

**Policy is terminated because coverage is provided under the
combined Medicaid and Health Choice 5A, Durable Medical
Equipment and Supplies**

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**Division of Medical Assistance
Durable Medical Equipment
and Supplies**

**NCHC Policy No.: 2011.09
Original Effective Date: July 1, 2010
Date of Termination: April 1, 2013**

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1.0 Description of the Procedure, Product, or Services

1.1 Durable Medical Equipment and Supplies

Medical equipment requirements are:

- a. Can withstand repeated use;
- b. Is primarily and customarily used to serve a medical purpose;
- c. Is not useful to a recipient in the absence of an illness or injury;
- d. Is appropriate for use in the home (For the purpose of this policy home includes a private residence or adult care home); and
- e. Is intended to be used by only one recipient.

All requirements above must be met before an item can be considered medical equipment.

Medical supplies are non-durable supplies that:

- a. Are disposable, consumable, and non-reusable in nature;
- b. Cannot withstand repeated use by more than one recipient;
- c. Are primarily and customarily used to serve a medical purpose;
- d. Are not useful to a recipient in the absence of illness or injury;
- e. Are ordered or prescribed by a physician, physician assistant, or nurse practitioner.

1.2 Categories of Durable Medical Equipment and Supplies

Durable Medical Equipment and Supplies refers to the following categories of equipment and related supplies for use in a recipient's home:

- a. **Inexpensive or Routinely Purchased:**
These items are purchased for a recipient.
- b. **Capped Rental or Purchased Equipment:**
These items are rented or purchased as follows:
 1. The item is **rented** if the physician, physician assistant, or nurse practitioner documents that the anticipated need is six months or less.
 2. The item may be **rented** or **purchased** if the physician, physician assistant, or nurse practitioner documents that the anticipated need exceeds six months. Once rental is initiated on an item, a subsequent request for prior approval of purchase of that item will be denied. The item becomes the property of the recipient when the accrued rental payments reach NCHC's allowable purchase price.
- c. **Equipment Requiring Frequent and Substantial Servicing:**
These items are rented. Oxygen and items dealing with oxygen delivery are in this category.

d. **Related Medical Supplies:**

Supplies are covered when they are provided for use with medical equipment owned by the recipient.

e. **Service and Repair:**

The service and repair of medical equipment owned by a recipient is covered over the useful life of the item. Refer to **Subsection 5.8, Servicing and Repairing Medical Equipment**, for additional information.

f. **Individually Priced Items:**

These items are reviewed on an individual basis and manually priced.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NC Health Choice (NCHC) recipients must be enrolled on the date of service. All NCHC recipients are eligible for Durable Medical Equipment and Supplies, subject to the limitations listed in **Section 5.0, Requirements for and Limitations on Coverage**.

3.0 When the Procedure, Product, or Services Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

The medical equipment and related supplies listed on the **Medicaid Durable Medical Equipment Fee Schedule** are covered when the item is medically necessary and appropriate for use in a recipient's home where the recipient resides. The fee schedule is available on DMA's Web site at <http://www.ncdhhs.gov/dma/fee/>.

Refer to **Subsection 1.1** for description of Durable Medical Equipment and Supplies. NCHC covers an item when medically necessary to maintain or improve a recipient's medical, physical, or functional level within the recipient's home. This medical need must be verified by the recipient's physician, physician assistant, or nurse practitioner.

Refer to **Subsection 5.3, Documenting Medical Necessity**, for specific coverage requirements.

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

NCHC shall not cover convenience items or features.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

Some Durable Medical Equipment and Supplies require prior approval. Items that require prior approval are identified on the Medicaid Durable Medical Equipment Fee Schedule by an asterisk (*). The fee schedule is available on DMA's Web site at <http://www.ncdhhs.gov/dma/fee/>.

Prior approval is valid for the time period approved on the Certificate of Medical Necessity/Prior Approval (CMN/PA) form. If a physician, physician assistant, or nurse practitioner decides that an item is needed for a longer period of time, a new CMN/PA form must be submitted.

Capped rental items have restrictions on the length of rental. Refer to **Subsection 1.2**, for information on capped rental items.

5.2 Prior Approval Requirements

Refer to **Attachment B, Completing the Certificate of Medical Necessity/Prior Approval Form (CMN/PA)**, for general instructions on completing the CMN/PA form. Refer to **Subsection 5.3, Documenting Medical Necessity**, for information on documenting medical necessity requirements for specific Durable Medical Equipment and Supplies.

5.3 Documenting Medical Necessity

Refer to **Attachment A: Claims Related Information, Section C, Procedure Codes** for a list of the HCPCS codes covered by NCHC and for the life expectancy and quantity limitations for each code.

Medical necessity must be documented by the MD, PA, NP for every item provided/billed regardless of any requirements for approval. A letter of medical necessity written and signed by the MD, PA, NP, or other licensed professional permitted to perform those tasks and responsibilities by their NC state licensing board, may be submitted along with the CMN/PA.

Note: the CMN/PA still must be completed and signed by the MD, PA, or NP. Refer to **Attachment B “Completing the CMN/PA.”**

5.3.1 Hospital Beds, Pediatric Beds and Related Supplies

All Hospital Beds require prior approval. They are covered by NCHC when they are medically necessary for the recipient:

- a. A **Fixed Height Hospital Bed** is medically necessary when one of the following is documented:
 1. The recipient’s condition requires positioning of the body (e.g., to alleviate pain, promote good body alignment, prevent contractures, and avoid respiratory infections) in ways not feasible in an ordinary bed; or
 2. The recipient’s condition requires special attachments that cannot be attached to and used on an ordinary bed.
- b. A **Variable Height Hi-Lo Hospital Bed** is medically necessary when one of the following is documented:
 1. The recipient’s condition requires positioning of the body to alleviate pain, promote good body alignment, prevent contractures, and avoid respiratory infections, etc, in ways not feasible in an ordinary bed; or
 2. The variable height feature is necessary for the recipient to ambulate and transfer in and out of bed.
- c. A **Semi-Electric Hospital Bed** with electric-powered adjustments to lower and raise head and foot is medically necessary when the following is documented:
 1. The recipient’s condition requires frequent change in body position; and
 2. There is an immediate need for a change in position and the recipient can operate the controls independently and make the adjustments.
- d. A **Total Electric Hospital Bed** with electric-powered adjustments to lower and raise head and foot is medically necessary when the following is documented:
 1. The recipient’s condition requires frequent change in body position; or
 2. There may be an immediate need for a change in position; and
 3. The recipient can operate the controls and make the adjustments; and
 4. The variable height feature must be medically justified.
- e. An **Oversized Hospital Bed and Replacement Innerspring Mattress** are medically necessary when all of the following criteria are met:
 1. Documentation submitted shows the recipient meets the medical necessity requirements for the comparable standard size equipment and the medical need for the oversized equipment;
 2. The recipient’s height, weight, and body measurements are included on the CMN/PA form and meet the weight requirements specified in the HCPCS code requested. The body measurements must be taken in the appropriate position for the requested equipment (i.e. supine for hospital beds); and

3. The dimensions of the requested equipment and the manufacturer's specified weight capacity for the equipment are included on the CMN/PA form.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, Hospital Beds and Related Supplies.**

Pediatric Beds

Pediatric Cribs, Pediatric Hospital Beds, and Safety Enclosures require prior approval and are covered when the recipient's diagnosis and medical condition deem it medically necessary. For prior approval one of the following criteria must be met:

- a. Documentation from the physician, physician assistant or nurse practitioner includes an order for the hospital grade crib, safety enclosure, or related supplies and documents that this is the most appropriate, medically necessary bed for the recipient.
- b. The recipient's condition requires positioning of the body (e.g., to alleviate pain, promote good body alignment, prevent contractures, avoid respiratory infections) in ways not feasible in an ordinary bed or crib.
- c. The recipient's condition requires a bed or crib with special attachments that cannot be attached to and used on an ordinary bed.

Pediatric Specialty Beds are beds, such as the *SleepSafe* or *Pedicraft* bed, that have special safety features that prevent entrapment or falls. These beds are designed for children with physical and cognitive disabilities who require a safe enclosed padded interior that allows quick and easy access for frequent or sudden medical attention. These beds and accessories are covered when the recipient's diagnosis and medical condition deem it medically necessary. Prior approval is required. For prior approval all of the following criteria must be met:

- a. Pediatric beds are deemed to be medically necessary when all the following criteria are met:
 1. Documentation from the physician, physician assistant or nurse practitioner includes an order for the hospital grade crib, safety enclosure, pediatric specialty bed or related supplies and documents that this is the most appropriate, medically necessary bed for the recipient;
 2. The diagnosis and medical condition of the recipient must support the need for the additional features these beds offer, for example severe spasticity, thrashing or uncontrolled movements, cognitive impairment, unsafe activities or behaviors which place the recipient at risk for injury and make the use of a specialty bed necessary;
 3. A letter of medical necessity or clinical evaluation from a physical therapist or occupational therapist involved in the care of the recipient that includes:
 - A. The specific detail to show how the requested equipment is medically necessary for the recipient; and

- B. An explanation of why a regular bed or a hospital bed with rails and rail pads does not meet the recipient's needs. This includes a description of other less expensive specialty beds that were considered and ruled out and why they were ruled out.

Note: The physical therapist or occupational therapist completing the letter of medical necessity and evaluation cannot be employed by or have a financial relationship with the medical equipment provider.

4. The home environment supports the use of a hospital grade crib, safety enclosure, or pediatric specialty bed and related supplies. Documentation must be included to demonstrate suitability in the home and utilization for the recipient; and
5. Documentation that the family or caregiver is willing and able to safely and appropriately use the equipment.

Hospital grade cribs, safety enclosures, and pediatric specialty beds are not considered medically necessary when used for caregiver convenience, behavior therapy, physical restraint, as a substitute for appropriate parental or caregiver supervision, or when a regular bed meets the needs of the recipient.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, Pediatric Beds and Cribs.**

Hospital Bed Related Supplies

The following items **do not** require prior approval:

- a. A **Replacement Mattress or Side Rails** for a hospital bed is covered when both of the following criteria are met:
 1. There is evidence that the mattress or side rails is worn out or broken and must be replaced; and
 2. Continued use of an approved recipient-owned hospital bed is medically necessary.
- b. A **Trapeze Bar** is covered when the recipient requires the accessory to reposition himself or herself in an approved hospital bed.
- c. A **Traction Frame** is covered when the recipient requires traction for a specific orthopedic diagnosis and the equipment is ordered by a physician for use with an approved hospital bed.
- d. A **Bed Pan or Urinal** is covered when the recipient is unable to move from the bed to the bathroom or bedside commode for elimination.
- e. A **Bed Cradle** is covered if the recipient requires protection of a body part from topical pressure.

The following items **do** require prior approval

- a. A **Heavy Duty Trapeze Bar** is covered when the recipient requires the accessory to reposition himself in an approved hospital bed and meets the weight requirement specified for the heavy duty trapeze bar. The recipient's weight must be stated on the CMN/PA form. Prior approval is required.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Hospital Beds and Related Supplies***.

