Washington State Health Care Authority

Washington Apple Health (Medicaid)

Medical Equipment and Supplies Billing Guide

July 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 **July 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 182-543 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.

---

* This publication is a billing instruction.

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 and 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
Integrated Apple Health Foster Care (AHFC)	Reworded the eligibility list to further clarify when clients may be eligible for this program	Clarification – no policy change
Enclosed beds	Added criteria for enclosed bed systems	Clarification on policy requirements
Throughout guide	Updated term "diaper" to "briefs"	Use of industry standard language
Coverage table	Removed policy comment referencing use of HCPCS code E0296	The agency no longer uses this code and inadvertently missed removing it from the guide.

Subject	Change	Reason for Change
Coverage/Limitations	Added – "The treating practitioner's order and a documented diagnosis of incontinence is required."	Clarification of what is needed when requesting incontinent supplies.

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).

Standard written order (SWO) – A standard written order (SWO) is a document required for certain medical equipment, prosthetics, orthotics, and supplies (MEPOS) items, outlining the specific item, quantity, and duration of need, and acting as evidence of a valid order from the treating healthcare provider. This document may also be referred to as a prescription.

The SWO must include the following information:

- Client's full name;
- Order date, which is the date the order was written or electronically signed by the treating practitioner;
- General item description, which may be either a general description (for example, "wheelchair" or "hospital bed"), a HCPCS code, a HCPCS code narrative, or a brand name or model number;
- For equipment, in addition to the base item description, the SWO may include all concurrently ordered options, accessories, or additional features that are separately billed or require an upgraded code (list each separately);
- If applicable, the quantity to be provided and the frequency of use;
- If applicable, the length of time the item is required; and
- The name, NPI, and signature of the treating practitioner, practitioner credentials, and the signature date.

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**).

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 must 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)**

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 before 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 "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 and 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) before serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment before 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.

Exceptions:

- 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.
- 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**.

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)

The following clients in foster care (either Tribal or dependency through the Department of Children, Youth, and Families [DCYF]), Adoption Support, Extended Foster Care (EFC), Alumni, and Unaccompanied Refugee Minors (URM) programs who are enrolled in Coordinated Care's (CCW) Apple Health Core Connections Foster Care (AHCC) program receive both medical and behavioral health services from CCW.

- Clients in foster care or in the URM program may stay covered through the end of the month they turn age 18 or when their dependency dismisses
- Clients who are receiving adoption support may stay covered through the end of the month they turn age 21 or when their adoption support case closes

- Clients who have opted into EFC at age 18 may stay covered through the end of the month they turn age 21. (Clients may opt in and out of EFC through the month they turn age 21.)
- Clients age 18 may stay covered through the end of the month they turn age 26 (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.

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 assigned to 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**.

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**.

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

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

Washington State Health Care Authority

Medical Equipment and Supplies Benefits

This billing guide provides information for billing medical equipment and 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 MES, related repairs, and services when all the following apply:

- Are 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**.
  - Equipment and supplies that are mainly for the comfort of the client or caregiver, for convenience, for safety, or for controlling the environment do not meet the definition of medical equipment 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, safety equipment, generators, battery packs, and air conditioners.

- Are 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 before 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 standard written order (SWO), dated within 180 days of the PA submission.

> **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**.

> **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 following does not apply:
>
> 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 standard written order (SWO), dated within 180 days of the PA submission.

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 must 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 before 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.

Medical necessity guidelines for medical equipment and supplies

HCA covers medical equipment and supplies (MES).

HCA requires providers to obtain prior authorization (PA) for certain medical equipment and supplies. See the **Providers billing guides and fee schedules** webpage under Medical equipment and supplies.

HCA reviews requests for PA on a case-by-case basis using evidence-based standards to determine medical necessity. This section outlines the routine guidelines to enhance the efficiency of PA 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

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.

HCPCS Codes:

The following HCPCS codes do **NOT** require PA:

E0243: Toilet rail, each

E0244: Raised toilet seat

E0245: Tub stool or bench

E0163: Commode chair with fixed arm

E0165: Commode chair with detacharm

E0167: Commode chair pail or pan, replacement only

E0175: Commode chair foot rest

The following HCPCS codes require PA:

E0168: Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each

E0240: Bath/shower chair, with or without wheels, any size

E0247: Transfer bench for tub or toilet with or without commode opening

E0248: Transfer bench, heavy duty, for tub or toilet with or without commode opening

Medical necessity guidelines (routine):

The routine medical necessity guidelines for bathroom equipment are as follows; 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
- When a provider is requesting prior 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.

Complex bathroom equipment

HCPCS Codes:

E0240: Bath/shower chair, with or without wheels, any size

Medical necessity guidelines (routine):

For mobile shower 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
  - Active 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.

> 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 standard and custom fitted gradient medical grade compression garments that are medically necessary treatment items for each affected body part. Custom fitted compression garments are garments that are uniquely sized and shaped to fit the exact dimensions of the affected extremity or part of the body of an individual, to provide accurate gradient compression to treat the medical condition.

HCA pays for items, as needed:

- To replace lost, stolen, or irreparably damaged items.
- If a patient's condition changes, such as a change in limb size.

All compression garments:

- Require prior authorization (PA)
- Must have a minimum pressure level of 30 millimeters of mercury (mmHg). Compression levels less than 30 mmHg can be obtained over the counter. HCA does not pay for over-the-counter compression garments.

> **Note**: HCPCS codes A6552 and A6554 do not require PA. Limit of two, per limb, per year. To exceed these limits, see Limitation Extension section in this guide.

HCPCS Codes:

A6515: Gradient compression wrap with adjustable straps, full leg, each, custom

A6516: Gradient compression wrap with adjustable straps, foot, each, custom

A6517: Gradient compression wrap with adjustable straps, below knee, each, custom

A6518: Gradient compression wrap with adjustable straps, arm, each, custom

A6519: Gradient compression garment, not otherwise specified, for nighttime use, each

A6520: Gradient compression garment, glove, padded, for nighttime use, each

A6521: Gradient compression garment, glove, padded, for nighttime use, custom, each

A6522: Gradient compression garment, arm, padded, for nighttime use, each

A6523: Gradient compression garment, arm, padded, for nighttime use, custom, each

A6524: Gradient compression garment, lower leg and foot, padded, for nighttime use, each

A6525: Gradient compression garment, lower leg and foot, padded, for nighttime use, custom, each

A6526: Gradient compression garment, full leg and foot, padded, for nighttime use, each

A6527: Gradient compression garment, full leg and foot, padded, for nighttime use, custom, each

A6528: Gradient compression garment, bra, for nighttime use, each

A6529: Gradient compression garment, bra, for nighttime use, custom, each

A6549: Gradient compression garment, not otherwise specified, for daytime use, each

A6553: Gradient compression stocking, below knee, 30-40 mmhg, custom, each

A6555: Gradient compression stocking, below knee, 40 mmhg or greater, custom, each

A6556: Gradient compression stocking, thigh length, 18-30 mmhg, custom, each

A6557: Gradient compression stocking, thigh length, 30-40 mmhg, custom, each

A6558: Gradient compression stocking, thigh length, 40 mmhg or greater, custom, each

A6559: Gradient compression stocking, full length/chap style, 18-30 mmhg, custom, each

A6560: Gradient compression stocking, full length/chap style, 30-40 mmhg, custom, each

A6561: Gradient compression stocking, full length/chap style, 40 mmhg or greater, custom, each

A6562: Gradient compression stocking, waist length, 18-30 mmhg, custom, each

A6563: Gradient compression stocking, waist length, 30-40 mmhg, custom, each

A6564: Gradient compression stocking, waist length, 40 mmhg or greater, custom, each

A6565: Gradient compression gauntlet, custom, each

A6566: Gradient compression garment, neck/head, each

A6567: Gradient compression garment, neck/head, custom, each

A6568: Gradient compression garment, torso and shoulder, each

A6569: Gradient compression garment, torso/shoulder, custom, each

A6570: Gradient compression garment, genital region, each

A6571: Gradient compression garment, genital region, custom, each

A6572: Gradient compression garment, toe caps, each

A6573: Gradient compression garment, toe caps, custom, each

A6574: Gradient compression arm sleeve and glove combination, custom, each

A6575: Gradient compression arm sleeve and glove combination, each

A6576: Gradient compression arm sleeve, custom, medium weight, each

A6577: Gradient compression arm sleeve, custom, heavy weight, each

A6578: Gradient compression arm sleeve, each

A6579: Gradient compression glove, custom, medium weight, each

A6580: Gradient compression glove, custom, heavy weight, each

A6581: Gradient compression glove, each

A6582: Gradient compression gauntlet, each

A6583: Gradient compression wrap with adjustable straps, below knee, each

A6585: Gradient compression wrap with adjustable straps, above knee, each

A6586: Gradient compression wrap with adjustable straps, full leg, each

A6587: Gradient compression wrap with adjustable straps, foot, each

A6588: Gradient compression wrap with adjustable straps, arm, each

A6589: Gradient pressure wrap with adjustable straps, bra, each

A6593: Accessory for gradient compression garment or wrap with adjustable straps, not otherwise specified

A6610: Gradient compression stocking, below knee, 18-30 mmhg, custom, each

A6611: Gradient compression wrap with adjustable straps, above knee, each, custom

E0678: Nonpneumatic sequential compression garment, full leg

E0679: Nonpneumatic sequential compression garment, half leg

E0682: Nonpneumatic sequential compression garment, full arm

Limitations:

Garments identified as daytime use or not otherwise specified: 3 garments per affected body part every 6 months

Garments identified as nighttime use: 2 garments per affected body part every 2 years

Medical necessity guidelines (routine):

The routine medical necessity guidelines for compression garments are as follows; 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

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.

