Washington State Health Care Authority

Washington Apple Health (Medicaid)

Home Infusion Therapy and Parenteral Nutrition Program Billing Guide

January 1, 2026

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, 2026**, 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 182-553 WAC.

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

> 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 with HCA.

How can I get HCA Apple Health provider documents?

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

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

Health care privacy toolkit

The Washington Health Care Privacy Toolkit 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).

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* This publication is a billing instruction.

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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
Early periodic screening, diagnosis, and treatment (EPSDT)	Added information regarding the services available through the EPSDT benefit	To provide information about EPSDT services and accessibility
Billing for By Report (BR) Items	Added instructions for billing for By Report (BR) items. Also clarified that the manufacturer price list or invoice must be dated within 12 months prior to the date of service and must substantiate the specific supply being billed	Billing clarification

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Resources Available

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

Definitions

This list defines terms and abbreviations, including acronyms, used in this guide.

Refer to chapter 182-500 WAC for a complete list of definitions for Washington Apple Health and WAC 182-553-200.

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

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

Hyperalimentation – See Parenteral Nutrition.

Intradialytic Parenteral Nutrition (IDPN) – Intravenous nutrition administered during hemodialysis. IDPN is a form of parenteral nutrition.

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About this Program

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

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

HCA's Home Infusion Therapy and Parenteral Nutrition program covers:

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

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

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

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

What are the requirements for reimbursement?

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

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

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Where may services be provided and how are they reimbursed?

- **Federally-Qualified Health Centers (FQHCs), physicians, and physician clinics** may provide home infusion therapy and parenteral nutrition services in a physician's office or physician clinic, unless the client resides in a nursing facility. Bill using the appropriate procedure codes from HCA's **Physician-Related Services/Health Care Professional Services Billing Guide.**
- **Nursing facilities**: Some services and supplies necessary for the administration of infusion are included in the facility's per diem rate for each client. See the **Coverage Table** to identify procedure codes that are included in the nursing facility per diem rate. A client's infusion pump, parenteral nutrition pump, insulin pump, solutions, and insulin infusion supplies are not included in the nursing facility per diem rate and are paid separately (see **WAC 182-553-500(6)**).
- **Outpatient hospital providers** may provide infusion therapy and parenteral nutrition. Bill using the appropriate revenue codes in HCA's **Outpatient Hospital Services Billing Guide.**
- **Clients in a state-owned facility**: Home infusion therapy and parenteral nutrition for HCA clients in state-owned facilities (state school, developmental disabilities (DD) facilities, mental health facilities, Western State Hospital, and Eastern State Hospital) are purchased by the facility through a contract with manufacturers. HCA does not pay separately for home infusion supplies and equipment or parenteral nutrition solutions for these clients (see **WAC 182-553-500(5)**).
- **Clients who have elected HCA's hospice benefit**: HCA pays for home infusion/parenteral nutrition separate from the hospice per diem rate only when both of the following apply:
    - The client has a pre-existing diagnosis that requires parenteral support.
    - The pre-existing diagnosis is unrelated to the diagnosis that qualifies the client for hospice.

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

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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 managed care webpage 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** 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 "Let's get started" 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 Aged, Blind, Disabled/Long-Term Services and Support (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 (MCOs). 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 an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may 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.

Exceptions:

- Apple Health Expansion clients are enrolled in managed care 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.
- Clients who are eligible to receive Reentry Initiative services and who are eligible for enrollment in an HCA-contracted managed care organization (MCO) will not start their first month of eligibility in the FFS program. 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, under *How to apply for or renew Apple Health (Medicaid) coverage*.

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 physical health services under the fee-for-service program.

In this situation, each managed care organization (MCO) 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 FFS Medicaid program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into an integrated managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care Alumni.

Integrated managed care (IMC)

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:

- Age 17 and younger who are in foster care (out of home placement)
- Age 20 and younger 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 health plan. For more information, visit **Apple Health Expansion**.

Reentry Initiative

The Reentry Demonstration Initiative (Reentry Initiative) is a new Apple Health (Medicaid) initiative under the Medicaid Transformation Project (MTP). Under this initiative, incarcerated people who are Apple Health-eligible may receive a limited set of health care services through fee-for-service (FFS) or their HCA-contracted managed care organization (MCO) for up to 90 days before their release from carceral facilities within Washington State. These services will ensure a person's healthy and successful reentry into their community. For more information, visit **Reentry from a carceral setting**.

