Washington Apple Health

Home Infusion Therapy And Parenteral Nutrition Program Provider Guide

April 1, 2016

Washington State Health Care Authority

About this guide*

This publication takes effect April 1, 2016, 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?

Subject	Change	Reason for Change
Important Changes to Apple Health Effective April 1, 2016	**Effective April 1, 2016,** important changes are taking place that **all providers** need to know. Information has been added regarding a new policy for early enrollment into managed care, the implementation of fully integrated managed care in the SW WA region, Apple Health Core Connections for foster children, Behavioral Health Organizations (formerly RSNs), and contact information for Southwest Washington.	Program changes

* This publication is a billing instruction.

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.

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Important Changes to Apple Health Effective April 1, 2016

These changes are important to all providers because they may affect who will pay for services.

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client's Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. A Provider FAQ is available online.

New MCO enrollment policy – earlier enrollment

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

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

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

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

How does this policy affect providers?

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

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

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs will replace the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the Mental Health Provider guide. BHOs use the Access to Care Standards (ACS) for mental health conditions and American Society of Addiction Medicine (ASAM) criteria for SUD conditions to determine client's appropriateness for this level of care.

Fully Integrated Managed Care (FIMC)

Clark and Skamania Counties, also known as SW WA region, is the first region in Washington State to implement the FIMC system. This means that physical health services, all levels of mental health services, and drug and alcohol treatment are coordinated through one managed care plan. Neither the RSN nor the BHO will provide behavioral health services in these counties.

Clients must choose to enroll in either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW). If they do not choose, they are auto-enrolled into one of the two plans. Each plan is responsible for providing integrated services that include inpatient and outpatient behavioral health services, including all SUD services, inpatient mental health and all levels of outpatient mental health services, as well as providing its own provider credentialing, prior authorization requirements and billing requirements.

Beacon Health Options provides mental health crisis services to the entire population in Southwest Washington. This includes inpatient mental health services that fall under the Involuntary Treatment Act for individuals who are not eligible for or enrolled in Medicaid, and short-term substance use disorder (SUD) crisis services in the SW WA region. Within their available funding, Beacon has the discretion to provide outpatient or voluntary inpatient mental health services for individuals who are not eligible for Medicaid. Beacon Health Options is also

responsible for managing voluntary psychiatric inpatient hospital admissions for non-Medicaid clients.

In the SW WA region some clients are not enrolled in CHPW or Molina for FIMC, but will remain in Apple Health fee-for-service managed by the agency. These clients include:

- Dual eligible – Medicare/Medicaid
- American Indian/Alaska Native (AI/AN)
- Medically needy
- Clients who have met their spenddown
- Noncitizen pregnant women
- Individuals in Institutions for Mental Diseases (IMD)
- Long-term care residents who are currently in fee-for-service
- Clients who have coverage with another carrier

Since there is no BHO (RSN) in these counties, Medicaid fee-for-service clients receive complex behavioral health services through the Behavioral Health Services Only (BHSO) program managed by MHW and CHPW in SW WA region. These clients choose from CHPW or MHW for behavioral health services offered with the BHSO or will be auto-enrolled into one of the two plans. A BHSO fact sheet is available online.

Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18th birthday

American Indian/Alaska Native (AI/AN) children will **not** be auto-enrolled, but may opt into CCW. All other eligible clients will be auto-enrolled.

AHCC complex mental health and substance use disorder services

AHCC clients who **live in** Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will use the BHO Access to Care Standards

to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.

AHCC clients who **live outside** Skamania or Clark County will receive complex mental health and substance use disorder services from the BHO and managed by DSHS.

Contact Information for Southwest Washington

Beginning on April 1, 2016, there will not be an RSN/BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to an individual who is not eligible for or enrolled in Medicaid.

If a provider does not know which MCO a client is enrolled in, this information can located by looking up the patient assignment in ProviderOne.

