Washington State Health Care Authority

Washington Apple Health (Medicaid)

Home Infusion Therapy and Parenteral Nutrition Program Billing Guide

January 1, 2020

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

About this guide*

This publication takes effect January 1, 2020, and supersedes earlier guides to this program.

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

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

What has changed?

Subject	Change	Reason for Change
Behavioral Health Organization (BHO)	Removed this section	Effective January 1, 2020, behavioral health services in all regions will be provided under integrated managed care.
Integrated Managed Care Regions	Effective January 1, 2020, integrated managed care is being implemented in the last three regions of the state: • **Great Rivers** (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties) • **Salish** (Clallam, Jefferson, and Kitsap counties) • **Thurston-Mason** (Mason and Thurston counties)	Effective January 1, 2020, HCA completed the move to whole person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (IMC).

* This publication is a billing instruction.

Subject	Change	Reason for Change
Infusion therapy equipment and supplies	HCPCS Code A4223 – Under Policy/Comments column, an invoice is requested, but no longer required	Policy Change
Continuous Glucose Monitoring (CGM)	• HCPCS Codes A9276, A9277, and A9278 – Added quantity information under Policy/Comments column and added "Do Not Bill With" codes • HCPCS Codes K0553 and K0554 – Added supply information under Policy/Comments column and added "Do Not Bill With" codes • Added blue note box about billing provision limits	To clarify agency policy

How can I get agency provider documents?

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

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

Where can I download agency forms?

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

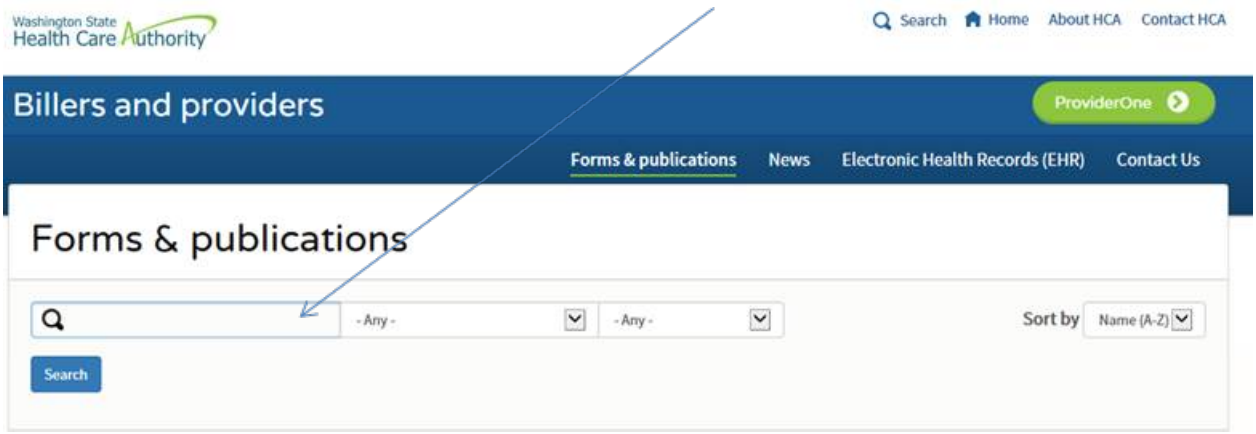

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Table of Contents

Alert! This Table of Contents is automated. Click on a page number to go directly to the page.

Resources Available

Topic	Resource Information
Becoming a provider or submitting a change of address or ownership	See the Billers and Providers webpage.
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic billing	
Finding agency documents (e.g., billing guides, fee schedules)	
Private insurance or third-party liability, other than agency managed care	
How do I obtain prior authorization or a limitation extension?	Providers may submit their requests online or by submitting the request in writing. See the agency's prior authorization webpage for details. Written requests for prior authorization or limitation extensions must include: • A completed, TYPED *General Information for Authorization Request* form, HCA 13-835. This request form MUST be the initial page when the request is submitted by fax. • A completed, *Fax/Written Request Basic Information* form, HCA 13-756, or the *Justification for Use of Miscellaneous Parenteral Supply Procedure Code (B9999)* form, HCA 13-721, and all the documentation listed on this form. Fax your request to: 866-668-1214. For information about downloading agency forms, see Where can I download agency forms?
The agency's maximum allowable fees	See the agency's Home Infusion Therapy and Parental Nutrition Program Fee Schedule

Definitions

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

Continuous glucose monitor – A device that continuously monitors and records interstitial fluid glucose levels and has three components: (1) a disposable subcutaneous sensor; (2) transmitter; and (3) monitor (or receiver). Some CGM systems are designed for short-term diagnostic or professional use. Other CGM systems are designed for long-term client use.

