Washington State Health Care Authority

Washington Apple Health (Medicaid)

Medical Equipment and Supplies Billing Guide

January 1, 2025

Washington State Health Care Authority

Disclaimer

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

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

About this guide*

This publication takes effect **January 1, 2025,** and supersedes earlier billing guides to this program. Unless otherwise specified, the program(s) in this guide are governed by the rules found in chapter 182-543 WAC.

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

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

- Medical Nutrition Therapy Billing Guide
- Home Infusion, Diabetic Treatment, and Parenteral Nutrition Program Billing Guide
- Prosthetic and Orthotic Devices Billing Guide

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

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business HCA.

How can I get HCA Apple Health provider documents?

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

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

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* This publication is a billing instruction.

Washington State Health Care Authority

Confidentiality toolkit for providers

The Washington State Confidentiality Toolkit for Providers is a resource for providers required to comply with health care privacy laws.

Where can I download HCA forms?

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

Copyright disclosure

What has changed?

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

Subject	Change	Reason for Change
Definition	Added definition of hospital bed	To align with recent WAC changes to 182-543-1000
About the program	Added the definition for medically necessary	Clarification and update to outdated language
About the program – Medical policy update	Moved section	Ease of information
Medical Equipment & Supplies Benefit Coverage	Rearranged some of the language order Moved medical documentation paragraphs to provider requirement section	Ease of reading information

Subject	Change	Reason for Change
Provider and manufacturer information	Updated language	Clarification and update to outdated language
Providers and supplier requirements	Added medical record documentation from previous section. Added note box "Some medical equipment may require a shorter timeline between prescription signature and PA submission."	Belongs in provider section Clarification based on supplier feedback
Medical necessity guidelines for Med Equipment and Supplies	Changed title from "Coverage" to "Medical Necessity Guidelines" Included the following medical equipment and supplies – See each section for details: Bathroom equipment, Complex bathroom equipment, Compression garments, Continuous glucose monitoring, Continuous passive motion (CPM) machine, Electrical neural stimulation (ENS), Hospital beds	To clarify the medical necessity requirements for medical equipment and supplies
Enclosed beds: Safety enclosures for pediatric hospital beds and enclosed bed systems	Added language to hospital bed section to include medical necessity guidelines and documentation requirements. See section for detailed information.	Clarification – not new policy
Mattresses and related equipment	Removed list of products table, referred to Coverage table link	Redundant language

Subject	Change	Reason for Change
Patient lifts, traction equipment, fracture frames, and transfer boards	Updated language to include medical necessity guidelines and HCPCS codes in equipment table. Added additional equipment to table. See section for detailed updates.	Clarification- HCPCS code E0637 is for sit-to-stand not a stander
Therapeutic positioning devices	Added additional language for car seats	Clarification
Positioning car seat	Added medical necessity guidelines	Clarification
Urological incontinence supplies and gloves	Removed section	Redundant information – already in WAC and codes in Coverage Table
Osteogenesis electrical stimulator (bone growth stimulator)	Specified which existing language was medical necessity guidelines – added link to HTCC decision	Clarification
Speech generating devices (SGD) and other communication devices	Added medical necessity criteria and removed additional authorization language	Clarification and removing redundant language already found in the authorization section of this billing guide
Ambulatory aids (canes, crutches, walkers, and related supplies)	Added specific HCPCS code and ambulatory item to the table	Clarification
Breast pumps	Added medical necessity criteria and HCPCS codes for pumps	Clarification
Miscellaneous medical equipment	Removed section	Redundant information

Subject	Change	Reason for Change
Negative pressure wound therapy for home use	Added additional language for medical necessity criteria, HTCC decision link and limitations to coverage	Clarification – no change to policy
Coverage Table	See table for detailed updates – particularly code status	Clarification
	HCPCS codes removed from PA: A4660, A4663, A4670, E2601, E2602, E0994, K0019, E0951, E0952, E2611, E2612, E2216, E2217, E2218, E2219, E2220, E2221, E2222	Agency decision
Manual and power-drive wheelchairs	Added language explaining requirements	Clarification
What is expedited prior authorization (EPA)	Removed language	Vendors do not create EPA number
Misc medical equipment – EPA table	For HCPCS code A4253 and A4259 – changed 60 days postpartum to 12 months post-partum	Update based on evidence-based standard of care
What are the general billing requirements	Added language for billing for By Report (BR) items	Billing clarification

Washington State Health Care Authority

Table of Contents

Resources Available

Topic	Resource Information
Becoming a provider or submitting a change of address or ownership	See HCA's Billers and Providers webpage
Finding out about payments, denials, claims processing, or HCA-contracted managed care organizations	See HCA's Billers and Providers webpage
Electronic billing	See HCA's Billers and Providers webpage
Finding HCA documents (e.g., Washington Apple Health billing guides, provider notices, and fee schedules)	See HCA's Billers and Providers webpage
Private insurance or third-party liability, other than HCA-contracted managed care	See HCA's Billers and Providers webpage
Requesting that equipment/supplies be added to the "covered" list in this billing guide	Phone: (800) 562-3022 Fax: (866) 668-1214
Requesting prior authorization or a limitation extension	Providers may submit prior authorization requests online through direct data entry into ProviderOne. See HCA's prior authorization webpage for details. Providers may also fax requests to 866-668-1214. The first page of the fax must be the completed *General Information for Authorization (GIA)* form, HCA 13-835. Do not include a fax cover sheet.
Questions about the payment rate listed in the fee schedule	Cost Reimbursement Analyst Professional Reimbursement PO Box 45510 Olympia, WA 98504-5510 (360) 753-9152 (fax)
Medicare Learning Network	MLN Homepage | CMS
PDAC – Medicare Contractor for Pricing, Data Analysis and Codes of HCPCS Level II DMEPOS Codes	PDAC – DME Coding System (DMECS) Information (dmepdac.com)

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to chapter 182-500 WAC and WAC 182-543-1000 for a complete list of definitions for Washington Apple Health.

Authorized treating and prescribing provider–

- A physician, nurse practitioner, clinical nurse specialist, or physician assistant who may order and conduct home health services, including face-to-face encounter services; or
- A certified nurse midwife under 42 C.F.R. 440.70 when furnished by a home health agency that meets the conditions of participation for Medicare who may conduct home health services, including face-to-face encounter services.

Date of delivery – The date the client actually took physical possession of an item or equipment. See Proof of delivery.

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

Disposable Supplies – Supplies which are designed as single-use products to be discarded after initial use.

EPSDT - See WAC 182-500-0005.

Health Care Common Procedure Coding System (HCPCS) – A standardized coding system established by the Centers for Medicare and Medicaid Services (CMS) that is used primarily to identify products, supplies and services, such as durable medical equipment, prosthetics, orthotics and supplies. This term is used interchangeably with procedure code.

Home – A location, other than a hospital or skilled nursing facility, where the client resides and receives care.

Hospital bed - A bed designed for use in a hospital or similar facility, or for use at home. It is characterized by its adjustability and various features, including the ability to elevate or lower the head, foot, or entire bed frame, often using a motorized mechanism. Hospital beds may also have side rails and other features to support patient care and comfort. They are used to provide patients with therapeutic support and to facilitate easier medical care and treatment.

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

Manual Wheelchair – See Wheelchair – Manual.

Medical equipment – Includes medical equipment and appliances, and medical supplies.

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

- Are primarily and customarily used to serve a medical purpose;
- Generally are not useful to a person in the absence of illness or injury;
- Can withstand repeated use;

- Can be reusable or removable; and
- Are suitable for use in any setting where normal life activities take place.

Medical supplies – Health care-related items that are:

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

Personal or comfort item – An item or service that primarily facilitates leisure or recreational activities or that primarily serves the comfort or convenience of the client or caregiver and is considered not medically necessary.

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 an authorized practitioner and a home health agency provider that describes the home health care to be provided at the client's residence. (WAC 182-551-2010)

Power Mobility Device (PMD) – Base codes include both integral frame and modular construction type power wheelchairs (PWCs) and power operated vehicles (POVs), in accordance with CMS guidelines.

Power Operated Vehicle – Chair-like battery powered mobility device for people with difficulty walking due to illness or disability, with integrated seating system, tiller steering, and three or four-wheel non-highway construction.

Power-Drive Wheelchair – See Wheelchair – Power.

Reusable Supplies – Supplies which are designed and intended for repeated use.

Safety enclosure frame/canopy – A passive bed enclosure that provides a solid framework and a soft canopy structure, which securely attaches to the bed. The enclosure provides access to the client through openings allowing the caregiver the ability to provide routine care to the client. It is an integral part of, or accessory to, a hospital bed.

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

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

Specialty bed – A hospital bed used primarily in the treatment of an individual with a disability, illness, or injury that has a pressure reducing or relieving support surface, such as foam, air, water, or gel mattress or overlay.

Speech generating device (SGD) - An electronic device or system that compensates for the loss or impairment of a speech function due to a congenital condition, an acquired disability, or a progressive neurological disease. The term

includes only that equipment used for the purpose of communication. Formerly known as augmentative communication device (ACD).

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

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

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

Warranty period – A guarantee or assurance, according to manufacturers' or providers' guidelines, of set duration from the date of purchase.

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

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

  - Is identified by its manufacturer as Hemi type with specific model numbers that include the Hemi description.
- **Pediatric**:
  - Has a narrower seat and shorter depth more suited to pediatric patients, usually adaptable to modifications for a growing child
- **Recliner**:
  - Has an adjustable, reclining back to facilitate weight shifts and provide support to the upper body and head
- **Tilt-in-Space**:
  - Has a positioning system that allows both the seat and back to tilt to a specified angle to reduce shear or allow for unassisted pressure releases
- **Heavy Duty**. Has one of the following:
  - Specifically manufactured to support a person weighing up to 300 pounds
  - Accommodating a seat width of up to 22 inches wide (not to be confused with custom manufactured wheelchairs)
- **Rigid**:
  - Is of ultra-lightweight material with a rigid (nonfolding) frame
- **Custom Heavy Duty**. Is either of the following:
  - Specifically manufactured to support a person weighing over 300 pounds
  - Accommodates a seat width of over 22 inches wide (not to be confused with custom manufactured wheelchairs)
- **Custom Manufactured Specially Built**:
  - Ordered for a specific client from custom measurements
  - Is assembled primarily at the manufacturer's factory

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

- **Custom power adaptable** to:
  - Alternative driving controls
  - Power recline and tilt-in-space systems
- **Noncustom power**:
  - Does not need special positioning or controls and has a standard frame
- **Pediatric**:
  - Has a narrower seat and shorter depth that is more suited to pediatric patients. Pediatric wheelchairs are usually adaptable to modifications for a growing child

About the Program

The federal government considers medical equipment and related supplies as services under the Medicaid program. For information about the Habilitative Services benefit, see **What are habilitative services under this program**?

HCA covers medical equipment and related supplies listed in this billing guide according to HCA rules and subject to the limitations and requirements within this guide. HCA pays for medical equipment and related supplies including modifications, accessories, and repairs when they are:

- 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 182-500-0070, means that there is no other equally effective, more conservative, or significantly less costly course of treatment available or suitable for the client requesting the service.
- Prescribed by a practitioner and within the scope of the practitioner's licensure, except for dual-eligible Medicare/Medicaid clients when Medicare is the primary payer and HCA is billed for a copay and/or deductible only.
- Authorized, as required in this billing guide, and in accordance with the following:
  - Chapter 182-501 WAC
  - Chapter 182-502 WAC
  - Chapter 182-543 WAC
- Provided and used within accepted medical or physical medicine community standards of practice.

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

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

> **Note**: See Authorization for specific details regarding authorization for the medical equipment program.

HCA bases its determination about which medical equipment services and related supplies require PA or EPA on utilization criteria (see **Authorization**). HCA considers all the following when establishing utilization criteria:

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

HCA evaluates a request for any medical equipment item listed under the provisions of WAC 182-501-0160 (see **Exception to Rule**). When EPSDT applies, HCA 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 HCA's current **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Billing Guide** for more information).

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

What are habilitative services under this program?

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

Applicable to those clients in the expanded population and covered by the Alternative Benefit Plan (ABP) only, HCA will cover wheelchairs, medical equipment, and devices to treat one of the qualifying conditions listed in HCA's **Habilitative Services Billing Guide**, under *Client Eligibility*.

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

Billing for habilitative services

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

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

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

Washington State Health Care Authority

Client Eligibility

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

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

How do I verify a client's eligibility?

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 HCA 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 HCA'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 HCA's Program Benefit Packages and Scope of Services webpage.

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

- **Online**: Go to **Washington Healthplanfinder** - select the "Apply Now" button. For patients age 65 and older, or on Medicare, go to **Washington Connections** – select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older, or on Medicare, complete the *Washington Apple Health Application for Age, Blind, Disabled/Long-Term Services and Supports (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

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

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

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

- Payment of covered services
- Payment of services referred by a provider participating with the 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.

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

Managed care enrollment

Most Apple Health clients are enrolled in HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination. **Exception:** Apple Health Expansion clients are enrolled in MC and will not start their first month of eligibility in the FFS program. For more information, visit Apple Health Expansion. Providers must check eligibility to determine enrollment for the month of service.

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

Checking eligibility

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

Client's options to change plans

Clients have a variety of options to change their plan:

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

  Go to Washington Healthplanfinder website.

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

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

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

Some Apple Health clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the fee-for-service program.

In this situation, each managed care plan will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in integrated managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the fee-for-service Medicaid program will reimburse providers for the covered services. 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

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

Integrated Apple Health Foster Care (AHFC)

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

Clients under this program are:

- Under the age of 18 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 team can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAS) team at 1-800-562-3022, Ext. 15480.

Apple Health Expansion

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

Fee-for-service Apple Health Foster Care

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

American Indian/Alaska Native (AI/AN) Clients

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

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

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

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

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

Medical Equipment & Supplies Benefits

This billing guide provides information for billing medical equipment & supplies (MES) for eligible clients. Providers must adhere to authorization requirements and medical necessity guidelines as outlined in the Washington Administrative Code (WAC), Provider Billing Guides, Provider Alerts, and the Core Provider Agreement.

HCA covers for MES, related repairs and services when all the following apply:

- Authorized, as required in this billing guide, and per the following:
  - **Chapter 182-501 WAC**
  - **Chapter 182-502 WAC**
  - **Chapter 182-543 WAC**
- Meet the definition of medical equipment and supplies, be classified as durable medical equipment within the Medicare program, and be primarily used for a medical purpose and not useful to a person without illness or injury, as outlined in **WAC 182-543-1000**.
  - Some items or accessories provided by a supplier may offer benefits to an individual. However, this does not inherently qualify them as 'medical equipment' or establish them as medically necessary, even if they have

potential medical use. Examples include, but are not limited to, generators, battery packs, and air conditioners.

- Equipment or upgrades that primarily serve comfort, leisure, or caregiver convenience may occasionally meet the definition of medical equipment but are generally not considered medically necessary.

- Be medically necessary, as defined in **WAC 182-500-0070**. Under this definition, medical necessity means that there is no other equally effective, more conservative, or significantly less costly course of treatment available or suitable for the client requesting the service.

Provider and Manufacturer Information

Payment for medical equipment/supplies and related services

HCA pays the following qualified providers on a fee-for-service basis for medical equipment, supplies, and related repairs and services listed in the Coverage Table of this billing guide. Providers must meet all of the following requirements:

- Be a provider of durable medical equipment and related repairs and services
- Be a medical equipment supplier, pharmacy, or home health agency with a national provider identifier (NPI) for medical supplies
- Be a provider who supplies medical equipment and supplies in the office (HCA may pay separately for medical supplies, subject to the provisions in HCA's resource-based relative value scale fee schedule)

A qualifying face-to-face encounter is with the treating provider within six (6) months prior to the start of services. See 42 CFR 410.38(c)(8).

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

> Note: Determining when a qualifying face-to-face encounter is required based on the medical equipment, not the place of service.

Providers and supplier requirements

Providers and suppliers of medical equipment and related services must meet all of the following:

- 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 HCA.
- Provide instructions for use of equipment.
- Furnish to clients only new equipment that includes full manufacturer and dealer warranties.
- Furnish, upon HCA request, documentation of proof of delivery, (See How do providers furnish proof of delivery?).
- Bill HCA using only the allowed procedure codes published within this billing guide.

