Washington State Health Care Authority

Washington Apple Health (Medicaid)

Medical Equipment & Non-CRT Wheelchairs Billing Guide

January 1, 2019

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This guide takes effect January 1, 2019, 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
Definitions	Revised the definition of "Medical equipment" and removed definitions that were redundant with the WAC or no longer needed	Updated to align with new WAC and federal regulations. (Removed definitions now fall under the broader definition of medical equipment.)
Throughout guide	Replaced "Durable medical equipment (DME)" with "medical equipment" Removed references to optional programs Prescriptions may be written only by physicians, not other primary care providers (advanced registered nurse practitioners or physician assistants)	 Updated to align with new WAC and federal regulations

* This publication is a billing instruction.

Subject	Change	Reason for Change
Client Eligibility: BHO, Changes for January 1, 2019, IMC, and Integrated Apple Health Foster Care	**Effective January 1, 2019,** some existing integrated managed care regions have new counties and many new regions and counties will be implemented.	Apple Health managed care organizations (MCOs) in certain RSAs will expand their coverage of behavioral health services (mental health and substance use disorder treatment), along with continuing to cover physical health services.
Coverage Table – Medical Equipment -	Removed "PA" and "Included in NF daily rate" columns; information moved to "Policy/Comments" column Removed noncovered codes	Streamlined table and removed unnecessary information for reading ease
Non-CRT Wheelchair Coverage Table	Removed "PA" column; information moved to "Policy/Comments" column. Removed noncovered codes	Streamlined table and removed unnecessary information for reading ease
Noncovered	Removed section	Removed to align with new WACs and federal rules
What is prior authorization (PA)?	Revised the requirement that when the agency receives a request for PA, the prescription must not be older than six months, instead of three months.	Revised to align with federal regulations
What is included in the rate?	Moved this section to Billing from Reimbursement; the information has not changed.	Relocated because the Reimbursement section has been removed. (See box below.)
Reimbursement	Removed section header	Moved pertinent information to other sections in the guide.
What types of medical equipment and related services does the agency pay for?	Added a link to the CMS list of medical equipment that requires a face-to-face encounter	Revised to align with federal regulations
Resources Available	Providers may now submit prior authorization (PA) requests online through direct data entry into ProviderOne	New online option for requesting PA

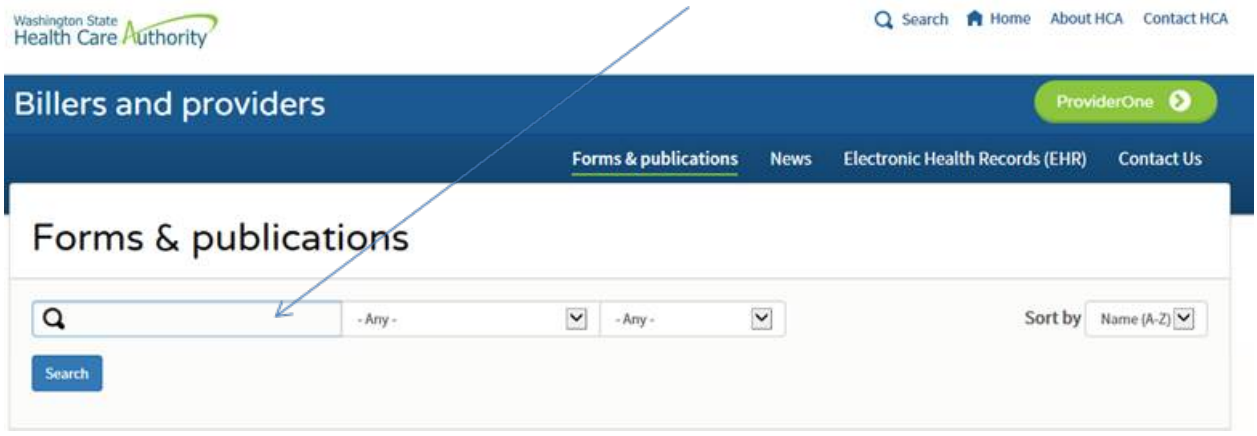
How can I get agency provider documents?

To access provider alerts, go to the agency's provider alerts webpage.

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

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and provider's webpage, select Forms & publications. Type the HCA form number into the **Search box** as shown below (Example: 13-835).



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Resources Available

Topic	Resource Information
Becoming a provider or submitting a change of address or ownership	See the agency's Billers and Providers webpage
Finding out about payments, denials, claims processing, or agency-contracted managed care organizations	
Electronic 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	Providers may submit prior authorization requests online through direct data entry into ProviderOne. See the agency's prior authorization webpage for details. Providers may also fax requests to 866-668-1214.
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 a person 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)

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 equipment – Includes medical equipment and appliances, and medical supplies. (WAC 182-543-1000)

Medical equipment and appliances - Health care-related items that:

- Are primarily and customarily used to serve a medical purpose;
- Generally are not useful to a person in the absence of illness or injury;
- Can withstand repeated use;
- Can be reusable or removable; and
- Are suitable for use in any setting where normal life activities take place.
- (WAC 182-543-1000)

Medical supplies – Health care-related items that are:

- Consumable, or disposable, or cannot withstand repeated use by more than one person;
- Required to address an individual medical disability, illness, or injury;
- Suitable for use in any setting which is not a medical institution and in which normal life activities take place; and
- Generally not useful to a person in the absence of illness or injury. (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)

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 medical equipment program cover?