5.3.2 Pressure-Reducing Support Surfaces—Group 1

Group I Pressure-Reducing Support Surfaces including an alternating pressure pad, pressure reducing mattress overlay, or air or gel pressure pad are covered by NCHC when they are medically necessary for the recipient.

These pressure-reducing support surfaces do not require prior approval, but documentation of medical necessity must be completed and maintained in the provider's records according to the guidelines listed in **Subsection 7.2, Record Keeping**.

Group I **Overlays or Mattresses** are covered when the recipient meets one of the following criteria:

- a. The recipient is completely immobile, i.e. cannot make changes in body position without assistance, or
- b. The recipient has limited mobility, i.e. cannot independently make changes in body position significant enough to alleviate pressure, and has one of the following:
 1. impaired nutritional status;
 2. fecal or urinary incontinence;
 3. altered sensory perception;
 4. compromised circulatory status; or
 5. inability to respond to pain.
- c. The recipient has any stage pressure ulcer on the trunk or pelvis and has one of the following conditions:
 1. impaired nutritional status;
 2. altered mental status;
 3. fecal or urinary incontinence;
 4. altered sensory perception; or
 5. a compromised circulatory status.

Note: The staging of pressure ulcers used in this policy is as follows:

Stage I nonblanchable erythema of intact skin

Stage II partial-thickness skin loss involving epidermis, dermis, or both

Stage III full-thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia

Stage IV full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures

Note: A foam overlay or mattress that does not have a waterproof cover is not considered durable and therefore non-covered.

All Group 1 Support Surfaces must be rented when the anticipated need for the item is six months or less, except for the **Replacement Pad for use with medically necessary alternating pressure pad owned by recipient** and the **Dry Pressure Pad for Mattress, standard mattress length and width**; which are purchase-only items. The Group I Support Surfaces may be rented or purchased when the physician, physician assistant, or nurse practitioner documents that the anticipated need exceeds six months.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, Pressure Reducing Support Surfaces – Group I.**

5.3.3 Pressure-Reducing Support Surfaces—Group 2

Group 2 Pressure-Reducing Support Surfaces, including a powered air flotation bed, powered pressure-reducing air mattress, or pressure reducing overlay, are covered by NCHC when they are medically necessary for the recipient:

Prior approval is required for all Group 2 support surfaces. Initial approval is given for a maximum of 3 months.

For initial approval, the recipient shall meet one of the conditions listed below:

- a. The recipient has the following:
 1. multiple Stage II pressure ulcers (ulcers with partial-thickness skin loss involving epidermis, dermis, or both) located on the trunk or pelvis; and
 2. the ulcers have worsened or remained the same over the past month; and
 3. the recipient has been on a comprehensive ulcer treatment program for at least the past month, which has included the use of an appropriate Group 1 support surface. Comprehensive ulcer treatment includes the following:
 - A. education of the recipient and caregiver on the prevention and management of pressure ulcers;
 - B. regular assessment by a physician, physician assistant, nurse practitioner, or other licensed healthcare practitioner (usually at least weekly for a recipient with a Stage III or IV ulcer);
 - C. appropriate turning and positioning;
 - D. appropriate wound care (for a Stage II, III, or IV ulcer);
 - E. appropriate management of moisture or incontinence; and
 - F. nutritional assessment and intervention consistent with the overall plan of care.
- b. The recipient has large or multiple Stage III or IV pressure ulcer(s) on the trunk or pelvis.

Note: The staging of pressure ulcers used in this policy is as follows:

Stage I nonblanchable erythema of intact skin

Stage II partial-thickness skin loss involving epidermis, dermis, or both

Stage III full-thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia

Stage IV full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures

- c. The recipient has a recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 calendar days) and has been on a Group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 calendar days).

Prior approval renewals will be given for a maximum of three months. The documentation requirements for continued renewal of prior approval are the same as those stated above for initial approval. Continued use of a Group 2 support surface is covered until the ulcer(s) is healed. If healing does not continue, there must be additional documentation in the clinical health care record to show:

- a. Other aspects of the care plan are being modified at least every four weeks to promote healing; and
- b. Use of the Group 2 support surface is medically necessary for wound management.

All items are rented and only become the property of the recipient when the monthly rental payments reach the purchase price.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, Pressure Reducing Support Surfaces – Group 2.**

5.3.4 Pressure-Reducing Support Surfaces—Group 3

An air fluidized bed combines air fluidized therapy and low air-loss therapy on an articulating frame providing recipient with maximum relief from bed pressure. An air fluidized bed is covered by NCHC when it is medically necessary for the recipient.

Prior approval is required. For initial approval, the recipient shall meet all the following criteria:

- a. The recipient has a Stage III (full thickness tissue loss) or Stage IV (deep tissue destruction) pressure sore, or is status post-op muscle/skin flap repair of a stage III or IV pressure sore;

Note: The staging of pressure ulcers used in this policy is as follows:

Stage I nonblanchable erythema of intact skin

Stage II partial-thickness skin loss involving epidermis, dermis, or both

Stage III full-thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia

Stage IV full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures

- b. The recipient is bedridden or chair bound as a result of severely limited mobility;
- c. The air-fluidized bed is prescribed in writing by the recipient's attending physician based upon a comprehensive assessment of the recipient after conservative treatment has been tried without success. Conservative treatment includes all of the following:
 - 1. education of the recipient and caregiver on the prevention and management of pressure ulcers;
 - 2. assessment by a physician, physician assistant, nurse; practitioner, or other licensed healthcare practitioner done at least weekly
 - 3. turning and positioning;
 - 4. use of a Group II support surface, if appropriate;
 - 5. topical wound care;
 - 6. management of moisture or incontinence; and
 - 7. nutritional assessment and intervention consistent with the overall plan of care;
- d. The recipient shall have been on the conservative treatment program for at least one month prior to use of the air-fluidized bed with no improvement or worsening of the ulcer. The evaluation must be performed within a week of initiating treatment with the air-fluidized bed;
- e. A trained adult caregiver is available to assist the recipient with activities of daily living, fluid balance, dry skin care, repositioning, recognition, management of altered mental status, dietary needs, prescribed treatments, and management and support of the air-fluidized bed system;
- f. A physician, physician assistant, or nurse practitioner directs the home treatment regimen, and re-evaluates and recertifies the need for the air-fluidized bed on a monthly basis; and
- g. All other alternative equipment has been considered and ruled out.

An air-fluidized bed is denied as not medically necessary under any of the following circumstances.

- a. The recipient has coexisting pulmonary disease (the lack of firm back support makes coughing ineffective and dry air inhalation thickens secretions).
- b. The recipient requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material.
- c. The caregiver is unwilling or unable to provide the type of care required by the recipient on an air-fluidized bed.

- d. Structural support is inadequate to support the weight of the air-fluidized bed system (it weighs around 1600 pounds).
- e. The home electrical system is insufficient for the anticipated increase in energy consumption.
- f. There are other known contraindications to the use of this bed.

Note: Initial prior approval for an air-fluidized bed is given for a maximum of one month. Renewals are given for a maximum of one month. The documentation requirements are the same for requests to renew approval. An air fluidized bed is typically needed only 6-12 weeks post-op.

Continued use of an air-fluidized bed is covered until the ulcer is healed. If healing does not continue, there must be additional documentation in the clinical health care record to show:

- a. Other aspects of the care plan are being modified to promote healing; and
- b. The use of the air-fluidized bed is medically necessary for wound management.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, Pressure Reducing Support Surfaces – Group 3.**

5.3.5 Negative Pressure Wound Therapy Electrical Pump, Stationary or Portable, and Related Supplies

Negative pressure wound therapy (NPWT) is the use of an electrical pump to convey sub-atmospheric pressure to a specialized wound dressing and thereby promote wound healing.

The NPWT pump and wound care set are covered by Medicaid when they are medically necessary for the recipient. These items require prior approval. Initial authorization is given for a maximum of three months.

For initial approval, the following criteria must be met:

The recipient has a chronic Stage III or Stage IV pressure ulcer, neuropathic ulcer, venous or arterial insufficiency ulcer, or chronic (present for at least 30 calendar days) ulcer of mixed etiology.

A complete wound therapy program, as described below, must have been considered and ruled out, or tried, prior to application of negative pressure wound therapy (NPWT):

- a. For all ulcers or wounds:
 - A. Documentation in the recipient's clinical health care record of evaluation, care, and wound measurement by a licensed medical professional permitted to perform those tasks and responsibilities by their NC state licensing board;
 - B. Application of dressings to maintain a moist wound environment;
 - C. Debridement of necrotic tissue if present; and

- D. Evaluation of and provision for adequate nutritional status.
- b. For Stage III or Stage IV ulcers:
 - 1. The recipient has been appropriately turned and positioned
 - 2. A group 2 or 3 support surface has been used for pressure ulcers on the posterior trunk or pelvis (Note: a Group 2 or 3 support surface is not required if the ulcer is not on the trunk or pelvis)
 - 3. Moisture and incontinence have been appropriately managed.
- c. For neuropathic (for example, diabetic) ulcers:
 - 1. The recipient has been on a comprehensive diabetic management program, and
 - 2. Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.
- d. For venous insufficiency ulcers:
 - 1. Compression bandages and/or garments have been consistently applied; or if contraindicated to Peripheral Artery Disease (PAD);
 - 2. Lower extremity elevation and ambulation have been encouraged.

NPWT pumps must be capable of accommodating more than one wound dressing set when a recipient has multiple wounds. Therefore, more than one NPWT pump billing per recipient for the same time period is not covered.

An NPWT pump and supplies is not medically necessary when any of the following are present:

- a. The presence in the wound of necrotic tissue with eschar, if debridement is not attempted;
- b. Untreated osteomyelitis within the vicinity of the wound;
- c. Cancer present in the wound;
- d. The presence of a fistula to an organ or body cavity within the vicinity of the wound.

For coverage to continue beyond the initial prior approval period, a licensed medical professional shall do the following:

- a. Directly assess the wound(s) treated with the NPWT pump;
- b. Supervise or directly perform the NPWT dressing changes; and
- c. On a **monthly** basis, document changes in the ulcer's dimension and characteristics.

Note: For the purposes of this policy, a licensed medical professional may be a physician, physician's assistant, registered nurse, licensed practical nurse, or physical therapist. The practitioner shall be licensed to assess wounds and administer wound care within the state where the beneficiary is receiving NPWT.

Re-authorizations for continued coverage are given for a maximum of one month. If the criteria are not fulfilled, continued coverage of the NPWT pump and supplies are not medically necessary and therefore not covered.

Lack of improvement of a wound, as used within this policy, is defined as a lack of progress in quantitative measurements of wound characteristics, including wound length and width (surface area) or depth measured serially and documented over a specified time interval. Wound healing is defined as improvement occurring in either surface area or depth of the wound.

Note: The staging of pressure ulcers used in this policy is as follows:

- Stage I** nonblanchable erythema of intact skin
- Stage II** partial-thickness skin loss involving epidermis, dermis, or both
- Stage III** full-thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia
- Stage IV** full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures

For a list of the specific HCPCS codes covered by Medicaid refer to **Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Negative Pressure Wound Therapy***.