- Provide a medical necessity justification for each item requested, specifying why the client's medical condition necessitates the equipment, rather than what the equipment does for the client.
- Provide documentation that states the client diagnosis, specific item or service requested, estimated length of need (weeks, months, or years), and quantity.
- Have a valid written order/prescription from the treating provider as a condition for payment. Use HCA's *Prescription* form HCA 13-794. (See **Where can I download HCA forms?**)
    - Include provider credentials.
    - Be signed by an authorized provider (see **Definitions**). Electronic signatures are acceptable. Stamped signatures are not acceptable.
    - Be dated by the provider on or before the date of delivery of the supply, equipment, or device. Prescriptions must not be backdated.
    - Be no older than one year from the date the provider signs the prescription, (Some medical equipment may require a shorter timeline between prescription signature and PA submission).
    - Include the client diagnosis.
    - State the item or service requested, diagnosis, quantity, and estimated length of need.

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

Note: Point-of-Sale (POS) – National Drug Codes (NDCs) considered as medical supplies submitted through the point-of-sale system are reimbursed at the **medical equipment and supplies fee schedule** associated with their HCPCS code.

- Medical record documentation, sourced from the client's Electronic Health Record (EHR), must provide credible evidence, as outlined in **WAC 182-501-0165**, to substantiate criteria for medical necessity as specified in this billing guide.
- In accordance with CMS guidelines on Medicaid documentation, the client's medical record must sufficiently demonstrate their condition, justify prescribed items and quantities, and specify the frequency of use or replacement if applicable. Mere submission of an agency form, supplier statement, or provider attestation, even if endorsed, is insufficient without supporting medical record information. Please refer to the **Documentation Matters Toolkit | CMS**.

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

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

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

- Manufacturer's literature.
- Manufacturer's pricing.
- Clinical research/case studies (including FDA approval, if required).
- Proof of the Centers for Medicare and Medicaid Services (CMS) certification, if applicable.
- Any additional information the requester feels will aid HCA in its determination.

Send requests to:

Medical Equipment Program Management Unit
PO Box 45506
Olympia WA 98504-5506

How do providers furnish proof of delivery?

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

- HCA requires a delivery slip as proof of delivery, and it must meet all of the following:
  - Include the client's name and a detailed description of the item(s) delivered, including the quantity and brand name
  - Include the serial number for medical equipment that may require future repairs
- When the provider or supplier submits a claim for payment to HCA, the date of service on the claim must be one of the following:
  - For a one-time delivery, the date the item was received by the client or authorized representative
  - For medical equipment for which HCA 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 that are not fitted to the client, the provider must furnish proof of delivery that the client received the equipment and/or supply, when HCA requests that information.
- If the provider uses a delivery/shipping service, the tracking slip is the proof of delivery. The tracking slip must include all the following:

  - The client's name or a reference to the client's package(s)
  - The delivery service package identification number
  - The delivery address
- If the provider/supplier delivers the product, the proof of delivery is the delivery slip. The delivery slip must include all of the following:
  - The client's name
  - The shipping service package identification number
  - The quantity, detailed description(s), and brand name(s) of the items being shipped
  - The serial number for medical equipment that may require future repairs
- When billing HCA, do both of the following:
  - Use the shipping date as the date of service on the claim if the provider uses a delivery/shipping service
  - Use the actual date of delivery as the date of service on the claim if the provider/supplier does the delivery

> **Note**: A provider must not use a delivery/shipping service to deliver items which must be fitted to the client.
>
> **Note**: HCA will not accept delivery receipts or attestations with modified or tampered delivery dates.

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

HCA does not pay for medical equipment furnished to HCA's clients when either of the following applies:

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

How does HCA decide whether to rent or purchase equipment?

- HCA bases its decision to rent or purchase wheelchairs, medical equipment, and supplies on the length of time the client needs the equipment.
- A provider must not bill HCA for the rental or purchase of equipment supplied to the provider at no cost by suppliers/manufacturers.
- HCA purchases **new** medical equipment only.

  - **A new** medical equipment item that is placed with a client initially as a rental item is considered a new item by HCA at the time of purchase.
  - **A used** medical equipment item that is placed with a client initially as a loaner must be replaced by the supplier with a new item prior to purchase by HCA.
- HCA requires a dispensing provider to ensure the medical equipment rented to a client is:
  - In good working order.
  - Comparable to equipment the provider rents to clients with similar medical equipment needs who are either private pay clients or who have other third-party coverage.
- HCA's minimum rental period for covered medical equipment is one day.
- HCA authorizes rental equipment for a specific period of time. The provider must request authorization from HCA for any extension of the rental period.
- HCA's reimbursement amount for rented medical equipment includes all the following:
  - Delivery to the client
  - Fitting, set-up, and adjustments
  - Maintenance, repair and/or replacement of the equipment
  - Return pickup by the provider
- HCA considers rented equipment to be purchased after a 12-month rental has been completed unless the equipment is restricted as rental only.
- Medical equipment and related services purchased by HCA for a client are the client's property.
- HCA may choose to rent, but not purchase, certain medical equipment for clients.
- HCA stops paying for any rented equipment effective the date of a client's death. HCA prorates monthly rentals as appropriate.

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

Washington State Health Care Authority

Medical necessity guidelines for medical equipment and supplies

HCA covers medical equipment and supplies (MES). HCA reviews requests for prior authorization using evidence-based standards to determine medical necessity. This section outlines the routine guidelines to enhance the efficiency of prior authorization reviews. Other clinical factors may also support medical necessity based on credible evidence from the electronic health record (EHR) in line with evidence-based standards.

It is important to note that the guidelines do not limit the payment for MES coverage solely to the listed criteria. Additional clinical factors may also establish medical necessity based on individual client needs and a review under WAC 182-501-0165.

Bathroom equipment

HCA pays for bathroom equipment that meets the definition of medical equipment when it is determined to be medically necessary. Bathroom equipment may include, but is not limited to, items such as commodes, toilet seat risers, shower/tub chairs and benches, tub transfer benches, mobile shower chairs and combination mobile shower commode chairs. Acute and/or chronic medical conditions may contribute to the determination of medical necessity.

HCPCS:

E0240: Bath/shower chair

E0243: Toilet rail

E0244: Toilet seat raised

E0245: Tub stool or bench

Medical necessity guidelines (routine):

The routine medical necessity guidelines for bathroom equipment are as follows. These guidelines are reviewed on a case-by-case basis. Other clinical factors may also establish medical necessity based on credible evidence from the electronic health record (EHR) and a review under WAC 182-501-0165:

- The client is at risk of falls or other injuries while performing activities of daily living (ADLs) necessary to maintain or improve their health, such as bathing and toileting

Complex bathroom equipment

HCPCS:

E0240: Bath/shower chair

Medical necessity guidelines (routine):

For mobile shower commode combination equipment with optional tilt and recline options the client must meet at least one of the following:

- Have neuromuscular conditions, spinal cord injuries, conditions with spasticity, significant lack of trunk tone or stability, risk for autonomic dysreflexia, or
- Be nonambulatory transfer dependent with:
  - Severe contractures; or
  - Pressure ulcers on the sacrum or gluteal region

Fee-for-service billing instructions:

Complex bathroom equipment requires prior authorization (PA) to establish medical necessity. See the **Authorization** section of this guide for information regarding PA.

Documentation requirements:

Providers must submit a medical necessity justification for each item requested, specifying why the client's medical condition necessitates the equipment, rather than what the equipment does for the client. Avoid using the equipment's function as a justification.

When a provider is requesting authorization for bathroom equipment, providers must use the *Bathroom Equipment* authorization form (HCA 13-872). **See Where Can I Download HCA Forms?**

> Note: The bathroom equipment authorization form is not required for complex bathroom equipment, such as combination tilt and recline chairs.

Compression garments

HCA pays for medical grade compression socks with minimum level of 20–30 millimeters of mercury (mmHg).

HCPCS:

A6549: G compression garment

Until further notice, suppliers must continue to bill HCA using HCPCS A6549 gradient compression garment, not otherwise specified for all compression garments requests.

Medical necessity guidelines (routine):

The routine medical necessity guidelines for bathroom equipment are as follows. These guidelines are reviewed on a case-by-case basis. Other clinical factors may also establish medical necessity based on credible evidence from the electronic health record (EHR) and a review under **WAC 182-501-0165**:

- The client has venous or lymphatic diseases or disorders, or
- Mixed venous/arterial insufficiency, or
- Varicose veins when accompanied with pain or skin ulceration, or both, or
- Thrombosis, thrombophlebitis, or
- Edema

See **Coverage Table** for limitations.

Fee-for-service billing instructions:

Compression garments require prior authorization (PA) to establish medical necessity. See the **Authorization** section of this guide for information regarding PA.

Beginning January 1, 2024, Medicare pays for lymphedema compression treatment items for Medicare Part B beneficiaries with a diagnosis of Lymphedema. For dual eligible clients with a diagnosis of Lymphedema, suppliers must first bill Medicare, according to Medicare billing guidance, before submitting for prior authorization with HCA.

For updated HCPCS codes used when billing Medicare only, reference CMS MM13286 - Lymphedema Compression Treatment Items: Implementation (cms.gov).

Documentation requirements:

Providers must submit a medical necessity justification for each item requested, specifying why the client's medical condition necessitates the equipment, rather than what the equipment does for the client. Avoid using the equipment's function as a justification.

Effective for dates of service on and after October 1, 2024, HCA's *Compression Garments* Authorization form 13-871 is no longer required. Prior authorization is still required.

Continuous Glucose Monitoring

For continuous glucose monitoring systems, including related equipment and supplies, see HCA's **Home Infusion, Diabetic Treatment and Parenteral Nutrition Program Billing Guide**.

Continuous Passive Motion (CPM) Machine

To be payable, the device must begin being used within 72 hours following surgery. The benefit is limited to that portion of the 3-week period following surgery when the device is used in the home. There is insufficient medical evidence to justify coverage of these devices for longer periods of time or for other applications.

HCPCS:

E0935: Cont pas motion exercise dev

(limitation up to 21 days of rental)

E0936: Cpm device, other than knee

(limitation up to 21 days of rental)

Medical necessity guidelines (routine):

The routine medical necessity guidelines for continuous passive motion machine are as follows. These guidelines are reviewed on a case-by-case basis. Other clinical factors may also establish medical necessity based on credible evidence from the electronic health record (EHR) and a review under WAC 182-501-0165:

Post-operative rehabilitation period:

- Total knee arthroplasty (TKA) or;
- Revision of a major component of a previous TKA

AND

- As an adjunct to ongoing physical therapy (PT) unless PT is contraindicated

Promotion of Cartilage Growth and Enhancement of Cartilage Healing

- The client is nonweight-bearing following specific procedures, until the client begins the weight-bearing phase of recovery. Specific procedures include:
    - Abrasion arthroplasty or microfracture procedure – for stimulating cartilage repair in damaged areas
    - Autologous chondrocyte transplantation – to facilitate the integration and maturation of transplanted cartilage cells
    - Chondroplasties of focal cartilage defects – for the repair and healing of localized cartilage damage
    - Surgery for intra-articular cartilage fractures – to promote cartilage healing post-surgery
    - Surgical treatment of osteochondritis dissecans – to enhance the healing process of the cartilage and underlying bone
    - Treatment of an intra-articular fracture of the knee (e.g., tibial plateau fracture repair) – to maintain joint mobility and support cartilage healing

- The client has other medical conditions, indicated when there is a high risk of developing joint stiffness or if early mobilization is critical to the surgical outcome:
  - Post-operative management of ligament reconstruction surgeries (e.g., ACL reconstruction)
  - Post-operative management of tendon repairs (e.g., rotator cuff repairs)

A CPM machine should not be used on patients with unstable fractures, severe joint instability, or active infection in the joint.

Fee-for-service billing instructions:

CPM devices require prior authorization (PA) to establish medical necessity. See the **Authorization** section of this guide for information regarding PA.

Documentation requirements:

Providers must submit a medical necessity justification for each item requested, specifying why the client's medical condition necessitates the equipment, rather than what the equipment does for the client. Avoid using the equipment's function as a justification.

Electrical Neural Stimulation (ENS)

Based upon review of evidence provided by the Health Technology Clinical Committee (HTCC), HCA does not consider this item or related supplies medically necessary outside of a medically supervised facility setting (e.g., in-home use). See **HTCC's finding and coverage decision**.

Hospital beds

HCA pays for one hospital bed, per client in a 10-year period with limitations. See **WAC 182-543-3000**.

Fee-for-service billing instructions:

Hospital beds require prior authorization (PA) to establish medical necessity. See the **Authorization** section of this guide for information regarding PA.

Documentation requirements:

Providers must submit a medical necessity justification for each item requested, specifying why the client's medical condition necessitates the equipment, rather than what the equipment does for the client. Avoid using the equipment's function as a justification.

When a provider is requesting authorization for a hospital bed, providers must use *Hospital Bed Evaluation* form (HCA 13-747). See **Where can I download HCA forms**?

Note: For other forms, see Medicaid Forms.

Enclosed beds: Safety enclosures for pediatric hospital beds and enclosed bed systems

The term "enclosed beds" is an umbrella term encompassing various products, including fully enclosed systems designed with additional protection or enclosure components. For the purposes of this billing guide, an enclosed bed system is not considered a hospital bed because it does not articulate. These custom beds are marketed primarily to individuals who may be prone to wandering or unsafe exiting from the bed. While these products are intended to enhance safety, they are considered a form of restraint.

Hospital beds with 360-degree enclosures (E0328, E0329) and safety enclosures (E0316)

This category is distinct from enclosed beds marketed to individuals. These systems are specifically designed for use with hospital beds and include 360-degree enclosures and safety enclosures.

The FDA has published concerns about the safety of enclosed bed systems. These concerns are based on reports of serious safety risks including entrapment and product misuse, as well as FDA Level 1 recalls. Given that these products are intended to prevent wandering or unsafe exiting from the bed, HCA recognizes the complexity of their potential use.

The decision to authorize payment for an enclosed bed will be based on a thorough individual clinical review, considering whether all other less restrictive and less intrusive methods to ensure safety have been explored and proven ineffective. These products will be reviewed for medical necessity on a case-by-case basis. The process outlined in **WAC 182-501-0165** will be followed in determining medical necessity, in keeping with the goal of balancing patient safety and access to appropriate care, as informed by available evidence-based literature and safety considerations.

HCPCS:

E0328: Ped hospital bed, manual

E0329: Ped hospital bed semi/elect

E0316: Bed safety enclosure

Medical Necessity Guidelines (routine):

The routine medical necessity guidelines for enclosed beds are as follows. These guidelines are reviewed on a case-by-case basis. Other clinical factors may also establish medical necessity based on credible evidence from the electronic health record (EHR) and a review under **WAC 182-501-0165**:

- The client must have a medical condition that prevents the safe use of a standard, non-medical crib or bed, necessitating the use of a hospital bed or an enclosed pediatric hospital bed (See **WAC 182-543-3000** for hospital bed medical necessity guidelines),

AND

- The client is at serious risk of unsafe exiting from the bed.

Fee-for-service billing instructions

Enclosed beds require prior authorization (PA) to establish medical necessity. See the **Authorization** section of this guide for information regarding PA.

Documentation Requirements:

Providers must submit a medical necessity justification for each item requested, specifying why the client's medical condition necessitates the equipment, rather than what the equipment does for the client. Avoid using the equipment's function as a justification.

When a provider is requesting authorization for a hospital bed or safety enclosure for hospital bed, providers must use *Hospital Bed Evaluation* form (HCA 13-747).

When a provider is requesting authorization for an enclosed bed system, a care plan must be submitted.

The care plan must be documented in the client's Electronic Health Record (EHR). The EHR chart notes must include all the following:

- Diagnosis, behaviors and symptoms
- Goals for the client
- Medical, behavioral, sleep interventions
    - Identify each of the less restrictive and less intrusive medical interventions tried and the dates associated with the interventions
- Intervention outcomes and clear explanation of why each intervention failed
- Plan for monitoring use of the enclosed bed system as a medical intervention and expected length of need.