See the **fee schedule** for rates, code status indicators, and modifiers.

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 HCA 13-871 is no longer required. PA 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 Codes:

E0935: Continuous passive motion exercise device for use on knee only

(limitation up to 21 days of rental)

E0936: Continuous passive motion exercise device for use 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 follow; 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: Enclosed bed systems, safety enclosures, and pediatric hospital beds

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 as safety equipment primarily to individuals who may be prone to wandering or unsafe exiting from the bed. While these products are marketed as safety equipment, they are considered by the FDA as a form of restraint.

The enclosed bed system may include the following components:

- Frame: Metal or aluminum rectangular frame
- Padding: Polyurethane or similar tubular foam padding for the aluminum frame
- Side panels and canopy: Four side panels made of polyurethane-coated nylon pack cloth, gray polyester mesh (or similar materials) and polyester coiled zippers with an enclosed canopy

The FDA has published concerns about the safety of these products, which are classified as "patient bed with canopy/restraints," with a regulation description of "protective restraint" and defined as "enclosed bed canopy system used as passive restraint." 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.

Considered not medically necessary. In most cases, enclosed bed systems are considered to be not medically necessary. Equipment and supplies that are mainly for the comfort of the client or caregiver, for convenience, solely for safety, or for controlling the environment do not meet the definition of medical equipment as outlined in WAC 182-543-1000.

Additionally, the evidence is insufficient to support clinical efficacy, safety, or improved health outcomes over other alternative treatment interventions. These beds are not designed for clients with medical conditions that require hospital beds with rails or 360-degree safety enclosures.

Requests for review. All requests are reviewed on a case-by-case basis for medical necessity. The evaluation process follows the guidelines outlined in WAC 182-501-0165 to determine clinical efficacy and safety while applying the definition of medical necessity described in WAC 182-500-0070.

The clinical review considers evidence-based practice guidelines, relevant studies, and credible evidence from the client's medical record.

360-degree safety enclosure frame/canopy (E0316)

This item is distinct from enclosed bed systems, as described under the Enclosed Beds section. It is specifically designed for use with hospital beds. This item is not designed for use with enclosed bed systems for nonmedical beds. Depending on the design of the product, it may fall under the FDA category of "patient bed with canopy/restraint."

HCPCS Codes:

E0316: Safety enclosure frame/canopy for use with hospital bed, any type

E0328: Hospital bed, pediatric, manual, 360-degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress

E0329: Hospital bed, pediatric, electric or semi-electric, 360-degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress

E0300: Pediatric crib, hospital grade, fully enclosed, with or without top enclosure

E1399: Durable Medical Equipment, miscellaneous

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:

HCA considers an enclosed bed to be medically necessary when all of the following are present:

- Diagnosis(es) that support the necessity of an enclosed bed
- Documentation of a specific risk from unrestricted mobility
- Medical records supporting medical necessity for the requested enclosed bed and any additional accessories or options
- Completed documentation from the medical provider
- A written monitoring plan approved by the primary care provider addressing all of the following:
    - The duration of daily use to be used exclusively while the client is sleeping
    - For when the client is in the enclosed bed
        - Specified time intervals the client will be monitored
        - How all the client's personal care needs will be met
        - An explanation of how any medical condition will be managed
    - A plan for management of safety concerns of potential entrapment and endangerment in case of emergency
- A documented transition plan away from the safety bed
- A home evaluation from a licensed occupational or physical therapist (or other clinician, e.g., prescribing physician, ARNP, PA-C) that is comprehensive and specific to the client and documents all of the following:
    - A comparative evaluation of various enclosed beds that explains the rationale and clinical need for the requested enclosed bed and components
    - Education to the caregivers regarding the use of the enclosed bed
    - Evaluation of trials of less restrictive strategies
    - An attestation there is no financial relationship with the vendor
    - An initial visual assessment and reassessments of the home to evaluate if the reason for the need of the bed is still present
- Documentation of equally effective less costly alternatives tried and reason for failure to include:
    - Bed modifications such as padding around a regular or hospital bed, bed tent or canopy attachment, bed rails and/or bed rail protectors
    - Mattress placed on floor

- Medications to address seizures, behaviors and/or sleeping issues
- Sensory and/or behavior modification strategies
- Environmental modification strategies such as using a child protection device on the doorknob or gates across doorways, monitoring devices and removing safety hazards from the room
- Protective and/or adaptive strategies such as helmets or specialized clothing

Prior authorization is required for additional accessories or bed modifications and must meet the following criteria:

- Are primarily and customarily used to serve a medical purpose
- Generally, are not useful to a person in the absence of a disability, 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.

Fee-for-service billing instructions

Enclosed beds require prior authorization (PA) to demonstrate that criteria are met and 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 submitting a PA request, a complete *Enclosed Bed Authorization Form* (HCA 09-0019) must be submitted with the request. To download an HCA form, see HCA's **Forms and Publications** webpage.

The following must be documented in the client's electronic health record (EHR) and made available upon HCA's request. The EHR documentation must include all of the following:

- Diagnosis, behaviors and symptoms
- Goals for the client
- Less restrictive and less intrusive medical, behavioral, and/or sleep interventions already tried, the outcomes, and a clear explanation of why each intervention failed
- Written monitoring plan
- Documented transition plan away from the bed

- Annual home evaluation

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 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 (PA) may be required. See Coverage Table for specific PA requirements and limitations.

HCPCS Codes:

E0621: Sling or seat, patient lift, canvas or nylon

E0635: Patient lift, electric with seat or sling

Medical necessity guidelines (routine):

The routine medical necessity guidelines for patient lifts are as follows; 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: Positioning seat for persons with special orthopedic needs

Medical necessity guidelines (routine):

The routine medical necessity guidelines for a positioning car seat are as follows; 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)

Based upon review of evidence provided by the Health Technology Clinical Committee (HTCC – 20090828B – Bone Growth Stimulation), HCA covers noninvasive osteogenesis electrical stimulators, that have pulsed electromagnetic field (PEMF) simulation, limited to one per client in a five-year period.

Medical necessity guidelines (routine):

The routine medical necessity guidelines for an osteogenesis electrical stimulator are as follows; 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 and 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

If the medical necessity guidelines above are met, use EPA 870000765 (Non-Spinal bone growth stimulator) or EPA 870000770 (Spinal bone growth stimulator). If the client does not meet EPA criteria, PA is required. 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 (PA) is not required. HCPCS code L8500.
- One speech generating device (SGD), per client every two years. PA is required. HCPCS codes E2500, E2502, E2504, E2506, E2508, E2510, E2512.

Fee-for-service billing instructions

SGDs require 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?**

Submit a plan of care that includes a training schedule for the selected device.

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 (PA) is not required.

Breast pumps

HCA pays for the purchase and rental of breast pumps with limitations.

Manual and electric breast pumps

HCA pays for the purchase (not rental) of manual and electric breast pumps without prior authorization (PA), with the limitation of one per client in a three-year period.

HCPCS Codes:

E0602: Breast pump, manual, any type

E0603: Breast pump, electric (ac and/or dc), any type

Hospital breast pumps

HCA pays for the rental (not purchase) of hospital grade breast pumps with PA. The rental of hospital-grade breast pumps is covered with a limitation of 3 months. A PA request may be submitted for an extension of the rental period beyond the 3-month limit.

HCPCS:

The following HCPCS code requires PA:
E0604: Breast pump, hospital grade, electric (ac and / or dc), any type

Medical necessity guidelines (routine):

The routine medical necessity guidelines for hospital grade breast pumps are as follows; 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, is receiving milk and 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 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 (NPWT) 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 Codes:

E2402: Negative pressure wound therapy electrical pump, stationary or portable

(Rental only)

A6550: Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories

A7000: Canister, disposable, used with suction pump, each

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

Coverage Table – Medical Equipment and 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 brief or pant, or rental reusable brief 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)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4640	RA	Replacement pad for use with medically necessary alternating pressure pad owned by patient	Purchase only. Included in NF daily rate.
	A6550		Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories	Purchase only. PA required. Electrical pump, includes all supplies and accessories
	A7000	NU	Canister, disposable, used with suction pump, each	Limit of 10 per client every 30 days. Allowed only when billed in conjunction with PA HCPCS code E2402.
N	A9286		Hygienic item or device, disposable or non-disposable, any type, each	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		Suction pump, home model, portable, for use on wounds	PA required
	E0181	NU/RR	Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty	PA required for rental only.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0182	NU	Pump for alternating pressure pad, for replacement only	Included in NF daily rate.
	E0183	NU	Powered pressure reducing underlay/pad, alternating, 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.
	E0185	NU/RR	Gel or gel-like pressure pad for mattress, standard mattress length and width	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/pillow/wedge, any shape or size, includes all components and accessories	Purchase only. Limit 1 per year. Included in NF daily rate.
DC	E0193		Powered air flotation bed (low air loss therapy)	See E0194
	E0194	NU/RR	Air fluidized bed	Considered purchased after 1 year's rental. PA or EPA required.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	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, standard mattress length and width	Considered purchased after 1 year's rental. PA required for rental. Included in NF daily rate.
	E0198	NU	Water pressure pad for mattress, standard mattress length and width	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0199	NU	Dry pressure pad for mattress, standard mattress length and width	Limit of 1 per client every 5 years. Included in NF daily rate.
DC	E0255		Hospital bed, variable height, hi-lo, with any type side rails, with mattress	See HCPCS codes E0292 and E0305 or E0310.
DC	E0256		Hospital bed, variable height, hi-lo, with any type side rails, without mattress	See HCPCS codes E0293 and E0305 or E0310.
DC	E0260		Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress	See HCPCS codes E0294 and E0305 or E0310.
DC	E0261		Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress	See HCPCS codes E0295 and E0305 or E0310.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
DC	E0265		Hospital bed, total electric (head, foot and height adjustments), with any type side rails, with mattress	See HCPCS codes E0305 or E0310.
DC	E0266		Hospital bed, total electric (head, foot and height adjustments), with any type side rails, without mattress	See HCPCS codes E0297 and E0305 or E0310.
	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 pressure-reducing air mattress	Considered purchased after 1 year's rental. PA or EPA required. Limit of 1 per client every 5 years.
	E0290	NU	Hospital bed, fixed height, without side rails, with mattress	
	E0291	NU	Hospital bed, fixed height, without side rails, without mattress	
	E0292	NU/RR	Hospital bed, variable height, hi-lo, without side rails, with mattress	Considered purchased after 1 year's rental. Limit of 1 per client every 10 years. PA required. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0293	NU/RR	Hospital bed, variable height, hi-lo, without side rails, without mattress	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	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress	Considered purchased after 1 year's rental. Limit of 1 per client every 10 years. PA or EPA required. Included in NF daily rate.
	E0295	NU/RR	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress	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	Pediatric crib, hospital grade, fully enclosed, with or without top enclosure	Considered purchased after 1 year's rental. PA required. Included in NF daily rate.
	E0301	NU	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress	PA required
DC	E0302		Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress	See E0304