5.3.6 Wheelchairs and Accessories

The following wheelchairs and wheelchair accessories are covered by NCHC, for use in a recipient's home, when they are medically necessary for the recipient. Prior approval is required for all wheelchairs.

Manual Wheelchairs

A **Manual Wheelchair** is covered when all of the following **basic criteria** are met:

- a. The recipient has a mobility limitation that significantly impairs his or her ability to participate in one or more mobility-related activities of daily living (MRADLs) in the home;
Note: For this policy MRADLs are defined as toileting, feeding, dressing, grooming, and bathing. To be considered significantly impaired means the mobility limitation prevents performance of the activity entirely, prevents the activity from being completed in a reasonable time frame, or places the recipient at high risk for injury when performing the activity, or at a heightened risk of morbidity secondary to attempts to perform the MRADL.
- b. The recipient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker;
- c. The recipient's home is accessible to the wheelchair and provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided;
- d. Use of a manual wheelchair is reasonably expected to significantly improve the recipient's ability to participate in MRADLs; and
- e. The recipient has sufficient upper extremity function and the physical and mental capabilities needed to safely self propel the manual wheelchair in the home throughout the course of a normal day **or** has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

Note: A wheelchair based solely for use outside the home is not covered.

Note: Payment is made for only one wheelchair at a time. Backup chairs are not covered as they are not medically necessary.

A **Standard Hemi (low seat) Wheelchair** is covered when all of the basic criteria are met plus the following:

- a. The recipient requires a lower seat height (17 to 18 inches) because of short stature or to enable the recipient to place his feet on the ground for propulsion.

A **Lightweight Wheelchair** is covered when all of the basic manual wheelchair coverage criteria are met plus the following:

- a. The recipient cannot self propel in a standard wheelchair in the home using arms or legs;
- b. The recipient can and does self propel safely and functionally in a lightweight wheelchair;
- c. The provider shall submit supporting documentation with the request that demonstrating the recipient has limitations in upper extremity strength or function that prevents propulsion of a standard wheelchair; and
- d. The recipient can safely propel the lightweight wheelchair.

A **High-Strength Lightweight Wheelchair** is covered when all of the basic manual wheelchair coverage criteria are met plus the following:

- a. The recipient cannot safely and functionally self propel in a standard or lightweight wheelchair using arms or legs while engaging in frequent activities in the home,
- b. The recipient spends a minimum of 6 hours each day in the wheelchair,
- c. The recipient can safely and functionally self propel in a high-strength lightweight wheelchair; and
- e. The provider shall submit supporting documentation with the request that demonstrating the recipient has limitations in upper extremity strength or function that prevents propulsion of a standard wheelchair.

An **Ultra Lightweight Wheelchair** is covered when all of the basic manual wheelchair coverage criteria are met plus the following:

- a. The routine activities the recipient engages in at home cannot be performed in a lightweight wheelchair;
- b. The features of the ultra lightweight wheelchair are required for the recipient to be functional;
- c. The recipient spends a minimum of 6 hours each day in the wheelchair; and
- d. The recipient can safely propel the ultra lightweight wheelchair

The following documentation must be submitted for prior approval:

- a. A clinical wheelchair evaluation must be performed by a physical or occupational therapist with specific training and experience in rehabilitation wheelchair evaluations, and describe the recipient's medical condition, mobility limitations, and other physical and functional limitations. The physical or occupational therapist performing the evaluation shall not have a financial relationship with the wheelchair supplier.

Note: An ultra lightweight wheelchair based solely on use outside the home is not covered.

- b. A Manufacturer's Suggested Retail Price (MSRP) quote for the requested wheelchair and accessories from the manufacturer.

A **Heavy-duty wheelchair** is covered when all of the basic manual wheelchair coverage criteria are met plus either of the following:

- a. The recipient weighs more than 250 pounds; or
- b. The recipient has severe spasticity.

An **Extra Heavy-duty wheelchair** is covered when all of the basic manual wheelchair coverage criteria are met plus the following:

- a. The recipient weighs more than 300 pounds.

A **Manual Adult Size Wheelchair, which includes tilt in space**, is covered when all of the basic manual wheelchair coverage criteria are met plus coverage criteria for the tilt in space option.

The following is required for prior approval:

- a. A clinical wheelchair evaluation must be performed by a physical or occupational therapist with specific training and experience in rehabilitation wheelchair evaluations, and describe the recipient's medical condition, mobility limitations, and other physical and functional limitations. The physical or occupational therapist performing the evaluation shall not have a financial relationship with the wheelchair supplier.
- b. A letter of medical necessity from the physical or occupational therapist that documents the medical need for the manual adult size wheelchair and all additional accessories requested.
- c. A MSRP quote for the requested wheelchair and accessories from the manufacturer.

For prior approval of the **tilt in space** feature the following criteria must be met:

- a. The recipient requires the tilt in space feature for proper positioning during daily activities, such as eating.
- b. The recipient has significant trunk or hip musculoskeletal deformity or abnormal tone in the trunk musculature and must be tilted to maintain postural control or spinal alignment,

- c. The recipient is unable to actively change his or her upright seating position and is at risk for loss of skin integrity.
- d. The recipient has respiratory, digestive or cardiac dysfunction that is functionally improved with the tilt/recline feature.
- e. The recipient must spend a minimum 6 hours per day in the wheelchair to qualify for the tilt in space feature.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Manual Wheelchairs***.

Rental Wheelchairs:

Prior approval for rental of a manual wheelchair can be granted for a maximum of 9 months when the recipient meets all of the basic manual wheelchair coverage criteria.

Transport Chairs/Rollabout Chairs

Adult and pediatric transport chairs, and a rollabout chair are covered by NCHC when they are medically necessary for the recipient. Prior approval is required for transport chairs, however a Rollabout chair does not require prior approval. These chairs are covered if the recipient needs to be mobilized by a caregiver.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Transport Chairs***.

Pediatric Manual Wheelchairs

Pediatric Manual Wheelchairs and accessories are covered by NCHC when they are medically necessary for the recipient. Prior approval is required for all pediatric wheelchairs.

Note: Pediatric wheelchairs are covered only for a child or an adult of very small stature. The wheelchair width or depth must be 14 inches or less to be coded as pediatric.

The following is required for prior approval:

- a. A clinical wheelchair evaluation must be performed by a physical or occupational therapist with specific training and experience in rehabilitation wheelchair evaluations, and describe the recipient's medical condition, mobility limitations, and other physical and functional limitations. The physical or occupational therapist performing the evaluation shall not have a financial relationship with the wheelchair supplier;
- b. A letter of medical necessity from the physical or occupational therapist that documents the medical need for mobility in the recipient's home and the medical need for the pediatric manual wheelchair selected and all additional accessories requested. This letter must also document the home's accessibility;
- c. A MSRP quote for the requested wheelchair and accessories from the manufacturer.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Pediatric Manual Wheelchairs***.

Oversized Manual Wheelchairs

Oversized Manual Wheelchairs for weights greater than 451 pounds are covered by NCHC when they are medically necessary for the recipient. Prior approval is required.

For prior approval all of the basic manual wheelchair coverage criteria must be met plus the following:

- a. The recipient shall meet the weight requirements for the specific wheelchair requested. The recipient's height, weight, and body measurements must be included with the request for prior approval; and
- b. The dimensions of the requested equipment and the manufacturer's specified weight capacity for the equipment must be submitted.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Oversized Manual Wheelchairs*.

Power Wheelchairs

All power wheelchairs require prior approval. The following information must be submitted with the prior approval request:

- a. A face-to-face examination which consists of an in-person visit to the recipient's treating physician for the purpose of requesting a power wheelchair and a comprehensive medical examination. The face-to-face examination must be documented in a detailed narrative note in the physician's chart in the same format used for other entries. The note must clearly indicate the major reason for the visit was a mobility examination. The note must document the recipient's strength, mobility and functional deficits, and support the need for a wheelchair to perform MRADLs in the recipient's home.

The face-to-face evaluation must be completed prior to the physician's order for the power chair and must support the medical necessity for the power wheelchair. This evaluation must provide subjective and objective information about the recipient's condition and progression of disease over time. It must clearly indicate ambulatory status, explain why a power wheelchair is needed as compared to a cane, walker, or manual wheelchair and address the medical justification for each accessory billed. Other clinical health care records (physician office records, hospital records, home health agency records, or physical and occupation therapy notes) can be submitted to supplement the information in the face-to-face evaluation.
- b. An onsite written assessment of the recipient's home that verifies and documents the recipient's environment supports the use of a power wheelchair. The home assessment can be performed by the wheelchair supplier and must include measurements of the physical layout of the home, doorway widths, doorway thresholds, and surfaces the chair will move over.
- c. A MSRP quote for the requested wheelchair and accessories from the manufacturer that gives a detailed description of the items requested.

Note: A wheelchair supplier generated form must not be used to document the physician's examination since a supplier generated form is not considered to be part of the clinical health care record.

Payment is made for only one wheelchair at a time. Backup chairs are not covered as they are not medically necessary.

A power wheelchair is not medically necessary when the underlying condition is reversible and the length of need is less than 3 months.

Standard Power Wheelchairs

Standard Power Wheelchairs, including Group 1 chairs and some Group 2 chairs without power options, are covered by NCHC when they are medically necessary for the recipient.

All of the following coverage criteria must be met:

- a. The recipient has a mobility limitation that significantly impairs his or her ability to participate in one or more MRADLs in the home.

Note: For this policy MRADL's are defined as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. To be considered **significantly impaired** means the mobility limitation prevents performance of the activity entirely, prevents the activity from being completed in a reasonable time frame, or places the recipient at high risk for injury when performing the activity, or at a heightened risk of morbidity secondary to attempts to perform the MRADL.

- b. The recipient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker
- c. The recipient does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADL's throughout the course of a normal day. Limitations of strength, endurance, range of motion, coordination, presence of pain, deformities, or the absence of one or both upper extremities must be noted in the assessment of upper extremity function.
- d. The recipient has the mental and physical capabilities to safely operate the power wheelchair and to assure it is cared for.
- e. Use of the power wheelchair is reasonably expected to significantly improve the recipient's ability to participate in MRADL's and is for use in the home.
- f. The recipient's home is accessible to the wheelchair and provides adequate access between rooms, maneuvering space, and surfaces for use of the power wheelchair that is provided.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Power Wheelchairs - Standard*.

Complex Rehab Power Wheelchairs

Complex rehab power wheelchairs, including power chairs with single or multiple power options, require prior approval. In addition to the face-to-face assessment, the onsite written assessment of the recipient's home, and the manufacturer's quote required for all power wheelchairs, the following are required:

- a. A clinical wheelchair evaluation must be performed by a physical or occupational therapist with specific training and experience in rehabilitation wheelchair evaluations, and describe the recipient's medical condition, mobility limitations, and other physical and functional limitations. The physical or occupational therapist performing the evaluation shall not have a financial relationship with the wheelchair supplier.
- b. A letter of medical necessity from the physical or occupational therapist that documents the medical need for the complex rehab power wheelchair and all additional accessories requested.

