Durable Medical Equipment (DME) & Noncomplex Rehabilitation Technology (CRT) Wheelchairs Billing Guide

July 1, 2016

Washington State Health Care Authority

About this guide*

This guide takes effect July 1, 2016, and supersedes earlier billing guides to this program.

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

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

- Nondurable Medical Supplies and Equipment (MSE) Billing Guide
- Medical Nutrition Therapy Billing Guide
- Home Infusion Therapy Billing Guide
- Prosthetic and Orthotic Devices Billing Guide

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

What has changed?

Subject	Change	Reason for Change
Name Change	The agency is changing the name of the Provider Guides to Billing Guides.	To align with the agency's new website redesign launching in August
Coverage Tables	Added "for rental" to prior authorization requirement for HCPCS code E0181.	Housekeeping/ clarification

How can I get agency provider documents?

To download and print agency provider notices and Washington Apple Health billing guides, go to the agency's Provider Publications website.

* This publication is a billing instruction.

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Important Changes to Apple Health Effective April 1, 2016

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

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

New MCO enrollment policy – earlier enrollment

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

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

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

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

How does this policy affect providers?

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

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

Behavioral Health Organization (BHO)

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

Fully Integrated Managed Care (FIMC)

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

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

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

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

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

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

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

Apple Health Core Connections (AHCC)

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

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

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

AHCC complex mental health and substance use disorder services

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

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

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

Contact Information for Southwest Washington

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

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

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

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

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

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

Resources Available

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

Definitions

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

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

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

EPSDT - See WAC 182-500-0005.

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

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

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

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

Medical supplies – Supplies that are:

- Primarily and customarily used to serve a medical purpose.
- Generally not useful to a person in the absence of illness or injury. (WAC 182-543-1000)

Nonreusable supplies – Supplies that are used only once and then are disposed of. (WAC 182-543-1000)

Orthotic device or orthotic – A corrective or supportive device that does one of the following:

- Prevents or corrects physical deformity or malfunction
- Supports a weak or deformed portion of the body. (WAC 182-543-1000)

Other durable medical equipment (other DME) – All durable medical equipment, excluding wheelchairs and wheelchair related items. (WAC 182-543-1000)

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

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

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

Resource Based Relative Value Scale (RBRVS) – A scale that measures the relative value of a medical service or intervention, based on amount of physician resources involved. (WAC 182-543-1000)

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

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

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

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

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

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

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

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

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

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

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

- Standard:
  - ✓ Usually is not capable of being modified
  - ✓ Accommodates a person weighing up to 250 pounds
  - ✓ Has a warranty period of at least one year
- Lightweight:
  - ✓ Composed of lightweight materials
  - ✓ Capable of being modified
  - ✓ Accommodates a person weighing up to 250 pounds
  - ✓ Usually has a warranty period of at least three years
- High strength lightweight:
  - ✓ Is usually made of a composite material
  - ✓ Is capable of being modified.
  - ✓ Accommodates a person weighing up to 250 pounds
  - ✓ Has an extended warranty period of over three years
  - ✓ Accommodates the very active person
- Hemi:
  - ✓ Has a seat-to-floor height lower than 18 inches to enable an adult to propel the wheelchair with one or both feet.
  - ✓ Is identified by its manufacturer as **Hemi** type with specific model numbers that include the **Hemi** description.
- Pediatric:

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

  Has an adjustable, reclining back to facilitate weight shifts and provide support to the upper body and head
- Tilt-in-Space:

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

  Has one of the following:
  - ✓ Specifically manufactured to support a person weighing up to 300 pounds
  - ✓ Accommodating a seat width of up to 22 inches wide (not to be confused with custom manufactured wheelchairs)
- Rigid:
  Is of ultra-lightweight material with a rigid (nonfolding) frame
- Custom Heavy Duty. Is either of the following:
  - ✓ Specifically manufactured to support a person weighing over 300 pounds
  - ✓ Accommodates a seat width of over 22 inches wide (not to be confused with custom manufactured wheelchairs)

- Custom Manufactured Specially Built:

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

  (WAC 182-543-1000)

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

- Custom power adaptable to:

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

- Noncustom power:

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

- Pediatric:

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

About the Program

(WAC 182-543-0500)

What products in general does the Durable Medical Equipment (DME) program cover?

The federal government considers durable medical equipment (DME) and related supplies as optional services under the Medicaid program, except when prescribed as an integral part of an approved plan of treatment under the home health program, or as required under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

> **Note:** The agency may reduce or eliminate coverage for optional services, consistent with legislative appropriations.

For information about the Habilitative Services benefit see What are habilitative services under this program?

The agency covers DME and related supplies listed in this billing guide, according to agency rules and subject to the limitations and requirements within this guide.

The agency pays for DME and related supplies including modifications, accessories, and repairs when they are:

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

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

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

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

> **Note:** See Authorization for specific details regarding authorization for the DME Program.

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

- High cost
- The potential for utilization abuse
- A narrow therapeutic indication
- Safety

The agency evaluates a request for any DME item listed as noncovered within this billing guide under the provisions of WAC 182-501-0160 (see Exception to Rule). When EPSDT applies, the agency evaluates a noncovered service, equipment, or supply according to the process in WAC 182-501-0165 to determine if it is:

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

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

What are habilitative services under this program?

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

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

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

Billing for habilitative services

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

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

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

Client Eligibility

How can I verify a patient's eligibility?

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

Verifying eligibility is a two-step process:

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

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

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's Health Care Coverage—Program Benefit Packages and Scope of Service Categories web page.

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

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

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

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

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

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

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

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

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

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

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

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

Provider/Manufacturer Information

What types of durable medical equipment (DME) and related services does the agency pay for?

(WAC 182-543-2000)

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

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

What requirements must providers and suppliers meet?

Providers and suppliers of DME and related services must:

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

- Furnish to clients only new equipment that includes full manufacturer and dealer warranties.
- Furnish, upon agency request, documentation of proof of delivery (see How do providers furnish proof of delivery?).
- Bill the agency using only the allowed procedure codes published within this billing guide.
- Have a valid prescription. a prescription must meet all of the following:
  - ✓ Be written on the agency's *Prescription* form, HCA 13-794
  - ✓ Be written by a physician, advanced registered nurse practitioner (ARNP), or physician's assistant certified (PAC)
  - ✓ Be written, signed (including the prescriber's credentials), and dated by the prescriber on the same day and before delivery of the supply, equipment, or device. Prescriptions must not be back-dated
  - ✓ Be no older than one year from the date the prescriber signs the prescription
  - ✓ State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity

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

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

(WAC 182-543-2100)

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

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

- Manufacturer's literature.
- Manufacturer's pricing.
- Clinical research/case studies (including FDA approval, if required).
- Proof of the Centers for Medicare and Medicaid Services (CMS) certification, if applicable.

- Any additional information the requester feels would aid the agency in its determination.

  Send requests to:

  DME Program Management Unit
  PO Box 45506
  Olympia WA 98504-5506

How do providers furnish proof of delivery?

(WAC 182-543-2200)

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

- The agency requires a delivery slip as proof of delivery, and it must meet all of the following:
  - ✓ Be signed and dated by the client or the client's authorized representative (the date of signature must be the date the item was received by the client)
  - ✓ Include the client's name and a detailed description of the item(s) delivered, including the quantity and brand name
  - ✓ Include the serial number for durable medical equipment (DME) that may require future repairs
- When the provider or supplier submits a claim for payment to the agency, the date of service on the claim must be one of the following:
  - ✓ For a one-time delivery, the date the item was received by the client or authorized representative
  - ✓ For DME for which the agency has established a monthly maximum, on or after the date the item was received by the client or authorized representative

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

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

  The tracking slip must include all of the following:

  - ✓ The client's name or a reference to the client's package(s)
  - ✓ The delivery service package identification number
  - ✓ The delivery address

- If the provider/supplier delivers the product, the proof of delivery is the delivery slip. The delivery slip must include all of the following:

  - ✓ The client's name
  - ✓ The shipping service package identification number
  - ✓ The quantity, detailed description(s), and brand name(s) of the items being shipped
  - ✓ The serial number for DME that may require future repairs

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

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

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

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

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

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

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

(WAC 182-543-2250)

- The agency bases its decision to rent or purchase wheelchairs, durable medical equipment (DME) and supplies on the length of time the client needs the equipment.
- A provider must not bill the agency for the rental or purchase of equipment supplied to the provider at no cost by suppliers/manufacturers.
- The agency purchases **new** DME equipment only.
  - ✓ **A new** DME item that is placed with a client initially as a rental item is considered a new item by the agency at the time of purchase.
  - ✓ **A used** DME item that is placed with a client initially as a rental item must be replaced by the supplier with a new item prior to purchase by the agency.
- The agency requires a dispensing provider to ensure the DME rented to a client is:
  - ✓ In good working order.
  - ✓ Comparable to equipment the provider rents to clients with similar medical equipment needs who are either private pay clients or who have other third-party coverage.
- The agency's minimum rental period for covered DME is one day.
- The agency authorizes rental equipment for a specific period of time. The provider must request authorization from the agency for any extension of the rental period.
- The agency's reimbursement amount for rented DME includes all of the following:
  - ✓ Delivery to the client
  - ✓ Fitting, set-up, and adjustments
  - ✓ Maintenance, repair and/or replacement of the equipment
  - ✓ Return pickup by the provider
- The agency considers rented equipment to be purchased after twelve months' rental unless the equipment is restricted as rental only.

- DME and related services purchased by the agency for a client are the client's property.
- The agency rents, but does not purchase, certain DME for clients.
- The agency stops paying for any rented equipment effective the date of a client's death. The agency prorates monthly rentals as appropriate.
- For a client who is eligible for both Medicare and Medicaid, the agency pays only the client's coinsurance and deductibles. The agency discontinues paying client's coinsurance and deductibles for rental equipment when either of the following apply:
    - ✓ The reimbursement amount reaches Medicare’s reimbursement cap for the equipment.
    - ✓ Medicare considers the equipment purchased.

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

Coverage – DME (Other)

(WAC 182-543-3000)

When does the agency cover hospital beds?

The agency covers, with prior authorization (PA), one hospital bed in a 10-year period, per client, with the following limitations:

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

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

How long does the agency pay for hospital bed rental?

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

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

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

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

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

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

The agency pays, with prior authorization (PA), for the initial purchase of a semi-electric hospital bed with mattress, with or without bed rails, when all of the following criteria are met:

- The client:

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

-AND-

- Is diagnosed with one of the following:

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

- Requests for PA must be submitted in writing to the agency and be accompanied by all of the following:

  ✓ A completed *General Information for Authorization* form, HCA 13-835 (see Authorization)

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

  ✓ Documentation of the client's life expectancy, in months and/or years, the client's diagnosis, the client's date of delivery and serial number of the hospital bed

  ✓ Be accompanied by written documentation, from the client or caregiver, indicating the client has not been previously provided a hospital bed, purchase or rental

Note: For other forms, see Medicaid Forms.