The federal government considers medical equipment and related supplies as 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 medical equipment 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 medical equipment 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, 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 medical equipment 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 medical equipment program.

The agency bases its determination about which medical equipment 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 medical equipment item listed 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, medical equipment 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.

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

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

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

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has 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.

Is the client enrolled in an agency-contracted managed care organization (MCO), in a behavioral health organization (BHO), or is the client receiving services through fee-for-service (FFS) Apple Health?

Verifying eligibility is a two-step process:

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

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

Step 2. **Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's Program Benefit Packages and Scope of Services webpage.

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

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

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

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

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

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

Yes. Medical equipment services and non-CRT wheelchairs 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.

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for.

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

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to 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 policies.

Behavioral Health Organization (BHO)

The Health Care Authority manages the contracts for behavioral health services (mental health and substance use disorder) for the following four Regional Service Areas (RSAs):

- **Great Rivers:** Includes Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties
- **North Sound:** Includes Island, San Juan, Skagit, Snohomish, and Whatcom counties
- **Salish:** Includes Clallam, Jefferson, and Kitsap counties
- **Thurston-Mason**: Includes Thurston and Mason counties

To view a map and table of the integrated managed care plans available within each region, please see Changes coming to Washington Apple Health. You may also refer to the agency's Apple Health managed care webpage.

See the agency's Mental Health Services Billing Guide for details.

Apple Health – Changes for January 1, 2019

Effective January 1, 2019, agency-contracted managed care organizations (MCOs) in certain Region Service Areas (RSAs) will expand their coverage of behavioral health services (mental health and substance use disorder treatment), along with continuing to cover physical health services. The RSAs are outlined in the Integrated Managed Care Regions section.

Apple Health clients who are not enrolled in an agency-contracted MCO for their physical health services (e.g., dual-eligible Medicare-Medicaid clients) will still receive their behavioral health services through one of the agency-contracted MCOs. The MCO will provide only behavioral health services for the client.

Most clients will remain with the same health plan, except in regions where client's plan will no longer be available. HCA will auto-enroll these clients to one of the offered plans.

Clients can change their plan at any time by:

- Visiting the ProviderOne Client Portal.
- Calling Apple Health Customer Service toll-free at 1-800-562-3022. This automated system is available 24 hours a day, 7 days a week.
- Requesting a change online through our secure Contact us – Apple Health (Medicaid) client web form. Select the topic "Enroll/Change Health Plans."

Visiting the Washington Healthplanfinder (only for clients with a Washington Healthplanfinder account).

Integrated managed care

For clients who live in an integrated managed care region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted MCO. The BHO will not provide behavioral health services in these regions.

Clients living in an integrated managed care region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

American Indian/Alaska Native (AI/AN) clients living in an integrated managed care region of Washington may choose to enroll in one of the agency-contracted MCOs available in that region or they may choose to receive all these services through Apple Health FFS. If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's American Indian/Alaska Native webpage.

For more information about the services available under the FFS program, see the agency's Mental Health Services Billing Guide and the Substance Use Disorder Billing Guide.

For full details on integrated managed care, see the agency's Changes to Apple Health managed care webpage.

Integrated managed care regions

Clients who reside in the following integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency's Apple Health managed care webpage.

Existing integrated managed care regions – Expanding January 1, 2019

- **North Central** (Chelan, Douglas, Grant, and Okanogan counties)
  The agency expanded this region to include Okanogan County

- **Southwest Washington** (Clark, Klickitat, and Skamania counties)
  The agency expanded this region to include Klickitat County

New integrated managed care regions – Effective January 1, 2019

The following new regions are implemented for integrated managed care:

- **Greater Columbia** (Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman counties)

- **King** (King County)

- **Pierce (**Pierce County)

- **Spokane** (Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties)

Integrated Apple Health Foster Care (AHFC)

Effective January 1, 2019, children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program will receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

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

Fee-for-service Apple Health Foster Care

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

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.

Provider/Manufacturer Information

What types of medical equipment and related services does the agency pay for?

(WAC 182-543-2000)

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

- Medical equipment providers for medical equipment 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

For more information about medical equipment that requires a face-to-face encounter, see the list of covered items published by the Centers for Medicare and Medicaid Services.

What requirements must providers and suppliers meet?

Providers and suppliers of medical equipment 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 (See Where can I download agency forms?)

  ✓ Be written by a physician

  ✓ 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:

Medical Equipment 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 medical equipment 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 medical equipment 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 medical equipment 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 medical equipment 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 ME.

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, medical equipment 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** medical equipment only.

  ✓ **A new** medical equipment 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** medical equipment 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 medical equipment 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 medical equipment 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 medical equipment 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.

- Medical equipment and related services purchased by the agency for a client are the client's property.

- The agency rents, but does not purchase, certain medical equipment 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 – Medical Equipment

(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 of 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, 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 to the agency using the online submission option (see the agency's Prior Authorization webpage for details) or be in writing and accompanied by all of the following:

  - ✓ A completed *General Information for Authorization* form, HCA 13-835, see Where can I download agency forms? (see Authorization for more information)

  - ✓ 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 one per client in a five-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 submitted to the agency online using the online submission option (see the agency's Prior authorization webpage for details) or be in writing and accompanied by all of the following:
  - ✓ A completed *General Information for Authorization* form, HCA 13-835, see Where can I download agency forms? (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 Where can I download agency forms? (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.