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

Hyperalimentation – See Parenteral Nutrition. (WAC 182-553-200)

Intradialytic Parenteral Nutrition (IDPN) – Intravenous nutrition administered during hemodialysis. IDPN is a form of parenteral nutrition. (WAC 182-553-200)

About this Program

What is the purpose of the Home Infusion Therapy and Parenteral Nutrition Program?

(WAC 182-553-100)

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

The agency's Home Infusion Therapy and Parenteral Nutrition program covers:

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

Who is eligible to provide home infusion supplies and equipment and parenteral nutrition solutions?

(WAC 182-553-400(1))

Eligible providers of home infusion supplies and equipment and parenteral nutrition solutions must:

- Have a signed Core Provider Agreement with the agency
- Be one of the following provider types:
  - ✓ Pharmacy provider
  - ✓ Durable medical equipment (DME) provider
  - ✓ Infusion therapy provider

What are the requirements for reimbursement?

(WAC 182-553-400(2))

The agency pays eligible providers for home infusion supplies and equipment and parenteral nutrition solutions only when the providers:

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

Where may services be provided and how are they reimbursed?

- **Federally-Qualified Health Centers (FQHCs), physicians, and physician clinics** may provide home infusion therapy and parenteral nutrition services in a physician's office or physician clinic, unless the client resides in a nursing facility. Bill using the appropriate procedure codes from the agency's Physician-Related Services/Health Care Professional Services Billing Guide.
- **Nursing facilities:** Some services and supplies necessary for the administration of infusion are included in the facility's per diem rate for each client. See the Coverage Table to identify procedure codes that are included in the nursing facility per diem rate. A client's infusion pump, parenteral nutrition pump, insulin pump, solutions, and insulin infusion supplies are not included in the nursing facility per diem rate and are paid separately (see WAC 182-553-500(6)).
- **Outpatient hospital providers** may provide infusion therapy and parenteral nutrition. Bill using the appropriate revenue codes in the agency's Outpatient Hospital Services Billing Guide.

- **Clients in a state-owned facility:** Home infusion therapy and parenteral nutrition for agency clients in state-owned facilities (state school, developmental disabilities (DD) facilities, mental health facilities, Western State Hospital, and Eastern State Hospital) are purchased by the facility through a contract with manufacturers. The agency does not pay separately for home infusion supplies and equipment or parenteral nutrition solutions for these clients (see WAC 182-553-500(5)).

- **Clients who have elected the agency's hospice benefit:** The agency pays for home infusion/parenteral nutrition separate from the hospice per diem rate only when both of the following apply:

  ✓ The client has a pre-existing diagnosis that requires parenteral support.

  ✓ That pre-existing diagnosis is unrelated to the diagnosis that qualifies the client for hospice.

Note: You must enter a "SCI=K" indicator in the *Claim Note* section of the electronic professional claim. (WAC 182-553-500(5)) This indicator means the claim is not associated with a terminal illness.

Client Eligibility

(WAC 182-553-300(1))

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

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

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

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

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

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

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

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

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

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

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

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

(WAC 182-553-300(2))

Yes. Most Medicaid-eligible clients are enrolled in one of the agency's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

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:

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

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Newborns of clients enrolled in managed care plans are the responsibility of the plan in which the mother is enrolled for the first 21 days of life. If the mother changes plans, the baby follows the mother.

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

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

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for. However, some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination.

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

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's Get Help Enrolling page.
- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

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Apple Health – Changes for January 1, 2020

Effective January 1, 2020, the Health Care Authority (HCA) completed the move to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

IMC is implemented in the last three regions of the state:

- **Great Rivers** (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties)
- **Salish** (Clallam, Jefferson, and Kitsap counties)
- **Thurston-Mason** (Mason and Thurston counties)

These last three regions have plan changes, with only Amerigroup, Molina, and United Healthcare remaining. There are changes to the plans available in these last three regions. The only plans that will be in these regions are Amerigroup, Molina, and United Healthcare. If a client is currently enrolled in one of these three health plans, their health plan will not change.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:
  Go to Washington HealthPlanFinder web site.