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0303	NU/RR	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress	Considered purchased after 1 year's rental. Limit of 1 per client every 10 years. PA required. Included in NF daily rate.
	E0304	NU/RR	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	Considered purchased after 1 year's rental. Limit of 1 per client every 10 years. PA required. Included in NF daily rate.
	E0305	NU/RR	Bed side rails, 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	Bed side rails, 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	Safety enclosure frame/canopy for use with hospital bed, any type	PA required. Included in NF daily rate. Frame/canopy for use with hospital bed.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0328		Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress	Purchase only. Limit of 1 per client every 10 years. PA required. Included in NF daily rate. For clients age 20 and younger. Use form HCA 13-747.
	E0329		Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress	Purchase only. Limit of 1 per client every 10 years. PA required. Included in NF daily rate. For clients age 20 and younger. Use form HCA 13-747.
	E0371	NU/RR	Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width	Considered purchased after 1 year's rental. PA or EPA required.
	E0372	NU/RR	Powered air overlay for mattress, standard mattress length and width	Considered purchased after 1 year's rental. PA or EPA required.
	E0373	NU/RR	Nonpowered advanced pressure reducing mattress	Considered purchased after 1 year's rental. PA or EPA required.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2402	RR	Negative pressure wound therapy electrical pump, stationary or portable	Rental only. PA required.

Fracture frames, trapeze, traction, and transfer equipment

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
DC	E0830		Ambulatory traction device, all types, each	
	E0840	NU	Traction frame, attached to headboard, cervical traction	
DC	E0849		Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible	
	E0850	NU	Traction stand, free standing, cervical traction	Limit of 1 per client every 5 years. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
DC	E0855		Cervical traction equipment not requiring additional stand or frame	
DC	E0856		Cervical traction device, with inflatable air bladder(s)	
	E0860	NU	Traction equipment, overdoor, cervical	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0870	NU	Traction frame, attached to footboard, extremity traction, (e.g., buck's)	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0880	NU	Traction stand, free standing, extremity traction	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0890	NU	Traction frame, attached to footboard, pelvic traction	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0900	NU	Traction stand, free standing, pelvic traction, (e.g., buck's)	Limit of 1 per client every 5 years. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0910	NU/RR	Trapeze bars, a/k/a patient helper, attached to bed, with grab bar	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	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar	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	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar	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 bed, includes weights	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, includes weights	Considered purchased after 1 year's rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.
	E0940	NU/RR	Trapeze bar, free standing, complete with grab bar	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)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0941	NU/RR	Gravity assisted traction device, any type	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 with cross bars, attached to bed, (e.g., balken, 4 poster)	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, attachments for complex pelvic traction	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0948	NU	Fracture frame, attachments for complex cervical traction	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0705	NU	Transfer device, any type, each	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)	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 or mechanical, includes any seat, sling, strap(s) or pad(s)	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)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0635	NU/RR	Patient lift, electric with seat or sling	Considered purchased after 1 year's rental. Limit of 1 per client every 5 years. PA required for rental. Included in NF daily rate.
	E0637	NU/RR	Combination sit to stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels	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/table system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or without wheels	Limit of 1 per client every 5 years. PA required. Included in NF daily rate. Considered purchased after 1 year's rental.
	E0639	NU	Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories	Limit of 1 per client every 5 years. PA required. Included in NF daily rate.

Noninvasive bone growth/nerve stimulators

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0740	NU/RR	Non-implanted pelvic floor electrical stimulator, complete system	Considered purchased after 1 year's rental. PA required. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0747	NU	Osteogenesis stimulator, electrical, non-invasive, other than spinal applications	Limit of 1 per client every 5 years. PA or EPA is required.
	E0748	NU	Osteogenesis stimulator, electrical, non-invasive, spinal applications	Limit of 1 per client every 5 years. PA or EPA is required.
	E0760	NU	Osteogenesis stimulator, low intensity ultrasound, non-invasive	Limit of 1 per client every 5 years. PA or EPA is required.

Communication devices

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2500	NU	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time	PA required.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2502	NU	Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time	PA required.
	E2504	NU	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	PA required.
	E2506	NU	Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time	PA required.
	E2508	NU	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device	PA required.
	E2510		Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	Purchase only. PA required.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2512	NU	Accessory for speech generating device, mounting system	PA required.
BR	E2599		Accessory for speech generating device, not otherwise classified	Purchase only. PA required.
	L8500		Artificial larynx, any type	Purchase only. Limit of 1 per client every 5 years.

Ambulatory aids

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4635		Underarm pad, crutch, replacement, each	Purchase only. Included in NF daily rate.
	A4636	NU	Replacement, handgrip, cane, crutch, or walker, each	Included in NF daily rate.
	A4637	NU	Replacement, tip, cane, crutch, walker, each	Included in NF daily rate.
	E0100	NU	Cane, includes canes of all materials, adjustable or fixed, with tip	Limit of 1 per client every 5 years. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0105	NU	Cane, quad or three prong, includes canes of all materials, adjustable or fixed, with tips	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0110	NU	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0111	NU	Crutch forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrips	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0112	NU	Crutches underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0113	NU	Crutch underarm, wood, adjustable or fixed, each, with pad, tip and handgrip	Limit of 1 per client every 5 years. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0114	NU	Crutches underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0116	NU	Crutch, underarm, other than wood, adjustable or fixed, with pad, tip, handgrip, with or without shock absorber, each	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0117	NU	Crutch, underarm, articulating, spring assisted, each	PA required.
DC	E8000		Gait trainer, pediatric size, posterior support, includes all accessories and components	See HCPCS code E8001.
BR	E8001		Gait trainer, pediatric size, upright support, includes all accessories and components	Purchase only. PA required. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
DC	E8002		Gait trainer, pediatric size, anterior support, includes all accessories and components	See HCPCS code E8001.
	E0130	NU	Walker, rigid (pickup), adjustable or fixed height	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0135	NU	Walker, folding (pickup), adjustable or fixed height	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0140	NU	Walker, with trunk support, adjustable or fixed height, any type	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0141	NU	Walker, rigid, wheeled, adjustable or fixed height	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0143	NU	Walker, folding, wheeled, adjustable or fixed height	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0144	NU	Walker, enclosed, four sided framed, rigid or folding, wheeled with posterior seat	Limit of 1 per client every 5 years. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0147	NU	Walker, heavy duty, multiple braking system, variable wheel resistance	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0148	NU	Walker, heavy duty, without wheels, rigid or folding, any type, each	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0149	NU	Walker, heavy duty, wheeled, rigid or folding, any type	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0153	NU	Platform attachment, forearm crutch, each	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0154	NU	Platform attachment, walker, each	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0155	NU	Wheel attachment, rigid pick-up walker, per pair	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0156	NU	Seat attachment, walker	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0157	NU	Crutch attachment, walker, each	Limit of 1 per client every 5 years. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0158	NU	Leg extensions for walker, per set of four (4)	Limit of 1 per client every 5 years. Included in NF daily rate.
	E0159	NU	Brake attachment for wheeled walker, replacement, each	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)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0163	NU	Commode chair, mobile or stationary, with fixed arms	Purchase only. Limit 1 every 3 years.
	E0165	NU	Commode chair, mobile or stationary, with detachable arms	Purchase only. Limit 1 every 3 years.
	E0167		Pail or pan for use with commode chair, replacement only	Purchase only. Limit 1 every 3 years.
	E0168	NU	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each	PA required. Use form HCA 13-872. Purchase only. Limit 1 every 3 years.
BR	E0168	SC	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each	PA required. Use form HCA 13-872 (Weight capacity: >600 lbs.) Purchase only. Limit 1 every 3 years.
	E0175		Foot rest, for use with commode chair, each	Purchase only. Limit 1 every 3 years.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	E0240		Bath/shower chair, with or without wheels, any size	PA required. Use form HCA 13-872
BR	E0243		Toilet rail, each	Purchase only. Limit 1 every 3 years.
BR	E0244		Raised toilet seat	Purchase only. Limit 1 every 3 years.
BR	E0245		Tub stool or bench	Purchase only. Limit 1 every 3 years.
BR	E0247		Transfer bench for tub or toilet with or without commode opening	PA required. Use form HCA 13-872
BR	E0248		Transfer bench, heavy duty, for tub or toilet with or without commode opening	PA required. Use form HCA 13-872
BR	E0700		Safety equipment, device or accessory, any type	Purchase only. Included in NF daily rate.

