Washington State Health Care Authority

Washington Apple Health (Medicaid)

Respiratory Care Billing Guide

October 1, 2025

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If the broken link is in the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **October 1, 2025**, and supersedes earlier billing guides to this program. Unless otherwise specified, the program in this guide is governed by the rules found in chapter 182-552 WAC.

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

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

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

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

Health care privacy toolkit for providers

The Washington Health Care Privacy Toolkit is a resource for providers required to comply with health care privacy laws.

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* This publication is a billing instruction.

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Where can I download HCA forms?

To download an HCA form, see HCA's **Forms & Publications webpage**. Type only the form number into the Search box (Example: 13-835).

Copyright disclosure

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Client Eligibility	Added information regarding the services available through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit	To provide information about EPSDT services and accessibility

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Resources Available

Topic	Contact Information
How do I obtain prior authorization or a limitation extension?	For all requests for prior authorization or limitation extensions, both these forms are required: • A completed, **typed** *General Information for Authorization* (HCA 13-835) form. This request form must be the initial page when you submit your request. • A completed *Oxygen and Respiratory Authorization Request* (HCA 15-298) form and all the documentation listed on this form and any other medical justification. See **Where can I download HCA forms?** Fax your request to: 866-668-1214.
How do I check on the status of a request for prior authorization or limitation extension?	• Call 800-562-3022 and select the topic • Call 800-562-3022, extension 15471
How do I get answers for billing questions?	Call 800-562-3022 and ask for the billing extension.
How do I obtain information regarding the Respiratory Care Program?	Do one of the following: • Refer to HCA's Billers and Providers **Contact Us** webpage • Contact the Respiratory Care program manager at: Division of Health Care Services Health Care Authority PO Box 45506 Olympia, WA 98504-5506
Who do I contact if I have a reimbursement question?	Cost Reimbursement Analyst Professional Reimbursement PO Box 45510 Olympia, WA 98504-5510

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to **chapter 182-500 WAC** for a complete list of definitions for Washington Apple Health.

Adult Family Home – A residential home, licensed to care for up to six residents, that provides rooms, meals, laundry, supervision, assistance with activities of daily living, and personal care. In addition to these services, some homes provide nursing or other special care and services. (**WAC 182-552-0005**)

Apnea – The cessation of airflow for at least 10 seconds. (WAC 182-552-0005)

Apnea-hypopnea index (AHI) – The average number of episodes of apnea and hypopnea per hour of sleep without the use of a positive airway pressure device. For the purposes of **chapter 182-552 WAC**, respiratory effort related arousals (RERAs) are not included in the calculation.

Arterial PaO2 – Measurement of partial pressure of arterial oxygen. (WAC 182-552-0005)

Authorized prescriber – A health care practitioner authorized by law or rule in the state of Washington to prescribe oxygen and respiratory care equipment, supplies, and services. (WAC 182-552-0005)

Bi-level respiratory assist device (RAD) with backup rate – A device that allows independent setting of inspiratory and expiratory pressures to deliver positive airway pressure (within a single respiratory cycle) by way of tubing and a noninvasive interface (such as a nasal or oral facial mask) to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs. In addition, these devices have a timed backup feature to deliver this air pressure whenever sufficient spontaneous inspiratory efforts fail to occur. (WAC 182-552-0005)

Bi-level respiratory assist device (RAD) without backup rate– A device that allows independent setting of inspiratory and expiratory pressures to deliver positive airway pressure (within a single respiratory cycle) by way of tubing and a noninvasive interface (such as a nasal, oral, or facial mask) to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs. (WAC 182-552-0005)

Blood gas study – For this guide, either an oximetry test or an arterial blood gas test. (WAC 182-552-0005)

Boarding Home – Adult residential care (ARC) facility, enhanced adult residential care (EARC) facility, or assisted living (AL) facility. (WAC 182-552-0005)

Capped rental – Applies to certain oxygen equipment for in-home medical assistance clients. After 36 months of rental by the provider, the equipment is considered capped (not reimbursed) for the next 24 months. (See **Payment for new equipment on capped rental items**.)

Central sleep apnea (CSA) – Is defined as meeting all the following criteria:

- An apnea-hypopnea index (AHI) greater than or equal to 5.
- Central apneas/hypopneas greater than 50% of the total apneas/hypopneas.

- Central apneas or hypopneas greater than or equal to 5 times per hour.
- Symptoms of either excessive sleepiness or disrupted sleep. (WAC 182-552-0005)

Chronic Obstructive Pulmonary Disease (COPD) – Any disorder that persistently obstructs bronchial airflow. COPD mainly involves two related diseases—chronic bronchitis and emphysema. Both cause chronic obstruction of air flowing through the airways and in and out of the lungs. The obstruction is generally permanent and worsens over time. (WAC 182-552-0005)

Complex Sleep Apnea (CompSA) – A form of central apnea specifically identified by the persistence or emergence of central apneas or hypopneas, upon exposure to CPAP or a bi-level respiratory assist device without a back-up rate feature, when obstructive events have disappeared. These clients predominantly have obstructive or mixed apneas during the diagnostic sleep study occurring at greater than or equal to five times per hour. With use of a CPAP or bi-level respiratory assist device without a back-up rate feature, the client shows a pattern of apneas and hypopneas that meets the definition of central sleep apnea (CSA). (WAC 182-552-0005)

Compressor – A pump driven appliance that mechanically condenses atmospheric air into a smaller volume under pressure. In respiratory care therapy, it is used to forcefully nebulize liquid solutions or emulsions into a vapor state, or mist for inhalation.

Concentrator – A device that increases the concentration of oxygen from the air.

Continuous Positive Airway Pressure (CPAP) – A single-level device that delivers a constant level of positive air pressure (within a single respiratory cycle) by way of tubing and an interface to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs. (WAC 182-552-0005)

Dependent Edema – Fluid in the tissues, usually ankles, wrists, and the arms. (WAC 182-552-0005)

Emergency Oxygen – The immediate, short-term administration of oxygen to a client who normally does not receive oxygen but is experiencing an acute episode that requires oxygen. (WAC 182-552-0005)

Erythrocythemia – More hematocrit (red blood cells) than normal, making it very difficult to oxygenate those cells. (WAC 182-552-0005)

FIO2 – The fractional concentration of oxygen delivered to the client for inspiration. For the purpose of this policy, the client's prescribed FIO2 refers to the oxygen concentration the client normally breathes when not undergoing testing to qualify for coverage of a Respiratory Assist Device (RAD). That is, if the client does not normally use supplemental oxygen, their prescribed FIO2 is that found in room air. (WAC 182-552-0005)

FEV1 – The forced expired volume in 1 second. (WAC 182-552-0005)

FVC – The forced vital capacity. (WAC 182-552-0005)

Group I – Clinical criteria, set by Medicare, to identify chronic oxygen clients with obvious respiratory challenges as evidenced by low oxygen saturation. For specific clinical criteria, see **Coverage criteria for oxygen**.)

Group II – Clinical criteria, set by Medicare, to identify borderline oxygen clients. Their blood saturation levels seem to be within the normal range, but additional extenuating issues suggest a need for oxygen. (For specific clinical criteria, see **Coverage criteria for oxygen.**)

Group III – Clinical criteria set by Medicare to identify chronic oxygen clients for whom intermittent home oxygen therapy is considered medically necessary (as documented by the client's clinical history) for the treatment of cluster headaches. (For specific clinical criteria, see **Coverage criteria for oxygen.**)

Home and Community Residential Settings – In-home, adult family home, or boarding home. (**WAC 182-552-0005**)

Hypopnea – A temporary reduction of airflow lasting at least ten seconds and accompanied with a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% decrease in oxygen saturation. The AHI is the average number of episodes of apnea and hypopnea per hour of sleep without the use of a positive airway pressure device. (WAC 182-552-0005)

Hypoxemia – Less than normal level of oxygen in the blood. (WAC 182-552-0005)

Month – For the purposes of this guide, means 30 days, regardless of the number of days in a specific calendar month. (WAC 182-552-0005)

Nebulizer – A medical device that administers drugs for inhalation therapy for clients with respiratory conditions such as asthma or emphysema. (WAC 182-552-0005)

Obstructive sleep apnea (OSA) – This syndrome refers to the interruption of breathing during sleep, due to obstructive tissue in the upper airway that collapses into the air passage with respiration. This may occur several hundred times a night and is thought to cause many symptoms, such as depression, irritability, sexual dysfunction, learning and memory difficulties, and the frequent complaint of excessive daytime sleepiness. (WAC 182-552-0005)

Oxygen – Medical grade liquid oxygen or compressed gas. (WAC 182-552-0005)

Oxygen Concentrator – A medical device that removes nitrogen from room air and retains almost pure oxygen (87–95%) for delivery to a client. (WAC 182-552-0005)

Oxygen System – All equipment necessary to provide oxygen to a client. (WAC 182-552-0005)

Portable Oxygen System – A system that allows the client to be independent of the stationary system for several hours, thereby providing mobility for the client. (WAC 182-552-0005)

Pulmonary hypertension – High blood pressure in the vessels that feed through the lungs, causing the right side of the heart to work harder to oxygenate blood. (WAC 182-552-0005)

RAD – Respiratory assist device

Reasonable Useful Lifetime (RUL) – Refers to the 36-month capped rental oxygen equipment; the RUL is 5 years. The RUL is not based on the chronological age of the equipment. It starts on the initial date of service and runs for 5 years from that date. (WAC 182-552-0005)

Respiratory Care – The care of a client with respiratory needs and all related equipment, oxygen, services, and supplies. (WAC 182-552-0005)

Respiratory Care Practitioner – A person licensed by the Department of Health according to chapter 18.89 RCW and chapter 246-928 WAC as a respiratory therapist (RT) or respiratory care practitioner (RCP). (WAC 182-552-0005)

Respiratory Effort Related Arousals (RERA) – These occur when there is a sequence of breaths that lasts at least ten seconds, characterized by increasing respiratory effort or flattening of the nasal pressure waveform, which lead to an arousal from sleep. However, they do not meet the criteria of an apnea or hypopnea. The degree to which RERAs are associated with the same sequelae as apneas and hypopneas is unknown, although clients with only RERAs can be symptomatic in terms of excessive daytime sleepiness. (WAC 182-552-0005)

Restrictive Thoracic Disorders – This refers to a variety of neuromuscular and anatomical anomalies of the chest/rib cage area that may result in hypoventilation, particularly while the client sleeps at night. Nocturnal hypoventilation is associated with a host of health hazards and can significantly impact the quality of life for these clients. The use of noninvasive positive pressure respiratory assist devices has been found helpful in reducing the episodes of nocturnal hypoventilation and the associated complications for a significant number of those clients who are able to use the device.

RUL – Also called Reasonable Useful Lifetime.

Stationary Oxygen System – Equipment designed to be used in one location, generally for the purpose of continuous use or frequent intermittent use. (WAC 182-552-0005)

Ventilator – A device to provide breathing assistance to clients with neuromuscular diseases, thoracic restrictive diseases, or chronic respiratory failure consequent to chronic obstructive pulmonary disease. It includes both positive and negative pressure devices.

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About the Program

What is the purpose of the Respiratory Care program?

(WAC 182-552-0001)

The purpose of the Respiratory Care program is to provide medically necessary respiratory care equipment, services, and supplies to eligible HCA clients who are not enrolled in a managed care plan and reside in:

- A home.
- A community residential setting.
- A skilled nursing facility.

When does HCA pay for respiratory care?

HCA pays for respiratory care when it is:

- Covered.
- Within the scope of the eligible client's medical care program.
- Medically necessary, as defined under WAC 182-500-0070.
- Prescribed by a physician, advanced registered nurse practitioner (ARNP), or physician assistant certified (PAC) within the scope of licensure.
- Authorized, as required within chapters 182-501, 182-502, and 182-552 WAC, and this billing guide.
- Billed according to this billing guide.
- Provided and used within accepted medical or respiratory care community standards of practice.

HCA evaluates on a case-by-case basis for medical necessity and appropriateness those items, procedures, and services that do not have an established procedure code available and which are billed using miscellaneous procedure codes. (WAC 182-552-0001)

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Client Eligibility

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

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

How do I verify a client's eligibility?

Providers must verify that a client has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent billing a service the HCA 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 HCA'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 following note box.

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 Apple Health client's benefit package, see HCA's Program Benefit Packages and Scope of Services webpage.

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

- **Online**: Go to Washington Healthplanfinder - select the "Let's get started" button. For patients age 65 and older or on Medicare, go to Washington Connections select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).

- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form. To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications webpage.** Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Support (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

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

(WAC 182-538-060 and 182-538-095)

Yes. Most Apple Health clients are enrolled in one of HCA-contracted managed care organizations (MCOs). For these clients, managed care enrollment is displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the MCO to an outside provider
- Facility fees associated with dental professional fees

Note: Site of service prior authorization for eligible managed care clients will continue to be determined by HCA for facilities associated with dental procedure codes.