- **Available to all Apple Health clients:**

  ✓ Visit the ProviderOne Client Portal website:

  ✓ Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

  ✓ Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

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

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

Some Medicaid clients do not meet he qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Clients who are not enrolled in an agency-contracted managed care plan are automatically enrolled in a BHSO, with the exception of American Indian/Alaska Native clients. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care (IMC)

Clients qualified for managed care enrollment and living in integrated managed care (IMC) regions will receive all physical health services, mental health services, and substance use disorder treatment through their agency-contracted managed care organization (MCO).

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

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

If a client does not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's American Indian/Alaska Native webpage.

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

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

Integrated managed care regions

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

Region	Counties	Effective Date
Great Rivers	Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum	January 1, 2020
Salish	Clallam, Jefferson, Kitsap	January 1, 2020
Thurston-Mason	Thurston, Mason	January 1, 2020
North Sound	Island, San Juan, Skagit, Snohomish, and Whatcom	July 1, 2019
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman	January 1, 2019
King	King	January 1, 2019
Pierce	Pierce	January 1, 2019
Spokane	Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties	January 1, 2019
North Central	Grant, Chelan, Douglas, and Okanogan	January 1, 2018 January 1, 2019 (Okanogan)
Southwest	Clark, Skamania, and Klickitat	April 2016 January 1, 2019 (Klickitat)

Integrated Apple Health Foster Care (AHFC)

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

Clients under this program are:

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

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

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact the agency's Foster Care Medical Team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

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

Are Primary Care Case Management (PCCM) clients covered?

Yes. For the client who has chosen to obtain care with a PCCM provider, this information is displayed on the client benefit inquiry screen in ProviderOne. These clients must obtain or be referred for services via a PCCM provider. The PCCM provider is responsible for coordination of care just like the PCP would be in a plan setting.

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

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

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

Coverage

Is medical necessity required for home infusion therapy?

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

When is infusion therapy covered in the home?

(WAC 182-553-300(3) and (4))

The agency will cover infusion therapy in the home when the client:

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

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

Is medical necessity required for parenteral nutrition?

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

When is parenteral nutrition covered?

(WAC 182-553-300(5))

To receive parenteral nutrition, a client must:

- Have a written physician order for all solutions and medications to be administered.
- Be able to manage their infusion in one of the following ways:
  - ✓ Independently
  - ✓ With a volunteer caregiver who can manage the infusion
  - ✓ By choosing to self-direct the infusion with a paid caregiver (WAC 388-71-05640)

-And-

To receive parenteral nutrition, a client must meet one of the following conditions that prevents oral or enteral intake to meet the client's nutritional needs:

- Have hyperemesis gravidarum or an impairment involving the gastrointestinal tract that lasts three months or longer, where either of these conditions prevents oral or enteral intake to meet the client's nutritional needs
- Be unresponsive to medical interventions other than parenteral nutrition
- Be unable to maintain weight or strength

When is parenteral nutrition not covered?

(WAC 182-553-300(6))

The agency does not cover parenteral nutrition services for a client who has a functioning gastrointestinal tract when the need for parenteral nutrition is only due to:

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

What if a client has a condition expected to last less than three months?

(WAC 182-553-300(7))

The agency covers parenteral nutrition for a client whose gastrointestinal impairment is expected to last less than three months when:

- The eligibility criteria are met.
- The client has a written physician order that documents the client is unable to receive oral or tube feedings.
- It is medically necessary for the gastrointestinal tract to be totally nonfunctional for a period of time.

When are intradialytic parenteral nutrition (IDPN) solutions covered?

(WAC 182-553-300(8))

The agency covers IDPN solutions when:

- The parenteral nutrition is not solely supplemental to deficiencies caused by dialysis.
- The client meets the eligibility criteria.

- The client is able to manage their infusion in one of the following ways:

  ✓ Independently
  ✓ With a volunteer caregiver who can manage the infusion
  ✓ By choosing to self-direct the infusion with a paid caregiver

What documentation is required?

