Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

MEDICAL ASSISTANCE ADMINISTRATION

Wheelchairs, Durable Medical Equipment, and Supplies

Billing Instructions

Chapter 388-543 WAC

October 2003

About this publication

This publication supersedes all previous MAA Wheelchairs, Durable Medical Equipment, and Supplies Billing Instructions.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its programs; however, MAA's response is based solely on the information provided to the [MAA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs. [WAC 388-502-0020(2)].

Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

Where do I send my claims?

Division of Program Support
PO Box 9247
Olympia WA 98507-9247

How do I request prior authorization?

All authorization issues, questions or comments should be addressed to:

Write/Call:
Division of Medical Management
Durable Medical Equipment
PO Box 45506
(800) 292-8064
(360) 586-5299 (fax)

How do I request a Limitation Extension?

Write/Call:
Division of Medical Management
Durable Medical Equipment
PO Box 45506
Olympia, WA 98504-5506
(800) 292-8064
(360) 586-5299 (fax)

Who do I contact about the actual reimbursement rate listed in the fee schedule?

DME - Program Manager
Professional Reimbursement
Division of Business and Finance
PO Box 45510
Olympia, WA 98504-5510
(360) 753-9152 (fax)

Who do I contact if I have questions regarding…

Policy, payments, denials, general questions regarding claims processing, Healthy Options, or to request billing instructions?

Provider Relations Section
(800) 562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

How do I obtain copies of billing instructions or numbered memoranda?

Go to MAA's web site at: http://maa.dshs.wa.gov, Provider Publications/Fee Schedules link.

Important Contacts (cont.)

How can I request that equipment/supplies be added to the "covered" list in these billing instructions?

Write/Call:

Division of Medical Management
DME Program Management Unit
PO Box 45506
Olympia, WA 98504-5506
(800) 292-8064
(360) 586-5299 Fax

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Definitions

This section defines terms, abbreviations, and acronyms used in this billing instruction.

Augmentative Communication Device (ACD) – See "speech generating device (SGD)." [WAC 388-543-1000]

Base Year – The year of the data source used in calculating prices. [WAC 388-543-1000]

By Report (BR) – A method of reimbursement for covered items, procedures, and services for which the department has no set maximum allowable fees.
[WAC 388-543-1000]

Client - An individual who has been determined eligible to receive medical or health care services under any MAA program.

Code of Federal Regulations (CFR) - Rules adopted by the federal government.

Community Services Office (CSO) - An office of the department's economic services administration that administers social and health services at the community level

Core Provider Agreement - The basic contract between MAA and an entity providing services to eligible clients. The core provider agreement outlines and defines terms of participation in medical assistance programs.

Date of Delivery – The date the client actually took physical possession of an item or equipment. [WAC 388-543-1000]

Department - The state Department of Social and Health Services [DSHS].

Disposable Supplies – Supplies that may be used once, or more than once, but are time limited. [WAC 388-543-1000]

Durable Medical Equipment (DME) – Equipment that:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of illness or injury; and
- Is appropriate for use in the client's place of residence.

[WAC 388-543-1000]

Expedited Prior Authorization – The process for obtaining authorization for selected durable medical equipment, and related supplies, prosthetics, orthotics, medical supplies and related services, in which providers use a set of numeric codes to indicate to MAA which acceptable indications/conditions/MAA-defined criteria are applicable to a particular request for DME authorization. [WAC 388-543-1000]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Fee-for-Service – The general payment method MAA uses to reimburse for covered medical services provided to clients, except those services covered under MAA's prepaid managed care programs.
[WAC 388-543-1000]

Health Care Financing Administration Common Procedure Coding System (HCPCS) – A coding system established by the Health Care Financing Administration to define services and procedures.
[WAC 388-543-1000]

Healthy Options – The name of the Washington State, Medical Assistance Administration's managed care program.

House Wheelchair – A nursing facility wheelchair that is included in the nursing facility's per-patient-day rate under chapter 74.46 RCW. [WAC 388-543-1000]

Limitation Extension – A process for requesting and approving covered services and reimbursement that exceeds a coverage limitation (quantity, frequency, or duration) set in WAC, billing instructions, or numbered memoranda. Limitation extensions require prior authorization. [WAC 388-543-1000)]

Managed Care - A comprehensive system of coordinated medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

Manual Wheelchair – See "Wheelchair – Manual." [WAC 388-543-1000]

Maximum Allowable - The maximum dollar amount MAA will reimburse a provider for a specific service, supply, or piece of equipment.

Medicaid - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the:

- Categorically needy program; or
- Medically needy program.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Medical Identification card(s) – The document MAA uses to identify a client's eligibility for a medical program. These cards were formerly known as medical assistance identification (MAID) cards.

Medically Necessary - A term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medical Supplies – Supplies that are:

- Primarily and customarily used to service a medical purpose; and
- Generally not useful to a person in the absence of illness or injury. [WAC 388-543-1000]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Nonreusable Supplies – Supplies that are used only once and then are disposed of. [WAC 388-543-1000]

Other DME – All durable medical equipment, excluding wheelchairs and related items.

Orthotic Device or Orthotic – A corrective or supportive device that:

- Prevents or corrects physical deformity or malfunction; or
- Supports a weak or deformed portion of the body. [WAC 388-543-1000]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Personal or Comfort Item – An item or service that primarily serves the comfort or convenience of the client. [WAC 388-543-1000]

Personal Computer – Any of a variety of electronic devices that are capable of accepting data and instructions, executing the instructions to process the data, and presenting the results. A PC has a central processing unit (CPU), internal and external memory storage, and various input/output devices such as a keyboard, display screen, and printer. A computer system consists of hardware (the physical components of the system) and software (the programs used by the computer to carry out its operations). [WAC 388-543-1000]

Plan of Care (POC) – (Also known as "plan of treatment" [POT]) A written plan of care that is established and periodically reviewed and signed by both a physician and a home health agency provider, that describes the home health care to be provided at the client's residence. [WAC 388-551-2010]

Power-Drive Wheelchair – See "Wheelchair – Power." [WAC 388-543-1000]

Prosthetic Device or Prosthetic – A replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice as defined by state law, to:

- Artificially replace a missing portion of the body;
- Prevent or correct physical deformity or malfunction; or
- Support a weak or deformed portion of the body. [WAC 388-543-1000]

Provider - Any person or organization that has a signed contract or core provider agreement with DSHS to provide services to eligible clients.

Remittance and status report (RA) - A report produced by Medicaid Management Information System (MMIS), MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions.

Resource Based Relative Value Scale (RBRVS) – A scale that measures the relative value of a medical service or intervention, based on amount of physician resources involved. [WAC 388-543-1000]

Reusable Supplies – Supplies that are to be used more than once. [WAC 388-543-1000]

Revised Code of Washington (RCW) - Washington State laws.

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; and
- Can be independently driven by a client.

[WAC 388-543-1000]

Specialty bed – A pressure reducing support surface, such as foam, air, water, or gel mattress or overlay. [WAC 388-543-1000]

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)."

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

Three- or Four-wheeled Scooter – A three- or four-wheeled vehicle meeting the definition of scooter (see “scooter”) and that has the following minimum features:

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

[WAC 388-543-1000]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Trendelenburg Position – A position in which the patient is lying on his or her back on a plane inclined thirty to forty degrees. This position makes the pelvis higher than the head, with the knees flexed and the legs and feet hanging down over the edge of the plane. [WAC 388-543-1000]

Usual and Customary Charge – The amount the provider typically charges to 50% or more of his or her non-Medicaid clients, including clients with other third-party coverage. [WAC 388-543-1000]

Warranty-wheelchair – A warranty, according to manufacturers' guidelines, of not less than one year from the date of purchase. [WAC 388-543-1000]

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 two hundred fifty pounds; and
  - ✓ Has a warranty period of at least one year.
- Lightweight:
  - ✓ Composed of lightweight materials;
  - ✓ Capable of being modified;
  - ✓ Accommodates a person weighing up to two hundred fifty pounds; and
  - ✓ 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 two hundred fifty pounds;
  - ✓ Has an extended warranty period of over three years; and
  - ✓ Accommodates the very active person.
- Hemi:
  - ✓ Has a seat-to-floor height lower than eighteen inches to enable an adult to propel the wheelchair with one or both feet: and
  - ✓ 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:

  ✓ Specifically manufactured to support a person weighing up to three hundred pounds; or
  ✓ Accommodating a seat width of up to twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

- Rigid: Is of ultra-lightweight material with a rigid (nonfolding) frame.

- Custom Heavy Duty:

  ✓ Specifically manufactured to support a person weighing over three hundred pounds; or
  ✓ Accommodates a seat width of over twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

- Custom Manufactured Specially Built:

  ✓ Ordered for a specific client from custom measurements; and
  ✓ Is assembled primarily at the manufacturer's factory.

[WAC 388-543-1000]

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; and
  ✓ 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.

[WAC 388-543-1000]

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

About the Program

What is the purpose of the Wheelchairs, Durable Medical Equipment (DME), and Supplies Program?

[Refer to WAC 388-543-1100]

The Medical Assistance Administration's (MAA) Wheelchair Durable Medical Equipment (DME) Program makes accessible to eligible MAA clients the purchase and/or rental of medically necessary DME equipment and supplies when they are not included in other reimbursement methodologies (e.g., inpatient hospital DRG, nursing facility daily rate, HMO, or managed health care programs). The federal government deems DME and related supplies as optional services under the Medicaid program, except when:

- Prescribed as an integral part of an approved plan of treatment under the home health program; or
- Required under the early and periodic screening, diagnosis and treatment (EPSDT)/Healthy Kids program.

MAA may reduce or eliminate coverage for optional services, consistent with legislative appropriations.

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Client Eligibility

Who is eligible? [Refer to Chapter 388-529 WAC]

Clients presenting Medical Identification cards with the following identifiers* are eligible for wheelchairs, durable medical equipment (DME), and supplies:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program – These clients are dual eligible (Medicare/Medicaid)
CNP **CHIP**	Categorically Needy Program - Children's Health Insurance Program
GA-U **No Out of State Care**	General Assistance - Unemployable
LCP **MNP**	Limited Casualty Program-Medically Needy Program
MNP **QMB**	Medically Needy Program-Qualified Medicare Beneficiaries – These clients are dual eligible (Medicare/Medicaid)

☞ ***Note:** To provide clarification as a result of significant inquiries, clients presenting Medical Identification cards with the following identifiers are not eligible for wheelchairs, DME, and supplies:

- ✓ **QMB-Medicare Only** (Qualified Medicare Beneficiary-Medicare Only)

Are clients enrolled in managed care eligible?

[Refer to WAC 388-538-060 and 095]

YES! Clients with an identifier in the HMO column on their Medical Identification card are enrolled in one of MAA's managed care plans. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their plan by calling the telephone number located on their Medical Identification card.

All medical services covered under a managed health care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

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

To prevent billing denials, please check the client's Medical Identification card prior to scheduling services and at the time of service to make sure proper authorization or referral is obtained from the PCP and/or plan.

MAA does not cover medical equipment and/or services provided to a client who is enrolled in a MAA-contracted managed care plan, but did not use one of the plan's participating provider. (WAC 388-543-1400 [9])

Are clients enrolled in Primary Care Case Management (PCCM) eligible?

Yes! For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain or be referred for services via the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting. Please refer to the client's Medical Identification card for the PCCM. (See the *Billing* section for further information.)

Note: To prevent billing denials, please check the client's Medical Identification card prior to scheduling services and at the time of the service to make sure proper authorization or referral is obtain from the PCCM.

Coverage

What is covered? [Refer to WAC 388-543-1100]

The Medical Assistance Administration (MAA) covers the following subject to the provisions of this billing instruction:

- Wheelchairs and other DME;
- Equipment and supplies prescribed in accordance with an approved plan of treatment under the home health program;
- Orthotic Devices;
- Equipment and supplies for the management of diabetes;
- Replacement batteries (for covered, purchased, medically necessary DME equipment); and
- Bilirubin lights (limited to rentals for at-home newborns with jaundice).

Note: Those HCPCS codes with a "#" symbol in the maximum allowable column of the fee schedule are not covered by MAA.

What are the general conditions of coverage?

MAA covers the services listed above when all of the following apply. They must be:

- Medically necessary (see *Definitions* section). The provider or client must submit sufficient objective evidence to establish medical necessity. Information used to establish medical necessity includes, but is not limited to, the following:

  ✓ A physiological description of the client's disease, injury, impairment, or other ailment, and any changes in the client's condition written by the prescribing physician, licensed prosthetist and/or orthotist, physical therapist, occupational therapist, or speech therapist; or

  ✓ Video and/or photograph(s) of the client demonstrating the impairments and the client's ability to use the requested equipment, when applicable.

- Within the scope of an eligible client's medical care program (see *Client Eligibility* section);
- Within accepted medical or physical medicine community standards of practice;
- Prior authorized (see *Prior Authorization* section);
- Prescribed by a physician or other licensed practitioner of the healing arts and are within the scope of his or her practice as defined by state law. The prescription must state the specific item or service requested, diagnosis, prognosis, estimated length of need (weeks or months, not to exceed six months before being reevaluated), and quantity; and
- Billed to the department as the payer of last resort only. MAA does not pay first and then collect from Medicare.

See the *Wheelchair Fee Schedule* and *Other DME Fee Schedule* sections (I and J) for a complete list of covered medical equipment and related supplies, repairs, and labor charges.

Note: The evaluation of a By Report (BR) item, procedure, or service for its medical appropriateness and reimbursement value on a case-by-case basis.

What are other specific conditions of coverage?

Clients Residing in a Nursing Facility

- MAA covers the following for a client in a nursing facility:
  - ✓ The purchase and repair of:
    - ➢ A speech generating device (SGD);
    - ➢ A wheelchair for the exclusive full-time use of a permanently disabled nursing facility resident when the wheelchair is not included in the nursing facility's per diem rate; or
    - ➢ A specialty bed; and
    - ➢ The rental of a specialty bed.
  - ✓ All other DME and supplies identified in this billing instruction are the responsibility of the nursing facility, in accordance with chapters 388-96 and 388-97 WAC.

Speech Generating Devices (SGD) [WAC 388-543-2200]

- MAA considers all requests for SGDs on a case-by-case basis.

- The SGD requested must be for a severe expressive speech impairment, and the medical condition must warrant the use of a device to replace verbal communication (e.g., to communicate medical information).

- In order for MAA to cover an SGD, the SGD must be a speech device intended for use by the individual who has a severe expressive speech impairment and have one of the following characteristics. For the purposes of these billing instructions, MAA uses the Medicare definitions for "digitized speech" and "synthesized speech" that were in effect as of April 1, 2002. The SGD must have:

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

- MAA requires a provider to submit a prior authorization request for SGDs. The request must be in writing and contain all of the following information:

  - ✓ A detailed description of the client's therapeutic history; including, at a minimum:

    - ➢ The medical diagnosis;
    - ➢ A physiological description of the underlying disorder;
    - ➢ A description of the functional limitations; and
    - ➢ The prognosis for improvement or degeneration.

  - ✓ A written assessment by a licensed speech language pathologist (SLP) that includes all of the following:

    - ➢ If the client has a physical disability, condition, or impairment that requires equipment, such as a wheelchair, or a device to be specially adapted to accommodate an SGD, and an assessment by the prescribing physician, licensed occupational therapist, or physical therapist;

    - ➢ Documented evaluations and/or trials of each SGD that the client has tried. This includes less costly types/models, and the effectiveness of each device in promoting the client's ability to communicate with health care providers, caregivers, and others;

    - ➢ The current communication impairment, including the type, severity, language skills, cognitive ability, and anticipated course of the impairment;

- An assessment of whether the client's daily communication needs could be met using other natural modes of communication;
- A description of the functional communication goals expected to be achieved, and treatment options;
- Documentation that the client's speaking needs cannot be met using natural communication methods; and
- Documentation that other forms of treatment have been ruled out.

✓ The provider has shown or has demonstrated all of the following:

- The client has reliable and consistent motor response, which can be used to communicate with the help of an SGD;
- The client has demonstrated the cognitive and physical abilities to utilize the equipment effectively and independently to communicate; and
- The client's treatment plan includes a training schedule for the selected device.

✓ A prescription for the SGD from the client's treating physician.

- MAA may require trial-use rental. All rental costs for the trial-use will be applied to the purchase price.
- **MAA covers SGDs only once every two years for a client who meets the above listed criteria.** MAA does not approve a new or updated component, modification, or replacement model for a client whose SGD can be repaired or modified. MAA may make exceptions to the above criteria based strictly on a finding of unforeseeable and significant changes to the client's medical condition. The prescribing physician is responsible for justifying why the changes in the client's medical condition were unforeseeable.

