Washington State Health Care Authority

Medicaid Provider Guide

Home Infusion Therapy/Parenteral Nutrition Program

[Chapter 182-553 WAC]

A Billing Instruction

About This Guide

This Guide supersedes all previous Agency *Home Infusion Therapy/Parenteral Nutrition Program Medicaid Provider Guides* published by the Agency.

> **Note:** The Agency now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

What Has Changed?

Reason for Change	Effective Date	Section/ Page No.	Subject	Change
Provider Notice 12-43	July 1, 2012	Coverage Table page C.8	Infusion Therapy Equipment and Supplies	Clarify the information to submit a claim for Procedure Code A4223
	July 1, 2012	Coverage Table page C.15	Insulin Infusion Pumps	Delete procedure code E0784 with Modifier NU.
	July 1, 2012	Coverage Table page C.15	Insulin Infusion Pumps	Revise comments for E0784 with Modifier RR.
	July 1, 2012	Coverage Table page C.17	Miscellaneous Infusion Supplies	Revise comments to add "Invoice required for procedure codes E1399 and B9999

Copyright Disclosure

How Can I Get Agency Provider Documents?

To view the Agency's provider notices and Medicaid provider guides go to the Agency's website at http://hrsa.dshs.wa.gov (click the ***Medicaid Provider Guides and Provider Notices*** link).

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Section E: Billing and Claim Forms

Important Contacts

Note: This section contains important contact information relevant to the Home Infusion Therapy/Parenteral Nutrition program. For more contact information, see the Agency's *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Agency's *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Finding out about payments, denials, claims processing, or Agency managed care organizations	
Electronic or paper billing	
Finding Agency documents (e.g., Medicaid provider guides, provider notices, 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 form, 13-835. This request form MUST be the initial page when you submit your request. • A completed Basic Information Request form, 13-756 or the Miscellaneous Parenteral Supply Procedure Code (B9999) form, 13-721, and all the documentation listed on this form. Fax your request to: 1-866-668-1214. See the Agency's *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in this Medicaid provider guide. Please refer to the Agency's *Medical Assistance Glossary* at http://hrsa.dshs.wa.gov/download/medical_assistance_glossary.htm for a more complete list of definitions.

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

Durable Medical Equipment (DME) – Equipment that:

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

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

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

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

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

Limitation Extension – A process for requesting reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which the Agency or Agency's designee routinely reimburses. Limitation extensions require prior authorization.

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

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

Prior Authorization Number – An identification number issued to providers who have a signed contract(s) with the Agency.

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

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

About the Program

What Is the Purpose of the Home Infusion Therapy/ Parenteral Nutrition Program? [Refer to WAC 182-553-100]

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

The Agency's Home Infusion Therapy/Parenteral Nutrition program covers:

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

Who Is Eligible to Provide Home Infusion Supplies and Equipment and Parenteral Nutrition Solutions? [Refer to WAC 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; and
- Be one of the following provider types:
  - ✓ Pharmacy provider;
  - ✓ Durable medical equipment (DME) provider; or
  - ✓ Infusion therapy provider.

What Are the Requirements for Reimbursement?

[Refer to WAC 182-553-400(2)]

The Agency or Agency's designee pays eligible providers for home infusion supplies and equipment and parenteral nutrition solutions only when the providers:

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

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

  Nursing Facilities: Some services and supplies necessary for the administration of infusion are included in the facility's per diem rate for each client. See the *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/or insulin infusion supplies are not included in the nursing facility per diem rate and are paid separately. [Refer to WAC 182-553-500(6)]

  Outpatient Hospital Providers may provide infusion therapy/parenteral nutrition and bill using revenue codes. See the Agency's *Outpatient Hospital Services Medicaid Provider Guide*.

Clients in a State-Owned Facility: Home infusion therapy/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 or Agency's designee does not pay separately for home infusion supplies and equipment or parenteral nutrition solutions for these clients. [Refer to WAC 182-553-500(5)]

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

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

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. [Refer to WAC 182-553-500(5)]

Client Eligibility

Who Is Eligible? [Refer to WAC 182-553-300(1)]

Eligible clients may receive the parenteral nutrition and home infusion supplies and equipment described in this Medicaid provider guide depending on their Benefit Package.

> **Note:** Refer to the *Scope of Healthcare Services Table* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Packages.

Please see the Agency's *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Are Clients Enrolled in an Agency Managed Care Plan Eligible? [Refer to WAC 182-553-300(2)]

When verifying eligibility using ProviderOne, if the client is enrolled in an Agency managed care plan, 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 managed care plan by calling the telephone number provided to them.

All medical services covered under a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

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

> **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 plan. See Agency's *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html 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.