For certified public expenditure (CPE) hospitals that provide medical services to Categorically Needy Medicaid Blind/Disabled clients, bill those services fee-for-service to HCA. To process those claims, the CPE hospital must obtain prior authorization from the MCO and submit that information to HCA in the Claim Note field on the claim in the manner shown below:

PA from [MCO Name]: [Authorization number]

> **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 HCA-contracted MCO, if appropriate. Providers must receive authorization from the client's MCO primary care provider before providing services, **except for emergency services**. See HCA's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.
>
> A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

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

Managed care enrollment

Most Apple Health clients are enrolled in an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination.

Exceptions:

- Apple Health Expansion clients are enrolled in managed care and will not start their first month of eligibility in the FFS program. For more information, visit Apple Health Expansion. Providers must check eligibility to determine enrollment for the month of service.
- Clients who are eligible to receive Reentry Initiative services and who are eligible for enrollment in an HCA-contracted managed care organization (MCO) will not start their first month of eligibility in the FFS program. Providers must check eligibility to determine enrollment for the month of service.

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

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to HCA's Apply for or renew coverage webpage.

Clients' options to change plans

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:

  Go to Washington Healthplanfinder website.

- **Available to all Apple Health clients:**
  - Visit the ProviderOne Client Portal website:
  - Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

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

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

Some Apple Health clients do not meet the qualifications for managed care enrollment or have the option to enroll in fee-for-service (FFS). These clients are eligible for physical health services under the FFS program.

In this situation, each managed care organization (MCO) will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in integrated managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the fee-for-service program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into an integrated managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care Alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

Integrated Apple Health Foster Care (AHFC)

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

Clients under this program are:

- Age 17 and younger who are in foster care (out of home placement) or in the Unaccompanied Refugee Minors (URM) program
- Age 20 and younger who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

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

The Apple Health Customer Services team can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAS) team at 1-800-562-3022, Ext. 15480.

Apple Health Expansion

Apple Health Expansion covers individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs and who receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted health plan. For more information, visit Apple Health Expansion.

Reentry Initiative

The Reentry Demonstration Initiative (Reentry Initiative) is a new Apple Health (Medicaid) initiative under the Medicaid Transformation Project (MTP). Under this initiative, incarcerated people who are Apple Health-eligible may receive a limited set of health care services through fee-for-service (FFS) or their HCA-contracted managed care organization (MCO) for up to 90 days before their release from carceral facilities within Washington State. These services will ensure a person's healthy and successful reentry into their community. For more information, visit **Reentry from a carceral setting**.

Fee-for-service Apple Health Foster Care

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

American Indian/Alaska Native (AI/AN) Clients

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

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

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) **American Indian/Alaska Native webpage**.

Early periodic screening, diagnosis, and treatment (EPSDT)

Early periodic screening, diagnosis, and treatment (EPSDT) includes all services that are medically necessary to address health conditions for clients age 20 and younger. Providers may reference program-specific billing guides for services and equipment not covered by this billing guide and must follow the rules for the EPSDT program described in **Chapter 182-534 WAC**. Published limits for services covered under EPSDT, if any, may be exceeded based on agency review of medical necessity described in **WAC 182-501-0165**.

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

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

Provider Requirements

What are the general responsibilities of a respiratory care provider?

This section includes general responsibilities for respiratory care providers. More specific requirements are described in different sections of this guide.

Providers must meet all the following requirements:

- The general provider requirements in chapters 182-502 and 182-552 WAC and this billing guide
- Maintain all rental equipment in good working condition on a continuous (24 hours a day, seven days a week) basis
- Provide a minimum warranty period of 1 year for all client-owned medical equipment (excluding disposable/non-reusable supplies). (See Warranty section.)

Licensed health care professionals

HCA requires that respiratory care providers employ a licensed health care professional whose scope of practice allows providing respiratory care, including:

- Checking equipment to meet the client's initial and ongoing needs.
- Communicating with the client's authorized prescriber about any concerns or recommendations.

See WAC 182-552-0200(1) and the Department of Health's licensing requirements for more information on licensing requirements.

Are providers responsible for verifying a client's coverage?

Providers must verify the client's eligibility in ProviderOne before providing services.

- If ProviderOne indicates the client is enrolled in a managed care plan, contact the client's MCO for all coverage conditions and limits on services. (See Client Eligibility).
- Bill HCA the usual and customary fee for clients not in managed care and residing at home, in a skilled nursing facility or in a community residential setting.

> **Note**: Also, see What are the client's rights to health care decisions?

What are the requirements for prescriptions?

Respiratory care providers must:

- Keep initial and subsequent prescriptions in the client's record.
- Verify that the client has a valid prescription. (See WACs 182-552-0200 and 182-552-0800). To be valid, a prescription must:
  - Be written, signed, and dated by a Medicaid-enrolled physician, advanced registered nurse practitioner (ARNP), or physician's assistant certified (PAC).

    Note: All respiratory supplies and equipment necessary for or ancillary to the administration or monitoring of medications, including oxygen, such as inhalation masks, spacers, nebulizers, vents, positive airway pressure machines and associated supplies may be ordered by non-physician practitioners (e.g., advanced registered nurse practitioners, physician assistants, etc.) within their scope of practice without a physician signature/co-signature.

    This applies to orders and prescriptions signed before February 1, 2019, and to future orders and prescriptions.

  - State the specific items or services requested, including the quantity, frequency, and duration/length of need.

    Note: Prescriptions that state only as needed or PRN are not sufficient.

  - For an initial prescription, not be older than 3 months from the date the prescriber signed the prescription.
  - For subsequent prescriptions, not be older than 1 year from the date the prescriber signs the prescription.

    (For more details about oxygen prescriptions, see **Requirements for valid oxygen prescriptions**.)

    Note: Under WAC 182-552-0200, HCA does not pay for respiratory care equipment or supplies when the authorized prescriber providing a client's evaluation or an item's medical justification also has a financial relationship with the provider, including employment or a contract.

What are the delivery requirements?

Respiratory care providers must:

- Obtain prior authorization (PA) from HCA, if required, before delivering respiratory care equipment and supplies to the client and billing HCA.
- Make regular deliveries of medically necessary oxygen to the client's home, skilled nursing facility, or community residential facility.
- Provide instructions to the client and the client's caregiver on the safe and proper use of the equipment provided.
- Furnish proof of direct delivery of equipment to a client or a client's authorized representative when requested by HCA. Proof of delivery must include:
  - The client's name.
  - Detailed description of the item(s) delivered, including the quantity, brand name, and serial number.
  - A signature and date by the client (or client's authorized representative) when the item was received. See WAC 182-552-0250.

What are the client's rights to health care decisions?

(42 CFR §489.102)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment.
- Make decisions concerning their own medical care.
- Prepare an advance directive, such as a living will or durable power of attorney, for their health care.

Coverage

What are the coverage criteria for respiratory care services?

This section describes general clinical criteria and policies for respiratory care services, equipment, and supplies.

Inhalation drugs and solutions are included in the Medicaid prescription drug program (see chapter 182-530 WAC).

> **Note:** Requests do not require prior authorization (PA) when meeting the clinical criteria for covered respiratory care for Medicaid clients. When requests do not meet the clinical criteria, as specified in this guide— including those associated with expedited prior authorization (EPA)—PA is required. HCA evaluates requests requiring PA on a case-by-case basis to determine whether they are medically necessary. (See WAC 182-552-0001(4) and (5) and WAC 182-552-1325). For more details about PA requests, including EPA and limitation extension, see Authorization.

For details about specific items, see the Coverage Table, which lists equipment and supplies with:

- Associated codes.
- Any authorization requirements (PA and EPA).
- Any limits and specific comments per code.

HCA does not pay for respiratory care equipment and supplies or related repairs and labor charges under fee-for-service (FFS) when the client is:

- An inpatient hospital client.
- Terminally ill and receiving hospice care.
- An enrollee in a risk-based MCO that includes coverage for such items or services.

Telemedicine

Telemedicine is covered under HCA's Respiratory Care program. Refer to HCA's **Provider Billing Guides and Fee Schedules webpage**, under *Telehealth*, for more information on the following:

- Telemedicine policy, under *Telemedicine policy and billing*
- Audio-only procedure code lists, under *Audio-only telemedicine*

For COVID PHE telemedicine/telehealth policies, refer to HCA's **Provider Billing Guides and Fee Schedules webpage**, under *Telehealth* and *Clinical policy and billing for COVID-19*.

What types of airway clearance devices does HCA cover?

Clinical criteria

Chest physiotherapy (CPT), also known as percussion and postural drainage (P/PD), is traditionally seen as the standard of care of secretion clearance methods. However, there are client instances when conventional manual CPT is unavailable, ineffective, or not tolerated.

HCA covers the following types of airway clearance devices when medically necessary for a person with a diagnosis characterized by excessive mucus production and difficulty clearing secretions:

- Mechanical percussors
- Oscillatory positive expiratory pressure devices
- Positive expiratory pressure devices
- Cough stimulating devices, including replacement batteries, alternating positive and negative airway pressure
- High frequency chest wall oscillation air-pulse generator system

> **Note:** High frequency chest wall oscillation air-pulse generator systems require prior authorization and must be accompanied by a completed *Application for Chest Wall Oscillator (Vest) form (HCA 13-0133 12/24)*. See *Where can I download HCA forms?*

For specific details about items covered, see **Miscellaneous** in the Coverage Table.

Does HCA cover the rental of apnea monitors?

Clinical criteria

HCA covers, without PA, the rental of an apnea monitor with recording feature for a maximum of 6 months when:

- The vendor has a licensed clinician who:
  - Is competent in pediatric respiratory care.
  - Is responsible for managing the client's apnea monitoring.
- The client is less than 1 year of age and meets at least **one** of the following clinical criteria:
  - Born less than 37-weeks' gestation, and the infant is not more than 43 weeks corrected gestational age
  - Had an apparent life-threatening apneic event (defined as requiring mouth-to-mouth resuscitation or vigorous stimulation)
  - Has been diagnosed with bradycardia and is being treated with caffeine, theophylline, or other stimulating agents
  - Has documented gastro-esophageal reflux, which results in apnea, bradycardia, or oxygen desaturation
  - Has documented apnea greater than 20 seconds in duration
  - Has apnea for periods less than 20 seconds in duration and accompanied by bradycardia, cyanosis, or pallor
  - Has bradycardia (defined as heart rate less than 100 beats per minute)
  - Has oxygen desaturation below 90%
  - Has neurologic/anatomic/metabolic or respiratory diseases affecting respiratory drive
  - Is a subsequent sibling of an infant who died of sudden infant death syndrome (SIDS) until the client is 1 month older than the age at which the earlier sibling died, and the client remains event-free

For each subsequent rental period:

- The client must continue to meet the clinical criteria for apnea monitors.
- The vendor must obtain PA from HCA.

The vendor must document the results of the use of the apnea monitor in the client's records.

For specific details about items covered, see Apnea monitor and supplies in the Coverage Table.

Does HCA cover bi-level respiratory assist devices (RADs)?

Clinical criteria

HCA covers, without PA, one bi-level respiratory assist device (RAD), with or without a back-up rate feature, per client every 5 years if the following criteria are met:

- The bi-level device has a data card.
- The client has one of the following conditions and meets the specific clinical criteria specified in this section:
  - Restrictive thoracic disorders (such as neuromuscular diseases or severe thoracic cage abnormalities)
  - Severe chronic obstructive pulmonary disease (COPD)
  - Central or complex sleep apnea
  - Hypoventilation syndrome

PA is required for bi-Level RADs if one of the following applies:

- The client does not meet the required clinical criteria.
- HCA has purchased a CPAP device or other RAD for the client within the last 5 years.
- The client has a concurrent rental for a noninvasive ventilator.

Bi-level RAD without the back-up rate feature

For a bi-level RAD without the back-up rate feature, HCA:

- Pays for rental of the device during an initial 3-month period.

  The treating authorized prescriber must:
  - Conduct a face-to-face clinical re-evaluation of the client between day 31 and day 91 of the rental period.
  - To continue rental of the device, document the following items in the client's file to show:
    - The progress of the client's relevant symptoms.
    - The client's compliance with using the device.
- Purchases the device after the requirements for the rental are met.

Bi-level RAD with the back-up rate feature

For a bi-level RAD with the back-up rate feature used with an invasive interface, HCA pays for the rental only.

For a bi-level RAD with the back-up rate feature used with a noninvasive interface, HCA:

- Pays for rental of the device during an initial 3-month period. The treating authorized prescriber must:
  - Conduct a face-to-face clinical re-evaluation of the client between 31 and 91 days of the rental period.
  - To continue rental of the device, document the following items in the client's file to show:
    - The progress of the client's relevant symptoms.
    - The client's compliance with using the device.
- Purchases after a total of 13 months of rental.