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**.

Are Primary Care Case Management (PCCM) clients covered?

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

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

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

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

Early periodic screening, diagnosis, and treatment (EPSDT)

Early periodic screening, diagnosis, and treatment (EPSDT) includes all services that are medically necessary to address health conditions for clients age 20 and younger. Providers may reference program-specific billing guides for services and equipment not covered by this billing guide; see also the rules for the EPSDT program described in **Chapter 182-534 WAC**. Published limits for services covered under EPSDT, if any, may be exceeded based on agency review of medical necessity described in **WAC 182-501-0165.**

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Coverage

Is medical necessity required for home infusion therapy?

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

When is infusion therapy covered in the home?

HCA will cover infusion therapy in the home when the client:

Has a written physician order for all solutions and medications to be administered.

- Is clinically stable and has a condition that does not warrant hospitalization.
- Agrees to comply with the protocol established by the infusion therapy provider for home infusions. If the client is not able to comply, the client's caregiver may comply.
- Consents, if necessary, to receive solutions and medications administered in the home through intravenous, enteral, epidural, subcutaneous, or intrathecal routes. If the client is not able to consent, the client's legal representative may consent.
- Lives in a residence that has adequate accommodations for administering infusion therapy, including:
    - Running water
    - Electricity
    - Telephone access
    - Receptacles for proper storage and disposal of drugs and drug products

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

Is medical necessity required for parenteral nutrition?

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

When is parenteral nutrition covered?

To receive parenteral nutrition, a client must:

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

And

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

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

When is parenteral nutrition not covered?

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

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

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

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

- The eligibility criteria are met.
- The client has a written physician order that documents the client is unable to receive oral or tube feedings.

- It is medically necessary for the gastrointestinal tract to be totally nonfunctional for a period of time.

When are intradialytic parenteral nutrition (IDPN) solutions covered?

HCA covers IDPN solutions when:

- The parenteral nutrition is not solely supplemental to deficiencies caused by dialysis.
- The client meets the eligibility criteria.
- The client can manage their infusion in one of the following ways:
  - Independently
  - With a volunteer caregiver who can manage the infusion
  - By choosing to self-direct the infusion with a paid caregiver

What documentation is required?

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

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

What equipment and supplies are covered?

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

- A written order from the provider is required for all equipment and supplies.
- Home infusion supplies are limited to one month's supply per client, per calendar month.
- Parenteral nutrition solutions are limited to one month's supply per client, per calendar month.
- Covered rental of pumps is limited to one type of infusion pump, one type of parenteral pump, and one type of insulin pump per client, per calendar month as follows:
  - HCA covers the rental payment for each type of infusion, parenteral, or insulin pump for up to 12 months. (HCA considers a pump purchased after 12 months of rental payment).

- All rent-to-purchase infusion parenteral and insulin pumps must be new equipment at the beginning of the rental period.
- HCA covers only one purchased infusion or parenteral pump, per client in a five-year period.
- HCA covers only one purchased insulin pump, per client in a four-year period.

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

HCA's payment for equipment rentals or purchases includes:

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

Is continuous glucose monitoring (CGM) covered?

Yes. HCA pays for FDA-approved continuous glucose monitoring systems and related monitoring equipment and supplies for personal, long-term use with expedited prior authorization (EPA) when the client meets EPA criteria.

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

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

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

> **Note:** For more information about the in-home use of professional, diagnostic, short-term continuous glucose monitoring for a minimum of a 72-hour period and the related billing codes, see the Physician-Related Services/Healthcare Professional Services Medicaid Billing Guide.