Primary Care Case Management

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. Please see Agency's *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Coverage

Home Infusion Therapy

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

When does the Agency or Agency's designee cover infusion therapy in the home? [Refer to WAC 182-553-300(3)(4)]

The Agency or Agency's designee will cover infusion therapy in the home when the client meets the following criteria. The client must:

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

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

Parenteral Nutrition

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

When Is Parenteral Nutrition Covered?
[Refer to WAC 182-553-300(5)]

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

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

When Is Parenteral Nutrition *NOT* Covered?
[Refer to WAC 182-553-300(6)]

The Agency or Agency's designee does not cover parenteral nutrition program services for a client who has a functioning gastrointestinal tract when the need for parenteral nutrition is only due to:

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

When Does the Agency or Agency's designee Cover Parenteral Nutrition for a Client Who Has a Condition Expected to Last less than Three Months? [Refer to WAC 182-553-300(7)]

The Agency or Agency's designee covers parenteral nutrition for a client whose gastrointestinal impairment is expected to last less than three months when:

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

When Does the Agency or Agency's designee Cover Intradialytic Parenteral Nutrition (IDPN) Solutions? [Refer to WAC 182-553-300(8)]

The Agency or Agency's designee covers intradialytic parenteral nutrition (IDPN) solutions when:

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

What Documentation Is Required To Be in the Client's Medical Record and Available to the Agency or Agency's designee Upon Request when Providing Parenteral Nutrition to Agency Clients?

See *Billing and Claim Forms* for CMS-1500 Claim Form instructions specific to the *Home Infusion Therapy/Parenteral Nutrition Program*.

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

Equipment/Supply Limitations

[Refer to WAC 182-553-500(1)(2)(3)(4)(5)(6)]

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

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

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

The following are considered included in the Agency's or Agency's designee's payment for equipment rentals or purchases:

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

Continuous Glucose Monitoring (CGM)

Procedure Code	EPA Code	Description	Criteria
A9276, A9277, A9278	870000023	Sensor, transmitter, and receiver for CGM	For in-home use of CGM for a 72 hour monitoring period with ***all*** of the following criteria: • Client is younger than 19 years of age, has diabetes mellitus (DM); Is insulin dependent; • Has had one or more severe episodes of hypoglycemia (blood glucos***e l***ess than or equal to 50 mg/dl) requiring assistance from another person, or complicated by a hypoglycemia-induced seizure; • Is ordered by a pediatrician; • The CGM monitor is FDA approved; • Verification with self-monitoring of blood glucose (SMBG) is needed prior to adjusting insulin. Do not use the CGM results to adjust insulin. "Requiring assistance" means that the client does not recognize the symptoms of hypoglycemia and/or is unable to respond appropriately. Limit: 2 monitoring periods of 72 hours each, per client every 12 months Invoice required.

Prior authorization (PA) is required for the use of CGM for longer than 72 hours OR if a client is enrolled in an Institutional Review Board (IRB) approved CGM trial. This applies to clients younger than 19 years of age.

All of the following documentation is required when submitting a request for PA:

- Client is younger than 19 years of age, has diabetes mellitus (DM), is insulin dependent;
- Has one or more severe episodes of hypoglycemia (blood glucose less than or equal to 50 mg/dl) requiring assistance from another person, or complicated by a hypoglycemia-induced seizure;
- Has first tried a 72 hour monitoring period;
- Has recurrent unexplained severe hypoglycemic events despite modifications in therapy;

- Is followed by a pediatric endocrinologist;
- Has appropriate A1c target goals;
- There are submitted results of SMBG—minimum of 4 times per day;
- The CGM device is FDA approved.

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.

Note: CGM is not covered for clients 19 years of age and older.

To submit a claim for the physician interpretation and report of CGM results, see procedure code 95251 (PA ***not*** required) in the *Physician-Related Services/Healthcare Professional Services Fee Schedule online at: http://hrsa.dshs.wa.gov/RBRVS/Index.html*.

Coverage Table

Infusion Therapy Equipment and Supplies

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

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

Infusion Therapy Equipment and Supplies (cont.)

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

Antiseptics & Germicides

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

Procedure Code	Modifier	Description	NH Per Diem?	Policy/Comments
A4245		Alcohol wipes, per box.	Y	1 box per client, per month. Not allowed in combination with A4244
A4246		Betadine or Phisohex solution, per pint.	Y	1 pint per client, per month. Not allowed in combination with A4247.
A4247		Betadine or iodine swabs/wipes, per box of 100.	Y	1 box per client, per month. Not allowed in combination with A42464
E0776-	NU	IV pole.	Y	**Purchase.**
E0776	RR	IV pole.	Y	**Rental per month**. **1 unit = 1 month**

Infusion Pumps

Note:

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

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

Infusion Pumps (cont.)

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

Parenteral Nutrition Infusion Pumps

Note:

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

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

Parenteral Nutrition Solutions

Note:

- Reimbursement is limited to a one-month's supply.
- When using half units of parenteral solutions, the Agency or Agency's designee 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.)**

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

Parenteral Nutrition Solutions (cont.)

Procedure 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 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.)

Procedure 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 B4189, B4193, B4197, B4199, B5000, B5100, and B5200.***

Parenteral Nutrition Solutions (cont.)