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

MOLINA HEALTHCARE	Molina Healthcare of Washington, Inc. 1-800-869-7165

COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009

Beacon Health Options	Beacon Health Options 1-855-228-6502

Resources Available

Topic	Resource Information
Becoming a provider or submitting a change of address or ownership	See the Resources Available web page.
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic or paper billing	
Finding agency documents (e.g., provider guides, fee schedules)	
Private insurance or third-party liability, other than agency managed care	
How do I obtain prior authorization or a limitation extension?	For all requests for prior authorization or limitation extensions, the following documentation is required: • A completed, TYPED *General Information for Authorization Request* form, HCA 13-835. This request form MUST be the initial page when the request is submitted by fax. • A completed, *Fax/Written Request Basic Information* form, HCA 13-756, or the *Justification for Use of Miscellaneous Parenteral Supply Procedure Code (B9999)* form, HCA 13-721, and all the documentation listed on this form. Fax your request to: 866-668-1214.
The agency's maximum allowable fees	See the agency's Home Infusion Therapy and Parental Nutrition Program Fee Schedule

Definitions

This list defines terms and abbreviations, including acronyms, used in this guide. See the agency's Medical Assistance Glossary for a more complete list of definitions.

Continuous glucose monitor – A device that continuously monitors and records interstitial fluid glucose levels and has three components: (1) a disposable subcutaneous sensor, (2) transmitter, and (3) monitor (or receiver). Some CGM systems are designed for short-term diagnostic or professional use. Other CGM systems are designed for long-term client use.

Disposable Supplies – Supplies that may be used once or more than once but cannot be used for an extended period of time.

Hyperalimentation – See Parenteral Nutrition. (WAC 182-553-200)

Intradialytic Parenteral Nutrition (IDPN) – Intravenous nutrition administered during hemodialysis. IDPN is a form of parenteral nutrition. (WAC 182-553-200)

Prior Authorization Number – An identification number issued to providers who have a signed contract with the agency.

About this Program

What is the purpose of the home infusion therapy and parenteral nutrition program?

(WAC 182-553-100)

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

The agency's Home Infusion Therapy and Parenteral Nutrition program covers:

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

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

(WAC 182-553-400(1))

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

- Have a signed Core Provider Agreement with the agency.
- Be one of the following provider types:
  - ✓ Pharmacy provider
  - ✓ Durable medical equipment (DME) provider
  - ✓ Infusion therapy provider

What are the requirements for reimbursement?

(WAC 182-553-400(2))

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

- Are able to provide home infusion therapy within their scope of practice.
- Have evaluated each client in collaboration with the client's physician, pharmacist, or nurse to determine whether home infusion therapy and parenteral nutrition is an appropriate course of action.
- Have determined that the therapies prescribed and the client's needs for care can be safely met.
- Have assessed the client and obtained a written physician order for all solutions and medications administered to the client in the client's residence or in a dialysis center through intravenous, epidural, subcutaneous, or intrathecal routes.
- Meet the requirements in WAC 182-502-0020 (Health care record requirements), including keeping legible, accurate, and complete client charts, and providing the documentation in the client's medical file.

Where may services be provided and how are they reimbursed?

- **Federally-Qualified Health Centers (FQHCs), physicians, and physician clinics** may provide home infusion therapy and parenteral nutrition services in a physician's office or physician clinic, unless the client resides in a nursing facility. Bill using the appropriate procedure codes from the agency's Physician-Related Services/Health Care Professional Services Medicaid Provider Guide.
- **Nursing facilities:** Some services and supplies necessary for the administration of infusion are included in the facility's per diem rate for each client. See the Coverage Table to identify procedure codes that are included in the nursing facility per diem rate. A client's infusion pump, parenteral nutrition pump, insulin pump, solutions, and insulin infusion supplies are not included in the nursing facility per diem rate and are paid separately (see WAC 182-553-500(6)).
- **Outpatient hospital providers** may provide infusion therapy and parenteral nutrition. Bill using the appropriate revenue codes in the agency's Outpatient Hospital Services Medicaid Provider Guide.