Coverage Table

Infusion therapy equipment and supplies

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

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

Antiseptics and germicides

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

Infusion pumps

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

Parenteral nutrition infusion pumps

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

Parenteral nutrition solutions

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

HCPCS Code	Modifier	Short Description	NH Per Diem?	Policy/Comments
B4164		Parenteral 50% dextrose solu	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200
B4168		Parenteral sol amino acid 3	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200
B4172		Parenteral sol amino acid 5	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200
B4176		Parenteral sol amino acid 7	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200
B4178		Parenteral sol amino acid>	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200
B4180		Parenteral sol carb>50%	N	Not allowed in combination with HCPCS codes B4189, B4193, B4197, B4199, B5000, B5100, and B5200
B4185		Parenteral sol 10 gm lipids	N	
B4189		Parenteral nutrition sol; 10-51 gms protein	N	
B4193		Parenteral sol 52-73 gm proi	N	
B4197		Parenteral sol 74-100 gm pro	N	
B4199		Parenteral sol>100gm prote	N	

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

Parenteral nutrition supplies

- Parenteral Nutrition Kits are considered **all-inclusive** for the items necessary to administer therapy.

  Number of units billed cannot exceed number of days.

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

Insulin infusion pumps

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

Insulin infusion supplies

HCPCS Code	Modifier	Short Description	NH Per Diem?	Policy/Comments
A4224		Supply insulin inf cath/wk		One unit = one week
A4225		Sup/ext insulin inf pump syr		
A4230		Infus insulin pump non needle	N	Two boxes per client, per month One unit = one box of ten
A4231		Infusion insulin pump needle	N	Two boxes per client, per month One unit = one box of ten
A4232		Syringe w/needle insulin 3cc	N	Two boxes per client, per month One unit = one box of ten

HCPCS Code	Modifier	Short Description	NH Per Diem?	Policy/Comments
A4602		Replace lithium battery 1.5v	N	Ten per client, per six months
K0601		Repl batt silver oxide 1.5v	N	Ten per client, per six months
K0602		Repl batt silver oxide 3 v	N	Ten per client, per six months
K0603		Repl batt alkaline 1.5 v	N	Nine per client, per three months
K0604		Repl batt lithium 3.6	N	
K0605		Repl batt lithium 4.5 v	N	

Miscellaneous infusion supplies

HCPCS Code	Modifier	Short Description	NH Per Diem?	Policy/Comments
A4927		Non-sterile gloves	Y	For billing instructions for this supply, see the Medical Equipment and Supplies Billing Guide
A4930		Sterile gloves per pair	Y	For billing instructions for this supply, see the Medical Equipment and Supplies Billing Guide
E1399		Durable medical equipment mi	N	Equipment repair, parts Requires prior authorization See instructions in Authorization Invoice required
E1399		Durable medical equipment mi	Y	10-quart chemotherapy waste container Requires prior authorization See instructions in Authorization Invoice required

HCPCS Code	Modifier	Short Description	NH Per Diem?	Policy/Comments
B9999		Parenteral sup not othrws c	N/A	Requires prior authorization See instructions in Authorization Invoice required
K0739		Repair/svc dme non-oxygen eq	N	Must submit invoice with claim that separates labor costs from other costs

Continuous Glucose Monitoring (CGM)

HCPCS/CPT® Code	Modifier	Short Description	NH Per Diem?	Do Not Bill With	Policy/Comments
A4238		Adju cgm supply allowance		A9276 A9277 A4239	1 unit of service = 1 month supply
A9276		Disposable sensor, cgm sys	N/A	A4238 A4239	1 unit = 1 day supply
A9277		External transmitter, cgm	N/A	A4238 A4239	
A9278		External receiver, cgm sys	N/A	E2102 E2103	Limit: 1 receiver per client every 3 years
E2102		Adju cgm receiver/monitor		A9278 E2103	Limit: 1 receiver per client every 3 years
A4239		Non-adju cgm supply allow		A4238	1 unit of service = 1 month supply Allowance includes all items necessary for the use of the device and includes, but is not limited to: CGM sensor, CGM transmitter, home BGM and related BGM supplies.
E2103		Non-adj cgm receiver/mon		E2102	Limit: 1 receiver per client every 3 years.

The billing provision is limited to a one-month supply; a one-month supply is equal to 30 days.

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

Washington State Health Care Authority

Authorization

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

What is prior authorization (PA)?

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

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

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

- Miscellaneous parenteral therapy supplies (**HCPCS code B9999**). See the Coverage Table in this guide for further details. To request prior authorization, fax a completed *General Information for Authorization* form (HCA 13-835) as your cover sheet and a *Justification for Use of Miscellaneous Parenteral Supply Procedure Code (B9999)* form (HCA 13-721) to the fax number listed on the form. See Where can I download HCA forms?
- Equipment repairs, parts, and 10-quart chemotherapy waste containers require prior authorization (**HCPCS code E1399**). To request prior authorization, fax a completed *General Information for Authorization* form (HCA 13-835) as your cover sheet and a *Fax/Written Request Basic Information* form (HCA 13-756) to the fax number listed on the form.
- Limitation Extensions.