Blood pressure monitoring

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	A4660		Sphygmomanometer/blood pressure apparatus with cuff and stethoscope	
BR	A4663		Blood pressure cuff only	Use for replacement BP cuffs
	A4670		Automatic blood pressure monitor	Limit of 1 per client, per 3 years.
	A9275		Home glucose disposable monitor, includes test strips	Purchase only.

Miscellaneous medical equipment

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A8000	NU	Helmet, protective, soft, prefabricated, includes all components and accessories	Limit of 2 per client, per year.
	A8001	NU	Helmet, protective, hard, prefabricated, includes all components and accessories	Limit of 2 per client, per year.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	A8002	NU	Helmet, protective, soft, custom fabricated, includes all components and accessories	Limit of 1 per client, per year. PA required.
BR	A8003	NU	Helmet, protective, hard, custom fabricated, includes all components and accessories	Limit of 1 per client, per year. PA required.
BR	A8004	NU	Soft interface for helmet, replacement only	Not allowed in addition to HCPCS codes A8000 – A8003.
	E0202	RR	Phototherapy (bilirubin) light with photometer	Rental only. Includes all supplies. Limit of 5 days of rental per client, per 12-month period.
	E0602	NU	Breast pump, manual, any type	Purchase only. Limit of 1 per client in a three-year period.
	E0603	NU	Breast pump, electric (ac and/or dc), any type	Purchase only. Limit of 1 per client in a three-year period.
	E0604	RR	Breast pump, hospital grade, electric (ac and / or dc), any type	Rental only PA or EPA is required. PA required for limitation extension.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0650	NU/RR	Pneumatic compressor, non-segmental home model	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	Non-segmental pneumatic appliance for use with pneumatic compressor, half arm	
	E0660	NU	Non-segmental pneumatic appliance for use with pneumatic compressor, full leg	
	E0665	NU	Non-segmental pneumatic appliance for use with pneumatic compressor, full arm	
	E0666	NU	Non-segmental pneumatic appliance for use with pneumatic compressor, half leg	
	E0935	RR	Continuous passive motion exercise device for use on knee only	Rental allowed for maximum of 21days. Limits = per knee. PA or EPA is required.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0936	RR	Continuous passive motion exercise device for use other than knee	PA required. Rental allowed for maximum of 21 days.
BR	E1399	NU	Durable medical equipment, miscellaneous	Purchase only. PA required.
	E2000	RR	Gastric suction pump, home model, portable or stationary, electric	Rental only. PA required.
	K0606	RR	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type	PA required
	K0607		Replacement battery for automated external defibrillator, garment type only, each	
	K0608		Replacement garment for use with automated external defibrillator, each	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	K0609		Replacement electrodes for use with automated external defibrillator, garment type only, each	
	K0739		Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes	For client-owned equipment only. PA required.
	T5001	NU/RR	Positioning seat for persons with special orthopedic needs	Limit of 1 per client every 5 years. PA required. Use code for positioning car seat and special needs adaptive sitters and feeders. Included in NF daily rate.

Other charges for medical equipment services

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A7048		Vacuum drainage collection unit and tubing kit, including all supplies needed for collection unit change, for use with implanted catheter, each	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 (PA) 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)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E1028	NU	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware, other	PA required HCPCS code E1028 must be submitted on one line for correct payment.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E1031	NU	Rollabout chair, any and all types with casters 5" or greater	PA required
	E1060	RR	Fully-reclining wheelchair, detachable arms, desk or full length, swing away detachable elevating legrests	EPA required
	K0001	NU/RR	Standard wheelchair	EPA required for rental only
	K0002	NU/RR	Standard hemi (low seat) wheelchair	PA required for rental only.
	K0003	NU/RR	Lightweight wheelchair	PA required for rental only
	K0004	NU	High strength, lightweight wheelchair	PA required
	K0006	NU/RR	Heavy duty wheelchair	PA required
BR	K0108	NU	Wheelchair component or accessory, not otherwise specified	PA required

Manual wheelchairs (noncovered HCPCS codes)

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
DC	E1050		Fully-reclining wheelchair, fixed full length arms, swing away detachable elevating leg rests	See HCPCS codes K0003 and E1226.
DC	E1070		Fully-reclining wheelchair, detachable arms (desk or full length) swing away detachable footrest	See HCPCS codes K0003 and E1226.
DC	E1083		Hemi-wheelchair, fixed full length arms, swing away detachable elevating leg rest	See HCPCS code K0002 and K0003.
DC	E1084		Hemi-wheelchair, detachable arms desk or full length arms, swing away detachable elevating leg rests	See HCPCS code K0002 and K0003.
DC	E1085		Hemi-wheelchair, fixed full length arms, swing away detachable foot rests	See HCPCS code K0002 and K0003.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
DC	E1086		Hemi-wheelchair detachable arms desk or full length, swing away detachable footrests	See HCPCS code K0002 and K0003.
DC	E1087		High strength lightweight wheelchair, fixed full length arms, swing away detachable elevating leg rests	See HCPCS code K0004.
DC	E1088		High strength lightweight wheelchair, detachable arms desk or full length, swing away detachable elevating leg rests	See HCPCS code K0004.
DC	E1089		High strength lightweight wheelchair, fixed length arms, swing away detachable footrest	See HCPCS code K0004.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
DC	E1090		High strength lightweight wheelchair, detachable arms desk or full length, swing away detachable foot rests	See HCPCS code K0004.
DC	E1092		Wide heavy duty wheel chair, detachable arms (desk or full length), swing away detachable elevating leg rests	See HCPCS code K0007.
DC	E1093		Wide heavy duty wheelchair, detachable arms desk or full length arms, swing away detachable footrests	See HCPCS code K0007.
DC	E1100		Semi-reclining wheelchair, fixed full length arms, swing away detachable elevating leg rests	See HCPCS code K0003 and E1226.
DC	E1130		Standard wheelchair, fixed full length arms, fixed or swing away detachable footrests	See HCPCS code K0001.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
DC	E1140		Wheelchair, detachable arms, desk or full length, swing away detachable footrests	See HCPCS code K0001.
DC	E1150		Wheelchair, detachable arms, desk or full length swing away detachable elevating legrests	See HCPCS code K0001.
DC	E1160		Wheelchair, fixed full length arms, swing away detachable elevating legrests	
DC	E1170		Amputee wheelchair, fixed full length arms, swing away detachable elevating legrests	See HCPCS code K0001 – K0005.
DC	E1171		Amputee wheelchair, fixed full length arms, without footrests or legrest	See HCPCS code K0001 – K0005.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
DC	E1172		Amputee wheelchair, detachable arms (desk or full length) without footrests or legrest	See HCPCS code K0001 – K0005.
DC	E1180		Amputee wheelchair, detachable arms (desk or full length) swing away detachable footrests	See HCPCS code K0001 – K0005.
DC	E1190		Amputee wheelchair, detachable arms (desk or full length) swing away detachable elevating legrests	See HCPCS code K0001 – K0005.
DC	E1195		Heavy duty wheelchair, fixed full length arms, swing away detachable elevating legrests	See HCPCS code K0007.
DC	E1200		Amputee wheelchair, fixed full length arms, swing away detachable footrest	See HCPCS code K0001 – K0005.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
DC	E1221		Wheelchair with fixed arm, footrests	See HCPCS code K0001 – K0014.
DC	E1222		Wheelchair with fixed arm, elevating legrests	See HCPCS code K0001 – K0014.
DC	E1223		Wheelchair with detachable arms, footrests	See HCPCS code K0001 – K0014.
DC	E1224		Wheelchair with detachable arms, elevating legrests	See HCPCS code K0001 – K0014.
DC	E1240		Lightweight wheelchair, detachable arms, (desk or full length) swing away detachable, elevating legrest	See HCPCS code K0003 or K0004.
DC	E1250		Lightweight wheelchair, fixed full length arms, swing away detachable footrest	See HCPCS code K0003 or K0004.
DC	E1260		Lightweight wheelchair, detachable arms (desk or full length) swing away detachable footrest	See HCPCS code K0003 or K0004.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
DC	E1270		Lightweight wheelchair, fixed full length arms, swing away detachable elevating legrests	See HCPCS code K0003 or K0004.
DC	E1280		Heavy duty wheelchair, detachable arms (desk or full length) elevating legrests	See HCPCS code K0007.
DC	E1285		Heavy duty wheelchair, fixed full length arms, swing away detachable footrest	See HCPCS code K0007.
DC	E1290		Heavy duty wheelchair, detachable arms (desk or full length) swing away detachable footrest	See HCPCS code K0007.
DC	E1295		Heavy duty wheelchair, fixed full length arms, elevating legrest	See HCPCS code K0007.

Power-operated vehicles (covered HCPCS codes)

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	K0800	NU	Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds	PA required. Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 and E2381 – E2396.
	K0801	NU	Power operated vehicle, group 1 heavy duty, patient weight capacity 301 to 450 pounds	PA required. Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 and E2381 – E2396.
	K0802	NU	Power operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds	PA required. Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 and E2381 – E2396.
	K0806	NU	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds	PA required. Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 and E2381 – E2396.
	K0807	NU	Power operated vehicle, group 2 heavy duty, patient weight capacity 301 to 450 pounds	PA required. Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 and E2381 – E2396.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	K0808	NU	Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600 pounds	PA required. Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 and E2381 – E2396.
BR	K0812	NU	Power operated vehicle, not otherwise classified	PA required. Not allowed in combination with HCPCS codes E1228, E1297, E1298, E2340 – E2343, K0056, E0997 – E0999, K0069 – K0072, K0077, K0099 and E2381 – E2396.

