Nondurable Medical Supplies & Equipment (MSE)

Billing Guide

April 1, 2016

About this guide*

This guide takes effect April 1, 2016, and supersedes earlier 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 and/or equipment related to any of the programs listed below must be billed using their specific provider billing guides:

- Wheelchairs & Durable Medical Equipment and Supplies Billing Guide
- Medical Nutrition Billing Guide
- Home Infusion Therapy Billing Guide
- Prosthetic/Orthotic Devices and Supplies 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
All	Fixed broken links, clarified language, etc.	Housekeeping
Important Changes to Apple Health Effective April 1, 2016	**Effective April 1, 2016**, Apple Health (Medicaid), important changes are taking place that **all providers** need to know. Information has been added regarding new policy for early enrollment into managed care, implementation of fully integrated managed care in SW WA Region, Apple Health Core Connections for Foster Children, Behavioral Health Organizations (formerly RSNs), and contact information for southwest Washington.	Program changes
Coverage Table	Removed status code indicator “N” and “P” because these types of changes are recorded in the *What has Changed* table	Obsolete indicators

* This publication is a billing instruction.

Subject	Change	Reason for Change
Billing	Updated instructions for Completing the CMS-1500 claim form. Providers should refer to the Provider Training Page, Medicaid 101 for electronic billing information.	Webinars no longer available
Coverage and limitations	Removed limitation under coverage/limitations as follows: Lumbosacral brace, rib belt, or hernia belt - 1 per 12-month period. ~~This brace is noncovered for pregnant clients~~	Policy change
Coverage Table	Removed status code indicator "Different Code (DC)" from the coverage table for HCPCS codes A4255, A4248, A4396	Policy change
Coverage Table	Changed status code indicator "DC" to "Not Covered (NC)" for HCPCS codes A4321, A4281, A4282, A4283, A4284, A4285, A4286	Policy change
Coverage Table	Added the following policy comment to HCPCS codes A4561 and A4562: See Physician-Related Services/Healthcare Professional Services Billing Guide	Clarification

How can I get agency provider documents?

To download and print agency billing guides guides, go to the agency's Provider Publications website.

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Important Changes to Apple Health Effective April 1, 2016

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

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

New MCO enrollment policy – earlier enrollment

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

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

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

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

How does this policy affect providers?

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

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

Behavioral Health Organization (BHO)

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

Fully Integrated Managed Care (FIMC)

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

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

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

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

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

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

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

Apple Health Core Connections (AHCC)

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

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

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

AHCC complex mental health and substance use disorder services

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

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

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

Contact Information for Southwest Washington

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

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

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

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

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

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

Resources

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Apple Health Billers and Providers web page.
Finding out about payments, denials, claims processing, or agency-contracted managed care organizations	
Electronic or paper billing	
Finding agency documents (e.g., provider billing guides, provider alerts, fee schedules)	
Private insurance or third-party liability, other than agency-contracted managed care	
Prior authorization, limitation extensions, or exception to rule	(800) 562-3022 (phone) (866) 668-1214 (fax)
How can I request that equipment/supplies be added to the covered list in this provider guide?	
Who do I contact about the actual reimbursement rate listed in the fee schedule?	Cost Reimbursement Analyst Professional Reimbursement PO Box 45510 Olympia, WA 98504-5510

Definitions

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

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

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

Healthcare Common Procedure Coding System (HCPCS) – A coding system established by the Health Care Financing Administration to define services and procedures.
(WAC 182-543-1000)

Medical Supplies – Supplies that are:

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

Other Durable Medical Equipment (other DME) – All durable medical equipment, excluding wheelchairs and wheelchair related items.

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

Plan of Care (POC) – (Also known as plan of treatment (POT)). A written plan of care that is established and periodically reviewed and signed by both a physician and a home health agency provider, that describes the home health care to be provided at the client's residence. (WAC 182-551-2010)

Pricing Cluster – A group of manufacturers' list prices for brands/models of DME, medical supplies and nondurable medical equipment that the agency considers when calculating the reimbursement rate for a procedure code that does not have a fee established by Medicare.

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

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

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)

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)

About the Program

(WAC 182-543-0500)

What products in general does the Nondurable Medical Supplies and Equipment (MSE) program cover?

The federal government considers nondurable medical supplies and equipment (MSE), as optional services under the Medicaid program, except when prescribed as an integral part of an approved plan of treatment under the home health program or 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.

The agency covers MSE listed within this provider guide, according to agency rules and subject to the limitations and requirements within this guide.

The agency pays for MSE when it is:

- 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.
  - ✓ An advanced registered nurse practitioner (ARNP).
  - ✓ A physician assistant certified (PAC).
  - ✓ A naturopathic 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 being billed for copay and/or deductible only.

- Authorized, as required in:
  - ✓ Chapter 182-501 WAC.
  - ✓ Chapter 182-502 WAC.
  - ✓ Chapter 182-543 WAC.
  - ✓ This guide, see Authorization.
- Provided and used within accepted medical or physical medicine community standards of practice.

The agency requires prior authorization (PA) for covered MSE when the clinical criteria are not met including the criteria associated with the expedited prior authorization (EPA) process.

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

The agency bases its determination about which MSE requires PA or EPA on utilization criteria. The agency considers all of the following when establishing utilization criteria:

- Cost
- The potential for utilization abuse
- A narrow therapeutic indication
- Safety

Note: See Authorization for more information.

The agency evaluates a request for any MSE item listed as noncovered 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 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.

The agency evaluates a request for a covered service that is subject to limitations or other restrictions and approves such a service beyond those limitations or restrictions when medically necessary, under the standards for covered services in WAC 182-501-0165 (see Coverage/Limitations).

Client Eligibility

(WAC 182-501-0060 and 182-501-0065)

How can I verify a patient's eligibility?

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

Verifying eligibility is a two-step process:

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

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

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

Note: Patients who wish to apply for Washington Apple Health can do so 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?

(WAC 182-538-060 and 182-538-095 or WAC 182-538-063 for managed care clients)

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

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

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

The agency does not pay for medical equipment and/or services provided to a client who is enrolled in an agency-contracted MCO, but did not use one of the plan's participating providers. (WAC 182-543-1100)

> **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 MCO. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Provider/Manufacturer Information

(WAC 182-543-2000)

What types of nondurable medical supplies and equipment (MSE) and related services does the agency pay for?

The agency pays qualified providers for nondurable medical supplies and equipment (MSE) on a fee-for-service basis as follows:

- MSE providers for MSE 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.

Providers and suppliers of MSE 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 I provide proof of delivery?).
- Bill the agency using only the allowed procedure codes within this billing guide (see Nondurable MSE Coverage Table).

- Have a valid prescription. To be valid, a prescription must:
  - ✓ Be written on the agency's *Prescription* form, HCA 13-794.
  - ✓ Be written by a physician, advanced registered nurse practitioner (ARNP), physician's assistant certified (PAC), or a naturopathic 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 only the copay and/or deductible, 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 providers, suppliers, or manufacturers may request the agency to include new equipment/supplies within this guide

- The request should include credible evidence, including but not limited to:
  - ✓ Manufacturer's literature.
  - ✓ Manufacturer's pricing.
  - ✓ Clinical research/case studies (including FDA approval, if required).
  - ✓ Proof of the Centers for Medicare and Medicaid Services (CMS) certification, if applicable.
  - ✓ Any additional information the requester feels would aid the agency in its determination.

Send requests to:

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

How do providers furnish proof of delivery?

(WAC 182-543-2200)

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

- The agency requires a delivery slip as proof of delivery, and it must:
  - ✓ 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.
  - ✓ For MSE that may require future repairs, include the serial number.
- 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 nondurable medical supplies 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:
  - ✓ 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:
  - ✓ The client's name.
  - ✓ The shipping service package identification number.
  - ✓ The quantity, detailed description(s), and brand name(s) of the items being shipped.
  - ✓ For MSE that may require future repairs, include the serial number.

- When billing the agency use one 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 prior authorization (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 MSE furnished to the agency's clients when:

- 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 MSE.

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

(WAC 182-543-2250)

- The agency bases its decision to rent or purchase nondurable medical equipment (MSE) 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** MSE equipment only.
  - ✓ **A new** MSE 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** MSE 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 MSE rented to a client is both of the following:
  - ✓ 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 MSE 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 MSE 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 a 12-month rental, unless the equipment is restricted as rental only.
- MSE purchased by the agency for a client are the client's property.
- The agency rents, but does not purchase, certain MSE 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 the client's coinsurance and deductibles for rental equipment when either of the following applies:
  - ✓ 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/Limitations

(WAC 182-543-5500)

What is covered?

The agency covers, without prior authorization (PA), the following nondurable medical supplies and equipment (MSE) and related services:

- Antiseptics and germicides:
  - ✓ Alcohol (isopropyl) or peroxide (hydrogen) - 1 pint per month
  - ✓ Alcohol wipes (box of 200) - 1 box per month
  - ✓ Betadine or phisoHex solution - 1 pint per month
  - ✓ Betadine or iodine swabs/wipes (box of 100) - 1 box per month
- Bandages, dressings, and tapes
- Batteries – replacement batteries:
  - ✓ The agency pays for the purchase of replacement batteries for wheelchairs.
  - ✓ The agency does not pay for wheelchair replacement batteries that are used for speech generating devices (SGDs) or ventilators. See the agency's Wheelchairs, Durable Medical Equipment, and Supplies Billing Guide for speech generating devices and the agency's Respiratory Care Billing Guide for ventilators.
- Blood monitoring/testing supplies:
  - ✓ Replacement battery of any type, used with a client-owned, medically necessary home or specialized blood glucose monitor - 1 in a 3-month period
  - ✓ Spring-powered device for lancet - 1 in a 6-month period

- ✓ Diabetic test strips as follows:
  - ➢ For children, age 20 and younger, as follows:
    - ▪ Insulin dependent, 300 test strips and 300 lancets per client, per month (DME providers must submit claims with EPA 870001265; Pharmacy POS providers must use EPA 85000000265 and must bill according to POS instructions – see the Prescription Drug Program)
    - ▪ For noninsulin dependent, 100 test strips and 100 lancets per client, per month
  - ➢ For adults age 21 and older:
    - ▪ Insulin dependent, 100 test strips and 100 lancets per client, per month
    - ▪ For noninsulin dependent , 100 test strips and 100 lancets per client, every 3 months
  - ➢ For pregnant women with gestational diabetes, the agency pays for the quantity necessary to support testing as directed by the client's physician, up to 60 days postpartum.
- ✓ See WAC 182-543-5500(12) for blood glucose monitors.