How do I obtain prior authorization (PA)?

You may obtain PA by sending a request, along with any required forms, to the fax number listed on the form. See HCA's ProviderOne Billing and Resource Guide for more information on requesting PA.

Expedited prior authorization (EPA)

What is expedited prior authorization (EPA)?

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

To bill HCA for diagnostic conditions, procedures, and services that meet the EPA criteria on the following pages, the provider must **use the 9-digit EPA number**. The first five or six digits of the EPA number must be **87000 or 870000**. The last three or four digits must be the EPA number assigned to the diagnostic

condition, procedure, or service that meets the EPA criteria (see EPA criteria coding list for codes). Enter the EPA number on the billing form in the authorization number field, or in the Authorization or Comments section when billing electronically.

HCA denies claims submitted without a required EPA number.

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

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

> **Note**: HCA requires PA when there is no option to create an EPA number.

EPA guidelines

Documentation

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

What is a limitation extension (LE)?

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

How is an LE request submitted for approval?

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

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

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

Does miscellaneous parenteral supply HCPCS code B9999 require prior authorization?

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

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

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

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

EPA criteria coding list

A complete EPA number is 9 digits. The first five or six digits of the EPA number must be **87000 or 870000**. The last three or four digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria. If the client does not meet the EPA criteria, prior authorization (PA) is required (see prior authorization). HCA reviews requests for prior authorization in accordance with WAC 182-501-0165.

EPA Code	Service Name	HCPCS	Criteria

870001535	Continuous glucose monitoring (CGM)	A9276, A9277, A9278, A4238, A4239, E2102, E2103	Invoice Required.
			
			Use for clients:
			• Age 18 and younger
			• Adults with Type 1 diabetes
			• Adults with Type 2 diabetes who are:
			  ○ Unable to achieve target HbA1C despite adherence to an appropriate glycemic management plan (after six [6] months) of intensive insulin therapy and testing blood glucose 4 or more times per day
			  ○ Suffering from one or more severe (blood glucose < 50 mg/dl or symptomatic) episodes of hypoglycemia despite adherence to an appropriate glycemic management plan (intensive insulin therapy; testing blood glucose 4 or more times per day)
			  ○ Unable to recognize, or communicate about, symptoms of hypoglycemia

870001536	Continuous glucose monitoring (CGM)	A9276, A9277, A9278, A4238, A4239, E2102, E2103	Invoice Required. Use for pregnant women any age with: • Type 1 diabetes • Type 2 diabetes and on insulin prior to pregnancy • Gestational diabetes whose blood glucose is not well controlled (HbA1C above target or experiencing episodes of hyperglycemia or hypoglycemia) during pregnancy and require insulin

Washington State Health Care Authority

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

For billing specific to medical equipment and supplies, see the **Medical Equipment and Supplies Billing Guide.**

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.

To accurately determine the MSRP and consider any supplier discounts, an itemized invoice is required rather than a quote. The invoice must 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.

The manufacturer price list or invoice must be dated within 12 months prior to the date of service and must substantiate the specific supply being billed.

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

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

- For a client receiving infusion therapy, the file must contain:
  - A copy of the written prescription for the therapy.
  - The client's age, height, and weight.
  - The medical necessity for the specific home infusion service.
- For a client receiving parenteral nutrition, the file must contain:
  - All the information listed above.
  - Any oral or enteral feeding trials and outcomes, if applicable.
  - The duration of gastrointestinal impairment.
  - The monitoring and reviewing of the client's lab values:
    - At the initiation of therapy.
    - At least once per month.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's **Billers, providers, and partners webpage**, under **Learn how to use ProviderOne,** select **Webinars**.

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

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

Name	Entry
Place of Service	Enter the following code: **Code** — **To be Used For** 12 — Client's residence 31 — Nursing facility (formerly (SNF) 32 — Nursing facility (formerly ICF) 33 — Custodial care facility 65 — End stage renal disease treatment facility