Miscellaneous medical equipment

The agency pays for miscellaneous medical equipment as follows:

- Blood glucose monitor (specialized or home) - One in a three-year period. See WAC 182-543-5500(12) for blood monitoring/testing supplies. For continuous glucose monitoring systems including related equipment and supplies, see the prior authorization (PA) criteria in the Home Infusion Billing Guide.
- 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 five-year period.
- Positioning car seat - One in a five-year period.

When does the agency cover the equipment for negative pressure wound therapy for home use?

The agency covers the purchase of the following wound care devices with limits. Prior authorization (PA) is required. Documentation of tried or considered wound care must be documented on the *Negative Pressure Wound Therapy* form (HCA 13-726).

Equipment	Limitation
Dressing set, electrical pump, stationary or portable	Purchase only
Canister, disposable, used with suction pump	Purchase only Limit of 5 per client every 30 days. Allowed only when billed in conjunction with prior authorized HCPCS code E2402
Electrical pump, stationary or portable	Rental only

Prior authorization requests for purchase must include *Prescription* form (HCA 13-794) and *Negative Pressure Wound Therapy* form (HCA 13-726). See Where can I download agency forms?

Client must show healing within 30 days for continuation of service.

The agency pays for a maximum of 4 months of negative pressure wound therapy beginning when the device was applied during an inpatient stay and prior to discharge into a home setting.

Coverage Table – Medical Equipment

Beds, mattresses, and related equipment

Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	A4640	RA or RE	Replacement pad for use with medically necessary alternating pressure pad owned by patient	Purchase only Included in NF daily rate
	A6550		Dressing set for negative pressure wound therapy electrical pump, stationary or portable, each	Purchase only PA required
	A7000		Canister, disposable, used with suction pump, each	Purchase only Limit of 5 per client every 30 days. Allowed only when billed in conjunction with prior authorized HCPCS code E2402
	K0743		Portable home suction pump	PA required
	E0181	NU RR	Powered pressure reducing mattress overlay/pad, alternating with pump. Includes heavy duty	PA required for rental
	E0182		Pump for alternating pressure pad	Replacement purchase only Included in NF daily rate

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

BR = By Report
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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E0184		Dry pressure mattress	Purchase only. Limit of 1 per client every 5 years Included in NF daily rate
	E0185	NU RR	Gel or gel-like pressure pad for mattress	Considered purchased after 1 year's rental. Limit of 1 per client every 5 years PA required for rental Included in NF daily rate
	E0186	NU RR	Air pressure mattress	For powered pressure reducing mattress see HCPCS code E0277. Considered purchased after 1 years' rental. PA required for rental Included in NF daily rate
	E0190		Positioning cushion/pillow/wedge, any shape or size	Purchase only PA required Included in NF daily rate
DC	E0193		Powered air flotation bed (low air loss therapy)	See E0194

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E0194	NU RR	Air fluidized bed	Considered purchased after 1 years' rental PA or EPA in Auth
	E0196		Gel pressure mattress	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0197	NU RR	Air pressure pad for mattress (standard mattress length and width)	Considered purchased after 1 years' rental PA required for rental Included in NF daily rate
	E0198		Water pressure pad for mattress, standard mattress length and width	Purchase only. Limit of 1 per client every 5 years Included in NF daily rate
	E0199		Dry pressure pad for mattress, standard mattress length and width	Purchase only. Limit of 1 per client every 5 years Included in NF daily rate
	E0250		Hospital bed, fixed height, with any type side rails, with mattress	
	E0251		Hospital bed, fixed height, with any type side rails, without mattress	

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
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
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	NC	Hospital bed, institutional type includes: oscillating, circulating and stryker frame, with mattress	
	E0271	NU	Mattress, inner spring	Limit of 1 per client every 5 years. Replacement only. Included in NF daily rate

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E0272		Mattress, foam rubber (replacement only)	Limit of 1 per client every 5 years. Purchase only Included in NF daily rate.
	E0277	NU RR	Powered pressure-reducing air mattress	Considered purchased after 1 years' rental PA or EPA in Auth
	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	Considered purchased after 1 years' rental. Limit of 1 per client every 10 years. PA or EPA in Auth Included in NF daily rate
	E0293	NU RR	Hospital bed, variable height, hi-lo, without side rails, without mattress	Considered purchased after 1 years' rental. Limit of 1 per client every 10 years. PA required Included in NF daily rate

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E0294	NU RR	Hospital bed, semi-electric (head and foot adjustments), without side rails, with mattress	Considered purchased after 1 years' rental. Limit of 1 per client every 10 years. PA or EPA in Auth Included in NF daily rate
	E0295	NU RR	Hospital bed, semi-electric (head and foot adjustments), without side rails, without mattress	Considered purchased after 1 years' rental. Limit of 1 per client every 10 years PA required Included in NF daily rate
	E0300	NU RR	Pediatric crib, hospital grade, fully enclosed	Considered purchased after 1 years' rental PA required Included in NF daily rate
	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	PA required
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

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	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	Considered purchased after 1 years' rental. Limit of 1 per client every 10 years PA required Included in NF daily rate
	E0304	NU RR	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	Considered purchased after 1 years' rental. Limit of 1 per client every 10 years PA required Included in NF daily rate