Mattresses and related equipment

HCA purchases hospital bed mattresses with the limitation of one in a five-year period.

HCPCS codes: See Beds, Mattresses and related equipment.

Fee-for-service billing instructions

Mattresses and related equipment require prior authorization (PA) to establish medical necessity. See the Authorization section of this guide for information regarding PA.

Documentation requirements

Providers must submit a medical necessity justification for each item requested, specifying why the client's medical condition necessitates the equipment, rather than what the equipment does for the client. Avoid using the equipment's function as a justification.

Patient lifts, traction equipment, fracture frames, and transfer boards

HCA covers the purchase of the following patient lifts, traction equipment, fracture frames, and transfer boards with limitations. Prior authorization may be required. See Coverage Table for specific PA requirements and limitations.

HCPCS:

E0621: Patient lift sling or seat

E0635: Patient lift electric

Medical necessity guidelines (routine):

The routine medical necessity guidelines for patient lifts are as follows. These guidelines are reviewed on an case-by-case basis. Other clinical factors may also establish medical necessity based on credible evidence from the electronic health record (EHR) and review under WAC 182-501-0165:

- The client requires a floor lift to transfer between bed and chair, wheelchair, or commode,

AND

- Without the use of a lift, the client would be confined to a bed.

For a multi-positional patient transfer system (E0635) the following routine medical necessity guidelines apply:

- The client meets the routine medical necessity guidelines for a lift; and

- The client requires supine positioning for transfers

Therapeutic positioning devices

HCA covers therapeutic positioning seats with the limitation of one in a five-year period.

HCA pays for therapeutic positioning car seats, for use in vehicles, (also known as a special needs or positioning car seats) which are designed to provide additional positioning support for children with medical conditions or disabilities or both.

In addition to safety requirements for transport in a vehicle, the positioning car seat must be for therapeutic positioning needs and considered medical in nature. 'Commercial car seats' do not meet the definition of medical equipment as outlined in WAC 182-543-1000 and 42 CFR 440.70(3). HCA does not cover commercial car seats.

Positioning car seat

HCPCS code:

T5001: Position seat spec orth need

Medical necessity guidelines (routine):

The routine medical necessity guidelines for a positioning car seat are as follows. These guidelines are reviewed on a case-by-case basis. Other clinical factors may also establish medical necessity based on credible evidence from the electronic health record (EHR) and a review under WAC 182-501-0165:

- The client is unable to sit safely in a conventional commercial car seat; and
- The client requires specialized positioning to be safely transported in a vehicle; and
- The client exhibits ONE or more of the following medical conditions:
    - Significant head and trunk instability and/or weakness
    - Significant hypotonicity, hypertonicity, athetosis (writhing movements), ataxia (loss of muscle control/coordination), spasticity, or muscle spasming which results in uncontrollable movement and position change
    - Absence or latency of protective reactions
    - Inability to maintain an unsupported sitting position independently

OR

    - Other significant positional needs that cannot be met in the conventional commercial car seat

AND

- The therapeutic positioning car seat is prescribed by a provider.

Fee-for-service billing instructions:

Positioning car seats require prior authorization (PA) to establish medical necessity. See the **Authorization** section of this guide for information regarding PA.

Documentation requirements

Providers must submit a medical necessity justification for each item requested, specifying why the client's medical condition necessitates the equipment, rather than what the equipment does for the client. Avoid using the equipment's function as a justification.

Osteogenesis electrical stimulator (bone growth stimulator)

HCA covers noninvasive osteogenesis electrical stimulators, that have pulsed electromagnetic field (PEMF) simulation, limited to one per client in a five-year period.

See HCA's **Health Technology Clinical Committee (HTCC)** decision for bone growth stimulators.

Medical necessity guidelines (routine):

The routine medical necessity guidelines for an osteogenesis electrical stimulator are as follows. These guidelines are reviewed on a case-by-case basis. Other clinical factors may also establish medical necessity based on credible evidence from the electronic health record (EHR) and a review under **WAC 182-501-0165**:

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

- The stimulators have pulsed electromagnetic field (PEMF) simulation
- The client meets **one or more of the following clinical criteria**:
    - Has a nonunion of a long bone fracture (which includes clavicle, humerus, phalanx, radius, ulna, femur, tibia, fibula, metacarpal & metatarsal) after three months have elapsed since the date of injury without healing

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

      -OR-
    - Diagnosed with congenital pseudarthrosis

HCA pays for the purchase of spinal bone growth stimulators when both of the following apply:

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

- Has a failed spinal fusion where a minimum of nine months have elapsed since the last surgery
- Is post-op from a multilevel spinal fusion surgery
- Is post-op from spinal fusion surgery where there is a history of a previously failed spinal fusion

HCA pays for the purchase of ultrasonic noninvasive bone growth stimulators when all of the following apply:

- Prescribed by a neurologist, an orthopedic surgeon, or a neurosurgeon; and
- The client meets all of the following criteria:
  - Nonunion confirmed by two radiographs minimum 90 days apart; and
  - Physician statement of no clinical evidence of fracture healing.
  -

Fee-for-service billing instructions

Osteogenesis electrical stimulators require prior authorization (PA) to establish medical necessity. See the **Authorization** section of this guide for information regarding PA.

Documentation requirements

Providers must submit a medical necessity justification for each item requested, specifying why the client's medical condition necessitates the equipment, rather than what the equipment does for the client. Avoid using the equipment's function as a justification.

Speech generating devices (SGD) and other communication devices

Medical necessity guidelines (routine):

The client has severe expressive speech impairment.

Approved SGDs must have one of the following:

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

HCA covers the following:

- One artificial larynx, any type, per client in a five-year period. Prior authorization is not required. HCPCS code L8500.

- One speech generating device (SGD), per client every two years. Prior authorization is required. HCPCS codes E2500, E2502, E2504, E2506, E2508, E2510, E2512.

Fee-for-service billing instructions

SGDs require prior authorization (PA) to establish medical necessity. See the Authorization section of this guide for information regarding PA.

Documentation requirements

Providers must submit a medical necessity justification for each item requested, specifying why the client's medical condition necessitates the equipment, rather than what the equipment does for the client. Avoid using the equipment's function as a justification.

When requesting authorization for SGD, providers must use *Speech Language Pathologist Evaluation for Speech Generating Devices* form, HCA 13-0127 is required. See Where can I download HCA forms?

Rental, repair, batteries

HCA may require trial-use rental of an SGD. HCA applies the rental costs for the trial-use to the purchase price.

HCA pays for the repair or modification of an SGD when all of the following are met:

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

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

HCA does not pay for back-up batteries for a SGD.

Ambulatory aids (canes, crutches, walkers, and related supplies)

HCA covers ambulatory aids with the limitation of one per client in a five-year period, including replacement underarm pads for crutches and replacement handgrips and tips for canes, crutches and walkers. Prior authorization is not required.

Breast pumps

HCA pays for the purchase of breast pumps with limitations.

Manual and electric breast pumps

HCA covers breast pumps without PA, with the limitation of one per client in a three-year period.

HCPCS:

E0602: Manual breast pump

E0603: Electric breast pump

Hospital grade breast pumps

HCPCS:

E0604: Hosp grade elec breast pump

The rental of hospital-grade breast pumps is covered with a limitation of 3 months. A prior authorization (PA) request may be submitted for an extension of the rental period beyond the 3-month limit.

Medical necessity guidelines (routine):

The routine medical necessity guidelines for hospital grade breast pumps are as follows. These guidelines are reviewed on a case-by-case basis. Other clinical factors may also establish medical necessity based on credible evidence from the electronic health record (EHR) and a review under **WAC 182-501-0165**:

- The infant, of a lactating parent, who is receiving milk experiences a prolonged hospitalization
- The parent has been discharged from the hospital; and
- One of the following conditions directly impacts the ability of the infant to feed from the parent:
    - Prematurity (including multiple gestation);
        - Neurologic disorder;
        - Genetic abnormality;
        - Anatomic or mechanical malformation (e.g., cleft lip or palate); or
        - Congenital malformation requiring surgery (e.g., respiratory, cardiac, gastrointestinal, or central nervous system malformation).

Fee-for-service billing instructions

Hospital grade breast pumps require prior authorization (PA) to establish medical necessity. See the **Authorization** section of this guide for information regarding PA.

Documentation requirements

Providers must submit a medical necessity justification for each item requested, specifying why the client's medical condition necessitates the equipment, rather than what the equipment does for the client. Avoid using the equipment's function as a justification.

Negative pressure wound therapy for home use

HCA covers negative pressure wound therapy (NPWT), also referred to as subatmospheric pressure wound therapy or vacuum-assisted wound therapy, when it is used in the treatment of low or nonhealing wounds. NPWT involves the application of subatmospheric pressure to the open wound with the goal of creating a controlled, closed wound amenable to surgical closure, grafting, or healing by secondary intention. NPWT is thought to promote wound healing by providing a warm, moist wound bed while removing wound fluid.

See the **Health Technology Clinical Committee (HTCC) decision** on Negative Pressure Wound Therapy (NPWT).

HCPCS:

E2402: Neg press wound therapy pump

(Rental only)

A6550: Neg pres wound ther drsg set

A7000: Disposable canister for pump

(limitation of 10 per 30 days and only allowed when billed in conjunction with E2402)

Medical necessity guidelines (routine):

The routine medical necessity guidelines for negative pressure wound therapy are as follows. These guidelines are reviewed on a case-by-case basis. Other clinical factors may also establish medical necessity based on credible evidence from the electronic health record (EHR) and a review under **WAC 182-501-0165**:

- The client has an open wound, and requires application of NPWT during inpatient hospital stay
- The client shows healing within 30 days for continuation of service

Limitations of coverage:

- A complete wound therapy program must have been tried and failed prior to NPWT or the complete wound therapy programs are contraindicated.

- Maximum of 4 months of negative pressure wound therapy beginning when the device was applied during an inpatient stay and prior to discharge into a home setting.

Discontinuation of coverage:

- Any measurable degree of wound healing has failed to occur over the prior month. Wound healing is defined as improvement occurring in either surface area (length times width) or depth of the wound

OR

- Four months (including the time NPWT was applied in an inpatient setting prior to discharge to the home) have elapsed using a NPWT pump in the treatment of the most recent wound. Noncovered indicators: Treatment is not covered in patients with contraindications referred to by the **FDA Safety Communication dated February 24, 2011**.

Fee-for-service billing instructions

NPWT prior authorization (PA) to establish medical necessity. See the **Authorization** section of this guide for information regarding PA.

Documentation requirements

Providers must submit a medical necessity justification for each item requested, specifying why the client's medical condition necessitates the equipment, rather than what the equipment does for the client. Avoid using the equipment's function as a justification.

When requesting authorization for NPWT, providers must use the *Negative Pressure Wound Therapy* form (HCA 13-726).

Washington State Health Care Authority

Coverage Table – Medical Equipment & Supplies

Coverage Table – Legends

Status Code Indicator

BR = By Report (Invoice or price list required)
D = Discontinued
DC = Same/similar covered code in fee schedule
DP = Service managed through a different program
N = New
P = Policy change

Modifiers

KS = Noninsulin dependent
KX = Insulin dependent
NU = New Equipment
RA = Replacement equipment
RB = Replacement as part of repair
RR = Equipment rental
SC = Medically necessary service or supply

Policy/Comments - Legend

EPA = Expedited Prior Authorization
NF = Nursing Facility
PA = Prior Authorization
*Not allowed in combination with any other disposable diaper or pant, or rental reusable diaper or pant.

Coverage Table

Note: Where used in the Coverage Table, a year means the period starting 365 days before the date of service.

For example: If a service is allowed once per client, per year, and it was provided on June 30, 2022, then the service would not be allowed for that client again until June 30, 2023.

Beds, mattresses, and related equipment

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4640	RA	Alternating pressure pad	Purchase only. Included in NF daily rate.
	A6550		Neg pres wound ther drsg set	Purchase only. PA required. Electrical pump, includes all supplies and accessories
	A7000	NU	Disposable canister for pump	Limit of 10 per client every 30 days. Allowed only when billed in conjunction with PA HCPCS code E2402.
N	A9286		Hygienic item, bed encasements	For clients age 20 and younger. Limit one set per client during a five-year period. Use EPA #870001604 for mattress (twin). Use EPA #870001605 for pillowcases (set of 2). Requires *Bed and Pillow Encasements* form HCA 13-0052 to be completed and submitted with the claim. See Where can I download HCA forms?
BR	K0743		Portable home suction pump	PA required
	E0181	NU/RR	Press pad alternating w/ pump	PA required for rental only.
	E0182	NU	Replace pump, alt press pad	Included in NF daily rate.
	E0183	NU	Powered pressure reducing under lay/pad with pump; includes heavy duty	Limit 1 per client every 5 years. Included in NF daily rate.
	E0184	NU	Dry pressure mattress	Limit of 1 per client every 5 years. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0185	NU/RR	Gel pressure mattress pad	Considered purchased after 1 year's rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.
	E0186	NU/RR	Air pressure mattress	For powered pressure reducing mattress see HCPCS code E0277. Considered purchased after 1 year's rental. PA required for rental. Included in NF daily rate.
BR	E0190		Positioning cushion	Purchase only. Limit 1 per year. Included in NF daily rate.
DC	E0193		Powered air flotation bed	See E0194
	E0194	NU/RR	Air fluidized bed	Considered purchased after 1 year's rental. PA or EPA required.
	E0196	NU	Gel pressure mattress	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0197	NU/RR	Air pressure pad for mattress	Considered purchased after 1 year's rental. PA required for rental. Included in NF daily rate.
	E0198	NU	Water pressure pad for mattr	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0199	NU	Dry pressure pad for mattres	Limit of 1 per client every 5 years. Included in NF daily rate.
DC	E0255		Hospital bed var ht w/mattr	See HCPCS codes E0292 and E0305 or E0310.
DC	E0256		Hospital bed var ht w/o matt	See HCPCS codes E0293 and E0305 or E0310.
DC	E0260		Hosp bed semi-electr w/matt	See HCPCS codes E0294 and E0305 or E0310.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
DC	E0261		Hosp bed semi-electr w/o mat	See HCPCS codes E0295 and E0305 or E0310.
DC	E0265		Hosp bed total electr w/mat	See HCPCS codes E0296 and E0305 or E0310.
DC	E0266		Hosp bed total elec w/o matt	See HCPCS codes E0297 and E0305 or E0310.
	E0271	NU	Mattress innerspring	Limit of 1 per client every 5 years. Replacement only. Included in NF daily rate.
	E0272	NU	Mattress foam rubber	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0277	NU/RR	Powered pres-redu air mattrs	Considered purchased after 1 year's rental. PA or EPA required. Limit of 1 per client every 5 years.
	E0290	NU	Hosp bed fx ht w/o rails w/m	
	E0291	NU	Hosp bed fx ht w/o rail w/o	
	E0292	NU/RR	Hosp bed var ht no sr w/matt	Considered purchased after 1 year's rental. Limit of 1 per client every 10 years. PA required. Included in NF daily rate.
	E0293	NU/RR	Hosp bed var ht no sr no mat	Considered purchased after 1 year's rental. Limited of 1 per client every 10 years. PA required. Included in NF daily rate.
	E0294	NU/RR	Hosp bed semi-elect w/ mattr	Considered purchased after 1 year's rental. Limit of 1 per client every 10 years. PA or EPA required. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0295	NU/RR	Hosp bed semi-elect w/o matt	Considered purchased after 1 year's rental. Limit of 1 per client every 10 years. PA required. Included in NF daily rate.
	E0300	NU/RR	Enclosed ped crib hosp grade	Considered purchased after 1 year's rental. PA required. Included in NF daily rate.
	E0301	NU	Hd hosp bed, 350-600 lbs	PA required
DC	E0302		Ex hd hosp bed > 600 lbs	See E0304
	E0303	NU/RR	Hosp bed hvy dty xtra wide	Considered purchased after 1 year's rental. Limit of 1 per client every 10 years. PA required. Included in NF daily rate.
	E0304	NU/RR	Hosp bed xtra hvy dty x wide	Considered purchased after 1 year's rental. Limit of 1 per client every 10 years. PA required. Included in NF daily rate.
	E0305	NU/RR	Rails bed side half length	Considered purchased after 1 year's rental. Limit of 1 per client every 10 years. Rental requires PA or EPA. Included in NF daily rate.
	E0310	NU/RR	Rails bed side full length	Considered purchased after 1 year's rental. Limit of 1 per client every 10 years. Rental requires PA or EPA. Included in NF daily rate.
	E0316	NU	Bed safety enclosure	PA required. Included in NF daily rate. Frame/canopy for use with hospital bed.
	E0328		Ped hospital bed, manual with 360-degree side	Purchase only. Limit of 1 per client every 10 years. PA required. Included in NF daily rate. For clients age 20 and younger. Use form HCA 13-747.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0329		Ped hospital bed semi/elect with 360-degree side	Purchase only. Limit of 1 per client every 10 years. PA required. Included in NF daily rate. For clients age 20 and younger. Use form HCA 13-747.
	E0371	NU/RR	Nonpower mattress overlay	Considered purchased after 1 year's rental. PA or EPA required.
	E0372	NU/RR	Powered air mattress overlay	Considered purchased after 1 year's rental. PA or EPA required.
	E0373	NU/RR	Nonpowered pressure mattress	Considered purchased after 1 year's rental. PA or EPA required.
	E2402	RR	Neg press wound therapy pump	Rental only. PA required.