Wheelchair Cushions

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2601	NU	General use wheelchair seat cushion, width less than 22 inches, any depth	
	E2602	NU	General use wheelchair seat cushion, width 22 inches or greater, any depth	
	E2603	NU	Skin protection wheelchair seat cushion, width less than 22 inches, any depth	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2604	NU	Skin protection wheelchair seat cushion, width 22 inches or greater, any depth	
	E2605	NU	Positioning wheelchair seat cushion, width less than 22 inches, any depth	
	E2606	NU	Positioning wheelchair seat cushion, width 22 inches or greater, any depth	
	E2607	NU	Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth	PA required
	E2608	NU	Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth	PA required
	E2622	NU	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth	PA required

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2623	NU	Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	PA required
	E2624	NU	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth	PA required
	E2625	NU	Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	PA required

Armrests and parts

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

Lower extremity positioning (leg rests, etc.)

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0951	NU	Heel loop/holder, any type, with or without ankle strap, each	
	E0952	NU	Toe loop/holder, any type, each	
	E0995	NU	Wheelchair accessory, calf rest/pad, replacement only, each	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 leg rests, pair (for use with capped rental wheelchair base)	PA required

Seat and positioning

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0950	NU	Wheelchair accessory, tray, each	PA required
	E0960	NU	Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware	PA required
	E0978	NU	Wheelchair accessory, positioning belt/safety belt/pelvic strap, each	PA required
	E0980	NU	Safety vest, wheelchair	PA required
	E0981	NU	Wheelchair accessory, seat upholstery, replacement only, each	PA required
	E0982	NU	Wheelchair accessory, back upholstery, replacement only, each	PA required

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0992	NU	Manual wheelchair accessory, solid seat insert	PA required
	E2231	NU	Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware	PA required
BR	E2291	NU	Back, planar, for pediatric size wheelchair including fixed attaching hardware	PA required
BR	E2292	NU	Seat, planar, for pediatric size wheelchair including fixed attaching hardware	PA required
BR	E2293	NU	Back, contoured, for pediatric size wheelchair including fixed attaching hardware	PA required

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	E2294	NU	Seat, contoured, for pediatric size wheelchair including fixed attaching hardware	PA required
	E2611	NU	General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware	
	E2612	NU	General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware	
	E2613	NU	Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware	PA required

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2614	NU	Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware	PA required
	E2615	NU	Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware	PA required
	E2616	NU	Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware	PA required

Hand rims, wheel, and tires (includes parts)

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0967	NU	Manual wheelchair accessory, hand rim with projections, any type, replacement only, each	PA required
	E2211	NU	Manual wheelchair accessory, pneumatic propulsion tire, any size, each	PA required
	E2212	NU	Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each	PA required
	E2213	NU	Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each	PA required

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2214	NU	Manual wheelchair accessory, pneumatic caster tire, any size, each	PA required
	E2215	NU	Manual wheelchair accessory, tube for pneumatic caster tire, any size, each	PA required
	E2216	NU	Manual wheelchair accessory, foam filled propulsion tire, any size, each	
	E2217	NU	Manual wheelchair accessory, foam filled caster tire, any size, each	
	E2218	NU	Manual wheelchair accessory, foam propulsion tire, any size, each	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2219	NU	Manual wheelchair accessory, foam caster tire, any size, each	
	E2220	NU	Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, replacement only, each	
	E2221	NU	Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each	
	E2222	NU	Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2224	NU	Manual wheelchair accessory, propulsion wheel excludes tire, any size, replacement only, each	PA required
	E2225	NU	Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each	PA required
	E2226	NU	Manual wheelchair accessory, caster fork, any size, replacement only, each	PA required
	K0065	NU	Spoke protectors, each	PA required
	K0069	NU	Rear wheel assembly, complete, with solid tire, spokes or molded, replacement only, each	PA required

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	K0070	NU	Rear wheel assembly, complete, with pneumatic tire, spokes or molded, replacement only, each	PA required
	K0071	NU	Front caster assembly, complete, with pneumatic tire, replacement only, each	PA required
	K0072	NU	Front caster assembly, complete, with semi-pneumatic tire, replacement only, each	PA required
	K0073	NU	Caster pin lock, each	PA required
	K0077	NU	Front caster assembly, complete, with solid tire, replacement only, each	PA required

Other accessories

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E0776	NU/RR	Iv pole	PA required
	E0961	NU	Manual wheelchair accessory, wheel lock brake extension (handle), each	Changed from pair to each with new description. PA required.
	E0971	NU	Manual wheelchair accessory, anti-tipping device, each	PA required
	E0973	NU	Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each	PA required
	E1029	NU	Wheelchair accessory, ventilator tray, fixed	PA required
	E1030	NU	Wheelchair accessory, ventilator tray, gimbaled	PA required

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2207	NU	Wheelchair accessory, crutch and cane holder, each	PA required
	E2208	NU	Wheelchair accessory, cylinder tank carrier, each	PA required
	K0105	NU	Iv hanger, each	PA required

Miscellaneous repair only

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	E2210	NU	Wheelchair accessory, bearings, any type, replacement only, each	PA required
	E2619	NU	Replacement cover for wheelchair seat cushion or back cushion, each	PA required

Syringes and needles

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4206		Syringe with needle, sterile, 1 cc or less, each	Included in NF daily rate
	A4207		Syringe with needle, sterile 2 cc, each	Included in NF daily rate
	A4208		Syringe with needle, sterile 3 cc, each	Included in NF daily rate
	A4209		Syringe with needle, sterile 5 cc or greater, each	Included in NF daily rate
	A4210		Needle-free injection device, each	Included in NF daily rate
	A4213		Syringe, sterile, 20 cc or greater, each	Included in NF daily rate
	A4215		Needle, sterile, any size, each	Included in NF daily rate
	A4322		Irrigation syringe, bulb or piston, each	Not allowed in combination with code A4320, A4355. Included in NF daily rate.

Blood monitoring/testing supplies

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4233		Replacement battery, alkaline (other than j cell), for use with medically necessary home blood glucose monitor owned by patient, each	Limit 1 every 3 months
	A4234		Replacement battery, alkaline, j cell, for use with medically necessary home blood glucose monitor owned by patient, each	Limit 1 every 3 months
	A4235		Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each	Limit 1 every 3 months
	A4236		Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4253	KX/KS	Blood glucose test or reagent strips for home blood glucose monitor, per 50 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		Platforms for home blood glucose monitor, 50 per box	
	A4256		Normal, low and high calibrator solution / chips	Included in NF daily rate.
	A4258		Spring-powered device for lancet, each	1 allowed per client, per 6 months. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4259	KX/KS	Lancets, per box of 100	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)	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 or phisohex solution, per pint	Max of 1 pint allowed per client, per month. Included in NF daily rate.
	A4247		Betadine or iodine swabs/wipes, per box	Max of 1 box allowed per client, per month. Included in NF daily rate
BR	A4248		Chlorhexidine containing antiseptic, 1 ml	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)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	A4649		Surgical supply; miscellaneous	PA required
	A6010		Collagen based wound filler, dry form, sterile, per gram of collagen	PA required
	A6011		Collagen based wound filler, gel/paste, per gram of collagen	PA required
	A6021		Collagen dressing, sterile, size 16 sq. in. or less, each	
	A6022		Collagen dressing, sterile, size more than 16 sq. in. but less than or equal to 48 sq. in., each	
	A6023		Collagen dressing, sterile, size more than 48 sq. in., each	PA required
	A6024		Collagen dressing wound filler, sterile, per 6 inches	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6025		Gel sheet for dermal or epidermal application, (e.g., silicone, hydrogel, other), each	
	A6154		Wound pouch, each	
	A6196		Alginate or other fiber gelling dressing, wound cover, sterile, pad size 16 sq. in. or less, each dressing	
	A6197		Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., each dressing	
	A6198		Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 48 sq. in., each dressing	
	A6199		Alginate or other fiber gelling dressing, wound filler, sterile, per 6 inches	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6203		Composite dressing, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing	
	A6204		Composite dressing, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	
	A6205		Composite dressing, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing	
	A6206		Contact layer, sterile, 16 sq. in. or less, each dressing	
	A6207		Contact layer, sterile, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6208		Contact layer, sterile, more than 48 sq. in., each dressing	
	A6209		Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	
	A6210		Foam dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	
	A6211		Foam dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing	
	A6212		Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6213		Foam dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	
	A6214		Foam dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing	
	A6215		Foam dressing, wound filler, sterile, per gram	
	A6216		Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	
	A6217		Gauze, non-impregnated, non-sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6218		Gauze, non-impregnated, non-sterile, pad size more than 48 sq. in., without adhesive border, each dressing	
	A6219		Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing	
	A6220		Gauze, non-impregnated, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	
	A6221		Gauze, non-impregnated, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6222		Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	
	A6223		Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing	
	A6224		Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size more than 48 sq. in., without adhesive border, each dressing	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6229		Gauze, impregnated, water or normal saline, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	
	A6230		Gauze, impregnated, water or normal saline, sterile, pad size more than 48 sq. in., without adhesive border, each dressing	
	A6231		Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size 16 sq. in. or less, each dressing	
	A6232		Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size greater than 16 sq. in., but less than or equal to 48 sq. in., each dressing	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6233		Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size more than 48 sq. in., each dressing	
	A6234		Hydrocolloid dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	
	A6235		Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	
	A6236		Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6237		Hydrocolloid dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing	
	A6238		Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	
	A6240		Hydrocolloid dressing, wound filler, paste, sterile, per ounce	
	A6241		Hydrocolloid dressing, wound filler, dry form, sterile, per gram	
	A6242		Hydrogel dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6243		Hydrogel dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	
	A6244		Hydrogel dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing	
	A6245		Hydrogel dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing	
	A6246		Hydrogel dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6247		Hydrogel dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing	
	A6248		Hydrogel dressing, wound filler, gel, per fluid ounce	
	A6251		Specialty absorptive dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	
	A6252		Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6253		Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing	
	A6254		Specialty absorptive dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing	
	A6255		Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	
	A6256		Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6257		Transparent film, sterile, 16 sq. in. or less, each dressing	
	A6258		Transparent film, sterile, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing	
	A6259		Transparent film, sterile, more than 48 sq. in., each dressing	
	A6260		Wound cleanser, any type, any size	
BR	A6261		Wound filler, gel/paste, per fluid ounce, not otherwise specified	PA required
BR	A6262		Wound filler, dry form, per gram, not otherwise specified	PA required
	A6266		Gauze, impregnated, other than water, normal saline, or zinc paste, sterile, any width, per linear yard	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6402		Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	
	A6403		Gauze, non-impregnated, sterile, pad size more than 16 sq. in. less than or equal to 48 sq. in., without adhesive border, each dressing	
	A6404		Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing	
	A6407		Packing strips, non-impregnated, sterile, up to 2 inches in width, per linear yard	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6441		Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per yard	
	A6442		Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard	
	A6443		Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard	
	A6444		Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 5 inches, per yard	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6445		Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard	
	A6446		Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard	
	A6447		Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard	
	A6448		Light compression bandage, elastic, knitted/woven, width less than three inches, per yard	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6449		Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard	
	A6450		Light compression bandage, elastic, knitted/woven, width greater than or equal to five inches, per yard	
	A6451		Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per yard	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6452		High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per yard	
	A6453		Self-adherent bandage, elastic, non-knitted/non-woven, width less than three inches, per yard	
	A6454		Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three inches and less than five inches, per yard	
	A6455		Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A6456		Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard	
	A6457		Tubular dressing with or without elastic, any width, per linear yard	
BR	A6501		Compression burn garment, bodysuit (head to foot), custom fabricated	PA required
BR	A6502		Compression burn garment, chin strap, custom fabricated	PA required
BR	A6503		Compression burn garment, facial hood, custom fabricated	PA required
BR	A6504		Compression burn garment, glove to wrist, custom fabricated	PA required

