</td>
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<td>K0042</td>
<td>NU</td>
<td>Standard size footplate each</td>
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<td>K0043</td>
<td>NU</td>
<td>1st lower extension tube</td>
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<td>K0044</td>
<td>NU</td>
<td>1st upper hanger bracket</td>
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<td>K0045</td>
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<td>Footrest complete assembly</td>
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<td>K0046</td>
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<td>Elevate legrest low extension</td>
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<td>Elevate legrest up hanger bracket</td>
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<td>K0050</td>
<td>NU</td>
<td>Ratchet assembly</td>
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<td>K0051</td>
<td>NU</td>
<td>Cam release assembly 1st/leg rest</td>
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<td>K0052</td>
<td>NU</td>
<td>Swingaway detach footrest</td>
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<tr>
<td>K0053</td>
<td>NU</td>
<td>Elevate footrest articulate</td>
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<td>K0056</td>
<td>NU</td>
<td>Seat height &lt;17 or &gt;=21 lb wt wheelchair</td>
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<td>K0065</td>
<td>NU</td>
<td>Spoke protectors</td>
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<td>K0069</td>
<td>NU</td>
<td>Rear wheel complete solid tire</td>
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<td>K0070</td>
<td>NU</td>
<td>Rear wheel complete pneum tire</td>
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<td>K0071</td>
<td>NU</td>
<td>Front caster complete pneum tire</td>
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<tr>
<td>K0072</td>
<td>NU</td>
<td>Frnt cstr cmpnt sem-pneum tir</td>
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<tr>
<td>K0073</td>
<td>NU</td>
<td>Caster pin lock each</td>
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<td>K0077</td>
<td>NU</td>
<td>Front caster assembly complete</td>
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**Note:** Billing provision limited to a one-month supply. One month equals 30 days.
### Complex Rehabilitation Technology (CRT)
#### Products and Related-Services

<table>
<thead>
<tr>
<th>Code</th>
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<th>Policy/Comments</th>
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<tr>
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<td>K0105</td>
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<td>Iv hanger</td>
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<td>K0108</td>
<td>NU</td>
<td>W/c component-accessory nos</td>
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<td>K0733</td>
<td>NU</td>
<td>12-24hr sealed lead acid</td>
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<td>K0868</td>
<td>NU</td>
<td>Pwc gp 4 std seat/back</td>
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<td></td>
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<td>NC</td>
<td>K0869</td>
<td>NU</td>
<td>Pwc gp 4 std cap chair</td>
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</tr>
<tr>
<td>NC</td>
<td>K0870</td>
<td>NU</td>
<td>Pwc gp 4 hd seat/back</td>
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<tr>
<td>NC</td>
<td>K0871</td>
<td>NU</td>
<td>Pwc gp 4 vhd seat/back</td>
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<td>K0877</td>
<td>NU</td>
<td>Pwc gp4 std sing pow opt s/b</td>
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<td>NC</td>
<td>K0878</td>
<td>NU</td>
<td>Pwc gp4 std sing pow opt cap</td>
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#### Equipment, Replacement, Repair

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<thead>
<tr>
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<td>K0739</td>
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<td>Repair/svc dme non-oxygen eq</td>
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<tr>
<td>E0776</td>
<td>NU, RR</td>
<td>IV Pole</td>
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#### Wheelchairs - Cushion

<table>
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<th>Short Description</th>
<th>Policy/Comments</th>
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<tr>
<td>E2601</td>
<td>NU</td>
<td>Gen w/c cushion wd &lt; 22 in</td>
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<tr>
<td>E2602</td>
<td>NU</td>
<td>Gen w/c cushion wd &gt;=22 in</td>
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</tr>
<tr>
<td>E2603</td>
<td>NU</td>
<td>Skin protect wc cus wd &lt;22in</td>
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</tr>
<tr>
<td>E2604</td>
<td>NU</td>
<td>Skin protect wc cus wd&gt;=22in</td>
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<tr>
<td>E2605</td>
<td>NU</td>
<td>Position wc cushion &lt;22 in</td>
<td></td>
</tr>
<tr>
<td>E2606</td>
<td>NU</td>
<td>Position wc cushion &gt;=22 in</td>
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</tr>
<tr>
<td>E2607</td>
<td>NU</td>
<td>Skin pro/pos wc cus wd &lt;22in</td>
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<tr>
<td>E2608</td>
<td>NU</td>
<td>Skin pro/pos wc cus wd&gt;=22in</td>
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<tr>
<td>E2609</td>
<td>NU</td>
<td>Custom fabricate w/c cushion</td>
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<tr>
<td>NC</td>
<td>E2610</td>
<td>NU</td>
<td>Powered w/c cushion</td>
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<tr>
<td>E2611</td>
<td>NU</td>
<td>Gen use back cush wd &lt;22in</td>
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<tr>
<td>E2612</td>
<td>NU</td>
<td>Gen use back cush wd&gt;=22in</td>
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<tr>
<td>E2613</td>
<td>NU</td>
<td>Position back cush wd &lt;22in</td>
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<tr>
<td>E2614</td>
<td>NU</td>
<td>Position back cush wd&gt;=22in</td>
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<tr>
<td>E2615</td>
<td>NU</td>
<td>Pos back post/lat wdth &lt;22in</td>
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</table>