Fracture frames, trapeze, traction, and transfer equipment

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
DC	E0830		Ambulatory traction device	
	E0840	NU	Tract frame attach headboard	
DC	E0849		Cervical pneum trac equip	
	E0850	NU	Traction stand free standing	Limit of 1 per client every 5 years. Included in NF daily rate.
DC	E0855		Cervical traction equipment	
DC	E0856		Cervic collar w air bladders	

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0860	NU	Tract equip cervical tract	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0870	NU	Tract frame attach footboard	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0880	NU	Trac stand free stand extrem	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0890	NU	Traction frame attach pelvic	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0900	NU	Trac stand free stand pelvic	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0910	NU/RR	Trapeze bar attached to bed	Considered purchased after 1 year's rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.
	E0911	NU/RR	Hd trapeze bar attach to bed	Considered purchased after 1 year's rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.
	E0912	NU/RR	Hd trapeze bar free standing	Considered purchased after 1 year rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.
	E0920	NU/RR	Fracture frame attached to b	Considered purchased after 1 year's rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.
	E0930	NU/RR	Fracture frame free standing	Considered purchased after 1 year's rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0940	NU/RR	Trapeze bar free standing	Considered purchased after 1 year's rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.
	E0941	NU/RR	Gravity assisted traction de	Considered purchased after 1 year's rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.
	E0946	NU/RR	Fracture frame dual w cross	Considered purchased after 1 year's rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.
	E0947	NU	Fracture frame attachmnts pe	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0948	NU	Fracture frame attachmnts ce	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0705	NU	Transfer device	Limit of 1 per client every 5 years. Included in NF daily rate.

Positioning devices (standers) and patient lifts

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0621	NU	Sling or seat, patient lift, canvas or nylon	Limit of 2 per client, per year. Included in NF daily rate.
	E0630	NU/RR	Patient lift hydraulic	Considered purchased after 1 year's rental. Limit of 1 per client every 5 years. Includes bath. PA required for rental. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0635	NU/RR	Patient lift electric	Considered purchased after 1 year's rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.
DC	E0636		Pt support and positioning sys	See E0635
	E0637	NU/RR	Combination sit to stand sys	Limit of 1 per client every 5 years. PA required. Included in NF daily rate. Considered purchased after 1 year's rental.
	E0638	NU	Standing frame sys	Limit of 1 per client every 5 years. PA required. Included in NF daily rate. Considered purchased after 1 year's rental.
	E0639	NU	Moveable patient lift system	Limit of 1 per client every 5 years. PA required. Included in NF daily rate.
	E0641	NU	Multi-position stnd fram sys	Limit of 1 per client every 5 years. PA required. Included in NF daily rate. Considered purchased after 1 year's rental.
	E0642	NU	Dynamic standing frame	Limit of 1 per client every 5 years. PA required. Included in NF daily rate. Considered purchased after 1 year's rental.

Noninvasive bone growth/nerve stimulators

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0740	NU/RR	Non-implant pelv flr e-stim	Considered purchased after 1 year's rental. PA required. Included in NF daily rate.
	E0747	NU	Elec osteogen stim not spine	Limit of 1 per client every 5 years. PA or EPA is required.
	E0748	NU	Elec osteogen stim spinal	Limit of 1 per client every 5 years. PA or EPA is required.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0760	NU	Osteogen ultrasound stimltor	Limit of 1 per client every 5 years. PA or EPA is required.

Communication devices

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2500	NU	SGD digitized pre-rec <=8min	PA required.
	E2502	NU	SGD prerec msg >8min <=20min	PA required.
	E2504	NU	SGD prerec msg>20min <=40min	PA required.
	E2506	NU	SGD prerec msg > 40 min	PA required.
	E2508	NU	SGD spelling phys contact	PA required.
	E2510		SGD w multi methods msg/accs	Purchase only. PA required.
	E2512	NU	SGD accessory, mounting sys	PA required.
BR	E2599		SGD accessory noc	Purchase only. PA required.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	L8500		Artificial larynx	Purchase only. Limit of 1 per client every 5 years.

Ambulatory aids

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4635		Underarm crutch pad	Purchase only. Included in NF daily rate.
	A4636	NU	Handgrip for cane etc	Included in NF daily rate.
	A4637	NU	Repl tip cane/crutch/walker	Included in NF daily rate.
	E0100	NU	Cane adjust/fixed with tip	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0105	NU	Cane adjust/fixed quad/3 pro	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0110	NU	Crutch forearm pair	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0111	NU	Crutch forearm each	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0112	NU	Crutch underarm pair wood	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0113	NU	Crutch underarm each wood	Limit of 1 per client every 5 years. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0114	NU	Crutch underarm pair no wood	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0116	NU	Crutch underarm each no wood	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0117	NU	Underarm springassist crutch	PA required.
DC	E8000		Posterior gait trainer	See HCPCS code E8001.
BR	E8001		Upright gait trainer	Purchase only. PA required. Included in NF daily rate.
DC	E8002		Anterior gait trainer	See HCPCS code E8001.
	E0130	NU	Walker rigid adjust/fixed ht	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0135	NU	Walker folding adjust/fixed	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0140	NU	Walker w trunk support	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0141	NU	Rigid wheeled walker adj/fix	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0143	NU	Walker folding wheeled w/o s	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0144	NU	Enclosed walker w rear seat	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0147	NU	Walker variable wheel resist	Limit of 1 per client every 5 years. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0148	NU	Heavy duty walker no wheels	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0149	NU	Heavy duty wheeled walker	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0153	NU	Forearm crutch platform attachment	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0154	NU	Walker platform attachment	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0155	NU	Walker wheel attachment, pair	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0156	NU	Walker seat attachment	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0157	NU	Walker crutch attachment	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0158	NU	Walker leg extenders set of4	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0159	NU	Brake for wheeled walker	Included in NF daily rate.

Bathroom equipment

All bathroom equipment accessories must have medical justification. See WAC 182-543-7100(5).

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0163	NU/RR	Commode chair with fixed arm	PA required. Use form HCA 13-872
	E0165	NU/RR	Commode chair with detacharm	PA required. Use form HCA 13-872
	E0167		Commode chair pail or pan, replacement only	PA required. Do not bill with E0165 and E0163. Use form HCA 13-872
	E0168	NU/RR	Heavyduty/wide commode chair	PA required. Use form HCA 13-872
BR	E0168	SC	Heavyduty/wide commode chair	PA required. Use form HCA 13-872 (Weight capacity: >600 lbs.)
	E0175		Commode chair foot rest	PA required
BR	E0240		Bath/shower chair	PA required. Use form HCA 13-872
BR	E0243		Toilet rail	PA required. Use form HCA 13-872
BR	E0244		Toilet seat raised	PA required. Use form HCA 13-872
BR	E0245		Tub stool or bench	PA required. Use form HCA 13-872
BR	E0247		Trans bench w/wo comm open	PA required. Use form HCA 13-872
BR	E0248		Hdtrans bench w/wo comm open	PA required. Use form HCA 13-872
BR	E0700		Safety equipment	Purchase only. Included in NF daily rate.

Blood pressure monitoring

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	A4660		Sphyg/bp app w cuff and stet	
	A4663		Dialysis blood pressure cuff	Use for replacement BP cuffs
	A4670		Automatic bp monitor, dial	Limit of 1 per client, per 3 years.
	A9275		Disp home glucose monitor	Purchase only.

Miscellaneous medical equipment

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A8000	NU	Soft protect helmet prefab	Limit of 2 per client, per year.
	A8001	NU	Hard protect helmet prefab	Limit of 2 per client, per year.
BR	A8002	NU	Soft protect helmet custom	Limit of 1 per client, per year. PA required.
BR	A8003	NU	Hard protect helmet custom	Limit of 1 per client, per year. PA required.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	A8004	NU	Repl soft interface, helmet	Not allowed in addition to HCPCS codes A8000 – A8003.
	E0202	RR	Phototherapy light w/ photom	Rental only. Includes all supplies. Limit of 5 days of rental per client, per 12-month period.
	E0602	NU	Manual breast pump	Purchase only. Limit of 1 per client in a three-year period.
	E0603	NU	Electric breast pump	Purchase only. Limit of 1 per client in a three-year period.
	E0604	RR	Hosp grade elec breast pump	Rental only PA or EPA is required. PA required for limitation extension.
	E0650	NU/RR	Pneuma compresor non-segment	Considered purchased after 1 year's rental. Limit of 1 per client every 5 years. Rental requires PA or EPA is required. Included in NF daily rate.
	E0655	NU	Pneumatic appliance half arm	
	E0660	NU	Pneumatic appliance full leg	
	E0665	NU	Pneumatic appliance full arm	
	E0666	NU	Pneumatic appliance half leg	
	E0935	RR	Cont pas motion exercise dev	Rental allowed for maximum of 21days. Limits = per knee. PA or EPA is required.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0936	RR	Cpm device, other than knee	PA required. Rental allowed for maximum of 21 days.
BR	E1399	NU	Misc. durable medical equipment mi	Purchase only. PA required.
	E2000	RR	Gastric suction pump hme mdl	Rental only. PA required.
	K0606		Aed garment w elec analysis	PA required
	K0607		Repl batt for aed	
	K0608		Repl garment for aed	
	K0609		Repl electrode for aed	
	K0739		Repair/svc dme non-oxygen eq	For client-owned equipment only. PA required.
BR	T5001	NU/RR	Position seat spec orth need	Limit of 1 per client every 5 years. PA required. Use code for positioning car seat. Included in NF daily rate.

Other charges for medical equipment services

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	A6549		Compression garments	Limit of 2 per limb, every 6 months. PA required
	A7048		Vacuum collection drainage unit, including all supplies	Limit 4 per month

Manual wheelchairs (covered HCPCS codes)

Wheelchairs (manual) – See WAC 182-543-4000, 182-543-4100, 182-543-4200, 182-543-4300.

Prior authorization is required. Required forms: *Medical Necessity for Wheelchair Purchase (for home clients only -authorization)* form HCA 19-0008 or *Medical Necessity for Wheelchair Purchase (for nursing facility (NF) clients)* form HCA 19-0006. See Where can I download HCA forms?

(For CRT Wheelchairs - see Complex Rehabilitation Technology Billing Guide)

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E1028	NU	W/c manual swingaway	PA required HCPCS code E1028 must be submitted on one line for correct payment.
	E1031	NU	Rollabout chair with casters	PA required
	E1060	RR	Wheelchair detachable arms	EPA required
	K0001	NU/RR	Standard wheelchair	EPA required for rental only

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	K0002	NU/RR	Stnd hemi (low seat) whlchr	PA required for rental only.
	K0003	NU/RR	Lightweight wheelchair	PA required for rental only
	K0004	NU	High strength ltwt whlchr	PA required
	K0006	NU/RR	Heavy duty wheelchair	PA required
BR	K0108	NU	W/c component-accessory nos	PA required

Manual wheelchairs (noncovered HCPCS codes)

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
DC	E1050		Whelchr fxd full length arms	See HCPCS codes K0003 and E1226.
DC	E1070		Wheelchair detachable foot r	See HCPCS codes K0003 and E1226.
DC	E1083		Hemi-wheelchair fixed arms	See HCPCS code K0002 and K0003.
DC	E1084		Hemi-wheelchair detachable a	See HCPCS code K0002 and K0003.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
DC	E1085		Hemi-wheelchair fixed arms	See HCPCS code K0002 and K0003.
DC	E1086		Hemi-wheelchair detachable a	See HCPCS code K0002 and K0003.
DC	E1087		Wheelchair lightwt fixed arm	See HCPCS code K0004.
DC	E1088		Wheelchair lightweight det a	See HCPCS code K0004.
DC	E1089		Wheelchair lightwt fixed arm	See HCPCS code K0004.
DC	E1090		Wheelchair lightweight det a	See HCPCS code K0004.
DC	E1092		Wheelchair wide w/ leg rests	See HCPCS code K0007.
DC	E1093		Wheelchair wide w/ foot rest	See HCPCS code K0007.
DC	E1100		Whchr s-recl fxd arm leg res	See HCPCS code K0003 and E1226.
DC	E1130		Whlchr stand fxd arm ft rest	See HCPCS code K0001.
DC	E1140		Wheelchair standard detach a	See HCPCS code K0001.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
DC	E1150		Wheelchair standard w/ leg r	See HCPCS code K0001.
DC	E1160		Wheelchair fixed arms	
DC	E1170		Whlchr ampu fxd arm leg rest	See HCPCS code K0001 – K0005.
DC	E1171		Wheelchair amputee w/o leg r	See HCPCS code K0001 – K0005.
DC	E1172		Wheelchair amputee detach ar	See HCPCS code K0001 – K0005.
DC	E1180		Wheelchair amputee w/ foot r	See HCPCS code K0001 – K0005.
DC	E1190		Wheelchair amputee w/ leg re	See HCPCS code K0001 – K0005.
DC	E1195		Wheelchair amputee heavy dut	See HCPCS code K0007.
DC	E1200		Wheelchair amputee fixed arm	See HCPCS code K0001 – K0005.
DC	E1221		Wheelchair spec size w foot	See HCPCS code K0001 – K0014.
DC	E1222		Wheelchair spec size w/ leg	See HCPCS code K0001 – K0014.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
DC	E1223		Wheelchair spec size w foot	See HCPCS code K0001 – K0014.
DC	E1224		Wheelchair spec size w/ leg	See HCPCS code K0001 – K0014.
DC	E1240		Whchr litwt det arm leg rest	See HCPCS code K0003 or K0004.
DC	E1250		Wheelchair lightwt fixed arm	See HCPCS code K0003 or K0004.
DC	E1260		Wheelchair lightwt foot rest	See HCPCS code K0003 or K0004.
DC	E1270		Wheelchair lightweight leg r	See HCPCS code K0003 or K0004.
DC	E1280		Whchr h-duty det arm leg res	See HCPCS code K0007.
DC	E1285		Wheelchair heavy duty fixed	See HCPCS code K0007.
DC	E1290		Wheelchair hvy duty detach a	See HCPCS code K0007.
DC	E1295		Wheelchair heavy duty fixed	See HCPCS code K0007.

Power-operated vehicles (covered HCPCS codes)

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	K0800	NU	Pov group 1 std up to 300lbs	PA required. Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396.
	K0801	NU	Pov group 1 hd 301-450 lbs	PA required. Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396.
	K0802	NU	Pov group 1 vhd 451-600 lbs	PA required. Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396.
	K0806	NU	Pov group 2 std up to 300lbs	PA required. Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396.
	K0807	NU	Pov group 2 hd 301-450 lbs	PA required. Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396.
	K0808	NU	Pov group 2 vhd 451-600 lbs	PA required. Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	K0812	NU	Power operated vehicle noc	PA required. Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 & E2381 – E2396.