See Billing for claim instructions specific to the Home Infusion Therapy and Parenteral Nutrition program.

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

What equipment and supplies are covered?

(WAC 182-553-500(1) through (6))

The agency covers the following equipment and supplies under the Home Infusion Therapy and Parenteral Nutrition program for eligible clients, subject to the limitations and restrictions listed below:

- A written physician order is required for all equipment and supplies. Advanced registered nurse practitioners (ARNPs) or physician assistants (PAs) ordering equipment and supplies must have a physician's signature on the request order.

- Home infusion supplies are limited to one month's supply per client, per calendar month.

- Parenteral nutrition solutions are limited to one month's supply per client, per calendar month.

- Covered rental of pumps is limited to one type of infusion pump, one type of parenteral pump, and one type of insulin pump per client, per calendar month as follows:

  ✓ The agency covers the rental payment for each type of infusion, parenteral, or insulin pump for up to 12 months. (The agency considers a pump purchased after 12 months of rental payment).

  ✓ All rent-to-purchase infusion parenteral and insulin pumps must be new equipment at the beginning of the rental period.

- ✓ The agency covers only one purchased infusion or parenteral pump, per client in a five-year period.
- ✓ The agency covers only one purchased insulin pump, per client in a four-year period.

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

The agency's payment for equipment rentals or purchases includes:

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

Is continuous glucose monitoring (CGM) covered?

(WAC 182-553-500)

Yes. The agency pays for FDA-approved continuous glucose monitoring systems and related monitoring equipment and supplies using the expedited prior authorization (EPA) process when the client meets the criteria.

For EPA criteria, see EPA #870001535 and EPA #870001536.

Providers may use the EPA process when the specific EPA criteria for that EPA code is met. If the client does not meet the EPA criteria, prior authorization (PA) is required (see prior authorization).

Note: For more information about the in-home use of professional or diagnostic continuous glucose monitoring for a 72-hour period, see the Physician-Related Services/Healthcare Professional Services Medicaid Billing Guide.

Coverage Table

Infusion therapy equipment and supplies

HCPCS Code	Modifier	Short Description	NH Per Diem?	Policy/Comments
A4220		Infusion pump refill kit	Y	Limited to one kit, per client, per month
A4221		Supp non-insulin inf cath/wk	Y	List drug(s) separately. (Includes dressings for the catheter site and flush solutions not directly related to drug infusion). The catheter site may be a peripheral intravenous line, a peripherally inserted central catheter (PICC), a centrally inserted intravenous line with either an external or subcutaneous port, or an epidural catheter. HCPCS code A4221 also includes all cannulas, needles, dressings, and infusion supplies (excluding the insulin reservoir) related to continuous subcutaneous insulin infusion via external insulin infusion pump (E0784). Four units = one month
A4222		Infusion supplies with pump	Y	HCPCS code A4222 includes the cassette or bag, diluting solutions, tubing, and other administration supplies, port cap changes, compounding charges and preparation charges.

Infusion therapy equipment and supplies (cont.)

HCPCS Code	Modifier	Short Description	NH Per Diem?	Policy/Comments
A4223		Infusion supplies w/o pump	Y	Includes the following: 1. Disposable elastomeric infusion pumps 2. Gravity flow with a standard roller clamp or another flow rate regulator 3. Related supplies A summary document of the therapy provided and the specific items used is required for payment. Please also submit an invoice, if available. Allowed in combination with HCPCS code A4222 when the client is infusing multiple therapies. Supporting documentation must be in the client's medical records.

Antiseptics and germicides

HCPCS Code	Modifier	Short Description	NH Per Diem?	Policy/Comments
A4246		Betadine/phisohex solution	Y	One pint per client, per month. Not allowed in combination with HCPCS codes A4247
A4247		Betadine/iodine swabs/wipes	Y	One box per client, per month. Not allowed in combination with HCPCS codes A4246
E0776	NU	Iv pole	Y	Purchase
E0776	RR	Iv pole	Y	Rental per month One unit = one month