What is the purchase limit on mattresses and related equipment?

The agency pays for, with prior authorization (PA), the following:

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

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

(WAC 182-543-3100)

The agency covers the purchase of the following, without prior authorization (PA), with limitations:

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

What is the purchase limitation for positioning devices?

(WAC 182-543-3200)

The agency covers, without prior authorization (PA), positioning devices with the following limitations:

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

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

(WAC 182-543-3300)

The agency covers, with PA, noninvasive osteogenesis electrical stimulators, limited to 1 per client, in a 5-year period.

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

- The stimulators have pulsed electromagnetic field (PEMF) simulation

- The client meets **one or more of the following clinical criteria:**

  ✓ Has a nonunion of a long bone fracture (which includes clavicle, humerus, phalanx, radius, ulna, femur, tibia, fibula, metacarpal & metatarsal) after three months have elapsed since the date of injury without healing

  -OR-

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

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

- Prescribed by a neurologist, an orthopedic surgeon, or a neurosurgeon
- The client meets one or more of the following clinical criteria:

  ✓ Has a failed spinal fusion where a minimum of nine months have elapsed since the last surgery

  ✓ Is post-op from a multilevel spinal fusion surgery

  ✓ Is post-op from spinal fusion surgery where there is a history of a previously failed spinal fusion

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

(WAC 182-543-3400)

The agency covers both of the following:

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

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

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

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

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

- The request must be in writing and be accompanied by all of the following:
  - ✓ A completed *General Information for Authorization* form, HCA 13-835 see WAC 182-543-7000
  - ✓ A copy of the client's prescription for an evaluation for a SGD
  - ✓ A completed *Speech Language Pathologist (SLP) Evaluation for Speech Generating Devices* form, HCA 15-310

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

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

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

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

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

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

The agency pays for replacement batteries for a SGD in accordance with WAC 182-543-5500(3).

The agency does not pay for back-up batteries for a SGD.

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

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

(WAC 182-543-3500)

The agency covers the purchase of the following ambulatory aids with stated limitations without prior authorization:

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

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

The agency pays for miscellaneous durable medical equipment (DME) as follows:

- Blood glucose monitor (specialized or home) - One in a 3-year period. See WAC 182-543-5500(12) for blood monitoring/testing supplies. The agency does not pay for continuous glucose monitoring systems including related equipment and supplies.
- Continuous passive motion (CPM) machine - Up to ten days rental and requires PA.
- Lightweight protective helmet/soft shell (including adjustable chin/mouth strap) - Two per 12-month period.
- Lightweight ventilated hard-shell helmet (including unbreakable face bar, woven chin strap with adjustable buckle and snap fastener, and one set of cushion pads for adjusting fit to head circumference) - Two per 12-month period.
- Pneumatic compressor - One in a 5-year period.
- Positioning car seat - One in a 5-year period.

Coverage Table – DME (Other)

Beds, mattresses, and related equipment

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
	A4640	RA or RE	Replacement pad for use with medically necessary alternating pressure pad owned by patient	No	Yes	Purchase only
	A6550		Dressing set for negative pressure wound therapy electrical pump, stationary or portable, each	Yes		Purchase only
	A7000		Canister, disposable, used with suction pump, each			Purchase only Limit of 5 per client every 30 days. Covered only when billed in conjunction with prior authorized HCPCS code E2402
NC	A9272		Wound suction, disposable, includes dressing, all accessories and components, any type, each			
	K0743		Portable home suction pump	Yes		
NC	K0744		Absorp drg < = 16 suction pump			

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
NC	K0745		Absorp drg > 16 <= 48 suction pump			
NC	K0746		Absorp drg > 48 suc pump			
	E0181	NU RR	Powered pressure reducing mattress overlay/pad, alternating with pump. Includes heavy duty	Yes for Rental		
	E0182		Pump for alternating pressure pad	No	Yes	Replacement purchase only
	E0184		Dry pressure mattress	No	Yes	Purchase only. Limit of 1 per client every 5 years
	E0185	NU RR	Gel or gel-like pressure pad for mattress	Yes for Rental	Yes	Considered purchased after 1 year's rental. Limit of 1 per client every 5 years
	E0186	NU RR	Air pressure mattress	Yes for Rental	Yes	For powered pressure reducing mattress see HCPCS code E0277. Considered purchased after 1 years' rental.
NC	E0187		Water pressure mattress			
	E0190		Positioning cushion/pillow/wedge, any shape or size	Yes	Yes	Purchase only
DC	E0193		Powered air flotation bed (low air loss therapy)			See E0194

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
	E0194	NU RR	Air fluidized bed	PA or EPA in Auth		Considered purchased after 1 years' rental
	E0196		Gel pressure mattress		Yes	Purchase only. Limit of 1 per client every 5 years.
	E0197	NU RR	Air pressure pad for mattress (standard mattress length and width)	Yes for Rental	Yes	Considered purchased after 1 years' rental
	E0198		Water pressure pad for mattress, standard mattress length and width	No	Yes	Purchase only. Limit of 1 per client every 5 years
	E0199		Dry pressure pad for mattress, standard mattress length and width	No	Yes	Purchase only. Limit of 1 per client every 5 years
	E0250		Hospital bed, fixed height, with any type side rails, with mattress			
	E0251		Hospital bed, fixed height, with any type side rails, without mattress			
DC	E0255		Hospital bed, variable height, hi-lo, with any type side rails, with mattress			See HCPCS codes E0292 and E0305 or E0310
DC	E0256		Hospital bed, variable height, hi-lo, with any type side rails, without mattress			See HCPCS codes E0293 and E0305 or E0310

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
DC	E0260		Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress			See HCPCS codes E0294 and E0305 or E0310
DC	E0261		Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress			See HCPCS codes E0295 and E0305 or E0310
DC	E0265		Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress			See HCPCS codes E0296 and E0305 or E0310
DC	E0266		Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress			See HCPCS codes E0297 and E0305 or E0310
	E0270		Hospital bed, institutional type includes: oscillating, circulating and stryker frame, with mattress			
	E0271	NU	Mattress, inner spring	No	Yes	Limit of 1 per client every 5 years. Replacement only.
	E0272		Mattress, foam rubber (replacement only)	No	Yes	Limit of 1 per client every 5 years. Purchase only.
NC	E0273		Bed board			
NC	E0274		Over-bed table			

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
	E0277	NU RR	Powered pressure-reducing air mattress	PA or EPA in Auth		Considered purchased after 1 years' rental
NC	E0280		Bed cradle, any type			
	E0290		Hospital bed, fixed height, without side rails, with mattress			
	E0291		Hospital bed, fixed height, without side rails, with mattress			
	E0292	NU RR	Hospital bed, variable height, hi-lo, without side rails, with mattress	PA or EPA in Auth	Yes	Considered purchased after 1 years' rental. Limit of 1 per client every 10 years.
	E0293	NU RR	Hospital bed, variable height, hi-lo, without side rails, without mattress	Yes	Yes	Considered purchased after 1 years' rental. Limit of 1 per client every 10 years.
	E0294	NU RR	Hospital bed, semi-electric (head and foot adjustments), without side rails, with mattress	PA or EPA in Auth	Yes	Considered purchased after 1 years' rental. Limit of 1 per client every 10 years.
	E0295	NU RR	Hospital bed, semi-electric (head and foot adjustments), without side rails, without mattress	Yes	Yes	Considered purchased after 1 years' rental. Limit of 1 per client every 10 years
NC	E0296	NU RR	Hospital bed, total electric (head, foot, and height adjustments), without side rails, with mattress			

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
NC	E0297	NU RR	Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress			
	E0300	NU RR	Pediatric crib, hospital grade, fully enclosed	Yes	Yes	Considered purchased after 1 years' rental
DC	E0301		Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress			See E0303
DC	E0302		Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress			See E0304
	E0303	NU RR	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress	Yes	Yes	Considered purchased after 1 years' rental. Limit of 1 per client every 10 years
	E0304	NU RR	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	Yes	Yes	Considered purchased after 1 years' rental. Limit of 1 per client every 10 years

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
	E0305	NU RR	Bedside rails, half length, pair	Rental requires PA or EPA in Auth	Yes	Considered purchased after 1 years' rental. Limit of 1 per client every 10 years
	E0310	NU RR	Bedside rails, full length, pair	Rental requires PA or EPA in Auth	Yes	Considered purchased after 1 years' rental. Limit of 1 per client every 10 years.
NC	E0315		Bed accessory: board, table, or support device, any type	No		

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
	E0316		Safety enclosure frame/canopy for use with hospital bed, any type	Yes	Yes	Purchase only
	E0328		Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress	Yes	Yes	Purchase only. Limit of 1 per client every 10 years.
	E0329		Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress	Yes	Yes	Purchase only. Limit of 1 per client every 10 years
NC	E0370		Air pressure elevator for heel	No		
	E0371	**NU RR**	Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width	PA or EPA in Auth		Considered purchased after 1 years' rental
	E0372	**NU RR**	Powered air overlay for mattress, standard mattress length and width	PA or EPA in Auth		Considered purchased after 1 years' rental
	E0373	**NU RR**	Nonpowered advanced pressure reducing mattress	PA or EPA in Auth		Considered purchased after 1 years' rental

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
	E2402	**RR**	Negative pressure wound therapy electrical pump, stationary or portable	Yes		Rental only

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Other patient room equipment

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
	E0621		Sling or seat, patient lift, canvas or nylon	No	Yes	Purchase only
NC	E0625		Patient lift, bathroom or toilet, not otherwise classified	No		
NC	E0627		Seat lift mechanism incorporated into a combination lift-chair mechanism	No		
NC	E0628		Separate seat lift mechanism for use with patient owned furniture – electric	No		
NC	E0629		Separate seat lift mechanism for use with patient owned furniture - nonelectric	No		
	E0630	NU RR	Patient lift, hydraulic, with seat or sling	Yes for Rental	Yes	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years. (Includes bath.)
	E0635	NU RR	Patient lift, electric, with seat or sling	Yes	Yes	Considered purchased after 1 years' rental
DC	E0636		Multipositional patient support system, with integrated lift, patient accessible controls			See E0635
NC	E0640		Patient lift, fixed system, includes all components/ accessories			

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
NC	E0656		Segmental pneumatic appliance for use with pneumatic compressor, trunk			
NC	E0657		Segmental pneumatic appliance for use with pneumatic compressor, chest			
NC	E0766		Electrical stimulation device used for cancer treatment, includes all accessories, any type			
NC	A4555 to be used with E0766		Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only			
NC	E0769		Electrical stimulation or electromagnetic wound treatment device, not otherwise classified.			
NC	E0770		Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified			
DC	E0830		Ambulatory traction device, all types, each.			
	E0840		Traction frame, attached to headboard, cervical traction.			