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E0305	NU RR	Bedside rails, half length, pair	Considered purchased after 1 years' rental. Limit of 1 per client every 10 years Rental requires PA or EPA in Auth Included in NF daily rate
	E0310	NU RR	Bedside rails, full length, pair	Considered purchased after 1 years' rental. Limit of 1 per client every 10 years. Rental requires PA or EPA in Auth Included in NF daily rate
NC	E0315		Bed accessory: board, table, or support device, any type	

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E0316		Safety enclosure frame/canopy for use with hospital bed, any type	Purchase only PA required Included in NF daily rate
	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	Purchase only. Limit of 1 per client every 10 years. PA required Included in NF daily rate
	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	Purchase only. Limit of 1 per client every 10 years PA required Included in NF daily rate
	E0371	NU RR	Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width	Considered purchased after 1 year's rental PA or EPA in Auth
	E0372	NU RR	Powered air overlay for mattress, standard mattress length and width	Considered purchased after 1 year's rental PA or EPA in Auth
	E0373	NU RR	Nonpowered advanced pressure reducing mattress	Considered purchased after 1 year's rental PA or EPA in Auth

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E2402	RR	Negative pressure wound therapy electrical pump, stationary or portable	Rental only PA required

Other patient room equipment

Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E0621		Sling or seat, patient lift, canvas or nylon	Purchase only Included in NF daily rate
			Patient lift, bathroom or toilet, not otherwise classified	
			Seat lift mechanism incorporated into a combination lift-chair mechanism	
			Separate seat lift mechanism for use with patient owned furniture - nonelectric	
	E0630	NU RR	Patient lift, hydraulic, with seat or sling	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years. (Includes bath.) PA required for rental Included in NF daily rate

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E0635	NU RR	Patient lift, electric, with seat or sling	Considered purchased after 1 years' rental PA required for rental Included in NF daily rate
DC	E0636		Multipositional patient support system, with integrated lift, patient accessible controls	See E0635
DC	E0830		Ambulatory traction device, all types, each.	
	E0840		Traction frame, attached to headboard, cervical traction.	
DC	E0849		Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible.	
	E0850		Traction stand, freestanding, cervical traction.	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
DC	E0855		Cervical traction equipment not requiring additional stand or frame.	
DC	E0856		Cervical traction device, cervical collar with inflatable air bladder.	

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E0860		Traction equipment, overdoor, cervical.	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0870		Traction frame, attached to footboard, simple extremity traction (e.g. Buck's).	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0880		Traction stand, freestanding, extremity traction (e.g., Buck's).	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0890		Traction frame, attached to footboard, pelvic traction.	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0900		Traction stand, freestanding, pelvic traction (e.g., Buck's).	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E0910	NU RR	Trapeze bar, also known as patient helper, attached to bed with grab bar.	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years. PA for rental Included in NF daily rate
	E0911	NU RR	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed with grab bar	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years. PA required for rental Included in NF daily rate
	E0912	NU RR	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar.	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years. PA required for rental Included in NF daily rate
	E0920	NU RR	Fracture frame, attached to bed. Includes weights.	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years. PA required for rental Included in NF daily rate

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E0930	NU RR	Fracture frame, freestanding, includes weights.	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years. PA required for rental Included in NF daily rate
	E0940	NU RR	Trapeze bar, freestanding, complete with grab bar.	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years. PA required for rental Included in NF daily rate
	E0941	NU RR	Gravity assisted traction device, any type.	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years. PA required for rental Included in NF daily rate

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E0946	NU RR	Fracture frame, dual with cross bars, attached to bed (e.g., Balken, 4-poster).	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years. PA required for rental Included in NF daily rate
	E0947		Fracture frame, attachments for complex pelvic traction.	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0948		Fracture frame, attachments for complex cervical traction.	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0705		Transfer board or device, any type, each.	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate

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Positioning devices

Code Status Indicator	HCPCS Code	Modifier	Description	Policy/ Comments
	E0637	NU RR	Combination sit-to-stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels.	Considered purchased after one years' rental PA required Included in NF daily rate
	E0638		Standing frame/table system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or without wheels.	Limit of 1 per client every 5 years. Purchase only. PA required Included in NF daily rate
	E0639		Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories.	Limit of 1 per client every 5 years. Purchase only. PA required Included in NF daily rate
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
DC	E0642		Standing frame system, mobile dynamic stander, any size including pediatric, (includes padding, straps, adjustable armrests, footboard, and support blocks.)	See E0637

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Noninvasive bone growth/nerve stimulators

Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E0740	NU RR	Incontinence treatment system, pelvic floor stimulator, monitor, sensor and/or trainer	Considered purchased after 1 years' rental PA required Included in NF daily rate
	E0747		Osteogenesis stimulator, electrical noninvasive, other than spinal applications	Purchase only. Limit of 1 per client every 5 years. PA or EPA in Auth
	E0748		Osteogenesis stimulator, electrical noninvasive, spinal applications	Purchase only. Limit of 1 per client every 5 years. PA or EPA in Auth
DP	E0749		Osteogenesis stimulator, electrical, surgically implanted	See Physician-Related Services/Health Care Professional Services Billing Guide
	E0760		Osteogenesis stimulator, low intensity ultrasound, noninvasive	Purchase only. Limit of 1 per client every 5 years. PA or EPA in Auth