Complex rehab power wheelchairs are covered if all of the criteria for a Standard Power Wheelchair are met plus the following:

- a. The recipient requires a drive control interface other than a hand or chin-operated standard proportional joystick.
- b. The recipient meets coverage criteria for a power tilt or a power recline seating system and the system is being used on the wheelchair. (Refer to *Wheelchair Accessories, Power Seating Systems*, for prior approval requirements for power tilt and/recline.)
- c. The wheelchair clinic evaluation must document the medical necessity for the wheelchair and its special features.
- d. A Group 3 power wheelchair is covered when the recipient's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity.
- e. Group 4 power wheelchairs have added capabilities that are not usually needed for use in the home. Options or features not for use in the home are not covered.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Power Wheelchairs – Complex Rehab*.

Heavy Duty Wheelchairs

Heavy duty power wheelchairs for recipients who weigh more than 300 pounds are covered by NCHC when they are medically necessary for the recipient. Prior approval is required.

For prior approval of heavy duty wheelchair all of the following must be submitted:

- a. Documentation shall substantiate the following two requirements:
 1. Recipient shall meet the weight requirements for the heavy duty power wheelchair requested; and
 2. Medical necessity for a comparable standard size wheelchair
- b. The recipient's height, weight, and body measurements must be included.
- c. The dimensions of the requested equipment and the manufacturer's specified weight capacity for the equipment must be submitted.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Power Wheelchairs – Heavy Duty*.

Wheelchair Accessories

Wheelchair Accessories are covered when they are medically necessary. The medical need must be documented and maintained in the provider's records, regardless of the need for prior approval.

Batteries

Batteries are covered when they are necessary to operate the power wheelchair that has been approved for the recipient. Prior approval is required only for Group 27 batteries.

Prior approval is required for Battery Chargers. Battery Chargers are covered when the criteria for a power wheelchair are met. An initial charger must be included in the allowance for a power wheelchair. The charger must be billed separately only when it is a replacement.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories - Batteries*.

Armrests

Adjustable Height Armrests are covered when the recipient requires an arm height that is different from that available using non-adjustable arms, and the recipient spends more than four hours per day in the wheelchair. Prior approval is required for adjustable height armrests.

Arm troughs are covered when the recipient requires additional support for the upper extremity not provided by the wheelchair armrest. Prior approval is not required.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories - Armrests*.

Cushions

General use wheelchair cushions are covered when the recipient has a diagnosis that causes deformities of the musculoskeletal system, has contractures such that the normal body alignment is significantly altered, and spends more than two hours per day in the wheelchair. Prior approval is not required.

Positioning wheelchair cushions are covered when the recipient has the potential for development of a musculoskeletal deformity of the trunk, or has already begun to develop such a deformity, and it can be ameliorated or retarded by the addition of a positioning cushion.

Skin protection and positioning wheelchair cushions may be covered if the recipient has a diagnosis or condition that causes skin breakdown due to immobility in a wheelchair for long periods of time. The recipient shall be wheelchair bound.

Prior approval is required for some wheelchair cushions. Refer to the NCHC DME fee schedule at <http://www.ncdhhs.gov/dma/fee/> to determine if prior approval is required. Items on the fee schedule requiring prior approval are identified by an asterisk.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories - Cushions*.

Headrest

Head/neck supports require prior approval. The recipient shall have all of the following for prior approval:

- a. Weakness or abnormal muscle tone in cervical musculature such that function in those muscles is significantly impaired and the headrest is needed to support the head; and
- b. The recipient is not able to actively maintain proper cervical positioning.

A head/neck support is approved when the recipient has a reclining back on the approved wheelchair.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories - Headrests*.

Reclining Back

A reclining back is covered when the recipient has any of the following:

- a. Severe trunk or hip bony deformity;
- b. Trunk or lower extremity casting or bracing the requires reclined positioning;
- c. Severe extensor tone of the trunk muscles;
- d. The need to rest in a recumbent position two or more times during the day and transfers between the wheelchair and bed are very difficult;
- e. Cannot tolerate upright positioning due to blood pressure instability; or
- f. Spends more than four hours per day in the wheelchair.

Prior approval is required.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Reclining Back*.

Leg rest

Elevating leg rests are covered when the recipient has any of the following:

- a. A musculoskeletal condition which prevents 90 degree flexion at the knee;
- b. The presence of a cast or brace which prevents 90 degrees of flexion at the knee;
- c. Circulation issues that require lower extremity elevation; or
- d. Meets the criteria for and has a reclining back on the wheelchair.

A residual limb support is covered when the recipient has had an amputation and the residual limb cannot be supported on a standard leg rest.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Leg Rest*.

Foot Rest/Shoe Holder

Footrests, footplates, shoe holders, and straps are covered when the recipient requires lower extremity support due to muscular weakness, neuromuscular dysfunction or orthopedic deformity.

Prior approval is required for some of these items. Refer to the Medicaid DME fee schedule at <http://www.ncdhhs.gov/dma/fee/> to determine when prior approval is required. Items on the fee schedule requiring prior approval are identified by an asterisk.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Foot Rest/Shoe Holder*.

Seat/Back

A non standard seat height for a high-strength lightweight or ultra lightweight wheelchair is covered when:

- a. The required seat height is at least 2 inches greater than or less than a standard option; and
- b. The recipient's body dimensions justify the need.

Non standard seat frames are covered when all of the following criteria are met:

- a. The recipient's dimensions justify the need for wheelchair seat width, depth, or height changes; and
- b. The seat width, depth, or height changes are needed to maintain or improve the recipient's medical, physical, or functional level.

A solid seat insert is covered when it is needed to provide a flat surface in a wheelchair with a sling seat so the recipient will be properly positioned.

A solid seat support base is covered when it replaces a sling seat and is needed to properly position the recipient in the wheelchair. A solid seat support base requires prior approval

A planar or contoured back is covered when the recipient meets all of the following criteria:

- a. Has a diagnosis that may result in deformities of the musculoskeletal system such that the normal body alignment could be significantly altered; and
- b. Spends more than two hours per day in the wheelchair.

A Growth Kit is covered when the addition of this feature significantly increases the lifetime of the recipient's currently appropriate wheelchair.

These items all require prior approval.

Replacement upholstery is covered when the upholstery is damaged or worn beyond repair and replacing the upholstery will increase the lifetime of the wheelchair. Prior approval is not required for replacement upholstery.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Seat/Back*.

Trunk/Extremity Alignment Support

Trunk/Extremity Alignment Supports, including lateral truck or hip supports, abductor or adductor pads, harnesses, straps, or positioning belts, are covered by NCHC when:

- a. The recipient has weakness or abnormal muscle tone in the trunk, body, or extremity musculature resulting in significantly impaired function in those muscles; or
- b. The recipient is unable to actively maintain proper trunk or extremity positioning.

All of these items require prior approval except for the positioning belts and safety vest.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Trunk/Extremity Support*.

Oversized Accessories

All oversized accessories require prior approval. For prior approval all of the following information must be included with the request:

- a. Recipient's height, weight, and body measurements; and
- b. The dimension of the requested equipment and the manufacturer's specified weight capacity for the equipment.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Oversized*.

Power Seating Systems

Power seating systems, including tilt, recline, and combination tilt and recline, require prior approval and are covered when the recipient meets all of the following:

- a. The recipient requires the tilt in space feature for proper positioning during daily activities, such as eating.
- b. The recipient has significant trunk or hip musculoskeletal deformity or abnormal tone in the trunk musculature and must be tilted to maintain postural control or spinal alignment,
- c. The recipient is unable to actively change his or her upright seating position and is at risk for loss of skin integrity.
- d. The recipient has respiratory, digestive or cardiac dysfunction that is functionally improved with the tilt/recline feature.
- e. The recipient shall spend a minimum of six hours per day in the wheelchair.
- f. The recipient does not have a caregiver available to perform this function manually.

Power seat elevation is covered when the recipient is not able to transfer from the wheelchair to bed or toilet without height adjustment or requires seat elevation to perform MRADL's in the home. Prior approval is required.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Power Seating Systems*.

Electronics

Electronic components for power wheelchairs are covered when they are medically necessary for the recipient to function in the power wheelchair that has been provided.

Replacement electronics require prior approval and are covered when the part replaced cannot be repaired, the warranty has expired, replacing the part significantly extends the life of the wheelchair, and the cost of replacing the part is less than the cost of a new comparable wheelchair.

Prior approval is required for most electronics. Refer to the Medicaid DME fee schedule at <http://www.ncdhhs.gov/dma/fee/> to determine when prior approval is required. Items on the fee schedule requiring prior approval are identified by an asterisk.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories – Electronics*.

Wheels, Tires, Casters

Propulsion tires, drive wheel tires, caster tires, tubes, valves, inserts, wheel locks, and replacement parts are covered when they are medically necessary for the recipient to function in the power wheelchair that has been provided.

These items do not require prior approval. Wheelchair replacement parts are covered when the part being replaced is no longer functional due to normal wear and tear and the approved wheelchair remains appropriate for the recipient's function.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories - Wheels, Tires, Casters*.

Other Accessories

Swing away retractable or removable hardware is covered when specialized mounting hardware is needed to improve the recipient's positioning or ability to use a joystick. Prior approval is not required.

A ventilator tray is covered when the recipient is dependent on mechanical ventilator support. Prior approval is not required.

Wheelchair trays are covered when the recipient's performance of daily function such as eating or fine motor activities requires this feature. A multi-adjustable tray requires prior approval.

Hand rims are covered when the recipient is unable to propel independently and functionally without special hand rims and is able to propel with special hand rims. Prior approval is not required.

Anti-rollback devices, gear reduction drive wheels, wheel braking systems and other accessories are covered when they allow the recipient to be mobile safely and independently in an approved wheelchair. A gear reduction drive wheel, wheel braking system, and lock require prior approval.

Motor and gear box replacements require prior approval and are covered when the part replaced cannot be repaired, the warranty has expired, replacing the part significantly extends the life of the wheelchair, and the cost of replacing the part is less than the cost of a new comparable wheelchair.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Wheelchair Accessories -Other*.

5.3.7 Activity/Positioning Chairs

Activity/Positioning Chairs are designed to provide stability and support, maintain body alignment, decrease likelihood of postural deformities, and enhance upper extremity function for recipients with physical disabilities. Activity/Positioning Chairs, Hi Lo Activity/Positioning Chairs, chair accessories, and Hi Lo Indoor Bases/Frames are covered for recipients. Prior approval is required.

Activity Chair

Activity Chairs and accessories are covered for a recipient who has mild to moderate physical disabilities and needs positioning support to sit and perform activities.

An Activity Chair is considered medically necessary when a recipient meets any one of the following criteria:

- a. Cannot safely sit in a regular chair, commercially available high chair, or other conventional seating option;
- b. Needs additional support and stability for fine motor activities;
- c. Has decreased trunk strength and motor control;
- d. Must use arms to maintain sitting balance;

- e. Requires external support to maintain upright position and good body alignment;
- f. Has no functional protective or righting reaction; or
- g. Must be in an upright supported position for safe and effective feeding and without this chair would have to be held by the caregiver for feeding.

All accessories must be medically justified.