- **Clients in a state-owned facility:** Home infusion therapy and parenteral nutrition for agency clients in state-owned facilities (state school, developmental disabilities (DD) facilities, mental health facilities, Western State Hospital and Eastern State Hospital) are purchased by the facility through a contract with manufacturers. The agency does not pay separately for home infusion supplies and equipment or parenteral nutrition solutions for these clients (see WAC 182-553-500(5)).

- **Clients who have elected the agency's hospice benefit:** The agency pays for home infusion/parenteral nutrition separate from the hospice per diem rate only when both of the following apply:

  ✓ The client has a pre-existing diagnosis that requires parenteral support.

  ✓ That pre-existing diagnosis is unrelated to the diagnosis that qualifies the client for hospice.

Note: When billing using a paper copy CMS-1500 claim form, you must enter a "K" indicator in "field 19" to identify that the infusion therapy services were unrelated to the terminal diagnosis. When billing electronically, you must enter a "K" indicator in the "comments" section. (WAC 182-553-500(5))

Client Eligibility

(WAC 182-553-300(1))

How can I verify a patient's eligibility?

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

Verifying eligibility is a two-step process:

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

If the patient is eligible for Washington Apple Health, proceed to **Step 2**. 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 Health Care Coverage—Program Benefit Packages and Scope of Service Categories web page.

Note: Patients who are not Washington 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 managed care eligible?

(WAC 182-553-300(2))

Yes. Home infusion therapy and parenteral nutrition are covered under the agency-contracted managed care organizations (MCOs) when the services are medically necessary. All services must be requested directly through the client's MCO.

Providers can verify a client's managed care enrollment through the ProviderOne client benefit inquiry screen.

Clients may contact their MCO by calling the telephone number provided to them.

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 both **prior** to scheduling services and at the **time of the service.** Also 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.

Newborns of clients enrolled in managed care plans are the responsibility of the plan in which the mother is enrolled for the first 21 days of life. If the mother changes plans, the baby follows the mother.

Are Primary Care Case Management (PCCM) clients covered?

Yes. For the client who has chosen to obtain care with a PCCM provider, this information is 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, check the client's eligibility both **prior** to scheduling services and at the **time of the service.** Also 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.

Coverage

Is medical necessity required for home infusion therapy?

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

When is infusion therapy covered in the home?

(WAC 182-553-300(3) and (4))

The agency will cover infusion therapy in the home when the client:

- Has a written physician order for all solutions and medications to be administered.
- Is able to manage their infusion in one of the following ways:
  - ✓ Independently
  - ✓ With a volunteer caregiver who can manage the infusion
  - ✓ By choosing to self-direct the infusion with a paid caregiver (see WAC 388-71-05640)
- Is clinically stable and has a condition that does not warrant hospitalization.
- Agrees to comply with the protocol established by the infusion therapy provider for home infusions. If the client is not able to comply, the client's caregiver may comply.
- Consents, if necessary, to receive solutions and medications administered in the home through intravenous, enteral, epidural, subcutaneous, or intrathecal routes. If the client is not able to consent, the client's legal representative may consent.
- Lives in a residence that has adequate accommodations for administering infusion therapy, including:
  - ✓ Running water.
  - ✓ Electricity.
  - ✓ Telephone access.
  - ✓ Receptacles for proper storage and disposal of drugs and drug products.

Note: The agency evaluates a request for home infusion therapy supplies and equipment or parenteral nutrition solutions that are not covered or are in excess of the home infusion therapy and parenteral nutrition program's limitations or restrictions, according to WAC 182-501-0165. See Authorization and WAC 182-553-500.

Is medical necessity required for parenteral nutrition?

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

When is parenteral nutrition covered?