Bathroom/Shower Equipment [WAC 388-543-2300]

- MAA considers a caster-style shower commode chair as the primary option for clients.
- MAA considers a wheelchair-style shower commode chair only if the client meets both of the following:
  - ✓ Is able to propel the equipment; and
  - ✓ Has special positioning needs that cannot be met by a caster-style chair.
- All other circumstances will be considered on a case-by-case basis, based on medical necessity.

Hospital Beds [WAC 388-543-2400]

- Beds covered by MAA are limited to hospital beds for rental or purchase. MAA bases the decision to rent or purchase a manual, semi-electric, or full electric hospital bed on the length of time the client needs the bed, as follows:
  - ✓ MAA initially authorizes a maximum of two months rental for a short-term need. Upon request, MAA may allow limitation extensions as medically necessary (see EPA criteria for hospital beds, section G);
  - ✓ MAA determines rental on a month-to-month basis if a client's prognosis is poor;
  - ✓ MAA considers a purchase if the need is for more than six months;
  - ✓ If the client continues to have a medical need for a hospital bed after six months, MAA may approve rental for up to an additional six months. MAA considers the equipment to be purchased after a total of twelve months' rental.
- MAA considers a manual hospital bed the primary option when the client has full-time caregivers.

- MAA considers a full electric hospital bed only if the client meets all of the following criteria:
  - ✓ The client's medical need requires the client to be positioned in a way that is not possible in a regular bed;
  - ✓ The position cannot be attained through less costly alternatives (e.g., the use of bedside rails, a trapeze, pillows, bolsters, rolled up towels or blankets);
  - ✓ The client's medical condition requires immediate position changes;
  - ✓ The client is able to operate the controls independently; and
  - ✓ The client needs to be in the Trendelenburg position.
- All other circumstances for hospital beds will be considered on a case-by-case basis, based on medical necessity. (See also EPA criteria in Section G.)

What if a service is covered but considered experimental or has restrictions or limitations? [WAC 388-543-1100 (3) and (4)]

- MAA 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 388-531-0050, under the provisions of WAC 388-501-0165 which relate to medical necessity.
- MAA evaluates a request for a covered service that is subject to limitations or other restrictions and approves such a service beyond those limitations or restrictions when medically necessary, under the standards for covered services in WAC 388-501-0165 (see page G.3 for limitation extensions).

How can I request that equipment/supplies be added to the "covered" list in this billing instruction? [WAC 388-543-1100 (7)]

An interested party may request MAA to include new equipment/supplies in these billing instructions by sending a written request to MAA's DME Program Management Unit (see *Important Contacts* section), plus all of the following:

- Manufacturer's literature;
- Manufacturer's pricing;
- Clinical research/case studies (including FDA approval, if required); and
- Any additional information the requestor feels is important.

What is not covered? [Refer to WAC 388-543-1300]

MAA pays only for durable medical equipment (DME) and related supplies and services that are medically necessary, listed as covered, meet the definition of DME and medical supplies (see *Definitions* section), and prescribed per the provider requirements in this billing instruction (see *Provider Requirements* section).

MAA considers all requests for covered DME, related supplies and services, and noncovered equipment and related supplies, and services, under the provisions of WAC 388-501-0165 which relate to medical necessity. When MAA considers that a request does not meet the requirements for medical necessity, the definition(s) of covered item(s), or is not covered, the client may appeal that decision under the provisions of WAC 388-501-0165.

MAA specifically excludes services and equipment in this billing instruction from fee-for-service (FFS) scope of coverage when the services and equipment do not meet the definition for a covered item, or the services are not typically medically necessary. This exclusion does not apply if the services and equipment are:

- Requested for a child who is eligible for services under the EPSDT program;
- Included as part of a managed care plan service package;
- Included in a waivered program; or
- Part of one of the Medicare programs for qualified Medicare beneficiaries.

Services and equipment that are not covered include, but are not limited to:

- Services, procedures, devices, or the application of associated services that the department of the Food and Drug Administration (FDA) and/or the Centers for Medicare and Medicaid (CMS) (formerly known as HCFA) consider investigative or experimental on the date the services are provided;

- Any service specifically excluded by statute;

- More costly services or equipment when MAA determines that less costly, equally effective services or equipment are available;

- A client's utility bills, even if the operation or maintenance of medical equipment purchased or rented by MAA for the client contributes to an increased utility bill (refer to the Aging and Adult Services Administration (AASA) COPES program for potential coverage);

- Hairpieces or wigs;

- Material or services covered under manufacturer's warranties;

- Procedures, prosthetics, or supplies related to gender dysphoria surgery;

- Shoe lifts less than one inch, arch supports, and nonorthopedic shoes;
- Supplies and equipment used during a physician office visit, such as tongue depressors and surgical gloves;
- Prosthetic devices dispensed for cosmetic reasons;
- Home improvements and structural modifications, including, but not limited to, the following:
  - ✓ Automatic door openers for the house or garage;
  - ✓ Electrical rewiring for any reason;
  - ✓ Elevator systems, elevators;
  - ✓ Lifts or ramps for the home;
  - ✓ Saunas;
  - ✓ Security systems, burglar alarms, call buttons, lights, light dimmers, motion detectors, and similar devices;
  - ✓ Swimming pools; and
  - ✓ Whirlpool systems, such as Jacuzzis, hot tubs, or spas.
- Non-medical equipment, supplies, and related services, including but not limited to, the following:
  - ✓ Back-packs, pouches, bags, baskets, or other carrying containers;
  - ✓ Bedboards/conversion kits, and blanket lifters (e.g., for feet);
  - ✓ Car seats for children under five, except for positioning car seats that are prior authorized. Refer to "*Rented DME and Supplies*" for car seats;
  - ✓ Cleaning brushes and supplies, except for ostomy-related cleaners/supplies;
  - ✓ Diathermy machines used to produce heat by high frequency current, ultrasonic waves, or microwave radiation;
  - ✓ Electronic communication equipment, installation services, or service rates including, but not limited to, the following:
    - ➢ Devices intended for amplifying voices (e.g., microphones);
    - ➢ Interactive communications computer programs used between patients and healthcare providers (e.g., hospitals, physicians), for self care home monitoring, or emergency response systems and services (refer to AASA COPES or outpatient hospital programs for emergency response systems and services);
    - ➢ Two-way radios; and
    - ➢ Rental of related equipment or services;

- ✓ Environmental control devices, such as air conditioners, air cleaners/purifiers, dehumidifiers, portable room heaters or fans (including ceiling fans), heating or cooling pads;
- ✓ Ergonomic equipment;
- ✓ Exercise classes or equipment such as exercise mats, bicycles, tricycles, stair steppers, weights, or trampolines;
- ✓ Generators;
- ✓ Computer software other than speech generating, printers, and computer accessories (such as anti-glare shields, backup memory cards, etc.);
- ✓ Computer utility bills, telephone bills, Internet service, or technical support for computers or electronic notebooks;
- ✓ Any communication device that is useful to someone without severe speech impairment (e.g., cellular telephone, walkie-talkie, pager, or electronic notebook);
- ✓ Racing stroller/wheelchairs and purely recreational equipment;
- ✓ Room fresheners/deodorizers;
- ✓ Bidet or hygiene systems, paraffin bath units, and shampoo rings;
- ✓ Timers or electronic devices to turn things on or off, which are not an integral part of the equipment;
- ✓ Vacuum cleaners, carpet cleaners/deodorizers, and/or pesticides/insecticides; or
- ✓ Wheeled reclining chairs, lounge and/or lift chairs (e.g., geri-chair, posture guard, or lazy boy).

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

  - ✓ Bathroom items, such as antiperspirant, astringent, bath gel, conditioner, deodorant, moisturizers, mouthwash, powder, shampoo, shaving cream, shower cap, shower curtains, soap (including antibacterial soap), toothpaste, towels, and weight scales;
  - ✓ Bedding items, such as bed pads, blankets, mattress covers/bags, pillows, pillow cases/covers; and sheets;
  - ✓ Bedside items, such as bed trays, carafes, and over-the-bed tables;
  - ✓ Clothing and accessories, such as coats, gloves (including wheelchair gloves), hats, scarves, slippers, and socks;
  - ✓ Clothing protectors and other protective cloth furniture covering;
  - ✓ Cosmetics, including corrective formulations, hair depilatories, and products for skin bleaching, commercial sun screens, and tanning;
  - ✓ Diverter valves for bathtub;
  - ✓ Eating/feeding utensils;
  - ✓ Emesis basins, enema bags, and diaper wipes;
  - ✓ Health club memberships;
  - ✓ Hot or cold temperature food and drink containers/holders;
  - ✓ Hot water bottles and cold/hot packs or pads not otherwise covered by specialized therapy programs;
  - ✓ Impotence devices;

- ✓ Insect repellants;
- ✓ Massage equipment;
- ✓ Medication dispensers, such as med-collators and count-a-dose, except as obtained under the compliance packaging program. See Chapter 388-530 WAC;
- ✓ Medicine cabinet and first aid items, such as adhesive bandages (e.g., Band-Aids, Curads), cotton balls, cotton-tipped swabs, medicine cups, thermometers, and tongue depressors;
- ✓ Page turners;
- ✓ Radios and televisions;
- ✓ Telephones, telephone arms, cellular phones, electronic beepers, and other telephone messaging services; and
- ✓ Toothettes and toothbrushes, waterpics, and peridontal devices whether manual, battery-operated, or electric.

- Certain wheelchair features and options are not considered by MAA to be medically necessary or essential for wheelchair use. This includes, but is not limited to, the following:

  - ✓ Attendant controls (remote control devices);
  - ✓ Canopies, including those for stroller and other equipment;
  - ✓ Clothing guards to protect clothing from dirt, mud, or water thrown up by the wheels (similar to mud flap for cars);
  - ✓ Identification devices (such as labels, license plates, name plates);
  - ✓ Lighting systems;
  - ✓ Speed conversion kits;
  - ✓ Tie-down restraints, except where medically necessary for client owned vehicles; and
  - ✓ Warning devices, such as horns and backup signals.

Note: MAA evaluates a request for any equipment or devices that are listed as noncovered in this billing instruction under the provisions of WAC 388-501-0165. [Refer to WAC 388-543-1100(2)]

Wheelchairs

Wheelchair Coverage [Refer to WAC 388-543-2000]

- The Medical Assistance Administration (MAA) bases its decisions regarding requests for wheelchairs on medical necessity and on a case-by-case basis. The following apply when MAA determines that a wheelchair is medically necessary for six months or less:

  - ✓ If the client lives at home, MAA rents a wheelchair for the client; or

  - ✓ If the client lives in a nursing facility, the nursing facility must provide a house wheelchair as part of the per diem rate paid by the Aging and Adult Services Administration (AASA).

- For the purchase of a wheelchair or for wheelchair accessories or modifications for nursing facility clients, MAA requires the provider to complete the Physical/Occupational Therapy Wheelchair Evaluation Form for Nursing Facility Clients (an electronic version can be obtained at http://www1.dshs.wa.gov/dshsforms/forms/eforms.html).

- ## Manual Wheelchairs

  MAA considers rental or purchase of a manual wheelchair for a home client who is nonambulatory or has limited mobility and requires a wheelchair to participate in normal daily activities. MAA determines the type of manual wheelchair based on the following:

  - ✓ 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 is such that the client:

    - ➢ Cannot self-propel a standard weight wheelchair; or

    - ➢ Requires custom modifications that cannot be provided on a standard weight wheelchair.

- ✓ A **high-strength lightweight wheelchair** for a client:
  - ➢ Whose medical condition is such that the client cannot self-propel a lightweight or standard weight wheelchair; or
  - ➢ Requires custom modifications that cannot be provided on a standard weight or lightweight wheelchair.
- ✓ A **heavy duty wheelchair** for a client who requires a specifically manufactured wheelchair designed to:
  - ➢ Support a person weighing up to 300 pounds; or
  - ➢ 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:
  - ➢ Support a person weighing over 300 pounds; or
  - ➢ Accommodate a seat width over 22 inches wide.
- ✓ A **rigid wheelchair** for a client:
  - ➢ With a medical condition that involves severe upper extremity weakness;
  - ➢ Who has a high level of activity; and
  - ➢ Who is unable to self-propel any of the above categories of wheelchair.
- ✓ A **custom manufactured wheelchair** for a client with a medical condition requiring wheelchair customization that cannot be obtained on any of the above categories of wheelchairs.

- # Power-drive Wheelchairs

  - ✓ MAA considers a power-drive wheelchair when the client's medical needs cannot be met by a less costly means of mobility. The prescribing physician must certify that the client can safely and effectively operate a power-drive wheelchair and that the client meets all of the following conditions:

    - ➢ The client's medical condition negates his or her ability to self-propel any of the wheelchairs listed in the manual wheelchair category;

    - ➢ A power-drive wheelchair will provide the client the only means of independent mobility; and

    - ➢ If a child, a power-drive wheelchair will enable a child to achieve age-appropriate independence and developmental milestones.

  - ✓ All other circumstances will be considered based on medical necessity and on a case-by-case basis. The following additional information is required for a three- or four-wheeled power-drive scooter-cart:

    - ➢ The prescribing physician certifies that the client's condition is stable; and

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

- For the purchase of a wheelchair or for wheelchair accessories or modifications for home clients, MAA has developed a form that may be used called the "Wheelchair Purchase Evaluation Form (for home clients only)" (an electronic version can be obtained at http://www1.dshs.wa.gov/dshsforms/forms/eforms.html).

- # Coverage of Multiple Wheelchairs

✓ MAA may cover two wheelchairs, a manual wheelchair and a power-drive wheelchair, for a noninstitutionalized client in certain situations. One of the following must apply:

- 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 radii;

- 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; or

- 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; the manual wheelchair would allow the caregiver to transport the client in a standard automobile or van. In these cases, MAA requires the client's situation to meet 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; and

  - Cabulance, public buses, or personal transit are neither available, practical, nor possible for financial or other reasons.

  All other circumstances are considered on a case-by-case basis, based on medical necessity.

✓ MAA considers the power-drive wheelchair to be the client's primary chair when the client has both a power-drive wheelchair and a manual wheelchair.

Physical/Occupational Therapy Wheelchair Evaluation Form for Nursing Facility Clients now located on DSHS's Electronic Forms Website.

CLICK HERE

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Wheelchair Purchase Evaluation Form (for home clients only) located on DSHS's Electronic Forms Website.

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Provider Requirements

Who is eligible for reimbursement by MAA for providing Wheelchairs, DME, and Related Supplies and Services?

(Refer to WAC 388-543-1200)

- MAA requires a provider who supplies DME and related supplies and services to an MAA client to meet all of the following.

  The provider must:

  - ✓ Have a core provider agreement with MAA;
  - ✓ Have the proper business license;
  - ✓ Have appropriately trained qualified staff; and
  - ✓ Be certified, licensed and/or bonded if required, to perform the services billed to MAA.

- MAA may reimburse qualified providers for DME and related supplies, repairs, and related services on a fee-for-service (FFS) basis as follows:

  - ✓ DME providers for DME and related repair services;
  - ✓ Medical equipment dealers, pharmacies, and home health agencies under their medical vendor provider number for medical supplies, subject to the limitations in this billing instruction; and
  - ✓ Physicians who provide medical equipment and supplies in the physician's office. MAA may pay separately for medical supplies, subject to the provisions in MAA's resource based relative value scale (RBRVS) fee schedule.

- MAA terminates from Medicaid participation any provider who violates program regulations and policies, as described in WAC 388-502-0020.

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Authorization

What is prior authorization?

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

Which items and services require prior authorization?

[Refer to WAC 388-543-1600]

MAA bases its determination about which durable medical equipment (DME) and related supplies and services require PA or EPA on utilization criteria. MAA considers all of the following when establishing utilization criteria:

- High cost;
- Potential for utilization abuse;
- Narrow therapeutic indication; and
- Safety.

MAA requires providers to obtain PA for the following:

- Augmentative communication devices (ACDs);
- Certain By Report (BR) DME and supplies as specified in this billing instruction;
- Blood glucose monitors requiring special features;
- Certain equipment rentals as specified in this billing instruction;
- Decubitus care products and supplies;
- Equipment parts and labor charges for repairs or modifications and related services;
- Orthopedic shoes and selected orthotics;
- Positioning car seats for children under five years of age;
- Wheelchairs, wheelchair accessories, wheelchair modifications, air, foam, and gel cushions, and repairs;
- Wheelchair-style shower/commode chairs;
- Other DME not specifically listed in this billing instruction and submitted as a miscellaneous procedure code; and
- Limitation extensions.