- a. A tilt/recline option is covered when the recipient:
 - 1. cannot maintain head control in the upright position
 - 2. requires pressure relief
 - 3. requires a tilted position to compensate for tonal changes, or
 - 4. must be tilted for proper digestion and to avoid reflux.
- b. A mobile base is covered when it is medically necessary to move the recipient to different parts of the home with the rest of the family for safety or for medically necessary activities.
- c. A Hi Lo feature is covered when height adjustments are needed for medically necessary activities or to allow the recipient to get into or out of the chair independently.

Hi Lo Positioning Activity Chair

Hi Lo Positioning Chairs and accessories are covered for a recipient who has more severe physical disabilities and needs optimum positioning support.

A Hi Lo Positioning Chair is considered medically necessary when a recipient meets any one of the following criteria:

- a. Has non functional head or trunk control requiring customized postural support to maintain a sitting position;
- b. Cannot sit unsupported due to poor static and dynamic sitting balance;
- c. Requires maximum support for upright positioning;
- d. Cannot interact with the environment without this level of support; or
- e. Requires varying sitting heights to participate in medically necessary activities.

Hi Lo Indoor Base/Frame

A Hi Lo Indoor Base is covered for recipient who has a wheelchair seating system that can be transferred from a mobility base to an indoor base and is used as an activity/positioning chair in the home. A Hi Lo Indoor Base is considered medically necessary when a recipient meets any one of the following criteria:

- a. A variety of heights are needed for the recipient to perform medically necessary activities in the home; or
- b. At the low height the recipient is able to get into and out of the chair independently.

A letter of medical necessity from a physical or occupational therapist involved in the care of the recipient is required for prior approval of all **Activity/Positioning Chairs and Frames**. The physical or occupational therapist completing the evaluation shall not be employed by or have a financial relationship with the medical equipment provider.

For prior approval, the medical equipment provider shall submit a completed CMN/PA form and supporting documentation from the physical or occupational therapist that:

- a. Demonstrates that the activity/positioning chair requested, and each of its components, are medically necessary and are the least expensive device that is appropriate for the recipient's medical condition.; and
- b. Describes other less expensive devices that were considered and provides rationale as to why they were not appropriate for the recipient.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Activity/Positioning Chairs*.

5.3.8 Patient Lift, Hydraulic or Mechanical

Hydraulic lifts are covered when both of the following criteria are met:

- a. The recipient's condition is such that periodic movement is necessary to effect improvement or to arrest or retard deterioration in the recipient's condition; and
- b. The recipient or family are not able to transfer the recipient safely.

Prior approval is required for a hydraulic or mechanical lift.

Note: Powered lifts are not covered as they are considered to be for caregiver convenience and not medically necessary.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Patient Lift*.

5.3.9 Oxygen, Oxygen Supplies, and Equipment

NCHC covers home oxygen therapy and related supplies and equipment for recipients who meet the following criteria:

- a. Arterial oxyhemoglobin saturation (SaO₂) equal to or less than 90% and have a documented supporting diagnosis.

Requirements for Qualifying Oxygen Analysis and Coverage

A qualifying oxygen analysis (either arterial blood gas (ABG) or pulse oximetry for SaO₂) must meet the following criteria.

- a. If the oxygen analysis is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than 2 calendar days prior to, the hospital discharge date; or
- b. If the qualifying oxygen analysis is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state—that is, not during a period of acute illness or exacerbation of their underlying disease.

- c. The oxygen analysis used to determine medical necessity must not be performed by a medical equipment supplier or a related corporation. In addition, the oxygen analysis must not be performed by a physician with a significant ownership interest in the medical equipment supplier or the laboratory performing such tests. These provisions include relationships through blood or marriage. A referring physician may perform the test in his office as part of routine care.
- d. The oxygen analysis must be performed by a clinician that does not have a vested interest in the company that supplies the oxygen, equipment and supplies.
- e. The initial oxygen analysis must be performed within the 30-calendar day period before the approved start date of treatment. Otherwise, the approved start date of treatment will be the date of the initial qualifying analysis.

Prior Approval Requirements

For initial approval on oxygen services, the following must be in block 25 of the CMN/PA form or on attached documentation:

- a. A short written statement from the recipient's physician, physician assistant, or nurse practitioner stating why the use of oxygen is indicated.
- b. Medical documentation from the recipient's physician, physician assistant, or nurse practitioner showing that the recipient has had an examination within 30 calendar days of the start of oxygen therapy. The documentation must include all of the following:
 1. The diagnosis of the disease requiring use of home oxygen;
 2. The oxygen flow rate needed; and
 3. An estimate of the frequency, duration of use, and length of need for the oxygen.
 4. Results of an oxygen analysis (either ABG study or pulse oximetry for SaO₂) as noted in the **Requirements for Qualifying Oxygen Analysis and Coverage**.

Initial prior approval is given for 12 months. Continuation prior approval for these recipients is required at the end of the 12 months. Another CMN/PA request must be submitted that includes a written statement from the physician, physician assistant, or nurse practitioner as to the need for the continuation of oxygen therapy as well as the date of the original oxygen testing and the results. If approved, continuation is granted for an additional 24 months.

At the end of 36 months, **all** recipients must be recertified. The provider must submit a new prior approval request for the continuation of oxygen therapy. This request must include a qualifying oxygen analysis that was obtained and reviewed by the treating physician within 6 months of the renewal date. Approval given at the 36-month renewal period is considered to be lifetime approval.

Note: Continuation prior approval for oxygen therapy is not required if oxygen therapy for use with a continuous positive airway pressure (CPAP) device or respiratory assist device (RAD) for obstructive sleep apnea (OSA) has been diagnosed and initially approved, or ventilator dependency for respiratory failure.

Special Reimbursement Explanation: Oxygen contents will be approved only for patient-owned equipment. This will include portable tanks, liquid oxygen, and

oxygen tanks that are used on an ongoing basis based on prior approval and medical necessity.

Examples of the coverage would include the following:

- a. For recipients receiving oxygen therapy delivered by an oxygen concentrator and also prescribed a portable oxygen system, reimbursement will be for rental on the oxygen concentrator and portable oxygen tank. There will be no reimbursement for contents that are used by the portable system, regardless of the amount of portable oxygen contents used in that month, as rental for the oxygen systems include contents.
- b. For recipients who are on stationary liquid oxygen system and portable liquid oxygen system, reimbursement will be rental at the published rate for both a stationary liquid oxygen system and a portable system. Contents are included in the published rate, and no additional contents will be approved for monthly rental.
- c. Portable oxygen systems—Recipients who meet the clinical coverage criteria for medical necessity may qualify for coverage of a portable oxygen system either by itself or to use in addition to a stationary system. The qualifying medical documentation must indicate that the recipient is mobile in the home and would benefit from the use of the portable oxygen system in the home. Portable oxygen systems that are used on a standby basis are not covered except in instances of a fragile infant with a tracheostomy.
- d. If a flow rate greater than 4 LPM is billed and the coverage criterion for the higher allowance is not met, payment will be limited to the standard fee schedule allowance. The higher oxygen allowable will be paid to the supplier at 1.5 times the rate. A modifier must be added to the oxygen code being used. If a modifier is used, then only the 1.5 times the rate will be reimbursed and there will be no payment for the portable oxygen system.
- e. Refer to **Attachment A, Section D**, for a list of the modifiers that must be used.

A **CO₂ Saturation Monitor with Accessories and Probes** is considered medically necessary when it is required to monitor carbon dioxide (CO₂) levels in recipients requiring oxygen therapy so that appropriate blood gas levels are achieved and maintained.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Oxygen Equipment and Supplies*.

5.3.10 Segmental and Non-Segmental Pneumatic Compressors and Appliances

A pneumatic compression device is covered only for the treatment of refractory lymphedema involving one or more limbs. This condition is a relatively uncommon medical problem. Causes of lymphedema include:

- a. Radical surgical procedures with removal of regional groups of lymph nodes (e.g., after radical mastectomy),
- b. Post-radiation fibrosis,

- c. Spread of malignant tumors to regional lymph nodes with lymphatic obstruction,
- d. Scarring of lymphatic channels,
- e. Onset of puberty (specifically Milroy's Disease), and
- f. Congenital anomalies.

Pneumatic compression devices are only covered as a treatment of last resort. Other less intensive treatment must have been tried first and found to be inadequate. Such treatments would include leg or arm elevation and custom-fabricated pressure stockings or sleeves.

Pneumatic compression devices are covered only when prescribed by a physician and when they are used with appropriate physician oversight. This oversight must include physician evaluation of the recipient's condition to determine medical necessity of the device, suitable instruction in the operation of the machine, a treatment plan defining the pressure to be used and the frequency and duration of use, and ongoing monitoring of use and response to treatment.

Block 24 of the CMN/PA form must be checked.

When the cause of the lymphedema is scarring of the lymphatic channels (generalized, refractory edema from venous insufficiency which is complicated by recurrent cellulitis), a pneumatic compression device may be covered only if all of the following criteria have been met:

- a. There is significant ulceration of the lower extremity(ies);
- b. The recipient has received repeated, standard treatment from a physician using such methods as a compression bandage system or its equivalent; and
- c. The ulcer(s) have failed to heal after 6 months of continuous treatment.

All pneumatic compressors and appliances require prior approval.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Pneumatic Compressors*.

5.3.11 Respiratory Devices for the Treatment of Respiratory Disorders other than Obstructive Sleep Apnea (OSA)

A respiratory assist device-bi-level (RAD) without back-up rate delivers adjustable, variable levels (within a single respiratory cycle) of positive air pressure by way of tubing and a noninvasive interface to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs (i.e., noninvasive positive pressure respiratory assistance: NIPPRA).

A respiratory assist device-bi-level (RAD) with back-up rate delivers adjustable, variable levels (within a single respiratory cycle) of positive air pressure by way of tubing and a noninvasive interface to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs. In addition, it has a timed back-up feature to deliver this air pressure whenever sufficient spontaneous inspiratory efforts fail to occur.

A RAD and related accessories are covered for recipients with any of the following respiratory disorders who demonstrate medical necessity for each disorder:

- a. Restrictive thoracic disorders:

The recipient shall meet any one of the following criteria:

1. Documentation of the recipient's progressive neuromuscular disease or severe thoracic cage abnormality and an arterial blood gas PaCO₂ (done while awake and breathing the recipient's usual fraction of inspired oxygen (FIO₂)) that is greater than or equal to 45 mmHg;
 2. Sleep oximetry demonstrating oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing the recipient's FIO₂; or
 3. For a progressive neuromuscular disease (only), maximal inspiratory pressure is less than 60cm H₂O or forced vital capacity is less than 50% predicted; and chronic obstructive pulmonary disease does not contribute significantly to the recipient's pulmonary limitation.
- b. Severe chronic obstructive pulmonary disease (COPD):
All of the following criteria must be met:
1. An arterial blood gas PaCO₂, done while awake and breathing the recipient's usual FIO₂, that is greater than or equal to 52 mmHg;
 2. Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the recipient's usual FIO₂ (whichever is higher); or
 3. Prior to initiating therapy, OSA (treatment with CPAP) has been considered and ruled out.

Prior approval is required for a RAD.