(WAC 182-553-300(5))

To receive parenteral nutrition, a client must:

- Have a written physician order for all solutions and medications to be administered.
- Be able to manage their infusion in one of the following ways:
  - ✓ Independently
  - ✓ With a volunteer caregiver who can manage the infusion
  - ✓ By choosing to self-direct the infusion with a paid caregiver (WAC 388-71-05640)

-And-

To receive parenteral nutrition, a client must meet one of the following conditions that prevents oral or enteral intake to meet the client's nutritional needs:

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

When is parenteral nutrition not covered?

(WAC 182-553-300(6))

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

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

What if a client has a condition expected to last less than three months?

(WAC 182-553-300(7))

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

- The eligibility criteria are met.

- The client has a written physician order that documents the client is unable to receive oral or tube feedings.

- It is medically necessary for the gastrointestinal tract to be totally nonfunctional for a period of time.

When are intradialytic parenteral nutrition (IDPN) solutions covered?

(WAC 182-553-300(8))

The agency covers IDPN solutions when:

- The parenteral nutrition is not solely supplemental to deficiencies caused by dialysis.
- The client meets the eligibility criteria.
- The client is able to manage their infusion in one of the following ways:
  - ✓ Independently
  - ✓ With a volunteer caregiver who can manage the infusion
  - ✓ By choosing to self-direct the infusion with a paid caregiver

What documentation is required?

See Billing and Claim Forms for CMS-1500 claim form instructions specific to the Home Infusion Therapy and Parenteral Nutrition program.

Note: The agency evaluates a request for home infusion therapy supplies and equipment or parenteral nutrition solutions that are not covered or are in excess of the home infusion therapy and parenteral nutrition program's limitations or restrictions, according to WAC 182-501-0165 and WAC 182-501-0169. See Authorization and WAC 182-553-500.

What equipment and supplies are covered?

(WAC 182-553-500(1) through (6))

The agency covers the following equipment and supplies under the Home Infusion Therapy and Parenteral Nutrition program for eligible clients, subject to the limitations and restrictions listed below:

- Home infusion supplies are limited to one month's supply per client, per calendar month.
- Parenteral nutrition solutions are limited to one month's supply per client, per calendar month.
- Covered rental of pumps is limited to one type of infusion pump, one type of parenteral pump, and one type of insulin pump per client, per calendar month as follows:
  - ✓ The agency covers the rental payment for each type of infusion, parenteral, or insulin pump for up to 12 months. (The agency considers a pump purchased after 12 months of rental payment).

- ✓ All rent-to-purchase infusion parenteral and insulin pumps must be new equipment at the beginning of the rental period.

- ✓ The agency covers only one purchased infusion or parenteral pump, per client in a five-year period.

- ✓ The agency covers only one purchased insulin pump, per client in a four-year period.

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

The agency's payment for equipment rentals or purchases includes:

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

Coverage Table

Infusion therapy equipment and supplies

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

Infusion therapy equipment and supplies (cont.)

HCPCS Code	Modifier	Description	NH Per Diem?	Policy/Comments
A4223		Infusion supplies not used with external infusion pump, per cassette or bag (list drug(s) separately)	Y	Includes the following: 1. Disposable elastomeric infusion pumps 2. Gravity flow with a standard roller clamp or another flow rate regulator 3. Related supplies Invoice required. Submit a summary document of the therapy provided and the specific items used. Not allowed in combination with HCPCS code A4222

Antiseptics and germicides

HCPCS Code	Modifier	Description	NH Per Diem?	Policy/Comments
A4246		Betadine or Phisohex solution, per pint	Y	One pint per client, per month. Not allowed in combination with HCPCS codes A4247
A4247		Betadine or iodine swabs/wipes, per box of 100	Y	One box per client, per month. Not allowed in combination with HCPCS codes A4246
E0776	NU	IV pole	Y	Purchase
E0776	RR	IV pole	Y	Rental per month One unit = one month

Infusion pumps

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

Infusion pumps (cont.)