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
DP	E0762		Transcutaneous electrical joint stimulation device system, includes all accessories	See Physician-Related Services/Health Care Professional Services Billing Guide
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	Policy/Comments
	E2500		Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time	Purchase only PA required
	E2502		Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time	Purchase only PA required
	E2504		Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	Purchase only PA required

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E2506		Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time	Purchase only PA required
	E2508		Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device	Purchase only PA required
	E2510		Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	Purchase only PA required
	E2512		Accessory for speech generating device, mounting system	Purchase only PA required
	E2599		Accessory for speech generating device, not otherwise classified	Purchase only PA required
	L8500		Artificial larynx, any type	Purchase only. Limit of 1 per client every 5 years

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Ambulatory aids

Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	A4635		Underarm pad, crutch, replacement, each	Purchase only Included in NF daily rate
	A4636		Replacement handgrip, cane, crutch, or walker, each	Purchase only Included in NF daily rate
	A4637		Replacement tip, cane, crutch, or walker, each	Purchase only Included in NF daily rate
	E0100		Cane; includes canes of all materials; adjustable or fixed, with tip	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0105		Cane, quad or three-prong; includes canes of all materials; adjustable or fixed, with tip	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0110		Crutches, forearm; includes crutches of various materials, adjustable or fixed; complete with tips and handgrips	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0111		Crutches, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrip	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0112		Crutches, underarm, wood, adjustable or fixed, per pair, with pads, tips/handgrips	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E0113		Crutch, underarm; wood; adjustable or fixed; each, with pad, tip and handgrip	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0114		Crutches, underarm; other than wood; adjustable or fixed; per pair, with pads, tips and handgrips	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0116		Crutch, underarm; other than wood; adjustable or fixed; each, with pad, tip and handgrip, with or without shock absorber, each	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0117		Crutch, underarm, articulating, spring assisted, each	Purchase only PA required
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	Purchase only PA required Included in NF daily rate
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	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0135		Walker; folding (pickup), adjustable or fixed height	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E0140		Walker, with trunk support, adjustable or fixed height, any type	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0141		Walker, rigid, wheeled, adjustable or fixed height	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0143		Walker, folding, wheeled, adjustable or fixed height	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0144		Walker, enclosed, four sided framed, rigid or folding, wheeled with posterior seat	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0147		Walker, heavy duty, multiple braking system, variable wheel resistance (over 250 lbs)	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0148		Walker, heavy duty, without wheels, rigid or folding, any type (over 250lbs)	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0149		Walker, heavy duty, wheeled, rigid or folding, any type (over 250 lbs)	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0153		Platform attachment, forearm crutch, each	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0154		Platform attachment, walker, each	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0155		Wheel attachment, rigid pick-up walker, per pair seat attachment, walker	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E0156		Seat attachment, walker	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0157		Crutch attachment, walker, each	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0158		Leg extensions for walker, per set of four (4)	Purchase only. Limit of 1 per client every 5 years. Included in NF daily rate
	E0159		Brake attachment for wheeled walker, replacement**,** each	Purchase only Included in NF daily rate

Bathroom equipment

HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
E0160		Sitz type bath or equipment, portable, used with or without commode			
E0161		Sitz type bath or equipment, portable, used with or without commode, with faucet attachment(s)			
E0162		Sitz bath chair			
E0163	NU RR	Commode chair, stationary, with fixed arms	Yes for Rental		
E0165	NU RR	Commode chair, stationary, with detachable arms	Yes for Rental		

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HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
E0167		Pail or pan, for use with commode chair (replacement)	No		
E0168	NU RR	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each	Yes for Rental		
E0170		Commode chair with integrated seat lift mechanism, electric, any type			
E0171		Commode chair with integrated seat lift mechanism, non-electric, any type			
E0172		Seat lift mechanism placed over or on top of toilet, any type			
E0175		Foot rest, for use with commode chair, each			
E0240		Bath/shower chair, with or without wheels, any size			
E0241		Bathtub wall rail, each			
E0242		Bathtub rail, floor base			
E0243		Toilet rail, each			
E0244		Raised toilet seat			
E0245		Tub stool or bench			

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

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Blood monitoring

HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
A4660		Sphygmomanometer/blood pressure apparatus with cuff and stethoscope	No		
A4663		Blood pressure cuff only	No		
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.
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 medical equipment

Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	A8000		Helmet, protective, soft, prefabricated, includes all components and accessories	Purchase only. Limit of 1 per client, per year.
	A8001		Helmet, protective, hard, prefabricated, includes all components and accessories	Purchase only. Limit of 1 per client, per year.
	A8002		Helmet, protective, soft, custom fabricated, includes all components and accessories	Purchase only. Limit of 1 per client, per year. PA required
	A8003		Helmet, protective, hard, custom fabricated, includes all components and	Purchase only. Limit of 1 per client, per year. PA required
	A8004		Soft interface for helmet, replacement only	Not allowed in addition to HCPCS codes A8000 – A8003
	E0202	RR	Phototherapy (bilirubin) light with photometer	Rental only. Includes all supplies. Limit of five days of rental per client per 12-month period.
	E0602		Breast pump, manual, any type	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	Policy/Comments
	E0603	NU	Breast pump, electric, AC and/or DC, any type	Purchase only. Limit of 1 per client per lifetime. Not allowed in combination with HCPCS codes E0604RR or E0602. PA required
	E0604	RR	Breast pump, **hospital grade**, electric (AC and/or DC), any type	Rental only. If client received a kit during hospitalization, an additional kit will not be covered. PA or EPA in Auth
	E0650	NU RR	Pneumatic compressor, nonsegmental home model	Considered purchased after 1 years' rental. Limit of 1 per client every 5 years. Rental requires PA or EPA in Auth NF included in daily rate
	E0651		Pneumatic compressor, segmental home model without calibrated gradient pressure	
	E0652		Pneumatic compressor, segmental home model with calibrated gradient pressure	