Required clinical criteria for using RADs with specific types of respiratory disorders

Type of Respiratory Disorder	Type of Device Paid for by HCA	PA	Required Clinical Criteria
Restrictive Thoracic Disorders	Bi-level RAD device with or without back-up rate feature	No – when all clinical criteria are met	The client has been diagnosed with a neuromuscular disease, such as amyotrophic lateral sclerosis (ALS) or a severe thoracic cage abnormality (for example, post-thoracoplasty for tuberculosis). Chronic obstructive pulmonary disease (COPD) does not contribute significantly to the person's pulmonary limitation. The client also meets one or more of these clinical criteria: • An arterial blood gas $PaCO_2$, done while awake and breathing the client's prescribed FIO_2 (fractionated inspired oxygen concentration) is ≥ 45 mm Hg. • Sleep oximetry demonstrates an oxygen saturation ≤ 88% for ≥ 5 minutes of nocturnal recording time (minimum record time of 2 hours), done while breathing the client's prescribed recommended FIO_2. • For a neuromuscular disease (only), either: Maximal inspiratory pressure is < 60 cm H2O **OR** Forced vital capacity is ≤ 50% predicted.

Type of Respiratory Disorder	Type of Device Paid for by HCA	PA	Required Clinical Criteria
Severe Chronic Obstructive Pulmonary Disease (COPD)	Bi-level RAD device without back-up rate feature	No—when all clinical criteria are met	The client meets all these clinical criteria: • An arterial blood gas $PaCO_2$, done while awake and breathing the client's prescribed FIO_2, is ≥ 52 mm Hg. • Sleep oximetry demonstrates oxygen saturation ≤ 88% for ≥ 5 minutes of nocturnal recording time (minimum recording time of 2 hours), done while breathing oxygen at 2 LPM or the client's prescribed FIO_2 (whichever is higher). • Before initiating therapy, obstructive sleep apnea and treatment with CPAP has been considered and ruled out.

Type of Respiratory Disorder	Type of Device Paid for by HCA	PA	Required Clinical Criteria
COPD (cont.)	Bi-level RAD device with the back-up rate feature	No—when all clinical criteria are met	Started any time **after the initial use of the bi-level RAD without the backup rate feature** when both these clinical criteria are met: • An arterial blood gas $PaCO_2$, done while awake and breathing, the client's prescribed FIO_2 shows that the client's $PaCO_2$ worsens ≥ 7 mm Hg compared to the original result from using the bi-level RAD without the back-up rate feature. • A facility-based PSG demonstrates oxygen saturation ≤ 88% for ≥ 5 minutes of nocturnal recording time (minimum recording time of 2 hrs) while using a bi-level RAD without the back-up feature. (Not caused by obstructive upper airway events—that is, AHI less than 5). **-OR-** Started at a time no sooner than 61 days **after initial use of the bi-level RAD without the back-up rate feature** when both these clinical criteria are met: • An arterial blood gas PaCO2, done while awake and breathing, the client's prescribed FIO_2 still remains ≥ 52 mm Hg. • Sleep oximetry while breathing with the bi-level RAD without the back-up rate demonstrates oxygen saturation ≤ 88% for ≥ 5 minutes of nocturnal recording time (minimum recording time of 2 hrs), done while breathing oxygen at 2 LPM or the client's prescribed FIO_2, whichever is higher.

Type of Respiratory Disorder	Type of Device Paid for by HCA	PA	Required Clinical Criteria
Central or Complex Sleep Apnea (not due to airway obstruction)	Bi-level RAD device *with or without* the back-up rate feature	No—when the client's polysomnogram test meets clinical criteria	The client's polysomnogram test reveals both: • The diagnosis of central sleep apnea (CSA) or complex sleep apnea (CompSA). • Significant improvement of the sleep-associated hypoventilation with the use of a bi-level RAD device with or without the back-up rate feature on the settings that will be prescribed for initial use at home, while breathing the client's usual FIO_2.
Obstructive Sleep Apnea (OSA)	Bi-level RAD device **without** the back-up rate feature	No—when all clinical criteria are met	The client meets the clinical criteria for a CPAP. However, the CPAP has been tried and proven ineffective. Ineffective in this case, is defined as documented failure to meet therapeutic goals using a CPAP during either: • The titration portion of a facility-based study. • Home use despite optimal therapy (that is, proper mask selection and fitting and appropriate pressure setting).

Type of Respiratory Disorder	Type of Device Paid for by HCA	PA	Required Clinical Criteria
Hypoventilation Syndrome	Bi-level RAD device **without** the back-up rate feature	No—when all clinical criteria are met	The client meets one of these three sets of clinical criteria: • An initial arterial blood gas $PaCO_2$, done while awake and breathing the client's prescribed FIO_2, ≥ to 45 mm Hg. • Spirometry shows an FEV1/FVC ≥ to 70% and an FEV1 ≥ 50% of predicted. **-OR-** • An arterial blood gas $PaCO_2$, done during sleep or immediately upon awakening, and breathing the client's prescribed FIO_2, shows the client's $PaCO_2$ worsened ≥ to 7 mm Hg compared to the original result. **-OR-** • A facility-based PSG demonstrates oxygen saturation ≤ 88% for ≥ to 5 continuous minutes of nocturnal recording time (minimum recording time of 2 hours) that is not caused by obstructive upper airway events—that is, AHI less than 5.

Type of Respiratory Disorder	Type of Device Paid for by HCA	PA	Required Clinical Criteria
Hypoventilation Syndrome (cont.)	Bi-level RAD device **with** the back-up rate feature	No—when all clinical criteria are met	The client meets both of these clinical criteria: • A covered bi-level RAD without the back-up rate feature is being used. • Spirometry shows an FEV1/FVC ≥ 70% and an FEV1 ≥ 50% of predicted. The client ***also*** meets one of these clinical criteria: • An arterial blood gas $PaCO_2$, done while awake and breathing the client's prescribed FIO_2, shows that the client's $PaCO_2$ worsens ≥ 7 mm Hg compared to the ABG result performed to qualify the client for the bi-level RAD without the back-up rate feature. **-OR-** • A facility-based PSG demonstrates oxygen saturation ≤ to 88% percent for ≥ 5 continuous minutes of nocturnal recording time (minimum recording time of 2 hours) that is not caused by obstructive upper airway events—that is, AHI less than 5 while using a bi-level RAD without the back-up rate feature.

Replacement of bi-level RAD equipment and supplies

- PA is required for the replacement of a bi-level RAD device if the client has had the device for less than 5 years.
- After 5 years, the client's authorized prescriber must conduct a face-to-face evaluation documenting that the client continues to use and benefit from the bi-level RAD device. A new polysomnogram (PSG) (sleep test), trial period, or PA is not required.
- HCA pays for replacement supplies for a bi-level RAD device, as identified in the Coverage Table.

For specific details about items covered, see **Apnea monitor and supplies** and **Ventilators and related respiratory equipment** in the Coverage Table.

HCA does not cover accessories or services not specifically identified in this guide.

Does HCA cover continuous positive airway pressure (CPAP) and supplies?

Clinical criteria

HCA covers, without PA, one continuous positive airway pressure (CPAP) device including related supplies, per client, every 5 years when all the following criteria are met:

- The client is diagnosed with obstructive sleep apnea using a clinical evaluation and a positive attended polysomnogram (PSG) performed in a sleep laboratory or performed during an unattended home sleep study.

> **Note**: HCA does not pay for a CPAP device when the client is diagnosed with upper airway resistance syndrome (UARS).

- CPAP is the least costly, most effective treatment modality.
- The CPAP device has a data card and is FDA approved.
- The item requested is not included in any other reimbursement methodology such as the diagnosis-related group (DRG).

Additional criteria for clients age 21 and older

- The client's polysomnogram demonstrates an apnea-hypopnea index (AHI) ≥ 15 events per hour with a minimum of 30 events.

-OR-

- The client's PSG demonstrates the AHI is ≥ 5 and ≤ 14 events per hour with a minimum of 10 events and clinical documentation of one of the following:
  - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia.
  - Hypertension, ischemic heart disease, or history of stroke.

Additional criteria for clients age 20 and younger

Clinical criteria must include:

- A documented diagnosis of obstructive sleep apnea (OSA).
- A PSG that demonstrates an apnea index (AI) or apnea-hypopnea index (AHI) ≥ 1 and one of the following:
  - Adenotonsillectomy has been unsuccessful in relieving OSA.
  - Adenotonsillar tissue is minimal.

- Adenotonsillectomy is inappropriate based on OSA being attributable to another underlying cause (such as craniofacial anomaly or obesity) or adenotonsillectomy is contraindicated.
- The client's family does not wish to pursue surgical intervention.

Note: The AHI is calculated on the average number of events per hour. If the AHI is calculated based on less than two hours of sleep or recording time, the total number of recorded events used to calculate the AHI must be at least the number of events that would have been required in a two-hour period (that is, must reach at least 30 events without symptoms or at least 10 events with symptoms).

Use of RAD instead of CPAP

If a client meets the criteria for CPAP, but a CPAP device has been tried and proven ineffective, HCA will cover a bi-level RAD without the back-up. Ineffective, in this case, means documented failure to meet therapeutic goals using a CPAP during either:

- The titration portion of a facility-based study.
- Home use despite optimal therapy (that is, proper mask selection and fitting and appropriate pressure setting).

Prior authorization for a CPAP device

PA is required for a CPAP device when any of the following occurs:

- The client does not meet the required **clinical criteria.**
- HCA has purchased either a CPAP or a bi-level RAD device for the client within the last 5 years.
- The client has a concurrent rental for a noninvasive ventilator.

Rental and purchase of a CPAP device

After the initial 3-month rental period for a CPAP device, HCA will consider purchasing this device for the client.

Note: The provider must submit a purchase request to HCA. The following documentation of clinical benefit must be recorded in the client's file:

- A face-to-face clinical re-evaluation of the client by the authorized prescriber, which documents that symptoms of obstructive sleep apnea are improved.

- A review of objective evidence by the authorized prescriber of the client's adherence* to use of the CPAP device.

* Adherence is defined as use of the CPAP device ≥ 4 hours per night on 70% of nights during a consecutive 30-day period anytime during the first 3 months of initial usage.

For specific details about CPAP-related covered items, see **Continuous positive airway pressure (CPAP) device** in the Coverage Table.

Replacement of CPAP equipment and supplies

- PA is required for the replacement of a CPAP device if the client has had the device for less than 5 years.
- After 5 years, the client's treating authorized prescriber must conduct a face-to-face evaluation documenting that the client continues to use and benefit from the CPAP device. A new PSG (sleep test), trial period, or PA is not required.
- HCA pays for replacement supplies for a CPAP device, as identified in **Apnea monitor and supplies** in the Coverage Table.

Does HCA cover mandibular advancement devices?

HCA covers one mandibular advancement device, per client, every 5 years when clinical criteria are met. Prior authorization is required. See HCA's **Sleep Centers** Billing Guide for more information, including how to bill.

Does HCA cover nebulizers and related compressors?

Clinical criteria

HCA covers, without PA, the purchase of a nebulizer and related compressor, with limits, when the following clinical criteria are met:

- The **small** volume nebulizer and related compressor are covered for administering inhalation drugs for:
  - The management of obstructive pulmonary disease.
  - A client with cystic fibrosis or bronchiectasis.
  - A client with HIV, pneumocystosis, or complications of organ transplants.
  - Persistent, thick, or tenacious pulmonary secretions.

- The **large** volume nebulizer and related compressor are covered to deliver humidity to a client who has thick, tenacious secretions and has:
  - Cystic fibrosis.
  - Bronchiectasis
  - A tracheostomy
  - A tracheobronchial stent

The filtered nebulizer is covered when necessary to administer pentamidine to clients with HIV, pneumocystosis, or complications of organ transplants.

HCA does not pay for a large volume nebulizer, related compressor/generator, and water or saline when used predominantly to provide room humidification.

For specific details about items covered, see **Nebulizers and accessories** in the Coverage Table.

Does HCA cover oximeters?

For clients age 17 and younger

Clinical criteria for standard oximeters

HCA covers the purchase of a standard oximeter, without PA, for clients age 17 and younger in the home when the client meets one of the following criteria:

- Has chronic lung disease and is on supplemental oxygen
- Has a compromised or artificial airway
- Has chronic lung disease requiring a ventilator or a bi-level RAD

Clinical criteria for enhanced oximeters

HCA covers the purchase of enhanced oximeters with expedited prior authorization (EPA) for clients age 17 and younger in the home when the clinical criteria for the standard oximeter and EPA criteria are met. See **EPA #870000006**. If the client does not meet the EPA criteria, PA is required. See **What is prior authorization (PA)?**

For clients age 18 and older

Clinical criteria for standard and enhanced oximeters

HCA covers the purchase of standard and enhanced oximeters for continuous pulse oximetry monitoring, with PA, for clients age 18 and older in the home when the client meets one of the following criteria:

- Has chronic lung disease and is on supplemental oxygen
- Has a compromised or artificial airway
- Has chronic lung disease requiring a ventilator or a bi-level RAD

For specific details about items covered, see **Miscellaneous equipment reimbursement** in the Coverage Table.