MAA requires providers to obtain PA for the following items and services **if the provider fails to meet the expedited prior authorization criteria in this billing instruction** (see "*What is expedited prior authorization?*" in Section G). This includes, but is not limited to, the following:

- Decubitus care mattresses, including flotation or gel mattress;
- Hospital beds;
- Low air loss flotation system;
- Osteogenic stimulator, noninvasive; and
- Transcutaneous electrical nerve stimulators.

General Policies for Prior Authorization **[WAC 388-543-1800]**

- For PA requests, MAA requires the prescribing provider to furnish patient-specific justification for base equipment and each requested line item accessory or modification as identified by the manufacturer as a separate charge. MAA does not accept general standards of care or industry standards for generalized equipment as justification.

- When MAA receives an initial request for PA, the prescription(s) for those items or services cannot be older than three months from the date MAA receives the request.

- All written authorization requests must include a valid prescription.

- MAA requires certain information from providers in order 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; and
  - ✓ Any modifications required, including the product or accessory number as shown in the manufacturer's catalog.

- MAA authorizes BR items that require PA and are listed in the fee schedule (see Sections I and J) only if medical necessity is established and the provider furnishes all of the following information to MAA:

  - ✓ A detailed description of the item or service to be provided;
  - ✓ The cost or charge for the item;
  - ✓ A copy of the manufacturer's invoice, price-list or catalog with the product description for the item being provided; and
  - ✓ A detailed explanation of how the requested item differs from an already existing code description.

- MAA does not reimburse for purchase, rental, or repair of medical equipment that duplicates equipment the client already owns or rents. If the requesting provider makes such a request, MAA requires the provider to submit for PA and explain the following:

  - ✓ 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.

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

- MAA authorizes rental equipment for a specific period of time. The provider must request authorization from MAA for any extension of the rental period.

☞ **Note:** Written requests for prior authorization must be submitted to MAA on a HCFA-1500 claim form with the date of service left blank and a copy of the prescription attached.

What is a Limitation Extension?

A limitation extension is when MAA allows additional units of service for a client when the provider can verify that the additional units of service are medically necessary. Limitation extensions require authorization.

☞ **Note:** Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

How do I request a limitation extension?

In cases where the provider feels that additional services are still medically necessary for the client, the provider must request MAA-approval in writing.

The request must state the following in writing:

1. The name and PIC number of the client;
2. The provider's name, provider number and fax number;
3. Additional service(s) requested;
4. Copy of last prescription and date dispensed;
5. The primary diagnosis code and HCPCS code; and
6. Client-specific clinical justification for additional services.

Send your written request for a limitation extension to:

Write:
Division of Medical Management
DME Program Management Unit
PO Box 45506
Olympia, WA 98504-5506
(360) 586-5299 (fax)

What is expedited prior authorization?

The expedited prior authorization process (EPA) is designed to eliminate the need for written and telephonic requests for prior authorization for selected durable medical equipment (DME) procedure codes. MAA allows payment during a continuous 12-month period for this process.

To bill MAA for DME that meet the EPA criteria on the following pages, the vendor must create a 9-digit EPA number. The first 6 digits of the EPA number must be **870000.** The last 3 digits must be the code number of the product and documented medical condition that meets the EPA criteria. Enter the EPA number on the HCFA-1500 claim form in the ***Authorization Number*** field or in the ***Authorization*** or ***Comments*** field when billing electronically. With HIPAA implementation, multiple authorization (prior/expedited) numbers can be billed on a claim. If you are billing **multiple** EPA numbers, you must list the 9-digit EPA numbers in field 19 of the claim form **exactly** as follows (*not all required fields are represented in the example*):

19. Line 1: 870000725/ Line 2: 870000726

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

Example: The 9-digit EPA number for rental of a semi-electric hospital bed for a client that meets all of the EPA criteria would be **870000725** (870000 = first 6 digits, 725 = product and documented medical condition).

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

- Other DME requiring prior authorization through the DME program;
- Products for which the documented medical condition does not meet all of the specified criteria; or
- Over-limitation requests.

The written or telephonic request for prior authorization process must be used when a situation does not meet the criteria for a selected DME code, or a requested rental exceeds the limited rental period indicated. Providers must submit the request to the DME Program Management Unit or call the authorization toll-free number at 1-800-292-8064 (see *Important Contacts* section). [WAC 388-543-1900(3)]

Expedited Prior Authorization Guidelines:

A. **Medical Justification (criteria)** - All information must come from the client's prescribing physician or therapist with an appropriately completed prescription. MAA does not accept information obtained from the client or from someone on behalf of the client (e.g. family).

B. **Documentation** - The billing provider **must keep** documentation of the criteria in the client's file. Upon request, a provider must provide documentation to MAA showing how the client's condition met the criteria for EPA. Keep documentation file for six (6) years. [Refer to WAC 388-543-1900(4)]

Note: MAA may recoup any payment made to a provider under this section if the provider did not follow the expedited authorization process and criteria. Refer to WAC 388-502-0100. [WAC 388-543-1900(5)]

EPA Criteria Coding List

Code	Criteria	Code	Criteria

RENTAL MANUAL WHEELCHAIRS

Procedure Code: K0001 RR

700 Standard manual wheelchair with all styles of arms, footrest, and/or legrests

Up to 2 months continuous rental in a 12-month period if **all** of 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 him/her totally non-weight bearing or is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file);
4) Does **not** have a rental hospital bed; and
5) Has a length of need, as determined by the prescribing physician, that is less than 6 months.

Procedure Code: K0003 RR

705 Lightweight Manual Wheelchair with all styles of arms, footrests, and/or legrests

Up to 2 months continuous rental in a 12-month period if **all** of 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 him/her totally non-weight bearing or is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file);
4) Does **not** have a rental hospital bed; and
5) Has a length of need, as determined by the prescribing physician, that is less than 6 months.

Procedure Code: K0006 RR

710 Heavy-duty Manual Wheelchair with all styles of arms, footrests, and/or legrests

Up to 2 months continuous rental in a 12-month period if **all** of 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 him/her totally non-weight bearing or is unable to use other aids to mobility, such as crutches or walker (reason must be documented in the client's file);
4) Does **not** have a rental hospital bed; and
5) Has a length of need, as determined by the prescribing physician, that is less than 6 months.

Procedure Code: E1060 RR

715 Fully Reclining Manual Wheelchair with detachable arms, desk or full-length and swing-away or elevating legrests

Up to 2 months continuous rental in a 12-month period if **all** of the following criteria are met. The client:

1) Requires a wheelchair to participate in normal daily activities and is unable to use other aids to 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; and
4) Has a length of need, as determined by the prescribing physician, that is less than 6 months.

Please see note on next page.

Note (For Rental Manual Wheelchairs):

1) If the client's medical condition does not meet **all** of the specified criteria, prior authorization must be obtained by submitting a request to the DME program (see *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
2) It is the vendors' responsibility to determine whether the client has already used the EPA rental period allowed under EPA criteria or if the client has already established rental through another vendor. The EPA rental is allowed only one time, per client, per 12-month period.
3) For extension of authorization beyond the EPA period, the normal prior authorization process is required. At this time, a new authorization number will be assigned.
4) Length of need/life expectancy, as determined by the prescribing physician, and medical justification (including **all** of the specified criteria) must be documented in the client's file.
5) 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, and in the hospital they are included in the Diagnoses Related Group (DRG) payment.
6) MAA 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 vendor of service is expected to supply the client with an equivalent loaner.
7) You may bill for only one procedure code, per client, per month.
8) All accessories are included in the reimbursement of the wheelchair rental code. They may not be billed separately.

RENTAL/PURCHASE HOSPITAL BEDS

Procedure Code: E0292 RR & E0310 RR OR E0305 RR

720 Manual Hospital Bed with mattress with or without bed rails

Up to 11 months continuous rental in a 12-month period if **all** of the following criteria are met. The client:

1) Has a length of need/life expectancy that is 12 months or less;
2) Has a medical condition 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 he/she is in the bed;
5) Does not have full-time caregivers; and
6) Does **not** also have a rental wheelchair.

Procedure Code: E0294 RR & E0310 RR OR E0305 RR

725 Semi-Electric Hospital Bed with mattress with or without Bed Rails

Up to 11 months continuous rental in a 12-month period if **all** of 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);

Continued on next page.

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 independently and safely operate the bed controls; and
5) Does **not** have a rental wheelchair.

Note:

1) If the client's medical condition does not meet **all** of the specified criteria, prior authorization must be obtained by submitting a request to the DME program (see the *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
2) It is the vendors' responsibility to determine whether the client has already used the EPA rental period allowed under EPA criteria or if the client has already established rental through another vendor. The EPA rental is allowed only one time, per client, per 12-month period.
3) Length of need/life expectancy, as determined by the prescribing physician, and medical justification (including all of the specified criteria) must be documented in the client's file. Monthly updates from the prescribing physician justifying continued rental, including length of need/life expectancy, must also be included in the client's file.
4) Authorization must be requested for the 12th month of rental at which time the equipment will be considered purchased. The authorization number will be pended for the serial number of the equipment. In such cases, the equipment the client has been using must have been new on or after the start of the rental contract or is documented to be in good working condition. A 1-year warranty will take effect as of the date the equipment is considered purchased if equipment is not new. Otherwise, normal manufacturer warranty will be applied.
5) If length of need is greater than 12 months, as stated by the prescribing physician, a prior authorization for purchase must be requested either in writing or via the toll-free line.
6) 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, and in the hospital they are included in the DRG payment.
7) MAA 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 vendor of service is expected to supply the client with an equivalent loaner.
8) Hospital beds **will not** be provided:

   a. As furniture;
   b. To replace a client-owned waterbed;
   c. For a client who does not own a standard bed with mattress, box spring, and frame; or
   d. 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.
9) Only one type of bed rail is allowed with each rental.
10) Mattress may **not** be billed separately.

Procedure Code: E0294 NU

726 Semi-Electric Hospital Bed with mattress with or without bed rails

Initial purchase if **all** of the following criteria are met. The client:

1) Has a length of need/life expectancy that is 12 months or more;
2) Has tried positioning devices such as: pillows, bolsters, foam wedges, and/or 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);

Continued on next page.

3) Has one of the following diagnosis:

   a. Quadriplegia;
   b. Tetraplegia;
   c. Duchenne's M.D.;
   d. ALS;
   e. Ventilator Dependant; or
   f. COPD or CHF with aspiration risk or shortness of breath that causes the need for an immediate position change of more than 30 degrees.

4) Must be able to independently and safely operate the bed controls.

Documentation Required:

1) Life expectancy, in months and/or years.
2) Client diagnosis including ICD-9-CM code.
3) Date of delivery and serial #.
4) Written documentation indicating client has not been previously provided a hospital bed, purchase or rental (i.e. written statement from client or caregiver).

☞ **Note:**

1) If the client's medical condition does not meet **all** of the specified criteria, prior authorization must be obtained by submitting a request to the DME program (see the *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
2) This 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.
3) It is the vendors' responsibility to determine if the client has previously been provided a hospital bed, either purchase or rental.
4) Hospital beds **will not** be covered:

   a. As furniture;
   b. To replace a client-owned waterbed;
   c. For a client who does not own a standard bed with mattress, box spring and frame; or
   d. 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.

LOW AIR LOSS THERAPY SYSTEMS

Procedure Code: E0371 & E0372 RR

730 Low Air Loss Mattress Overlay

Initial 30-day rental followed by one additional 30-day rental in a 12-month period if **all** of 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); and
5) Has appropriate nutritional program to heal ulcers.

Procedure Code: E0277 & E0373 RR

735 Low Air Loss Mattress without bed frame

Initial 30-day rental followed by an additional 30 days rental in a 12-month period if **all** of 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); and
6) Has appropriate nutritional program to heal ulcers.

740 Low Air Loss Mattress without bed frame

Initial 30-day rental in a 12-month period upon hospital discharge following a flap surgery.

Procedure Code: E0194 RR

750 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 must be completed for each rental segment and signed and dated by nursing staff in facility or client's home (an electronic version can be obtained at http://www1.dshs.wa.gov/dshsforms/forms/eforms.html).
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:

1) If the client's medical condition does not meet **all** of the specified criteria, prior authorization must be obtained by submitting a request to the DME program (see the *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
2) It is the vendors' responsibility to determine whether the client has already used the EPA rental period allowed under EPA criteria or if the client has already established rental through another vendor. The EPA rental is allowed only one time, per client, per 12-month period.
3) For extension of authorization beyond the EPA period, prior authorization must be obtained either by submitting the request in writing or calling the toll-free authorization line. At this time a new authorization number will be assigned.

NONINVASIVE BONE GROWTH/NERVE STIMULATORS

Procedure Code: E0730 RR

760 Transcutaneous Electrical Nerve Stimulator (TENS)

Up to 2 months continuous rental in a 12-month period if **all** of the following criteria are met. The client:

1) Demonstrates a condition that is causing chronic intractable pain, defined as pain that is of long duration that has been difficult to manage;
2) Has a pain level documented at 6 or greater on a scale of one to 10;
3) Has a date of onset at least 6 months ago;
4) Has had no surgery within the previous 3 months;
5) Is receiving continual pain and/or anti-inflammatory medication;
6) Has had at least 5 physical therapy visits during the past 6 months with no perceptible improvement in pain relief or activity level; and
7) Has an objective of decreasing/ discontinuing medications and increasing level of activity.

Procedure Code: E0730 NU

761 Transcutaneous Electrical Nerve Stimulator (TENS)

Purchase unit after 2 months of EPA or prior authorized rental if **all** of the following criteria are met. The client:

1) Is using the unit 6 or more hours per day or 2 or more hours per day for the Alpha Stim brand;
2) Has a pain level documented at 5 or less on a scale of one to 10;
3) Has had a reduction in prescription medication use for chronic intractable pain condition; and
4) Has an increased activity level.

Procedure Code: E0747 NU & E0760 NU

765 Non-Spinal Bone Growth Stimulator

Allowed for purchase 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 & metatarsal) after 6 months have elapsed since the date of injury without healing; or
2) Has a failed fusion of a joint other than in the spine where a minimum of 6 months has elapsed since the last surgery.

Procedure Code: E0748 NU

770 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 have elapsed since the last surgery; or
2) Is post-op from a multilevel spinal fusion surgery; or
3) Is post-op from spinal fusion surgery where there is a history of a previously failed spinal fusion.

☞ **Note:**

1) If the client's medical condition does not meet **all** of the specified criteria, prior authorization must be obtained by submitting a request to the DME program (see the *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
2) It is the vendors' responsibility to determine whether the client has already used the EPA rental period allowed under EPA criteria or if the client has already established rental through another vendor. The EPA rental is allowed only one time, per client, per 12-month period.
3) For extension of authorization beyond the EPA period, prior authorization must be obtained either by submitting the request in writing or calling the toll-free authorization line. At this time a new authorization number will be assigned.

MISCELLANEOUS DURABLE MEDICAL EQUIPMENT

Procedure Code: E0603 & E0604 RR

800 Breast pump, electric

Unit may be rented for the following lengths of time and when the criteria are met. The client:

1) Has a maximum of 2 weeks during any 12-month period for engorged breasts;
2) Has a maximum of 3 weeks during any 12-month period if the client is on a regimen of antibiotics for a breast infection;
3) Has a maximum of 2 months during any 12-month period if the client has a newborn with a cleft palate; or
4) Has a maximum of 2 months during any 12-month period if the client meets **all** of the following:

   a. Has a hospitalized premature newborn;
   b. Has been discharged from the hospital; and
   c. Is taking breast milk to hospital to feed newborn.

Procedure Code: E0935 RR

810 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; or
4) Total knee replacement.

Procedure Code: E0650 RR

820 Extremity pump

Up to 2 months rental during a 12-month period for treatment of severe edema.

Purchase of the equipment should be requested and rental not allowed when equipment has been determined to be:

1) Medically effective;
2) Medically necessary; and
3) A long-term, permanent need.

Procedure Code: E1399

755 Prone stander, child size (child up to 48" tall). Includes padding, chest, and foot straps. Purchase of 1 every 5 years per client when the following criteria are met:

1) Prescribed by a physician
2) Client does not reside in a nursing facility.

Procedure Code: E1399

756 Prone stander, youth size (child up to 58" tall). Includes padding, chest and foot straps. Purchase of 1 every 5 years per client when all of the following criteria are met:

1) Prescribed by a physician
2) Client does not reside in a nursing facility.