Note: A RAD device **with a back-up rate** is not covered for a recipient with COPD during the first two months, because therapy with a RAD device **without a back-up rate** with proper adjustments of the device's settings and recipient's accommodation to its use will usually result in sufficient improvement without the need of a back-up rate.

For those COPD recipients who qualify for a RAD device without a back-up rate, if at a time no sooner than the 61 calendar days after initial issue and compliant use of the device, the treating physician believes the recipient requires a RAD device with a back-up rate, the device will be covered if all of the following criteria are met:

- A. An arterial blood gas PaCO₂, repeated no sooner than 61 calendar days after initiation of compliant use of the RAD device without a back-up rate, done while awake and breathing the recipient's usual FIO₂, still remains greater than or equal to 52 mm Hg;
 - B. A sleep oximetry, repeated no sooner than 61 calendar days after initiation of compliant use of a RAD device without a back-up rate, and while breathing with the device, demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the patient's usual FIO₂ (whichever is higher);
 - C. A signed and dated statement from the treating physician, completed no sooner than 61 calendar days after initiation of the RAD device without a back-up rate, declaring that the patient has been compliantly using the device (an average of four hours per 24-hour period) but that the patient is NOT benefiting from its use.
- c. Central sleep apnea:
The recipient shall meet all of the following criteria:

1. A polysomnogram documenting the Central Sleep Apnea (CSA);
2. Exclusion of Obstructive Sleep Apnea (OSA) as the predominant cause of sleep-associated hypoventilation;
3. Ruling out of CPAP as effective therapy of OSA is a component of the sleep-associated hypoventilation;
4. Oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing the patient's usual FIO₂; and
5. Significant improvement of the sleep-associated hypoventilation with the use of a RAD device without a back-up rate on the settings that will be prescribed for initial use at home, while breathing the patient's usual FIO₂.

Note: For recipients with CSA, an apnea-hypopnea index (AHI) of 5 to 10 is acceptable if the physician who is a sleep specialist provides appropriate documentation on the physician's letterhead stationary of medical necessity for the RAD in each individual case.

Requirements for Coverage

- f. A polysomnogram must be submitted with the initial request for RAD with those diagnoses that have a polysomnogram requirement in the criteria.
 1. **NCHC does not accept polysomnograms that are performed by a medical equipment provider.**
 2. The polysomnogram must be based on a minimum of two hours of recorded sleep time without the use of a CPAP/RAD device, reported by the polysomnogram. The polysomnogram must include sleep staging and other sleep parameters such as airflow, respiratory effort, and oxygen saturation by oximetry.
- g. If the polysomnogram criteria listed above are **not** met, claims submitted for reimbursement of a RAD and related accessories will be denied as not medically necessary.
- h. For an item to be covered by NCHC a written signed and dated order from the "treating physician" must be received by the supplier before the CMN/PA is submitted for prior approval. The treating physician is one who is qualified by virtue of experience and training in non-invasive respiratory assistance, to order and monitor the use of the respiratory assist devices.
- i. If there is a discontinuation of the RAD at any time, the provider is expected to determine that the RAD has been discontinued and stop billing for the equipment and related accessories.
- j. A RAD device with a back-up rate is not medically necessary if the primary diagnosis is OSA.

Initial Approval: For a RAD to be covered, the treating physician, physician assistant, or nurse practitioner, must fully document in the recipient's clinical health care record those symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc.

The physician, physician assistant, or nurse practitioner must document in block 11 and 25 of the CMN/PA form and attach the required documentation that the recipient meets the medical necessity requirement for RAD therapy along with the results of the polysomnogram (if required based on the diagnosis).

Initial approval for a RAD is given for a period of **six months**.

Note: The RAD device without a back-up rate is reimbursed as rental only and not to exceed a total of monthly rental payments equal to the purchase price. The RAD device with a back-up rate is reimbursed as a rental only item.

Renewal Approval: For renewal approval and continued coverage of the RAD beyond the first six months of therapy, no sooner than the fifth month after initiating therapy:

- a. The provider must obtain a statement of compliance from the treating physician declaring that the recipient is using the device an average of four hours per 24-hour period this must be submitted along with the CMN/PA request for renewal. Failure of the recipient to be consistently using the RAD for an average of four hours per the 24-hour period by the time of the reevaluation would represent non-compliant use and constitute reason for NCHC to deny continued coverage as not medically necessary; and
- b. A statement must be submitted by the physician, physician assistant, or nurse practitioner indicating the progress of relevant symptoms and that the RAD is still medically necessary.

Note: A non-heated or heated humidifier is covered by NCHC with the use of a RAD. The treating physician must specify which type of humidifier the recipient is to use.

Respiratory Devices for the Treatment of Obstructive Sleep Apnea

A bi-level device without back-up rate delivers adjustable, variable levels (within a single respiratory cycle) of positive air pressure by way of tubing and a noninvasive interface to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs. This is also called noninvasive positive pressure respiratory assistance (NPPRA).

Continuous positive airway pressure (CPAP) therapy is the use of a CPAP device and related equipment to deliver a constant level of positive air pressure into the throat to prevent the collapse of the airway during inhalation. This is done by way of tubing and noninvasive interface such as nasal, oral or face mask.

The CPAP and Bi-level require prior approval.

The CPAP device or bi-level device and related accessories are covered for recipients who demonstrate medical necessity by meeting all of the following criteria:

- a. Has a diagnosis of obstructive sleep apnea (OSA)
- b. Has a documented, attended by qualified personnel, facility-based polysomnogram that meets the following criteria:
 1. The AHI is greater than or equal to 15 events per hour; **or**
 2. The AHI is from 5 to 14 events per hour with documented symptoms of:
 - A. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; **or**
 - B. Hypertension, ischemic heart disease, or history of stroke.

The bi-level device is covered for recipients who meet the criteria listed above and the prescribing physician, physician assistant, or nurse practitioner documents that the recipient meets one of the following conditions:

- a. has had an unsuccessful six-month trial on a CPAP device;
- b. is unable to tolerate CPAP;

- c. has special needs that have been documented on the physician's letterhead stationery by a physician who is a sleep specialist.

Note: An AHI of 5 to 10 is acceptable if the physician who is a sleep specialist provides appropriate documentation on the physician's letterhead stationery of medical necessity for the CPAP device or bi-level device in each individual case.

Requirements for Coverage:

- a. A polysomnogram must be submitted with the initial request for prior approval of a CPAP device or bi-level device.

Note: NCHC does not accept polysomnograms that are performed by a medical equipment provider.

- b. Polysomnograms must be provided according to requirements listed in Medicaid's Clinical Coverage Policy 1A-20, *Sleep Studies and Polysomnography Services*, on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>.
- c. The polysomnogram must be based on a minimum of two hours of recorded sleep time without the use of the CPAP device or bi-level device, reported by the polysomnogram. The polysomnogram must include sleep staging and other sleep parameters such as airflow, respiratory effort, and oxygen saturation by oximetry.
- d. If the polysomnogram criteria listed above are not met, claims submitted for reimbursement of the CPAP device or bi-level device and related accessories are not medically necessary, and therefore not covered.
- e. For an item to be covered by NCHC, a written signed and dated order from the "treating physician" must be received by the supplier before the CMN/PA is submitted for prior approval. If the supplier submits a CMN/PA without first receiving the completed order, the prior approval request is denied as not medically necessary.
- f. If there is discontinuation of the CPAP device or bi-level device at any time, the provider is expected to determine this, and stop billing for the equipment and related accessories.
- g. Auto-titrating CPAP devices are billed the same as a CPAP device.
- h. A non-heated or heated humidifier is covered by NCHC with the use of a CPAP/bi-level. The treating physician shall specify which type of humidifier the recipient is to use.

Initial Approval:

For initial approval, the physician, physician assistant, or nurse practitioner shall:

- a. Document in block 11 and 25 of the CMN/PA form, or on attached documentation, that the recipient has OSA and meets the medical necessity requirements for CPAP therapy.
- b. Submit results of the non-titrated polysomnogram summary (preferably in the non-narrative form).

The initial approval and coverage for a CPAP device or bi-level device is for a period of 6 months.

Note: A CPAP device or bi-level device is reimbursed as rental only. Reimbursement is not to exceed a total of monthly rental payments equal to the purchase price.

Renewal Approval:

Renewal approval and continued coverage of the CPAP device or bi-level device beyond the first six months of therapy, requires that, no sooner than the 5th month after initiating therapy the provider shall:

- a. Determine from the treating physician that the recipient is continuing to use the CPAP device or bi-level device; **and**
- b. Submit a statement from the physician, physician assistant, or nurse practitioner indicating that the CPAP device or bi-level device is still medically necessary. This information is acceptable in lieu of a polysomnogram for prior approval renewal only.

If the criteria listed above are not met, continued coverage of a CPAP device or bi-level device and related equipment and accessories is not medically necessary.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Respiratory Devices*.

Other Respiratory Devices

A **ventilator** is covered for treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic pulmonary disease. It includes both positive and negative types. Prior approval is required for a ventilator.

An **Intermittent Positive Pressure Breathing (IPPB)** machine and humidifier are covered if the recipient's ability to breathe is severely impaired because of any of the following:

- a. the recipient has unstable hyperventilation with CO₂ retention that can be reduced or prevented from rising with frequent mechanical assistance; or
- b. the recipient requires intermittent or constant use of assisted or controlled ventilation to maintain adequate respiration because of chronic hypoventilation.

Note: The recipient shall have pulmonary function test evidence of difficulty removing bronchial secretions or reversible bronchial constriction that is better after IPPB. In the absence of medical indication, reimbursement is limited to compressor-driven nebulization.

Prior approval is required for an IPPB machine. To renew prior approval, a statement is needed from the physician, physician assistant, or nurse practitioner indicating the recipient's overall condition has not changed and the IPPB remains medically indicated. This information is acceptable in lieu of a repeat pulmonary function test for renewal of prior approval only.

An **air power source** requires prior approval and is covered if it is required for use with medically necessary medical equipment for purposes of operating equipment that is not self-contained or cylinder driven.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Respiratory Devices - Other*.

Nebulizers

A nebulizer with compressor and related supplies is considered medically necessary when the recipient's ability to breathe is severely impaired.

Self-contained, ultrasonic nebulizer and related supplies are considered to be medically necessary when:

- a. the recipient's ability to breathe is severely impaired; and
- b. the prescribing physician, physician assistant, or nurse practitioner states that the ultrasonic nebulizer is medically necessary for the recipient to receive a smaller particle size than an ordinary nebulizer will provide.

Prior approval is required for an ultrasonic nebulizer.

Sterile saline is deemed medically necessary when used with the above equipment and accessories.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Respiratory Devices – Nebulizers*.