**Note:** Billing provision limited to a one-month supply. One month equals 30 days.
<table>
<thead>
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<th>Policy/Comments</th>
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<td>E2617</td>
<td></td>
<td>NU</td>
<td>Custom fab w/c back cushion</td>
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<tr>
<td>E2619</td>
<td></td>
<td>NU</td>
<td>Replace cover w/c seat cushion</td>
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<td>E2620</td>
<td></td>
<td>NU</td>
<td>Wc planar back cush wd &lt;22in</td>
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<td>E2621</td>
<td></td>
<td>NU</td>
<td>Wc planar back cuth wd&gt;=22in</td>
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<tr>
<td>E2622</td>
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<td>NU</td>
<td>Adj skin pro w/c cus wd&lt;22in</td>
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**Wheelchairs - Modifications**

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<td>Wheelchair special seat dept</td>
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<td>NU</td>
<td>Wheelchair spec seat depth/w</td>
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</tbody>
</table>

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

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

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

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

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

Is authorization required for CRT?
*(WAC 182-543-7100)*

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

What documentation is required for requesting PA?

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

- *General Information for Authorization* form, HCA 13-835 (see WAC 182-543-7000 Authorization)

- *Medical Necessity for Wheelchair Purchase (for home clients only)* form, HCA 13-727 or *Medical Necessity for Wheelchair Purchase for Nursing Facility Clients* form, HCA 13-729 from the client’s physician or therapist

- The agency’s *Prescription Form*, HCA 13-794. For nursing facility clients, a copy of the telephone order, signed by the physician, for the wheelchair assessment is required in place of the prescription form.

Facility or therapist letterhead must be used for any documentation that does not appear on an agency form.
When the agency receives the initial request for PA, the prescription(s) (or telephone order) for those CRT products or related services must not be older than three months from the date the agency receives the request.

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

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

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

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

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

- A detailed description of the item(s) or service(s) to be provided
- The cost or charge for the item(s)
- A copy of the manufacturer's invoice, price-list or catalog with the product description for the item(s) being provided
- A detailed explanation of how the requested item(s) differs from an already existing code description
The agency does not pay for the purchase or repair of CRT that duplicates equipment the client already owns. If the provider believes the purchase or repair of CRT is not duplicative, the provider must request PA and submit the following to the agency, as appropriate:

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

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

**Submitting photos and x-rays for CRT requests**

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

You may register with MEA as follows:

- Go to MEA’s [website](#)
- Select Provider Registration (on the menu bar below the banner)
- Enter “FastWDSHS” in the promotion code box

Contact MEA toll-free at (888) 329-9988, ext. 2, with any questions. When this option is chosen, you can fax your request to the agency and indicate the MEA# in the NEA field (box 18) on the PA Request Form.

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

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

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

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

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

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

5. Mail to the agency.
What is the agency’s reimbursement policy for CRT?

(WAC 182-543-9000(1))

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

- To agency-enrolled qualified complex rehabilitation technology (CRT) suppliers under their national provider identifier (NPI) numbers, subject to the limitations found within this provider guide

- When billed with the appropriate taxonomy number for CRT and related services (332BC3200X)

- In accordance with the health care common procedure coding system (HCPCS) guidelines for product classification and code assignation

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

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

- Providers’ usual and customary charges
- Established rates, except as provided in How do I bill for clients eligible for Medicare and Medicaid?
What resources does the agency use in setting maximum allowable fees for CRT? **(WAC 182-543-9000)(2) and (3))**

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

- Commercial data bases
- Manufacturers' catalogs
- Medicare fee schedules
- Wholesale prices

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

What is included in the rate for CRT? **(WAC 182-543-9000)(8))**

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

- Any adjustments or modifications to the equipment required within three months of the date of delivery, or are covered under the manufacturer’s warranty (this does not apply to adjustments required because of changes in the client's medical condition)

- Any pick-up and/or delivery fees or associated costs (e.g., mileage, travel time, gas, etc.)