Procedure Code: E1399

757 Prone stander, infant size (infant up to 38" tall). Includes padding, chest and foot straps. Purchase of 1 every 5 years per client when all of the following criteria are met:

1) Prescribed by a physician
2) Client does not reside in a nursing facility.

Procedure Code: E1399

758 Prone stander, adult size (adult up to 75" tall). Includes padding, chest and foot straps. Limit of 1 per client every 5 years allowed when all of the following criteria are met:

1) Prescribed by a physician
2) Client does not reside in a nursing facility.

Procedure Code: E1399

759 Shower, hand-held. Purchase allowed when all of the following criteria are met:

1) Prescribed by a physician
2) Client does not reside in a nursing facility.

Procedure Code: E1399

764 Breast pump kit for electric breast pump. Purchase allowed when <u>all</u> of the following criteria are met:

1) When needed for use with an authorized electric breast pump; (either prior authorization or EPA);
2) Client is not in a nursing facility.
3) Prescribed by a physician.

Procedure Code: E1399

766 Bath seat without back. Purchase allowed when all of the following criteria are met:

1) Prescribed by a physician
2) Client does not reside in a nursing facility.

Procedure Code: E1399

767 Heavy duty bath chair (for clients over 250lbs.) Purchase allowed when all of the following criteria are met:

1) Prescribed by a physician
2) Client does not reside in a nursing facility.

Procedure Code: E1399

771 Padded or unpadded shower/commode chair, wheeled, with casters. Purchase allowed when all of the following criteria are met:

1) Prescribed by a physician
2) Client does not reside in a nursing facility.

Procedure Code: E1399

772 Adjustable bath seat with back. Purchase allowed when all of the following criteria are met:

1) Prescribed by a physician
2) Client does not reside in a nursing facility.

Procedure Code: E1399

773 Adjustable bath/shower chair with back, padded seat. Purchase allowed when all of the following criteria are met:

1) Prescribed by a physician
2) Client does not reside in a nursing facility.

Procedure Code: E1399

774 Pediatric bath chair; includes head pad, chest and leg straps. Purchase allowed when all of the following criteria are met:

1) Prescribed by a physician
2) Client does not reside in a nursing facility.

Procedure Code: E1399

776 Youth bath chair, includes head pad, chest and leg straps. Purchase allowed when all of the following criteria are met:

1) Prescribed by a physician
2) Client does not reside in a nursing facility.

Procedure Code: E1399

777 Adult bath chair, includes head pad, chest and leg straps. Purchase allowed when all of the following criteria are met:

1) Prescribed by a physician
2) Client does not reside in a nursing facility.

Procedure Code: E1399

778 Potty chair, child, small/medium. Includes anterior/lateral support, hip strap, adjustable seat/back. Purchase allowed when all of the following criteria are met:

1) Prescribed by a physician
2) Client does not reside in a nursing facility.

Procedure Code: E1399

779 Potty chair, child, large. Includes anterior/lateral support, hip strap, adjustable seat/back. Purchase allowed when all of the following criteria are met:

1) Prescribed by a physician
2) Client does not reside in a nursing facility.

☞ **Note:**

1) If the client's medical condition does not meet **all** of the specified criteria, prior authorization must be obtained by submitting a request to the DME program (see the *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
2) It is the vendors' responsibility to determine whether the client has already used the EPA rental period allowed under EPA criteria or if the client has already established rental through another vendor. The EPA rental is allowed only one time, per client, per 12-month period.
3) For extension of authorization beyond the EPA period, prior authorization must be obtained either by submitting the request in writing or calling the toll-free authorization line. At this time a new authorization number will be assigned.

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Low Air-Loss Therapy Systems Form located on DSHS's Electronic Forms Website.

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Reimbursement

General Reimbursement for DME and Related Supplies and Services [Refer to WAC 388-543-1400(1-5)]

- MAA reimburses a qualified provider who serves a client who is not enrolled in a department-contracted managed care plan only when all of the following apply:

  - ✓ The provider meets all of the conditions in WAC 388-502-0100; and

  - ✓ MAA does not include the item/service for which the provider is requesting reimbursement in other reimbursement rate methodologies. Other methodologies include, but are not limited to, the following:

    - ➢ Hospice providers' per diem reimbursement;
    - ➢ Hospital's diagnosis related group (DRG) reimbursement;
    - ➢ Managed care plans' capitation rate; and
    - ➢ Nursing facilities' per diem rate.

- MAA sets maximum allowable fees for DME and related supplies using available published information, such as:

  - ✓ Commercial databases for price comparisons;
  - ✓ Manufacturers' catalogs;
  - ✓ Medicare fee schedules; and
  - ✓ Wholesale prices.

- MAA may adopt policies and/or rates that are inconsistent with those set by Medicare if MAA determines that such actions are in the best interest of its clients.

- MAA updates the maximum allowable fees for DME and supplies no more than once per year, unless otherwise directed by the legislature. MAA may update the rates for different categories of medical equipment at different times during the year.

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

What criteria does MAA use to determine whether to purchase or rent DME for clients? [Refer to WAC 388-543-1100(8)]

MAA bases the decision to purchase or rent DME for a client, or to pay for repairs to client-owned equipment on medical necessity.

MAA purchases or rents medically necessary equipment and supplies only when the item requested is not included in other reimbursement methodologies. Other reimbursement methodologies include, but are not limited to:

- Hospitals' diagnosis-related group (DRG) reimbursement;
- Inpatient hospital ratio of cost to charges (RCC) reimbursement;
- Nursing facilities' per diem rate;
- Hospice providers' per diem reimbursement; or
- Managed care plans' capitation rate.

The amount MAA pays for medically necessary services is the lower of the usual and customary charges or rates established by MAA and:

- The services are within the scope of care in this billing instructions (see *Coverage* section);
- The services are properly authorized;
- The services are properly billed;
- The services are billed in a timely manner as described under WAC 388-502-0150;
- The client is certified as eligible; and
- Third-party payment procedures are followed.

Purchased DME and Related Supplies

[WAC 388-543-1500]

- DME and related supplies purchased by MAA for a client is the client's property. MAA reimbursement for covered DME and related supplies includes all of the following:

  - ✓ Any adjustments or modifications to the equipment that are required within three months of the date of delivery. This does not apply to adjustments required because of changes in the client's medical condition;

  - ✓ Fitting and set-up; and

  - ✓ Instruction to the client or client's caregiver in the appropriate use of the equipment, device, and/or supplies.

- MAA charges the dispensing provider for any costs it incurs to have another provider repair equipment if all of the following apply:

  - ✓ Any DME that MAA considers purchased according to these billing instructions (see "*Rented DME and Supplies"* in section H) requires repair during the applicable warranty period;

  - ✓ The dispensing provider is unwilling or unable to fulfill the warranty; and

  - ✓ The client still needs the equipment.

- MAA rescinds purchase orders for the following reasons:

  - ✓ If the equipment was not delivered to the client before the client:

    - ➢ Dies;
    - ➢ Loses medical eligibility;
    - ➢ Becomes covered by a hospice agency; or
    - ➢ Becomes covered by an MAA managed care plan.

  - ✓ A provider may incur extra costs for customized equipment that may not be easily resold. In these cases, for purchase orders rescinded per the stipulations listed above, MAA may pay the provider an amount it considers appropriate to help defray these extra costs. MAA requires the provider to submit justification sufficient to support such a claim.

  - ✓ A client may become a managed care plan client before MAA completes the purchase of prescribed medical equipment. If this occurs:

    - ➢ MAA rescinds the purchase order until the managed care primary care provider (PCP) evaluates the client; then

    - ➢ MAA requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary (see *Definitions* section); then

    - ➢ The managed care plan's applicable reimbursement policies apply to the purchase or rental of the equipment.

Rented DME and Related Supplies [WAC 388-543-1700]

- MAA's reimbursement amount for rented DME includes all of the following:

  - ✓ Delivery to the client;
  - ✓ Fitting, set-up, and adjustments;
  - ✓ Maintenance, repair and/or replacement of the equipment; and
  - ✓ Return pickup by the provider.

- MAA requires a dispensing provider to ensure the DME rented to an MAA client is both of the following:

  - ✓ In good working order; and

  - ✓ 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.

- MAA considers rented equipment to be purchased after 12 months' rental unless one of the following apply:

  - ✓ The equipment is restricted as rental only; or
  - ✓ Other MAA published issuances state otherwise.

- MAA rents, but does not purchase, certain medically necessary equipment for clients. This includes, but is not limited to, the following:

  - ✓ Bilirubin lights for newborns at home with jaundice; and
  - ✓ Electric breast pumps.

- MAA's minimum rental period for covered DME is one day.

- MAA requires that both the begin date and the end date of a rental segment be indicated on the HCFA-1500 claim form in the "dates of service," "from," and "to" areas for all rental billings.

- If a fee-for-service (FFS) client becomes a managed care plan client, both of the following apply:
  - ✓ MAA stops paying for any rented equipment on the last day of the month preceding the month in which the client becomes enrolled in the managed care plan; and
  - ✓ The plan determines the client's continuing need for the equipment and is responsible for reimbursing the provider.
- MAA stops paying for any rented equipment effective the date of a client's death. MAA prorates monthly rental as appropriate.
- For a client who is eligible for both Medicaid and Medicare, MAA pays only the client's coinsurance and deductibles for rental equipment when either of the following applies:
  - ✓ The reimbursement amount reaches Medicare's reimbursement cap for the equipment; or
  - ✓ Medicare considers the equipment purchased.
- MAA does not obtain or pay for insurance coverage against liability, loss and/or damage to rental equipment that a provider supplies to an MAA client.

When does MAA not reimburse under fee-for-service?
[WAC 388-543-1100 (5)]

MAA does not reimburse for DME and related supplies and repairs and labor charges under fee-for-service (FFS) when the client is any of the following:

- An inpatient hospital client;
- Eligible for both Medicare and Medicaid, and is staying in a nursing facility in lieu of hospitalization;
- Terminally ill and receiving hospice care; or
- Enrolled in a risk-based managed care plan that includes coverage for such items and/or services.

DME and Supplies Provided in Physician's Office

MAA does not pay a DME provider for medical supplies used in conjunction with a physician office visit. MAA pays the office physician for these supplies, as stated in the Resource Based Relative Value Scale (RBRVS), when it is appropriate.

Warranty

- MAA requires providers to:

  - ✓ Furnish to MAA clients only new equipment that includes full manufacturer and dealer warranties; and
  - ✓ Include a warranty on equipment for one year after the date MAA considers rented equipment to be purchased as provided in this billing instruction (see "*Rented DME and Supplies"* in section H). (Refer to WAC 388-543-1500[3][4])

- MAA charges the dispensing provider 50% of the total amount MAA paid toward rental and eventual purchase of the first equipment if the rental equipment must be replaced during the warranty period. All of the following must apply:

  - ✓ Any medical equipment that MAA considers purchased according to this billing instruction (see "*Rented DME and Supplies"* in section H) requires replacement during the applicable warranty period;

  - ✓ The dispensing provider is unwilling or unable to fulfill the warranty; and

  - ✓ The client still needs the equipment.

MINIMUM WARRANTY PERIODS	
Wheelchair Frames (Purchased New) and Wheelchair Parts	**Warranty**
Powerdrive *(depending on model)*	1 year - lifetime
Ultralight	lifetime
Active Duty Lightweight *(depending on model)*	5 years - lifetime
All Others	1 year
Electrical Components	**Warranty**
All electrical components whether new or replacement parts including batteries	6 months - 1 year
Other DME	**Warranty**
All other DME not specified above (excludes disposable/ non-reusable supplies)	1 year

Wheelchair Fee Schedule

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

Manual Wheelchairs (Covered HCPCS Codes)

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E1031	NU	$1,496.80	Rollabout chair, any and all types with casters five inches or greater.
E1060	RR	$124.22	Fully reclining wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests. **See Expedited Prior Authorization (EPA), Section G.**
E1161	NU	$2,366.09	Manual adult size wheelchair, includes tilt in space.
NEW! E1231	NU	80%	Wheelchair, pediatric size, tilt- in- space, rigid, adjustable, with seating system.
E1232	NU	80%	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system.
E1233	NU	80%	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system.
NEW! E1234	NU	$1,928.95	Wheelchair, pediatric size,tilt in space, folding, adjustable, without seating system.
NEW! E1235	NU	$1,857.43	Wheelchair, pediatric size, rigid, adjustable, with seating system.
NEW! E1236	NU	$1,638.73	Wheelchair, pediatric size, folding, adjustable, with seating system.
E1237	NU RR	$1,653.05 $165.30	Wheelchair, pediatric size, rigid, adjustable, without seating system.

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E1238	NU	$1,723.55	Wheelchair, pediatric size, folding, adjustable, without seating system.
K0001	NU RR	$546.20 $54.62	Standard wheelchair (all styles of arms, foot rests, and/or leg rests). **See Expedited Prior Authorization (EPA), Section G (for rental only).**
NEW! K0002	NU RR	$695.60 $69.56	Standard hemi(low seat) for wheelchair
K0003	NU RR	$895.80 $89.59	Lightweight wheelchair (all styles of arms, foot rests, and/or leg rests). **See Expedited Prior Authorization (EPA), Section G (for rental only).**
K0004	NU	$1,336.40	High strength, lightweight wheelchair.
K0005	NU	$1,848.76	Ultralightweight wheelchair.
K0006	NU RR	$1254.10 $125.41	Heavy-duty wheelchair (all styles of arms, foot rests, and/or leg rests). **See Expedited Prior Authorization (EPA), Section G.**
K0007	NU	$1,785.00	Extra heavy-duty wheelchair.
K0009	NU	80%	Other manual wheelchair/base.

MANUAL WHEELCHAIRS (Noncovered HCPCS Codes)

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E1037		#	Transport chair, pediatric size
E1038		#	Transport chair, adult size

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E1050		#	Fully reclining wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests (see codes K0003 & E1226)
E1070		#	Fully reclining wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests (see codes K0003 & E1226)
E1083		#	Hemi-wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests (see code K0002 or K0003)
E1084		#	Hemi-wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests (see code K0002 or K0003)
E1085		#	Hemi-wheelchair; fixed full-length arms, swing-away, detachable footrests (see code K0002 or K0003)
E1086		#	Hemi-wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests (see code K0002 or K0003)
E1087		#	High-strength lightweight wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests (see K0004)
E1088		#	High-strength lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests (see K0004)
E1089		#	High-strength lightweight wheelchair; fixed-length arms, swing-away, detachable footrests (see K0004)
E1090		#	High-strength lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests (see K0004)

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E1092		#	Wide, heavy-duty wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests (see K0007)
E1093		#	Wide, heavy-duty wheelchair; detachable arms, desk or full-length arms, swing-away, detachable footrests (see K0007)
E1100		#	Semi-reclining wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests (see K0003 & E1226)
E1110		#	Semi-reclining wheelchair; detachable arms, desk or full-length, elevating legrests (see K0003 & E1226)
E1130		#	Standard wheelchair; fixed full-length arms, fixed or swing-away, detachable footrests (see K0001)
E1140		#	Wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests (see K0001)
E1150		#	Wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests (see K0001)
E1160		#	Wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests
E1170		#	Amputee wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests. (see K0001 - K0005)
E1171		#	Amputee wheelchair; fixed full-length arms, without footrests or legrests. (see K0001 - K0005)
E1172		#	Amputee wheelchair; detachable arms, desk or full-length, without footrests or legrests. (see K0001 - K0005)

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E1180		#	Amputee wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests. (see K0001 - K0005)
E1190		#	Amputee wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests. (See K0001 - K0005)
E1195		#	Heavy duty wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests. (See K0007)
E1200		#	Amputee wheelchair; fixed full-length arms, swing-away, detachable footrests. (See K0001 - K0005)
E1240		#	Lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests. (See K0003 or K0004)
E1250		#	Lightweight wheelchair; fixed full-length arms, swing-away, detachable, footrests. (See K0003 or K0004)
E1260		#	Lightweight wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests. (See K0003 or K0004)
E1270		#	Lightweight wheelchair; fixed full-length arms, swing-away, detachable elevating legrests. (See K0003 or K0004)
E1280		#	Heavy-duty wheelchair; detachable arms, desk or full-length, elevating legrests. (See K0007)
E1285		#	Heavy-duty wheelchair; fixed full-length arms, swing-away, detachable footrests. (See K0007)
E1290		#	Heavy-duty wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests. (See K0007)

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E1295		#	Heavy-duty wheelchair; fixed full-length arms, elevating legrests. (See K0007)

POWER WHEELCHAIRS (Covered HCPCS Codes)

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E1230	NU	$2,261.79	Power operated vehicle (three- or four-wheel nonhighway), specify brand name and model number.
NEW! K0010	NU RR	$4,259.90 $425.99	Standard-weight frame motorized/power wheelchair
K0011	NU RR	$5,296.50 $529.65	Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking.
K0012	NU RR	$3,249.20 $324.92	Lightweight portable motorized/power wheelchair.
K0014	NU	85%	Other motorized/power wheelchair base.