Wheelchair Cushions

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2601	NU	Gen w/c cushion wdth < 22 in	
	E2602	NU	Gen w/c cushion wdth >=22 in	
	E2603	NU	Skin protect wc cus wd <22in	PA required
	E2604	NU	Skin protect wc cus wd>=22in	PA required
	E2605	NU	Position wc cush wdth <22 in	PA required
	E2606	NU	Position wc cush wdth>=22 in	PA required
	E2607	NU	Skin pro/pos wc cus wd <22in	PA required

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2608	NU	Skin pro/pos wc cus wd>=22in	PA required
	E2622	NU	Adj skin pro w/c cus wd<22in	PA required
	E2623	NU	Adj skin pro wc cus wd>=22in	PA required
	E2624	NU	Adj skin pro/pos cus<22in	PA required
	E2625	NU	Adj skin pro/pos wc cus>=22	PA required

Armrests and parts

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0994	NU	Wheelchair arm rest	
	K0019	NU	Arm pad repl, each	

Lower extremity positioning (leg rests, etc.)

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0951	NU	Loop heel	

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0952	NU	Toe loop/holder, each	
	E0995	NU	Wc calf rest, pad replacemnt	PA required
	K0038	NU	Leg strap each	PA required
	K0039	NU	Leg strap h style each	PA required
	K0041	NU	Large size footplate each	PA required
	K0195	NU	Elevating whlchair leg rests	PA required

Seat and positioning

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0950	NU	Tray	PA required
	E0960	NU	W/c shoulder harness/straps	PA required
	E0978	NU	W/c acc,saf belt pelv strap	PA required
	E0980	NU	Wheelchair safety vest	PA required

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0981	NU	Seat upholstery, replacement	PA required
	E0982	NU	Back upholstery, replacement	PA required
	E0992	NU	Wheelchair solid seat insert	PA required
	E2231	NU	Solid seat support base	PA required
BR	E2291	NU	Planar back for ped size wc	PA required
BR	E2292	NU	Planar seat for ped size wc	PA required
BR	E2293	NU	Contour back for ped size wc	PA required
BR	E2294	NU	Contour seat for ped size wc	PA required
	E2611	NU	Gen use back cush wdth <22in	
	E2612	NU	Gen use back cush wdth>=22in	
	E2613	NU	Position back cush wd <22in	PA required

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2614	NU	Position back cush wd>=22in	PA required
	E2615	NU	Pos back post/lat wdth <22in	PA required
	E2616	NU	Pos back post/lat wdth>=22in	PA required

Hand rims, wheel, and tires (includes parts)

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0967	NU	Man wc rim/projection rep ea	PA required
	E2211	NU	Pneumatic propulsion tire	PA required
	E2212	NU	Pneumatic prop tire tube	PA required
	E2213	NU	Pneumatic prop tire insert	PA required
	E2214	NU	Pneumatic caster tire each	PA required
	E2215	NU	Pneumatic caster tire tube	PA required

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2216	NU	Foam filled propulsion tire	
	E2217	NU	Foam filled caster tire each	
	E2218	NU	Foam propulsion tire each	
	E2219	NU	Foam caster tire any size ea	
	E2220	NU	Solid propuls tire, repl, ea	
	E2221	NU	Solid caster tire repl, each	
	E2222	NU	Solid caster integ whl, repl	
	E2224	NU	Propulsion whl excl tire rep	PA required
	E2225	NU	Caster wheel excludes tire	PA required
	E2226	NU	Caster fork replacement only	PA required
	K0065	NU	Spoke protectors	PA required
	K0069	NU	Rr whl compl sol tire rep ea	PA required

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	K0070	NU	Rr whl compl pne tire rep ea	PA required
	K0071	NU	Fr cstr comp pne tire rep ea	PA required
	K0072	NU	Fr cstr semi-pne tire rep ea	PA required
	K0073	NU	Caster pin lock each	PA required
	K0077	NU	Fr cstr asmb sol tire rep ea	PA required

Other accessories

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0776	NU/RR	W/c IV pole	PA required
	E0961	NU	W/c brake extension	Changed from pair to each with new description. PA required.
	E0971	NU	W/c anti-tipping devi	PA required
	E0973	NU	W/c access det adj armrest	PA required
	E1029	NU	W/c vent tray fixed	PA required

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E1030	NU	W/c vent tray gimbaled	PA required
	E2207	NU	Crutch and cane holder	PA required
	E2208	NU	Cylinder tank carrier	PA required
	K0105	NU	W/c IV hanger	PA required

Miscellaneous repair only

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2210	NU	Pwc acc, lith-based battery	PA required
	E2619	NU	Replace cover w/c seat cush	PA required

Syringes and needles

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4206		1 cc sterile syringe & needle	Included in NF daily rate
	A4207		2 cc sterile syringe & needle	Included in NF daily rate

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4208		3 cc sterile syringe & needle	Included in NF daily rate
	A4209		5+ cc sterile syringe & needle	Included in NF daily rate
	A4210		Nonneedle injection device	Included in NF daily rate
	A4213		20 mL or greater, syringe only	Included in NF daily rate
	A4215		Sterile needle	Included in NF daily rate
	A4322		Irrigation syringe	Not allowed in combination with code A4320, A4355. Included in NF daily rate.

Blood monitoring/testing supplies

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4233		Alkalin batt for glucose mon	Limit 1 every 3 months
	A4234		J-cell batt for glucose mon	Limit 1 every 3 months
	A4235		Lithium batt for glucose mon	Limit 1 every 3 months
	A4236		Silvr oxide batt glucose mon	

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4253	KX/KS	Blood glucose/reagent strips	Included in NF 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 noninsulin dependent; for children age 20 and younger insulin dependent, 300 test strips and 300 lancets per month (medical equipment 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 Billing Guide
	A4255		Glucose monitor platforms	
	A4256		Calibrator solution/chips	Included in NF daily rate.
	A4258		Lancet device each	1 allowed per client, per 6 months. Included in NF daily rate.
	A4259	KX/KS	Lancets per box	Included in NF 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 noninsulin dependent; for children age 20 and younger insulin dependent, 300 test strips and 300 lancets per month (medical equipment 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 Billing Guide

Antiseptics and germicides

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4244		Alcohol or peroxide per pint	Max of 1 pint allowed per client, per 6 months. Included in NF daily rate.
	A4245		Alcohol wipes per box	Max of 1 box allowed per client, per month. Included in NF daily rate.
	A4246		Betadine/phisohex solution	Max of 1 pint allowed per client, per month. Included in NF daily rate.
	A4247		Betadine/iodine swabs/wipes	Max of 1 box allowed per client, per month. Included in NF daily rate
BR	A4248		Chlorhexidine antisept	Max of 1 box allowed per client, per month. Included in NF daily rate.

Bandages, dressings, and tapes

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

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	A4649		Surgical supplies, misc.	PA required
	A6010		Collagen based wound filler	PA required
	A6011		Collagen gel/paste wound fil	PA required
	A6021		Collagen dressing <=16 sq in	
	A6022		Collagen drsg>16<=48 sq in	

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6023		Collagen dressing >48 sq in	PA required
	A6024		Collagen dsg wound filler	
	A6025		Silicone gel sheet, each	
	A6154		Wound pouch each	
	A6196		Alginate dressing <=16 sq in	
	A6197		Alginate drsg >16 <=48 sq in	
	A6198		Alginate dressing > 48 sq in	
	A6199		Alginate drsg wound filler	
	A6203		Composite drsg <= 16 sq in	
	A6204		Composite drsg >16<=48 sq in	
	A6205		Composite drsg > 48 sq in	
	A6206		Contact layer <= 16 sq in	
	A6207		Contact layer >16<= 48 sq in	
	A6208		Contact layer > 48 sq in	
	A6209		Foam drsg <=16 sq in w/o bdr	

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6210		Foam drg >16<=48 sq in w/o b	
	A6211		Foam drg > 48 sq in w/o brdr	
	A6212		Foam drg <=16 sq in w/border	
	A6213		Foam drg >16<=48 sq in w/bdr	
	A6214		Foam drg > 48 sq in w/border	
	A6215		Foam dressing wound filler	
	A6216		Non-sterile gauze<=16 sq in	
	A6217		Non-sterile gauze>16<=48 sq	
	A6218		Non-sterile gauze > 48 sq in	
	A6219		Gauze <= 16 sq in w/border	
	A6220		Gauze >16 <=48 sq in w/bordr	
	A6221		Gauze > 48 sq in w/border	
	A6222		Gauze <=16 in no w/sal w/o b	
	A6223		Gauze >16<=48 no w/sal w/o b	

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6224		Gauze > 48 in no w/sal w/o b	
	A6229		Gauze >16<=48 sq in watr/sal	
	A6230		Gauze > 48 sq in water/salne	
	A6231		Hydrogel dsg<=16 sq in	
	A6232		Hydrogel dsg>16<=48 sq in	
	A6233		Hydrogel dressing >48 sq in	
	A6234		Hydrocolld drg <=16 w/o bdr	
	A6235		Hydrocolld drg >16<=48 w/o b	
	A6236		Hydrocolld drg > 48 in w/o b	
	A6237		Hydrocolld drg <=16 in w/bdr	
	A6238		Hydrocolld drg >16<=48 w/bdr	
	A6240		Hydrocolld drg filler paste	
	A6241		Hydrocolloid drg filler dry	
	A6242		Hydrogel drg <=16 in w/o bdr	
	A6243		Hydrogel drg >16<=48 w/o bdr	

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6244		Hydrogel drg >48 in w/o bdr	
	A6245		Hydrogel drg <= 16 in w/bdr	
	A6246		Hydrogel drg >16<=48 in w/b	
	A6247		Hydrogel drg > 48 sq in w/b	
	A6248		Hydrogel drsg gel filler	
	A6251		Absorpt drg <=16 sq in w/o b	
	A6252		Absorpt drg >16 <=48 w/o bdr	
	A6253		Absorpt drg > 48 sq in w/o b	
	A6254		Absorpt drg <=16 sq in w/bdr	
	A6255		Absorpt drg >16<=48 in w/bdr	
	A6256		Absorpt drg > 48 sq in w/bdr	
	A6257		Transparent film <= 16 sq in	
	A6258		Transparent film >16<=48 in	
	A6259		Transparent film > 48 sq in	
	A6260		Wound cleanser any type/size	

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	A6261		Wound filler gel/paste /oz	PA required
BR	A6262		Wound filler dry form / gram	PA required
	A6266		Impreg gauze no h20/sal/yard	
	A6402		Sterile gauze <= 16 sq in	
	A6403		Sterile gauze>16 <= 48 sq in	
	A6404		Sterile gauze > 48 sq in	
	A6407		Packing strips, non-impreg	
	A6441		Pad band w>=3" <5"/yd	
	A6442		Conform band n/s w<3"/yd	
	A6443		Conform band n/s w>=3"<5"/yd	
	A6444		Conform band n/s w>=5"/yd	
	A6445		Conform band s w <3"/yd	
	A6446		Conform band s w>=3" <5"/yd	
	A6447		Conform band s w >=5"/yd	
	A6448		Lt compres band <3"/yd	

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6449		Lt compres band >=3" <5"/yd	
	A6450		Lt compres band >=5"/yd	
	A6451		Mod compres band w>=3"<5"/yd	
	A6452		High compres band w>=3"<5"yd	
	A6453		Self-adher band w <3"/yd	
	A6454		Self-adher band w>=3" <5"/yd	
	A6455		Self-adher band >=5"/yd	
	A6456		Zinc paste band w >=3"<5"/yd	
	A6457		Tubular dressing	
BR	A6501		Compres burngarment bodysuit	PA required
BR	A6502		Compres burngarment chinstrp	PA required
BR	A6503		Compres burngarment facehood	PA required
BR	A6504		Cmprsburngarment glove-wrist	PA required
BR	A6505		Cmprsburngarment glove-elbow	PA required

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	A6506		Cmprsburngrmnt glove-axilla	PA required
BR	A6507		Cmprs burngarment foot-knee	PA required
BR	A6508		Cmprs burngarment foot-thigh	PA required
BR	A6509		Compres burn garment jacket	PA required
BR	A6510		Compres burn garment leotard	PA required
BR	A6511		Compres burn garment panty	PA required
BR	A6512		Compres burn garment, noc	PA required
BR	A6513		Compress burn mask face/neck	PA required
BR	A6594		G comp bandge liner lwr extr	PA required
BR	A6595		G comp bandge liner upr extr	PA required
BR	A6596		G comp bandge conform gauze	PA required
BR	A6597		G comp bandage long stretch	PA required
BR	A6598		G comp bandage med stretch	PA required
BR	A6599		G comp bandage short stretch	PA required

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	A6600		G com bandge hgh dn foam sht	PA required
BR	A6601		G com bandge hgh dn foam pad	PA required
BR	A6602		G com bandge hgh dn foamroll	PA required
BR	A6603		G com bandge low dn foamchnl	PA required
BR	A6604		G com bandge low dn foam flt	PA required
BR	A6605		G com bandage padded foam	PA required
BR	A6606		G com bandage padded textile	PA required
BR	A6607		G com bandage tub protct lyr	PA required
BR	A6608		G com bandage tub protct pad	PA required
BR	A6609		G compression bandaging	PA required
	S8431		Compression bandage	
BR	T5999		Supply, nos	PA required
BR	Q0508		Mis supp/acc imp VAD	PA required

Tapes

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4450		Non-waterproof tape	Unless needed for the first 6 weeks of post-surgery, all bandages, dressings, and tapes are included in the NF daily rate.)
	A4452		Waterproof tape	
	A4461		Surgicl dress hold non-reuse	
	A4463		Surgical dress holder reuse	
	A4465		Non-elastic extremity binder	

Ostomy supplies

(Note: Items in this category are not taxable)

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4361		Ostomy face plate	Max of 10 allowed per client, per month. Not allowed in combination with codes A4375, A4376, A4379, or A4380.
	A4362		Solid skin barrier	For ostomy only.
	A4363		Ostomy clamp, replacement	
	A4364		Adhesive, liquid or equal	Max of 4 allowed per client, per month. For ostomy or catheter.
	A4366		Ostomy vent	

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4367		Ostomy belt	Max of 2 allowed per client every 6 months.
	A4368		Ostomy filter	Not allowed in combination with code A4418, A4419, A4423, A4424, A4425, or A4427.
	A4369		Skin barrier liquid per oz	
	A4371		Skin barrier powder per oz	
	A4372		Skin barrier solid 4x4 equiv	
	A4373		Skin barrier with flange	
	A4375		Drainable plastic pch w fcpl	Max of 10 allowed per month, per client. Not allowed in combination with code A4361, A4377, or A4378.
	A4376		Drainable rubber pch w fcplt	Max of 10 allowed per month, per client. Not allowed in combination with code A4361, A4377, or A4378.
	A4377		Drainable plstic pch w/o fp	Max of 10 allowed per month, per client. Not allowed in combination with code A4375, A4376, or A4378.
	A4378		Drainable rubber pch w/o fp	Max of 10 allowed per month, per client. Not allowed in combination with code A4375, A4376, or A4377.
	A4379		Urinary plastic pouch w fcpl	Max of 10 allowed per month, per client. Not allowed in combination with code A4361, A4381, A4382, or A4383.
	A4380		Urinary rubber pouch w fcplt	Max of 10 allowed per month, per client. Not allowed in combination with code A4361, A4381, A4382, or A4383.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4381		Urinary plastic pouch w/o fp	Max of 10 allowed per month, per client. Not allowed in combination with code A4379, A4380, A4382, or A4383.
	A4382		Urinary hvy plstc pch w/o fp	Max of 10 allowed per month, per client. Not allowed in combination with code A4379, A4380, A4381, A4383.
	A4383		Urinary rubber pouch w/o fp	Max of 10 allowed per client per month. Not allowed in combination with code A4379, A4380, A4381, A4382.
	A4384		Ostomy faceplt/silicone ring	
	A4385		Ost skn barrier sld ext wear	
	A4387		Ost clsd pouch w att st barr	Max of 30 allowed per client, per month.
	A4388		Drainable pch w ex wear barr	Max of 10 allowed per client, per month.
	A4389		Drainable pch w st wear barr	Max of 10 allowed per client, per month.
	A4390		Drainable pch ex wear convex	Max of 10 allowed per client, per month.
	A4391		Urinary pouch w ex wear barr	Max of 10 allowed per client, per month.
	A4392		Urinary pouch w st wear barr	Max of 10 allowed per client, per month.
	A4393		Urine pch w ex wear bar conv	Max of 10 allowed per client, per month.
	A4394		Ostomy pouch liq deodorant	