Does HCA cover oxygen?

HCA covers oxygen without PA when the clinical criteria are met.

Requirements for valid oxygen prescriptions

- HCA requires a valid prescription for oxygen under WAC 182-552-0200.
- When prescribing oxygen, follow these requirements:
  - Include the flow rate of oxygen, estimated length of need, frequency and duration of oxygen use, and the client's target oxygen saturation level on the prescription. Prescriptions that state only as needed or PRN are not sufficient.
  - Both initial and ongoing oxygen prescriptions must include documentation of the client's oxygen saturations or lab values to support the need for continued oxygen use.
- HCA requires that documentation be kept in the client's record for oxygen saturation and lab values to verify the medical necessity of continued oxygen.
  - Oxygen saturation measurements must be performed by a provider or a supplier of laboratory services.
  - For an inpatient hospital client anticipated to require oxygen when going home, oxygen saturation must be measured within two days of discharge.
  - HCA does not accept lifetime certificates of medical need (CMNs). See WAC 182-552-0800.

Coverage criteria for oxygen

Clients	Criteria	Renew prescription	Documented verification by provider

For Group I clients	Any of the following:
	• An arterial PaO_2 at or below 55mm Hg or an arterial oxygen saturation (SaO_2) at or below 88% taken at rest (awake) while breathing room air
	• An arterial PaO_2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88% for at least 5 minutes
	  • Taken during sleep for a client who demonstrates an arterial PaO_2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89% while awake
	  • In this instance, oxygen and oxygen equipment are reasonable and necessary only during sleep.
	• A decrease in arterial PaO_2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5% from baseline saturation taken during sleep associated with symptoms of hypoxia (for example, impairment of cognitive processes and nocturnal restlessness or insomnia).
	  • In this instance, oxygen and oxygen equipment are reasonable and necessary only during sleep
		At least every 12 months thereafter, or length of need as specified by authorized prescriber, provided that clinical criteria continue to be met	For both the initial and renewal prescriptions, document how the client specifically meets the criteria.
			For ongoing coverage, the provider or a supplier of laboratory services must perform the oxygen saturation measurements.

Clients	Criteria	Renew prescription	Documented verification by provider
For Group I clients (cont.)	• An arterial PaO_2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88%, taken during exercise for a client who demonstrates an arterial PaO_2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89% during the day while at rest. • In this case, oxygen is provided during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air.	At least every 12 months thereafter, or length of need as specified by authorized prescriber, provided that clinical criteria continue to be met	For both the initial and renewal prescriptions, document how the client specifically meets the criteria. For ongoing coverage, the provider or a supplier of laboratory services must perform the oxygen saturation measurements.
For Group II clients	The presence of an arterial PaO_2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89% **AND** Any of the following: • Dependent edema suggesting congestive heart failure. • Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or **P** pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF). • Erythrocythemia with a hematocrit greater than 56%.	3 months after initial prescription and annually thereafter, provided that clinical criteria continue to be met	For both the initial and renewal prescriptions, document how the client specifically meets the criteria. For ongoing coverage, the provider or a supplier of laboratory services must perform the oxygen saturation measurements.

Clients	Criteria	Renew prescription	Documented verification by provider

For Group III clients	All the following:
	• At least five attacks of severe, strictly unilateral pain which is orbital, supraorbital, temporal, or in any combination of these sites, lasting 15-180 minutes and occurring from once every other day to eight times a day.
	• At least one of the following symptoms or signs, ipsilateral to the headache:
	  • Conjunctival injection and/or lacrimation
	  • Nasal congestion and/or rhinorrhea
	  • Eyelid oedema
	  • Forehead and facial sweating
	  • Miosis and/or ptosis
	• Occurring with a frequency between one every other day and eight per day
	• Not better accounted for by another ICHD-3 diagnosis.
	• Prevents ability to function in all activities
	• Other treatment has failed
		At least every 12 months thereafter, or length of need as specified by authorized prescriber, provided that clinical criteria continue to be met	For both the initial and renewal prescriptions, document how the client specifically meets the criteria.
			For ongoing coverage, the provider or a supplier of laboratory services must perform the oxygen saturation measurements.

Renting capped rental oxygen systems and contents

- Capped rental applies **only** to in-home oxygen use by medical assistance clients. Oxygen systems are considered **capped rental** (provider continues to own the equipment) after 36 months.
- HCA makes only 36 rental payments for stationary oxygen system and portable oxygen system equipment.
- During the rental period, HCA's payment includes any supplies, accessories, oxygen contents, delivery and associated costs, instructions, maintenance, servicing, and repairs.
- Throughout the 36-month capped rental period, the supplier who provides the oxygen equipment for the first month must continue to provide any necessary oxygen equipment and related items and services.
- The supplier (provider) must continue to provide the client with properly functioning oxygen equipment (including maintenance and repair), and

associated supplies for the remaining 24 months of the equipment's reasonable useful lifetime (RUL).

- During the remaining 24 months, the supplier may bill HCA only for:
  - Oxygen contents.
  - Disposable supplies.
  - Maintenance fees, which are limited to one every 6 months.
- The provider may replace the equipment any time after the end of the 5-year RUL, which begins a new 36-month rental period.
- Using the **EPA** process, providers may restart a 36-month rental period in any of the following situations:
  - The initial provider is no longer providing oxygen equipment or services.
  - The initial provider's core provider agreement with HCA is terminated or expires.
  - The client moves to an area that is not part of the provider's service area. (This applies to Medicaid-only clients.)
  - The client moves into a permanent residential setting.
  - A pediatric client is transferred to an adult provider.
- Once a provider requests and receives PA, HCA may authorize a restart of the 36-month rental period when:
  - Extenuating circumstances occur, resulting in a loss or destruction of oxygen equipment (for example, fire, or flood). (See WAC 182-501-0050(7)).
  - The client was exercising reasonable care.

Note: For further details, see the EPA criteria table and the EPA process in Authorization.

Payment for new equipment on capped rental items

Capped rental equipment is considered to have a reasonable useful lifetime of 5 years. HCA pays for new equipment on capped rental items for eligible clients after 5 years of continuous use, at which point the capped rental period of 36 months will start again.

Stationary and portable oxygen systems and contents

HCA covers, without PA, the rental of a stationary oxygen system and a portable oxygen system, as follows:

- For clients age 20 and younger, when prescribed by the client's treating practitioner.

- For clients age 21 and older, when prescribed by a practitioner and the client meets Group I, Group II, or Group III clinical criteria. (See **Coverage criteria for oxygen**.) PA is required for clients age 21 and older, who do not meet clinical criteria.
- Stationary oxygen systems are one of the following:
  - Compressed gaseous oxygen
  - Stationary liquid oxygen
  - A concentrator
- A portable oxygen system can be either gas or liquid.

For specific details about items covered, see **Oxygen and oxygen equipment**.

Rental

- HCA pays a maximum of one rental payment every 30 days (1 unit=30 days) per client for stationary or portable oxygen systems, including oxygen contents.
- Billing and payment are based on a 30-day period, not a monthly calendar period. The period starts on the day of delivery and is a rolling 30-day period.
- The rental of a stationary oxygen system and a portable oxygen system is covered without prior authorization for clients who are:
  - Age 20 and younger, when prescribed by the client's treating practitioner.
  - Age 21 and older, when prescribed by a practitioner and the client meets Group I, Group II, or Group III clinical criteria.
- PA is required for clients age 21 and older who do not meet clinical criteria for rental of a stationary oxygen system or a portable oxygen system.

Additional Rental Information

HCA pays a monthly amount per client for oxygen and oxygen equipment. For stationary oxygen equipment, this monthly amount covers the oxygen equipment, contents, and supplies and is subject to adjustment depending on the amount of oxygen prescribed (liters per minute – LPM) and whether portable oxygen is also prescribed.

Prescribed flow rate (liters per minute-LPM) of oxygen when client is at rest

Modifier	Description
QE	Prescribed amount of stationary oxygen **while at rest is less than 1 LPM**
QF	Prescribed amount of stationary oxygen **while at rest exceeds 4 LPM and portable oxygen is prescribed**
QG	Prescribed amount of stationary oxygen **while at rest is greater than 4 LPM**

If the prescribed amount of oxygen is less than 1 LPM, HCA reduces the maximum allowable amount for stationary oxygen rental by 50%.

HCA increases the maximum allowable amount for stationary oxygen equipment rental under the following conditions. If both conditions apply, vendors use the higher of either of the following add-ons. Vendors are not paid for both add-ons.

- **Volume adjustment – Add On**
  - If the prescribed amount of oxygen for stationary equipment exceeds 4 liters per minute, the fee schedule amount for stationary oxygen rental is increased by 50%.
  - If the prescribed liter flow for stationary oxygen equipment is different than the flow for portable oxygen equipment, or the flow is different for when the client is at rest or is exercising, vendors must use the prescribed amount for stationary systems and for clients at rest.
  - If the prescribed liter flow is different for day and night use, venders use the average of the two rates.
- **Portable Oxygen - Add-On** – If portable oxygen is prescribed, the fee schedule amount for portable equipment is added to the fee schedule amount for stationary oxygen equipment rental.

Varying prescribed flow rate (liters per minute – LPM) of oxygen

To provide greater specificity in the modifiers used for oxygen volume adjustment in instances where there are varying prescribed flow rates, use one of the following modifiers on the claim to identify the prescribed flow rate and to ensure appropriate use of modifiers in all cases based on the prescribed flow rate at rest (or at night or based on the average of the rate at rest and at night, if applicable).

Modifier	Description
QA	Prescribed amount of stationary oxygen **while at rest is less than 1 LPM**
QB	Prescribed amount of stationary oxygen **while at rest exceeds 4 LPM and portable oxygen is prescribed**
QR	Prescribed amount of stationary oxygen **while at rest is greater than 4 LPM**

Contents

HCA pays a maximum of one payment for oxygen contents per client, every 30 days, when the client owns the oxygen system or when the capped rental period is met.

Maintenance

HCA pays one maintenance fee every six months for an oxygen concentrator and oxygen transfilling equipment only when the capped rental period is met or the client owns the oxygen concentrator. The maintenance fee is 50% of the monthly rental rate.

What types of services, equipment, and supplies does HCA not pay for?

- HCA does not pay for oxygen therapy and related services, equipment or supplies for clients age 21 and older with, but not limited to, any one of the following conditions:
  - Angina pectoris in the absence of hypoxemia.
  - Dyspnea without cor pulmonale or evidence of hypoxemia.
  - Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia.
- HCA does not pay separately for:
  - Accessories, such as humidifiers, necessary for the effective use of oxygen equipment. These are included in the monthly rental payment.
  - Spare tanks of oxygen and related supplies as back-up or for travel.

Does HCA cover suction pumps and supplies?

HCA:

- Covers suction pumps and supplies when medically necessary for airway clearance or tracheostomy suctioning.
- Pays for a maximum of two suction devices per client in a 5-year period as follows:
  - HCA rents one primary suction device (stationary or portable) per client for use in the home and one secondary suction device per client for back-up or portability.
  - HCA considers the suction devices purchased after 12 months' rental.

For specific details about items covered, see Suction pump/supplies.

Does HCA cover customized tracheostomy/laryngectomy tubes?

HCA covers the purchase of customized tracheostomy/laryngectomy tubes. HCA pays for tracheostomy/laryngectomy tubes when the client meets one or more of the following clinical criteria:

- Continuous and severe stoma or mucosa, or both, breakdown is not responsive to treatment and results in difficult to maintain standard tracheostomy tube placement.
- Frequent tracheostomy tube dislodgment of standard tracheostomy tubes occurs due to a client-specific medical diagnosis
- HCA determines medical necessity after clinical review

Prior authorization (PA) is required and must include the following:

- Documentation of client-specific medical necessity for customized tracheostomy tube, including the above clinical criteria.
- Documentation of treatment, including stoma care and standard tracheostomy alternatives such as changing brand, style, and size that have been tried and failed. Include dates of treatment.
- Certification by the client's physician that less costly alternatives have been tried and failed, or could be reasonably expected to fail, or are inappropriate for the client

> **Note:** Prescribe the most cost-effective alternative, including the least costly, customized tube. Client-specific medical necessity for a customized tracheostomy tube does not include a diagnosis of tracheostomy, chronic respiratory failure, or ventilator dependence.

See Tracheostomy care supplies for applicable HCPCS codes, modifiers, and limitations.