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	A6505		Compression burn garment, glove to elbow, custom fabricated	PA required
BR	A6506		Compression burn garment, glove to axilla, custom fabricated	PA required
BR	A6507		Compression burn garment, foot to knee length, custom fabricated	PA required
BR	A6508		Compression burn garment, foot to thigh length, custom fabricated	PA required
BR	A6509		Compression burn garment, upper trunk to waist including arm openings (vest), custom fabricated	PA required
BR	A6510		Compression burn garment, trunk, including arms down to leg openings (leotard), custom fabricated	PA required
BR	A6511		Compression burn garment, lower trunk including leg openings (panty), custom fabricated	PA required

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	A6512		Compression burn garment, not otherwise classified	PA required
BR	A6513		Compression burn mask, face and/or neck, plastic or equal, custom fabricated	PA required
BR	A6594		Gradient compression bandaging supply, bandage liner, lower extremity, any size or length, each	PA required
BR	A6595		Gradient compression bandaging supply, bandage liner, upper extremity, any size or length, each	PA required
BR	A6596		Gradient compression bandaging supply, conforming gauze, per linear yard, any width, each	PA required
BR	A6597		Gradient compression bandage roll, elastic long stretch, linear yard, any width, each	PA required

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	A6598		Gradient compression bandage roll, elastic medium stretch, per linear yard, any width, each	PA required
BR	A6599		Gradient compression bandage roll, inelastic short stretch, per linear yard, any width, each	PA required
BR	A6600		Gradient compression bandaging supply, high density foam sheet, per 250 square centimeters, each	PA required
BR	A6601		Gradient compression bandaging supply, high density foam pad, any size or shape, each	PA required
BR	A6602		Gradient compression bandaging supply, high density foam roll for bandage, per linear yard, any width, each	PA required

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	A6603		Gradient compression bandaging supply, low density channel foam sheet, per 250 square centimeters, each	PA required
BR	A6604		Gradient compression bandaging supply, low density flat foam sheet, per 250 square centimeters, each	PA required
BR	A6605		Gradient compression bandaging supply, padded foam, per linear yard, any width, each	PA required
BR	A6606		Gradient compression bandaging supply, padded textile, per linear yard, any width, each	PA required
BR	A6607		Gradient compression bandaging supply, tubular protective absorption layer, per linear yard, any width, each	PA required

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	A6608		Gradient compression bandaging supply, tubular protective absorption padded layer, per linear yard, any width, each	PA required
BR	A6609		Gradient compression bandaging supply, not otherwise specified	PA required

Tapes

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4450		Tape, non-waterproof, per 18 square inches	Unless needed for the first 6 weeks of post-surgery, all bandages, dressings, and tapes are included in the NF daily rate.)
	A4452		Tape, waterproof, per 18 square inches	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4461		Surgical dressing holder, non-reusable, each	
	A4463		Surgical dressing holder, reusable, each	
	A4465		Non-elastic binder for extremity	

Ostomy supplies

(Note: Items in this category are not taxable)