Infusion pumps

HCPCS Code	Modifier	Short Description	NH Per Diem?	Policy/Comments
E0779	RR	Amb infusion pump mechanical	N	Rental per month
E0780	NU	Mech amb infusion pump <8hrs	N	Purchase
E0781	RR	External ambulatory infus pu	N	Rental per month
E0791	RR	Parenteral infusion pump sta	N	Rental per month

Parenteral nutrition infusion pumps

HCPCS Code	Modifier	Short Description	NH Per Diem?	Policy/Comments
B9004	NU	Parenteral infus pump portab	N	Purchase
B9004	RR	Parenteral infus pump portab	N	Rental per month One unit = one month
B9006	NU	Parenteral infus pump statio	N	Purchase
B9006	RR	Parenteral infus pump statio	N	Rental per month One unit = one month

Parenteral nutrition solutions

Note: When using half units of parenteral solutions, the agency will reimburse for 1 unit every other day, otherwise allowed once per day. In the event an odd number of days of therapy are delivered, you may round the last day of therapy to the closest unit. **(Example: If delivering 250 ml of 50% dextrose for 21 consecutive days, bill for 11 units of parenteral solution.)**

HCPCS Code	Modifier	Short Description	NH Per Diem?	Policy/Comments
B4164		Parenteral 50% dextrose solu	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200
B4168		Parenteral sol amino acid 3.	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200
B4172		Parenteral sol amino acid 5.	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200
B4176		Parenteral sol amino acid 7-	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200
B4178		Parenteral sol amino acid >	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200
B4180		Parenteral sol carb > 50%	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200
B4185		Parenteral sol 10 gm lipids	N	
B4189		Parenteral sol amino acid &	N	
B4193		Parenteral sol 52-73 gm prot	N	

Parenteral nutrition solutions (cont.)

HCPCS Code	Modifier	Short Description	NH Per Diem?	Policy/Comments
B4197		Parenteral sol 74-100 gm pro	N	
B4199		Parenteral sol > 100gm prote	N	
B4216		Parenteral nutrition additiv	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200
B5000		Parenteral sol renal-amirosy	N	
B5100		Parenteral solution hepatic	N	

Parenteral nutrition supplies

Note:
- Parenteral Nutrition Kits are considered **all-inclusive** for the items necessary to administer therapy.
- Number of units billed cannot exceed number of days.

HCPCS Code	Modifier	Short Description	NH Per Diem?	Policy/Comments
B4220		Parenteral supply kit premix	N	Per day One unit = one day Not allowed in combination with HCPCS code B4222
B4222		Parenteral supply kit homemi	N	Per day One unit = one day Not allowed in combination with HCPCS code B4220
B4224		Parenteral administration ki	N	Per day One unit = one day

Insulin infusion pumps

HCPCS Code	Modifier	Short Description	NH Per Diem?	Policy/Comments
E0784	RR	Ext amb infusn pump insulin	N	Covered without prior authorization for Type I Diabetes Prior authorization required for Type II Diabetes Includes case Rental per month One unit = one month Maximum of 12 months' rental Pump is considered purchased after 12 months' rental Limited to one pump per client in a four year period
E0784		Omnipod		Covered under pharmacy benefit. Requires prior authorization.

Insulin infusion supplies

HCPCS Code	Modifier	Short Description	NH Per Diem?	Policy/Comments
A4224		Supply insulin inf cath/wk		One unit = one week
A4225		Sup/ext insulin inf pump syr		
A4230		Infus insulin pump non needl	N	Two boxes per client, per month One unit = one box of ten
A4231		Infusion insulin pump needle	N	Two boxes per client, per month One unit = one box
A4232		Syringe w/needle insulin 3cc	N	Two boxes per client, per one month One unit = one box of ten
A4602		Replace lithium battery 1.5v	N	Ten per client per six months
K0601		Repl batt silver oxide 1.5 v	N	Ten per client per six months
K0602		Repl batt silver oxide 3 v	N	Ten per client per six months
K0603		Repl batt alkaline 1.5 v	N	Nine per client per three months
K0604		Repl batt lithium 3.6 v	N	
K0605		Repl batt lithium 4.5 v	N	