POWER WHEELCHAIRS (Noncovered HCPCS Codes)

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E1210		#	Motorized wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests. (See K0010 - K0014)

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E1211		#	Motorized wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating legrests. (See K0010 - K0014)
E1212		#	Motorized wheelchair; fixed full-length arms, swing-away, detachable footrests. (See K0010 - K0014)
E1213		#	Motorized wheelchair; detachable arms, desk or full-length, swing-away, detachable footrests. (See K0010 - K0014)

Special Size Wheelchairs - Power or Manual (Noncovered HCPCS Codes)

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E1220		#	Wheelchair; specially sized or constructed (indicate brand name, model number, if any, and justification). (See K0009 or K0014)
E1221		#	Wheelchair with fixed arm, footrests. (See K0001 - K0014)
E1222		#	Wheelchair with fixed arm, elevating legrests. (See K0001 - K0014)
E1223		#	Wheelchair with detachable arms, footrests. (See K0001 - K0014)
E1224		#	Wheelchair with detachable arms, elevating legrests. (See K0001 - K0014)

Wheelchair Modifications, Accessories, and Repairs

All modifications, accessories, and repairs require prior authorization.

Cushions

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E0176		$91.04	Air pressure pad or cushion, nonpositioning.
NEW! E0178		$121.34	Gel or gel-like pressure pad or cushion, nonpositioning.
NEW! E0179		$11.96	Dry pressure pad or cushion, nonpositioning
E0192		$387.01	Low pressure and positioning equalization pad, for wheelchair.
E0962		$59.49	One-inch cushion, for wheelchair (without cover, each).
E0963		$71.06	Two-inch cushion, for wheelchair (without cover, each).
E0964		$67.39	Three-inch cushion, for wheelchair (without cover, each).
E0965		$72.04	Four-inch cushion, for wheelchair (without cover, each).
E0977		$65.41	Wedge cushion, wheelchair.

Custom Frame Up-Charges

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
NEW! E1014		80%	Reclining back, addition to pediatric wheelchair
E1225		80%	Manual wheelchair accessory, semi-reclining back (recline greater than 15 degrees, but less than 80 degrees), each.
NEW! E1226		80%	Manual wheelchair accessory, fully reclining back, each. ***Replaces HCPCS code K0028 for dates of service on and after April 1, 2004.***
NEW! E1227		80%	Special height arms for wheelchair (Up-charge by construction)
E1228		80%	Special back height for wheelchair.
E1296		#	Special wheelchair seat height from floor (See K0056)
NEW! E1297		80%	Special wheelchair seat depth, by upholstery
NEW! E1298		80%	Special wheelchair seat depth and/or width, by construction
NEW! E2201		80%	Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches
NEW! E2202		80%	Manual wheelchair accessory, nonstandard seat frame width, 24-27 inches
NEW! E2203		80%	Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches
NEW! E2204		80%	Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 inches
NEW! E2340		80%	Power wheelchair accessory, nonstandard seat frame width, 20-23 inches

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
NEW! E2341		80%	Power wheelchair accessory, nonstandard seat frame width, 24-27 inches
NEW! E2342		80%	Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 inches
NEW! E2343		80%	Power wheelchair accessory, nonstandard seat frame depth, 22-25 inches
~~*K0028*~~		~~*BR*~~	~~*Manual, fully reclining back.*~~ ***Discontinued with dates of service on and after April 1, 2004. Replaced with HCPCS code E1226.***
~~K0054~~		~~80%~~	~~Seat width of 10, 11, 12, 15, 17, or 20 inches for a high-strength, lightweight, or ultralightweight wheelchair.~~ ***Discontinued with dates of service on and after April 1, 2004.***
~~K0055~~		~~80%~~	~~Seat depth of 15, 17 or 18 inches for a high strength, lightweight or ultralightweight wheelchair.~~ ***Discontinued with dates of service on and after April 1, 2004.***
K0056		80%	Seat height less than 17 inches or equal to or greater than 21 inches for a high strength, lightweight, or ultralightweight wheelchair.
~~K0057~~		~~80%~~	~~Seat width 19 or 20 inches for heavy duty or extra heavy-duty chair.~~ ***Discontinued with dates of service on and after April 1, 2004.***
~~K0058~~		~~80%~~	~~Seat depth 17 or 18 inches for a motorized/power wheelchair~~ ***Discontinued with dates of service on and after April 1, 2004.***

Armrests and Parts

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
NEW! E0973		84%	Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each. ***Replaces HCPCS code K0016 for dates of service on and after April 1, 2004.***
NEW! E0994		84%	Armrest, each (replacement only)
K0015		84%	Detachable, nonadjustable height armrest, each.
~~K0016~~		~~84%~~	~~Detachable, adjustable height armrest, complete assembly, each.~~ ***Discontinued with dates of service on and after April 1, 2004. Replaced with HCPCS code E0973.***
NEW! K0017		84%	Detachable, adjustable height armrest, base, each (replacement only)
NEW! K0018		84%	Detachable, adjustable height armrest, upper portion, each (replacement only)
NEW! K0019		84%	Arm pad, each (replacement only)
K0020		84%	Fixed, adjustable height armrest, pair.
K0106		$107.16	Arm trough, each.

Lower Extremity Positioning (legrests, etc.)

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E0951		$18.98	Heel loop/holder, with or without ankle strap, each. ***Current code but also replaced HCPCS code K0035 for dates of service on and after April 1, 2004.***

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E0952		$18.83	Toe loop/holder each. ***Replaces HCPCS code K0036 for dates of service on and after April 1, 2004.***
E0990		84%	Wheelchair accessory, elevating leg rest, complete assembly, each. ***Replaces HCPCS code K0048 for dates of service on and after April 1, 2004.***
E0995		84%	Wheelchair accessory, calf rest/pad, each. ***Replaces code HCPCS code K0049 for dates of service on and after April 1, 2004.***
~~K0035~~		~~$24.52~~	~~Heel loop with ankle strap, each.~~ ***Discontinued with dates of service on and after April 1, 2004. Replaced with HCPCS code E0951.***
~~K0036~~		~~$18.83~~	~~Toe loop, each.~~ ***Discontinued with dates of service on and after April 1, 2004. Replaced with HCPCS code E0952.***
K0037		$48.16	High mount flip-up footrest, each.
K0038		84%	Leg strap, each
K0039		84%	Leg strap, H style, each
K0040		$74.67	Adjustable angle footplate, each.
K0041		$52.92	Large size footplate, each.
K0042		84%	Standard size footplate, each
K0043		84%	Footrest, lower extension tube, each
K0044		84%	Footrest, upper hanger bracket, each (replacement)
K0045		84%	Footrest, complete assembly.
K0046		84%	Elevating legrest, lower extension tube, each
K0047		84%	Elevating legrest, upper hanger bracket, each (replacement)

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
~~K0048~~		~~84%~~	~~Elevating legrest, complete assembly.~~ ***Discontinued with dates of service on and after April 1, 2004. Replaced with HCPCS code E0990.***
~~K0049~~		~~84%~~	~~Calf pad, each.~~ ***Discontinued with dates of service on and after April 1, 2004. Replaced with HCPCS code E0995.***
K0050		84%	Ratchet assembly (replacment)
K0051		84%	Cam release assembly, footrest or legrest, each (replacement)
K0052		84%	Swingaway, detachable footrests, each.
K0053		84%	Elevating footrests, articulating (telescoping), each

Seating and Positioning

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E0950		$103.95	Wheelchair accessory, tray, each
E0955		$202.18	Wheelchair accessory, headrest, cushioned, prefabricated, including fixed mounting hardware, each
E0956		$98.58	Wheelchair accessory, lateral trunk or hip support, prefabricated, including fixed mounting hardware, each
E0957		$137.93	Wheelchair accessory, medial-thigh support, prefabricated, including fixed mounting hardware, each

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E0960		$90.98	Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware.
E0978		$42.70	Wheelchair accessory, safety belt/pelvic strap, each. ***Replaces HCPCS code K0031 for dates of service on and after April 1, 2004.***
E0980		$33.06	Safety vest, wheelchair
E0981		84%	Wheelchair accessory, seat upholstery, replacement only, each. ***Replaces HCPCS codes K0032 and K0033 for dates of service on and after April 1, 2004.***
E0982		84%	Wheelchair accessory, back upholstery, replacement only, each. ***Replaces HCPCS code K0026 for dates of service on and after April 1, 2004.***
E0992		$95.15	Manual wheelchair accessory, solid seat insert.
E1012		84%	Integrated seating system, planar, for pediatric wheelchair
E1013		84%	Integrated seating system, contoured, for pediatric wheelchair
E1026		$192.90	Lateral thoracic support, contoured, for pediatric wheelchair, each (includes hardware)
E1027		$275.06	Lateral/anterior support, for pediatric wheelchair, each (includes hardware)
K0023		$94.09	Solid back insert, planar back, single density foam, attached with straps
K0024		$309.35	Solid back insert, planar back, single density foam, with adjustable hook-on hardware.

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
~~K0026~~		~~BR~~	~~Back upholstery for ultralightweight or high-strength lightweight wheelchair.~~ ***Discontinued with dates of service on and after April 1, 2004. Replaced with HCPCS code E0982.***
~~K0027~~		~~BR~~	~~Back upholstery for wheelchair type other than ultralightweight or high-strength lightweight wheelchair.~~ ***Discontinued with dates of service on and after April 1, 2004. Replaced with HCPCS code E0982.***
~~K0030~~		~~$202.85~~	~~Solid seat insert, planar seat, single density foam.~~ ***Discontinued with dates of service on and after April 1, 2004.***
~~K0031~~		~~$42.70~~	~~Safety belt/pelvic strap, each.~~ ***Discontinued with dates of service on and after April 1, 2004. Replaced with HCPCS code E0978.***
~~K0032~~		~~84%~~	~~Seat upholstery for ultralightweight or high-strength lightweight wheelchair.~~ ***Discontinued with dates of service on and after April 1, 2004. Replaced with HCPCS code E0981.***
~~K0033~~		~~84%~~	~~Seat upholstery for wheelchair type other than ultralightweight or high-strength lightweight wheelchair.~~ ***Discontinued with dates of service on and after April 1, 2004. Replaced with HCPCS code E0981.***
NEW! K0114		84%	Back support system for use with a wheelchair, with inner frame, prefabricated
K0115		84%	Seating system, back module, posterior-lateral control, with or without lateral supports, custom fabricated for attachment to wheelchair base.
NEW! K0116		84%	Seating system, combined back & seat module, custom fabricated for attatchment to wheelchair base

Handrims, Wheels, and Tires (includes parts)

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E0967		84%	Manual wheelchair accessory, hand rim with projections, each. ***Replaces HCPCS codes K0062 and K0063 for dates of service on and after April 1, 2004.***
E0997		84%	Caster with fork
E0998		84%	Caster without fork
E0999		84%	Pneumatic tire with wheel
E1001		84%	Wheel, single
K0059		$31.72	Plastic coated handrim, each.
K0060		84%	Steel handrim, each
K0061		84%	Aluminum handrim, each
~~K0062~~		~~84%~~	~~Handrim with 8 to 10 vertical or oblique projections, each.~~ ***Discontinued with dates of service on and after April 1, 2004. Replaced with HCPCS code E0967.***
~~K0063~~		~~84%~~	~~Handrim with 12 to 16 vertical or oblique projections, each.~~ ***Discontinued with dates of service on and after April 1, 2004. Replaced with HCPCS code E0967.***
K0064		84%	Zero pressure tube (flat free insert), any size, each.
K0065		$44.46	Spoke protectors, each.
K0066		84%	Solid tire, any size, each.
K0067		84%	Pneumatic tire, any size, each.
K0068		84%	Pneumatic tire tube, each (any size).

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
K0069		84%	Rear wheel assembly, complete, with solid tire, spokes or molded, each.
K0070		84%	Rear wheel assembly, complete with pneumatic tire, spokes or molded, each.
K0071		84%	Front caster assembly, complete, with pneumatic tire, each.
K0072		84%	Front caster assembly, complete, with semipneumatic tire, each.
K0073		84%	Caster pin lock, each.
K0074		84%	Pneumatic caster tire, any size, each.
K0075		84%	Semipneumatic caster tire, any size, each.
K0076		84%	Solid caster tire, any size, each.
K0077		84%	Front caster assembly, complete, with solid tire, each.
K0078		84%	Pneumatic caster tire tube, each.
NEW! K0090		84%	Rear wheel tire for power wheelchair, any size, each
NEW! K0091		84%	Rear wheel tire tube other than zero pressure for power wheelchair, any size, each
NEW! K0092		84%	Rear wheel assembly for power wheelchair, complete, each
NEW! K0093		84%	Rear wheel zero pressure tire tube (flat free insert) for power wheelchair, any size, each
NEW! K0094		84%	Wheel tire for power base, any size, each
NEW! K0095		84%	Wheel tire tube other than zero pressure for each base, any size, each
NEW! K0096		84%	Wheel assembly for power base, complete, each

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
NEW! K0097		84%	Wheel zero pressure tire tube (flat free insert) for power base, any size, each
NEW! K0099		84%	Front caster for power wheelchair

Other Accessories (manual and power)

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E0958		84%	Manual wheelchair accessory, one-arm drive attachment, each.
E0959		$44.21	Manual wheelchair accessory, adapter for amputee, each.
E0961		$12.28	Manual wheelchair accessory, wheel lock brake extension (handle), each. **Changed from pair to each with new description.**
E0971		$55.89	Anti-tipping device, wheelchair (pair).
E0974		$38.36	Manual wheelchair accessory, anti-rollback device, each. **Changed from pair to each with new description.**
NEW! E1015		84%	Shock absorber for manual wheelchair, each
NEW! E1017		84%	Heavy duty shock absorber for heavy duty or extra heavy duty manual wheelchair, each
NEW! E1020		84%	Residual limb support system for wheelchair
NEW! E1029		84%	Wheelchair accessory, ventilator tray, fixed
NEW! E1030		84%	Wheelchair accessory, ventilator tray, gimbaled
NEW! K0081		84%	Wheel lock assembly, complete, each

NEW!	K0102	84%	Crutch and cane holder, each
	K0104	$118.78	Cylinder tank carrier, each.
NEW!	K0105	84%	IV hanger, each
	K0108	84%	Other accessories.