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
DC	E0849		Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible.			
	E0850		Traction stand, freestanding, cervical traction.	No	Yes	Purchase only. Limit of 1 per client every 5 years.
DC	E0855		Cervical traction equipment not requiring additional stand or frame.			
DC	E0856		Cervical traction device, cervical collar with inflatable air bladder.			
	E0860		Traction equipment, overdoor, cervical.	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0870		Traction frame, attached to footboard, simple extremity traction (e.g. Buck's).	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0880		Traction stand, freestanding, extremity traction (e.g., Buck's).	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0890		Traction frame, attached to footboard, pelvic traction.	No	Yes	Purchase only. Limit of 1 per client every 5 years.

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
	E0900		Traction stand, freestanding, pelvic traction (e.g., Buck's).	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0910	NU RR	Trapeze bar, also known as patient helper, attached to bed with grab bar.	Yes for Rental	Yes	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years.
	E0911	NU RR	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed with grab bar	Yes for Rental.	Yes	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years.
	E0912	NU RR	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar.	Yes for Rental	Yes	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years.
	E0920	NU RR	Fracture frame, attached to bed. Includes weights.	Yes for Rental	Yes	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years.
	E0930	NU RR	Fracture frame, freestanding, includes weights.	Yes for Rental	Yes	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years.

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
	E0940	NU RR	Trapeze bar, freestanding, complete with grab bar.	Yes for Rental	Yes	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years.
	E0941	NU RR	Gravity assisted traction device, any type.	Yes for Rental	Yes	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years.
	E0946	NU RR	Fracture frame, dual with cross bars, attached to bed (e.g., Balken, 4-poster).	Yes for Rental	Yes	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years.
	E0947		Fracture frame, attachments for complex pelvic traction.	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0948		Fracture frame, attachments for complex cervical traction.	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0705		Transfer board or device, any type, each.	No	Yes	Purchase only. Limit of 1 per client every 5 years.

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Positioning devices

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/ Comments
	E0637	NU RR	Combination sit to stand system, any size including pediatric, with seat lift feature, with or without wheels (includes padded seat, knee support, foot plates, foot straps, formed table and cup holder and hydraulic actuator).	Yes	Yes	Considered purchased after one years' rental
	E0638		Standing frame/table system, one position (e.g. upright, supine, or prone stander), any size including pediatric with or without legs.	No	Yes	Limit of 1 per client every 5 years. Purchase only.
	E0639		Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories.	Yes	Yes	Limit of 1 per client every 5 years. Purchase only.
DC	E0641		Standing frame system, multi-position (e.g. three-way stander), any size including pediatric, (includes padding, straps, adjustable armrests, footboard, and support blocks.)			See E0637

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/ Comments
DC	E0642		Standing frame system, mobile dynamic stander, any size including pediatric, (includes padding, straps, adjustable armrests, footboard, and support blocks.)			See E0637

Noninvasive bone growth/nerve stimulators

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
NC	E0720		TENS, two lead, localized stimulation			
NC	E0731		Form-fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)			
	E0740	NU RR	Incontinence treatment system, pelvic floor stimulator, monitor, sensor and/or trainer	Yes	Yes	Considered purchased after 1 years' rental
NC	E0744		Neuromuscular stimulator for scoliosis			
NC	E0745		Neuromuscular stimulator, electronic shock unit			

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
NC	E0746		Electromyography (EMG) biofeedback device			
	E0747		Osteogenesis stimulator, electrical noninvasive, other than spinal applications	PA or EPA in Auth		Purchase only. Limit of 1 per client every 5 years.
	E0748		Osteogenesis stimulator, electrical noninvasive, spinal applications	PA or EPA in Auth		Purchase only. Limit of 1 per client every 5 years.
DP	E0749		Osteogenesis stimulator, electrical, surgically implanted			See Physician-Related Services/Health Care Professional Services Billing Guide
NC	E0755		Electronic salivary reflex stimulator (intraoral/noninvasive)			
	E0760		Osteogenesis stimulator, low intensity ultrasound, noninvasive	PA or EPA in Auth		Purchase only. Limit of 1 per client every 5 years.
NC	E0761		Non-thermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device			

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
DP	E0762		Transcutaneous electrical joint stimulation device system, includes all accessories			See Physician-Related Services/Health Care Professional Services Billing Guide
NC	E0764		Functional neuromuscular stimulator, transcutaneous stimulation of muscles of ambulation with computer control, used for walking by spinal cord injured			
DP	E0765		FDA approved nerve stimulator, with replaceable batteries, for treatment of nausea and vomiting			See Physician-Related Services/Health Care Professional Services Billing Guide

Communication devices

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
NC	E1902		Communication board, non-electronic augmentative or alternative communication device			
	E2500		Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time	Yes		Purchase only

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
	E2502		Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time	Yes		Purchase only
	E2504		Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	Yes		Purchase only
	E2506		Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time	Yes		Purchase only
	E2508		Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device	Yes		Purchase only
	E2510		Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	Yes		Purchase only
NC	E2511		Speech generating software program, for personal computer or personal digital assistant			

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
	E2512		Accessory for speech generating device, mounting system	Yes		Purchase only
	E2599		Accessory for speech generating device, not otherwise classified	Yes		Purchase only
	L8500		Artificial larynx, any type	No		Purchase only. Limit of 1 per client every 5 years

Ambulatory aids

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
	A4635		Underarm pad, crutch, replacement, each	No	Yes	Purchase only
	A4636		Replacement handgrip, cane, crutch, or walker, each	No	Yes	Purchase only
	A4637		Replacement tip, cane, crutch, or walker, each	No	Yes	Purchase only
	E0100		Cane; includes canes of all materials; adjustable or fixed, with tip	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0105		Cane, quad or three-prong; includes canes of all materials; adjustable or fixed, with tip	No	Yes	Purchase only. Limit of 1 per client every 5 years.

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
	E0110		Crutches, forearm; includes crutches of various materials, adjustable or fixed; complete with tips and handgrips	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0111		Crutches, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrip	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0112		Crutches, underarm, wood, adjustable or fixed, per pair, with pads, tips/handgrips	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0113		Crutch, underarm; wood; adjustable or fixed; each, with pad, tip and handgrip	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0114		Crutches, underarm; other than wood; adjustable or fixed; per pair, with pads, tips and handgrips	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0116		Crutch, underarm; other than wood; adjustable or fixed; each, with pad, tip and handgrip, with or without shock absorber, each	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0117		Crutch, underarm, articulating, spring assisted, each	Yes		Purchase only

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
NC	E0118		Crutch substitute, lower leg platform, with or without wheels, each			
DC	E8000		Gait trainer, pediatric size, posterior support, includes all accessories and components			See HCPCS code E8001
	E8001		Gait trainer, pediatric size, upright support, includes all accessories and components	Yes	Yes	Purchase only
DC	E8002		Gait trainer, pediatric size, anterior support, includes all accessories and components			See HCPCS code E8001
	E0130		Walker, rigid (pickup), adjustable or fixed height	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0135		Walker; folding (pickup), adjustable or fixed height	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0140		Walker, with trunk support, adjustable or fixed height, any type	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0141		Walker, rigid, wheeled, adjustable or fixed height	No	Yes	Purchase only. Limit of 1 per client every 5 years.

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
	E0143		Walker, folding, wheeled, adjustable or fixed height	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0144		Walker, enclosed, four sided framed, rigid or folding, wheeled with posterior seat	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0147		Walker, heavy duty, multiple braking system, variable wheel resistance (over 250 lbs)	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0148		Walker, heavy duty, without wheels, rigid or folding, any type (over 250lbs)	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0149		Walker, heavy duty, wheeled, rigid or folding, any type (over 250 lbs)	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0153		Platform attachment, forearm crutch, each	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0154		Platform attachment, walker, each	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0155		Wheel attachment, rigid pick-up walker, per pair seat attachment, walker	No	Yes	Purchase only. Limit of 1 per client every 5 years.

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
	E0156		Seat attachment, walker	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0157		Crutch attachment, walker, each	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0158		Leg extensions for walker, per set of four (4)	No	Yes	Purchase only. Limit of 1 per client every 5 years.
	E0159		Brake attachment for wheeled walker, replacement**,** each	No	Yes	Purchase only

Bathroom equipment

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
NC	E0160		Sitz type bath or equipment, portable, used with or without commode			
NC	E0161		Sitz type bath or equipment, portable, used with or without commode, with faucet attachment(s)			
NC	E0162		Sitz bath chair			

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
NC	E0163	NU RR	Commode chair, stationary, with fixed arms	Yes for Rental		
NC	E0165	NU RR	Commode chair, stationary, with detachable arms	Yes for Rental		
NC	E0167		Pail or pan, for use with commode chair (replacement)	No		
NC	E0168	NU RR	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each	Yes for Rental		
NC	E0170		Commode chair with integrated seat lift mechanism, electric, any type			
NC	E0171		Commode chair with integrated seat lift mechanism, non-electric, any type			
NC	E0172		Seat lift mechanism placed over or on top of toilet, any type			
NC	E0175		Foot rest, for use with commode chair, each			
NC	E0240		Bath/shower chair, with or without wheels, any size			
NC	E0241		Bathtub wall rail, each			

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
NC	E0242		Bathtub rail, floor base			
NC	E0243		Toilet rail, each			
NC	E0244		Raised toilet seat			
NC	E0245		Tub stool or bench			
NC	E0246	NU	Transfer tub rail attachment, each			
NC	E0247		Transfer bench for tub or toilet with or without commode opening			
NC	E0248		Transfer bench, heavy duty, for tub or toilet with or without commode opening (over 250 lbs)	No		
NC	E0275		Bed pan, standard, metal or plastic			
NC	E0276		Bed pan, fracture, metal or plastic			
NC	E0325		Urinal; male, jug-type, any material			
NC	E0326		Urinal; female, jug-type, any material			
NC	E0350		Control unit for electronic bowel irrigation/ evacuation system			

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
NC	E0352		Disposable pack (water reservoir bag, speculum, valving mechanism and collection bag/box) for use with the electronic bowel irrigation/evacuation system			
	E0700		Safety equipment (e.g., belt, harness or vest)	No	Yes	Purchase only
NC	E0248	NU	Durable medical equipment, miscellaneous. (Heavy duty bath chair (for clients over 250 lbs.))			