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E0655		Extremity sleeve: nonsegmental pneumatic appliance for use with pneumatic compressor, half arm	Purchase only
	E0660		Extremity sleeve: nonsegmental pneumatic appliance for use with pneumatic compressor, full leg	Purchase only
	E0665		Extremity sleeve: nonsegmental pneumatic appliance for use with pneumatic compressor, full arm	Purchase only
	E0666		Extremity sleeve: nonsegmental pneumatic appliance for use with pneumatic compressor, half leg	Purchase only
	E0667		Segmental pneumatic appliance for use with pneumatic compressor, full leg	
	E0668		Segmental pneumatic appliance for use with pneumatic compressor, full arm	
	E0669		Segmental pneumatic appliance for use with pneumatic compressor, half leg	
	E0670		Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk	

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	E0671		Segmental gradient pressure pneumatic appliance, full leg	
	E0672		Segmental gradient pressure pneumatic appliance, full arm	
	E0673		Segmental gradient pressure pneumatic appliance, half leg	
	E0675		Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)	
	E0676		Intermittent limb compression device (includes all accessories), not otherwise specified	
	E0691		Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area two square feet or less	
	E0692		Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, four foot panel	
	E0693		Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, six foot panel	
	E0694		Ultraviolet multidirectional light therapy system in six foot cabinet, includes bulbs/lamps, timer and eye protection	

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	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	Rental allowed for maximum of 10 days. Limit = per knee. PA or EPA in Auth
	E0936	RR	Continuous passive motion exercise device for use other than knee	PA required
	E1300		Whirlpool, portable (overtub type)	
	E1310		Whirlpool, nonportable (built-in type)	
	E1399	NU	Medical equipment, miscellaneous. (Breast pump kit, electric)	Purchase only PA required
	E2000	RR	Gastric suction pump, home model, portable or stationary, electric	Rental only PA required
	K0606		Automatic external defibrillator, with integrated electrocardiogram analysis, garment type	
	K0607		Replacement battery for automated external defibrillator, garment type only, each	
	K0608		Replacement garment for use with automated external defibrillator, each	

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	K0609		Replacement electrodes for use with automated external defibrillator, garment type only, each	
	K0739		Labor, other medical equipment repairs (other than wheelchairs), per quarter hour. (Trouble shooting, delivery, evaluations, travel time, etc. are included in the reimbursement of the items).	For client-owned equipment only PA required
	K0900		Customized medical equipment, other than wheelchair	
	T5001	NU RR	Positioning seat for persons with special orthopedic needs, for use in vehicles (7 years and older)	Limit of 1 per client every 5 years PA required for rental and for clients age 6 and younger NF included in daily rate

Other charges for medical equipment services

HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
A9273		Hot water bottle, ice cap or collar, heat and/or wrap, any type			
A9281		Reaching/grabbing device, any type, any length, each			
A9282		Wig, any type, each			

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HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
E0200		Heat/Cold Application. Heat lamp, without stand (table model), includes bulb, or infrared element			
E0203		Therapeutic lightbox, minimum 10,000 lux, table top model			
E0205		Heat lamp, with stand, includes bulb, or infrared element			
E0210		Electric heat pad, standard			
E0215		Electric heat pad, moist			
E0217		Water circulating heat pad with pump			
E0218		Water circulating cold pad with pump			
E0221		Infrared heating pad system			
E0225		Hydrocollator unit, includes pads			
E0231		Non-contact wound warming device (temperature control unit, AC adapter and power cord) for use with warming card and wound cover			

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HCPCS Code	Modifier	Description	PA?	Included in NF Daily Rate	Policy/Comments
E0232		Warming card for use with the non-contact wound warming device and non-contact wound warming wound cover			
E0235		Paraffin bath unit, portable (see medical supply HCPCS code A4265 for paraffin)			
E0236		Pump for water circulating pad			
E0239		Hydrocollator unit, portable			
E0249		Pad for water circulating heat unit			
E1399	NU RR	Medical equipment, miscellaneous (Other nonlisted medical equipment not otherwise listed)	Yes		Provide complete description including copy of manufacturer's product information and price catalog with request for authorization.
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 Where can I download agency forms? (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	Policy/Comments
	E1028	NU	Wheelchair accessory, manual swingway, retractable or removable mounting hardware for joystick, other control interface or position accessory	PA required
	E1031	NU	Rollabout chair, any and all types with casters five inches or greater	PA required
	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	PA required

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

DC = Same/similar covered code in fee schedule
N = New
P = Policy change
DP = Service managed through a different program
PA = Prior Authorization Required

Code Status Indicator	HCPCS Code	Modifier	Description	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	PA required
	K0006	NU RR	Heavy-duty wheelchair (all styles of arms, foot rests, and/or leg rests)	Yes. See Authorization
	K0108	NU	Wheelchair component or accessory, not otherwise specified	PA required