Manual Wheelchair Conversions

	HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
NEW!	E0983		84%	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control
NEW!	E0984		84%	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control
NEW!	E0985		84%	Wheelchair accessory, seat lift mechanism
NEW!	E0986		84%	Manual wheelchair accessory, push-rim activated power assist, each
NEW!	E1065		84%	Power attachment (to convert any wheelchair to motorized wheelchair, e.g., Solo)

Power Wheelchair Add-on Functions and Controls

	HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
NEW!	E1002		84%	Wheelchair accessory, power seating system, tilt only
NEW!	E1003		84%	Wheelchair accessory, power seating system, recline only, without shear reduction

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E1004		84%	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction
E1005		84%	Wheelchair accessory, power seating system, recline only, with power shear reduction
E1006		84%	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction
E1007		84%	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction
E1008		84%	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction
E1009		84%	Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and legrest, each
E1010		84%	Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, each
E1016		84%	Shock absorber for power wheelchair, each
E1018		84%	Heavy duty shock absorber for heavy duty or extra heavy duty power wheelchair, each
E1019		84%	Wheelchair accessory, power seating system, heavy duty feature, patient weight capacity greater than 250 pounds and less than or equal to 400 pounds.
E1021		84%	Wheelchair accessory, power seating system, extra heavy duty feature, weight capacity greater than 400 pounds.
E1028		84%	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
			accessory
E2300		84%	Power wheelchair accessory, power seat elevation system
E2301		84%	Power wheelchair accessory, power standing system
E2310		84%	Power wheelchair accessory, electronic connection between wheelchair controller & one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware
E2311		84%	Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware
E2320		84%	Power wheelchair accessory, hand or chin control interface, remote joystick or touchpad, proportional, including all related electronics, and fixed mounting hardware
E2321		84%	Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware
E2322		84%	Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware
E2323		84%	Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E2324		84%	Power wheelchair accessory, chin cup for chin control interface
E2325		84%	Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware
E2326		84%	Power wheelchair accessory, breath tube kit for sip and puff interface
E2327		84%	Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware
E2328		84%	Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware
E2329		84%	Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware
E2330		84%	Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware
E2331		84%	Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware
E2351		84%	Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E2399		84%	Power wheelchair accessory, not otherwise classified interface, including all related electronics and any type mounting hardware

Batteries and Chargers

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E2360		$104.43	Power wheelchair accessory, 22 NF non-sealed lead acid battery, each. ***Replaces HCPCS code K0082 for dates of service on and after April 1, 2004.***
E2361		$139.47	Power wheelchair accessory, 22 NF sealed lead acid battery, each (e.g. gel cell, absorbed glassmat). ***Replaces HCPCS code K0083 for dates of service on and after April 1, 2004.***
E2363		$186.00	Power wheelchair accessory, group 24 sealed lead acid battery, each(e.g. gel cell, absorbed glassmat)
E2365		$112.17	Power wheelchair accessory, U-1sealed lead acid battery, each (e.g. gell cell, absorbed glassmat)
E2366		84%	Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each. ***Replaces HCPCS code K0088 for dates of service on and after April 1, 2004***.
E2367		84%	Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each
~~K0082~~		~~$102.48~~	~~22 NF non-sealed lead acid battery, each.~~ ***Discontinued with dates of service on and after April 1, 2004. Replaced with HCPCS code E2360.***

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
~~K0083~~		~~$163.06~~	~~22 NF sealed lead acid battery, each (e.g., gel cell, absorbed glass mat).~~ ***Discontinued with dates of service on and after April 1, 2004. Replaced with HCPCS code E2361.***
~~K0088~~		~~$262.62~~	~~Battery charger, single mode, for use with only one battery type, sealed or non-sealed.~~ ***Discontinued with dates of service on and after April 1, 2004. Replaced with HCPCS code E2366.***

Miscellaneous Repair Only

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
NEW! E1011		84%	Modification to pediatric wheelchair, width adjustment package (not to be dispensed with initial chair)
E1340		$17.43	Repair or nonroutine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes. (Troubleshooting, delivery, evaluations, travel time, etc. are included in the reimbursement for the parts and accessories.)
NEW! K0098		84%	Drive belt for power wheelchair
NEW! K0452		84%	Wheelchair bearings, any type

Accessories (Noncovered HCPCS Codes)

HCPCS Code	Modifier	April 1, 2004 Maximum Allowable	Description
E0177		#	Water pressure pad or cushion, nonpositioning.
E0953		#	Pneumatic tire, each (see code K0067)
E0954		#	Semi-pneumatic caster, each (see code K0075)
E0966		#	Manual wheelchair accessory, headrest extension, each
E0968		#	Commode seat, wheelchair
E0969		#	Narrowing device, wheelchair
E0970		#	No. 2 footplates, except for elevating legrest (see K0037 & K0042)
E0996		#	Tire, solid, each (see K0066)
E1000		#	Tire, pneumatic caster (see K0074)
E2362		#	Power wheelchair accessory, group 24 non-sealed lead acid battery, each
E2364		#	Power wheelchair accessory, U-1 non-sealed lead acid battery, each
K0195		#	Elevating leg rest, pair (for use with capped rental wheelchair base)

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"Other DME" Fee Schedule

Beds, Mattresses, and Related Equipment

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
A4640	RP	$56.67	Replacement pad for use with medically necessary alternating pressure pad **owned by patient. Purchase only.** Included in nursing facility daily rate.
A6550		$27.42	Dressing set for negative pressure wound therapy electrical pump, stationary or portable, each. **Purchase only. Requires prior authorization.**
A6551		$24.53	Canister set for negative pressure wound therapy electrical pump, stationary or portable, each. **Purchase only. Requires prior authorization.**
E0180	NU RR	$215.70 $21.57	Pressure pad, alternating with pump. **Rental requires prior authorization. Deemed purchased after 1 year's rental.** Included in nursing facility daily rate.
E0181	NU RR	$239.20 $23.92	Pressure pad, alternating with pump; heavy duty. For clients over 250 lbs. **Rental requires prior authorization. Deemed purchased after 1 year's rental.** Included in nursing facility daily rate.
E0182		$261.80	Pump for alternating pressure pad. **Replacement purchase only.** Included in nursing facility daily rate.
E0184		$194.70	Dry pressure mattress. Included in nursing facility daily rate. **Purchase Only.**
E0185	NU RR	$319.86 $31.98	Gel or gel-like pressure pad for mattress. Included in nursing facility daily rate. **Rental requires prior authorization. Deemed purchased after 1 year's rental.**

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0186	NU RR	$203.00 $20.30	Air pressure mattress. **Rental requires prior authorization, purchase does not. For powered pressure reducing mattress see code E0277. Deemed purchased after 1 year's rental.** Included in nursing facility daily rate**.**
E0187		#	Water pressure mattress.
E0190		$30.04	Positioning cushion/pillow/wedge, any shape or size. Included in nursing facility daily rate. **Purchase only.**
E0193		#	Powered air flotation bed (low air loss therapy).
E0194	NU RR	$29,010.00 $96.70/day	Air fluidized bed. **Requires prior authorization or expedited prior authorization. Deemed purchased after 1 year's rental. See Expedited Prior Authorization (EPA), Section G.**
E0196		$324.90	Gel pressure mattress**. Requires prior authorization.** Included in nursing facility daily rate. **Purchase only.**
E0197	NU RR	$221.58 $22.15	Air pressure pad for mattress (standard mattress length and width). Included in nursing facility daily rate. **Rental requires prior authorization. Deemed purchased after 1 year's rental.**
E0198		$188.34	Water pressure pad for mattress, standard mattress length and width. Included in nursing facility daily rate. **Purchase only.**
E0199		$32.05	Dry pressure pad for mattress, standard mattress length and width. **Purchase only.** Included in nursing facility daily rate.
E0250		#	Hospital bed, fixed height, with any type side rails, with mattress.
E0251		#	Hospital bed, fixed height, with any type side rails, without mattress.

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0255		#	Hospital bed, variable height, hi-lo, with any type side rails, with mattress. (see E0292 and E0305 or E0310)
E0256		#	Hospital bed, variable height, hi-lo, with any type side rails, without mattress. (see E0293 and E0305 or E0310)
E0260		#	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress. (see E0294 and E0305 or E0310)
E0261		#	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress. (see E0295 and E0305 or E0310)
E0265		#	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress. (see E0296 and E0305 or E0310)
E0266		#	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress. (see E0297 and E0305 or E0310)
E0270		#	Hospital bed, institutional type includes: oscillating, circulating and Stryker frame, with mattress.
E0271	NU	$222.04	Mattress, inner spring. Included in nursing facility daily rate. Replacement only.
E0272		$191.78	Mattress, foam rubber (replacement only). Included in nursing facility daily rate. **Purchase only.**
E0273		#	Bed board
E0274		#	Over-bed table
E0277	NU RR	$7,552.50 $25.18/day	Powered pressure-reducing air mattress. **Requires prior authorization or expedited prior authorization. See Expedited Prior Authorization (EPA), Section G. Deemed purchased after 1 year's rental.** Included in nursing facility daily rate.

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0280		#	Bed cradle, any type.
E0290		#	Hospital bed, fixed height, without side rails, with mattress.
E0291		#	Hospital bed, fixed height, without side rails, with mattress.
E0292	NU RR	$840.40 $84.04	Hospital bed, variable height, hi-lo, without side rails, with mattress. **Requires prior authorization or expedited prior authorization. Deemed purchased after 1 year's rental.** Included in the nursing facility daily rate. **See Expedited Prior Authorization (EPA), Section G.**
E0293	NU RR	$704.60 $70.46	Hospital bed, variable height, hi-lo, without side rails, without mattress. **Requires prior authorization. Deemed purchased after 1 year's rental.** Included in nursing facility daily rate.
E0294	NU RR	$1,306.50 $130.65	Hospital bed, semi-electric (head and foot adjustments), without side rails, with mattress. **Requires prior authorization or expedited prior authorization. Deemed purchased after 1 year's rental.** Included in nursing facility daily rate. **See Expedited Prior Authorization (EPA), Section G.**
E0295	NU RR	$1,215.70 $121.57	Hospital bed, semi-electric (head and foot adjustments), without side rails, without mattress. **Requires prior authorization. Deemed purchased after 1 year's rental.** Included in nursing facility daily rate.
E0296	NU RR	$1,642.00 $164.20	Hospital bed, total electric (head, foot, and height adjustments), without side rails, with mattress. **Requires prior authorization. Deemed purchased after 1 year's rental.** Included in nursing facility daily rate.

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0297	NU RR	$1,406.70 $140.67	Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress. **Requires prior authorization. Deemed purchased after 1 year's rental.** Included in nursing facility daily rate.
E0300	NU RR	$2,838.62 $283.86	Pediatric crib, hospital grade, fully enclosed. **Requires prior authorization. Deemed purchased after 1 year's rental.** Included in nursing facility daily rate.
E0301		#	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.
E0302		#	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress.
E0303	NU RR	$3,039.80 $10.13/day	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. **Requires prior authorization. Deemed purchased after 1 year's rental.**
E0304	NU RR	$7,706.70 $25.60/day	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress. **Requires prior authorization. Deemed purchased after 1 year's rental.**
E0305	NU RR	$177.90 $17.79	Bedside rails, half length, pair. **Deemed purchased after 1 year's rental.** Included in nursing facility daily rate. **Rental requires prior authorization or expedited prior authorization. See Expedited Prior Authorization (EPA), Section G.**
E0310	NU RR	$194.14 $19.41	Bedside rails, full length, pair. **Deemed purchased after 1 year's rental.** Included in nursing facility daily rate. **Rental requires prior authorization or expedited prior authorization. See Expedited Prior Authorization (EPA), Section G.**

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0315		#	Bed accessory: board, table, or support device, any type.
E0316		$2,030.70	Safety enclosure frame/canopy for use with hospital bed, any type. **Requires prior authorization.** Included in nursing facility daily rate. **Purchase only.**
E0370		#	Air pressure elevator for heel.
E0371	NU RR	$4,447.80 $14.83/day	Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width. **Requires prior authorization or expedited prior authorization. Deemed purchased after 1 year's rental. See Expedited Prior Authorization (EPA), Section G.**
E0372	NU RR	$5,393.40 $17.98/day	Powered air overlay for mattress, standard mattress length and width. **Requires prior authorization or expedited prior authorization. Deemed purchased after 1 year's rental. See Expedited Prior Authorization (EPA), Section G.**
E0373	NU RR	$6,144.70 $20.48/day	Nonpowered advanced pressure reducing mattress. **Requires prior authorization or expedited prior authorization. Deemed purchased after 1 year's rental. See Expedited Prior Authorization (EPA), Section G.**
E2402	RR	$57.21/day	Negative pressure wound therapy electrical pump, stationary or portable. **Rental only. Requires prior authorization.**

Other Patient Room Equipment

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0621		$95.99	Sling or seat, patient lift, canvas or nylon. **Purchase only.** Included in nursing facility daily rate.
E0625		#	Patient lift, Kartop, bathroom or toilet.
E0627		#	Seat lift mechanism incorporated into a combination lift-chair mechanism.
E0628		#	Separate seat lift mechanism for use with patient owned furniture - electric.
E0629		#	Separate seat lift mechanism for use with patient owned furniture - nonelectric.
E0630	NU RR	$1,013.80 $101.38	Patient lift, hydraulic, with seat or sling. **Deemed purchased after 1 year's rental.** Included in nursing facility daily rate. **Rental requires prior authorization.** (Includes bath.)
E0635	NU RR	BR BR	Patient lift, electric, with seat or sling. **Deemed purchased after 1 year's rental.** Included in nursing facility daily rate. **Requires prior authorization.**
E0636		#	Multipositional patient support system, with integrated lift, patient accessible controls.
E0830		#	Ambulatory traction device, all types, each.
E0840		$73.28	Traction frame, attached to headboard, cervical traction. **Purchase only.** Included in nursing facility daily rate.
E0850		$105.06	Traction stand, freestanding, cervical traction. **Purchase only.** Included in nursing facility daily rate.
E0855		#	Cervical traction equipment not requiring additional stand or frame.
E0860		$38.21	Traction equipment, overdoor, cervical. **Purchase only.** Included in nursing facility daily rate.

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0870		$116.31	Traction frame, attached to footboard, simple extremity traction (e.g. Buck's). **Purchase only.** Included in nursing facility daily rate.
E0880		$125.54	Traction stand, freestanding, extremity traction (e.g., Buck's). **Purchase only.** Included in nursing facility daily rate.
E0890		$120.41	Traction frame, attached to footboard, pelvic traction. **Purchase only.** Included in nursing facility daily rate.
E0900		$128.12	Traction stand, freestanding, pelvic traction (e.g., Buck's). **Purchase only.** Included in nursing facility daily rate.
E0910	NU RR	$186.80 $18.68	Trapeze bar, also known as patient helper, attached to bed with grab bar. **Deemed purchased after 1 year's rental.** Included in nursing facility daily rate. **Rental requires prior authorization.**
E0920	NU RR	$426.70 $42.67	Fracture frame, attached to bed. Includes weights. **Deemed purchased after 1 year's rental.** Included in nursing facility daily rate. **Rental requires prior authorization.**
E0930	NU RR	$456.90 $45.69	Fracture frame, freestanding, includes weights. **Deemed purchased after 1 year's rental.** Included in nursing facility daily rate. **Rental requires prior authorization.**
E0940	NU RR	$347.70 $34.77	Trapeze bar, freestanding, complete with grab bar. **Deemed purchased after 1 year's rental.** Included in nursing facility daily rate. **Rental requires prior authorization.**
E0941	NU RR	$369.00 $36.90	Gravity assisted traction device, any type. **Deemed purchased after 1 year's rental.** Included in nursing facility daily rate. **Rental requires prior authorization.**

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0946	NU RR	$591.60 $59.16	Fracture frame, dual with cross bars, attached to bed (e.g., Balken, 4-poster). **Deemed purchased after 1 year's rental.** Included in nursing facility daily rate. **Rental requires prior authorization.**
E0947		$515.49	Fracture frame, attachments for complex pelvic traction. **Purchase only.** Included in nursing facility daily rate.
E0948		$586.59	Fracture frame, attachments for complex cervical traction. **Purchase only.** Included in nursing facility daily rate.
E0972		$46.85	Wheelchair accessory, transfer board or device, each. **Purchase only.** Included in nursing facility daily rate.

Positioning Devices

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0637	NU RR	$2,104.97 $210.49	Combination sit-to-stand system, any size, with seat lift feature, with or without wheels. (includes padded seat, knee support, foot plates, foot straps, formed table and cup holder and hydraulic actuator) **Requires prior authorization. Deemed purchased after one year's rental.** Included in nursing facility daily rate.
E0638		$853.57	Standing frame system, any size, with or without wheels. (includes padding, straps, adjustable armrests, footboard and support blocks.) **Limit of 1 per client every 5 years.** Included in nursing facility daily rate. **Purchase only.**

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E1399	NU	$1,808.00	Durable medical equipment, miscellaneous. (Prone stander, child size (child up to 48" tall). Includes padding, chest and foot straps). **Limit of 1 per client every 5 years**. Included in nursing facility daily rate. **Purchase only.** ***EPA #870000755 must be used when billing this item.*** **See Expedited Prior Authorization (EPA), Section G.**
E1399	NU	$2,156.00	Durable medical equipment, miscellaneous. (Prone stander, youth size (youth up to 58" tall). Includes padding, chest and foot straps). **Limit of 1 per client every 5 years**. Included in nursing facility daily rate. **Purchase only**. ***EPA #870000756 must be used when billing this item.*** **See Expedited Prior Authorization (EPA), Section G.**
E1399	NU	$1,286.40	Durable medical equipment, miscellaneous. (Prone stander, infant size (infant up to 38" tall). Includes padding, chest and foot straps). **Limit of 1 per client every 5 years**. Included in nursing facility daily rate. **Purchase only**. ***EPA #870000757 must be used when billing this item.*** **See Expedited Prior Authorization (EPA), Section G.**
E1399	NU	$1,800.00	Durable medical equipment, miscellaneous. (Prone stander, adult size (adult up to 75" tall). Includes padding, chest and foot straps). **Limit of 1 per client every 5 years**. Included in nursing facility daily rate. **Purchase only**. ***EPA #870000758 must be used when billing this item.*** **See Expedited Prior Authorization (EPA), Section G.**

Noninvasive Bone Growth/Nerve Stimulators

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0720		#	TENS, two lead, localized stimulation.
E0730	NU RR	$370.56 $37.05	Transcutaneous electrical nerve stimulation device, four or more leads, for multiple nerve stimulation. Includes 4 lead wires, 4 electrodes, battery charger and gel. **Requires prior authorization or expedited prior authorization. See Expedited Prior Authorization (EPA), Section G.**
E0731		#	Form-fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)
E0740	NU RR	$522.87 $52.28	Incontinence treatment system, pelvic floor stimulator, monitor, sensor and/or trainer. **Requires prior authorization. Deemed purchased after 1 year's rental.** Included in nursing facility daily rate.
E0744		#	Neuromuscular stimulator for scoliosis
E0745		#	Neuromuscular stimulator, electronic shock unit.
E0746		#	Electromyography (EMG) biofeedback device.
E0747		$3,601.28	Osteogenesis stimulator, electrical noninvasive, other than spinal applications. **Purchase only. Requires prior authorization or expedited prior authorization. See Expedited Prior Authorization (EPA), Section G.**
E0748		$3,577.94	Osteogenesis stimulator, electrical noninvasive, spinal applications. **Purchase only. Requires prior authorization or expedited prior authorization. See Expedited Prior Authorization (EPA), Section G.**
E0749		#	Osteogenesis stimulator, electrical, surgically implanted.
E0752		#	Implantable neurostimulator electrode, each.