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Blood monitoring

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
NC	A4660		Sphygmomanometer/blood pressure apparatus with cuff and stethoscope	No		
NC	A4663		Blood pressure cuff only	No		
NC	A4670		Automatic blood pressure monitor	No		
	A9275		Home glucose disposable monitor, include test strips	No		Purchase only
	E0607		Home blood glucose monitor	No		Purchase only. Limit of 1 per client, per 3 years.
	E2100		Blood glucose monitor with integrated voice synthesizer	Yes		Purchase only. Limit of 1 per client, per 3 years.
NC	E2101		Blood glucose monitor with integrated lancing/blood sample			

Support devices/orthotics

See the Prosthetics and Orthotics Billing Guide for Support Devices/Orthotics Codes.

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Miscellaneous durable medical equipment

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
	A8000		Helmet, protective, soft, prefabricated, includes all components and accessories	No		Purchase only. Limit of 1 per client, per year.
	A8001		Helmet, protective, hard, prefabricated, includes all components and accessories	No		Purchase only. Limit of 1 per client, per year.
	A8002		Helmet, protective, soft, custom fabricated, includes all components and accessories	Yes		Purchase only. Limit of 1 per client, per year.
	A8003		Helmet, protective, hard, custom fabricated, includes all components and	Yes		Purchase only. Limit of 1 per client, per year.
	A8004		Soft interface for helmet, replacement only			Not allowed in addition to HCPCS codes A8000 – A8003
	E0202	RR	Phototherapy (bilirubin) light with photometer	No		Rental only. Includes all supplies. Limit of five days of rental per client per 12-month period.
	E0602		Breast pump, manual, any type	No		Purchase only. Limit of 1 per client per lifetime. Not allowed in combination with E0603 or E0604RR.

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
	E0603	NU	Breast pump, electric, AC and/or DC, any type	Yes		Purchase only. Limit of 1 per client per lifetime. Not allowed in combination with HCPCS codes E0604RR or E0602.
	E0604	RR	Breast pump, **hospital grade**, electric (AC and/or DC), any type	PA or EPA in Auth		Rental only. If client received a kit during hospitalization, an additional kit will not be covered.
	E0650	NU RR	Pneumatic compressor, nonsegmental home model	Rental requires PA or EPA in Auth	Yes	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years.
NC	E0651		Pneumatic compressor, segmental home model without calibrated gradient pressure			
NC	E0652		Pneumatic compressor, segmental home model with calibrated gradient pressure			

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
	E0655		Extremity sleeve: nonsegmental pneumatic appliance for use with pneumatic compressor, half arm	No		Purchase only
	E0660		Extremity sleeve: nonsegmental pneumatic appliance for use with pneumatic compressor, full leg	No		Purchase only
	E0665		Extremity sleeve: nonsegmental pneumatic appliance for use with pneumatic compressor, full arm	No		Purchase only
	E0666		Extremity sleeve: nonsegmental pneumatic appliance for use with pneumatic compressor, half leg	No		Purchase only
NC	E0667		Segmental pneumatic appliance for use with pneumatic compressor, full leg			
NC	E0668		Segmental pneumatic appliance for use with pneumatic compressor, full arm			
NC	E0669		Segmental pneumatic appliance for use with pneumatic compressor, half leg			

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
NC	E0670		Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk			
NC	E0671		Segmental gradient pressure pneumatic appliance, full leg			
NC	E0672		Segmental gradient pressure pneumatic appliance, full arm			
NC	E0673		Segmental gradient pressure pneumatic appliance, half leg			
NC	E0675		Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)			
NC	E0676		Intermittent limb compression device (includes all accessories), not otherwise specified			
NC	E0691		Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area two square feet or less			
NC	E0692		Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, four foot panel			

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
NC	E0693		Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, six foot panel			
NC	E0694		Ultraviolet multidirectional light therapy system in six foot cabinet, includes bulbs/lamps, timer and eye protection			
NC	E0710		Restraint, any type (body, chest, wrist or ankle)			
	E0935	RR	Continuous passive motion exercise device for use on knee only (complete). Includes continuous passive motion softgoods kit	PA or EPA in Auth		Rental allowed for maximum of 10 days. Limit = per knee.
	E0936	RR	Continuous passive motion exercise device for use other than knee	Yes		
NC	E1300		Whirlpool, portable (overtub type)			
NC	E1310		Whirlpool, nonportable (built-in type)			
	E1399	NU	Durable medical equipment, miscellaneous. (Breast pump kit, electric)	Yes		Purchase only
	E2000	RR	Gastric suction pump, home model, portable or stationary, electric	Yes		Rental only

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
NC	K0606		Automatic external defibrillator, with integrated electrocardiogram analysis, garment type			
NC	K0607		Replacement battery for automated external defibrillator, garment type only, each			
NC	K0608		Replacement garment for use with automated external defibrillator, each			
NC	K0609		Replacement electrodes for use with automated external defibrillator, garment type only, each			
	K0739		Labor, other DME repairs (other than wheelchairs), per quarter hour. (Trouble shooting, delivery, evaluations, travel time, etc. are included in the reimbursement of the items).	Yes		For client-owned equipment only
NC	K0900		customized durable medical equipment, other than wheelchair			
	T5001	NU RR	Positioning seat for persons with special orthopedic needs, for use in vehicles (7 years and older)	Yes for Rental Yes for clients 6 years of age and younger	Yes	Limit of 1 per client every 5 years

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Other charges for DME services

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
NC	A9273		Hot water bottle, ice cap or collar, heat and/or wrap, any type			
NC	A9281		Reaching/grabbing device, any type, any length, each			
NC	A9282		Wig, any type, each			
NC	E0200		Heat/Cold Application. Heat lamp, without stand (table model), includes bulb, or infrared element			
NC	E0203		Therapeutic lightbox, minimum 10,000 lux, table top model			
NC	E0205		Heat lamp, with stand, includes bulb, or infrared element			
NC	E0210		Electric heat pad, standard			
NC	E0215		Electric heat pad, moist			
NC	E0217		Water circulating heat pad with pump			
NC	E0218		Water circulating cold pad with pump			
NC	E0221		Infrared heating pad system			
NC	E0225		Hydrocollator unit, includes pads			

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
NC	E0231		Non-contact wound warming device (temperature control unit, AC adapter and power cord) for use with warming card and wound cover			
NC	E0232		Warming card for use with the non-contact wound warming device and non-contact wound warming wound cover			
NC	E0235		Paraffin bath unit, portable (see medical supply HCPCS code A4265 for paraffin)			
NC	E0236		Pump for water circulating pad			
NC	E0239		Hydrocollator unit, portable			
NC	E0249		Pad for water circulating heat unit			
BR	E1399	NU RR	Durable medical equipment, miscellaneous (Other nonlisted durable medical equipment not otherwise listed)	Yes		Provide complete description including copy of manufacturer's product information and price catalog with request for authorization.
NC	E1831		Static progressive stretch toe device, extension and/or flexion			

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Coverage for Non-CRT Wheelchairs

(WAC 182-543-4000)

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

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

What are the general guidelines for wheelchairs?

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

- *General Information for Authorization* form, HCA 13-835 (see WAC 182-543-7000 Authorization)
- *Medical Necessity for Wheelchair Purchase (for home clients only)* form, HCA 13-727 from the client's physician or therapist
- The agency's *Prescription* form, HCA 13-794

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

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

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

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

(WAC 182-543-4100)

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

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

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

- A standard wheelchair if the client's medical condition requires the client to have a wheelchair to participate in normal daily activities
- A standard lightweight wheelchair if the client's medical condition does not allow the client to use standard weight wheelchair because of one of the following:
  - ✓ The client cannot self-propel a standard weight wheelchair.
  - ✓ Custom modifications cannot be provided on a standard weight wheelchair
- A high-strength lightweight wheelchair for a client who meets one of the following:
  - ✓ Whose medical condition doesn't allow the client to self-propel a lightweight or standard weight wheelchair
  - ✓ Requires custom modifications that cannot be provided on a standard weight or lightweight wheelchair
- A heavy duty wheelchair for a client who requires a specifically manufactured wheelchair designed to meet one of the following:
  - ✓ Support a person weighing 300 pounds and over
  - ✓ Accommodate a seat width up to 22 inches wide (not to be confused with custom heavy-duty wheelchairs)

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

  ✓ Support a person weighing 300 pounds and over

  ✓ Accommodate a seat width over 22 inches wide

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

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

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

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

Does the agency cover power-drive wheelchairs?

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

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

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

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

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

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

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

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

What are the guidelines for clients with multiple wheelchairs?

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

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

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

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

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

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

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

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

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

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

Non-CRT Wheelchair Coverage Table

Manual wheelchairs (covered HCPCS codes)

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/Comments
	E1031	NU	Rollabout chair, any and all types with casters five inches or greater	Yes	
NC	E1039		Transport chair, adult size, heavy duty, patient weight capacity greater than 300 pounds		
	E1060	RR	Fully reclining wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating leg rests	Yes. See EPA	
	K0001	NU RR	Standard wheelchair (all styles of arms, foot rests, and/or leg rests)	Yes. See EPA (for rental only).	
	K0002	NU RR	Standard hemi(low seat) for wheelchair	Yes	

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

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/Comments
	K0003	NU RR	Lightweight wheelchair (all styles of arms, foot rests, and/or leg rests)	Yes. See Authorization (for rental only).	
	K0004	NU	High strength, lightweight wheelchair	Yes	
	K0006	NU RR	Heavy-duty wheelchair (all styles of arms, foot rests, and/or leg rests)	Yes. See Authorization	

Manual wheelchairs (noncovered HCPCS codes)

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/Comments
NC	E1037		Transport chair, pediatric size		
NC	E1038		Transport chair, adult size, patient weight capacity up to and including 300 pounds		
DC	E1050		Fully reclining wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests		See HCPCS codes K0003 and E1226

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/Comments
DC	E1070		Fully reclining wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests		See HCPCS codes K0003 and E1226
DC	E1083		Hemi-wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests		See HCPCS code K0002 or K0003
DC	E1084		Hemi-wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating leg rests		See HCPCS code K0002 or K0003
DC	E1085		Hemi-wheelchair; fixed full-length arms, swing-away, detachable footrests		See HCPCS code K0002 or K0003
DC	E1086		Hemi-wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests		See HCPCS code K0002 or K0003
DC	E1087		High-strength lightweight wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests		See HCPCS code K0004
DC	E1088		High-strength lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating leg rests		See HCPCS code K0004
DC	E1089		High-strength lightweight wheelchair; fixed-length arms, swing-away, detachable footrests		See HCPCS code K0004