Manual wheelchairs (noncovered HCPCS codes)

Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
DC	E1050		Fully reclining wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests	See HCPCS codes K0003 and E1226
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

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
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
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

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Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
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
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

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	Policy/Comments
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
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

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

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PA = Prior Authorization Required

Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
DC	E1285		Heavy-duty wheelchair; fixed full-length arms, swing-away, detachable footrests	See HCPCS code K0007
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

Power-operated vehicles (covered HCPCS codes)

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

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

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PA = Prior Authorization Required

Code Status Indicator	HCPCS Code	Modifier	Description	Policy/Comments
	K0802	NU	Power operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396 PA required
	K0806	NU	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396 PA required
	K0807	NU	Power operated vehicle, group 2 heavy duty, patient weight capacity 301 to 450 pounds	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396 PA required
	K0808	NU	Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600 pounds	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396 PA required
BR	K0812	NU	Power operated vehicle, not otherwise classified	Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396 PA required

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

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Note: HCPCS code E1028 (wheelchair accessory, manual swingaway, retractable or removable mounting hardware) must be submitted on one line for correct payment.

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

DC = Same/similar covered code in fee schedule
DP = Service managed through a different program
N = New
P = Policy change
PA = Prior Authorization Required

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 Where can I download agency forms? (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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PA = Prior Authorization Required

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 Where can I download agency forms? (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.

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

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DP = Service managed through a different program
N = New
P = Policy change
PA = Prior Authorization Required

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

Cushions

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/ Comments
	E2601	NU	General use wheelchair seat cushion, width less than 22 inches, any depth	Yes	
	E2602	NU	General use wheelchair seat cushion, width 22 inches or greater, any depth	Yes	
	E2603	NU	Skin protection wheelchair seat cushion, width less than 22 inches, any depth	Yes	
	E2604	NU	Skin protection wheelchair seat cushion, width 22 inches or greater, any depth	Yes	
	E2605	NU	Positioning wheelchair seat cushion, width less than 22 inches, any depth	Yes	
	E2606	NU	Positioning wheelchair seat cushion, width 22 inches or greater, any depth	Yes	
	E2607	NU	Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth	Yes	
	E2608	NU	Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth	Yes	
	K0739	NU	Repair or nonroutine service for 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	NU	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth	Yes	
	E2623	NU	Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	Yes	
	E2624	NU	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth	Yes	
	E2625	NU	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	NU	Armrest, each (replacement only)	Yes	
	K0019	NU	Arm pad, each (replacement only)	Yes	

Lower extremity positioning (leg rests, etc.)

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/ Comments
	E0951	NU	Heel loop/holder, with or without ankle strap, each	Yes	
	E0952	NU	Toe loop/holder each	Yes	
	E0995	NU	Wheelchair accessory, calf rest/pad, each	Yes	
	K0038	NU	Leg strap, each	Yes	
	K0039	NU	Leg strap, H style, each	Yes	
	K0041	NU	Large size footplate, each	Yes	
	K0195	NU	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	NU	Wheelchair accessory, tray, each (includes all attaching hardware)	Yes	
	E0960	NU	Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware	Yes	
	E0978	NU	Wheelchair accessory, safety belt/pelvic strap, each	Yes	
	E0980	NU	Safety vest, wheelchair	Yes	
	E0981	NU	Wheelchair accessory, seat upholstery, replacement only, each	Yes	
	E0982	NU	Wheelchair accessory, back upholstery, replacement only, each	Yes	
	E0992	NU	Manual wheelchair accessory, solid seat insert	Yes	
	E2231	NU	Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware	Yes	
BR	E2291	NU	Back, planar, for pediatric size wheelchair including fixed attaching hardware	Yes	
BR	E2292	NU	Seat, planar, for pediatric size wheelchair including fixed attaching hardware	Yes	
BR	E2293	NU	Back, contoured, for pediatric size wheelchair including fixed attaching hardware	Yes	
BR	E2294	NU	Seat, contoured, for pediatric size wheelchair including fixed attaching hardware	Yes	
	E2611	NU	General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware	Yes	
	E2612	NU	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	NU	Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware	Yes	
	E2614	NU	Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware	Yes	
	E2615	NU	Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware	Yes	
	E2616	NU	Positioning wheelchair back, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware	Yes	

Hand rims, wheels, and tires (includes parts)

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/ Comments
	E0967	NU	Manual wheelchair accessory, hand rim with projections, each	Yes	
	E2211	NU	Manual wheelchair accessory, pneumatic propulsion tire, any size, each	Yes	
	E2212	NU	Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each	Yes	
	E2213	NU	Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each	Yes	
	E2214	NU	Manual wheelchair accessory, pneumatic caster tire, any size, each	Yes	
	E2215	NU	Manual wheelchair accessory, tube for pneumatic caster tire, any size, each	Yes	
	E2216	NU	Manual wheelchair accessory, foam filled propulsion tire, any size, each	Yes	