Does HCA cover ventilator equipment and supplies?

Primary ventilator

- HCA covers the rental of a ventilator, equipment, and disposable ventilator supplies when the client requires periodic or mechanical ventilation for the treatment of chronic respiratory failure resulting from hypoxemia or hypercapnia.
- HCA covers medically necessary ventilator equipment rental and related disposable supplies when all the following apply:
  - There is a prescription for the ventilator.
  - The ventilator is to be used exclusively by the client for whom it is requested.
  - The ventilator is FDA-approved.
  - The item requested is not included in any other reimbursement methodology such as, but not limited to, diagnosis-related group (DRG).

- HCA's monthly rental rate includes ventilator maintenance and accessories, including but not limited to:
  - Alarms
  - Adapters
  - Batteries
  - Cables
  - Chargers
  - Circuits, and filters
  - Connectors
  - Fittings
  - Humidifiers
  - Nebulizers
  - Temperature probes
  - Tubing

> **Note:** HCA does not pay separately for ventilator accessories unless the client owns the ventilator system.

Secondary (back-up) ventilators

HCA covers a secondary (back-up) ventilator at 50% of the monthly rental rate when one or more of the following clinical criteria are met:

- The client cannot maintain spontaneous or adequate ventilation for four or more consecutive hours.
- The client lives in an area where a replacement ventilator cannot be provided within two hours.
- The client requires mechanical ventilation during mobility as prescribed in their plan of care.

Multi-function ventilators

HCA covers the rental of a multi-function ventilator when a client meets criteria for a ventilator **and** requires invasive ventilation **and** at least requires suction.

> **Note**: Refer to Does HCA cover ventilator equipment and supplies? and Does HCA cover suction pumps and supplies? for coverage criteria.

- The following therapies/supplies/equipment are included in the reimbursement for HCPCS code E0467 and are not separately reimbursed:
  - Ventilator (includes ventilator maintenance and accessories, including but not limited to: alarms, adapters, batteries, cables, chargers, circuits, filters, connectors, fittings, humidifiers, temperature probes, and tubing)
  - Oxygen and oxygen equipment
  - Nebulizer, compressor, and related accessories
  - Aspirator and related accessories
  - Cough stimulator
  - Mechanical insufflation-exsufflation devices and related accessories
  - High-frequency chest wall oscillation devices and related accessories
  - Oscillatory positive expiratory pressure devices
- The following is considered a duplicate request and will be denied: The client is currently in a rental month for any therapies/supplies/equipment included in the reimbursement for HCPCS code E0467.
- The billing provider's prior authorization request must include documentation that the client meets coverage criteria.

Prior Authorization (PA)

- Multi-function ventilators require prior authorization.
- Noninvasive ventilators (HCPCS code E0466) require PA when the agency reimbursed RAD, BiPAP, or CPAP devices for the client in the last five years.

Expedited Prior Authorization (EPA)

All ventilators except multi-function ventilators require EPA. See **What is expedited prior authorization (EPA)**? At the time of authorization, the following criteria must be documented in the patient record and available to HCA upon request:

- Medical history (not required if request is for continuation of services)
- Diagnosis and degree of impairment
- Degree of ventilatory support required (e.g., continuous, nocturnal only)
- Ventilator settings/parameters including mode and type of ventilator ordered at time of authorization request

The EPA is valid for either 6 or 12 months. If the client has no clinical potential for weaning, HCA's EPA is valid for 12 months. If the client has the potential to be weaned, HCA's EPA is valid for 6 months.

For specific details about items covered, see **Ventilators and related respiratory equipment**.

How does HCA decide to rent or purchase equipment?

- HCA bases its decision to rent or purchase respiratory care equipment and supplies on the cost and length of time the client needs the equipment.
- A provider must not bill HCA for the rental or purchase of equipment supplied to the provider at no cost by suppliers or manufacturers.
- HCA purchases **new** respiratory equipment only.
    - A new respiratory item that is placed with a client initially as a rental item is considered a new item by HCA at the time of purchase.
    - A used respiratory item that is placed with a client initially as a rental item must be replaced by the supplier with a new item before HCA purchases it.
- HCA requires a dispensing provider to ensure that the respiratory equipment rented to a client:
    - Is in good working order.
    - Is comparable to equipment the provider rents to clients with similar medical equipment needs who are either private pay clients or who have other third-party coverage.
- HCA's minimum rental period for covered respiratory care equipment and supplies is one day.
- HCA's payment for rented respiratory care equipment and supplies includes:
    - A full-service warranty.
    - Cost of delivery to, or pick-up from, the client's residence and, when appropriate, to and from the room in which the equipment will be used.
    - Fitting, set-up, adjustments, and modifications.
    - Maintenance, repair and replacement, and cleaning of the equipment.
    - Instructions to the client and the client's caregiver for safe and proper use of the equipment.
    - All medically necessary accessories, contents, and disposable supplies, unless separately billable according to these billing instructions.
- HCA considers some rented equipment to be purchased after 12 months' rental unless the equipment is restricted as rental only or is otherwise defined in this guide.
- Respiratory care equipment and related services purchased by HCA for a client are the client's property, unless identified as capped rental items by HCA. Capped rental items are considered the property of the provider.
- In the event of a client's ineligibility, death, or discontinued use of equipment, rental fees end on the last day of eligibility, life, or medically necessary usage. Payment is prorated in these cases.
- For a client who is eligible for both Medicare and Medicaid, HCA discontinues paying the client's coinsurance and deductible for rental equipment when either of the following applies:

- The payment amount reaches Medicare's payment cap for the equipment.
- Medicare considers the equipment purchased.

What rental equipment does HCA not pay for?

HCA does not pay for:

- Insurance coverage against liability, loss, or damage to rental equipment that a provider supplies to a client.
- Defective equipment.
- The cost of materials covered under the manufacturer's warranty or administrative fees charged by the manufacturer to perform warranty or repair work.
- Repair or replacement of equipment because of the client's carelessness, negligence, recklessness, or misuse, in accordance with **WAC 182-501-0050**. (HCA may request documentation, such as a police report, for equipment repair or replacement at its discretion.)

Coverage Table

Bill With:	Taxonomy 332BX2000X.
Do Not Bill With:	**Any procedure code listed in the Do Not Bill With column of the fee schedule is AT NO TIME allowed in combination with the primary code located in the Healthcare Common Procedure Coding System (HCPCS) Code column.**
Maximum Allowance:	Rentals are calculated on a 30-day basis unless otherwise indicated. In those instances where rental is required before purchase, the rental price is applied towards the purchase price.
Rentals:	From and to dates are required on all rental billings. **(1 month equals 30 days.)**

REMINDER: See the Respiratory care fee schedule for payment requirements.

Notes: Providers must monitor the number of supplies and accessories a client is actually using and assure the client has nearly exhausted the supply on hand before dispensing any additional items.

For **policy requirements**, including clinical criteria, for different types of equipment and supplies, see What are the coverage criteria for respiratory care services? For an **explanation of PA**, including EPA and limitation extension, see Authorization.

Modifiers

RR= Rental equipment

RA = Replacement

MS= Maintenance/service

NU= New Equipment

TW= Backup equipment (not vent)

SC=Enhanced oximeter

NC= Not Covered

RB = Replacement of a part furnished as part of a repair

U2= Back up ventilator

AU = Item furnished in conjunction with a urological, ostomy or tracheostomy supply

****Requires specific modifier based on LPM. See instructions within Coverage Table.

Note: Billing provision limited to a 1-month supply. One month equals 30 days.

Apnea monitor and supplies

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
NC	E0618		Apnea monitor, without recording feature			
	E0619	RR	Apnea monitor, with recording feature		PA	Maximum of 6 months rental without PA if criteria are met. (For more about criteria, see Apnea monitors in Coverage Criteria.) PA required after the initial 6 months.
	A4556	NU	Electrodes (e.g., Apnea monitor), per pair	A4558		Purchase only. For use only when client is unable to tolerate carbon patch electrodes. Limit: 15 pairs every 30 days.
NC	A4557		Lead Wires, e.g., apnea monitor per pair			
NC	A4558	NU	Conductive paste or gel	A4556		

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	E0601	RR NU RA	Continuous positive airway pressure (CPAP) device	E0470 E0471 E0472		Requires results of sleep study performed in an HCA- approved sleep center. No PA is required for rental or purchase if criteria are met. (For more about criteria, see CPAP in Coverage Criteria.) Rental limit: 1 unit per month, maximum of 3-months mandatory rental. Limit includes 3-month rental. If criteria met, submit for purchase. Purchase limit: 1 unit per client, every 5 years. Purchase price is amount allowed after 3 months mandatory rental. Use of RA modifier – the RA modifier allows for the replacement of a CPAP at the end of the 5-year limit when the machine is no longer functional or cost effective to repair. This eliminates the 3-month rental requirement for this situation.
NC	E0605		Vaporizer, Room Type			
	A7027	NU	Combination oral/nasal mask, used with continuous positive airway pressure device, each		PA	

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	A7028	NU	Oral cushion for combination oral/nasal mask, replacement only, each		PA	
	A7029	NU	Nasal pillows for combination oral/nasal mask, replacement only, pair		PA	
	A7030	NU	Full face mask, used with positive airway pressure device, each	A7031		Limit: 1 every 6 months. (Cushion, pillows, and interface can be replaced every 3 months.)
	A7031	NU	Face mask interface, replacement for full face mask, each	A7030		Limit: 1 every 3 months, not ordered within 3 months of A7030.
	A7032	NU	Cushion for use on nasal mask interface, replacement only, each	A7033 A7034		Limit: 1 every 3 months, not ordered within 3 months of A7034.
	A7033	NU	Pillow for use on nasal cannula type interface, replacement only, pair	A7032 A7034		Limit: 1 every 3 months, not ordered within 3 months of A7034.
	A7034	NU	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap	A7032 A7033		Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap
	A7035	NU	Headgear used with positive airway pressure device			Limit: 1 every 6 months

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	A7036	NU	Chinstrap used with positive airway pressure device			Limit: 1 every 6 months
	A4604	NU	Tubing with integrated heating element for use with positive airway pressure device	A7010 A7037		Limit: 1 every 6 months
	A7037	NU	Tubing used with positive airway pressure device	A7010 A4604		Limit: 1 every 6 months
	A7038	NU	Filter, disposable, used with positive airway pressure device			Limit: 2 every 30 days
	A7039	NU				Limit: 1 every 6 months
NC	A7044		Oral interface, used with positive airway pressure device, each			
NC	A7045		Exhalation port (with or without swivel) used with accessories for positive airway devices, replacement only			
	A7046	NU	Water chamber for humidifier, used with positive airway pressure device, replacement, each			Limit: 1 every 6 months
NC	A7047		Oral interface used with respiratory suction pump, each			

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	E0561	NU	Humidifier, nonheated, used with positive airway pressure device			
	E0562	NU	Humidifier, heated, used with positive airway pressure device			Purchase only Limit: 1 per 5 years
	E0470	RR NU RA	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	E0601 E0471 E0472	PA PA is necessary only if the client does not meet the Medicare clinical criteria; or if a CPAP machine (E0601), or a BiPAP machine (E0470) has been purchased within the last 5 years.	(Example: BiPAP S) Requires results of sleep study performed in an HCA- approved sleep center when prescribed for sleep apnea. Purchase required after maximum of 3 months mandatory rental. Client compliance and effectiveness must be documented prior to purchase. Purchase price is amount allowed after 3 months mandatory rental. Limit includes 3-month rental. If criteria are met, submit for a purchase. Purchase limit: 1 unit per client, every 5 years. RA modifier allows for the replacement of a BiPAP at the end of the 5-year limit when the machine is no longer functional or cost effective to repair. This eliminates the 3-month rental requirement for this situation.

IPPB machine and accessories

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
NC	E0500	RR	IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source (includes mouthpiece and tubing)	E0570		

Nebulizers and accessories

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	E0565	RR	Compressor, air power source for equipment which is not self-contained or cylinder driven			Rental for 13 months, then considered purchased. Limit: 1 per client every 5 years.
	E0570	NU	Nebulizer with compressor	A4619 A4217 A7007 A7010 A7012 A7014 A7018 E0500	EPA See EPA criteria table for clients not meeting clinical criteria.	PA not required if client meets clinical criteria. (For more about criteria, see Does HCA cover nebulizers and related compressors? in Coverage Criteria.) Limit: 1 per client, every 5 years. AC/DC adapters used with this equipment are considered included in nebulizer payment.
NC	E0572		Aerosol compressor, adjustable pressure, light duty for intermittent use			

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
NC	E0574		Ultrasonic/electronic aerosol generator with small volume nebulizer			
NC	E0575		Nebulizer ultrasonic, large volume			
NC	E0580		Nebulizer, with compressor and heater			
NC	E0585		Nebulizer, with compressor and heater			
	E1352		Oxygen accessory, flow regulator capable of positive inspiratory pressure			
	E1372	NU	Immersion external heater for nebulizer		PA	
	A7003	NU	Administration set, with small volume non-filtered pneumatic nebulizer, disposable			Purchase only. Limit: 1 per client, every 30 days.
	A7004	NU	Small volume nonfiltered pneumatic nebulizer, disposable	A7005		Purchase only. Limit: 2 per client, every 30 days.
	A7005	NU	Administration set, with small volume non-filtered pneumatic nebulizer, non-disposable	A7004		Purchase only. Limit: 1 per client, every 6 months.