- Braces, belts, and supportive devices:
  - ✓ Knee brace (neoprene, nylon, elastic, or with a hinged bar) - 2 per 12-month period
  - ✓ Ankle, elbow, or wrist brace - 2 per 12-month period
  - ✓ Lumbosacral brace, rib belt, or hernia belt - 1 per 12-month period.
  - ✓ Cervical head harness/halter, cervical pillow, pelvic belt/harness/boot, or extremity belt/harness - 1 per 12-month period

- Decubitus care products:
  - ✓ Cushion (gel, sacroiliac, or accuback) and cushion cover (any size) - 1 per 12-month period
  - ✓ Synthetic or lamb's wool sheepskin pad - 1 per 12-month period
  - ✓ Heel or elbow protectors - 4 per 12-month period
- Ostomy supplies:
  - ✓ Adhesive for ostomy or catheter: cement; powder; liquid (e.g., spray or brush) or paste (any composition, e.g., silicone or latex) - 4 total ounces per month
  - ✓ Adhesive or non-adhesive disc or foam pad for ostomy pouches - 10 per month
  - ✓ Adhesive remover or solvent - 3 ounces per month
  - ✓ Adhesive remover wipes, 50 per box - 1 box per month
  - ✓ Closed pouch, with or without attached barrier, with a 1- or 2-piece flange, or for use on a faceplate - 60 per month
  - ✓ Closed ostomy pouch with attached standard wear barrier, with built-in 1-piece convexity - 10 per month
  - ✓ Continent plug for continent stoma - 30 per month
  - ✓ Continent device for continent stoma - 1 per month
  - ✓ Drainable ostomy pouch, with or without attached barrier, or with 1- or 2-piece flange - 20 per month
  - ✓ Drainable ostomy pouch with attached standard or extended wear barrier, with or without built-in 1-piece convexity - 20 per month
  - ✓ Drainable ostomy pouch for use on a plastic or rubber faceplate (only 1 type of faceplate allowed) - 10 per month
  - ✓ Drainable urinary pouch for use with a plastic, heavy plastic, or rubber faceplate (only 1 type of faceplate allowed) - 10 per month
  - ✓ Irrigation bag - 2 every 6 months
  - ✓ Irrigation cone and catheter, including brush - 2 every 6 months

- ✓ Irrigation supply, sleeve - 1 per month
- ✓ Ostomy belt (adjustable) for appliance - 2 every 6 months
- ✓ Ostomy convex insert - 10 per month
- ✓ Ostomy ring - 10 per month
- ✓ Stoma cap - 30 per month
- ✓ Ostomy faceplate - 10 per month. The agency does not pay for either of the following when billed in combination with an ostomy faceplate with:
  - ➢ Drainable pouches with plastic face plate attached.
  - ➢ Drainable pouches with rubber face plate.

- Syringes and needles
- Urological supplies - diapers and related supplies:
  - ✓ The standards and specifications in this section apply to all disposable incontinence products (e.g., briefs, diapers, pull-up pants, underpads for beds, liners, shields, guards, pads, and undergarments)
  - ✓ All of the following apply to all disposable incontinence products:
    - ➢ All materials used in the construction of the product must be safe for the client's skin and harmless if ingested
    - ➢ Adhesives and glues used in the construction of the product must not be water-soluble and must form continuous seals at the edges of the absorbent core to minimize leakage
    - ➢ The padding must provide uniform protection
    - ➢ The product must be hypoallergenic
    - ➢ The product must meet the flammability requirements of both federal law and industry standards
    - ➢ All products are covered for client personal use only

- ✓ In addition, diapers must:
  - ➢ Be hourglass shaped with formed leg contours.
  - ➢ Have an absorbent filler core that is at least one-half inch from the elastic leg gathers.
  - ➢ Have leg gathers that consist of at least 3 strands of elasticized materials.
  - ➢ Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials.
  - ➢ Have a back sheet that is moisture impervious and is at least 1.00 mm thick, designed to protect clothing and linens.
  - ➢ Have a top sheet that resists moisture returning to the skin.
  - ➢ Have an inner lining that is made of soft, absorbent material.
  - ➢ Have either a continuous waistband, or side panels with a tear-away feature, or refastenable tapes, as follows:
    - ▪ For child diapers, at least 2 tapes, 1 on each side
    - ▪ The tape adhesive must release from the back sheet without tearing, and permit a minimum of 3 fastening/unfastening cycles
- ✓ In addition pull-up pants and briefs must meet the following specifications:
  - ➢ Be made like regular underwear with an:
    - ▪ Elastic waist.
    - ▪ Have at least 4 tapes, 2 on each side or 2 large tapes, one on each side.
  - ➢ Have an absorbent core filler that is at least one-half inch from the elastic leg gathers
  - ➢ Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling
  - ➢ Have leg gathers that consist of at least 3 strands of elasticized materials

- Have a back sheet that is:
  - Moisture impervious, is at least 1.00 mm thick.
  - Designed to protect clothing and linens.
- Have an inner lining made of soft, absorbent material.
- Have a top sheet that resists moisture returning to the skin.

✓ In addition, underpads are covered only when used for clients with incontinence, and only when used for protection on a client's bed, and must meet the following specifications:

- Have an absorbent layer that is at least one and one-half inches from the edge of the underpad.
- Be manufactured with a waterproof backing material.
- Be able to withstand temperatures not to exceed 140 degrees Fahrenheit.
- Have a covering or facing sheet that is made of nonwoven, porous materials that have a high degree of permeability, allowing fluids to pass through and into the absorbent filler. The patient contact surface must be soft and durable.
- Have filler material that is highly absorbent. It must be heavy weight fluff filler or the equivalent.
- Have 4-ply, nonwoven facing, sealed on all 4 sides.

✓ In addition liners, shields, guards, pads, and undergarments are covered for incontinence only and must meet the following specifications:

- Have channels to direct fluid throughout the absorbent area, and leg gathers to assist in controlling leakage, and/or be contoured to permit a more comfortable fit.
- Have a waterproof backing designed to protect clothing and linens.
- Have an inner liner that resists moisture returning to the skin.
- Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials.
- Have pressure-sensitive tapes on the reverse side to fasten to underwear.

- For undergarments only, be contoured for a good fit, have at least 3 elastic leg gathers, and may be belted or unbelted.

✓ The agency pays for urological products when they are used alone. The following are examples of products in which the agency does not pay for when used in combination with:

- Disposable diapers.
- Disposable pull-up pants and briefs.
- Disposable liners, shields, guards, pads, and undergarments.
- Rented reusable diapers (e.g., from a diaper service).
- Rented reusable briefs (e.g., from a diaper service) or pull-up pants.

✓ The agency approves a client's use of a combination of products only when the client uses different products for daytime and nighttime use.

Example: Pull-up pants for daytime use and disposable diapers for nighttime use. The total quantity of all products in this section used in combination cannot exceed the monthly limitation for the product with the highest limit.

✓ Purchased disposable diapers (any size) are limited to 200 per month for clients age 3 and older.

- Reusable cloth diapers (any size) are limited to:
  - Purchased - 36 per year.
  - Rented - 200 per month.

✓ Disposable briefs and pull-up pants (any size) are limited to:

- 200 per month for a child age 3 to 18.
- 150 per month for an adult age 19 and older.

✓ Reusable briefs, washable protective underwear, or pull-up pants (any size) are limited to:

- Purchased - 4 per year.
- Rented - 150 per month.

✓ Disposable pant liners, shields, guards, pads, and undergarments are limited to 200 per month.

- ✓ Underpads for beds are limited to:
  - Disposable (any size) - 180 per month.
  - Purchased, reusable (large) - 42 per year.
  - Rented, reusable (large) - 90 per month.

- ✓ Urological supplies - urinary retention:
  - Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube - 2 per month. The agency does not pay for these when billed in combination with any of the following:
    - With extension drainage tubing for use with urinary leg bag or urostomy pouch (any type, any length), with connector/adapter.
    - With an insertion tray with drainage bag, and with or without catheter.
  - Bedside drainage bottle, with or without tubing - 2 per 6 month period.
  - Extension drainage tubing (any type, any length), with connector/adapter, for use with urinary leg bag or urostomy pouch. The agency does not pay for these when billed in combination with a vinyl urinary leg bag, with or without tube.
  - External urethral clamp or compression device (not be used for catheter clamp) - 2 per 12-month period.
  - Indwelling catheters (any type) - 3 per month.
  - Insertion trays:
    - Without drainage bag and catheter - 120 per month. The agency does not pay for these when billed in combination with other insertion trays that include drainage bag, catheters, and/or individual lubricant packets.
    - With indwelling catheters - 3 per month - The agency does not pay for these when billed in combination with other insertion trays without drainage bag and/or indwelling catheter; individual indwelling catheters; and/or individual lubricant packets.

- Intermittent urinary catheter - 120 per month - The agency does not pay for these when billed in combination with an insertion tray with or without drainage bag and catheter; or other individual intermittent urinary catheters.

- Irrigation syringe (bulb or piston) - The agency does not pay for these when billed in combination with irrigation tray or tubing.