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/Comments
DC	E1090		High-strength lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests		See HCPCS code K0004
DC	E1092		Wide, heavy-duty wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating leg rests		See HCPCS code K0007
DC	E1093		Wide, heavy-duty wheelchair; detachable arms, desk or full-length arms, swing-away, detachable footrests		See HCPCS code K0007
DC	E1100		Semi-reclining wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests		See HCPCS codes K0003 and E1226
DC	E1110		Semi-reclining wheelchair; detachable arms, desk or full-length, elevating leg rests		See HCPCS codes K0003 and E1226
DC	E1130		Standard wheelchair; fixed full-length arms, fixed or swing-away, detachable footrests		See HCPCS code K0001
DC	E1140		Wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests		See HCPCS code K0001
DC	E1150		Wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating leg rests		See HCPCS K0001

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/Comments
DC	E1160		Wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests		
DC	E1170		Amputee wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests		See HCPCS codes K0001 - K0005
DC	E1171		Amputee wheelchair; fixed full-length arms, without footrests or leg rests		See HCPCS codes K0001 - K0005
DC	E1172		Amputee wheelchair; detachable arms, desk or full-length, without footrests or leg rests		See HCPCS codes K0001 - K0005
DC	E1180		Amputee wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests		See codes K0001 - K0005
DC	E1190		Amputee wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating leg rests		See codes K0001 - K0005
DC	E1195		Heavy duty wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests		See HCPCS code K0007
DC	E1200		Amputee wheelchair; fixed full-length arms, swing-away, detachable footrests		See codes K0001 - K0005

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/Comments
DC	E1221		Wheelchair with fixed arm, footrests		See HCPCS K0001 - K0014
DC	E1222		Wheelchair with fixed arm, elevating leg rests		See HCPCS K0001 - K0014
DC	E1223		Wheelchair with detachable arms, footrests		See HCPCS K0001 - K0014
DC	E1224		Wheelchair with detachable arms, elevating leg rests		See HCPCS K0001 - K0014
DC	E1240		Lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating leg rests		See HCPCS code K0003 or K0004
DC	E1250		Lightweight wheelchair; fixed full-length arms, swing-away, detachable, footrests		See HCPCS code K0003 or K0004
DC	E1260		Lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests		See HCPCS code K0003 or K0004
DC	E1270		Lightweight wheelchair; fixed full-length arms, swing-away, detachable elevating leg rests		See HCPCS code K0003 or K0004
DC	E1280		Heavy-duty wheelchair; detachable arms, desk or full-length, elevating leg rests		See HCPCS code K0007
DC	E1285		Heavy-duty wheelchair; fixed full-length arms, swing-away, detachable footrests		See HCPCS code K0007

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/Comments
DC	E1290		Heavy-duty wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests		See HCPCS code K0007
DC	E1295		Heavy-duty wheelchair; fixed full-length arms, elevating leg rests		See HCPCS code K0007

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Power operated vehicles (covered HCPCS codes)

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/Comments
	K0800	NU	Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds	Yes	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099, E2360 – E2372, E2381 – E2396 & K0733
	K0801	NU	Power operated vehicle, group 1 heavy duty, patient weight capacity, 301 to 450 pounds	Yes	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099, E2360 – E2372, E2381 – E2396 & K0733

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/Comments
	K0802	NU	Power operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds	Yes	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099, E2360 – E2372, E2381 – E2396 & K0733
	K0806	NU	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds	Yes	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099, E2360 – E2372, E2381 – E2396 & K0733
	K0807	NU	Power operated vehicle, group 2 heavy duty, patient weight capacity 301 to 450 pounds	Yes	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099, E2360 – E2372, E2381 – E2396 & K0733

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

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/Comments
	K0808	NU	Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600 pounds	Yes	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099, E2360 – E2372, E2381 – E2396 & K0733
BR	K0812	NU	Power operated vehicle, not otherwise classified	Yes	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099, E2360 – E2372, E2381 – E2396 & K0733

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

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Modifications, Accessories, and Repairs for Non-CRT Wheelchairs

(WAC 182-543-4300)

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

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

- A completed *General Information for Authorization* form, HCA 13-835. (See WAC 182-543-7000 Authorization)
- A completed *Prescription* form, HCA 13-794
- A completed *Medical Necessity for Wheelchair Purchase (for home clients only)* form, HCA 13-727
- The make, model, and serial number of the wheelchair to be modified
- The modification requested
- Any specific information regarding the client's medical condition that necessitates the modification

Note: The date on the *Medical Necessity for Wheelchair Purchase (for home clients only)* form, HCA 13-727, must not be dated prior to the date on the *Prescription* form, HCA 13-794.

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

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When does the agency pay for transit option restraints?

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

When does the agency cover non-CRT wheelchair repairs?

The agency covers, with prior authorization (PA), non-CRT wheelchair repairs. To receive payment, providers must submit all of the following to the agency:

- *General Information for Authorization* form, HCA 13-835 (see Authorization for more information)
- A completed *Medical Necessity for Wheelchair Purchase (for home clients only)* form, HCA 13-727
- The make, model, and serial number of the wheelchair to be repaired
- The repair requested

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

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Non-CRT Wheelchair Modifications, Accessories, and Repairs Coverage Table

Cushions

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/ Comments
	E2601		General use wheelchair seat cushion, width less than 22 inches, any depth	Yes	
	E2602		General use wheelchair seat cushion, width 22 inches or greater, any depth	Yes	
	E2603		Skin protection wheelchair seat cushion, width less than 22 inches, any depth	Yes	
	E2604		Skin protection wheelchair seat cushion, width 22 inches or greater, any depth	Yes	
	E2605		Positioning wheelchair seat cushion, width less than 22 inches, any depth	Yes	
	E2606		Positioning wheelchair seat cushion, width 22 inches or greater, any depth	Yes	
	E2607		Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth	Yes	
	E2608		Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth	Yes	
	K0739		Repair or nonroutine service for durable medical equipment requiring the skill of a technician, labor	Yes	

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/ Comments
	E2622		Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth	Yes	
	E2623		Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	Yes	
	E2624		Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth	Yes	
	E2625		Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	Yes	

Armrests and parts

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/ Comments
	E0994		Armrest, each (replacement only)	Yes	
	K0019		Arm pad, each (replacement only)	Yes	

Lower extremity positioning (leg rests, etc.)

Code Status Indicator	HCPCSCode	Modifier	Description	PA?	Policy/ Comments
	E0951		Heel loop/holder, with or without ankle strap, each	Yes	
	E0952		Toe loop/holder each	Yes	
	E0995		Wheelchair accessory, calf rest/pad, each	Yes	
	K0038		Leg strap, each	Yes	
	K0039		Leg strap, H style, each	Yes	
	K0041		Large size footplate, each	Yes	
	K0195		Elevating leg rests, pair (for use with capped rental wheelchair base)		

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Seating and positioning

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/ Comments
	E0950		Wheelchair accessory, tray, each (includes all attaching hardware)	Yes	
	E0960		Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware	Yes	
	E0978		Wheelchair accessory, safety belt/pelvic strap, each	Yes	
	E0980		Safety vest, wheelchair	Yes	
	E0981		Wheelchair accessory, seat upholstery, replacement only, each	Yes	
	E0982		Wheelchair accessory, back upholstery, replacement only, each	Yes	
	E0992		Manual wheelchair accessory, solid seat insert	Yes	
	E2231		Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware	Yes	
BR	E2291		Back, planar, for pediatric size wheelchair including fixed attaching hardware	Yes	
BR	E2292		Seat, planar, for pediatric size wheelchair including fixed attaching hardware	Yes	
BR	E2293		Back, contoured, for pediatric size wheelchair including fixed attaching hardware	Yes	
BR	E2294		Seat, contoured, for pediatric size wheelchair including fixed attaching hardware	Yes	
	E2611		General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware	Yes	
	E2612		General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware	Yes	

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/ Comments
	E2613		Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware	Yes	
	E2614		Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware	Yes	
	E2615		Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware	Yes	
	E2616		Positioning wheelchair back, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware	Yes	
BR	E2617		Custom fabricated wheelchair back cushion, any size, including any type mounting hardware	Yes	

Hand rims, wheels, and tires (includes parts)

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/ Comments
	E0967		Manual wheelchair accessory, hand rim with projections, each	Yes	
	E2211		Manual wheelchair accessory, pneumatic propulsion tire, any size, each	Yes	
	E2212		Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each	Yes	
	E2213		Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each	Yes	
	E2214		Manual wheelchair accessory, pneumatic caster tire, any size, each	Yes	

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/ Comments
	E2215		Manual wheelchair accessory, tube for pneumatic caster tire, any size, each	Yes	
	E2216		Manual wheelchair accessory, foam filled propulsion tire, any size, each	Yes	
	E2217		Manual wheelchair accessory, foam filled caster tire, any size, each	Yes	
	E2218		Manual wheelchair accessory, foam propulsion tire, any size, each	Yes	
	E2219		Manual wheelchair accessory, foam caster tire, any size, each	Yes	
	E2220		Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each	Yes	
	E2221		Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, each	Yes	
	E2222		Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, each	Yes	
	E2224		Manual wheelchair accessory, propulsion wheel excludes tire, any size, each	Yes	
	E2225		Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each	Yes	
	E2226		Manual wheelchair accessory, caster fork, any size, replacement only, each	Yes	
	K0065		Spoke protectors, each	Yes	
	K0069		Rear wheel assembly, complete, with solid tire, spokes or molded, each	Yes	
	K0070		Rear wheel assembly, complete with pneumatic tire, spokes or molded, each	Yes	
	K0071		Front caster assembly, complete, with pneumatic tire, each	Yes	
	K0072		Front caster assembly, complete, with semi-pneumatic tire, each	Yes	
	K0073		Caster pin lock, each	Yes	
	K0077		Front caster assembly, complete, with solid tire, each	Yes	

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Other accessories

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/ Comments
	E0776	NU, RR	IV Pole	Yes	
	E0958		Manual wheelchair accessory, one-arm drive attachment, each	Yes	
	E0959		Manual wheelchair accessory, adapter for amputee, each	Yes	
	E0961		Manual wheelchair accessory, wheel lock brake extension (handle), each	Yes	Changed from pair to each with new description
	E0971		Manual wheelchair accessory, anti-tipping device, each	Yes	
	E0973		Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each	Yes	
	E1029		Wheelchair accessory, ventilator tray, fixed	Yes	
	E1030		Wheelchair accessory, ventilator tray, gimbaled	Yes	
	E2207		Wheelchair accessory, crutch and cane holder, each	Yes	
	E2208		Wheelchair accessory, cylinder tank carrier, each	Yes	
	K0105		IV hanger, each	Yes	