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	A7006	NU	Administration set, with small volume filtered pneumatic nebulizer.			Purchase only. Limit: 1 per client, every 30 days. For Pentamidine administration only.
	A7007	NU	Large volume nebulizer, disposable, unfilled, used with aerosol compressor	E0570		Limit: 10 per client, every 30 days.
NC	A7008		Large volume nebulizer, disposable, prefilled, used with aerosol compressor			
NC	A7009		Reservoir bottle, non-disposable, used with large volume ultrasonic nebulizer			
	A7010	NU	Corrugated tubing, disposable, used with large volume nebulizer, 100 feet	A7037 A4604 E0570		Purchase only. Limit: 1 unit per client, every 60 days.
	A7012	NU	Water collection device, used with large volume nebulizer (e.g., aerosol drainage bag)	E0570		Only paid in conjunction with E0565. Must bill on same claim with E0565. Purchase only. Limit: 8 per client, every 30 days.
	A7013	NU	Filter, disposable, used with aerosol compressor	A7014		For use with E0570 or E0565. Purchase only. Limit: 2 per client, every 30 days.

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	A7014	NU	Filter, non-disposable, used with aerosol compressor or ultrasonic generator	A7013 E0570		Only when using E0565. Must bill on same claim with E0565. Purchase only. Limit: 1 per client, every 90 days.
	A7015	NU	Aerosol mask, used with DME nebulizer			Purchase only. Limit: 1 per client, every 30 days.
	A4619	NU	Face tent	E0424 E0431 E0434 E0439 E0570 E1390 E1392 K0738		Purchase only. Limit: 1 per client, every 30 days.
NC	A7016		Dome and mouth piece, used with small volume ultrasonic nebulizer			
NC	A7017		Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen			
	A7018	NU	Water, distilled, used with large volume nebulizer, 1000 ml	E0570 A4217		Limit is 50 units, per client, every 30 days. 1 unit = 1000ml.

Oxygen and oxygen equipment

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	A4615	NU	Cannula, nasal	E0424 E0431 E0434 E0439 E1390 E1392 K0738		May only be billed for client-owned equipment or following the 36-month capped rental period until the end of the 5-year lifetime for the following equipment: E0424, E0431, E0434, E0439, E1390, E1392, and K0738. Limit: 2 per client, every 30 days.
	A4616	NU	Tubing (oxygen), per foot	E0424 E0431 E0434 E0439 E0471 E0472 E1390 E1392 K0738		May only be billed for client-owned equipment or following the 36-month capped rental period until the end of the 5-year lifetime for the following equipment: E0424, E0431, E0434, E0439, E1390, E1392, and K0738. Limit: 1 tube per client, every 30 days.

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	A4620	NU	Variable concentration mask	E0424 E0431 E0434 E0439 E1390 E1392 K0738		May only be billed for client-owned equipment or following the 36-month capped rental period until the end of the 5-year lifetime for the following equipment: E0424, E0431, E0434, E0439, E1390, E1392, and K0738. Limit: 2 per client, every 30 days.

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	E0424	RR MS QA** QB** QR** QE** QF** QG**	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	A4615-A4620 E0439 E0441-E0444 E1390 E1392	EPA See the **EPA criteria table** for criteria to restart the 36-month capped rental period.	Limit: 1 per client, every 30 days, for a maximum reimbursed period of 36 months. Following the capped rental period, the same vendor continues to be responsible for the equipment and provision of oxygen services to the client until the 5-year reasonable, useful lifetime of the equipment has been met. For maintenance and capped rental information, see **Stationary and portable oxygen systems and contents.** **Modifiers are based on liters per minute (LPM). See Stationary and portable oxygen systems and contents.
NC	E0425		Stationary compressed gas system, purchase: includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing			

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
NC	E0430		Portable gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, cannula or mask, and tubing			
	E0431	RR MS QA** QB** QR** QE** QF** QG**	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing	A4615-A4620 E0434 E0441-E0444 K0738	EPA See the **EPA criteria table** for criteria to restart the 36-month capped rental period.	Limit: 1 per client, every 30 days, for a maximum reimbursed period of 36 months. Following the capped rental period, the same vendor continues to be responsible for the equipment and provision of oxygen services to the client until the 5-year reasonable, useful lifetime of the equipment has been met. For maintenance and capped rental information, see **Stationary and portable oxygen systems and contents.** **Modifiers are based on liters per minute (LPM). See Stationary and portable oxygen systems and contents.

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	K0738	RR MS QA** QB** QR** QE** QF** QG**	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing	A4615-A4620 E0431 E0434 E0441-E0444	EPA See the **EPA criteria table** for criteria to restart the 36-month capped rental period.	Limit: 1 per client, every 30 days, for a maximum reimbursed period of 36 months. Following the capped rental period, the same vendor continues to be responsible for the equipment and provision of oxygen services to the client until the 5-year reasonable, useful lifetime of the equipment has been met. For maintenance and capped rental information, see **Stationary and portable oxygen systems and contents.** **Modifiers are based on liters per minute (LPM). See **Stationary and portable oxygen systems and contents.**

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
NC	E0433		Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge			

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	E0434	RR MS QA** QB** QR** QE** QF** QG**	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adapter, contents, gauge, cannula or mask and tubing	A4615-A4620 E0431 E0441-E0444 E1392 K0738	EPA See the **EPA criteria table** for criteria to restart the 36-month capped rental period.	Limit: 1 per client, every 30 days, for a maximum reimbursed period of 36 months. Following the capped rental period, the same vendor continues to be responsible for the equipment and provision of oxygen services to the client until the 5-year reasonable, useful lifetime of the equipment has been met. For maintenance and capped rental information, see **Stationary and portable oxygen systems and contents.** **Modifiers are based on liters per minute (LPM). See **Stationary and portable oxygen systems and contents.**
NC	E0435		Portable liquid oxygen system, purchase: includes portable container, supply reservoir, humidifier, flowmeter, contents gauge, cannula or mask, tubing, and refill adapter			

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	E0439	RR MS QA** QB** QR** QE** QF** QG**	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	A4615-A4620 E0424 E0441-E0444 E1390 E1392	EPA See the **EPA criteria table** for criteria to restart the 36-month capped rental period.	Limit: 1 per client, every 30 days, for a maximum reimbursed period of 36 months. Following the capped rental period, the same vendor continues to be responsible for the equipment and provision of oxygen services to the client until the 5-year reasonable, useful lifetime of the equipment has been met. For maintenance and capped rental information, see **Stationary and portable oxygen systems and contents.** **Modifiers are based on liters per minute (LPM). See **Stationary and portable oxygen systems and contents.**
NC	E0440		Stationary liquid oxygen system, purchase; includes use of reservoir, contains indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing			

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	E0441		Stationary oxygen contents, gaseous. One month's supply equals one unit.	E0424 E0431 E0434 E0439 E0442 E0443 E0444 E1390 E1392 K0738		Limit: 1 per client, every 30 days. 30-day supply equals one unit. Providers may bill this code for the 24 months following a 36-month capped rental period, or if the client owns the oxygen equipment. Provider needs to add comment on the claim as to which criteria have been met.
	E0442		Stationary oxygen contents, liquid). One month's supply equals one unit	E0424 E0431 E0434 E0439 E0441 E0443 E0444 E1390 E1392 K0738		Limit: 1 per client, every 30 days. 30-day supply equals one unit. Providers may bill this code for the 24 months following a 36-month capped rental period, or if the client owns the oxygen equipment. Provider needs to add comment on the claim as to which criteria have been met.

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	E0443		Portable oxygen contents, gaseous. One month's supply equals one unit	E0424 E0431 E0434 E0439 E0441 E0442 E0444 E1390 E1392 K0738		Limit: 1 per client, every 30 days. 30-day supply equals one unit. Providers may bill this code for the 24 months following a 36-month capped rental period, or if the client owns the oxygen equipment. Provider needs to add comment on the claim as to which criteria have been met.
	E0444		Portable oxygen contents, liquid. One month's supply equals one unit	E0424 E0431 E0434 E0439 E0441 E0443 E1390 E1392 K0738		Limit: 1 per client, every 30 days. 30-day supply equals one unit. Providers may bill this code for the 24 months following a 36-month capped rental period, or if the client owns the oxygen equipment. Provider needs to add comment on the claim as to which criteria have been met.
NC	E0455		Oxygen tent, excluding croup or pediatric tents			
NC	E0457		Chest Sll (Cuirass)			
NC	E0459		Chest wrap			

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
NC	E0446		Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories			
NC	E1354		Oxygen accessory, wheeled cart for portable cylinder or portable concentrator			
NC	E1355		Stand/rack			
NC	E1356		Oxygen accessory, battery pack/cartridge for portable concentrator, any type			
NC	E1357		Oxygen accessory, battery charger for portable concentrator, any type			
NC	E1358		Oxygen accessory, DC power adapter for portable concentrator, any type			

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	E1390	RR MS QA** QB** QR** QE** QF** QG**	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow	A4615-A4620 E0424 E0439 E0441 E0442 E0443 E0444	EPA Refer to the EPA criteria table for criteria to restart the 36-month capped rental period.	Limit: 1 per client, every 30 days, for a maximum reimbursed period of 36 months. For maintenance and capped rental information, see Stationary and portable oxygen systems and contents. **Modifiers are based on liters per minute (LPM). See Stationary and portable oxygen systems and contents.
NC	E1391		Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each			

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	E1392	RR MS QA** QB** QR** QE** QF** QG**	Portable oxygen concentrator, rental.	A4615-A4620 E0424 E0431 E0434 E0439 E0441 E0442 E0443 E0444	EPA Refer to the EPA criteria table for criteria to restart the 36-month capped rental period.	Limit: 1 per client, every 30 days, for a maximum reimbursed period of 36 months. Following the capped rental period, the same vendor continues to be responsible for the equipment and provision of oxygen services to the client until the 5-year reasonable, useful lifetime of the equipment has been met. For maintenance and capped rental information, see Stationary and portable oxygen systems and contents. **Modifiers are based on liters per minute (LPM). See Stationary and portable oxygen systems and contents.
NC	E1405		Oxygen and water vapor enriching system with heated delivery			
NC	E1406		Oxygen and water vapor enriching system without heated delivery			

Suction pump/supplies

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	A4605	NU	Tracheal suction catheter, closed system, each A4624 Limit 1 per day per client.	A4624		Tracheal suction catheter, closed system, each A4624 Limit 1 per day per client.
	A4624	NU	Tracheal suction catheter, any type, other than closed system, each	A4605	A4605	Purchase only. Limit: 150 per client age 8 years and older, every 30 days. 300 per client under age 8, every 30 days.
	A4628	NU	Oropharyngeal suction catheter (Yankauer), each			Purchase only. Limit: 4 per client, every 30 days.
	A7000	NU	Canister, disposable, used with suction pump, each	A7001		Purchase only. Limit: 5 per client every 30 days for primary suction pump; 5 per client every 30 days for secondary suction pump. Use modifiers **NU** and **TW** together for the secondary pump.
	A7001	NU	Canister, non-disposable, used with suction pump, each	A7000		Purchase only. Limit: 1 every 12 months.
	A7002	NU	Tubing, used with suction pump, each			Purchase only. Limit: 15 per client, every 30 days.

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	E0600	RR TW	Respiratory suction pump, home model, portable or stationary, electric			Limit: 2 in 5 years per client, one for use in the home and one for back-up or portability. Bill **RRTW** when billing for the backup unit. Deemed purchased after 12 months rental. HCA allows payment for suction supplies, (e.g., gloves and sterile water) when billed by Durable Medical Equipment (DME) providers and pharmacists. (See Resources Available)

Tracheostomy care supplies

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
NC	A4481		Tracheostoma filter, any type, any size, each			
NC	A4483		Moisture exchanger, disposable, for use with invasive mechanical ventilation			
NC	A4608		Transtracheal oxygen catheter, each			

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	A4623		Tracheostomy, inner cannula (disposable replacement only)			Purchase only. Limit: 1 per client, each day.
	A4625		Tracheostomy care kit for new tracheostomy	A4626 A4629		Includes: basin or tray, trach dressing, gauze sponges, pipe cleaners, cleaning brush, cotton tipped applicators, twill tape, drape, and sterile gloves. Limit: 1 per client, each day. Use this code for first 14 days only, then use A4629. A4625 should not be billed again after the first 14 days. Purchase only.
NC	A4626		Tracheostomy cleaning brush, each			
	A4629		Tracheostomy care kit for established tracheostomy	A4625 A4626		Includes: basin or tray, trach dressing, gauze sponges, pipe cleaners, cleaning brush, cotton tipped applicators, twill tape, drape, and sterile gloves. Limit: 1 per client, each day. Use after the first 14 days. Do not bill A4625 after the first 14 days. Purchase only.