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4395		Ostomy pouch solid deodorant	
	A4396		Peristomal hernia supprt blt	
	A4398		Ostomy irrigation bag	Max of 2 allowed per client, every 6 months.
	A4399		Ostomy irrig cone/cath w brs	Max of 2 allowed per client, every 6 months.
	A4400		Ostomy irrigation set	Max of 2 allowed per client, every 6 months.
	A4404		Ostomy ring each	Max of 10 allowed per client, per month.
	A4405		Nonpectin based ostomy paste	
	A4406		Pectin based ostomy paste	
	A4407		Ext wear ost skn barr <=4sq"	
	A4408		Ext wear ost skn barr >4sq"	
	A4409		Ost skn barr convex <=4 sq i	
	A4410		Ost skn barr extnd >4 sq	
	A4411		Ost skn barr extnd =4sq	
	A4412		Ost pouch drain high output	Max of 10 allowed per client, every 30 days.
	A4413		2 pc drainable ost pouch	Max of 10 allowed per client, per month.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4414		Ost sknbar w/o conv<=4 sq in	
	A4415		Ost skn barr w/o conv >4 sqi	
	A4416		Ost pch clsd w barrier/filtr	Max of 30 allowed per client, per month. Not allowed in combination with A4368.
	A4417		Ost pch w bar/bltinconv/fltr	Max of 30 allowed per client, per month. Not allowed in combination with A4368.
	A4418		Ost pch clsd w/o bar w filtr	Max of 30 allowed per client, per month. Not allowed in combination with A4368.
	A4419		Ost pch for bar w flange/flt	Max of 30 allowed per client, per month. Not allowed in combination with A4368.
BR	A4421		Ostomy supply misc	PA required
BR	A4422		Ost pouch absorbent material	
	A4423		Ost pch for bar w lk fl/fltr	Max of 30 allowed per client, per month. Not allowed in combination with A4368.
	A4424		Ost pch drain w bar & filter	Max of 10 allowed per client, per month. Not allowed in combination with A4368.
	A4425		Ost pch drain for barrier fl	Max of 10 allowed per client, per month. Not allowed in combination with A4368.
	A4426		Ost pch drain 2 piece system	Max of 10 allowed per client, per month.
	A4427		Ost pch drain/barr lk flng/f	Max of 10 allowed per client, per month. Not allowed in combination with A4368.
	A4428		Urine ost pouch w faucet/tap	Max of 10 allowed per client, per month.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4429		Urine ost pouch w bltinconv	Max of 10 allowed per client, per month.
	A4430		Ost urine pch w b/bltin conv	Max of 10 allowed per client, per month.
	A4431		Ost pch urine w barrier/tapv	Max of 10 allowed per client, per month.
	A4432		Os pch urine w bar/fange/tap	Max of 10 allowed per client, per month.
	A4433		Urine ost pch bar w lock fln	Max of 10 allowed per client, per month.
	A4434		Ost pch urine w lock flng/ft	Max of 10 allowed per client, per month.
	A4435		1pc ost pch drain hgh output	Max of 10 allowed per client, per month.
BR	A4436		Irr supply sleev reus per mo	Max of 1 allowed per client, per month. PA required.
BR	A4437		Irr supply sleev disp per mo	PA required
	A4455		Adhesive remover per ounce	Max of 3 allowed per client, per month.
	A5051		Pouch clsd w barr attached	Max of 60 allowed per client, per month.
	A5052		Clsd ostomy pouch w/o barr	Max of 60 allowed per client, per month.
	A5053		Clsd ostomy pouch faceplate	Max of 60 allowed per client, per month.
	A5054		Clsd ostomy pouch w/flange	Max of 60 allowed per client, per month.
	A5055		Stoma cap	Max of 30 allowed per client, per month.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A5061		Pouch drainable w barrier at	Max of 20 allowed per client, per month.
	A5062		Drnble ostomy pouch w/o barr	Max of 20 allowed per client, per month.
	A5063		Drain ostomy pouch w/flange	Max of 20 allowed per client, per month.
	A5071		Urinary pouch w/barrier	Max of 20 allowed per client, per month.
	A5072		Urinary pouch w/o barrier	Max of 20 allowed per client, per month.
	A5073		Urinary pouch on barr w/flng	Max of 20 allowed per client, per month.
	A5081		Stoma plug or seal, any type	Max of 30 allowed per client, per month.
	A5082		Continent stoma catheter	Max of 1 allowed per client, per month.
	A5083		Stoma absorptive cover	See code A6219.
	A5093		Ostomy accessory convex inse	Max of 10 allowed per client, per month.
	A5120		Skin barrier, wipe or swab	For ostomy only
	A5121		Solid skin barrier 6x6	For ostomy only
	A5122		Solid skin barrier 8x8	For ostomy only
	A5126		Disk/foam pad +or- adhesive	Max of 10 allowed per client, per month.

Urological supplies

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4310		Insert tray w/o bag/cath	Max of 60 per client, per month. Not allowed in combination with A4311, A4312, A4313, A4314, A4315, A4316, A4353, or A4354. Included in NF daily rate.
	A4311		Catheter w/o bag 2-way latex	Max of 3 allowed per client, per month. Not allowed in combination with code A4310, A4314, or A4338. Included in NF daily rate.
	A4312		Cath w/o bag 2-way silicone	Max of 3 allowed per client, per month. Not allowed in combination with code A4310, A4315, or A4344. Included in NF daily rate.
	A4313		Catheter w/bag 3-way	Max of 3 allowed per client, per month. Not allowed in combination with code A4310, A4316, or A4346. Included in NF daily rate.
	A4314		Cath w/drainage 2-way latex	Max of 3 allowed per client, per month. Not allowed in combination with code A4310, A4311, A4338, A4354, or A4357. Included in NF daily rate.
	A4315		Cath w/drainage 2-way silcne	Max of 3 allowed per client, per month. Not allowed in combination with code A4310, A4312, A4344, A4354, or A4357. Included in NF daily rate.
	A4316		Cath w/drainage 3-way	Max of 3 allowed per client, per month. Not allowed in combination with code A4310, A4313, A4346, A4354, or A4357. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4320		Irrigation tray	Max of 30 allowed per client, per month. Not allowed in combination with code A4322 or A4355. Included in NF daily rate.
	A4326		Male external catheter	Max of 60 allowed per client, per month. Included in NF daily rate.
	A4327		Fem urinary collect dev cup	Included in NF daily rate
	A4328		Fem urinary collect pouch	Included in NF daily rate
	A4330		Stool collection pouch	Included in NF daily rate
	A4331		Extension drainage tubing	Included in NF daily rate Not allowed in combination with code A4354, A5105, A5113, or A5114.
	A4332		Lube sterile packet	Included in NF daily rate
	A4333		Urinary cath anchor device	Included in NF daily rate
	A4334		Urinary cath leg strap	Included in NF daily rate
	A4335		Incontinence supply	Included in NF daily rate (age 3 and older.) EPA required.
	A4336		Urethral insert	PA required
	A4338		Indwelling catheter latex	Max of 3 allowed per client, per month. Not allowed in combination with code A4311 or A4314. Included in NF daily rate.
	A4340		Indwelling catheter special	Max of 3 allowed per client, per month. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4344		Cath indw foley 2 way silicn	May be all silicone or polyurethane. Max of 3 allowed per client, per month. Not allowed in combination with code A4312 or A4315. Included in NF daily rate. Note: Cannot be billed on the same date of service as A4314.
	A4346		Cath indw foley 3 way	Max of 3 allowed per client, per month. Not allowed in combination with code A4313 or A4316. Included in NF daily rate.
	A4349		Disposable male external cat	Max of 35 allowed per client, per month. Included in NF daily rate.
	A4351		Straight tip urine catheter	Max of 120 allowed per client, per month. Not allowed in combination with code A4352 or A4353.
	A4352		Coude tip urinary catheter	Max of 120 allowed per client, per month. Not allowed in combination with code A4351 or A4353.
	A4353		Intermittent urinary cath	Max of 120 allowed per client, per month. Not allowed in combination with A4310, A4351, A4352, or A4354. Includes sterile no touch catheter systems. Included in NF daily rate.
	A4354		Cath insertion tray w/bag	PA required. Not allowed in combination with A4310, A4314, A4315, A4316, A4353, A4357, A4358, and A5112. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4355		Bladder irrigation tubing	Max of 30 allowed per client, per month. Not allowed in combination with A4320 and A4322. Included in NF daily rate.
	A4356		Ext ureth clmp or compr dvc	Max of 2 allowed per client, per year. Included in NF daily rate.
	A4357		Bedside drainage bag	Max of 2 allowed per client, per month. Not allowed in combination with code A4314-A4316 or A4354. Included in NF daily rate.
	A4358		Urinary leg or abdomen bag	Max of 2 allowed per client, per month. Not allowed in combination with code A5113, A5114, A4354, or A5105. Included in NF daily rate.
	A4360		Disposable ext urethral dev	Max of 2 allowed per client, per month.
	A4402		Lubricant per ounce	Included in NF daily rate. For insertion of urinary catheters.
BR	A4453		Rec cath man pump enema repl	Requires PA. Rectal catheter for use with the manual pump-operated enema system (A4459), replacement only.
	A4456		Adhesive remover, wipes	Max of 50 wipes allowed per client, per month.
BR	A4457		Enema tube any type repl	PA required. Not allowed in combination with code A4459

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	A4459		Manual pump operated enema system, includes balloon, catheter and all accessories, reusable, any type	PA required. Manual pump enema systems are medically necessary for the management of neurogenic bowel when conservative bowel management methods have failed. Conservative methods include: diet modification (high fiber and fluid supplementation), minimization of constipating medications, osmotic and/or stimulant laxatives, prosecretory agents, suppositories, mini-enemas, digital stimulation, manual evacuation (lower motor neuron bowel), or enemas.
BR	A4520		Incontinence garment anytype	PA required. Included in NF daily rate.
	A5056		1 pc ost pouch w filter	
	A5057		1 pc ost pou w built-in conv	
	A5102		Bedside drain btl w/wo tube	Max of 2 allowed per client, per 6 months. Included in NF daily rate.
	A5105		Urinary suspensory	Max of 2 allowed per client, per month. Not allowed in combination with code A4358, A5112, A5113, or A5114. Included in NF daily rate.
	A5112		Urinary leg bag	Max of 1 allowed per client, per month. Not allowed in combination with code A4354, A5105, A5113, or A5114. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A5113	RA	Latex leg strap	Not allowed in combination with code A4358, A5105, or A5112. Included in NF daily rate.
	A5114	RA	Foam/fabric leg strap	Not allowed in combination with code A4358, A5105, or A5112. Included in NF daily rate.
	T4521		Adult size brief/diaper sm	Medical exceptions to max quantity or age limitations require PA. Max of 200 diapers purchased per client, per month. For clients age 20 and older. Recommended for waist sizes 24" – 32." Included in NF daily rate.
	T4522		Adult size brief/diaper med	Medical exceptions to max quantity or age limitations require PA. Max of 200 diapers purchased per client, per month. For clients age 20 and older. Recommended for waist sizes 32" – 44." Included in NF daily rate.
	T4523		Adult size brief/diaper lg	Medical exceptions to max quantity or age limitations require PA. Max of 200 diapers purchased per client, per month. For clients age 20 and older. Recommended for waist sizes 45" – 58." Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	T4524		Adult size brief/diaper xl	Medical exceptions to max quantity or age limitations require PA. Max of 200 diapers purchased per client, per month. For clients age 20 and older. Recommended for waist sizes 56" – 64." Included in NF daily rate.
	T4525	59 (To designate daytime use only)	Adult size pull-on sm	Medical exceptions to max quantity or age limitations require PA. Max of 200 pull-ons for clients age 6 through 20, per month. Max of 150 allowed for clients age 20 and older, per month. Included in NF daily rate.
	T4526	59 (To designate daytime use only)	Adult size pull-on med	Medical exceptions to max quantity or age limitations require PA. Max of 200 pull-ons for clients age 6 through 20, per month. Max of 150 allowed for clients age 20 and older, per month. Recommended for waist sizes 32" – 44." Included in NF daily rate.
	T4527	59 (To designate daytime use only)	Adult size pull-on lg	Medical exceptions to max quantity or age limitations require PA. Max of 200 pull-ons for clients age 6 through 20, per month. Max of 150 allowed for clients age 20 and older, per month. Recommended for waist sizes 45" – 58." Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	T4528	59 (To designate daytime use only)	Adult size pull-on xl	Medical exceptions to max quantity or age limitations require PA. Max of 200 pull-ons for clients age 6 through 20, per month. Max of 150 allowed for clients age 20 and older, per month. Recommended for waist sizes 56" – 64." Included in NF daily rate.
	T4529		Ped size brief/diaper sm/med	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 NF daily rate.
	T4530	59 (To designate daytime use only)	Ped size brief/diaper lg	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 NF daily rate.
	T4531	59 (To designate daytime use only)	Ped size pull-on sm/med	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 NF daily rate.
	T4532	59 (To designate daytime use only)	Ped size pull-on lg	Medical exceptions to max quantity or age limit require PA. For clients age 3-20. Max of 200 pull-ons, per client, per month. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	T4533	59 (To designate daytime use only)	Youth size brief/diaper	For clients age 6-20 Recommended for waist sizes 18" – 26". Max of 200 diapers purchased per client, per month. Included in NF daily rate.
	T4534	59 (To designate daytime use only)	Youth size pull-on	Medical exceptions to max quantity or age limit require PA. For clients age 6-20. Recommended for waist sizes 17" – 26" Max of 200 pull-ons purchased per client, per month. Included in NF daily rate.
	T4535	59 (To designate daytime use only)	Disposable liner/shield/pad	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. Included in NF daily rate.
	T4536	NU	Reusable pull-on any size	For clients age 3 and older. Max of 4 per client, per year. Included in NF daily rate.
	T4536	RR	Reusable pull-on any size	For clients age 3 and older. Max of 150 allowed per client, per month. Included in NF daily rate.
	T4537	NU	Reusable underpad bed size	Limit 42 per year. Not allowed in combination with code T4541 or T4537 (RR).
	T4537	RR	Reusable underpad bed size	Limit 90 per month. Not allowed in combination with code T4541 or T4537 (NU). Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	T4538	RR	Diaper serv reusable 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 NF daily rate.
	T4539	NU	Reuse diaper/brief any size	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 NF daily rate.
	T4541		Large disposable underpad	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 NF daily rate.
	T4543		Adult disp brief/diap abv xl	For clients age 20 and older. Recommended for waist sizes 65" – 84" Max of 200 pieces purchased per client, per month. Included in NF daily rate.
	T4544	59 (To designate daytime use only)	Adlt disp und/pull on abv xl	For clients age 6 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. Included in NF daily rate.

Braces, belts, and supportive devices

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	A4467		Belt strap sleev grmnt cover	
	A4565		Slings	Max of 2 allowed per client, per year. Included in NF daily rate.
	A4570		Splint	Max of 1 allowed per client per year. Included in NF daily rate.
	E0942		Cervical head harness/halter	Max of 1 allowed per client per year. Included in NF daily rate.
	E0944		Pelvic belt/harness/boot	Max of 1 allowed per client per year. Not allowed for use during pregnancy. Included in NF daily rate.
	E0945		Belt/harness extremity	Max of 1 allowed per client per year. Not allowed for use during pregnancy. Included in NF daily rate.

Decubitus care products

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0188		Synthetic sheepskin pad	Max of 1 allowed per client per year. Included in NF daily rate.
	E0189		Lambswool sheepskin pad	Max of 1 allowed per client per year. Included in NF daily rate.
	E0191		Protector heel or elbow	Max of 4 allowed per client per year. Included in NF daily rate.