Apnea Monitor and Supplies

For initial and renewal approval of an apnea monitor, the physician, physician assistant, or nurse practitioner shall indicate in block 25 of the CMN/PA form or attach documentation showing that any one of the following applies to the recipient:

- a. There has been an observed or recorded episode of prolonged apnea (greater than 10 seconds) within the last three months that is documented by medical personnel and associated with bradycardia, reflux, cyanosis or pallor;
- b. The recipient is a sibling of a sudden infant death syndrome (SIDS) child. If the sibling was three months of age or less at the time of death, the recipient is covered up to six months of age. If the sibling was four months of age or older at the time of death, the recipient is covered up to three months beyond the sibling's age at death;
- c. The recipient has had an event or events requiring vigorous stimulation or resuscitation within the past three months;
- d. The recipient is an infant with bronchopulmonary dysplasia who requires oxygen and displays medical instability; or
- e. The recipient is less than two years of age and has a tracheostomy. After two years of age, additional documentation from the prescribing physician, physician assistant, or nurse practitioner justifying extended medical necessity for the apnea monitor must be attached.

Prior approval is required.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Respiratory Devices – Apnea Monitor*.

Percussor

Percussors are covered for mobilizing respiratory secretions when the recipient or operator of the powered percussor has received appropriate training by a physician, physician assistant, nurse practitioner or a therapist, and no one competent or able to administer manual therapy is available. Block 25 on CMN/PA must be checked.

Prior approval is required.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Respiratory Devices – Percussor*.

Oximeter

For initial and renewal approval of a **non-recording oximeter**, the physician, physician assistant, or nurse practitioner shall indicate in block 25 of the CMN/PA form or on attached documentation that the equipment is for continuous or intermittent use and at least one of the following applies to the recipient:

- a. The recipient is dependent on both a ventilator and supplemental oxygen;
- b. The recipient has a tracheostomy and is dependent on supplemental oxygen;
- c. The recipient requires supplemental oxygen and has unstable saturations;
- d. The recipient is on supplemental oxygen and weaning is in process; or
- e. The recipient has an appropriately documented respiratory diagnosis and requires short-term oximetry to rule out hypoxemia. In this case coverage will be allowed for a maximum of seven days.

Prior approval is required.

For initial and renewal approval of a **recording oximeter**, the physician, physician assistant, or nurse practitioner must indicate in block 25 of the CMN/PA form or on attached documentation that:

- a. the recipient's condition meets one of the coverage criteria for a non-recording oximeter, and
- b. the recording oximeter is required to monitor the recipient during a specific event such as a weaning attempt from oxygen or ventilator, feeding times for an infant, or other times for which documentation of the recipient's oxygen saturation rate is needed.

Prior approval is required.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Respiratory Devices – Oximeter*.

5.3.12 Transcutaneous Electrical Nerve Stimulation Devices

For initial and renewal approval, the physician, physician assistant, or nurse practitioner must indicate in block 25 of the CMN/PA form or on attached documentation that the main application is to control or suppress chronic painful states that are not amenable to control through elimination of the cause. The following information is also required:

- a. The specific diagnosis related to the need for the unit;
- b. Date of onset and duration of pain;
- c. Specific area(s) of pain;
- d. Prognosis; and
- e. The physician, physician assistant, or nurse practitioner's statement that other appropriate treatments to ameliorate the pain have been tried without success. The specific treatments, including pain medications, must be included in the statement.
- f. A statement from the physician, physician assistant, or nurse practitioner that the recipient has improved tolerance for activities of daily living with use of the TENS unit.
- g. A pain scale and body map that shows the severity of the pain and the specific locations of the pain.

Prior approval is required for a TENS unit.

Note: The TENS must be rented for 30 to 60 calendar days prior to requesting purchase.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Transcutaneous Electric Nerve Stimulation*.

5.3.13 Osteogenesis Stimulators

An electrical non-invasive osteogenesis stimulator for non-spinal applications is covered for the following conditions:

- a. Non-union of a long bone (clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal, or metatarsal) fracture defined as radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with the osteogenesis stimulator;
- b. Failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the last surgery; and
- c. Congenital pseudarthrosis

Non-union of a long bone fracture must be documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 calendar days, each including multiple views of the fracture site, and with a written interpretation by a physician, physician assistant, or nurse practitioner stating that there has been no evidence of fracture healing between the two sets of radiographs. An osteogenesis stimulator for a non-healed long bone fracture of less than six months duration or a lack of fusion of less than 12 months duration is not medically necessary and claims will be denied.

A non-invasive electrical osteogenesis stimulator for spinal applications is covered when medical necessity is documented and the recipient has one of the following:

- a. a failed spinal fusion where a minimum of nine months has elapsed since the last surgery;
- b. a multilevel spinal fusion surgery. A multilevel spinal fusion is one that involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.); or
- c. following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site.

A non-invasive, low-intensity ultrasonic osteogenesis stimulator is covered if all of the following criteria are met:

- a. Non-union of a fracture documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 calendar days, each including multiple views of the fracture site, and with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs;
- b. Fracture is not of the skull or vertebrae; and
- c. Fracture is not tumor related.

All osteogenesis stimulators require prior approval.

Note: For specific diagnosis requirements related to the coverage of osteogenesis stimulators refer to **Attachment A, B, Diagnosis Codes.**

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Osteogenesis Stimulators*

5.3.14 External Insulin Infusion Pump

An external insulin infusion pump is used in a recipient with diabetes to provide continuous subcutaneous insulin infusion to implement intensive diabetes management with the goal of achieving near-normal levels of blood glucose. Prior approval is required for the infusion pump, gray adapter, and piston rod. An external insulin infusion pump and related supplies are covered for a recipient who demonstrates medical necessity by meeting one of the following criteria:

External insulin infusion pumps will be covered for recipients who meet one of the following criteria:

- a. Has a diagnosis of diabetes mellitus, are insulin dependent, and have an HbA1C greater than 6.5%, with clinical health care record documentation that justifies the medical necessity for the insulin pump.

Note: Except for neonatal diabetes, a diagnosis of diabetes for 6 weeks is required before the pump is approved)

- b. Has been on an external insulin infusion pump prior to enrollment in NCHC, when clinical health care record documentation justifies the medical necessity for the insulin pump and that pump is no longer functional, there is documentation from the manufacturer that the pump cannot be repaired, and the warranty has expired.

(See also **Subsections 5.8, Servicing and Repairing Durable Medical Equipment, and 5.9, Replacing Durable Medical Equipment.**)

Recipients with Gestational Diabetes

External insulin infusion pumps will be covered for recipients who have a diagnosis of gestational diabetes and are insulin dependent when there is either clinical health care record documentation of erratic blood glucose readings, despite maximum compliance, or other documented evidence that adequate control is not being achieved. Refer to **Attachment A: B, Diagnosis Codes**, for the specific diagnosis requirements for coverage for an external insulin infusion pump.

Prior Approval Requirements for All Recipients

For prior approval the physician, physician assistant, or nurse practitioner experienced in pump therapy who orders the pump must document all of the following:

- a. The recipient's status shall be monitored during the time he or she uses the pump
- b. The recipient (or caregiver, if applicable) has demonstrated the ability and commitment to comply with the regimen of pump care, frequent self-monitoring of blood glucose, and careful attention to diet and exercise; and has completed a comprehensive diabetes education program.

The external insulin infusion pump will be covered as a purchase item for all recipients meeting coverage criteria except for those with gestational diabetes. For gestational diabetes recipients meeting coverage criteria, the external insulin infusion pump will be provided only as a rental through the end of the delivery month. If the recipient requires continued use of the insulin pump post-partum, prior approval will again be required. If approved, payments will continue until the combined payments for gestational and post-partum use cap at the purchase price.

Replacement Pumps

NCHC may cover a replacement external insulin infusion pump if the pump is no longer functional, there is documentation from the manufacturer that the pump cannot be repaired, and the warranty has expired.

A replacement pump is *not* medically necessary simply because the pump is out of warranty or is no longer being manufactured. Replacement of a functioning external insulin infusion pump with a newer advanced model is *not* covered.

Refer to **Subsections 5.8, Servicing and Repairing Durable Medical Equipment, and 5.9, Replacing Durable Medical Equipment.**

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, External Insulin Infusion Pump.**

5.3.15 Blood Glucose Monitors and Continuous Glucose Monitors and Related Supplies

Blood Glucose Monitors

NCHC covers blood glucose monitors, syringes, strips, lancets, and other related supplies when all of the following coverage criteria are met:

- a. The recipient has a diagnosis of insulin dependent diabetes, non-insulin dependent diabetes or gestational diabetes, or glycogen storage disease which is being treated by a physician;
- b. The glucose monitor and related accessories and supplies have been ordered by the physician who is treating the recipient's diabetes;
- c. The recipient or the recipient's caregiver has successfully completed training or is scheduled to begin training in the use of the monitor, test strips, and lancets;
- d. The recipient or the recipient's caregiver is capable of using the test results to assure the recipient's appropriate glycemic control; and
- e. The device is for home use.

A blood glucose monitor with an **integrated voice synthesizer** requires prior approval. All of the coverage criteria for a Blood Glucose Monitor must be met for prior approval plus the following additional criteria:

The recipient's physician certifies that:

- a. the recipient has a severe visual impairment (defined as a best corrected visual acuity of 20/200 or worse); and
- b. documents the recipient's best corrected visual acuity of 20/200 or worse.

Continuous Glucose Monitoring System and Related Supplies for ages 6 through 18 years

A Continuous Glucose Monitoring System (CGMS) is an FDA approved device that measures the glucose in the interstitial fluid throughout the day and night. CGMS should be used in **conjunction** with self monitoring blood glucose testing.

Medicaid covers CGMS and related supplies when the following criteria are met:

1. insulin dependant diabetes and;
2. documentation of recurrent unexplained severe hypoglycemic episodes or fasting hyperglycemia, nocturnal hypoglycemic episodes, hypoglycemic unawareness **or**
3. recipient has an external insulin pump which communicates with a CGMS

Prior Approval is required for CGMS.

Note: For the specific diagnosis requirements for coverage of a blood glucose monitor refer to **Attachment A: B, Diagnosis Codes**.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Glucose Monitors and Supplies*.

5.3.16 Ultraviolet Light Therapy

Ultraviolet light therapy requires prior approval and is covered when **all** of the following criteria are met:

- a. the severity of the recipient's condition is such that it has **not** been significantly improved by conventional treatment;
- b. the recipient has involvement over more than 20 percent of his or her body; and
- c. a trial period of light treatment in a clinical setting has been successful.

Block 24 on the CMN/PA form must be checked, indicating that the recipient's status will be monitored by the physician, physician assistant, or nurse practitioner while the equipment is provided.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, Phototherapy**.

5.3.17 Continuous Passive Motion Exercise Device for Use on Knee Only

A continuous passive motion exercise device is covered for recipients who have received a total knee replacement.

To qualify for coverage, use of the device must commence within two days following surgery. In addition, coverage is limited to that portion of the 3-week period following surgery during which the device is used in the recipient's home. There is insufficient evidence to justify coverage of these devices for longer periods of time or for other applications.

Block 24 on the CMN/PA form must be checked, indicating that the recipient's status will be monitored by the physician while this equipment is provided.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, Continuous Passive Motion Exercise Device**.

5.3.18 High-Frequency Chest Wall Oscillation Device

A high-frequency chest wall oscillation (HFCWO) device is an airway clearance device consisting of an inflatable vest connected by tubes to an air-pulse generator. This device is covered for recipients with a diagnosis of cystic fibrosis, bronchiectasis, and some neurological and neuromuscular conditions that compromise the ability to actively clear secretions from the respiratory tract.