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
NC	A7501		Tracheostoma valve, including diaphragm, each			
NC	A7502		Replacement diaphragm/faceplate for tracheostoma valve, each			
NC	A7503		Filter holder or filter cap, reusable, for use in a tracheostoma heat and moisture exchange system, each			
NC	A7504		Filter for use in a tracheostoma heat and moisture exchange system, each			
NC	A7505		Housing, reusable without adhesive, for use in a heat and moisture exchange system or with a tracheostoma valve, each			
NC	A7506		Adhesive disc for use in a heat and moisture exchange system or with tracheostoma valve, any type, each			
	A7507		Filter holder and integrated filter without adhesive, for use in a tracheostoma heat and moisture exchange system, each			Limit: 1 each day for clients age 8 and older. Limit: 3 each day for clients under age 8. Purchase only.

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
NC	A7508		Housing and integrated adhesive, for use in a tracheostoma heat and moisture exchange system or with a tracheostoma valve, each			
	A7509		Filter holder and integrated filter housing, and adhesive, for use as tracheostoma heat and moisture exchange system (condenser, disposable e.g., artificial nose), each			Limit: 1 each day for clients age 8 and older. Limit: 3 each day for clients under age 8. Purchase only.
	A7520	SC (for customized trach only)	Tracheostomy/laryngectomy tube, non-cuffed, polyvinyl-chloride (PVC), silicone or equal, each		PA (for customized trach only)	For clinical criteria for customized trachs, see **Does HCA cover customized tracheostomy/laryngectomy tubes?** Limit per client, per 30 days: 1 if removable inner cannula or 4 each per 30 days if no removable inner cannula.

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	A7521	SC (for customized trach only)	Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each		PA (for customized trach only)	For clinical criteria for customized trachs, see Does HCA cover customized tracheostomy/laryngectomy tubes? Limit: 1 per client every 30 days if removable inner cannula or 4 per client every 30 days if no removable inner cannula.
	A7522		Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each			Limit: 1 per client every 30 days if removable inner cannula or 4 per client every 30 days if no removable inner cannula.
NC	A7523		Tracheostomy shower protector, each			
NC	A7524		Tracheostoma stent/stud/button, each			
	A7525		Tracheostomy mask, each			Purchase only. Limit: 4 per client, every 30 days.
	A7526		Tracheostomy tube collar/holder, each			Limit: 1 per day, 30 per month
NC	A7527		Tracheostomy/laryngectomy tube plug/stop			

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	E1399	RR	Heated humidifier with temperature modifier and alarms for clients who have a tracheostomy		PA	For clients who have a tracheostomy but are not ventilator dependent. 1-month rental
	L8501		Tracheostomy speaking valve			Purchase only. Limit: 1 every 6 months.
	S8189		Tracheostomy supply not otherwise classified		PA	

Ventilators and related respiratory equipment

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	E0465	RR NU	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)		EPA	Payment includes all necessary accessories, fittings, tubing, and humidifier. 30-days equals 1 unit. In addition to **RR, U2** modifier is required when claiming a secondary or **backup** ventilator for the same client. (For more details, see Does HCA cover ventilator equipment and supplies? in Coverage Criteria.) Rental only. For client-owned ventilators only: Bill with **MS** modifier - use when claiming a 6-month maintenance check. Limit of 1 per 6 months allowed for client-owned equipment beginning 1 year from date of purchase. Maintenance checks are paid at 50% of the rental rate for client-owned equipment.
	E0466	RR	Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)		EPA	**U2** modifier is required when claiming a secondary or **backup** ventilator for the same client. (For more details, see Does HCA cover ventilator equipment and supplies? in Coverage Criteria.)

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
						Rental only. 30-days equals 1 unit. For client-owned ventilators only: Bill with **MS** modifier - use when claiming a 6-month maintenance check. Limit of 1 per 6 months allowed for client-owned equipment beginning 1 year from date of purchase. Maintenance checks are paid at 50% of the rental rate for client-owned equipment.
	E0467	RR	Home ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions	A4216 A4217 A4604 A4605 A4619 A4624 A4628 A7000-A7007 A7012-A7015 A7017 A7020 A7025-A7039 A7044-A7047 A7525 E0424 E0431 E0433 E0434 E0439	PA	Rental Only 30 days equals one unit

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
				E0441-E0444 E0465 E0466 E0470 E0471 E0472 E0482 E0483 E0484 E0486 E0561 E0562 E0565 E0570 E0572 E0585 E0600 E0601 E1372 E1390 E1391 E1392 E1405 E1406 K0738		

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	E0471	RR RA	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	A4611-A4613 A4616-A4618 E0470 E0472 E0601	PA	PA is necessary only if a CPAP machine (E0601), or a BiPAP machine (E0470) has been purchased within the last 5 years, or if the clinical criteria are not met. (For more about criteria, see Does HCA cover bi-level respiratory assist devices (RADs)? in Coverage Criteria.) Monthly Rental only. Deemed purchased after 13 months of rental. Purchase Limit: 1 per client every 5 years. Use of **RA** modifier – the RA modifier allows for the replacement of E0471 at the end of the 5-year limit when the machine is no longer functional or cost effective to repair. This eliminates the 13-month rental requirement.
	E0472	RR	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device)	A4611-A4613 A4616-A4618 E0470 E0471 E0601		Payment includes all necessary accessories, fittings, tubing, and humidifier. Rental only. 30-days equals 1 unit.

Miscellaneous

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	A4216		Sterile saline or (sterile) water, 10 ml			Limit: 100 units every thirty days.
	A4217		Sterile saline or (sterile) water, 500 ml	A7018 E0570		Limit: 50 units every thirty days.
NC	A4218		Sterile saline or (sterile) water, metered dose			
	A4450	AU	Tape, non-waterproof, per 18 square inches			
	A4452	AU	Tape, waterproof, per 18 square inches			
	A4614	NU	Peak expiratory flow rate meter, handheld			Purchase only. Limit: 3 per client, every 12 months.
	A4627	NU	Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler (e.g., Aerovent)			Limit: 6 per child (17 and younger), every 12 months; 3 per adult, (18 and older) every 12 months.
	A9284		Spirometer, non-electronic, includes all accessories			

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	E0445	NU	Oximeter device for measuring blood oxygen levels non-invasively	E0445 SC	PA	Standard oximeter. PA required for clients age 18 and older. PA not required for clients age 17 and younger who meet clinical criteria. Purchase limit - 1 in a 24-month period per client, regardless of age.
	E0445	SC	Oximeter device for measuring blood oxygen levels non-invasively	E0445 NU	PA/ EPA EPA required for clients who are 17 years and younger and meet clinical criteria. (See the EPA criteria table)	Enhanced oximeter. PA required for clients 18 years and older; or for clients under 18 who do not meet clinical criteria. (For more details, see Does HCA cover oximeters? in Coverage Criteria.) Limit = 1 per client every 36 months.
	E1399		Replacement cable for enhanced oximeter		PA	Limit= 2 per client per year.
	A4606	NU	Oxygen probe for use with oximeter device, replacement	A4606 RA		NU = Nondisposable probe. Limit = 1 per client every 180 days.
	A4606	RA	Oxygen probe for use with oximeter device, replacement	A4606 NU		RA = Disposable probe. Limit = 4 per client every 30 days.

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	E1399	RB	Durable medical equipment, miscellaneous		PA	For equipment without an assigned HCPCS code. RB = Only for parts used in the repair of client-owned equipment. (See When does HCA pay for repairs on client-owned equipment? in Authorization.)
	K0740		Repair or nonroutine service for oxygen equipment requiring the skill of a technician, labor component, per 15 minutes		PA	For client-owned equipment only. Must include invoice with actual labor time defined in units. (See When does HCA pay for repairs on client-owned equipment? in Authorization.) 1 unit = 15 min.
	E0480	NU	Percussor, electric or pneumatic, home model			Purchase only. Limit: 1 per client, per lifetime.
NC	E0481		Intrapulmonary percussive ventilations system and related accessories			
	E0482	RR	Cough stimulating device, alternating positive and negative airway pressure		PA	Limit: 1 per client, per lifetime. Deemed purchased after 12 months of rental.
	A4601		Lithium ion rechargeable for non-prosthetic use, replacement only		PA	Limit: 1 per client, per every 5 years.

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	A7020	NU	Interface for cough stimulating device, includes all components, replacement only		PA	
	E0483	RR	High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each		PA Requires submission of a completed HCA 13-0133 form to accompany the PA request. See **Note.**	Rental includes vest and generator, all repairs, and replacements. Manufacturer will replace vest (during either rental or purchase period) for change in user's size. Limit: 1 per client, per lifetime. Deemed purchased after 12 months of rental.
	A7025	NU	High frequency chest wall oscillation system vest, replacement for use with client owned equipment, each		PA Requires submission of a completed HCA 13-0133 form to accompany the PA request. See **Note.**	
	E0484	NU	Oscillatory positive expiratory pressure device, non-electric, any type, each			Limit: 1 per client every 180 days.
	S8185	NU	Flutter device			Purchase only. Limit: 1 every 6 months.
NC	E0487		Spirometer, electronic, includes all accessories			

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
NC	S8186		Swivel adaptor			
NC	S8210		Mucus trap			
	S8999	NU	Resuscitation bag, disposable, adult/pediatric size			Purchase only. Limit: 1 every 6 months.

Miscellaneous equipment reimbursement

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	A4611	NU	Battery, heavy duty; replacement for client-owned ventilator	E0472		Gel cell only. Purchase only. Limit: 1 every 24 months.
	A4612	NU	Battery cables; replacement for client-owned ventilator	E0472		Purchase only. Limit of 1 every 24 months.
	A4613	NU	Battery charger; replacement for client-owned ventilator	E0472		Gel cell only. Purchase only. Limit of 1 every 24 months.
NC	A4617	NU	Mouthpiece			

Code status indicator	HCPCS Code	Modifier	Description	Do not bill with	EPA /PA?	Policy/Comments
	A4618	NU	Breathing circuits	E0424 E0431 E0434 E0439 E0472 E1390 E1392 K0738		Purchase only for client -owned equipment. Limit: 4 per client, every 30 days.
NC	E0550		Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery			
NC	E0555		Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flow meter			
NC	E0560		Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery			
NC	K0462	RR	Temporary replacement for client-owned equipment being repaired, any type			

Washington State Health Care Authority

Authorization

What are the general authorization requirements?

- HCA requires providers to obtain authorization for covered respiratory care as required in:
  - Chapters 182-552, 182-501 and 182-502 WAC.
  - Published HCA billing guides.
  - Situations where the required clinical criteria are not met.
- When a service requires authorization, the provider must properly request authorization under HCA's rules and billing guides.
  - When authorization is not properly requested, HCA rejects and returns the request to the provider for further action.
  - HCA does not consider the rejection of a request to be a denial of service.
- HCA's authorization of service(s) does not necessarily guarantee payment.
- HCA evaluates requests for authorization of covered respiratory care equipment and supplies that exceed limitations in this chapter on a case-by-case basis under WAC 182-501-0169.
- HCA may recoup any payment made to a provider if HCA later determines that the service was not properly authorized or did not meet the expedited prior authorization (EPA) criteria. (See WAC 182-502-0100(1)(c)).

> **Notes**: For submitting claims with authorization numbers, see Billing with authorization numbers in this guide. For more detailed information on requesting authorization, see HCA's ProviderOne billing and resource guide.

What is prior authorization (PA)?

Prior authorization (PA) is HCA's approval for certain medical services, equipment, or supplies **before** being provided to clients (except when the items and services are covered by a third-party payer.) PA is a precondition for provider payment. The item or service must be delivered to the client **before** the provider bills HCA.

What are the criteria for PA?

- With PA, HCA may consider covering new respiratory care items that do not have assigned healthcare common procedure coding system (HCPCS) codes and are not listed in HCA's published issuances.
- For these, the provider must furnish all the following information to HCA 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.
  - In addition, for PA requests, HCA requires the prescribing provider to furnish **client-specific** justification for respiratory care.
- HCA does not accept general standards of care or industry standards for generalized equipment as justification.
- When HCA receives the initial request for PA, the prescription(s) for those items or services must not be older than 3 months from the date HCA receives the request.
- HCA does not pay for the purchase, rental, or repair of respiratory care equipment that duplicates equipment clients already own or rent.
- If providers believe the purchase, rental, or repair of respiratory care equipment is not duplicative, they may request PA by submitting the following to HCA:
  - Reasons the existing equipment no longer meets the client's medical needs.
  - Reasons the existing equipment could not be repaired or modified to meet the client's medical needs.
  - Upon request, documentation showing how the client's condition meets the criteria for PA.
- A provider may resubmit a request for PA for an item or service that HCA has denied. HCA requires the provider to include new documentation that is relevant to the request.