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Batteries and chargers

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/ Comments
NC	E2358		Power wheelchair accessory, GR 34 nonsealed leadacid battery	Yes	
NC	E2359		Power wheelchair accessory, GR sealed leadacid battery	Yes	
	E2360		Power wheelchair accessory, 22 NF non-sealed lead acid battery, each	Yes	
	E2361		Power wheelchair accessory, 22 NF sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)	Yes	
	E2363		Power wheelchair accessory, group 24 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)	Yes	
	E2365		Power wheelchair accessory, U-1sealed lead acid battery, each (e.g. gell cell, absorbed glassmat)	Yes	
	E2366		Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each	Yes	
	E2371		Power wheelchair accessory, group 27 sealed lead acid battery, (e.g. gell cell, absorbed glassmat), each	Yes	
	E2372		Power wheelchair accessory, group 27 non-sealed lead acid battery, each	Yes	
NC	E2397		Power wheelchair accessory, lithium-based battery, each		

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/ Comments
	K0733		Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	Yes	

Miscellaneous repair only

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/ Comments
	E2210		Wheelchair accessory, bearings, any type, replacement only, each	Yes	
	E2619		Replacement cover for wheelchair seat cushion or back cushion, each	Yes	

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Clients Residing in a Skilled Nursing Facility

(WAC 182-543-5700)

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

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

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

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

Requests for PA must meet all of the following:

- Be for the exclusive full-time use of a skilled nursing facility resident
- Not be included in the skilled nursing facility's per diem rate
- Include a completed *General Information for Authorization* form, HCA 13-835
- Include a copy of the telephone order, signed by the physician, for the wheelchair assessment
- Include a completed *Medical Necessity for Wheelchair Purchase for Nursing Facility Clients* form, HCA 13-729

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

- A completed *Prescription* form, HCA 13-794
- A completed *Medical Necessity for Wheelchair Purchase for Nursing Facility Clients* form, HCA 13-729. The date on form 13-729 must not be prior to the date on the *Prescription* form, HCA 13-794 (see Authorization for more information)
- The make, model, and serial number of the wheelchair to be modified
- The modification requested.
- Specific information regarding the client's medical condition that necessitates modification to the wheelchair

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

- A completed *Medical Necessity for Wheelchair Purchase for Nursing Facility (NF) Clients* form, HCA 13-729. See WAC 182-543-7000, Authorization
- The make, model, and serial number of the wheelchair to be repaired
- The repair requested

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

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

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

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

The agency pays for the purchase or rental of a specialty bed (a heavy-duty bariatric bed is not a specialty bed), with prior authorization (PA), when both of the following apply:

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

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

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

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

  This includes, but is not limited to the following:

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

Noncovered

(WAC 182-543-6000)

What is not covered?

The agency pays only for durable medical equipment (DME), related supplies, and related services listed as covered within this billing guide and in chapter 182-543 WAC.

The agency does not cover:

- A client's utility bills, even if the operation or maintenance of medical equipment purchased or rented by the agency for the client contributes to an increased utility bill.
- Instructional materials such as pamphlets and video tapes.
- Hairpieces or wigs.
- Material or services covered under manufacturer's warranties.
- Shoe lifts less than one inch, arch supports, and nonorthopedic shoes.
- Supplies and equipment used during a physician office visit, such as tongue depressors and surgical gloves.
- Home improvements and structural modifications, including, but not limited to, the following:
    - ✓ Automatic door openers for the house or garage
    - ✓ Electrical rewiring for any reason
    - ✓ Elevator systems, elevators
    - ✓ Installation or customization of existing bathtubs or shower stalls
    - ✓ Lifts or ramps for the home
    - ✓ Overhead ceiling track lifts
    - ✓ Racing stroller/wheelchairs and purely recreational equipment
    - ✓ Saunas
    - ✓ Security systems, burglar alarms, call buttons, lights, light dimmers, motion detectors, and similar devices
    - ✓ Swimming pools

- ✓ Timers or electronic devices to turn things on or off, which are not an integral part of the equipment
- ✓ Wheeled reclining chairs, lounge and/or lift chairs (e.g., geri-chair, posture guard, or lazy boy)
- ✓ Whirlpool systems, such as Jacuzzis, hot tubs, or spas

- Functional electrical stimulation (FES) bike.

- Wearable defibrillators.

- Personal and comfort items that do not meet the DME definition, including, but not limited to, the following:

  - ✓ Bathroom items, such as antiperspirant, astringent, bath gel, conditioner, deodorant, moisturizers, mouthwash, powder, shampoo, shaving cream, shower cap, shower curtains, soap (including antibacterial soap), toothpaste, towels, and weight scales

  - ✓ Bedding items, such as mattress pads, blankets, mattress covers/bags, pillows, pillow cases/covers, sheets, and bumper pads

  - ✓ Bedside items, such as bed trays, carafes, and over-the-bed tables

  - ✓ Clothing and accessories, such as coats, gloves (including wheelchair gloves), hats, scarves, slippers, socks, custom vascular supports (CVS), surgical stockings, gradient compression stockings, and gradient compression stockings (pantyhose style) and lumbar supports for pregnancy

  - ✓ Clothing protectors, surgical masks, and other protective cloth furniture covering

  - ✓ Cosmetics, including corrective formulations, hair depilatories, and products for skin bleaching, commercial sun screens, and tanning

  - ✓ Diverter valves for bathtub and hand held showers

  - ✓ Eating/feeding utensils

  - ✓ Emesis basins, enema bags, and diaper wipes

  - ✓ Health club memberships

  - ✓ Hot or cold temperature food and drink containers/holders

  - ✓ Hot water bottles and cold/hot packs or pads not otherwise covered by specialized therapy programs

  - ✓ Impotence devices

- ✓ Insect repellants
- ✓ Massage equipment
- ✓ Medication dispensers, such as med-collators and count-a-dose, except as obtained under the compliance packaging program (see chapter 182-530 WAC)
- ✓ Medicine cabinet and first aid items, such as adhesive bandages (e.g., Band-Aids, Curads), cotton balls, cotton-tipped swabs, medicine cups, thermometers, and tongue depressors
- ✓ Sharps containers
- ✓ Page turners
- ✓ Radios and televisions
- ✓ Telephones, telephone arms, cellular phones, electronic beepers, and other telephone messaging services
- ✓ Toothettes and toothbrushes, water pics, and periodontal devices whether manual, battery-operated, or electric

- Certain wheelchair features and options are not considered by the agency to be medically necessary or essential for wheelchair use. This includes, but is not limited to, the following:
  - ✓ Attendant controls (remote control devices)
  - ✓ Canopies, including those for stroller and other equipment
  - ✓ Clothing guards to protect clothing from dirt, mud, or water thrown up by the wheels (similar to mud flap for cars)
  - ✓ Identification devices (such as labels, license plates, name plates)
  - ✓ Lighting systems
  - ✓ Speed conversion kits
  - ✓ Tie-down restraints, except where medically necessary for client owned vehicles
  - ✓ Warning devices, such as horns and backup signals
  - ✓ Hub Lock brake
  - ✓ Decals

- ✓ Replacement key or extra key
- ✓ Trays for clients in a skilled nursing facility
- ✓ New durable medical equipment, supplies, or related technology that the agency has not evaluated for coverage (see How can equipment/supplies be added to the covered list? for more information)

What is an exception to rule (ETR)?

The agency evaluates a request for any DME, related supplies, and related services listed as noncovered within this billing guide under the provisions of WAC 182-501-0160.

When EPSDT applies, the agency evaluates a noncovered service, equipment, or supply according to the process in WAC 182-501-0165 to determine if it is:

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

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

Requests for ETR must be submitted in writing to the fax number located on the agency's form and include all of the following:

- A completed *General Information for Authorization*, HCA 13-835 form
- A completed *Prescription*, HCA 13-794, form
- A letter explaining how the client's situation meets the provisions of WAC 182-501-0160. For ETR requests for compression garments or bathroom equipment, complete one of the following agency forms **instead** of the letter of explanation:
  - ✓ *Exception to Rule Request Compression Garments*, HCA 13-871 form
  - ✓ *Exception to Rule Request Bathroom Equipment*, HCA 13-872 form

Authorization

What is authorization?

(WAC 182-543-7000)

Authorization is the agency's approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Prior authorization (PA), expedited prior authorization (EPA) and limitation extensions (LE) are forms of authorization.**

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

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

For prior authorization (PA), a provider must submit a written request to the agency as specified. (See What is prior authorization (PA)?)

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

> **Note:** Applicable forms may be downloaded from the agency's Medicaid Forms web page.

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

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

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

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

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

What is prior authorization (PA)?

(WAC 182-543-7100)

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

All PA requests must be accompanied by a completed *General Information for Authorization* form, HCA 13-835, in addition to any program specific agency forms as required within this billing guide.

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

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

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

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

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

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

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

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

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

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

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

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

How are photos and X-rays submitting for medical and DME requests?

There are two ways to submit photos and x-rays for medical and DME requests.

1. Use the FastLook™ and FastAttach™ services provided by Medical Electronic Attachment, Inc. (MEA).

Register with MEA by:

- Going to MEA's website.
- Selecting Provider Registration (on the menu bar below the banner).
- Entering **FastWDSHS** in the promotional code box.

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

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

2. Mail your requests, the agency requires you to:

- Place X-rays in a large envelope.
- Attach the PA request form and any other additional pages to the envelope.
- Put the client's name, ProviderOne ID#, and section the request is for on the envelope.
- Place in a larger envelope for mailing. Multiple sets of requests can be mailed together.
- Mail to the agency.

What is expedited prior authorization (EPA)?

(WAC 182-543-7300)

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

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

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

A written or telephone request for prior authorization is required when a situation does not meet the EPA criteria for DME procedure codes.

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

To bill the agency for DME that meet the EPA criteria on the following pages, the vendor must create a 9-digit EPA number. The first five or six digits of the EPA number will be 870000 or 87000**.** The last three or four digits is the specific code which meets the EPA criteria.

Enter the EPA number on the CMS-1500 claim form in the ***Authorization Number*** field or in the ***Authorization*** field (at claim level or line level) when billing electronically or direct data entry (DDE). With HIPAA implementation, multiple authorization (prior/expedited) numbers can be billed on a claim. If you are billing **multiple** EPA numbers, you must list the 9-digit EPA numbers in ***field 19*** of the paper claim form ***exactly*** as follows (*not all required fields are represented in the example*):

19. Line 1: 870000730/ Line 2: 870000735

If you are billing only one EPA or PA number on a paper CMS-1500 claim form, continue to list the 9-digit EPA number in field 23 of the claim form.