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4361		Ostomy faceplate, each	Max of 10 allowed per client, per month. Not allowed in combination with codes A4375, A4376, A4379, or A4380.
	A4362		Skin barrier; solid, 4 x 4 or equivalent; each	For ostomy only.
	A4363		Ostomy clamp, any type, replacement only, each	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4364		Adhesive, liquid or equal, any type, per oz	Max of 4 allowed per client, per month. For ostomy or catheter.
	A4366		Ostomy vent, any type, each	
	A4367		Ostomy belt, each	Max of 2 allowed per client every 6 months.
	A4368		Ostomy filter, any type, each	Not allowed in combination with code A4418, A4419, A4423, A4424, A4425, or A4427.
	A4369		Ostomy skin barrier, liquid (spray, brush, etc.), per oz	
	A4371		Ostomy skin barrier, powder, per oz	
	A4372		Ostomy skin barrier, solid 4 x 4 or equivalent, standard wear, with built-in convexity, each	
	A4373		Ostomy skin barrier, with flange (solid, flexible or accordion), with built-in convexity, any size, each	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4375		Ostomy pouch, drainable, with faceplate attached, plastic, each	Max of 10 allowed per month, per client. Not allowed in combination with code A4361, A4377, or A4378.
	A4376		Ostomy pouch, drainable, with faceplate attached, rubber, each	Max of 10 allowed per month, per client. Not allowed in combination with code A4361, A4377, or A4378.
	A4377		Ostomy pouch, drainable, for use on faceplate, plastic, each	Max of 10 allowed per month, per client. Not allowed in combination with code A4375, A4376, or A4378.
	A4378		Ostomy pouch, drainable, for use on faceplate, rubber, each	Max of 10 allowed per month, per client. Not allowed in combination with code A4375, A4376, or A4377.
	A4379		Ostomy pouch, urinary, with faceplate attached, plastic, each	Max of 10 allowed per month, per client. Not allowed in combination with code A4361, A4381, A4382, or A4383.
	A4380		Ostomy pouch, urinary, with faceplate attached, rubber, each	Max of 10 allowed per month, per client. Not allowed in combination with code A4361, A4381, A4382, or A4383.
	A4381		Ostomy pouch, urinary, for use on faceplate, plastic, each	Max of 10 allowed per month, per client. Not allowed in combination with code A4379, A4380, A4382, or A4383.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4382		Ostomy pouch, urinary, for use on faceplate, heavy plastic, each	Max of 10 allowed per month, per client. Not allowed in combination with code A4379, A4380, A4381, A4383.
	A4383		Ostomy pouch, urinary, for use on faceplate, rubber, each	Max of 10 allowed per client per month. Not allowed in combination with code A4379, A4380, A4381, A4382.
	A4384		Ostomy faceplate equivalent, silicone ring, each	
	A4385		Ostomy skin barrier, solid 4 x 4 or equivalent, extended wear, without built-in convexity, each	
	A4387		Ostomy pouch, closed, with barrier attached, with built-in convexity (1 piece), each	Max of 30 allowed per client, per month.
	A4388		Ostomy pouch, drainable, with extended wear barrier attached, (1 piece), each	Max of 10 allowed per client, per month.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4389		Ostomy pouch, drainable, with barrier attached, with built-in convexity (1 piece), each	Max of 10 allowed per client, per month.
	A4390		Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each	Max of 10 allowed per client, per month.
	A4391		Ostomy pouch, urinary, with extended wear barrier attached (1 piece), each	Max of 10 allowed per client, per month.
	A4392		Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each	Max of 10 allowed per client, per month.
	A4393		Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each	Max of 10 allowed per client, per month.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4394		Ostomy deodorant, with or without lubricant, for use in ostomy pouch, per fluid ounce	
	A4395		Ostomy deodorant for use in ostomy pouch, solid, per tablet	
	A4396		Ostomy belt with peristomal hernia support	
	A4398		Ostomy irrigation supply; bag, each	Max of 2 allowed per client, every 6 months.
	A4399		Ostomy irrigation supply; cone/catheter, with or without brush	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		Ostomy skin barrier, non-pectin based, paste, per ounce	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4406		Ostomy skin barrier, pectin-based, paste, per ounce	
	A4407		Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 inches or smaller, each	
	A4408		Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each	
	A4409		Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4410		Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each	
	A4411		Ostomy skin barrier, solid 4 x 4 or equivalent, extended wear, with built-in convexity, each	
	A4412		Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), without filter, each	Max of 10 allowed per client, every 30 days.
	A4413		Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), with filter, each	Max of 10 allowed per client, per month.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4414		Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 x 4 inches or smaller, each	
	A4415		Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4 x 4 inches, each	
	A4416		Ostomy pouch, closed, with barrier attached, with filter (1 piece), each	Max of 30 allowed per client, per month. Not allowed in combination with A4368.
	A4417		Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (1 piece), each	Max of 30 allowed per client, per month. Not allowed in combination with A4368.
	A4418		Ostomy pouch, closed; without barrier attached, with filter (1 piece), each	Max of 30 allowed per client, per month. Not allowed in combination with A4368.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4419		Ostomy pouch, closed; for use on barrier with non-locking flange, with filter (2 piece), each	Max of 30 allowed per client, per month. Not allowed in combination with A4368.
BR	A4421		Ostomy supply; miscellaneous	PA required
BR	A4422		Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each	
	A4423		Ostomy pouch, closed; for use on barrier with locking flange, with filter (2 piece), each	Max of 30 allowed per client, per month. Not allowed in combination with A4368.
	A4424		Ostomy pouch, drainable, with barrier attached, with filter (1 piece), each	Max of 10 allowed per client, per month. Not allowed in combination with A4368.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4425		Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (2 piece system), each	Max of 10 allowed per client, per month. Not allowed in combination with A4368.
	A4426		Ostomy pouch, drainable; for use on barrier with locking flange (2 piece system), each	Max of 10 allowed per client, per month.
	A4427		Ostomy pouch, drainable; for use on barrier with locking flange, with filter (2 piece system), each	Max of 10 allowed per client, per month. Not allowed in combination with A4368.
	A4428		Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (1 piece), each	Max of 10 allowed per client, per month.
	A4429		Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each	Max of 10 allowed per client, per month.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4430		Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each	Max of 10 allowed per client, per month.
	A4431		Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (1 piece), each	Max of 10 allowed per client, per month.
	A4432		Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet-type tap with valve (2 piece), each	Max of 10 allowed per client, per month.
	A4433		Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each	Max of 10 allowed per client, per month.
	A4434		Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type tap with valve (2 piece), each	Max of 10 allowed per client, per month.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4435		Ostomy pouch, drainable, high output, with extended wear barrier (one-piece system), with or without filter, each	Max of 10 allowed per client, per month.
BR	A4436		Irrigation supply; sleeve, reusable, per month	Max of 1 allowed per client, per month. PA required.
BR	A4437		Irrigation supply; sleeve, disposable, per month	PA required
	A4455		Adhesive remover or solvent (for tape, cement or other adhesive), per ounce	Max of 3 allowed per client, per month.
	A5051		Ostomy pouch, closed; with barrier attached (1 piece), each	Max of 60 allowed per client, per month.
	A5052		Ostomy pouch, closed; without barrier attached (1 piece), each	Max of 60 allowed per client, per month.
	A5053		Ostomy pouch, closed; for use on faceplate, each	Max of 60 allowed per client, per month.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A5054		Ostomy pouch, closed; for use on barrier with flange (2 piece), each	Max of 60 allowed per client, per month.
	A5055		Stoma cap	Max of 30 allowed per client, per month.
	A5061		Ostomy pouch, drainable; with barrier attached, (1 piece), each	Max of 20 allowed per client, per month.
	A5062		Ostomy pouch, drainable; without barrier attached (1 piece), each	Max of 20 allowed per client, per month.
	A5063		Ostomy pouch, drainable; for use on barrier with flange (2 piece system), each	Max of 20 allowed per client, per month.
	A5071		Ostomy pouch, urinary; with barrier attached (1 piece), each	Max of 20 allowed per client, per month.
	A5072		Ostomy pouch, urinary; without barrier attached (1 piece), each	Max of 20 allowed per client, per month.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A5073		Ostomy pouch, urinary; for use on barrier with flange (2 piece), each	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 device; catheter for continent stoma	Max of 1 allowed per client, per month.
	A5083		Continent device, stoma absorptive cover for continent stoma	See code A6219.
	A5093		Ostomy accessory; convex insert	Max of 10 allowed per client, per month.
	A5120		Skin barrier, wipes or swabs, each	For ostomy only
	A5121		Skin barrier; solid, 6 x 6 or equivalent, each	For ostomy only
	A5122		Skin barrier; solid, 8 x 8 or equivalent, each	For ostomy only
	A5126		Adhesive or non-adhesive; disk or foam pad	Max of 10 allowed per client, per month.

Urological and incontinence supplies

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4295		Intermittent urinary catheter; straight tip, hydrophilic coating, each	Max of 180 allowed, per client, per month. Not allowed in combination with codes A4352 or A4353
	A4296		Intermittent urinary catheter; coude (curved) tip, hydrophilic coating, each	Max of 180 allowed, per client, per month. Not allowed in combination with codes A4295, A4351, A4352, or A4354.
	A4297		Intermittent urinary catheter; hydrophilic coating, with insertion supplies	Max of 180 allowed, per client, per month. Not allowed in combination with codes A4353, A4310, A4351, A4352, or A4354. Includes sterile no touch catheter systems. Included in NF daily rate.
	A4310		Insertion tray without drainage bag and without catheter (accessories only)	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		Insertion tray without drainage bag with indwelling catheter, foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.)	Max of 3 allowed per client, per month. Not allowed in combination with code A4310, A4314, or A4338. Included in NF daily rate.
	A4312		Insertion tray without drainage bag with indwelling catheter, foley type, two-way, all silicone	Max of 3 allowed per client, per month. Not allowed in combination with code A4310, A4315, or A4344. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4313		Insertion tray without drainage bag with indwelling catheter, foley type, three-way, for continuous irrigation	Max of 3 allowed per client, per month. Not allowed in combination with code A4310, A4316, or A4346. Included in NF daily rate.
	A4314		Insertion tray with drainage bag with indwelling catheter, foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.)	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		Insertion tray with drainage bag with indwelling catheter, foley type, two-way, all silicone	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		Insertion tray with drainage bag with indwelling catheter, foley type, three-way, for continuous irrigation	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.
	A4320		Irrigation tray with bulb or piston syringe, any purpose	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 with integral collection chamber, any type, each	Max of 60 allowed per client, per month. Included in NF daily rate.
	A4327		Female external urinary collection device; meatal cup, each	Included in NF daily rate
	A4328		Female external urinary collection device; pouch, each	Included in NF daily rate

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4330		Perianal fecal collection pouch with adhesive, each	Included in NF daily rate
	A4331		Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each	Included in NF daily rate Not allowed in combination with code A4354, A5105, A5113, or A5114.
	A4332		Lubricant, individual sterile packet, each	Included in NF daily rate
	A4333		Urinary catheter anchoring device, adhesive skin attachment, each	Included in NF daily rate
	A4334		Urinary catheter anchoring device, leg strap, each	Included in NF daily rate
	A4335		Incontinence supply; miscellaneous	Included in NF daily rate (age 3 and older.) EPA required.
	A4336		Incontinence supply, urethral insert, any type, each	PA required
	A4338		Indwelling catheter; foley type, two-way latex with coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each	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; specialty type, (e.g., coude, mushroom, wing, etc.), each	Max of 3 allowed per client, per month. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4344		Indwelling catheter, foley type, two-way, all silicone or polyurethane, each	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		Indwelling catheter; foley type, three way for continuous irrigation, each	Max of 3 allowed per client, per month. Not allowed in combination with code A4313 or A4316. Included in NF daily rate.
	A4349		Male external catheter, with or without adhesive, disposable, each	Max of 35 allowed per client, per month. Included in NF daily rate.
	A4351		Intermittent urinary catheter; straight tip, with or without coating (teflon, silicone, or silicone elastomeretc.)	Max of 180 allowed per client, per month. Not allowed in combination with code A4295, A4352, or A4353.
	A4352		Intermittent urinary catheter; coude (curved) tip, with or without coating (teflon, silicone, or silicone elastomericetc.)	Max of 180 allowed per client, per month. Not allowed in combination with code A4296, A4351, or A4353.
	A4353		Intermittent urinary catheter, with insertion supplies	Max of 180 allowed per client, per month. Not allowed in combination with A4297, A4310, A4351, A4352, or A4354. Includes sterile no touch catheter systems. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4354		Insertion tray with drainage bag but without catheter	PA required. Not allowed in combination with A4297, A4310, A4314, A4315, A4316, A4353, A4357, A4358, and A5112. Included in NF daily rate.
	A4355		Irrigation tubing set for continuous bladder irrigation through a three-way indwelling foley catheter, each	Max of 30 allowed per client, per month. Not allowed in combination with A4320 and A4322. Included in NF daily rate.
	A4356		External urethral clamp or compression device (not to be used for catheter clamp), each	Max of 2 allowed per client, per year. Included in NF daily rate.
	A4357		Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each	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 drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each	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 external urethral clamp or compression device, with pad and/or pouch, each	Max of 2 allowed per client, per month.
	A4402		Lubricant per ounce	Included in NF daily rate. For insertion of urinary catheters.
BR	A4453		Rectal catheter with or without balloon, for use with any type transanal irrigation system, each	Requires PA. Manual transanal irrigation system, includes water reservoir, pump, tubing, and accessories, without catheter, any type. (A4459), replacement only.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4456		Adhesive remover, wipes, any type, each	Max of 50 wipes allowed per client, per month.
BR	A4457		Manual transanal irrigation system, includes water reservoir, pump, tubing, and accessories, without catheter, any type	PA required. Not allowed in combination with code A4459
BR	A4459		Manual transanal irrigation system, includes water reservoir, pump, tubing, and accessories, without catheter, 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 any type	PA required. Included in NF daily rate.
	A5056		Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each	
	A5057		Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (1 piece), each	