- Irrigation tray with syringe (bulb or piston) - 30 per month. The agency does not pay for these when billed in combination with an irrigation syringe (bulb or piston), or irrigation tubing set.

- Irrigation tubing set - 30 per month - The agency does not pay for these when billed in combination with an irrigation tray or an irrigation syringe (bulb or piston).

- Leg straps (latex foam and fabric) - Replacement only.

- Male external catheter, specialty type, or with adhesive coating or adhesive strip - 60 per month.

- Urinary suspensory with leg bag, with or without tube - 2 per month. The agency does not pay for these when billed in combination with:

  - Latex urinary.
  - Leg bag.
  - Urinary suspensory.
  - Without a leg bag.
  - Extension drainage tubing.
  - Leg strap.

- Urinary suspensory without leg bag, with or without tube - 2 per month.

- Urinary leg bag, vinyl, with or without tube - 2 per month - The agency does not pay for these when billed in combination with drainage bag and without catheter.

- Urinary leg bag, latex - 1 per month - The agency does not pay for these when billed in combination with or without catheter.

- Miscellaneous supplies:

  - ✓ Bilirubin light therapy supplies when provided with a bilirubin light which the agency prior authorized - 5 day supply.

  - ✓ Continuous passive motion (CPM) softgoods kit - 1 with rental of CPM machine.

- ✓ Eye patch with elastic, tied band, or adhesive, to be attached to an eyeglass lens - 1 box of 20.
- ✓ Eye patch (adhesive wound cover) - 1 box of 20.
- ✓ Nonsterile gloves – 200, per client, per month.
  - ➢ For clients residing in an assisted living facility, the agency pays, with PA, for **additional** nonsterile gloves up to the quantity necessary as directed by the client's physician, not to exceed a total of 400 per client, per month.
  - ➢ Prior authorization (PA) requests must include a completed:
    - ▪ *General Information for Authorization* form, HCA 13-835; and
    - ▪ *Limitation Extension Request Incontinent Supplies and Gloves* form, HCA 13-870.
- ✓ Sterile gloves – 30 pair, per client, per month.

- Miscellaneous MSE:
  - ✓ Bilirubin light or light pad - 5 day rental per 12-month period for at-home newborns with jaundice.

Nondurable MSE Coverage Table

Syringes and needles

Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4206		Syringe with needle, sterile 1cc, each	No	Included in nursing facility daily rate
	A4207		Syringe with needle, sterile 2cc, each	No	Included in nursing facility daily rate
	A4208		Syringe with needle, sterile 3cc, each	No	Included in nursing facility daily rate
	A4209		Syringe with needle, sterile 5cc or greater, each	No	Included in nursing facility daily rate
	A4210		Needle free injection device, each	No	Included in nursing facility daily rate
NC	A4211		Supplies for self-administered injections		See Physician-Related Services/Health Care Professional Services Billing Guide
	A4213		Syringe, sterile, 20 cc or greater	No	
	A4215		Needle, sterile, any size, each	No	Included in nursing facility daily rate
	A4322		Irrigation syringe, bulb or piston, each	No	Included in nursing facility daily rate. Not allowed in combination with code A4320, A4355

Legend

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

Blood monitoring/testing supplies

Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4233		Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each	No	
	A4234		Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each	No	
	A4235		Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each	No	
	A4236		Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each	No	
NC	A4252		Blood ketone test or reagent strip, each		
	A4253	KX or KS	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips	No	Included in nursing facility daily rate. 1 unit billed = 1 box of 50 strips (e.g. 1 unit = 50, 2 units = 100 strips; 3 units = 150 strips, etc.) **Limits:** 100/month for insulin dependent 100/3 months non-insulin dependent
	A4255		Platforms for home blood glucose monitor, 50 per box		

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4256		Normal, low and high calibrator solution/chips	No	Included in nursing facility daily rate
	A4258		Spring-powered device for lancet, each	No	One (1) allowed per client every 6 months. Included in nursing facility daily rate
	A4259	KX or KS	Lancets, per box of 100	No	Included in nursing facility daily rate. 1 unit = 1 box of 100 lancets (e.g. 1 unit = 100; 2 units = 200; 3 units = 300, etc.) **Limits:** 100/month for insulin dependent; 100/3 months non-insulin dependent

Antiseptics and germicides

Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4244		Alcohol or peroxide, per pint	No	Max of one (1) pint allowed per client per 6 months. Included in nursing facility daily rate.
	A4245		Alcohol wipes, per box (of 200)	No	Max of one (1) box allowed per client per month. Included in nursing facility daily rate.

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4246		Betadine or pHisoHex solution, per pint	No	Max of one (1) pint allowed per client per month. Included in nursing facility daily rate.
	A4247		Betadine or iodine swabs/wipes, per box (of 100)	No	Max of one (1) box allowed per client per month. Included in nursing facility daily rate.
	A4248		Chlorhexidine containing antiseptic 1 ml		

Bandages, dressings, and tapes

(Unless needed for the first 6 weeks of post-surgery, all bandages, dressings, and tapes are included in the nursing facility daily rate.)

Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/ Comments
	A4649		Surgical supply; miscellaneous	Yes	
	A6010		Collagen based wound filler, dry form, sterile, per gram of collagen	Yes	
	A6011		Collagen based wound filler, gel/paste, sterile, per gram of collagen	Yes	
	A6021		Collagen dressing, sterile, pad size 16 sq. in. or less, each	No	
	A6022		Collagen dressing, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., each	No	
	A6023		Collagen dressing, sterile, pads size more than 48 sq. in	Yes	
	A6024		Collagen dressing wound filler, sterile, per 6 inches	No	

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/ Comments
	A6025		Gel sheet for dermal or epidermal application, (e.g., silicone, hydrogel, other), each	No	
	A6154		Wound pouch, each	No	
	A6196		Alginate or other fiber gelling dressing, wound cover, sterile, pad size 16 sq. in. or less, each dressing	No	
	A6197		Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., each dressing	No	
	A6198		Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 48 sq. in, each dressing	No	
	A6199		Alginate or other fiber gelling dressing, wound filler, sterile, per 6 inches	No	
	A6203		Composite dressing, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing	No	
	A6204		Composite dressing, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in. with any size adhesive border, each dressing	No	
	A6205		Composite dressing, sterile, pad size more than 48 sq. in. with any size adhesive border, each dressing	No	
	A6206		Contact layer, sterile, 16 sq. in. or less, each dressing	No	
	A6207		Contact layer, sterile, more than 16 sq. in., but less than or equal to 48 sq. in., each dressing	No	
	A6208		Contact layer, sterile, more than 48 sq. in., each dressing	No	
	A6209		Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	No	

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/ Comments
	A6210		Foam dressing, wound cover, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing	No	
	A6211		Foam dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing	No	
	A6212		Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing	No	
	A6213		Foam dressing, wound cover, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing	No	
	A6214		Foam dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing	No	
	A6215		Foam dressing, wound filler, sterile, per gram	No	
	A6216		Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	No	
	A6217		Gauze, non-impregnated, non-sterile pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing	No	
	A6218		Gauze, non-impregnated, non-sterile pad size more than 48 sq. in., without adhesive border, each dressing	No	
	A6219		Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing	No	
	A6220		Gauze, non-impregnated, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing	No	

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/ Comments
	A6221		Gauze, non-impregnated, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing	No	
	A6222		Gauze, impregnated with other than water, normal saline or hydrogel, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	No	
	A6223		Gauze, impregnated with other than water, normal saline or hydrogel, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing	No	
	A6224		Gauze, impregnated with other than water, normal saline or hydrogel, sterile, pad size more than 48 sq. in., without adhesive border, each dressing	No	
NC	A6228		Gauze, impregnated, water or normal saline, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing		
	A6229		Gauze, impregnated, water or normal saline, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing	No	
	A6230		Gauze, impregnated, water or normal saline, sterile,pad size more than 48 sq. in., without adhesive border, each dressing	No	
	A6231		Gauze, impregnated, hydrogel, for direct wound contact sterile, pad size 16 sq. in. or less, each dressing	No	
	A6232		Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size greater than 16 sq. in., but less than or equal to 48 sq. in., each dressing	No	

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/ Comments
	A6233		Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size more than 48 sq. in., each dressing	No	
	A6234		Hydrocolloid dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	No	
	A6235		Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing	No	
	A6236		Hydrocolloid dressing, wound cover sterile, pad size more than 48 sq. in., without adhesive border, each dressing	No	
	A6237		Hydrocolloid dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing	No	
	A6238		Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing	No	
NC	A6239		Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing		
	A6240		Hydrocolloid dressing, wound filler, paste, sterile, per fluid oz	No	
	A6241		Hydrocolloid dressing, wound filler, dry form, sterile, per gram	No	
	A6242		Hydrogel dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	No	
	A6243		Hydrogel dressing, wound cover, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing	No	

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	A6244		Hydrogel dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing	No	
	A6245		Hydrogel dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing	No	
	A6246		Hydrogel dressing, wound cover, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing	No	
	A6247		Hydrogel dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing	No	
	A6248		Hydrogel dressing, wound filler, sterile, gel, per fluid oz	No	
NC	A6250		Skin sealants, protectants, moisturizers, ointments, any type, any size		
	A6251		Specialty absorptive dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	No	
	A6252		Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing	No	
	A6253		Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing	No	
	A6254		Specialty absorptive dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing	No	

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/ Comments
	A6255		Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing	No	
	A6256		Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing	No	
	A6257		Transparent film, sterile, 16 sq. in. or less, each dressing	No	
	A6258		Transparent film, sterile, more than 16 sq. in., but less than or equal to 48 sq. in., each dressing	No	
	A6259		Transparent film, sterile, more than 48 sq. in., each dressing	No	
	A6260		Wound cleaners, sterile, any type, any size (per ounce)	No	
	A6261		Wound filler, gel/paste, sterile, per fluid ounce, not elsewhere classified	Yes	
	A6262		Wound filler, dry form, sterile, per gram, not elsewhere classified	Yes	
	A6266		Gauze, impregnated, other than water, normal saline, or zinc paste, sterile, any width, per linear yard	No	
	A6402		Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	No	
	A6403		Gauze, non-impregnated, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing	No	
	A6404		Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing	No	