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0754		#	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator.
E0755		#	Electronic salivary reflex stimulator (intraoral/noninvasive)
E0756		#	Implantable neurostimulator pulse generator
E0757		#	Implantable neurostimulator radiofrequency receiver
E0758		#	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver.
E0759		#	Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement.
E0760		$2,973.20	Osteogenesis stimulator, low intensity ultrasound, noninvasive. **Purchase only. Requires prior authorization or expedited prior authorization. See Expedited Prior Authorization (EPA), Section G.**
E0761		#	Non-thermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device.
E0765		#	FDA approved nerve stimulator, with replaceable batteries, for treatment of nausea and vomiting.
K0600		#	Functional neuromuscular stimulator, transcutaneous stimulation of muscles of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program.

Communication Devices

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E1902		#	Communication board, non-electronic augmentative or alternative communication device.
E2500		$391.06	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time. **Purchase only. Replaced HCPCS code K0541. Requires prior authorization.**
E2502		$1,195.80	Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time. **Purchase only. Requires prior authorization.**
E2504		$1,577.42	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time. **Purchase only. Requires prior authorization.**
E2506		$2,312.96	Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time. **Purchase only. Requires prior authorization.**
E2508		$3,576.61	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device. **Purchase only. Requires prior authorization.**
E2510		$6,768.25	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access. **Purchase only. Requires prior authorization.**
E2511		#	Speech generating software program, for personal computer or personal digital assistant.
E2512		$416.93	Accessory for speech generating device, mounting system. **Purchase only. Requires prior authorization.**

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E2599		BR	Accessory for speech generating device, not otherwise classified. **Purchase only. Requires prior authorization.**
L8500		$626.11	Artificial larynx, any type. **Purchase only.**

Ambulatory Aids

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
A4635		$5.12	Underarm pad, crutch, replacement, each. Included in nursing facility daily rate. **Purchase only.**
A4636		$4.21	Replacement handgrip, cane, crutch, or walker, each. Included in nursing facility daily rate. **Purchase only.**
A4637		$1.81	Replacement tip, cane, crutch, or walker, each. Included in nursing facility daily rate. **Purchase only.**
E0100		$21.07	Cane; includes canes of all materials; adjustable or fixed, with tip. Included in nursing facility daily rate. **Purchase only.**
E0105		$49.11	Cane, quad or three-prong; includes canes of all materials; adjustable or fixed, with tip. Included in nursing facility daily rate. **Purchase only.**
E0110		$77.59	Crutches, forearm; includes crutches of various materials, adjustable or fixed; complete with tips and handgrips. Included in nursing facility daily rate. **Purchase only.**
E0111		$53.26	Crutches, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrip. Included in nursing facility daily rate. **Purchase only.**

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0112		$37.00	Crutches, underarm, wood, adjustable or fixed, per pair, with pads, tips/handgrips. Included in nursing facility daily rate. **Purchase only.**
E0113		$21.13	Crutch, underarm; wood; adjustable or fixed; each, with pad, tip and handgrip. Included in nursing facility daily rate. **Purchase only.**
E0114		$44.51	Crutches, underarm; other than wood; adjustable or fixed; per pair, with pads, tips and handgrips. Included in nursing facility daily rate. **Purchase only.**
E0116		$23.82	Crutch, underarm; other than wood; adjustable or fixed; each, with pad, tip and handgrip. Included in nursing facility daily rate. **Purchase only.**
E0117		$192.71	Crutch, underarm, articulating, spring assisted, each. **Requires prior authorization. Purchase only.**
E0118		#	Crutch substitute, lower leg platform, with or without wheels, each.
E0130		$70.23	Walker, rigid (pickup), adjustable or fixed height. Included in nursing facility daily rate. **Purchase only.**
E0135		$83.84	Walker; folding (pickup), adjustable or fixed height. Included in nursing facility daily rate. **Purchase only.**
E0140		$360.71	Walker, with trunk support, adjustable or fixed height, any type. Included in nursing facility daily rate**.** **Purchase only.**
E0141		$115.29	Walker, rigid, wheeled, adjustable or fixed height. Included in nursing facility daily rate. **Purchase only.**
E0143		$120.23	Walker, folding, wheeled, adjustable or fixed height. **Purchase only.**
E0144		$318.45	Walker, enclosed, four sided framed, rigid or folding, wheeled with posterior seat. Included in nursing facility daily rate. **Purchase only.**

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0147		$574.81	Walker, heavy duty, multiple braking system, variable wheel resistance. (over 250 lbs) Included in nursing facility daily rate. **Purchase only.**
E0148		$127.05	Walker, heavy duty, without wheels, rigid or folding, any type. (over 250lbs) Included in nursing facility daily rate. **Purchase only.**
E0149		$223.20	Walker, heavy duty, wheeled, rigid or folding, any type. (over 250 lbs) Included in nursing facility daily rate. **Purchase only.**
E0153		$68.68	Platform attachment, forearm crutch, each. Included in nursing facility daily rate. **Purchase only.**
E0154		$70.51	Platform attachment, walker, each. Included in nursing facility daily rate. **Purchase only.**
E0155		$26.83	Wheel attachment, rigid pick-up walker, per pair seat attachment, walker. Included in nursing facility daily rate. **Purchase only.**
E0156		$186.97	Seat attachment, walker. Included in nursing facility daily rate. **Purchase only.**
E0157		$77.27	Crutch attachment, walker, each. Included in nursing facility daily rate. **Purchase only.**
E0158		$32.18	Leg extensions for walker, per set of four (4). Included in nursing facility daily rate. **Purchase only.**
E0159		$17.87	Brake attachment for wheeled walker, replacement, each. Included in nursing facility daily rate. **Purchase only.**

Bathroom Equipment

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0160		#	Sitz-type bath or equipment, portable, used with or without commode.
E0161		#	Sitz-type bath or equipment, portable, used with or without commode, with faucet attachment(s).
E0162		#	Sitz bath chair.
E0163	NU RR	$110.29 $11.02	Commode chair, stationary, with fixed arms. **Deemed purchased after 1 year's rental.** Included in nursing facility daily rate. **Rental requires prior authorization.**
E0164	NU RR	$181.40 $18.14	Commode chair, mobile, with fixed arms. **Deemed purchased after 1 year's rental.** Included in nursing facility daily rate. **Rental requires prior authorization.**
E0165	NU RR	$185.80 $18.58	Commode chair, stationary, with detachable arms. **Deemed purchased after 1 year's rental.** Included in nursing facility daily rate. **Rental requires prior authorization.**
E0166	NU RR	$282.80 $28.28	Commode chair, mobile, with detachable arms. **Deemed purchased after 1 year's rental.** Included in nursing facility daily rate. **Rental requires prior authorization.**
E0167		$12.00	Pail or pan, for use with commode chair. **Included in purchase price of commode.** Included in nursing facility daily rate. **Purchase only.**
E0168	NU RR	$150.92 $15.09	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each. **Rental requires prior authorization. Deemed purchased after 1 year's rental.** Included in nursing facility daily rate.
E0169		#	Commode chair with seat lift mechanism.

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0175		BR	Foot rest, for use with commode chair, each. **Requires prior authorization.** Included in nursing facility per-diem. **Purchase only.**
E0240		#	Bath/shower chair, with or without wheels, any size.
E0241		$48.03	Bathtub wall rail, each. Included in nursing facility daily rate. **Purchase only.**
E0242		$32.60	Bathtub rail, floor base. Included in nursing facility daily rate. **Purchase only.**
E0243		$43.78	Toilet rail, each. Included in nursing facility daily rate. **Purchase only.**
E0244		$105.68	Raised toilet seat. Included in nursing facility daily rate. **Purchase only.**
E0245		$64.00	Tub stool or bench. Included in nursing facility daily rate. **Purchase only.**
E0246	NU	$30.23	Transfer tub rail attachment, each. Included in nursing facility daily rate. **Purchase only.**
E0247		$174.35	Transfer bench for tub or toilet with or without commode opening. Included in nursing facility daily rate. **Purchase only.**
E0248		$247.81	Transfer bench, heavy duty, for tub or toilet with or without commode opening. (over 250 lbs) Included in nursing facility daily rate. **Purchase only.**
E0275		$15.31	Bed pan, standard, metal or plastic. **Purchase only.**
E0276		$11.31	Bed pan, fracture, metal or plastic. **Purchase only.**
E0325		$10.11	Urinal; male, jug-type, any material. **Purchase only.** Included in nursing facility daily rate.
E0326		$10.50	Urinal; female, jug-type, any material. **Purchase only.** Included in nursing facility daily rate.

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0350		BR	Control unit for electronic bowel irrigation/evacuation system. **Requires prior authorization**. Included in nursing facility daily rate. **Purchase only.**
E0352		BR	Disposable pack (water reservoir bag, speculum, valving mechanism and collection bag/box) for use with the electronic bowel irrigation/evacuation system. **Requires prior authorization.** Included in nursing facility daily rate. **Purchase only.**
E0700		$36.00	Safety equipment (e.g., belt, harness or vest). Included in the nursing facility daily rate. **Purchase only.**
E1399	NU	$32.10	Durable medical equipment, miscellaneous. (Bath seat without back). Included in nursing facility daily rate. **Purchase only.** ***EPA #870000766 must be used when billing this item.*** **See Expedited Prior Authorization (EPA), Section G.**
E1399	NU	$33.11	Durable medical equipment, miscellaneous. (Shower, hand-held). Included in nursing facility daily rate. **Purchase only.** ***EPA #870000759 must be used when billing this item.*** **See Expedited Prior Authorization (EPA), Section G.**
E1399	NU RR	$637.21 $63.72	Durable medical equipment, miscellaneous. (Padded or unpadded shower/commode chair, wheeled, with casters). **Deemed purchased after 1 year's rental. Rental requires prior authorization.** Included in nursing facility daily rate. ***EPA #870000771 must be used when billing this item for purchase.*** **See Expedited Prior Authorization (EPA), Section G.**
E1399	NU	$59.12	Durable medical equipment, miscellaneous. (Adjustable bath seat with back). Included in nursing facility daily rate. **Purchase only.** ***EPA #870000772 must be used when billing this item.*** **See Expedited Prior Authorization (EPA), Section G.**

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E1399	NU	$351.20	Durable medical equipment, miscellaneous. (Adjustable bath/shower chair with back, padded seat). Included in nursing facility daily rate. **Purchase only.** ***EPA #870000773 must be used when billing this item*****. See Expedited Prior Authorization (EPA), Section G.**
E1399	NU	$318.40	Durable medical equipment, miscellaneous. (Pediatric bath chair; includes head pad, chest and leg straps). Included in nursing facility daily rate. **Purchase only.** ***EPA #870000774 must be used when billing this item*****. See Expedited Prior Authorization (EPA), Section G.**
E1399	NU	$696.00	Durable medical equipment, miscellaneous. (Youth bath chair, includes head pad, chest and leg straps). Included in nursing facility daily rate. **Purchase only.** ***EPA #870000776 must be used when billing this item.*** **See Expedited Prior Authorization (EPA), Section G.**
E1399	NU	$1,172.00	Durable medical equipment, miscellaneous. (Adult bath chair, includes head pad, chest and leg straps). Included in nursing facility daily rate. **Purchase only.** ***EPA #870000777 must be used when billing this item.*** **See Expedited Prior Authorization (EPA), Section G.**
E1399	NU	$1,000.00	Durable medical equipment, miscellaneous. (Potty chair, child, small/medium. Includes anterior/lateral support, hip strap, adjustable seat/back). **Purchase only.** Included in nursing facility daily rate. ***EPA #870000778 must be used when billing this item.*** **See Expedited Prior Authorization (EPA), Section G.**
E1399	NU	$1,253.75	Durable medical equipment, miscellaneous. (Potty chair, child, large. Includes anterior/lateral support, hip strap, adjustable seat/back). **Purchase only.** Included in nursing facility daily rate. ***EPA #870000779 must be used when billing this item.*** **See Expedited Prior Authorization (EPA), Section G.**

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E1399	NU	$168.99	Durable medical equipment, miscellaneous. (Heavy duty bath chair (for clients over 250 lbs.)). Included in nursing facility daily rate. **Purchase only.** ***EPA #870000767 must be used when billing this item.*** **See Expedited Prior Authorization (EPA), Section G.**

Blood Monitoring

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
A4660		$31.45	Sphygmomanometer/blood pressure apparatus with cuff and stethoscope. **Purchase only.**
A4663		$26.11	Blood pressure cuff only. **Purchase only.**
A4670		$91.56	Automatic blood pressure monitor. **Purchase only.**
E0607		$66.82	Home blood glucose monitor. **Purchase only. Limit of 1 per client, per 3 years.**
E2100		$581.60	Blood glucose monitor with integrated voice synthesizer. **Requires prior authorization. Purchase only. Limit of 1 per client, per 3 years.**
E2101		#	Blood glucose monitor with integrated lancing/blood sample.

Support Devices/Orthotics

See the Prosthetics and Orthotics Billing Instructions for Support Devices/Orthotics Codes

Miscellaneous Durable Medical Equipment

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0202	RR	$6.19/day	Phototherapy (bilirubin) light with photometer. **Rental only. Includes all supplies. Limit of five days of rental per client per 12-month period.**
E0602		$30.39	Breast pump, manual, any type. **Purchase only.**
E0603	RR	$2.79/per day	Breast pump, electric, AC and/or DC, any type. **Rental only. Requires prior authorization or expedited prior authorization. See Expedited Prior Authorization (EPA), Section G.**
E0604	RR	$2.79/per day	Breast pump, heavy duty, hospital grade, piston operated, pulsatile vacuum suction/release cycles, vacuum regulator, supplies, transformer, electric, AC and/or DC. **Rental only. Requires prior authorization or expedited prior authorization. See Expedited Prior Authorization (EPA), Section G.**
E0650	NU RR	$720.22 $72.02	Pneumatic compressor, nonsegmental home model. **Deemed purchased after 1 year's rental.** Included in nursing facility daily rate. **Rental requires prior authorization or expedited prior authorization. See Expedited Prior Authorization (EPA), Section G.**
E0651		#	Pneumatic compressor, segmental home model without calibrated gradient pressure.
E0652		#	Pneumatic compressor, segmental home model with calibrated gradient pressure.
E0655		$107.92	Extremity sleeve: nonsegmental pneumatic appliance for use with pneumatic compressor, half arm. **Purchase only.**
E0660		$159.75	Extremity sleeve: nonsegmental pneumatic appliance for use with pneumatic compressor, full leg. **Purchase only.**

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0665		$126.87	Extremity sleeve: nonsegmental pneumatic appliance for use with pneumatic compressor, full arm. **Purchase only.**
E0666		$138.08	Extremity sleeve: nonsegmental pneumatic appliance for use with pneumatic compressor, half leg. **Purchase only.**
E0667		#	Segmental pneumatic appliance for use with pneumatic compressor, full leg
E0668		#	Segmental pneumatic appliance for use with pneumatic compressor, full arm
E0669		#	Segmental pneumatic appliance for use with pneumatic compressor, half leg
E0671		#	Segmental gradient pressure pneumatic appliance, full leg.
E0672		#	Segmental gradient pressure pneumatic appliance, full arm.
E0673		#	Segmental gradient pressure pneumatic appliance, half leg.
E0675		#	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system).
E0691		#	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area two square feet or less
E0692		#	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, four foot panel.
E0693		#	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, six foot panel.