What is the PA process?

Online direct data entry into Provider One

Providers may submit a PA request online through direct data entry into ProviderOne. See HCA's **Prior authorization webpage** for details.

Written requests

Providers who chose to submit a written PA request to HCA must include:

- A completed *General Information for Authorization* (HCA 13 835) form.
- A completed *Oxygen and Respiratory Authorization Request* (HCA 15-298) form.
- A prescription.
- Any other required documentation.

(See **Where can I download HCA forms?**)

Additional information required for PA

For purchase or rental of equipment, providers must also provide:

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

(See **WAC 182-501-0165**.)

Is PA required for repairs to client-owned equipment?

Note: HCA considers equipment to be client-owned if:

- It is not identified as a capped rental item in this billing guide.
- HCA has reached the maximum payment for the item.

Yes. To be paid for a repair of client-owned equipment, the provider must submit a PA request to HCA for repairs and must include:

- A completed *General Information for Authorization* (HCA 13-835) form showing, by line, the HCPCS codes being requested with corresponding billed

charges. See **Prior authorization** webpage for details or **Where can I download HCA forms?** if submitting written PA request.

- A manufacturer pricing sheet showing the manufacturer's list price, manufacturer's suggested retail price, or a manufacturer invoice showing the cost of the repair and identifying and itemizing the parts. The invoice must indicate the wholesale acquisition cost, the manufacturer's list price, or MSRP for all parts used in the repair for which payment is being sought.
- A statement on company letterhead indicating that the equipment or parts are no longer covered by warranty.
- The serial number of the equipment being repaired.

If the equipment did not come with a serial number or the number is no longer legible or on the equipment, the provider must:

  - Assign a new number.
  - Attach it to the equipment.
  - Include this information on company letterhead.
- Specific respiratory care labor code (K0740).
- Actual labor time used for repairs.

When does HCA pay for repairs on client-owned equipment?

HCA pays for the repair (parts and labor) of client-owned respiratory equipment as follows. PA is required.

- HCA bases the decision to pay for repairs to client-owned equipment on cost and length of time the client needs the equipment.
- HCA considers the age of the equipment.
- In addition, all these criteria must be met:
  - All warranties are expired.
  - The cost of the repair is less than 50% of the cost of a new item and the provider has supporting documentation.
  - The repair has a warranty for a minimum of 90 days.

> **Note**: If a provider does not obtain PA, HCA will deny the billing and the client must not be held financially responsible for the service.

HCA's payment rate for client-owned equipment includes, **but is not limited to:**

- A manufacturer's warranty for a minimum warranty period of 1 year for medical equipment, not including disposable/nonreusable supplies.

- Instructions to the client and the client's caregiver for safe and proper usage of the equipment.
- The cost of delivery to the client's residence or skilled nursing facility and, when appropriate, to the room in which the equipment will be used.

HCA does not cover:

- Repairs (parts or labor) to equipment under warranty.
    - This includes equipment that was rented and subsequently considered client-owned by HCA, but still under warranty.
- A **base** or minimum labor fee that is added to the charges for the actual labor in doing the repair.
- Equipment, when there is evidence of malicious damage, culpable neglect, or wrongful disposition.

What is expedited prior authorization (EPA)?

The expedited prior authorization (EPA) process eliminates the need for written requests for PA of selected respiratory care procedure codes. Services requiring EPA are identified in the **EPA criteria table**.

What are the EPA criteria?

- For EPA, a provider must document how the EPA criteria are met and have supporting medical documentation. The provider must include all documentation in the client's file, available to HCA on request.
- The provider must use the appropriate EPA number and process when billing HCA.
- When a situation does not meet the EPA criteria for selected respiratory care procedure codes, a written request for PA is required.
- HCA may recoup any payment made to a provider if the provider did not follow the EPA criteria and process.

What is the EPA process?

Providers must create a 9-digit EPA number for selected respiratory care procedure codes:

- The first five or six digits of the EPA number must be 870000.
- The last three or four digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria. (See the **EPA criteria table**.)

Example: In billing E0570 for a **Nebulizer** when the client is 2 years old and has been diagnosed with acute bronchiolitis, the EPA number would be **870000900**. (**870000** = first six digits of all EPA numbers; **900** = last three digits of an EPA number, indicating the clinical criteria and the equipment you are billing.)

Note: When the client's situation does not meet published criteria, authorization is necessary.

What is a limitation extension (LE)?

A limitation extension (LE) is HCA's method that allows for the provider to furnish more units than are typically allowed.

HCA limits the amount, frequency, or duration of certain covered respiratory care, and pays up to the stated limit without requiring PA. (Limits are based on what is normally considered medically necessary, for quantities sufficient for a 30-day supply for one client.)

What are the LE criteria?

- The provider must request PA for an LE to exceed the stated limits for respiratory care equipment and supplies using the required process.
- The provider must provide justification that the additional units of service are medically necessary.
- HCA evaluates LE requests on a case-by-case basis under WAC 182-501-0169.

Note: LEs do not override the client's eligibility or program limitations. Not all categories of eligibility can receive all services. For example: Kidney dialysis is excluded under the Family Planning Only Program.

What is the LE process?

Online direct data entry into Provider One

Providers may submit a limitation extension request online through direct data entry into ProviderOne. See HCA's Prior authorization webpage for details.

Written requests

Providers who request an LE using HCA's written/fax authorization process must include the following:

- A completed *General Information for Authorization* (HCA 13 835) form.
- A completed *Oxygen and Respiratory Authorization Request* (HCA 15-298) form.
- A prescription.
- Any other required documentation.

See **Where can I download HCA forms?**

EPA criteria table

EPA 870000+ last 3 digits below	Criteria	HCPCS Code	Modifier	Do not bill with
006	Enhanced Oximeter With all the following features: • Alarms for heart rate and oxygen saturation • Adjustable alarm volume • Memory for download • Internal rechargeable battery Client must be age 17 and younger, in the home, and meet the clinical criteria for standard oximeters. See **Does HCA cover oximeters?** Purchase limit of 1 per client, every 3 years.	E0445	SC	E0455 NU
000	Home Ventilator (invasive and non-invasive) – Includes primary and secondary or backup ventilator for chronic respiratory failure. If the client has no clinical potential for weaning, the EPA is valid for 12 months. If the client has the potential to be weaned, then the EPA is valid for 6 months.	E0465 E0466	RR U2	

EPA 870000+ last 3 digits below	Criteria	HCPCS Code	Modifier	Do not bill with
052	Restart 36-month oxygen capped rental when meeting one of the following criteria: • The initial provider is no longer providing oxygen equipment or services. • The initial provider's Core Provider Agreement with HCA is terminated or expires. • The client moves to an area that is not part of the provider's service area. (This applies to Medicaid-only clients.) • The client moves into a permanent residential setting. • A pediatric client is transferred to an adult provider.	E1390, E1392	RR	
900	Nebulizer with compressor. Use this EPA for clients who do not meet the clinical criteria (in **Does HCA cover nebulizers and related compressors?**), but who have a diagnosis of acute bronchiolitis, or acute bronchitis requiring the administration of nebulized medications.	**E0570**	NU	E0500

Washington State Health Care Authority

Noncovered Services

What types of services are not covered by HCA?

- In addition to the noncovered services found in WAC 182-501-0070, HCA does not cover:
  - Emergency or stand-by oxygen systems, including oxygen as needed.
  - Portable nebulizer.
  - Kits and concentrates for use in cleaning respiratory equipment.
  - Intrapulmonary percussive ventilation system and related accessories.
  - Battery for a CPAP.
  - An item or service which primarily serves as a convenience for the client or caregiver.
  - Oximetry checks.
  - Loaner equipment.
- HCA evaluates a request for respiratory care that is listed as noncovered in this guide under the provisions of WAC 182-501-0160.

Washington State Health Care Authority

Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information, see HCA's **ProviderOne Billing and Resource Guide webpage** and scroll down to Paperless billing at HCA.

For providers approved to bill paper claims, visit the same webpage and scroll down to *Paper Claim Billing Resource*.

What are the general billing requirements?

Providers must follow HCA's **ProviderOne billing and resource guide**. These billing requirements include:

- Time limits 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.
- Standards for record keeping.

For billing specific to medical equipment and supplies, see the **Medical Equipment and Supplies Billing Guide.**

Billing with authorization numbers

- Refer to the **ProviderOne billing and resource guide** for instructions on how to add authorization numbers to electronic claims.
- With HIPAA implementation, multiple authorization (prior or expedited) numbers may be submitted on a claim when billing electronically. The authorization number must be placed in the correct data field of the claim. Do not put authorization numbers in the comment field, as they cannot be processed.

Is information available to bill for clients eligible for both Medicare and Medicaid?

For more information on billing Medicare/Medicaid crossover claims, see HCA's ProviderOne billing and resource guide.

> **Note:** When Medicare has paid as primary insurance and you are billing HCA as the secondary payer, HCA does not require PA for services.

How does HCA handle third-party liability coverage?

If the client has third-party liability (TPL) coverage for a service requiring authorization by HCA, and the TPL payer denies payment for that service, authorization must be obtained through HCA. A denial from the TPL payer must be submitted with the request.

If the TPL payer is paying for the service, no authorization through HCA is required.

(For more information, see Authorization. For more information on TPL coverage, see HCA's ProviderOne billing and resource guide.)

What is included in the payment rate?

HCA's payment rates for respiratory care include:

- Any adjustments or modifications to the equipment that are either required within 3 months of the delivery date or are covered under the manufacturer's warranty.
- Pick-up, delivery, or associated costs such as mileage, travel time, or gas.
- Telephone calls.
- Shipping, handling, and postage.
- Fitting and setting up.
- Instructions to the client or client's caregiver about the use of oxygen or respiratory care equipment and supplies.

Where can I find the fee schedule?

See HCA's fee schedule.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's Billers, providers, and partners webpage, under Learn how to use ProviderOne, select Webinars.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA electronic data interchange (EDI) webpage.

The following claim instructions relate to Respiratory Care:

Name	Entry
Prior Authorization Number	When applicable. If the service hardware being billed requires prior authorization
Place of Service	These are the only appropriate codes for this program: **Facility Type** — **To Be Used For** 12 — Home (client's residence) 13 — Assisted living facility 14 — Group home 31 — Skilled nursing facility 32 — Nursing facility 99 — Other
Units	For multiple quantities of supplies, enter the number of items dispensed and all the dates or dates spanned that the supplies were used. Unless the procedure code description specifically indicates pack, cans, bottles, or other quantity, the **each** is each single item.

How does a provider bill for supplies?

When a provider bills for supplies that are limited to a specific number per day, the provider needs to bill a span of dates that matches the number of units billed. For example, if a supply has a limit of three per day, and the provider wants to bill for a 10-day supply, the provider must bill for a span of dates that covers 10 days and the units billed should be 30.

- When a provider bills for a monthly rental, the provider must bill 30 days at a time unless any of these situations occur:
  - It is a short-term rental (less than a month).
  - There is a break in service or eligibility for the client.

  - It is the last month the provider supplies the equipment to the client, and the client did not have the equipment for 30 days.
- Examples of correct billing are:
  - The first month and day the client gets service is February 1, and the provider will be continuing to bill for the rental. The provider should bill for February, 2/1/20XX – 3/2/20XX (non-leap year); and then for March, 3/3/20XX – 4/1/20XX; for April, 4/2/20XX – 5/1/20XX; and for May, 5/2/20XX – 5/31/20XX.
  - The first month and day the client gets service is October 15 and the provider will be continuing to bill for the rental. The provider should bill for October, 10/15/20XX – 11/13/20XX; and then for November, 11/14/20XX – 12/13/20XX.
- First and last date of rental are considered in the "day count" for the month and must equal 30 days.
- When a provider bills for supplies that have no limit or are limited to a specific number of units in a month, the provider must bill using a single date of service with at least 30 days between claims.

Warranty

When do I need to make warranty information available?

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

- Date of purchase
- Applicable serial number
- Model number or other unique equipment identifier
- Warranty period

When is the dispensing provider responsible for costs?

The dispensing provider who furnishes respiratory care equipment or supplies to a client is responsible for any costs incurred to have a different provider repair the equipment when all the following apply:

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

If rental respiratory equipment or supplies must be replaced during the warranty period, HCA recoups 50% of the total amount previously paid toward the rental costs and eventual purchase of the equipment or supplies if:

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