Miscellaneous supplies

Code Status	HCPCS Code	Modifier(s)	Short Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4927		Non-sterile gloves	Quantities exceeding 2 units per month require PA. One unit = 100 gloves. Included in NF daily rate and in home health care rate.
	A4930		Sterile, gloves per pair	Max of 30 per client, per month. Included in NF daily rate and in home health care rate.
	A6410		Sterile eye pad	Max of 20 allowed per client, per month. Included in NF daily rate.
	A6411		Non-sterile eye pad	Max of 1 allowed per client, per month. Included in NF daily rate.
BR	T5999		Supply, nos	PA required
	S8265		Haberman feeder	

Coverage/Limitations

What is covered?

HCA covers the following nondurable medical supplies and equipment (MSE) and related services. Prior authorization is not required.

- 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
- 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. See the **Home Infusion, Diabetic Treatment, and Parenteral Nutrition Program Billing Guide**.
  - 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 (medical equipment 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 Billing Guide**)
      - 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
  - See WAC **182-543-5500**(12) for blood glucose monitors.
- 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 disk 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 - 30 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. HCA 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
- Miscellaneous supplies:
  - Eye patch (adhesive wound cover) - 1 box of 20.
  - 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

Coverage for Non-CRT Wheelchairs

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

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

What are the general guidelines for wheelchairs?

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

- For a faxed submission, providers are required to submit the *General Information for Authorization* form, HCA 13-835, see Where can I download HCA forms?
- A functional mobility assessment completed by a licensed physical therapist or licensed occupational therapist, dated within 60 days of the submission, along with medical record documentation to support medical necessity.
- *Medical Necessity for Wheelchair Purchase (for home clients only)* form, HCA 19-0008 from the client's physician or therapist
- HCA's *Prescription* form, HCA 13-794

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

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

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

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

HCA covers the rental or purchase (one per client in a 5-year period) of a manual wheelchair for clients who reside at home and are nonambulatory or who have limited mobility and require a wheelchair to participate in normal daily activities.

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

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

- A standard wheelchair if the client's medical condition requires the client to have a wheelchair to participate in normal daily activities
- A standard lightweight wheelchair if the client's medical condition does not allow the client to use standard weight wheelchair because of one of the following:
    - The client cannot self-propel a standard weight wheelchair.
    - Custom modifications cannot be provided on a standard weight wheelchair
- A high-strength lightweight wheelchair for a client who meets one of the following:
    - Whose medical condition doesn't allow the client to self-propel a lightweight or standard weight wheelchair
    - Requires custom modifications that cannot be provided on a standard weight or lightweight wheelchair
- A heavy-duty wheelchair for a client who requires a specifically manufactured wheelchair designed to meet one of the following:
    - Support a person weighing 300 pounds and over
    - Accommodate a seat width up to 22 inches wide (not to be confused with custom heavy-duty wheelchairs)
- A custom heavy-duty wheelchair for a client who requires a specifically manufactured wheelchair designed to meet one of the following:
    - Support a person weighing 300 pounds and over
    - Accommodate a seat width over 22 inches wide
- A rigid wheelchair for a client who meets all the following:
    - Has a medical condition that involves severe upper extremity weakness
    - Has a high level of activity
    - Is unable to self-propel any of the above types of wheelchairs
- A custom manufactured wheelchair for a client with a medical condition requiring wheelchair customization that cannot be obtained on any of the categories of wheelchairs listed in this billing guide.
- Pediatric wheelchairs/positioning strollers having a narrower seat and shorter depths more suited to pediatric patients, usually adaptable to modifications for a growing child.

Does HCA cover power-drive wheelchairs?

HCA covers power-drive wheelchairs when the prescribing provider certifies that all the following clinical criteria are met:

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

- The client's medical condition negates his or her ability to self-propel any of the wheelchairs listed in the manual wheelchair category
- A power-drive wheelchair will do one of the following:
  - Provide the client the only means of independent mobility
  - Enable a child to achieve age-appropriate independence and developmental milestones

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

- The prescribing provider certifies that the client's condition is stable.

- The client is unlikely to require a standard power-drive wheelchair within the next two years.

What are the guidelines for clients with multiple wheelchairs?

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

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

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

- The architecture of the client's home is completely unsuitable for a power-drive wheelchair, such as narrow hallways, narrow doorways, steps at the entryway, and insufficient turning radius
- The architecture of the client's home bathroom is such that power-drive wheelchair access is not possible, and the client needs a manual wheelchair to safely and successfully complete bathroom activities and maintain personal cleanliness
- The client has a power-drive wheelchair, but also requires a manual wheelchair because the power-drive wheelchair cannot be transported to meet the client's community, workplace, or educational activities. In this case, the manual wheelchair would allow the caregiver to transport the client in a standard automobile or van. HCA requires the client's situation to meet both of the following conditions:
  - The client's activities that require the second wheelchair must be located farther than one-fourth of a mile from the client's home.

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

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

Washington State Health Care Authority

Modifications, Accessories, and Repairs for Non-CRT Wheelchairs

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

HCA covers wheelchair accessories and modifications that are specifically identified by the manufacturer as separate line-item charges. Prior authorization is required. The accessories and modifications must be medically necessary. To receive payment, providers must submit all the following to HCA:

- For a faxed submission, a completed *General Information for Authorization* form, HCA 13-835, see **Where can I download HCA forms**?
- A completed *Prescription* form, HCA 13-794
- For new modifications, a functional mobility assessment completed by a licensed physical therapist or licensed occupational therapist, dated within 60 days of the submission, along with medical record documentation to support medical necessity.
- A completed *Medical Necessity for Wheelchair Purchase (for home clients only)* form, HCA 19-0008
- The make, model, and serial number of the wheelchair to be modified
- The modification requested
- Any specific information regarding the client's medical condition that necessitates the modification

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

DC = Same/similar covered code in fee schedule

DP = Service managed through a different program

PA = Prior Authorization Required

N = New

P = Policy change

Transit option restraints

HCA pays for transit option restraints for public and private transportation.

Non-CRT wheelchair repairs

HCA covers non-CRT wheelchair repairs. Prior authorization is required. The equipment must remain medically necessary for the client at the time of repairs. To receive payment, providers must submit all the following to HCA:

- For faxed submission, the *General Information for Authorization* form, HCA 13-835, see **Where can I download HCA forms**? (see **Authorization** for more information)
- A functional mobility assessment completed by a licensed physical therapist or licensed occupational therapist, dated within 60 days of the submission, along with medical record documentation to support medical necessity.
- A completed *Medical Necessity for Wheelchair Purchase (for home clients only)* form, HCA 19-0008
- The make, model, and serial number of the wheelchair to be repaired
- The repair requested

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

Clients Residing in a Skilled Nursing Facility

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

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

HCA pays for the following covered medical equipment and related supplies outside of the skilled nursing facility per diem rate, when medically necessary, subject to the limitations in this billing guide:

- Wheelchairs – one per client in a 5-year period
- Speech generating devices (SGD)
- Specialty beds

Manual and power-drive wheelchairs

HCA pays for one manual or one power-drive wheelchair for clients with prior authorization (PA), when medically necessary according to the requirements in WAC 182-542-5700. See Authorization section in this guide for information regarding PA.

Requests for PA must meet all the following:

- Be for the exclusive full-time use of a skilled nursing facility resident
- Not be included in the skilled nursing facility's per diem rate
- Include a copy of the telephone order, signed by the provider, for the wheelchair assessment, dated within 90 days of the PA submission
- A functional mobility assessment for mobility equipment completed by either a licensed physical therapist or licensed occupational therapist, dated within 60 days of the submission, along with medical record documentation to support medical necessity
- A qualifying face-to-face encounter with the treating provider within 6 months prior to the start of services
- Include a completed *Medical Necessity for Wheelchair Purchase for Nursing Facility Clients* form, HCA 19-0006. This form must be client specific and completed by ONLY the referring therapist. Suppliers may not complete this form.

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

- A completed *Prescription* form, HCA 13-794, dated within 90 days of the PA submission. See **Where can I download HCA forms**?
- For new modifications, a functional mobility assessment, addressing the new modifications, completed by a licensed physical therapist or licensed occupational therapist, dated within 60 days of the submission, along with medical record documentation to support medical necessity
- A completed *Medical Necessity for Wheelchair Purchase for Nursing Facility Clients* form, HCA 19-0006. This form must be client specific and completed by ONLY the referring therapist. Suppliers may not complete this form.
- 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 and continued medical necessity to the wheelchair

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

- A completed *Medical Necessity for Wheelchair Purchase for Nursing Facility (NF) Clients* form, HCA 19-0006. This form must be client specific and completed by ONLY the referring therapist. Suppliers may not complete this form.
- The make, model, and serial number of the wheelchair to be repaired
- The repair requested

The equipment must remain medically necessary for HCA to cover repairs.

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, under Part A, HCA does not reimburse for medical equipment and related supplies, prosthetics, orthotics, medical supplies, related services, and related repairs and labor charges under fee-for-service (FFS).

Speech generating devices (SGD)

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

Specialty beds

HCA pays for the purchase or rental of a specialty bed (a heavy-duty bariatric bed is not a specialty bed) when both of the following apply. Prior authorization is required.

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

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

What does HCA pay for outside the per diem rate?

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

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

  This includes, but is not limited to the following:

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

Washington State Health Care Authority

Exception to Rule

What is an exception to rule (ETR)?

HCA evaluates a request for any medical equipment, related supplies, and related services under the provisions of WAC 182-501-0160.

When EPSDT applies, HCA 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 HCA'S current **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Billing Guide** for more information).

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

Requests for ETR may be submitted online through direct data entry into the ProviderOne system or in writing to the fax number located on HCA's form and include all the following:

- A completed *General Information for Authorization*, HCA 13-835 form, see **Where can I download HCA forms**?
- A completed *Prescription*, HCA 13-794, form

A letter explaining how the client's situation meets the provisions of WAC 182-501-0160.

Washington State Health Care Authority

Authorization

What is authorization?

Authorization is HCA'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**.

HCA requires providers to obtain authorization for covered medical equipment and related supplies as follows:

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

What is prior authorization (PA)?

HCA 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 HCA.

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

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

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

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

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

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

For PA requests, HCA requires the prescribing provider to provide a medical necessity justification for each item requested, specifying why the client's medical condition necessitates the equipment, rather than what the equipment does for the client.

Medical record documentation, sourced from the client's Electronic Health Record (EHR), must provide credible evidence, as outlined in WAC 182-501-0165, to substantiate criteria for medical necessity as specified in this billing guide.

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

- 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 met the criteria for PA or EPA

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

How do I request prior authorization (PA)?

When a procedure's EPA criteria has not been met or the covered procedure requires PA, providers must request prior authorization from HCA. Procedures that require PA are listed in the fee schedule. HCA does not retrospectively authorize any health care services that require PA after they have been provided except when a client has delayed certification of eligibility.

Online direct data entry into ProviderOne

Providers may submit a prior authorization request online through direct data entry into ProviderOne (see HCA's **prior authorization webpage** for details).

Fax Request to (866) 668-1214

If providers choose to submit a faxed PA request, the following must be provided:

- The *General Information for Authorization* form, HCA 13-835. See **Where can I download HCA forms?** This form must be page one of the faxed request and must be typed. Do not include a fax cover sheet.

Providers and suppliers should submit ALL of the following with a request for prior authorization:

- Credible evidence as outlined in WAC 182-501-0165.
- Any HCA forms as outlined in this billing guide.
- Medical necessity justification for each item requested, specifying why the client's medical condition necessitates the equipment rather than what the equipment does for the client.
- Medical record documentation, sourced from the client's Electronic Health Record (HER), that provides credible evidence as outlined in WAC 182-501-0165, to substantiate criteria for medical necessity as specified under the **Coverage Determination Process** section of this billing guide.
- The client's medical record must sufficiently demonstrate their condition, justify prescribed items and quantities, and specify frequency of use or replacement, if applicable. Mere submission of an HCA form, supplier statement, or provider attestation, even if endorsed, is insufficient without supporting medical record information. Reference **Documentation Matters Toolkit | CMS**.

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

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

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

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

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

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

> **Note**: See HCA's **ProviderOne Billing and Resource Guide** and review the Prior Authorization (PA) chapter for more information on requesting authorization.

What is expedited prior authorization (EPA)?

The expedited prior authorization (EPA) process is designed to eliminate the need for online or faxed submission for prior authorization for selected medical equipment procedure codes.

HCA requires a provider to create an authorization number for EPA for selected medical equipment procedure codes. The authorization number must be used when the provider bills HCA.

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

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

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

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

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

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

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

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

What is a limitation extension (LE)?

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

Certain covered items have limitations on quantity and frequency. These limits are designed to avoid the need for PA for items normally considered medically necessary and for quantities sufficient for a 30-day supply for one client.

HCA requires a provider to request PA for a limitation extension (LE) to exceed the stated limits for ME, and medical supplies. See HCA's **Prior authorization webpage** for details.

HCA evaluates requests for LE under the provisions of WAC **182-501-0169**.

Washington State Health Care Authority

EPA Criteria Coding List

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

Note: **The following pertains to expedited prior authorization (EPA) numbers 870000700 - 870000820**:

1. If the medical condition does not meet **all** the specified criteria, prior authorization (PA) must be obtained. See HCA's Prior authorization webpage for details.
2. It is the supplier's responsibility to determine whether the client has already used the product allowed with the EPA criteria within the allowed time period, or to determine if the client has already established EPA through another supplier during the specified time period.
3. For extension of authorization beyond the EPA amount allowed, the normal PA process is required.
4. A valid authorized practitioner's prescription is required as described in WAC 182-543-2000(2)(c))
5. Documentation of the length of need/life expectancy must be kept in the client's file, as determined by the prescribing provider and medical justification (including **all** the specified criteria).

Rental Manual Wheelchairs

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

Rental Manual Wheelchairs

HCPCS Codes	Modifier	EPA Code	Description	Criteria (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
K0001	RR	870000700	Standard manual wheelchair with all styles of arms, footrest and/or leg rests	Up to 2 months continuous rental in a 12-month period if **all** the following criteria are met. The client: 1. Weighs 250 lbs. or less. 2. Requires a wheelchair to participate in normal daily activities. 3. Has a medical condition that renders the client totally non-weight bearing or is unable to use other aids for mobility, such as crutches or walker (reason must be documented in the client's file). 4. Does not have a rental hospital bed. 5. Has a length of need, as determined by the prescribing provider, that is less than 6 months.
K0003	RR	870000705	Lightweight manual wheelchair with all styles of arms, footrests and/or leg rests	Up to 2 months continuous rental in a 12-month period if **all** the following criteria are met. The client: 1. Weighs 250 lbs. or less. 2. Can self-propel the lightweight wheelchair and is unable to propel a standard weight wheelchair. 3. Has a medical condition that renders the client totally non-weight bearing or is unable to use other aids for mobility, such as crutches or walker (reason must be documented in the client's file). 4. Does not have a rental hospital bed. 5. Has a length of need, as determined by the prescribing provider, that is less than 6 months.

HCPCS Codes	Modifier	EPA Code	Description	Criteria (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
K0006	RR	870000710	Heavy-duty manual wheelchair with all styles of arms, footrests, and/or leg rests	Up to 2 months continuous rental in a 12-month period if **all** the following criteria are met. The client: 1. Weighs over 250 lbs. 2. Requires a wheelchair to participate in normal daily activities. 3. Has a medical condition that renders the client totally non-weight bearing or is unable to use other aids for mobility, such as crutches or walker (reason must be documented in the client's file). 4. Does not have a rental hospital bed. 5. Has a length of need, as determined by the prescribing provider, that is less than 6 months
E1060	RR	870000715	Fully reclining manual wheelchair with detachable arms, desk or full-length and swing-away or elevating leg rests	Up to 2 months continuous rental in a 12-month period if **all** the following criteria are met. The client: 1. Requires a wheelchair to participate in normal daily activities and is unable to use other aids for mobility, such as crutches or walker (reason must be documented in the client's file). 2. Has a medical condition that does not allow them to sit upright in a standard or lightweight wheelchair (must be documented). 3. Does not have a rental hospital bed. 4. Has a length of need, as determined by the prescribing provider, that is less than 6 months.