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0694		#	Ultraviolet multidirectional light therapy system in six foot cabinet, includes bulbs/lamps, timer and eye protection.
E0701		$153.35	Helmet with face guard and soft interface material, prefabricated. **Limit of two per client per year.** Included in nursing facility daily rate. **Purchase only.**
E0710		#	Restraint, any type (body, chest, wrist or ankle)
E0935	RR	$14.49/day	Passive motion exercise device, complete. **Rental allowed for maximum of 10 days.** Includes continuous passive motion soft goods kit. **Requires prior authorization or expedited prior authorization. See Expedited Prior Authorization (EPA), Section G.**
E1300		#	Whirlpool, portable (overtub type)
E1310		#	Whirlpool, nonportable (built-in type)
E1399	NU	$35.45	Durable medical equipment, miscellaneous. (Breast pump kit, electric). **Purchase only. *EPA #870000764 must be used when billing this item.* See Expedited Prior Authorization (EPA), Section G.**
E2000	RR	$51.83	Gastric suction pump, home model, portable or stationary, electric. **Rental only. Requires prior authorization.**
K0606		#	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type.
K0607		#	Replacement battery for automated external defibrillator, garment type only, each.
K0608		#	Replacement garment for use with automated external defibrillator, each.
K0609		#	Replacement electrodes for use with automated external defibrillator, garment type only, each.

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
T5001	NU RR	$640.74 $64.07	Positioning seat for persons with special orthopedic needs, for use in vehicles (5 years and older). **Rental and less than 5 years of age require prior authorization.** Included in nursing facility daily rate.

Other Charges for DME Services

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0200		#	Heat/Cold Application. Heat lamp, without stand (table model), includes bulb, or infrared element.
E0203		#	Therapeutic lightbox, minimum 10,000 lux, table top model
E0205		#	Heat lamp, with stand, includes bulb, or infrared element
E0210		#	Electric heat pad, standard.
E0215		#	Electric heat pad, moist.
E0217		#	Water circulating heat pad with pump.
E0218		#	Water circulating cold pad with pump.
E0220		#	Hot water bottle
E0221		#	Infrared heating pad system.
E0225		#	Hydrocollator unit, includes pads.
E0230		#	Ice cap or collar

HCPCS Code	Modifier	October 1, 2004 Maximum Allowable	Description
E0231		#	Non-contact wound warming device (temperature control unit, AC adapter and power cord) for use with warming card and wound cover.
E0232		#	Warming card for use with the non-contact wound warming device and non-contact wound warming wound cover.
E0235		#	Paraffin bath unit, portable (see medical supply code A4265 for paraffin)
E0236		#	Pump for water circulating pad.
E0238		#	Nonelectric heat pad, moist.
E0239		#	Hydrocollator unit, portable.
E0249		#	Pad for water circulating heat unit.
E1340		$17.43	Labor, other DME repairs (other than wheelchairs), per quarter hour. (Trouble shooting, delivery, evaluations, travel time, etc. are included in the reimbursement of the items). **Requires prior authorization. For client-owned equipment only.**
E1399	NU RR	BR BR	Durable medical equipment, miscellaneous. (Other nonlisted durable medical equipment not otherwise listed). **Provide complete description including copy of manufacturer's product information and price catalog with request for authorization. Requires prior authorization.**

Please discard pages J.27-J.30 in your current billing instructions.

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

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[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  - ✓ The provider fails to meet these listed requirements; and
  - ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

Exception: If billing Medicare Part B crossover claims, bill the amount submitted to Medicare.

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM name in field 17 on the HCFA-1500 claim form; and
- Enter the seven-digit, MAA-assigned identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

How do I bill for clients who are eligible for Medicare and Medical Assistance?

If a client is eligible for both Medicare and Medical Assistance (otherwise known as "dual-eligible"), **you must first submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claim (see page K.1).
- Codes billed to MAA must match codes billed to Medicare when billed as a Medicare Part B crossover claim.

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do not submit paid lines with denied lines. This could cause a delay in payment or a denial.

- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment or a denial.

- If Medicare denies a service that requires prior authorization by MAA, MAA will waive the prior authorization requirement but will still require authorization. Authorization or denial of your request will be based upon medical necessity.

☞ **Note:**

✓ Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.
✓ A Medicare Remittance Notice or EOMB must be attached to each claim.

Payment Methodology – Part B

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, we use Medicare's allowed amount.)

- Medicare's payment is deducted from the amount selected above.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.

- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

1) The provider accepts assignment; and

2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical Identification card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA *Remittance and Status Report* for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA *Remittance and Status Report* showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the *Comments* field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on MAA's website at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records must be kept? (Refer to WAC 388-502-0020)

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome;
  - ✓ Specific claims and payments received for services; and
  - ✓ Any specifically required forms for the provision of DME.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.
(Refer to WAC 388-502-0020[2])

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

General Guidelines:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

- **Do not use red ink pens, highlighters, "post-it notes," or stickers** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. Make sure ink is not too light or faded.

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field **Description/Instructions**

1a. **Insured's I.D. No.**: Required. Enter the MAA Patient (client) Identification Code (PIC). This information is obtained from the client's current monthly Medical Identification card and consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d) An alpha or numeric character (tie breaker).

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.
3. A PIC for Mary C. Johnson's newborn baby would look like this: MC010667JOHNSB and would show a **B** indicator in *field 19.*

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: When applicable, enter the referring physician or Primary Care Case Manager name.

17a. **I.D. Number of Referring Physician**: When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

19. **Reserved For Local Use**: When applicable, enter indicator **B** to indicate *Baby on Parent's PIC*. Please specify *twin A or B, triplet A, B, or C* here. **If you have more than one EPA number to bill, place both numbers here.**

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4. A valid ICD-9-CM code will be required.

22. **Medicaid Resubmission**: When applicable. If the billing is resubmitted beyond the 365-day billing time limit, you must enter the ICN to verify that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

23. **Prior Authorization/EPA Number**: When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

MAA does not accept "continued" claim forms. Each claim form must be totaled separately.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403). **Do not use slashes, dashes, or hyphens to separate month, day, year.**

24B. **Place of Service**: Required. These are the only appropriate code(s) for this billing instruction:

Code Number	To Be Used For
04	Homeless shelter
12	Client's residence
13	Assisted living facility
14	Group home
31	Nursing facility
32	Nursing facility
99	Other

24C. **Type of Service**: Not Required.

24D. **Procedures, Services or Supplies HCPCS**: Required. Enter the appropriate Centers for Medicare and Medicaid (CMS) (formerly known as HCFA) Common Procedure Coding System (HCPCS) procedure code for the services being billed.
MODIFIER: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM. A valid ICD-9-CM code is required. MAA no longer allows the use of an unspecified/dummy diagnosis code such as V58.9.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units (up to 999) for each line. These figures must be whole units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

MAA does not accept "continued" claim forms. Each claim form must be totaled separately.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

P.I.N. #: Required. Enter the individual provider number assigned to you by MAA.

PLEASE DO NOT STAPLE IN THIS AREA

SAMPLE

PRIOR AUTHORIZATION REQUEST

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): PT 071342 SMITH A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, PAT

3. PATIENT'S BIRTH DATE MM 07 DD 13 YY 42 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): PO BOX 17

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☒ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DR JOHNSON

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 8888888

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 436 .
2. .
3. .
4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 354912345

PHYSICIAN OR SUPPLIER INFORMATION

24.	A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	10	01	03	07	01	03	12		K0004	NU	436	91200	1				
2	10	01	03	07	01	03	12		K0055		436	11800	1				
3	10	01	03	10	01	03	12		K0015		436	12600	1				
4	10	01	03	10	01	03	12		K0048		436	29200	1				
5	10	01	03	10	01	03	12		K0108		436	11300	1				
6																	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. $ TOTAL CHARGE: 156100

29. $ AMOUNT PAID

30. $ BALANCE DUE: 156100

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

ANYTOWN DME
206-555-1111

PIN# 9200000 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

SAMPLE

WHEELCHAIR PURCHASE

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): PT 071342 SMITH A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, PAT

3. PATIENT'S BIRTH DATE MM 07 DD 13 YY 42 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): PO BOX 17

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ ***If yes***, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DR JOHNSON

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 8888888

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 436 . __
2. ____ . __
3. ____ . __
4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 354912345

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10	01	03	07	01	03	12		K0011	NU	436	500000	1				
2			07													
3																
4																
5												1				
6																

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. $ TOTAL CHARGE: 500000

29. $ AMOUNT PAID

30. $ BALANCE DUE: 500000

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

ANYTOWN DME
206-555-1111

PIN# 9200000 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

SAMPLE

WITH EXPEDITED PRIOR AUTHORIZATION

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): PT 071342 SMITH A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, PAT

3. PATIENT'S BIRTH DATE MM 07 DD 13 YY 42 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): PO BOX 17

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DR JOHNSON

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 8888888

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE: LINE 1: 870000725/LINE 2: 870000759

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 436 . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10	01	03	07	31	03	12		E0294	RR	436	21000	1				
2 10	01	03	07	01	03	12		E1399		436	3500	1				
3																
4																
5												1				
6																

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. $ TOTAL CHARGE: 24500

29. $ AMOUNT PAID

30. $ BALANCE DUE: 24500

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

ANYTOWN DME
206-555-1111

PIN# 9200000 GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Common Questions Regarding Medicare Part B/ Medicaid Crossover Claims

Q: Why do I have to mark "XO," in box 19 on crossover claim?

A: The "XO" allows our mailroom staff to identify crossover claims easily, ensuring accurate processing for payment.

Q: What fields do I use for HCFA-1500 Medicare information?

A:

In Field:	Please Enter:
19	an "XO"
24K	Medicare's allowed charges
29	Medicare's total deductible
30	Medicare's total payment
32	Medicare's EOMB process date, and the third-party liability amount

Q: When I bill Medicare denied lines to MAA, why is the claim denied?

A: Your bill is not a crossover when Medicare denies your claim or if you are billing for Medicare-denied lines. The Medicare EOMB must be attached to the claim. Do not indicate "XO."

Q: How do my claims reach Medicaid after I've sent them to Medicare?

A: After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to MAA for any supplemental Medicaid payment. When the remarks code is, *"MA07-The claim information has also been forwarded to Medicaid for review*," it means that your claim has been forwarded to MAA.

Q: What if my claim(s) does not appear on the RA?

A: If **Medicare has paid** and the Medicare crossover claim does not appear on the MAA Remittance Advice and Status Report (RA) within 45 days of the Medicare statement date, you should bill MAA the *paid lines* on the HCFA-1500 claim form **with** an "XO" in box 19.

If **Medicare denies** a service, bill MAA the *denied lines*, using the HCFA-1500 claim form **without** an "XO" on the claim.

REMEMBER! Attach a copy of Medicare's EOMB.

REMEMBER! You must submit your claim to MAA within six months of the Medicare statement date if Medicare has **paid** or 365 days from date of service if Medicare has **denied**.

Note: Claims billed to MAA with payment by Medicare must be submitted with the same procedure code used to bill Medicare.

How to Complete the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

General Guidelines:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

- **Do not use red ink pens, highlighters, "post-it notes," or stickers** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. Make sure ink is not too light or faded.

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be billed electronically.

FIELD DESCRIPTION

1a. **Insured's I.D. No.**: Required. Enter the MAA Patient Identification Code (PIC). This information is obtained from the client's current monthly Medical Identification card and consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- ✓ Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

19. **Reserved For Local Use - Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission**: When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403). **Do not use slashes, dashes, or hyphens to separate month, day, or year (MMDDYY).**

24B. **Place of Service**: Required. These are the only appropriate code(s) for this billing instruction:

Code Number	To Be Used For
04	Homeless shelter
12	Client's residence
13	Assisted living facility
14	Group home
31	Nursing facility
32	Nursing facility
99	Other

24C. **Type of Service**: Not Required.

24D. **Procedures, Services or Supplies HCPCS**: Required. Enter the appropriate Centers for Medicare and Medicaid (CMS) (formerly known as HCFA) Common Procedure Coding System (HCPCS) procedure code for the services being billed.
MODIFIER: When appropriate enter a modifier.

24E. **Diagnosis Code**: Enter appropriate diagnosis code for condition.

24F. **$ Charges**: Required. **Enter the amount you billed Medicare for the service performed.** If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. **Days or Units**: Required. Enter the number of units billed and paid for by Medicare.

24K. **Reserved for Local Use**: Required. Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **Accept Assignment**: ***Required***. Check **yes.**

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. **Balance Due**: Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **Name and Address of Facility Where Services Are Rendered**: Required. Enter Medicare Statement Date ***and*** any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required.

P.I.N. #: Required. Enter the individual provider number assigned to you by MAA.

PLEASE DO NOT STAPLE IN THIS AREA

SAMPLE

APPROVED OMB-0938-0008

MEDICARE PART B CROSSOVER
(DO NOT FORGET TO ATTACH MEDICARE'S EOMB)

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): PT 071342 SMITH A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, PAT

3. PATIENT'S BIRTH DATE MM 07 DD 13 YY 42 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): PO BOX 17

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE: XO

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07	01	03	07	31	03	12		E0260	RR	436	12013	1				120.13
2 07	01	03	07	31	03	12		K0004	RR	436	9560	1				95.60
3																
4																
5												1				
6																

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. $ TOTAL CHARGE 21573

29. $ AMOUNT PAID 4314

30. $ BALANCE DUE 17259

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

9/01/03

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

ANYTOWN DME
206-555-1111

PIN# 9200000 GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Appendix A [Refer to WAC 388-543-2100]

Reimbursement Methodology for Wheelchairs

1. The Medical Assistance Administration (MAA) reimburses a Durable Medical Equipment (DME) provider for purchased wheelchairs for a home or nursing facility client based on the specific brand and model of wheelchair dispensed. MAA decides which brands and/or models of wheelchairs are eligible for reimbursement based on all of the following:

   a) The client's medical needs;
   b) Product quality;
   c) Cost; and
   d) Available alternatives.

2. For wheelchair rentals and wheelchair accessories (e.g., cushions and backs), MAA uses either:

   a) The Medicare fees that are current on April 1 of each year; or

   b) MAA's maximum allowable reimbursement is based on a percentage of the manufacturer's list price in effect on January 31 of the base year, or the invoice for the specific item. MAA uses the following percentages:

      i) For basic standard wheelchairs, sixty-five percent;
      ii) For add-on accessories and parts, eighty-four percent;
      iii) For upcharge modifications and cushions, eighty percent;
      iv) For all other manual wheelchairs, eighty percent; and
      v) For all other power-drive wheelchairs, eighty-five percent.

4. MAA determines rental reimbursement for categories of manual and power-driven wheelchairs based on average market rental rates or Medicare rates.

5. MAA evaluates and updates the wheelchair fee schedule once per year.

6. MAA implements wheelchair rate changes on April 1 of the base year, and the rates are effective until the next rate change.

Appendix B [Refer to WAC 388-543-2500]

Reimbursement Methodology for Other DME

1. MAA establishes reimbursement rates for purchased other DME.

   a) For other durable medical equipment that have a Medicare rate established for a new purchase, MAA uses the rate that is in effect on January first of the year in which MAA sets the reimbursement.

   b) For other durable medical equipment that do not have a Medicare rate established for a new purchase, MAA uses a pricing cluster to establish the rate.

2. Establishing a pricing cluster and reimbursement rates.

   a) In order to make up a pricing cluster for a procedure code, MAA determines which brands/models of other DME its clients most frequently use. MAA obtains prices for these brands/models from manufacturer catalogs or commercial databases. MAA may change or otherwise limit the number of brands/models included in the pricing cluster, based on the following:

      i. Client medical needs;
      ii. Product quality;
      iii. Introduction of new brands/models;
      iv. A manufacturer discontinuing or substituting a brand/model; and/or
      v. Cost.

   b) If a manufacturer list price is not available for any of the brands/models used in the pricing cluster, MAA calculates the reimbursement rate at the manufacturer's published cost to providers plus a 35 percent mark-up.

c) For each brand used in the pricing cluster, MAA discounts the manufacturer's list price by 20 percent.

i. If six or more brands/models are used in the pricing cluster, MAA calculates the reimbursement rate at the 17th percentile of the pricing cluster.

ii. If five brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the fourth highest discounted list price, as described in 2b on page 2.

iii. If four brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the third highest discounted list price, as described in 2b on page 2.

iv. If three brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the third highest discounted list price, as described in 2b on page 2.

v. If two or fewer brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the highest discounted list price, as described in 2b on page 2.

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