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

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

The written or telephonic request for PA process must be used when a situation does not meet the criteria for a selected DME code. Providers must submit the request to the DME authorization Unit or call for authorization.

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

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What is a limitation extension (LE)?

(WAC 182-543-7200)

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

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

The agency requires a provider to request PA for a limitation extension (LE) in order to exceed the stated limits for nondurable medical equipment (DME), and medical supplies.

All requests for PA must be accompanied by a completed *General Information for Authorization* form, HCA 13-835 in addition to any program specific agency forms as required within this billing guide.

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

EPA Criteria Coding List

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

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

1. If the medical condition does not meet **all** of the specified criteria, prior authorization (PA) must be obtained by submitting a request in writing to the agency (see Resources Available) or by calling the authorization toll-free number at (800) 562-3022 ext. 15466.

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

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

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

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

Code	Criteria	Code	Criteria

RENTAL MANUAL WHEELCHAIRS

HCPCS Procedure Code: K0001 RR

700 Standard manual wheelchair with all styles of arms, footrest, and/or legrests

Up to 2 months continuous rental in a 12-month period if ***all*** of the following criteria are met. The client:

1) Weighs 250 lbs. or less.
2) Requires a wheelchair to participate in normal daily activities.
3) Has a medical condition that renders him/her totally non-weight bearing or is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file).
4) Does ***not*** have a rental hospital bed.
5) Has a length of need, as determined by the prescribing physician, that is less than 6 months.

HCPCS Procedure Code: K0003 RR

705 Lightweight Manual Wheelchair with all styles of arms, footrests, and/or legrests

Up to 2 months continuous rental in a 12-month period if ***all*** of the following criteria are met. The client:

1) Weighs 250 lbs. or less;
2) Can self-propel the lightweight wheelchair and is unable to propel a standard weight wheelchair;
3) Has a medical condition that renders him/her totally non-weight bearing or is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file);
4) Does ***not*** have a rental hospital bed; and
5) Has a length of need, as determined by the prescribing physician, that is less han 6 months.

HCPCS Procedure Code: K0006 RR

710 Heavy-duty Manual Wheelchair with all styles of arms, footrests, and/or legrests

Up to 2 months continuous rental in a 12-month period if ***all*** of the following criteria are met. The client:

1) Weighs over 250 lbs.
2) Requires a wheelchair to participate in normal daily activities.
3) Has a medical condition that renders him/her totally non-weight bearing or is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file)
4) Does ***not*** have a rental hospital bed.
5) Has a length of need, as determined by the prescribing physician, that is less than 6 months.

HCPCS Procedure Code: E1060 RR

715 Fully Reclining Manual Wheelchair with detachable arms, desk or full-length and swing-away or elevating legrests

Up to 2 months continuous rental in a 12-month period if ***all*** of the following criteria are met. The client:

1) Requires a wheelchair to participate in normal daily activities and is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file);
2) Has a medical condition that does not allow them to sit upright in a standard or lightweight wheelchair (must be documented);
3) Does ***not*** have a rental hospital bed; and
4) Has a length of need, as determined by the prescribing physician, that is less than 6 months.

Note (For Rental Manual Wheelchairs):

1) The EPA rental is allowed only one time, per client, per 12-month period.
2) If the client is hospitalized or is a resident of a nursing facility and is being discharged to a home setting, rental may not start until the date of discharge. Documentation of the date of discharge must be included in the client's file. Rentals for clients in a skilled nursing facility are included in the nursing facility daily rate, and in the hospital they are included in the Diagnoses Related Group (DRG) payment.
3) The agency does not rent equipment during the time that a request for similar purchased equipment is being assessed, when authorized equipment is on order, or while the client-owned equipment is being repaired and/or modified. The vendor of service is expected to supply the client with an equivalent loaner.
4) You may bill for only one procedure code, per client, per month.
5) All accessories are included in the reimbursement of the wheelchair rental code. They may not be billed separately.

RENTAL/PURCHASE HOSPITAL BEDS

HCPCS Code: E0292 RR & E0310 RR OR E0305 RR

720 Manual Hospital Bed with mattress with or without bed rails

Up to 11 months continuous rental in a 12-month period if **all** of the following criteria are met.

The client:

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

HCPCS Code: E0294 RR & E0310 RR OR E0305 RR

725 Semi-Electric Hospital Bed with mattress with or without Bed Rails

Up to 11 months continuous rental in a 12-month period if **all** of the following criteria are met.

The client:

1) Has a length of need/life expectancy that is 12 months or less.
2) Has tried pillows, bolsters, and/or rolled up blankets/towels in own bed, and determined ineffective in meeting positioning needs (nature of ineffectiveness must be documented in the client's file).
3) Has a chronic or terminal condition such as COPD, CHF, lung cancer or cancer that has metastasized to the lungs, or other pulmonary conditions that cause the need for immediate upper body elevation.
4) Must be able to independently and safely operate the bed controls.
5) Does **not** have a rental wheelchair.
6) Has a completed *Hospital Bed Evaluation* form, HCA 13-747.

Note:

1) The EPA rental is allowed only one time, per client, per 12-month period.
2) Authorization must be requested for the 12th month of rental at which time the equipment will be considered purchased. The authorization number will be pended for the serial number of the equipment. In such cases, the equipment the client has been using must have been new on or after the start of the rental contract or is documented to be in good working condition. A 1-year warranty will take effect as of the date the equipment is considered purchased if equipment

is not new. Otherwise, normal manufacturer warranty will be applied.
3) If length of need is greater than 12 months, as stated by the prescribing physician, a PA for purchase must be requested either in writing or via the toll-free line.
4) If the client is hospitalized or is a resident of a nursing facility and is being discharged to a home setting, rental may not start until the date of discharge. Documentation of the date of discharge must be included in the client's file. Rentals for clients in a skilled nursing facility are included in the nursing facility daily rate, and in the hospital they are included in the DRG payment.
5) The agency does not rent equipment during the time that a request for similar purchased equipment is being assessed, when authorized equipment is on order, or while the client-owned equipment is being repaired and/or modified. The vendor of service is expected to supply the client with an equivalent loaner.
6) Hospital beds **will not** be provided:

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

9) Only one type of bed rail is allowed with each rental.
10) Mattress may **not** be billed separately.

HCPCS Code: E0294 NU

726 Semi-Electric Hospital Bed with mattress with or without bed rails

Initial purchase if **all** of the following criteria are met. The client:

1) Has a length of need/life expectancy that is 12 months or more.
2) Has tried positioning devices such as: pillows, bolsters, foam wedges, and/or rolled up blankets/towels in own bed, and been determined ineffective in meeting positioning needs (nature of ineffectiveness must be documented in the client's file).
3) Has one of the following diagnosis:

   a. Quadriplegia
   b. Tetraplegia
   c. Duchenne's M.D.
   d. ALS
   e. Ventilator dependent
   f. COPD or CHF with aspiration risk or shortness of breath that causes the need for an immediate position change of more than 30 degrees

4) Must be able to independently and safely operate the bed controls.

Documentation Required:

1) Life expectancy, in months and/or years
2) Client diagnosis including ICD code
3) Date of delivery and serial #
4) Written documentation indicating client has not been previously provided a hospital bed, purchase, or rental (i.e. written statement from client or caregiver)
5) A completed *Hospital Bed Evaluation* form, HCA 13-747

Note:
1) The EPA criteria is to be used only for an initial purchase per client, per lifetime. It is not to be used for a replacement or if EPA rental has been used within the previous 24 months.
2) It is the vendors' responsibility to determine if the client has not been previously provided a hospital bed, either purchase or rental.
3) Hospital beds **will not** be covered:

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

LOW AIR LOSS THERAPY SYSTEMS

HCPCS Code: E0371 & E0372 RR

730 Low Air Loss Mattress Overlay

Initial 30-day rental followed by one additional 30-day rental in a 12-month period if **all** of the following criteria are met. The client:

1) Is bed-confined 20 hours per day during rental of therapy system.
2) Has at least one stage 3 decubitus ulcer on trunk of body.
3) Has acceptable turning and repositioning schedule.
4) Has timely labs (every 30 days).
5) Has appropriate nutritional program to heal ulcers.

HCPCS Code: E0277 & E0373 RR

735 Low Air Loss Mattress without bed frame

Initial 30-day rental followed by an additional 30 days rental in a 12-month period if **all** of the following criteria are met. The client:

1) Is bed-confined 20 hours per day during rental of therapy system.
2) Has multiple stage 3/4 decubitus ulcers or one stage 3/4 with multiple stage 2 decubitus ulcers on trunk of body.
3) Has ulcers on more than one turning side.
4) Has acceptable turning and repositioning schedule.
5) Has timely labs (every 30 days).
6) Has appropriate nutritional program to heal ulcers.

740 Low Air Loss Mattress without bed frame

Initial 30-day rental in a 12-month period upon hospital discharge following a flap surgery

HCPCS Code: E0194 RR

750 Air Fluidized Flotation System including bed frame

Initial 30-day rental in a 12-month period upon hospital discharge following a flap surgery

For All Low Air Loss Therapy Systems

Documentation Required:

1) A *Low Air-Loss Therapy Systems* form, HCA 13-728 must be completed for each rental segment and signed and dated by nursing staff in facility or client's home.
2) A new form must be completed for each rental segment.
3) A re-dated prior form will not be accepted.
4) A dated picture must accompany each form.

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

NONINVASIVE BONE GROWTH/NERVE STIMULATORS

HCPCS Code: E0747 NU & E0760 NU

765 Non-Spinal Bone Growth Stimulator

Allowed **only** for purchase of brands that have pulsed electromagnetic field simulation (PEMF) when one or more of the following criteria is met. The client:

1) Has a nonunion of a long bone fracture (which includes clavicle, humerus, phalanges, radius, ulna, femur, tibia, fibula, metacarpal and metatarsal) after 6 months has elapsed since the date of injury without healing.
2) Has a failed fusion of a joint other than in the spine where a minimum of 6 months has elapsed since the last surgery.

HCPCS Code: E0748 NU

770 Spinal Bone Growth Stimulator

Allowed for purchase when the prescription is from a neurologist, an orthopedic surgeon, or a neurosurgeon and when one or more of the following criteria is met. The client:

1) Has a failed spinal fusion where a minimum of 9 months has elapsed since the last surgery.
2) Is post-op from a multilevel spinal fusion surgery.
3) Is post-op from spinal fusion surgery where there is a history of a previously failed spinal fusion.