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/ Comments
	A6407		Packing strips, non-impregnated, sterile, up to two inches in width, per linear yard	No	
NC	A6413		Adhesive bandage, first-aid type, any size, each		
	A6441		Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per yard	No	
	A6442		Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard	No	
	A6443		Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard	No	
	A6444		Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to five inches, per yard	No	
	A6445		Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard	No	
	A6446		Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard	No	
	A6447		Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard	No	
	A6448		Light compression bandage, elastic, knitted/woven, width less than three inches, per yard	No	
	A6449		Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard	No	

Legend

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/ Comments
	A6450		Light compression bandage, elastic, knitted/woven, width greater than or equal to five inches, per yard	No	
	A6451		Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50 percent maximum stretch, width greater than or equal to three inches and less than five inches, per yard	No	
	A6452		High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50 percent maximum stretch, width greater than or equal to three inches and less than five inches, per yard	No	
	A6453		Self-adherent bandage, elastic, non-knitted/non-woven,width less than three inches, per yard	No	
	A6454		Self-adherent bandage, elastic, non-knitted/non-woven,width greater than or equal to three inches and less than five inches, per yard	No	
	A6455		Self-adherent bandage, elastic, non-knitted/non-woven,width greater than or equal to five inches, per yard	No	
	A6456		Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard	No	
	A6457		Tubular dressing with or without elastic, any width, per linear yard	No	
	A6501		Compression burn garment, bodysuit (head to foot), custom fabricated	Yes	
	A6502		Compression burn garment, chin strap, custom fabricated	Yes	
	A6503		Compression burn garment, facial hood, custom fabricated	Yes	

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/ Comments
	A6504		Compression burn garment, glove to wrist, custom fabricated	Yes	
	A6505		Compression burn garment, glove to elbow, custom fabricated	Yes	
	A6506		Compression burn garment, glove to axilla, custom fabricated	Yes	
	A6507		Compression burn garment, foot to knee length, custom fabricated	Yes	
	A6508		Compression burn garment, foot to thigh length, custom fabricated	Yes	
	A6509		Compression burn garment, upper trunk to waist including arm openings (vest), custom fabricated	Yes	
	A6510		Compression burn garment, trunk, including arms down to leg openings (leotard), custom fabricated	Yes	
	A6511		Compression burn garment, lower trunk including leg openings (panty), custom fabricated	Yes	
	A6512		Compression burn garment, not otherwise classified	Yes	
	A6513		Compression burn mask, face and/or neck, plastic or equal, custom fabricated	Yes	
	S8431		Compression bandage, roll	No	
	T5999		Supply, not otherwise specified (dressing other)	Yes	

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Tapes

(Unless needed for the first 6 weeks of post-surgery, all bandages, dressings, and tapes are included in the nursing facility daily rate.)

Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/ Comments
	A4450		Tape, non-waterproof, per 18 square inches	No	
	A4452		Tape, waterproof, per 18 square inches	No	
	A4461		Surgical dressing holder, non-reusable, each	No	
	A4463		Surgical dressing holder, reusable, each	No	
	A4465		Nonelastic binder for extremity	No	
	A4466		Garment, belt, sleeve or other covering, elastic or similar stretchable	Yes	

Ostomy supplies

(Note: Items in this category are not taxable)

Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4361		Ostomy faceplate, each	No	Max of 10 allowed per client per month. Not allowed in combination with codes A4375, A4376, A4379, or A4380
	A4362		Skin barrier, solid, four by four or equivalent, each	No	For ostomy only
	A4363		Ostomy clamp, any type, replacement only, each	No	

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4364		Adhesive; liquid, or equal, any type, per oz	No	Max of 4 allowed per client per month. For ostomy or catheter
	A4366		Ostomy vent, any type, each	No	
	A4367		Ostomy belt, each	No	Max of two (2) allowed per client every six months.
	A4368		Ostomy filter, any type, each	No	Not allowed in combination with code A4418, A4419, A4423, A4424, A4425 or A4427
	A4369		Ostomy skin barrier, liquid (spray, brush, etc.), per oz	No	
	A4371		Ostomy skin barrier, powder, per oz	No	
	A4372		Ostomy skin barrier, solid 4 x 4 or equivalent, standard wear with built-in convexity, each	No	
	A4373		Ostomy skin barrier, with flange (solid, flexible, or accordion), with built-in convexity, any size, each	No	
	A4375		Ostomy pouch, drainable, with faceplate attached, plastic, each	No	Max of 10 allowed per client per month. Not allowed in combination with code A4361, A4377, or A4378

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4376		Ostomy pouch, drainable, with faceplate attached, rubber, each	No	Max of 10 allowed per client per month. Not allowed in combination with code A4361, A4377, or A4378
	A4377		Ostomy pouch, drainable, for use on faceplate, plastic, each	No	Max of 10 allowed per client per month. Not allowed in combination with code A4375, A4376, or A4378
	A4378		Ostomy pouch, drainable, for use on faceplate, rubber, each	No	Max of 10 allowed per client per month. Not allowed in combination with code A4375, A4376, or A4377
	A4379		Ostomy pouch, urinary, with faceplate attached, plastic, each	No	Max of 10 allowed per client per month. Not allowed in combination with code A4361, A4381, A4382, or A4383
	A4380		Ostomy pouch, urinary, with faceplate attached, rubber, each	No	Max of 10 allowed per client per month. Not allowed in combination with code A4361, A4381, A4382, or A4383
	A4381		Ostomy pouch, urinary, for use on faceplate, plastic, each	No	Max of 10 allowed per client per month. Not allowed in combination with code A4379, A4380, A4382, or A4383
	A4382		Ostomy pouch, urinary, for use on faceplate, heavy plastic, each	No	Max of 10 allowed per client per month. Not allowed in combination with code A4379, A4380, A4381, or A4383

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	A4383		Ostomy pouch, urinary, for use on faceplate, rubber, each	No	Max of 10 allowed per client per month. Not allowed in combination with code A4379, A4380, A4381, or A4382
	A4384		Ostomy faceplate equivalent, silicone ring, each	No	
	A4385		Ostomy skin barrier, solid 4x4 or equivalent, extended wear, without built-in convexity, each	No	
	A4387		Ostomy pouch, closed, with barrier attached, with built-in convexity (1 piece), each	No	Max of 30 allowed per client per month
	A4388		Ostomy pouch, drainable, with extended wear barrier attached, (1 piece), each	No	Max of 10 allowed per client per month
	A4389		Ostomy pouch, drainable, with barrier attached, with built-in convexity (1 piece), each	No	Max of 10 allowed per client per month
	A4390		Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each	No	Max of 10 allowed per client per month
	A4391		Ostomy pouch, urinary, with extended wear barrier attached, (1 piece), each	No	Max of 10 allowed per client per month
	A4392		Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each	No	Max of 10 allowed per client per month
	A4393		Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each	No	Max of 10 allowed per client per month

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4394		Ostomy deodorant for use in ostomy pouch, liquid, per fluid ounce	No	
	A4395		Ostomy deodorant for use in ostomy pouch, solid, per tablet	No	
	A4396		Ostomy belt with peristomal hernia support		
	A4397		Irrigation supply; sleeve, each	No	Max of one (1) allowed per client per month
	A4398		Ostomy irrigation supply; bag, each	No	Max of two (2) allowed per client every 6 months
	A4399		Ostomy irrigation supply; cone/catheter, including brush	No	Max of two (2) allowed per client every 6 months
	A4400		Ostomy irrigation set	No	Max of two (2) allowed per client every 6 months
	A4404		Ostomy ring, each	No	Max of 10 allowed per client per month
	A4405		Ostomy skin barrier, non-pectin based, paste, per ounce	No	
	A4406		Ostomy skin barrier, pectin based, paste, per ounce	No	
	A4407		Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity,4 x 4 inches or smaller, each	No	
	A4408		Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each	No	

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4409		Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4x4 inches or smaller, each	No	
	A4410		Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each	No	
	A4411		Ostomy skin barrier, solid 4x4 or equivalent, extended wear, with built-in convexity, each	No	
	A4412		Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), with filter, each	No	Max of 10 allowed per client every 30 days
	A4413		Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), with filter, each	No	Max of 10 allowed per client per month
	A4414		Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4x4 inches or smaller, each	No	
	A4415		Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4 x 4 inches, each	No	
	A4416		Ostomy pouch, closed, with barrier attached, with filter (one piece), each	No	Max of 30 allowed per client per month. Not allowed in combination with A4368
	A4417		Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (one piece), each	No	Max of 30 allowed per client per month. Not allowed in combination with A4368

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4418		Ostomy pouch, closed; without barrier attached, with filter (one piece), each	No	Max of 30 allowed per client per month. Not allowed in combination with A4368
	A4419		Ostomy pouch, closed; for use on barrier with non-locking flange, with filter (two piece), each	No	Max of 30 allowed per client per month. Not allowed in combination with A4368
NC	A4420		Ostomy pouch, closed; for use on barrier with locking flange (two piece), each		
	A4421		Ostomy supply; misc	Yes	
	A4422		Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each	No	
	A4423		Ostomy pouch, closed; for use on barrier with locking flange, with filter (two piece), each	No	Max of 30 allowed per client per month. Not allowed in combination with A4368
	A4424		Ostomy pouch, drainable, with barrier attached, with filter (one piece), each	No	Max of 10 allowed per client per month. Not allowed in combination with A4368
	A4425		Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (two piece system), each	No	Max of 10 allowed per client per month. Not allowed in combination with A4368
	A4426		Ostomy pouch, drainable; for use on barrier with locking flange (two piece system), each	No	Max of 10 allowed per client per month