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A5102		Bedside drainage bottle with or without tubing, rigid or expandable, each	Max of 2 allowed per client, per 6 months. Included in NF daily rate.
	A5105		Urinary suspensory with leg bag, with or without tube, each	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 drainage bag, leg or abdomen, latex, with or without tube, with straps, each	Max of 1 allowed per client, per month. Not allowed in combination with code A4354, A5105, A5113, or A5114. Included in NF daily rate.
	A5113	RA	Leg strap; latex, replacement only, per set	Not allowed in combination with code A4358, A5105, or A5112. Included in NF daily rate.
	A5114	RA	Leg strap; foam or fabric, replacement only, per set	Not allowed in combination with code A4358, A5105, or A5112. Included in NF daily rate.
	T4521		Adult sized disposable incontinence product, brief/diaper, small, each	Medical exceptions to max quantity or age limitations require PA. Max of 200 briefs purchased per client, per month. For clients age 20 and older. Recommended for waist sizes 24" – 32." Included in NF daily rate.
	T4522		Adult sized disposable incontinence product, brief/diaper, medium, each	Medical exceptions to max quantity or age limitations require PA. Max of 200 briefs purchased per client, per month. For clients age 20 and older. Recommended for waist sizes 32" – 44." Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	T4523		Adult sized disposable incontinence product, brief/diaper, large, each	Medical exceptions to max quantity or age limitations require PA. Max of 200 briefs purchased per client, per month. For clients age 20 and older. Recommended for waist sizes 45" – 58." Included in NF daily rate.
	T4524		Adult sized disposable incontinence product, brief/diaper, extra large, each	Medical exceptions to max quantity or age limitations require PA. Max of 200 briefs 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 sized disposable incontinence product, protective underwear/pull-on, small size, each	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 sized disposable incontinence product, protective underwear/pull-on, medium size, each	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.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	T4527	59 (To designate daytime use only)	Adult sized disposable incontinence product, protective underwear/pull-on, large size, each	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.
	T4528	59 (To designate daytime use only)	Adult sized disposable incontinence product, protective underwear/pull-on, extra large size, each	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		Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each	Medical exceptions to max quantity or age limit require PA. For clients age 3-20. Recommended for waist sizes 13" – 19" Max of 200 briefs purchased per client, per month. Included in NF daily rate.
	T4530	59 (To designate daytime use only)	Pediatric sized disposable incontinence product, brief/diaper, large size, each	Medical exceptions to max quantity or age limit require PA. For clients age 3-20. Max of 200 briefs purchased per client, per month. Included in NF daily rate.
	T4531	59 (To designate daytime use only)	Pediatric sized disposable incontinence product, protective underwear/pull-on, small/medium size, each	Medical exceptions to max quantity or age limit require PA. For clients age 3-20. Max of 200 briefs purchased per client, per month. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	T4532	59 (To designate daytime use only)	Pediatric sized disposable incontinence product, protective underwear/pull-on, large size, each	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.
	T4533	59 (To designate daytime use only)	Youth sized disposable incontinence product, brief/diaper, each	For clients age 6-20 Recommended for waist sizes 18" – 26". Max of 200 briefs purchased per client, per month. Included in NF daily rate.
	T4534	59 (To designate daytime use only)	Youth sized disposable incontinence product, protective underwear/pull-on, each	Medical exceptions to max quantity or age limit require PA. For clients age 6-20. Recommended for waist sizes 17" – 26" Max of 200 pull-ons purchased per client, per month. Included in NF daily rate.
	T4535	59 (To designate daytime use only)	Disposable liner/shield/guard/pad/undergarment, for incontinence, each	Medical exceptions to max quantity require PA. Not to be used inside any other product. For clients age 3 and older. Max of 200 pieces allowed per client, per month. Included in NF daily rate.
	T4536	NU	Incontinence product, protective underwear/pull-on, reusable, any size, each	For clients age 3 and older. Max of 4 per client, per year. Included in NF daily rate.
	T4536	RR	Incontinence product, protective underwear/pull-on, reusable, any size, each	For clients age 3 and older. Max of 150 allowed per client, per month. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	T4537	NU	Incontinence product, protective underpad, reusable, bed size, each	Limit 42 per year. Not allowed in combination with code T4541 or T4537 (RR).
	T4537	RR	Incontinence product, protective underpad, reusable, bed size, each	Limit 90 per month. Not allowed in combination with code T4541 or T4537 (NU). Included in NF daily rate.
	T4538	RR	Diaper service, reusable diaper, each diaper	Medical exceptions to max quantity or age limit require PA. For clients age 3 and older. Max of 200 briefs allowed per client, per month. Included in NF daily rate.
	T4539	NU	Incontinence product, diaper/brief, reusable, any size, each	Medical exceptions to max quantity or age limit require PA. For clients age 3 and older. Max of 36 briefs allowed per client, per month. Included in NF daily rate.
	T4541		Incontinence product, disposable underpad, large, each	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 sized disposable incontinence product, protective brief/diaper, above extra large, each	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.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	T4544	59 (To designate daytime use only)	Adult sized disposable incontinence product, protective underwear/pull-on, above extra large, each	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)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
BR	A4467		Belt, strap, sleeve, garment, or covering, any type	
	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		Extremity belt/harness	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)	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, any size	Max of 1 allowed per client per year. Included in NF daily rate.
	E0191		Heel or elbow protector, each	Max of 4 allowed per client per year. Included in NF daily rate.

Miscellaneous supplies

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	A4927		Gloves, non-sterile, per 100	Quantities exceeding 2 units per month require PA. One unit = 100 gloves. Included in NF daily rate and in home health care rate.
	A4930		Gloves, sterile, per pair	Max of 30 per client, per month. Included in NF daily rate and in home health care rate.
	A6410		Eye pad, sterile, each	Max of 20 allowed per client, per month. Included in NF daily rate.
	A6411		Eye pad, non-sterile, each	Max of 1 allowed per client, per month. Included in NF daily rate.

Code Status	HCPCS Code	Modifier(s)	Description	Policy/Comments (Note: Billing provisions are limited to a one-month supply. One month equals 30 days.)
	S8265		Haberman feeder for cleft lip/palate	
BR	E1832		Static progressive stretch finger device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories	PA required

Coverage/Limitations

Medical equipment and supplies

HCA covers nondurable medical equipment and supplies and related services, including incontinent supplies. The treating practitioner's order and documented diagnosis of incontinence is required. Prior authorization (PA) is not required.

See WAC 182-543-5000 for Medical Supplies and Related Services.

HCA approves a client's use of a combination of incontinence products only when the client uses different products for daytime and nighttime use. Identify the product used for daytime and nighttime use by using modifier 59 to indicate daytime use only.

> **Example**: State the number of pull-on over the allowed maximum for daytime use (using modifier 59). State the number of disposable briefs for nighttime use. When using more than one type of product for daytime and nighttime use during the same day, the total amount used each month cannot be more than the monthly limit for the product that allows the highest amount.
>
> **Note**: Bill one size only of briefs or pull-on pants per month. HCA does not pay for multiple sizes.

For details and codes, see Urological and Incontinence Supplies in the Coverage table.

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
- A standard written order (SWO), dated within 180 days of the PA submission

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 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. See the Coverage Table in this guide for details on policy and requirements.

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:
  - Their medical condition does not allow the client to self-propel a lightweight or standard weight wheelchair
  - They require 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 their 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 pays to maintain both wheelchairs.

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 (PA) 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 standard written order (SWO), dated within 180 days of the PA submission
- For new modifications, medical records to support medical necessity for the newly requested accessory or option and a functional mobility assessment completed by a licensed physical therapist or licensed occupational therapist, dated within 60 days of the submission.
- 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 PA. Rental rates are monthly unless otherwise indicated. See HCA's **provider billing guides and fee schedules webpage**.

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 (PA) 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 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 180 days of the PA submission
- Include 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
- Document a qualifying face-to-face encounter with the treating provider within 6 months before 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 PA. To receive payment, providers must submit all of the following to HCA:

- A standard written order (SWO), dated within 90 days of the PA submission.

- 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. PA is required. 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). Prior authorization (PA) is required. 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 (PA) 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

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.

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

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 PA 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 PA 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 must 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 (EHR), 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. Clinical records from a primary care provider or specialist, dated within the past 180 days, that document the medical condition necessitating the equipment are required.

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)?).

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 (PA) 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.

PA 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 EPA process and criteria.

HIPAA 5010 does not allow multiple authorization (prior/expedited) numbers per claim. If billing an electronic claim, enter the EPA number 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 (limitation extension) requests.

Providers must request PA 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 medical equipment, 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 medical equipment 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.
- Providers 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.
- Prior authorization (PA) 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 before 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 *are not* 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 3 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 9 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 must 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 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 before the date of service and must substantiate the specific supply being billed.

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 5/15/2025-5/15/2025 on the first claim. For the next claim with a date of service in June, use 6/14/2025-6/14/2025 (30 days between dates of service).
    - May claim: 5/15/2025-5/15/2025, 200 units
    - June claim: 6/14/2025-6/14/2025, 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: 5/15/2025-5/15/2025, 200 units
    - May claim line 2: 5/15/2025-5/15/2025, 100 units, authorization #
    - June claim line 1: 6/14/2025-6/14/2025, 200 units
    - June claim line 2: 6/14/2025-6/14/2025, 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

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, 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 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?

Providers 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