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

MISCELLANEOUS DURABLE MEDICAL EQUIPMENT

HCPCS Code: E0604 RR

800 Breast pump, electric

Unit may be rented for the following lengths of time and when the criteria are met. The client:

1) Has a maximum of 2 weeks during any 12-month period for engorged breasts.
2) Has a maximum of 3 weeks during any 12-month period if the client is on a regimen of antibiotics for a breast infection.
3) Has a maximum of 2 months during any 12-month period if the client has a newborn with a cleft palate.
4) Has a maximum of 2 months during any 12-month period if the client meets **all** of the following:

    a. Has a hospitalized premature newborn
    b. Has been discharged from the hospital
    c. Is taking breast milk to hospital to feed newborn

HCPCS Code: E0935 RR

810 Continuous Passive Motion System (CPM)

Up to 10 days rental during any 12-month period, upon hospital discharge, when the client is diagnosed with one of the following:

1) Frozen joints
2) Intra-articular tibia plateau fracture
3) Anterior cruciate ligament injury
4) Total knee replacement

HCPCS Code: E0650 RR

820 Extremity pump

Up to 2 months rental during a 12-month period for treatment of severe edema.

Purchase of the equipment should be requested and rental not allowed when equipment has been determined to be all of the following:

1) Medically effective
2) Medically necessary
3) A long-term, permanent need

Which EPA numbers have been discontinued and have been replaced by national codes?

The following table contains a crosswalk of EPA numbers that have been discontinued and the national codes that have taken their place:

Discontinued EPA#	Description	National Code
870000755	Child Prone Stander	E0638
870000756	Adult/Youth Prone Stander	E0638
870000757	Infant Prone Stander	E0638
870000758	Adult Prone Stander	E0638
870000766	Bath seat w/o back	E0247
870000771	Caster Shower/commode chair	E0240
870000772	Adj Bath Seat with back	E0247
870000773	Adj Bath/Shower Chair w/back	E0247
870000774	Pediatric Bath Chair	E0240
870000776	Youth Bath Chair	E0240
870000777	Adult Bath Chair	E1399 (with PA)
870000778	Small Potty Chair	E1399 (with PA)
870000779	Large Potty Chair	E1399 (with PA)
870000767	Heavy Duty Bath Chair	E0248
870000764	Kit for Electric Breast Pump	E1399 (with PA)

Billing and Claim Forms

What are the general billing requirements?

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

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

What billing requirements are specific to durable medical equipment (DME)?

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

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

How does a provider bill for a managed care client?

(WAC 182-543-8100)

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

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

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

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

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

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

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

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

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

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

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

(WAC 182-543-8200)

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

- The agency requires a provider to accept Medicare assignment before any Medicaid reimbursement.
- In accordance with WAC 182-502-0110(3):

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

- ✓ If the service provided is covered by Medicare but is not covered by the agency, the agency pays only the deductible and/or coinsurance up to Medicare's allowed amount.

Where can the agency's required forms be found?

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

- *Negative Pressure Wound Therapy* form, HCA 13-726
- *Medical Necessity for Wheelchair Purchase (for home client only)* form, HCA 13-727
- *Low Air-Loss Therapy Systems* form, HCA 13-728
- *Medical Necessity for Wheelchair Purchase for Nursing Facilities (NF) Clients* form, HCA 13-729
- *Hospital Bed Evaluation* form, HCA 13-747
- *Exception to Rule Request: Bathroom Equipment* form, HCA 13-872
- *Exception to Rule Request: Compression Garments*, HCA 13-871
- The *Speech Language Pathologist (SLP) Evaluation for Speech Generating Devices* form, HCA 15-310

How does a provider complete the CMS-1500 claim form?

Instructions on how to bill professional claims and crossover claims electronically can be found on the Medicaid Providers Training page under Medicaid 101. Also, see Appendix I of the agency's ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 claim form.

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

Field No.	Name	Entry
24B	Place of Service	These are the only appropriate code(s) for this billing guide: **Code** **To Be Used For** 12 Client's residence 13 Assisted living facility 32 Nursing facility 31 Skilled nursing facility 99 Other

Reimbursement

What are the general reimbursement guidelines for durable medical equipment (DME) and related supplies and services?

(WAC 182-543-9000(1))

The agency pays qualified providers who meet all of the conditions in WAC 182-502-0100, for durable medical equipment (DME), supplies, repairs, and related services provided on a fee-for-service (FFS) basis as follows:

- Payment is made to agency-enrolled DME providers, pharmacies, and home health agencies under their national provider identifier (NPI) numbers, subject to the limitations found within this billing guide.
- Payment is in accordance with the health care common procedure coding system (HCPCS) guidelines for product classification and code assignation.

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

Reminder: See the agency's fee schedules for payment requirements.

When does the agency set rates?

(WAC 182-543-9000(2))

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

- Commercial databases.
- Manufacturers' catalogs.
- Medicare fee schedules.
- Wholesale prices.

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

How often does the agency update rates?

(WAC 182-543-9000(4)-(6))

The agency updates the maximum allowable fees for DME related supplies, and related services at least once per year, unless otherwise directed by the legislature or considered necessary by the agency.

The agency is the payor of last resort for clients with Medicare or third party insurance.

The agency does not pay for medical equipment and/or services provided to a client who is enrolled in an agency-contracted managed care organization (MCO), but who did not use one of the plan's participating providers.

What is included in the rate?

(WAC 182-543-9000(8))

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

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

What are the payment methodologies of DME under other programs?

(WAC 182-543-9000(9))

DME, supplies, repairs, and related services supplied to eligible clients under the following payment methodologies are included in those methodologies and are not paid under fee-for-service:

- Hospice providers' per diem payment
- Hospital's diagnosis-related group (DRG) payment methodology
- Managed care organizations' capitation rate
- Skilled nursing facility per diem rate
- Professional services' resource-based relative value system reimbursement (RBRVS) rate

> **Note:** The agency does not pay for medical equipment and/or services provided to a client who is enrolled in an agency-contracted MCO, but who did not use one of the plan's participating providers.

What is the payment methodology for other DME?

(WAC 182-543-9100(1)-(3))

The agency sets, evaluates and updates the maximum allowable fees for purchased other DME at least once yearly using one or more of the following:

- The current Medicare rate, as established by the federal centers for Medicare and Medicaid services (CMS), for a new purchase if a Medicare rate is available
- A pricing cluster
- On a by-report basis

Establishing payment rates for purchased other DME based on pricing clusters.

- A pricing cluster is based on a specific HCPCS code.
- The agency's pricing cluster is made up of all the brands/models for which the agency obtains pricing information. However, the agency may limit the number of brands/models

included in the pricing cluster. The agency considers all of the following when establishing the pricing cluster:

- ✓ A client's medical needs
- ✓ Product quality
- ✓ Introduction, substitution or discontinuation of certain brands/models
- ✓ Cost

- When establishing the fee for other DME items in a pricing cluster, the maximum allowable fee is the median amount of available manufacturer's list prices for all brands/models as noted in the pricing cluster.

The agency evaluates a by report (BR) item, procedure, or service for its medical necessity, appropriateness and payment value on a case-by-case basis. The agency calculates the payment rate for these items at 80% of the manufacturer's list price.

What are the monthly rental reimbursement rates for Other DME?

(WAC 182-543-9100(4))

The agency's maximum allowable fee for monthly rental is established using one of the following:

- For items with a monthly rental rate on the current Medicare fee schedule, as established by the federal centers for Medicare and Medicaid services (CMS), the agency equates its maximum allowable fee for monthly rental to the current Medicare monthly rental rate.

- For items that have a new purchase rate, but no monthly rental rate on the current Medicare fee schedule, as established by the federal centers for Medicare and Medicaid services (CMS), the agency sets the maximum allowable fee for monthly rental at one-tenth of the new purchase price of the current Medicare rate.

- For items not included in the current Medicare fee schedule, as established by the federal centers for Medicare and Medicaid services (CMS), the agency considers the maximum allowable monthly payment rate as by-report. The agency calculates the monthly payment rate for these items at one-tenth of 80% of the manufacturer's list price.

What are the daily rental payment rates for other DME?

(WAC 182-543-9100(5)-(7))

The agency's maximum allowable fee for daily rental is established using one of the following:

- For items with a daily rental rate on the current Medicare fee schedule, as established by the federal centers for Medicare and Medicaid services (CMS), the agency equates its maximum allowable fee for daily rental to the current Medicare daily rental rate.
- For items that have a new purchase rate but no daily rental rate on the current Medicare fee schedule, as established by the federal centers for Medicare and Medicaid services (CMS), the agency sets the maximum allowable fee for daily rental at one-three-hundredth of the new purchase price of the current Medicare rate.
- For items not included in the current Medicare fee schedule, as established by the federal centers for Medicare and Medicaid services (CMS), the agency considers the maximum allowable daily payment rate as by-report. The agency calculates the daily payment rate at one-three-hundredth of 80% of the manufacturer's list price.

The agency does not pay for DME and related supplies, related services, and related repairs and labor charges under fee-for-service (FFS) when the client is any of the following:

- An inpatient hospital client
- Eligible for both Medicare and Medicaid, and is staying in a skilled nursing facility in lieu of hospitalization
- Terminally ill and receiving hospice care
- Enrolled in a risk-based MCO that includes coverage for such items and/or services

The agency rescinds any purchase order for a prescribed item if the equipment was not delivered to the client before the client:

- Dies.
- Loses medical eligibility.
- Becomes covered by a hospice agency.
- Becomes covered by an agency-contracted MCO.

A provider may incur extra costs for customized equipment that may not be easily resold. In these cases, for purchase orders rescinded, the agency may pay the provider an amount it considers

appropriate to help defray these extra costs. The agency requires the provider to submit justification sufficient to support such a claim.

What is the payment methodology used by the agency for wheelchairs?

(WAC 182-543-9200)

The agency pays a DME provider for purchased wheelchairs based on the specific brand and model of wheelchair dispensed. The agency decides which brands and/or models of wheelchairs are eligible for payment based on all of the following:

- A client's medical needs
- Product quality
- Cost
- Available alternatives

The agency sets, evaluates and updates the maximum allowable fees at least once yearly for wheelchair purchases, wheelchair rentals, and wheelchair accessories (e.g., cushions and backs) using the lesser of the following:

- The current Medicare fees
- The actual invoice for the specific item
- A percentage of the manufacturer's list price

The agency uses the following percentages for:

Equipment	Percentage of Manufacturer List Price
Basic standard wheelchairs	65 %
Add-on accessories and parts	84%
Upcharge modifications and cushions	80%
All other manual wheelchairs	80%
All other power-drive wheelchairs	85%

Warranty

When do I need to make warranty information available?

(WAC 182-543-9000(10))

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

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

When is the dispensing provider responsible for costs?

(WAC 182-543-9000(11))

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

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

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

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

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