Miscellaneous infusion supplies

HCPCS Code	Modifier	Short Description	NH Per Diem?	Policy/Comments
A4927		Non-sterile gloves	Y	One unit = One box of 100 gloves Units exceeding two per month require prior authorization.
A4930		Sterile, gloves per pair	Y	
E1399		Durable medical equipment mi	N	Equipment repair, parts Requires prior authorization See instructions in Authorization. Invoice required
E1399		Durable medical equipment mi	Y	10 quart chemotherapy waste container Requires prior authorization See instructions in Authorization. Invoice required
B9999		Parenteral supp not othrws c	N/A	Requires prior authorization See instructions in Authorization. Invoice required
K0739		Repair/svc dme non-oxygen eq	N	Prior authorization is required Must submit invoice with claim that separates labor costs from other costs

Continuous Glucose Monitoring (CGM)

HCPCS Code	Modifier	Short Description	NH Per Diem?	Do Not Bill With	Policy/Comments
A9276		Disposable sensor, cgm sys	N/A	K0553, K0554	• 1 unit = 1 day supply
A9277		External transmitter, cgm	N/A	K0553, K0554	• 1 unit = 1 day supply
A9278		External receiver, cgm sys	N/A	K0553, K0554	• Limit: 1 receiver per client every 3 years
K0553		Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply	N/A	A9276, A9277, A9278	• 1 unit of service = 1 month supply • Allowance includes all items necessary for the use of the device and includes, but is not limited to: CGM sensor, CGM transmitter, home BGM and related BGM supplies.
K0554		Receiver (Monitor), dedicated, for use with therapeutic continuous glucose monitor system	N/A	A9276, A9277, A9278	• When K0554 is covered the related supply allowance (code K0553) is also covered. • Limit: 1 receiver per client every 3 years.

Closed loop systems are not covered. Verification with self-monitoring of blood glucose (SMBG) is needed prior to adjusting insulin. Do not use the CGM results to adjust insulin.

To submit a claim for the physician interpretation and report of CGM results, see CPT code 95251 (PA **not** required) in the agency's current Physician-Related Services/Healthcare Professional Services Medicaid Billing Guide.

Note: Billing provision limited to a one-month supply; a one-month supply is equal to 30 days.

Note: EPA applies to all codes on this page. For EPA criteria, see EPA #870001535 and EPA #870001536

Authorization

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

What is prior authorization (PA)?

PA 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. **Expedited prior authorization (EPA) and limitation extensions (LE) are forms of PA.**

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

For the Home Infusion Therapy and Parenteral Nutrition program, providers must obtain PA for:

- Miscellaneous parenteral therapy supplies (**HCPCS code B9999**). See the Coverage Table in this guide for further details. To request prior authorization, fax a completed *General Information for Authorization* form (HCA 13-835) as your cover sheet and a *Justification for Use of Miscellaneous Parenteral Supply Procedure Code (B9999)* form (HCA 13-721) to the fax number listed on the form. See Where can I download agency forms?

- Equipment repairs, parts, and 10 quart chemotherapy waste containers require prior authorization (**HCPCS code E1399)**. To request prior authorization, fax a completed *General Information for Authorization* form (HCA 13-835) as your cover sheet and a *Fax/Written Request Basic Information* form (HCA 13-756) to the fax number listed on the form.

- Limitation Extensions.

How do I obtain prior authorization (PA)?

You may obtain PA by sending a request, along with any required forms, to the fax number listed on the form.

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

Expedited prior authorization (EPA)

What is expedited prior authorization (EPA)?

Expedited prior authorization (EPA) is designed to eliminate the need for written authorization. The agency establishes authorization criteria and identifies the criteria with specific codes, enabling providers to create an EPA number using those codes.

To bill the agency for diagnostic conditions, procedures, and services that meet the EPA criteria on the following pages, the provider must **use the 9-digit EPA number.** The first five or six digits of the EPA number must be **87000** or **870000**. The last three or four digits must be the EPA number assigned to the diagnostic condition, procedure, or service that meets the EPA criteria (see EPA criteria coding list for codes). Enter the EPA number on the billing form in the authorization number field, or in the Authorization or Comments section when billing electronically.

The agency denies claims submitted without a required EPA number.

The agency denies claims submitted without the appropriate diagnostic condition, procedure, or service as indicated by the last three digits of the EPA number.

The billing provider must document in the client's file how the EPA criteria were met and make this information available to the agency on request. If the agency determines the documentation does not support the criteria being met, the agency will deny the claim.