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Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/ Comments
	E2217	NU	Manual wheelchair accessory, foam filled caster tire, any size, each	Yes	
	E2218	NU	Manual wheelchair accessory, foam propulsion tire, any size, each	Yes	
	E2219	NU	Manual wheelchair accessory, foam caster tire, any size, each	Yes	
	E2220	NU	Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each	Yes	
	E2221	NU	Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, each	Yes	
	E2222	NU	Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, each	Yes	
	E2224	NU	Manual wheelchair accessory, propulsion wheel excludes tire, any size, each	Yes	
	E2225	NU	Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each	Yes	
	E2226	NU	Manual wheelchair accessory, caster fork, any size, replacement only, each	Yes	
	K0065	NU	Spoke protectors, each	Yes	
	K0069	NU	Rear wheel assembly, complete, with solid tire, spokes or molded, each	Yes	
	K0070	NU	Rear wheel assembly, complete with pneumatic tire, spokes or molded, each	Yes	
	K0071	NU	Front caster assembly, complete, with pneumatic tire, each	Yes	
	K0072	NU	Front caster assembly, complete, with semi-pneumatic tire, each	Yes	
	K0073	NU	Caster pin lock, each	Yes	
	K0077	NU	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	
	E0961	NU	Manual wheelchair accessory, wheel lock brake extension (handle), each	Yes	Changed from pair to each with new description
	E0971	NU	Manual wheelchair accessory, anti-tipping device, each	Yes	
	E0973	NU	Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each	Yes	
	E1029	NU	Wheelchair accessory, ventilator tray, fixed	Yes	
	E1030	NU	Wheelchair accessory, ventilator tray, gimbaled	Yes	
	E2207	NU	Wheelchair accessory, crutch and cane holder, each	Yes	
	E2208	NU	Wheelchair accessory, cylinder tank carrier, each	Yes	
	K0105	NU	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 lead acid battery	Yes	
NC	E2359		Power wheelchair accessory, GR sealed lead acid battery	Yes	
NC	E2397		Power wheelchair accessory, lithium-based battery, each		

Miscellaneous repair only

Code Status Indicator	HCPCS Code	Modifier	Description	PA?	Policy/ Comments
	E2210	NU	Wheelchair accessory, bearings, any type, replacement only, each	Yes	
	E2619	NU	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 medical equipment 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; see Where can I download agency forms?
- 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 19-0006

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, see Where can I download agency forms?
- A completed *Medical Necessity for Wheelchair Purchase for Nursing Facility Clients* form, HCA 19-0006. The date on form 19-0006 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 19-0006. 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 medical equipment 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

Exception to Rule

What is an exception to rule (ETR)?

The agency evaluates a request for any medical equipment, related supplies, and related services 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 may be submitted online through direct data entry into the ProviderOne system or 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, see Where can I download agency forms?
- 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 medical equipment 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. See Where can I download agency forms?

> **Note:** Applicable forms may be downloaded from the agency's Billers and Providers webpage.

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.

Providers may submit PA requests online through direct data entry into ProviderOne. See the agency's prior authorization webpage for details.

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 six 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 medical equipment 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 submitted for medical and medical equipment requests?

For submitting photos and X-rays for medical and medical equipment PA requests, use the FastLook™ and FastAttach™ services provided by Vyne Medical.

Register with Vyne Medical through their website.

Contact Vyne Medical at 865-293-4111 with any questions.

When this option is chosen, fax the request to the agency and indicate the MEA# in box 18 on the *General Information for Authorization* (HCA 13-835) form. **There is an associated cost, which will be explained by the MEA services.**

Note: See the agency ProviderOne Billing and Resource Guide and review the Prior Authorization (PA) chapter for more information on requesting authorization.

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 medical equipment procedure codes.

The agency requires a provider to create an authorization number for EPA for selected medical equipment 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.

Prior authorization is required when a situation does not meet the EPA criteria for medical equipment procedure codes. See the agency's Prior authorization webpage for details.

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 medical equipment that meets 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. HIPAA 5010 does not allow multiple authorization (prior/expedited) numbers per claim. If billing an electronic claim, enter the EPA at the claim level in the *Prior Authorization* section.

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

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

Providers must request prior authorization when a situation does not meet the criteria for a selected medical equipment code. See the agency's Prior authorization webpage for details.

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 ME, 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 ME, and medical supplies. See the agency's Prior authorization webpage for details.

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. See the agency's Prior authorization webpage for details.

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 than 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. See Where can I download agency forms?

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
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. See Where can I download agency forms?

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. See Where can I download agency forms?
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 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

All claims must be submitted electronically to the agency, except under limited circumstances. For more information about this policy change, see Paperless Billing at HCA.
For providers approved to bill paper claims, see the agency's Paper Claim Billing Resource.

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 medical 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 does not pay a medical equipment 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 physician evaluates the client.

  - ✓ The agency requires the physician to write a new prescription if the physician 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 physician evaluates the client.

  - ✓ The agency requires the physician to write a new prescription if the physician 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.

What is included in the rate?

(WAC 182-543-9000(8))

The agency's payment rate for purchased or rented covered medical equipment, 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 medical equipment, 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.

Where can I find the fee schedules for medical equipment and non-CRT wheelchairs?

See the agency's fee schedule.

Where can the agency's required forms be found?

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

- *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 19-0006
- *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
- *Speech Language Pathologist (SLP) Evaluation for Speech Generating Devices* form, HCA 15-310

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's Billers and Providers webpage, under ProviderOne Resources, Webinars.

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

The following claim instructions relate to medical equipment providers:

Name	Entry
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

Warranty

When do I need to make warranty information available?

(WAC 182-543-9000(13))

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(14))

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
Medical Equipment	**Warranty**
All other medical equipment not specified above (excludes disposable/non-reusable supplies)	1 year