HCPCS Code	Modifier	Description	NH Per Diem?	Policy/Comments
E0791	RR	Parenteral infusion pump, stationary, single or multi-channel	N	Rental per month

Parenteral nutrition infusion pumps

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

Parenteral nutrition solutions

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

HCPCS Code	Modifier	Description	NH Per Diem?	Policy/Comments
B4164		Parenteral nutrition solution; carbohydrates (dextrose), 50% or less (500 ml = 1 unit) home mix	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200
B4168		Parenteral nutrition solution; amino acid, 3.5% (500 ml = 1 unit) home mix	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200
B4172		Parenteral nutrition solution; amino acid, 5.5% through 7% (500 ml = 1 unit) – home mix	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200
B4176		Parenteral nutrition solution; amino acid, 7% through 8.5% (500 ml = 1 unit) – home mix	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200
B4178		Parenteral nutrition solution; amino acid greater than 8.5% (500 ml = 1 unit) - home mix	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200

Parenteral nutrition solutions (cont.)

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

Parenteral nutrition solutions (cont.)

HCPCS Code	Modifier	Description	NH Per Diem?	Policy/Comments
B4197		Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 74 to 100 grams of protein – premix	N	
B4199		Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, over 100 grams of protein – premix	N	
B4216		Parenteral nutrition; additives (vitamins, trace elements, heparin, electrolytes) – home mix, per day	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200

Parenteral nutrition solutions (cont.)

HCPCS Code	Modifier	Description	NH Per Diem?	Policy/Comments
B5000		Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal – amirosyn RF, nephramine, renamine – premix	N	
B5100		Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic – freamine HBC, hepatmine - premix	N	

Parenteral nutrition supplies

Note:
- Parenteral Nutrition Kits are considered **all-inclusive** for the items necessary to administer therapy.
- Number of units billed cannot exceed number of days.

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

Insulin infusion pumps

HCPCS Code	Modifier	Description	NH Per Diem?	Policy/Comments
E0784	RR	External ambulatory infusion pump, insulin	N	Covered without prior authorization for Type I Diabetes Prior authorization required for Type II Diabetes Includes case Rental per month One unit = one month Maximum of 12 months' rental Pump is considered purchased after 12 months' rental Limited to one pump per client in a four year period

Insulin infusion supplies

HCPCS Code	Modifier	Description	NH Per Diem?	Policy/Comments
A4230		Infusion set for external insulin pump, non-needle cannula type	N	Two boxes per client, per month One unit = one box of ten
A4231		Infusion set for external insulin pump, needle type	N	Two boxes per client, per month One unit = one box
A4232		Syringe with needle for external insulin pump, sterile, 3cc	N	Two boxes per client, per one month One unit = one box of ten
A4602		Replacement battery for external infusion pump owned by patient, lithium, 1.5 volt	N	Ten per client per six months
K0601		Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt	N	Ten per client per six months
K0602		Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt	N	Ten per client per six months
K0603		Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt	N	Nine per client per three months
K0604		Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt	N	
K0605		Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt	N	

Miscellaneous infusion supplies

HCPCS Code	Modifier	Description	NH Per Diem?	Policy/Comments
A4927		Gloves, nonsterile, per box of 100 gloves	Y	One unit = One box of 100 gloves Units exceeding two per month require prior authorization.
A4930		Gloves, sterile, per pair	Y	
E1399		Equipment repair, parts	N	Requires prior authorization See instructions in Authorization.
E1399		10 quart chemotherapy waste container	Y	Requires prior authorization See instructions in Authorization. Invoice required
B9999		No other code for parenteral supplies	N/A	Requires prior authorization See instructions in Authorization. Invoice required
K0739		Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes	N	Prior authorization is required Must submit invoice with claim that separates labor costs from other costs

Continuous Glucose Monitoring (CGM)