Note: The agency requires PA when there is no option to create an EPA number.

EPA guidelines

Documentation

The provider must verify medical necessity for the EPA number submitted. The client's medical record documentation must support the medical necessity and be available upon the agency's request. If the agency determines the documentation does not support the EPA criteria requirements, the agency will deny the claim.

What is a limitation extension (LE)?

An LE is authorization for cases when the agency determines that it is medically necessary to provide more units of service than allowed in the agency's WAC and billing guides.

How is an LE request submitted for approval?

Submit the request for LE authorization by using the written/fax authorization process. **Requests for LE authorization must include all of the following:**

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

Fax the completed *Fax/Written Request Basic Information* form, HCA 13-756, to the fax number listed on the form. See Where can I download agency forms?

Does miscellaneous parenteral supply HCPCS code B9999 require prior authorization?

Yes. Miscellaneous HCPCS code B9999 requires prior authorization. In order to be reimbursed for B9999, you must **first** complete the *General Information for Authorization* form (HCA 13-835) as your cover sheet and a *Justification for use of Miscellaneous Parenteral Supply Procedure Code (B9999)* form, HCA 13-721, and fax it to the fax number listed on the form for review and approval. Keep a copy of the request in the client's file. See Where can I download agency forms?

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

When submitting a request for authorization, attach supporting documentation. This documentation must consist of all of the following:

- Name of the agency and NPI
- Client's name and ProviderOne client ID
- Date of service
- Explanation of client-specific medical necessity
- Invoice
- Name of primary piece of equipment and whether the equipment is rented or owned
- Copy of original prescription

EPA criteria coding list

A complete EPA number is 9 digits. The first five or six digits of the EPA number must be **87000 or 870000**. The last three or four digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria. If the client does not meet the EPA criteria, prior authorization (PA) is required (see prior authorization).

EPA Code-	Service Name	CPT/HCPCS/Dx	Criteria
870001535	Continuous glucose monitoring (CGM)		Invoice Required. Use for clients: • Age 18 and younger • Adults with Type 1 diabetes • Adults with Type 2 diabetes who are: ✓ Unable to achieve target HbA1C despite adherence to an appropriate glycemic management plan (after six [6] months) of intensive insulin therapy and testing blood glucose 4 or more times per day ✓ Suffering from one or more severe (blood glucose < 50 mg/dl or symptomatic) episodes of hypoglycemia despite adherence to an appropriate glycemic management plan (intensive insulin therapy; testing blood glucose 4 or more times per day) ✓ Unable to recognize, or communicate about, symptoms of hypoglycemia
870001536	Continuous glucose monitoring (CGM)		Invoice Required. Use for pregnant women any age with: • Type 1 diabetes • Type 2 diabetes and on insulin prior to pregnancy • Gestational diabetes whose blood glucose is not well controlled (HbA1C above target or experiencing episodes of hyperglycemia or hypoglycemia) during pregnancy and require insulin

Billing

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

What are the general billing requirements?

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

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

What records must be kept in the client's file?

(WAC 182-553-400)

In addition to the documentation required under WAC 182-502-0020 (Health care record requirements), the following records specific to the Home Infusion Therapy and Parenteral Nutrition Program must be kept in the client's file:

- For a client receiving infusion therapy, the file must contain:
  - ✓ A copy of the written prescription for the therapy.
  - ✓ The client's age, height, and weight.
  - ✓ The medical necessity for the specific home infusion service.

- For a client receiving parenteral nutrition, the file must contain:

  - ✓ All the information listed above.
  - ✓ Any oral or enteral feeding trials and outcomes, if applicable.
  - ✓ The duration of gastrointestinal impairment.
  - ✓ The monitoring and reviewing of the client's lab values:

    - ➢ At the initiation of therapy.
    - ➢ At least once per month.
    - ➢ When the client or the client's lab results are unstable.

How do I bill claims electronically?

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

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

The following claim instructions relate to the Home Infusion Therapy and Parenteral Nutrition program:

Name	Entry
Place of Service	Enter the following code: **Code** **To Be Used For** 12 Client's residence 31 Nursing facility (formerly SNF) 32 Nursing facility (formerly ICF) 33 Custodial care facility 65 End Stage Renal Disease Treatment Facility