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4427		Ostomy pouch, drainable; for use on barrier with locking flange, with filter (two piece system), each	No	Max of 10 allowed per client per month. Not allowed in combination with A4368
	A4428		Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (one piece), each	No	Max of 10 allowed per client per month
	A4429		Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (one piece), each	No	Max of 10 allowed per client per month
	A4430		Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (one piece), each	No	Max of 10 allowed per client per month
	A4431		Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (one piece), each	No	Max of 10 allowed per client per month
	A4432		Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet-type tap with valve (two piece), each	No	Max of 10 allowed per client per month
	A4433		Ostomy pouch, urinary; for use on barrier with locking flange (two piece), each	No	Max of 10 allowed per client per month
	A4434		Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type tap with valve (two piece), each	No	Max of 10 allowed per client per month
	A4435		Ostomy pouch, drainable, high output, with extended wear barrior (one piece system), with or without filter each	No	Maximum of 10 allowed per client per month

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4455		Adhesive remover or solvent (for tape, cement, or other adhesive), per oz	No	Max of 3 allowed per client per month
	A5051		Ostomy pouch, closed; with barrier attached (one piece) each	No	Max of 60 allowed per client per month
	A5052		Ostomy pouch, closed; without barrier attached (one piece) each	No	Max of 60 allowed per client per month
	A5053		Ostomy pouch, closed; for use on faceplate each	No	Max of 60 allowed per client per month
	A5054		Ostomy pouch, closed; for use on barrier with flange (two piece) each	No	Max of 60 allowed per client per month
	A5055		Stoma cap	No	Max of 30 allowed per client per month
	A5061		Ostomy pouch, drainable; with barrier attached (one piece) each	No	Max of 20 allowed per client per month
	A5062		Ostomy pouch, drainable; without barrier attached (one piece) each	No	Max of 20 allowed per client per month
	A5063		Ostomy pouch, drainable; for use on barrier with flange (two piece system) each	No	Max of 20 allowed per client per month
	A5071		Ostomy pouch, urinary, with barrier attached (one piece) each	No	Max of 20 allowed per client per month
	A5072		Ostomy pouch, urinary, without barrier attached (one piece) each	No	Max of 20 allowed per client per month
	A5073		Ostomy pouch, urinary, for use on barrier with flange (two piece) each	No	Max of 20 allowed per client per month
	A5081		Stoma plug or seal, any type	No	Max of 30 allowed per client per month
	A5082		Continent device; catheter for continent stoma	No	Max of one (1) allowed per client per month
DC	A5083		Continent device, stoma absorptive cover for continent stoma.		**See code A6219.**

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A5093		Ostomy accessory, convex insert	No	Max of 10 allowed per client per month
	A5120		Skin barrier, wipes or swabs, each	No	Ostomy only
	A5121		Skin barrier, solid, 6 x 6 or equivalent, each	No	For ostomy only
	A5122		Skin barrier, solid, 8 x 8 or equivalent, each	No	For ostomy only
	A5126		Adhesive or non-adhesive; disk or foam pad. Maximum of 10 allowed per client per month	No	
NC	A5131		Appliance cleaner, incontinence and ostomy appliances, per 16 oz		

Urological supplies

Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4310		Insertion tray without drainage bag and without catheter (accessories only)	Yes	Max of 120 per client, per month. Not allowed in combination with A4311, A4312, A4313, A4314, A4315, A4316, A4353, or A4354 Included in nursing facility daily rate.
	A4311		Insertion tray without drainage bag with indwelling catheter, Foley type, two-way latex, with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.)	No	Max of 3 allowed per client per month. Not allowed in combination with code A4310, A4314, or A4338 Included in nursing facility daily rate.

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4312		Insertion tray without drainage bag, with indwelling catheter, Foley type, two-way all silicone	No	Maximum of 3 allowed per client per month. Not allowed in combination with code A4310, A4315, or A4344 Included in nursing facility daily rate.
	A4313		Insertion tray without drainage bag with indwelling catheter, Foley type, three-way for continuous irrigation	No	Maximum of 3 allowed per client per month. Not allowed in combination with code A4310, A4316, or A4346 Included in nursing facility daily rate.
	A4314		Insertion tray with drainage bag, with indwelling catheter, Foley type, two-way latex, with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.)	No	Max of 3 allowed per client per month. Not allowed in combination with code A4310, A4311, A4338, A4354 or A4357 Included in nursing facility daily rate.
	A4315		Insertion tray with drainage bag, with indwelling catheter, Foley type, two-way all silicone	No	Max of 3 allowed per client per month. Not allowed in combination with code A4310, A4312, A4344, A4354 or A4357 Included in nursing facility daily rate.
	A4316		Insertion tray with drainage bag with indwelling catheter, Foley type, three-way for continuous irrigation	No	Max of 3 allowed per client per month. Not allowed in combination with code A4310, A4313, A4346, A4354 or A4357 Included in nursing facility daily rate.

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4320		Irrigation tray with bulb or piston syringe, any purpose	No	Max of 30 allowed per client per month. Not allowed in combination with code A4322, A4355 Included in nursing facility daily rate.
NC	A4321		Therapeutic agent for urinary catheter irrigation		
	A4326		Male external catheter specialty type with integral collection chamber, each	No	Max of 60 allowed per client per month. Included in nursing facility daily rate
	A4327		Female external urinary collection device; metal cup, each	No	Included in nursing facility daily rate
	A4328		Female external urinary collection device; pouch, each	No	Included in nursing facility daily rate
	A4330		Perianal fecal collection pouch with adhesive, each	No	Included in nursing facility daily rate
	A4331		Extension drainage tubing, any type, any length, with connector/adapter, for use with urinary leg bag or urostomy pouch, each	No	Included in nursing facility daily rate
	A4332		Lubricant, individual sterile packet, for insertion of urinary catheter, each	No	Included in nursing facility daily rate
	A4333		Urinary catheter anchoring device, adhesive skin attachment, each	No	Included in nursing facility daily rate
	A4334		Urinary catheter anchoring device, leg strap, each	No	Included in nursing facility daily rate
	A4335		Incontinence supply; miscellaneous. (diaper doublers, each)	Yes. See EPA	Included in nursing facility daily rate. (age 3 and up)

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4336		Incontinence supply; urethral insert, any type, each	Yes	
NC	A4337		Incontinent rectal insert		
	A4338		Indwelling catheter; Foley type, two-way latex, with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each	No	Max of 3 allowed per client per month. Included in nursing facility daily rate. Not allowed in combination with code A4311 or A4314
	A4340		Indwelling catheter; specialty type (e.g., coude, mushroom, wing, etc.), each	No	Max of 3 allowed per client per month. Included in nursing facility daily rate
	A4344		Indwelling catheter, Foley type, two-way, all silicone, each	No	Max of 3 allowed per client, per month. Included in nursing facility daily rate. Not allowed in combination with code A4312 or A4315
	A4346		Indwelling catheter, Foley type, three-way for continuous irrigation, each	No	Max of 3 allowed per client, per month. Included in nursing facility daily rate. Not allowed in combination with code A4313 or A4316
	A4349		Male external catheter, with or without adhesive, disposable, each	No	Max allowable of 60 per client, per month. Included in nursing facility daily rate
	A4351		Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each	No	Max of 120 allowed per client per month. Not allowed in combination with code A4352 or A4353

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4352		Intermittent urinary catheter; coude (curved) tip with or without coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.), each	No	Max of 120 allowed per client per month. Not allowed in combination with code A4351 or A4353
	A4353		Intermittent urinary catheter, with insertion supplies	Yes	Not allowed in combination with A4310, A4351, A4352, or A4354. Includes sterile **no touch** catheter systems Included in nursing facility daily rate.
	A4354		Insertion tray with drainage bag but without catheter	Yes	Not allowed in combination with A4310, A4314, A4315, A4316, A4353, A4357-A4358, and A5112 Included in nursing facility daily rate.
	A4355		Irrigation tubing set for continuous bladder irrigation through a three-way indwelling Foley catheter, each	No	Max of 30 allowed per client per month. Not allowed in combination with A4320, A4322 Included in nursing facility daily rate.
	A4356		External urethral clamp or compression device (not to be used for catheter clamp), each	No	Max of two (2) allowed per client per year. Included in nursing facility daily rate
	A4357		Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each.	No	Max of two (2) allowed per client per month. Not allowed in combination with code A4314-A4316 or A4354 Included in nursing facility daily rate.

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A4358		Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each.	No	Max of two (2) allowed per client per month. Not allowed in combination with code A5113, A5114, A4354, or A5105 Included in nursing facility daily rate.
	A4360		Disposable external urethral clamp or compression device	No	Max of two (2) allowed per client per year
	A4402		Lubricant, per oz.	No	Included in nursing facility daily rate. (For insertion of urinary catheters.)
	A4456		Adhesive remover, wipes, any type, each	No	Max of 50 wipes allowed per client, per month
	A4520		Incontinence garment, any type, (e.g. brief, diaper), each.	Yes	Included in nursing facility daily rate
	A5056		1 piece ostomy pouch with filter	No	
	A5057		1 piece ostomy pouch with built-in Convex	No	
	A5102		Bedside drainage bottle, with or without tubing, rigid or expandable, each	No	Max of two (2) allowed per client per 6 months. Included in nursing facility daily rate
	A5105		Urinary suspensory; with leg bag, with or without tube	No	Max of two (2) allowed per client per month. Included in nursing facility daily rate. Not allowed in combination with code A4358, A5112, A5113 or A5114

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	A5112		Urinary leg bag; latex	No	Max of one (1) allowed per client per month. Included in nursing facility daily rate. Not allowed in combination with code A4354, A5105, A5113 or A5114
	A5113	RA	Leg strap; latex, replacement only, per set	No	Included in nursing facility daily rate. Not allowed in combination with code A4358, A5105, or A5112
	A5114	RA	Leg strap; foam or fabric, replacement only, per set	No	Included in nursing facility daily rate. Not allowed in combination with code A4358, A5105, or A5112
	T4521		Adult-sized disposable incontinence product, brief/diaper, small, each	Medical exceptions to max quantity or age limitation require PA	For clients age 20 and older. Recommended for waist sizes 24”–32” *Max of 200 diapers purchased per client per month. Included in nursing facility daily rate.