HCPCS Code	Modifier	Description	NH Per Diem?	Policy/Comments
A9276		Sensor; Invasive (subcutaneous), disposable for use with interstitial continuous glucose monitoring system One unit = One day supply	N/A	**Allowed only for clients age 18 and younger with an FDA-approved CGM device.** Prior authorization and invoice required. When requesting PA, the client must: • Be diagnosed with insulin dependent diabetes mellitus. • Be followed by an endocrinologist. • Either have had one or more severe episodes of hypoglycemia or be enrolled in an Institutional Review Board-approved trial.
A9277		Transmitter; External, for use with interstitial continuous glucose monitoring system	N/A	
A9278		Receiver (monitor); external, for use with interstitial continuous glucose monitoring system	N/A	

Closed loop systems are not covered. Verification with self-monitoring of blood glucose (SMBG) is needed prior to adjusting insulin. Do not use the CGM results to adjust insulin.

To submit a claim for the physician interpretation and report of CGM results, see CPT code 95251 (PA **not** required) in the agency's current Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide.

Authorization

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

What is written/fax authorization?

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

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

- Miscellaneous parenteral therapy supplies (**HCPCS code B9999**). See the Coverage Table in this guide for further details. To request prior authorization, fax a completed *Justification for Use of Miscellaneous Parenteral Supply Procedure Code (B9999)* form, HCA 13-721, to the fax number listed on the form.

- Equipment repairs, parts, and 10 quart chemotherapy waste containers require prior authorization (**HCPCS code E1399)**. To request prior authorization, fax a completed *Fax/Written Request Basic Information* form, HCA 13-756, to the fax number listed on the form.

- Limitation Extensions.

How do I obtain written/fax authorization?

You may obtain authorization by sending a request, along with any required forms, to the fax number listed on the form.

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

What is a limitation extension (LE)?

An LE is authorization for cases when the agency determines that it is medically necessary to provide more units of service than allowed in the agency's WAC and provider guides.

How is an LE request submitted for approval?

Submit the request for LE authorization by using the written/fax authorization process. **Requests for LE authorization must include all of the following:**

- Name of the agency and NPI
- Client's name and ProviderOne client ID
- Procedure code and description of supply needed
- Copy of the original prescription
- Explanation of client-specific medical necessity to exceed limitation

Fax the completed *Fax/Written Request Basic Information* form, HCA 13-756, to the fax number listed on the form.

Does miscellaneous parenteral supply HCPCS code B9999 require prior authorization?

Yes. Miscellaneous HCPCS code B9999 requires prior authorization. In order to be reimbursed for B9999, you must **first** complete the *Justification for use of Miscellaneous Parenteral Supply Procedure Code (B9999)* form, HCA 13-721, and fax it to the fax number listed on the form for review and approval. Keep a copy of the request in the client's file.

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

When submitting a request for authorization, attach supporting documentation. This documentation must consist of all of the following:

- Name of the agency and NPI
- Client's name and ProviderOne client ID
- Date of service
- Explanation of client-specific medical necessity
- Invoice
- Name of primary piece of equipment and whether the equipment is rented or owned
- Copy of original prescription

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:

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

(WAC 182-553-400)

In addition to the documentation required under WAC 182-502-0020 (Health care record requirements), the following records specific to the Home Infusion Therapy and Parenteral Nutrition Program must be kept in the client's file:

- For a client receiving infusion therapy, the file must contain:
  - ✓ A copy of the written prescription for the therapy.
  - ✓ The client's age, height, and weight.
  - ✓ The medical necessity for the specific home infusion service.
- For a client receiving parenteral nutrition, the file must contain:
  - ✓ All the information listed above.
  - ✓ Any oral or enteral feeding trials and outcomes, if applicable.
  - ✓ The duration of gastrointestinal impairment.
  - ✓ The monitoring and reviewing of the client's lab values:
    - ➢ At the initiation of therapy.
    - ➢ At least once per month.
    - ➢ When the client or the client's lab results are unstable.

How is the CMS-1500 claim form completed?

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

The following CMS-1500 claim form instructions relate to the Home Infusion Therapy and Parenteral Nutrition program:

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