Rental of manual or semi-electric hospital bed

- The EPA rental is allowed only one time, per client, per 12-month period.
- Authorization must be requested for the 12th month of rental, at which time the equipment will be considered purchased. The authorization number will be pended for the serial number of the equipment. In such cases, the equipment the client has been using must have been new on or after the start of the rental contract or is documented to be in good working condition. A 1-year warranty will take effect as of the date the equipment is considered purchased if equipment is not new. Otherwise, normal manufacturer warranty will be applied.
- If length of need is greater than 12 months, as stated by the prescribing provider, a PA for purchase must be requested.
- If the client is hospitalized or is a resident of a nursing facility and is being discharged to a home setting, rental may not start until the date of discharge. Documentation of the date of discharge must be included in the client's file. Rentals for clients in a skilled nursing facility are included in the nursing facility daily rate. Rentals in the hospital are included in the DRG payment.
- HCA does not rent equipment during the time that a request for similar purchased equipment is being assessed, when authorized equipment is on order, or while the client-owned equipment is being repaired and/or modified. The supplier of service is expected to supply the client with an equivalent loaner.
- Hospital beds *will not* be provided:
    - As furniture
    - To replace a client-owned waterbed
    - For a client who does not own a standard bed with mattress, box spring, and frame
    - If the client's standard bed is in an area of the home that is currently inaccessible by the client such as an upstairs bedroom
- Only one type of bed rail is allowed with each rental.
- Mattress may not be billed separately.

Rental/Purchase Hospital Beds

HCPCS Codes	Modifier	EPA Code	Description	Criteria (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
E0292 **E0310** **E0305**	RR	870000720	Manual hospital bed with mattress with or without bed rails	The client: 1. Has a length of need/life expectancy that is 12 months or less. 2. Has a medical conditional that requires positioning of the body that cannot be accomplished in a standard bed (reason must be documented in the client's file). 3. Has tried pillows, bolsters, and/or rolled up blankets/towels in client's own bed, and determined to not be effective in meeting client's positioning needs (nature of ineffectiveness must be documented in the client's file). 4. Has a medical condition that necessitates upper body positioning at no less than a 30-degree angle the majority of time the client is in the bed. 5. Has full-time caregivers. 6. Does **not** also have a rental wheelchair.

HCPCS Codes	Modifier	EPA Code	Description	Criteria (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
E0294 **E0310** **E0305**	RR	870000725	Semi-electric hospital bed with mattress with or without bed rails	Up to 11 months continuous rental in a 12-month period if **all** the following criteria are met. The client: 1. Has a length of need/life expectancy that is 12 months or less. 2. Has tried pillows, bolsters, and/or rolled up blankets/towels in own bed, and determined ineffective in meeting positioning needs (nature of ineffectiveness must be documented in the client's file). 3. Has a chronic or terminal condition such as COPD, CHF, lung cancer or cancer that has metastasized to the lungs, or other pulmonary conditions that cause the need for immediate upper body elevation. 4. Must be able to operate the bed controls independently and safely. 5. Does **not** have a rental wheelchair. 6. Has a completed *Hospital Bed Evaluation* form, HCA 13-747. See Where can I download HCA forms?

Purchase of manual or semi-electric hospital bed

The EPA criteria is to be used only for an initial purchase per client, per lifetime. It is not to be used for a replacement or if EPA rental has been used within the previous 24 months.

- For hospital beds, the date of delivery to the client and serial number of the hospital bed must be submitted prior to payment.
- It is the supplier's responsibility to determine if the client has not been previously provided a hospital bed, either purchase or rental.
- Hospital beds *will not* be covered:
  - As furniture
  - To replace a client-owned waterbed
  - For a client who does not own a standard bed with mattress, box spring and frame
  - If the client's standard bed is in an area of the home that is currently inaccessible by the client such as an upstairs bedroom

Purchase of hospital beds

HCPCS Codes	Modifier	EPA Code	Description	Criteria (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
E0294	NU	870000726	Semi-electric hospital bed with mattress with or without bed rails	Initial purchase if **all** the following criteria are met. The client: 1. Has a length of need/life expectancy of 12 months or more. 2. Has tried positioning devices like pillows, bolsters, foam wedges, rolled up blankets/towels in own bed, and been determined ineffective in meeting positioning needs (nature of ineffectiveness must be documented in the client's file). 3. Has one of the following diagnoses: a. Quadriplegia b. Tetraplegia c. Duchenne's M.D. d. ALS e. Ventilator dependent f. COPD or CHF with aspiration risk or shortness of breath that causes the need for immediate position change of more than 30 degrees. 4. Must be able to operate the bed controls independently and safely. **Documentation Required**: 1. Life expectancy, in months and/or years. 2. Client diagnosis including ICD code. 3. Date of delivery and serial number. 4. Written documentation that client has not previously had a hospital bed, purchase, or rental (i.e., written statement from client or caregiver). 5. A completed *Hospital Bed Evaluation* form, HCA 13-747. See Where can I download HCA forms?

Low air loss therapy systems

HCPCS Codes	Modifier	EPA Code	Description	Criteria (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
E0371 **E0372**	RR	870000730	Low air loss mattress overlay	Initial 30-day rental followed by one additional 30-day rental in a 12-month period if **all** the following criteria are met. The client: 1. Is bed-confined 20 hours per day during rental of therapy system. 2. Has at least one stage 3 decubitus ulcer on trunk of body. 3. Has acceptable turning and repositioning schedule. 4. Has timely labs (every 30 days). 5. Has appropriate nutritional program to heal ulcers.
E0277 **E0373**	RR	870000735	Low air loss mattress without bed frame	Initial 30-day rental followed by an additional 30-day rental in a 12-month period if **all** the following criteria are met. The client: 1. Is bed-confined 20 hours per day during rental of therapy system. 2. Has multiple stage 3/4 decubitus ulcers or one stage 3/4 with multiple stage 2 decubitus ulcers on trunk of body. 3. Has ulcers on more than one turning side. 4. Has acceptable turning and repositioning schedule. 5. Has timely labs (every 30 days). 6. Has appropriate nutritional program to heal ulcers.
E0277 **E0373**	RR	870000740	Low air loss mattress without bed frame	Initial 30-day rental in a 12-month period upon hospital discharge following a flap surgery.

HCPCS Codes	Modifier	EPA Code	Description	Criteria (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
E0194	RR	870000750	Air fluidized flotation system including bed frame	Initial 30-day rental in a 12-month period upon hospital discharge following a flap surgery. **For All Low Air Loss Therapy Systems** **Documentation Required:** 1. A *Low Air-Loss Therapy Systems* form, HCA 13-728, must be completed for each rental segment and signed and dated by nursing staff in facility or client's home. See Where can I download HCA forms? 2. A new form must be completed for each rental segment. 3. A re-dated prior form will not be accepted. 4. A dated picture must accompany each form.

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

Noninvasive bone growth/nerve stimulators

HCPCS Codes	Modifier	EPA Code	Description	Criteria (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
E0747 **E0760**	NU	870000765	Non-spinal bone growth stimulator	Allowed **only** for purchase of brands that have pulsed electromagnetic field simulation (PEMF) when one or more of the following criteria is met. The client: 1. Has a nonunion of a long bone fracture (which includes clavicle, humerus, phalanges, radius, ulna, femur, tibia, fibula, metacarpal and metatarsal) after 6 months has elapsed since the date of injury without healing. 2. Has a failed fusion of a joint other than in the spine where a minimum of 6 months has elapsed since the last surgery.

HCPCS Codes	Modifier	EPA Code	Description	Criteria (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
E0748	NU	870000770	Spinal bone growth stimulator	Allowed for purchase when the prescription is from a neurologist, an orthopedic surgeon, or a neurosurgeon and when one or more of the following criteria is met. The client: 1. Has a failed spinal fusion where a minimum of 9 months has elapsed since the last surgery. 2. Is post-op from a multilevel spinal fusion surgery. 3. Is post-op from spinal fusion surgery where there is a history of a previously failed spinal fusion.

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

Miscellaneous medical equipment

HCPCS Codes	Modifier	EPA Code	Description	Criteria (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
E0604	RR	870000800	Breast pump, electric	Unit may be rented for up to 3 months when one of the following conditions directly impacts the ability of the infant to feed from the parent: 1. Prematurity (including multiple gestation); 2. Neurologic disorder; 3. Genetic abnormality; 4. Anatomic or mechanical malformation (e.g., cleft lip or palate); or 5. Congenital malformation requiring surgery (e.g., respiratory, cardiac, gastrointestinal, or central nervous system malformation).

HCPCS Codes	Modifier	EPA Code	Description	Criteria (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
E0935	RR	870000810	Continuous passive motion system (CPM)	Up to 10 days rental during any 12-month period, upon hospital discharge, when the client is diagnosed with one of the following: 1. Frozen joints 2. Intra-articular tibia plateau fracture 3. Anterior cruciate ligament injury 4. Total knee replacement
E0650	RR	870000820	Extremity pump	Up to 2 months rental during a 12-month period for treatment of severe edema. Purchase of the equipment should be requested and rental not allowed when equipment has been determined to be all of the following: 1. Medically effective 2. Medically necessary 3. A long-term, permanent need
A4253 **A4259**		870001263	Blood glucose test strips/lancets	For pregnant people with gestational diabetes, HCA pays for the quantity necessary to support testing as directed by the client's provider For pregnant people with gestational diabetes, HCA pays for the quantity necessary to support testing as directed by the client's provider, up to 12 months postpartum.
A4253 **A4259**		870001265	Blood glucose test strips/lancets for children through age 20	100 over limit – for children only
A4927		870001262	Additional gloves for clients who live in an assisted living facility	Will be allowed up to the quantity necessary as directed by the client's provider, 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).

HCPCS Codes	Modifier	EPA Code	Description	Criteria (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
A4335		870000851	Incontinence supply, use for diaper doublers, each (age3 and older)	Purchase of 90 per month allowed when the product is: 1. Used for extra absorbency at nighttime only. 2. Prescribed by a physician. 3. Used inside of a brief, diaper, or pull-on.
A4335		870000852	Incontinence supply, use for diaper doublers, each (age 3 and older)	Up to equal amount of diapers/briefs received if **one** of the following criteria for clients is met: 1. Tube fed 2. On diuretics or other medication that causes frequent/large amounts of output 3. Brittle diabetic with blood sugar problems
A9286		870001604	Hygienic item, bed encasement, mattress (twin) (age 20 and younger)	See *Bed and Pillow Encasements* form HCA 13-0052. See Where can I download HCA forms?
A9286		870001605	Hygienic item, bed encasement, pillowcases (set of 2) (age 20 and younger)	See *Bed and Pillow Encasements* form HCA 13-0052. See Where can I download HCA forms?

Billing

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

What are the general billing requirements?

Providers must follow HCA'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 By Report (BR) items:

HCA evaluates each by-report (BR) item, procedure, or service individually to determine its medical necessity, appropriateness, and reimbursement value. HCA's reimbursement rate is based on a percentage of the manufacturer's list price or manufacturer's suggested retail price (MSRP), or a percentage of the wholesale acquisition cost (WAC). HCA uses specific percentages for these calculations. See WAC 182-543-9000.

Please note that to accurately determine the MSRP and consider any supplier discounts, an itemized **invoice** is required rather than a **quote**. The invoice should include the manufacturer's list price, any applicable discounts, and the final cost to the supplier. Providing the correct documentation is essential for the evaluation process.

What billing requirements are specific to medical equipment and supplies?

Equipment

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

HCA does not pay a medical equipment provider for medical supplies used in conjunction with a provider office visit. HCA pays for these supplies when it is appropriate. See HCA's Physician-Related Services/Health Care Professional Services Billing Guide.

Supplies

When billing HCA for medical supplies, the claim must be for a single date of service, with at least 30 days in between claims.

Examples:

- For a date of service (DOS) in the month of May, use 5/15/19-5/15/19 on the first claim. For the next claim with a date of service in June, use 6/14/19-6/14/19 (30 days between dates of service).
    - May claim: 5/15/2019-5/15/2019, 200 units
    - June claim: 6/14/2019-6/14/2019, 200 units

- If the claim is for a limit over the allowed amount and HCA has authorized a limitation extension, bill on two separate lines: one claim line for the allowed amount and one claim line for the exceeded limit. The claim line with the additional authorized limit must include the authorization number.
    - May claim line 1: 5/15/2019-5/15/2019, 200 units
    - May claim line 2: 5/15/2019-5/15/2019, 100 units, authorization #
    - June claim line 1: 6/14/2019-6/14/2019, 200 units
    - June claim line 2: 6/14/2019-6/14/2019, 100 units, authorization #

Note: Use date spans when billing for rentals **only**

How does a provider bill for a managed care client?

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

- HCA stops paying for any rented equipment on the last day of the month preceding the month in which the client becomes enrolled in the MCO.
- The MCO determines the client's continuing need for the equipment and is responsible for paying the provider.
- A client may become an MCO enrollee before HCA completes the purchase of the prescribed medical equipment. HCA considers the purchase complete when the product is delivered and HCA is notified of the serial number. If the client becomes an MCO enrollee before HCA completes the purchase, the following occur:
    - HCA rescinds HCA's authorization with the supplier until the MCO's provider evaluates the client.
    - HCA requires the authorized practitioner to write a new prescription if the provider determines the equipment is still medically necessary as defined in WAC 182-500-0070.
    - The MCO's applicable reimbursement policies apply to the purchase or rental of the equipment.
- A client may be disenrolled from an MCO and placed into fee-for-service before the MCO completes the purchase of prescribed medical equipment.

- HCA rescinds the MCO's authorization with the supplier until the client's provider evaluates the client.
- HCA requires the authorized practitioner to write a new prescription if the provider determines the equipment is still medically necessary as defined in WAC 182-500-0070.
- HCA's applicable reimbursement policies apply to the purchase or rental of the equipment.

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

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

HCA requires a provider to accept Medicare assignment before any Medicaid reimbursement.

Under WAC 182-502-0110(3):

If the service provided is covered by Medicare and Medicaid, HCA pays the lesser amount allowed, minus the amount already paid.

If the service provided is covered by Medicare but is not covered by HCA, HCA pays the deductible and/or coinsurance up to Medicare's allowed amount for qualified Medicare beneficiary (QMB) clients only.

What is included in the rate?

HCA's payment rate for purchased or rented covered medical equipment, related supplies, and related services include:

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

Where can I find the fee schedules for medical equipment and supplies?

See HCA's fee schedule.

Where can HCA's required forms be found?

The following forms can be downloaded from HCA's Forms and publications webpage:

Negative Pressure Wound Therapy form, HCA 13-726

Medical Necessity for Wheelchair Purchase (for home client only) form, HCA 19-0008

Low Air-Loss Therapy Systems form, HCA 13-728

Medical Necessity for Wheelchair Purchase for Nursing Facilities (NF) Clients form, HCA 19-0006

Hospital Bed Evaluation form, HCA 13-747

Bathroom Equipment form, HCA 13-872

Compression Garments form, HCA 13-871

Speech Language Pathologist (SLP) Evaluation for Speech Generating Devices form, HCA 13-0127

Limitation Extension Request Incontinent Supplies and Gloves form, HCA 13-870

How do I bill claims electronically?

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

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

The following claim instructions relate to medical equipment providers:

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

Warranty

When do I need to make warranty information available?

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

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

When is the dispensing provider responsible for costs?

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

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

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

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

Minimum warranty periods

Item	Type	Warranty
Wheelchair frames (purchased new) and wheelchair parts	Powerdrive (**depending on model**)	1 year - lifetime
Wheelchair frames (purchased new) and wheelchair parts	Ultralight	Lifetime
Wheelchair frames (purchased new) and wheelchair parts	Active Duty Lightweight (**depending on model**)	5 years – lifetime
Wheelchair frames (purchased new) and wheelchair parts	All others	1 year
Electrical components	All electrical components whether new or replacement parts including batteries	6 months – 1 year
Medical equipment	All other medical equipment not specified above (excludes disposable/non-reusable supplies)	1 year