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	T4522		Adult-sized disposable incontinence product, brief/diaper, medium, each	Medical exceptions to max quantity or age limitation require PA	For clients age 20 and older. Recommended for waist sizes 32" – 44" *Max of 200 diapers purchased per client, per month. Included in nursing facility daily rate.
	T4523		Adult-sized disposable incontinence product, brief/diaper, large, each	Medical exceptions to max quantity or age limitation require PA	For clients age 20 and older. Recommend for waist sizes 45" – 58" *Max of 200 diapers purchased per client, per month. Included in nursing facility daily rate.
	T4524		Adult-sized disposable incontinence product, brief/diaper, extra-large, each	Medical exceptions to max quantity or age limit require PA	For clients age 20 years and older. Recommend for waist sizes 56" – 64" *Max of 200 diapers purchased per client, per month. Included in nursing facility daily rate.

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	T4525		Adult-sized disposable incontinence product, protective underwear/pull-on, small size, each	No	For clients age 6 and older. Recommended for waist sizes 24”-32”. Max of 200 allowed for clients age 6 through 19, per month; max of 150 allowed for clients age 20 and older, per month. ***Use modifier 59** to designate daytime use only. Included in nursing facility daily rate.
	T4526		Adult-sized disposable incontinence product, protective underwear/pull-on, medium size, each	No	For clients age 6 and older. Recommended for waist sizes 32” – 44” Max of 200 allowed for clients age 6-19, per month; max of 150 allowed for clients age 20 and older, per month ***Use modifier 59** to designate daytime use only. Included in nursing facility daily rate.

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	T4527		Adult-sized disposable incontinence product, protective underwear/pull-on, large size, each	No	For clients age 6 and older. Recommended for waist sizes 45" – 58" Max of 200 allowed for clients age 6-19, per month; max of 150 pieces allowed for clients age 20, per month. ***Use modifier 59 is used** to designate daytime only usage. Included in nursing facility daily rate.
	T4528		Adult-sized disposable incontinence product, protective underwear/ pull-on, extra-large size, each	No	For clients age 6 and older. Recommended for waist sizes 56" – 64" Max of 200 allowed for clients age 6-19, per month; max of 150 allowed for clients age 20 and older, per month. ***Use modifier 59** to designate daytime only usage. Included in nursing facility daily rate.

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	T4529		Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each	Medical exceptions to max quantity or age limit require PA	For clients age 3-20. Recommended for waist sizes 13" – 19" *Max of 200 diapers purchased per client, per month Included in nursing facility daily rate
	T4530		Pediatric sized disposable incontinence product, brief/diaper, large size, each	Medical exceptions to max quantity or age limit require PA	For clients age 3-20 *Max of 200 diapers purchased per client, per month. Included in nursing facility daily rate.
	T4531		Pediatric sized disposable incontinence product, protective underwear/pull-on, small/medium size, each	Medical exceptions to max quantity or age limit require PA.	For clients age 3-20 Max of 200 diapers purchased per client, per month. ***Use modifier 59** to designate daytime only usage Included in nursing facility daily rate
	T4532		Pediatric sized disposable incontinence product, protective underwear/pull-on, large size, each	No	For clients age 3-20 Max of 200 diapers purchased per client, per month. ***Use modifier 59** to designate daytime only usage Included in nursing facility daily rate

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	T4533		Youth sized disposable incontinence product, brief/diaper, each	No	For clients age 6-20. Recommended for waist sizes 18" – 26" *Max of 200 diapers purchased per client, per month Included in nursing facility daily rate
	T4534		Youth sized disposable incontinence product, protective underwear/pull-on, each	Medical exceptions to max quantity or age limit require PA	For clients age 6-20. Recommended for waist sizes 17" – 26" Max of 200 allowed per client, per month ***Use modifier 59** to designate daytime only usage Included in nursing facility daily rate.
	T4535		Disposable liner/shield/guard/pad/under garment, for incontinence, each	Medical exceptions to max quantity require PA Not to be used inside any other product	For clients age 3 and older. Max of 200 pieces allowed per client, per month ***Use modifier 59** to designate daytime only usage. Included in nursing facility daily rate.

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	T4536	NU	Incontinence product, protective underwear/pull-on, reusable, any size, each	No	For clients age 3 and older. *Max of 4 per client, per year Included in nursing facility daily rate.
	T4536	RR	Incontinence product, protective underwear/pull-on, reusable, any size, each	No	For clients age 3 and older. Max of 150 allowed per client, per month. Included in nursing facility daily rate.
	T4537	NU	Incontinence product, protective underpad, reusable, bed size, each	No	Limit 42 per year. Not allowed in combination with code T4541, T4542, or T4537 (RR).
	T4537	RR	Incontinence product, protective underpad, reusable, bed size, each	No	Limit 90 per month. Not allowed in combination with code T4541, T4542, or T4537 (NU). Included in nursing facility daily rate.
	T4538	RR	Diaper service, reusable diaper, each diaper	Medical exceptions to max quantity or age limit require PA.	For clients age 3 and older. *Max of 200 diapers allowed per client, per month. Included in nursing facility daily rate.

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	T4539	NU	Incontinence product, diaper/brief, reusable, any size, each	Medical exceptions to max quantity or age limit require PA.	For clients age 3 and older. Max of 36 diapers allowed per client, per month. Included in nursing facility daily rate.
NC	T4540		Incontinence product, protective underpad, reusable, chair size, each		
	T4541		Incontinence product, disposable underpad, large, each	No	For use on the client's bed only. Requires a minimum underpad size of 810 square inches. Max of 180 pieces allowed per client, per month. Not allowed in combination with code T4537 (NU) or T4537 (RR). Included in nursing facility daily rate.
	T4543		Adult-sized disposable incontinence product, protective brief/diaper, above extra large, each	No	For clients age 20 and older. (Recommended for waist sizes 65” – 84”) *Max of 200 pieces purchased per client, per month. Included in nursing facility daily rate.

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/Comments
	T4544		Adult-sized disposable incontinence product, protective underwear/ pull-on above extra-large, each	No	For clients age six and older. (Recommended for waist sizes 65" and over). Max of 200 allowed for clients age 6 to 19, per month; max of 150 allowed per clients age 20 and older, per month. ***Use modifier 59** to designate daytime use only. Included in nursing facility daily rate.

Braces, belts, and supportive devices

Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/ Comments
NC	A4490		Surgical stocking above knee length, each		
NC	A4495		Surgical stocking thigh length, each		
NC	A4500		Surgical stocking below knee length, each		
NC	T4542		Incontinence product, disposable underpad, small size, each		
NC	A4510		Surgical stocking full length, each, (pantyhose style)		
	A4565		Slings	No	Max of two allowed per client per year. Included in nursing facility daily rate.

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/ Comments
	A4570		Splint	No	Max of one allowed per client per year. Included in nursing facility daily rate.
NC	A4600		Sleeve for intermittent limb compression device, replacement only, each		
NC	A6530		Gradient compression stocking, below knee, 18-30 MMHG, each		
NC	A6531		Gradient compression stocking, below knee, 30-40 MMHG, each		
NC	A6532		Gradient compression stocking, below knee, 40-50 MMHG, each		
NC	A6533		Gradient compression stocking, thigh length, 18-30 MMHG, each		
NC	A6534		Gradient compression stocking, thigh length, 30-40 MMHG, each		
NC	A6535		Gradient compression stocking, thigh length, 40-50 MMHG, each		
NC	A6536		Gradient compression stocking, full length/chap style, 18-30 MMHG, each		
NC	A6537		Gradient compression stocking, full length/chap style, 30-40 MMHG, each		
NC	A6538		Gradient compression stocking, full length/chap style, 40-50 MMHG, each		
NC	A6539		Gradient compression stocking, waist length (pantyhose style), 18-30 MMHG, each		

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/ Comments
NC	A6540		Gradient compression stocking, waist length, 30-40 MMHG, each. (pantyhose style)		
NC	A6541		Gradient compression stocking, waist length, 40-50 MMHG, each. (pantyhose style)		
NC	A6544		Gradient compression stocking, garter belt		
NC	A6545		Gradient compression wrap, non-elastic, below knee, 30-50 mmhg, each		
NC	A6549		Gradient compression stocking, not otherwise specified		
NC	A9283		Foot pressure off loading/supportive device, any type, each		
	E0942		Cervical head harness/halter	No	Max of one allowed per client, per year. Included in nursing facility daily rate.
	E0944		Pelvic belt/harness/boot	No	Max of one allowed per client per year. Not allowed for use during pregnancy. Included in nursing facility daily rate.
	E0945		Extremity belt/harness	No	Max of one allowed per client, per year. Not allowed for use during pregnancy. Included in nursing facility daily rate.

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Decubitus care products

Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/ Comments
	E0188		Synthetic sheepskin pad	No	Max of one allowed per client, per year. Included in nursing facility daily rate.
	E0189		Lambswool sheepskin pad	No	Max of one allowed per client, per year. Included in nursing facility daily rate.
	E0191		Heel or elbow protector, each	No	Max of four allowed per client, per year. Included in nursing facility daily rate.