Procedure 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	
B5200		Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress - branch chain amino acids - premix.	N	

Parenteral Nutrition Supplies

Note:

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

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

Insulin Infusion Pumps

Note:

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

Procedure Code	Modifier	Description	NH Per Diem?	Policy/Comments
~~E0784~~	~~NU~~	~~External ambulatory infusion pump, insulin, includes case.~~	~~N~~	~~**1 per client, per 4 years. Purchase.**~~
E0784	RR	External ambulatory infusion pump, insulin.	N	**Includes case.** **Rental per month**. **1 unit = 1 month**. Maximum of 12 months rental. Pump is considered purchased after 12 months of rental. Limited to 1 pump per client in a 4 year period.

Insulin Infusion Supplies

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

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

Miscellaneous Infusion Supplies

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

Procedure Code	Modifier	Description	NH Per Diem?	Policy/Comments
A4927		Gloves, nonsterile, per box of 100 gloves.	Y	1 unit = 1 box of 100 gloves. Units exceeding two (2) per month require prior authorization.
A4930		Gloves, sterile, per pair.	Y	
E1399		Equipment repair, parts.	N	Requires prior authorization. See instructions in *Authorization.* Invoice required.
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)

Procedure Code	Modifier	Description	NH Per Diem?	Policy/Comments
A9276		Sensor; Invasive (subcutaneous), disposable for use with interstitial continuous glucose monitoring system 1 unit = 1 day supply	N/A	EPA or PA required. See EPA number 870000023 on page C.5 for clients younger than 19 years of age 2 monitoring periods of 72 hours each, per client every 12 months Invoice required.
A9277	RR	Transmitter; External, for use with interstitial continuous glucose monitoring system	N/A	EPA or PA required. See EPA number 870000023 on page C.5 for clients younger than 19 years of age 2 monitoring periods of 72 hours each, per client every 12 months Invoice required.
A9278	RR	Receiver (monitor); external, for use with interstitial continuous glucose monitoring system	N/A	EPA or PA required. See EPA number 870000023 on page C.5 for clients younger than 19 years of age 2 monitoring periods of 72 hours each, per client every 12 months Invoice required.

To submit a claim for the physician interpretation and report of CGM results, see procedure code 95251 (PA ***not*** required) in the *Physician-Related Services/Healthcare Professional Services Fee Schedule online at: http://hrsa.dshs.wa.gov/RBRVS/Index.html*.

Authorization

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

Written/Fax Authorization

What is written/fax authorization?

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

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

- Miscellaneous parenteral therapy supplies (**procedure code B9999**). See *Coverage Table* for further details. To request prior authorization, fax a completed Justification for use of Miscellaneous Parenteral Supply Procedure Code (B9999) form, 13-721, to the Agency or Agency's designee (see *Important Contacts*).

- Equipment repairs, parts, and 10 quart chemotherapy waste containers require prior authorization (**procedure code E1399)**. To request prior authorization, fax a completed Fax/Written Request Basic Information form, 13-756, to the Agency or Agency's designee (see *Important Contacts*).

- Limitation Extensions - See next page.

To download the forms above, go to: http://hrsa.dshs.wa.gov/mpforms.shtml

How do I obtain written/fax authorization?

You may obtain authorization by sending a request, along with any required forms, to the Agency or Agency's designee (see *Important Contacts*).

Note: Please see the Agency's *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for more information on requesting authorization.

Limitation Extension

What is a Limitation Extension?

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

How do I get LE authorization?

LE authorization may be obtained by using the written/fax authorization process. **Your request must include the following:**

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

You may obtain authorization by faxing a completed 13-756 form to the Agency or Agency's designee (see *Important Contacts*).

Miscellaneous Parenteral Supply Procedure Code B9999

Miscellaneous procedure code B9999 requires prior authorization. In order to be reimbursed for B9999, you must **first** complete the Justification for use of Miscellaneous Parenteral Supply Procedure Code (B9999) form, 13-721, and fax it to the Agency or Agency's designee (see *Important Contacts*) for review and approval. Keep a copy of your request in the client's file.

To download this form, go to: http://hrsa.dshs.wa.gov/mpforms.shtml.

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

Include the following supporting documentation with your fax for approval:

- Agency name and NPI;
- Client's ProviderOne Client ID;
- Date of service;
- Name of primary piece of equipment and whether the equipment is rented or owned;
- Invoice;
- Prescription; and
- Explanation of client-specific medical necessity.

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Agency's *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Agency or Agency's designee for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Billing for clients eligible for both Medicare and Medicaid;
- Third-party liability; and
- Record keeping requirements.

What Records Specific to Home Infusion Therapy/ Parenteral Nutrition Providers Must Be Kept in the Client's File? **[WAC 182-553-400]**

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

Fee Schedule

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

Completing the CMS-1500 Claim Form

Note: Refer to the Agency's *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for general instructions on completing the CMS-1500 Claim Form.

The following CMS-1500 Claim Form instructions relate to the Home Infusion Therapy/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