- Telephone calls

- Shipping, handling, and/or postage

- Routine maintenance of CRT products including:
  - Testing
  - Cleaning
  - Regulating
  - Assessing the client’s equipment

- Fitting and/or set-up
Complex Rehabilitation Technology (CRT)
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- Instruction to the client or client's caregiver in the appropriate use of the equipment, device, and/or supplies

What is the payment methodology for CRT?
(WAC 182-543-9250)

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

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

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

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

- For add-on CRT accessories and parts, 84% of MSRP or 140% of AC
- For up-charge modifications, seating systems, back and seat cushions, 80% of MSRP or 140% of AC
- For CRT manual wheelchair base, 85% of MSRP or 140% of AC
- For CRT power-drive wheelchair base, 85% of MSRP or 140% of AC

- The agency may adopt policies, procedures, and/or rates that are inconsistent with those set by Medicare if the agency determines that such actions are necessary.
- The agency does not pay for DME and related supplies, related services, and related repairs and labor charges under fee-for-service (FFS) when the client is any of the following:
  - An inpatient hospital client
  - Eligible for both Medicare and Medicaid, and is staying in a skilled nursing facility in lieu of hospitalization
  - Terminally ill and receiving hospice care
  - Enrolled in a risk-based managed care organization that includes coverage for such items and/or services

- The agency rescinds any purchase order for a prescribed item if the equipment was not delivered to the client before the client:
  - Dies
  - Loses medical eligibility
  - Becomes covered by a hospice agency
  - Becomes covered by a managed care organization

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

What warranty information should I keep?  
(WAC 182-543-9000(9))

CRT providers must make the following warranty information available to the agency upon request:

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

When is the dispensing provider responsible for costs?  
(WAC 182-543-9000(10))

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

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

<table>
<thead>
<tr>
<th>Wheelchair Frames (Purchased New) and Wheelchair Parts</th>
<th>Warranty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Powerdrive <em>(depending on model)</em></td>
<td>One (1) year - lifetime</td>
</tr>
<tr>
<td>Ultralight</td>
<td>Lifetime</td>
</tr>
<tr>
<td>Active Duty Lightweight <em>(depending on model)</em></td>
<td>Five (5) years - lifetime</td>
</tr>
<tr>
<td>All Others</td>
<td>One (1) year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Electrical Components</th>
<th>Warranty</th>
</tr>
</thead>
<tbody>
<tr>
<td>All electrical components whether new or replacement parts including batteries</td>
<td>Six (6) months - 1 year</td>
</tr>
</tbody>
</table>
Billing and Claim Forms

What are the general billing requirements?

Providers must follow the agency’s ProviderOne Billing and Resource Guide. These billing requirements include all of the following:

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

What billing requirements are specific to CRT?

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

How do I bill for a managed care client?

(WAC 182-543-8100)

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

- The MCO determines the client's continuing need for the CRT products and related services and is responsible for paying the provider
- A client may become an MCO enrollee before the agency completes the purchase of prescribed CRT. The agency considers the purchase complete when the product is delivered and the agency is notified of the serial number. If the client becomes an MCO enrollee before the agency completes the purchase:
  - The agency rescinds the agency’s authorization with the vendor until the MCO’s primary care provider (PCP) evaluates the client.
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✓ Then the agency requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary as defined in WAC 182-500-0070

✓ Then the MCO’s applicable reimbursement policies apply to the purchase of the equipment

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

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

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

✓ The agency’s applicable reimbursement policies apply to the purchase of the CRT product

How do I bill for clients eligible for Medicare and Medicaid?
(WAC 182-543-8200)

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

• The agency requires a provider to accept Medicare assignment before any Medicaid reimbursement.

• In accordance with WAC 182-502-0110(3):

✓ If the service provided is covered by Medicare and Medicaid, the agency pays the deductible and coinsurance up to Medicare's allowed amount or the agency’s allowed amount, whichever is less.

✓ If the service provided is covered by Medicare but is not covered by the agency, the agency pays only the deductible and/or coinsurance up to Medicare’s allowed amount.
How do I complete the CMS-1500 claim form?

Note: Refer to the agency ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 claim form.

The following CMS-1500 claim form instructions relate to CRT providers:

<table>
<thead>
<tr>
<th>Field No.</th>
<th>Name</th>
<th>Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>24B</td>
<td>Place of Service</td>
<td>These are the only appropriate code(s) for this provider guide:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Code To Be Used For</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12 Client's residence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13 Assisted living facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>32 Nursing facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>31 Skilled nursing facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99 Other</td>
</tr>
</tbody>
</table>

Where can I find the CRT fee schedule?

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

Note: Bill the agency your usual and customary charge.