Miscellaneous supplies

Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/ Comments
NC	A4250		Urine test or reagent strips or tablets (100 tablets or strips)		
NC	A4265		Paraffin, per pound		
NC	A4281		Tubing for breast pump, replacement		
NC	A4282		Adapter for breast pump, replacement		
NC	A4283		Cap for breast pump bottle, replacement		
NC	A4284		Breast shield and splash protector for use with breast pump, replacement		
NC	A4285		Polycarbonate bottle for use with breast pump, replacement		

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/ Comments
NC	A4286		Locking ring for breast pump, replacement		
NC	A4290		Sacral nerve stimulation test lead, each		
NC	A4458		Enema bag with tubing, reusable		
NC	A4459		Manual pump-operated enema system, includes balloon, catheter and all accessories, reusable, any type		
NC	A4559		Coupling gel/paste, for use with ultrasound device, per ounce		
DP	A4561		Pessary, rubber, any type		See Physician-Related Services/ Healthcare Professional Services Billing Guide
DP	A4562		Pessary, non rubber, any type		See Physician-Related Services/ Healthcare Professional Services Billing Guide
NC	A4633		Replacement bulb/lamp for ultraviolet light therapy system, each		
NC	A4634		Replacement bulb for therapeutic light box, tabletop model		
NC	A4639		Replacement pad for infrared heating pad system, each		
	A4927		Gloves, nonsterile, per box of 100	Quantities exceeding 2 units per month require PA.	One unit = box of 100. Included in nursing facility daily rate and in home health care rate.

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Code Status Indicator	HCPCS Code	Modifier	Short Description	PA?	Policy/ Comments
NC	A4928		Surgical mask, per 20		
	A4930		Gloves, sterile, per pair	Limit 30 per month	Included in nursing facility daily rate and in home health care rate
NC	A4931		Oral thermometer, reusable, any type, each		
NC	A4932		Rectal thermometer, reusable, any type, each		
NC	A6000		Non-contact wound warming wound cover for use with the non-contact wound warming device and warming card		
	A6410		Eye pad, sterile, each	No	Max of 20 allowed per client, per month. Included in nursing facility daily rate.
	A6411		Eye pad, non-sterile, each	No	Max of one allowed per client, per month. Included in nursing facility daily rate.
NC	A6412		Eye patch, occlusive, each		
NC	A9180		Pediculosis (lice infestation) treatment, topical, for administration by patient/caretaker		
	T5999		Supply, not otherwise specified. (DME Miscellaneous. Other medical supplies not listed.)	Yes	
	S8265		Haberman feeder for cleft lip/palate	No	

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Clients Residing in a Skilled Nursing Facility

(WAC 182-543-5700)

What does the per diem rate include for a skilled nursing facility?

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 in this billing guide.

The agency pays for the following covered nondurable medical supplies and equipment (MSE) outside of the skilled nursing facility per diem rate, subject to the limitations in this guide.

Manual and power-drive wheelchairs

(WAC 182-543-5700(2))

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:

- 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, 13-835.
- Include a copy of the telephone order, signed by the physician, for the wheelchair assessment.
- Include a completed *Medical Necessity for Wheelchair Purchase for Nursing Facility Clients* form, 13-729.

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

- A completed *Prescription* form, 13-794.
- A completed *Medical Necessity for Wheelchair Purchase for Nursing Facility Clients* form, 13-729. The date on form 13-729 must not be prior to the date on the *Prescription* form, 13-794. (See Reimbursement 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 the following to the agency:

- A completed Medical Necessity for *Wheelchair Purchase For Nursing Facility (NF) Clients* form, 13-729.
- 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 MSE and labor charges under fee-for-service (FFS).

Speech generating devices (SGD)

(WAC 182-543-5700(2))

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).

Specialty beds

(WAC 182-543-5700(2))

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:

- 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 Reimbursement section for more information.)

What does the agency pay for outside the per diem rate?

(WAC 182-543-5700(13))

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

Noncovered

What is not covered?

(WAC 182-543-6000)

The agency pays only for nondurable medical supplies and equipment (MSE) and related services listed as covered in this billing guide. The agency evaluates a request for any MSE and related services listed as noncovered within this billing guide and in WAC 182-501-0070, under the provisions of WAC 182-501-0160.

The agency does not cover:

- A client's utility bills, even if the operation or maintenance of medical equipment purchased or rented by the agency for the client contributes to an increased utility bill.
- Instructional materials such as pamphlets and video tapes.
- Hairpieces or wigs.
- Material or services covered under manufacturer's warranties.
- Supplies and equipment used during a physician office visit, such as tongue depressors and surgical gloves.
- Non-medical equipment, supplies, and related services, including but not limited to, the following:
    - ✓ Cleaning brushes and supplies, except for ostomy-related cleaners/supplies
    - ✓ Diathermy machines used to produce heat by high frequency current, ultrasonic waves, or microwave radiation

- ✓ Electronic communication equipment, installation services, or service rates including, but not limited to, the following:
  - ➢ Devices intended for amplifying voices (e.g., microphones).
  - ➢ Interactive communications computer programs used between patients and health care providers (e.g., hospitals, physicians), for self-care home monitoring, or emergency response systems and services (refer to the Aging and Long-Term Services COPES program or the agency's outpatient hospital program for emergency response systems and services)
  - ➢ Two-way radios
  - ➢ Rental of related equipment or services
  - ➢ Devices requested for the purpose of education
- ✓ Environmental control devices, such as air conditioners, air cleaners/purifiers, dehumidifiers, portable room heaters or fans (including ceiling fans), heating or cooling pads, and light boxes
- ✓ Ergonomic equipment
- ✓ Exercise classes or equipment such as bicycles, exercise mats, exercise balls, tricycles, stair steppers, weights, or trampolines
- ✓ Generators
- ✓ Computer software other than speech generating, printers, and computer accessories (such as anti-glare shields, backup memory cards, etc.)
- ✓ Computer utility bills, telephone bills, Internet service, or technical support for computers or electronic notebooks
- ✓ Any communication device that is useful to someone without severe speech impairment (e.g., cellular telephone, electronic notebook, two way radio, pager, walkie-talkie, or electronic notebook)
- ✓ Racing stroller/wheelchairs and purely recreational equipment
- ✓ Room fresheners/deodorizers
- ✓ Bidet or hygiene systems, paraffin bath units, and shampoo rings
- ✓ Timers or electronic devices to turn things on or off, which are not an integral part of the equipment
- ✓ Vacuum cleaners, carpet cleaners/deodorizers, and/or pesticides/insecticides

- ✓ Wheeled reclining chairs, lounge and/or lift chairs (e.g., geri-chair, posture guard, or lazy boy)

- Blood pressure monitoring:
  - ✓ Sphygmomanometer/blood pressure apparatus with cuff and stethoscope
  - ✓ Blood pressure cuff only
  - ✓ Automatic blood pressure monitor
- Transcutaneous electrical nerve stimulation (TENS) devices and supplies, including battery chargers
- Functional electrical stimulation (FES) bike
- Life vest
- Disinfectant spray
- Periwash
- Bathroom equipment used inside or outside of the physical space of a bathroom:
  - ✓ Bath stools
  - ✓ Bathtub wall rail (grab bars)
  - ✓ Bed pans
  - ✓ Bedside commode chairs
  - ✓ Control unit for electronic bowel irrigation/evacuation system
  - ✓ Disposable pack for use with electronic bowel system
  - ✓ Raised toilet seat
  - ✓ Safety equipment (including but not limited to belt, harness or vest)
  - ✓ Shower chairs
  - ✓ Shower/commode chairs
  - ✓ Sitz type bath or equipment
  - ✓ Standard and heavy duty bath chairs
  - ✓ Toilet rail
  - ✓ Transfer bench for tub or toilet
  - ✓ Urinal male/female

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

  - ✓ Antiperspirant
  - ✓ Astringent
  - ✓ Bath gel
  - ✓ Conditioner
  - ✓ Deodorant
  - ✓ Moisturizers
  - ✓ Mouthwash
  - ✓ Powder
  - ✓ Shampoo
  - ✓ Shaving cream
  - ✓ Shower cap
  - ✓ Shower curtains
  - ✓ Soap (including antibacterial soap)
  - ✓ Toothpaste
  - ✓ Towels
  - ✓ Weight scales

- Bedding items:

  - ✓ Blankets
  - ✓ Bumper pads
  - ✓ Mattress covers/bags
  - ✓ Mattress pads
  - ✓ Pillow cases/covers
  - ✓ Pillows
  - ✓ Sheets

- Bedside items as follows:

  - ✓ Bed trays
  - ✓ Carafes
  - ✓ Over-the-bed tables

- Clothing and accessories:
  - ✓ Coats
  - ✓ Custom vascular supports (CVS)
  - ✓ Gloves (including wheelchair gloves)
  - ✓ Gradient compression stockings (pantyhose style)
  - ✓ Gradient compression stockings
  - ✓ Hats
  - ✓ Lumbar supports for pregnancy
  - ✓ Scarves
  - ✓ Slippers
  - ✓ Socks
  - ✓ Surgical stockings
- Clothing protectors, surgical masks, and other protective cloth furniture covering
- Cosmetics, including corrective formulations, hair depilatories, and products for skin bleaching, commercial sun screens, and tanning
- Diverter valves for bathtub and hand held showers
- Eating/feeding utensils
- Emesis basins, enema bags, and diaper wipes
- Health club memberships
- Hot or cold temperature food and drink containers/holders
- Hot water bottles and cold/hot packs or pads not otherwise covered by specialized therapy programs
- Impotence devices
- Insect repellants
- Massage equipment
- Medication dispensers, such as med-collators and count-a-dose, except as obtained under the compliance packaging program. (see Chapter 182-530 WAC)
- Medicine cabinet and first aid items, such as adhesive bandages (e.g., Band-Aids, Curads), cotton balls, cotton-tipped swabs, medicine cups, thermometers, and tongue depressors
- Sharps containers

- Page turners
- Radios and televisions
- Telephones, telephone arms, cellular phones, electronic beepers, and other telephone messaging services
- Toothettes and toothbrushes, waterpics, and periodontal devices whether manual, battery-operated, or electric
- Certain wheelchair features and options are not considered by the agency to be medically necessary or essential for wheelchair use. This includes, but is not limited to:
  - ✓ Attendant controls (remote control devices)
  - ✓ Canopies, including those for stroller and other equipment
  - ✓ Clothing guards to protect clothing from dirt, mud, or water thrown up by the wheels (similar to mud flap for cars)
  - ✓ Identification devices (such as labels, license plates, name plates)
  - ✓ Lighting systems
  - ✓ Speed conversion kits
  - ✓ Tie-down restraints, except where medically necessary for client owned vehicles;
  - ✓ Warning devices, such as horns and backup signals
  - ✓ Hub lock brake
  - ✓ Decals
  - ✓ Replacement key or extra key
  - ✓ Trays for clients in a skilled nursing facility
- New durable medical equipment, supplies, or related technology that the agency has not evaluated for coverage (see WAC 182-543-2100)

Note: The agency evaluates a request for any equipment or devices that are listed as noncovered in this billing guide under the provisions of WAC 182-501-0165. (See WAC 182-543-0500(2)).

Authorization

(WAC 182-543-7000)

What is authorization?

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 nondurable medical equipment and supplies (MSE) and related services as required in:

- This billing guide.
- Any applicable numbered memoranda.
- Chapter 182-501 WAC, chapter 182-502 WAC, and chapter 182-543 WAC.
- When the clinical criteria required within this section are not met.

For PA, a provider must submit a written request to the agency as specified (see When does the agency require PA?).

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

For 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 When is EPA used?).

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

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 section 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).

When does the agency require prior authorization (PA)?

(WAC 182-543-7100)

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

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

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

What information does the agency require for PA?

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

- 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 nondurable medical supplies and equipment (MSE) that do not have assigned Healthcare Common Procedure Coding System (HCPCS) codes and are not listed in the agency's billing guides. These items require PA.

When making authorization requests, providers must furnish the agency with all of the following information 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 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 the following to the agency:

- Why the existing equipment no longer meets the client's medical needs.

-OR-

- Why the existing equipment could not be repaired or modified to meet those medical needs.

-AND-

- Upon request, documentation showing how the client's condition meets the criteria for PA or EPA.

When an item or service has been denied by the agency, a provider may re-submit a request for PA for the denied item or service. Upon re-submission for PA, the agency requires the provider to submit any additional documentation that further supports the client's need for the item or service that was previously denied.

Submitting photos and x-rays for medical and MSE requests

For submitting photos and x-rays for medical and MSE requests, use the FastLook™ and FastAttach™ services provided by Medical Electronic Attachment, Inc. (MEA).

You may register with MEA by:

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

Contact MEA at 1-888-329-9988, ext. 2, with any questions.

When this option is chosen, you can fax your request to the agency and indicate the MEA# in the MEA field (box 18) on the PA Request Form.

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 a limitation extension (LE)?

(WAC 182-543-7200)

The agency limits the amount, frequency, or duration of certain covered nondurable medical equipment and supplies (MSE), and pays up to the stated limit without requiring 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 MSE.

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

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

When is expedited prior authorization (EPA) used?

(WAC 182-543-7300)

EPA is designed to eliminate the need for written and telephonic requests for PA for selected nondurable medical supplies and equipment (MSE) procedure codes.

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

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

A written or telephone request for PA is required when a situation does not meet the EPA criteria for selected MSE procedure codes.

The agency may recoup any payment made to a provider under this section if the provider did not follow the required EPA process and criteria.

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

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

19. Line 1: 870000725/ Line 2: 870000726

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

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

- Other MSE requiring PA through the Durable Medical Equipment program.
- Products for which the documented medical condition does not meet ***all*** of the specified criteria.
- Over-limitation requests.

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

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

Washington State Expedited Prior Authorization Criteria Coding List

Miscellaneous Supplies

Note: The following pertains to expedited prior authorization (EPA) numbers 851 - 852:

1. If the medical condition does not meet **all** of the specified criteria, prior authorization must be obtained by submitting a request in writing to DME Program Management Unit or by calling the agency (see the Resources section within this billing guide).
2. It is the vendor's responsibility to determine whether the client has already used the product allowed with the EPA criteria within the previous 30 days.
3. For extension of authorization beyond the EPA amount allowed, the normal prior authorization process is required.
4. Must have a valid physician prescription as described in WAC 182-543-2000(2)(c)
5. Length of need/life expectancy, as determined by the prescribing physician, and medical justification (including **all** of the specified criteria) must be documented in the client's file.
6. You may bill for only one procedure code, per client, per month.

Procedure Code	Description	EPA Code	Criteria
A4335	Incontinence supply, use for diaper doublers, each (age 3 and up).	851	Purchase of 90 per month allowed when all of the following criteria are met: a) Product is used for extra absorbency at nighttime only b) When prescribed by a physician
		852	Up to equal amount of diapers/briefs received if **one** of the following criteria for clients is met: a) Tube fed b) On diuretics or other medication that causes frequent/large amounts of output c) Brittle diabetic with blood sugar problems
A4927	Additional gloves for clients who live in an assisted living facility	1262	Will be allowed up to the quantity necessary as directed by the client's physician, not to exceed a total of 400 per month. Allowed for Place of Service 13 (assisted living and adult family home) and 14 (group home).

Procedure Code	Description	EPA Code	Criteria
A4253 A4259	Blood glucose test strips and lancets for pregnant women with gestational diabetes	1263	Up to the quantity necessary to support testing as directed by their physician, up to 60 days post delivery
	300 test strips/lancets per month for children through age 20	1265	100 over limit - for children only
	300 test strips/lancets per month for children through age 20	0265	Pharmacy POS providers: Use EA number 85000000265

Billing and Claim Forms

What are the general billing requirements?

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

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

Billing for clients eligible for both Medicare and Medicaid

Medicare Part D

Clients covered by Part D Medicare may have coverage for diabetes supplies associated with the administration of insulin. These medical supplies include the following:

- Syringes
- Needles
- Alcohol swabs
- Gauze
- Inhaled insulin devices

If you are unable to bill Part D Medicare on behalf of a client, you will need to refer the client to a supplier that can.

For more information on how to bill for clients eligible for both Medicare and Medicaid, refer to the agency's ProviderOne Billing and Resource Guide.

Third-party liability (TPL)

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

Completing the CMS-1500 claim form

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

The following CMS-1500 claim form instructions relate to the nondurable medical supplies and equipment:

Field No.	Name	Entry
24B	Place of Service	These are the only appropriate code(s) for this billing guide: **Code** — **To Be Used For** 12 — Client's residence 13 — Assisted living facility 14 — Group Home 32 — Nursing facility 31 — Skilled nursing facility 99 — Other

Reimbursement

What is the general reimbursement for nondurable medical supplies and equipment (MSE) and related services?

(WAC 182-543-9400)

The agency sets, evaluates and updates the maximum allowable fees for medical supplies and nondurable medical equipment (MSE) and supplies at least once yearly using one or more of the following:

- The current Medicare rate, as established by the federal centers for Medicare and Medicaid services (CMS), if a Medicare rate is available
- A pricing cluster
- Based on input from stakeholders or other relevant sources that the agency determines to be reliable and appropriate
- On a by-report basis

Establishing reimbursement rates for medical supplies and MSE items based on pricing clusters.

- A pricing cluster is based on a specific Healthcare Common Procedure Coding System (HCPCS) code.
- The agency's pricing cluster is made up of all the brands for which the agency obtains pricing information. However, the agency may limit the number of brands included in the pricing cluster if doing so is in the best interests of its clients as determined by the agency. The agency considers all of the following when establishing the pricing cluster:
  - ✓ A client's medical needs
  - ✓ Product quality
  - ✓ Cost
  - ✓ Available alternatives
- When establishing the fee for medical supplies or other MSE items in a pricing cluster, the maximum allowable fee is the median amount of available manufacturers' list prices.

The agency evaluates a by-report (BR) item, procedure, or service for medical necessity, appropriateness and reimbursement value on a case-by-case basis. The agency calculates the reimbursement rate at 85% of the manufacturer's list price.

For clients residing in skilled nursing facilities, see WAC 182-543-5700.

What is the payment methodology for medical supplies and related services?

(WAC 182-543-9400)

The agency sets, evaluates and updates the maximum allowable fees for medical supplies and MSE items at least once per year using one or more of the following:

- The current Medicare rate, as established by the federal centers for Medicare and Medicaid services (CMS), if a Medicare rate is available
- A pricing cluster
- Based on input from stakeholders or other relevant sources that the agency determines to be reliable and appropriate
- On a by-report basis

Establishing payment rates for medical supplies and MSE items based on pricing clusters.

- A pricing cluster is based on a specific HCPCS code.
- The agency's pricing cluster is made up of all the brands for which the agency obtains pricing information. However, the agency may limit the number of brands included in the pricing cluster if doing so is in the best interests of its clients as determined by the agency. The agency considers all of the following when establishing the pricing cluster:
  - ✓ A client's medical needs
  - ✓ Product quality
  - ✓ Cost
  - ✓ Available alternatives
- When establishing the fee for medical supplies or other MSE items in a pricing cluster, the maximum allowable fee is the median amount of available manufacturers' list prices.

The agency evaluates a by-report (BR) item, procedure, or service for medical necessity, appropriateness and reimbursement value on a case-by-case basis. The agency calculates the reimbursement rate at 85% of the manufacturer's list price.
For clients residing in skilled nursing facilities. (See the Clients Residing in a Skilled Nursing Facility within this guide).

Where is the fee schedule for MSE?

See the Medical Supplies and Equipment Fee Schedule.