This device is covered when the recipient's disease is characterized by daily productive cough for at least six continuous months or frequent exacerbations (more than two per year) requiring antibiotic therapy. In addition, there must be well-documented failure of standard treatments (e.g. chest percussion, positional drainage, deep breathing exercises) to adequately mobilize mucus.

Prior approval is required. The initial approval is for a trial period of three months rental. A request for subsequent purchase of the device may be considered based on the following documented results of the initial trial period:

- a. Recipient compliance with device use and established plan of care;
- b. Significant improvement of symptoms with use of the HWFCO device; and
- c. Decreased hospitalizations for the qualifying diagnosis during the initial trial period

The oscillatory positive expiratory pressure (PEP) device and the Flutter device facilitate secretion removal. The PEP uses a counterweighted plug and magnet to create air flow oscillation. The Flutter uses a steel ball which vibrates inside a cone, causing air flow vibration. These devices are considered medically necessary when needed to mobilize secretions and assist with airway clearance. They do not require prior approval.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *High Frequency Chest Wall Oscillation*.

5.3.19 Cough-Stimulating Device, Alternating Positive and Negative Airway Pressure

A mechanical insufflator–exsufflator is an electric cough-stimulating device that utilizes a blower and a valve to alternately apply positive and then negative pressure to the recipient's airway. The shift in pressure produces a high expiratory flow from the lungs, stimulating a cough. This device assists recipients to clear retained bronchopulmonary secretions. Air is delivered to and from the recipient via a breathing circuit incorporating a flexible tube, a bacterial filter, and either a facemask, a mouthpiece, or an adapter to a tracheostomy or endotracheal tube.

A mechanical insufflator–exsufflator or a cough-stimulating device is covered for recipients who are unable to cough and clear secretions effectively and who meet all of the following criteria:

- a. A diagnosis of a neuromuscular disease or high-level spinal cord injury (Refer to **Attachment A, B, Diagnosis Codes**, for the specific diagnosis codes required for this device;
- b. Has a significant impairment of chest wall or diaphragmatic movement, resulting in an inability to effectively cough and clear retained secretions;

- c. Lack of success with other standard respiratory treatments such as chest percussion and postural drainage, intermittent positive pressure breathing (IPPB), incentive spirometry, inhalers, positive expiratory pressure (PEP) therapy, or flutter devices; and
- d. Physician-documented evidence that the recipient or caregiver is willing and able to use the device as prescribed

Prior approval is required. Initial approval may be granted for 6 months if the recipient meets all of the following criteria:

- a. Has a supporting medical diagnoses;
- b. There is evidence that recipient has tried other methods to control secretions, such as chest percussion and postural drainage, IPPB, incentive spirometry, inhalers, PEP mask therapy, or flutter devices, without significant response (methods should be described);
- c. Has intolerance to, contraindication of, or unavailability of, home chest physiotherapy; and
- d. Has had incidents in past year of respiratory illnesses requiring physician office or emergency room visits, hospitalizations, or antibiotics

For subsequent approvals, continued medical necessity must be reestablished for each successive 6 months by evidence of recipient/caregiver compliance and improved disease management since beginning use of cough-stimulating device (as indicated by fewer infections requiring antibiotics and fewer hospitalizations).

Cough-stimulating devices are not covered for recipients with chronic obstructive pulmonary disease (COPD), bullous emphysema, susceptibility to pneumothorax or pneumomediastinum, or recent barotraumas (an injury occurring after exposure to sudden contractions or expansions of air). A cough-stimulating device will not be covered for recipients tolerating and demonstrating response to other techniques for cough assistance and secretion removal.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Cough Stimulating Device*.

5.3.20 Farrell Valve Enteral Gastric Pressure Relief System

The Farrell valve is a vented, closed, disposable system used for gastric pressure relief with some enterally fed recipients. It is used to eliminate the buildup of gastric reflux and gas in the stomach and around the outside of a feeding tube. The Farrell valve is not indicated or required for all enterally fed recipients. NCHC will cover the Farrell valve when all of the following criteria are met:

- a. the recipient is receiving continuous enteral feedings via either gravity or pump;
- b. there is documented evidence of disorders or complications with enteral feedings, such as, but not limited to, gastric dysmotility, abdominal distention, aspiration pneumonia, anti-reflux surgery, gastric pseudo-obstruction, tracheoesophageal fistula, or atresia repair; and
- c. other attempted gastric decompression measures have failed.

The Farrell valve is not covered when clinical documentation demonstrates that the recipient is tolerating continuous enteral feedings without difficulty or complications.

Prior approval is required for the Farrell valve. Initial prior approval is for a maximum of one valve per day per recipient for a maximum period of six months. For additional approvals, medical necessity must be re-established for each successive six months.

The clinical health care record must contain documentation by the physician, physician assistant, or nurse practitioner substantiating the medical necessity requirement. A starting date and expected duration for the use of the Farrell valve must also be included. The medical necessity should specifically address the recipient's complicating factors, such as: gastric dysmotility, distention, reflux, aspiration risk, excessive gastric residuals, pain, neurological impairments, and dates of any anti-reflux procedures. The inability of the recipient to tolerate enteral feedings without the Farrell valve must be documented.

Note: Only one Farrell valve per day is allowed. The valve should not be provided and billed under routine enteral feeding supply kits.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Farrell Valve*.

5.3.21 Canes, Crutches, Walkers, Gait Trainers, and Accessories

Canes and Crutches

Canes and crutches are covered when **all** of the following criteria are met:

- a. The recipient has a mobility limitation that significantly impairs his or her ability to participate in one or more mobility-related activities of daily living (MRADLs) in the home;

The MRADLs to be considered in this and all other statements in this policy are toileting, feeding, dressing, grooming, and bathing performed in customary locations in the home.

A mobility limitation is one that:

1. prevents the recipient from accomplishing the MRADL entirely; or
 2. places the recipient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
 3. prevents the recipient from completing the MRADL within a reasonable time frame.
- b. The recipient is able to safely use the cane or crutch; and
 - c. The functional mobility deficit can be sufficiently resolved by use of a cane or crutch.

If all of the criteria are not met, the cane or crutch will be denied as not medically necessary.

A crutch substitute, lower leg platform, requires prior approval and is covered if the recipient meets the above criteria and is not able to safely use crutches or a walker.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Canes and Crutches*.

Heavy Duty Canes and Crutches

Heavy duty canes and crutches are covered for recipients who weigh more than 250 pounds. Prior approval is required. The recipient's height, weight, and body measurements must be included on the CMN/PA form as well as the dimensions of the requested equipment and the manufacturer's specified weight capacity for the equipment.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Canes and Crutches – Heavy Duty*.

Walkers

A standard walker and related accessories is covered if **all** of the following criteria are met:

- a. The recipient has a mobility limitation that significantly impairs his or her ability to participate in one or more MRADLs in the home

A mobility limitation is one that:

1. Prevents the recipient from accomplishing the MRADL entirely, or
2. Places the recipient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform the MRADL; or
3. Prevents the recipient from completing the MRADL within a reasonable time frame.

The recipient is able to safely use the walker.

The functional mobility deficit can be sufficiently resolved with use of a walker.

Prior approval is not required for walkers. All of the criteria must be met for the walker to be considered medically necessary.

Glides/skis for use with a walker require prior approval and are covered when the recipient requires them to mobilize an approved walker.

To substantiate medical necessity for heavy duty walkers, the recipient's height, weight, and body measurements must be included on the CMN/PA form as well as the manufacturer's specified weight capacity for the equipment.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Walkers*.

Gait Trainers

A gait trainer is a device similar to a walker and consists of a wide-based steel frame with four casters or wheels. It provides considerable postural support for recipients who have severe motor and balance dysfunction and who require moderate to maximum support for ambulation. Additional components, called positioners or stabilizers, are added to offer additional support and control.

A gait trainer with accessories requires prior approval and is covered for recipients ages 6 through 18, if an evaluation by a physical or occupational therapist documents that the following criteria are met:

- a. The recipient needs moderate to maximal support for walking due to impaired balance reactions or pelvic or trunk instability, or has a Gross Motor Function Classification System (GMFCS) score of 3 or greater.
- b. The recipient is able to initiate movement without caregiver assistance, and there is a purposeful need for the movement.

The physical or occupational therapist must document medical necessity for all components included with the gait trainer. The physical or occupational therapist completing the evaluation cannot be employed by the medical equipment provider.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Gait Trainers*.

5.3.22 Miscellaneous Durable Medical Equipment and Supplies

A manual ventilation bag requires prior approval and is covered when a recipient has a life-threatening diagnosis and requires ventilator support.

Cervical traction equipment is covered for use in a recipient's home if it is ordered by a physician for treatment of a specified orthopedic diagnosis.

Transfer boards or other transfer devices are covered when a recipient requires the device in order to complete transition from one position to another, e.g., from bed to wheelchair or wheelchair to bathtub seat.

An IV pole is covered when a recipient receives either parenteral or enteral fluids in the home.

A paraffin bath is covered when a recipient has a documented diagnosis for which paraffin treatment is deemed beneficial by the recipient's physician.

An over tub portable whirlpool bath unit is covered when a recipient has a documented diagnosis for which whirlpool treatment is deemed beneficial by the recipient's physician.

Peak flow meters are covered when a recipient's physician deems it medically necessary for the recipient to monitor his peak expiratory flow rate on a regular basis.

Supplies for use with metered dose inhalers are covered when ordered by the physician who has also ordered a medically necessary metered dose inhaler for the recipient.

Sterile and non sterile gloves are covered for use with medically necessary Durable Medical Equipment and Supplies for the protection of the recipient. Gloves must be required to maintain or improve a recipient's medical, physical or functional level.

An ambulatory infusion pump is covered when a recipient requires covered IV medications to be administered in the home.

A respiratory suction pump, catheters, canisters, and tubing are covered if a recipient is physically unable to independently expectorate respiratory secretions.

For prior approval requirements refer to the Medicaid DME fee schedule on DMA's Web site at <http://www.ncdhhs.gov/dma/fee/>. Items that require prior approval are identified on the Medicaid Durable Medical Equipment Fee Schedule by an asterisk (*).

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Miscellaneous Durable Medical Equipment and Supplies*.

5.3.23 Nutrition

Oral Nutrition Products/Metabolic Formulas

Oral Nutrition products are covered for NCHC recipient's ages 6 through 18 when required to ameliorate a medical condition, prevent severe health complications, prevent worsening health outcomes, or improve clinical and functional benefits.

Metabolic Formulas are covered for Medicaid recipients ages 6 through 18 for in-born errors of metabolism diagnosed at birth and before the age of 10 years.

Oral nutrition products and metabolic formulas include formulas, such as Peptamen, Peptamen Jr., and PhenylAde; modular components, such as thickening agents and single nutrients (used in treatment of inborn errors of metabolism); and feeding systems, such as Pigeon feeding systems.

Examples of conditions that may indicate a need for oral nutrition products include: inborn errors of metabolism, such as phenylketonuria (PKU) or galactosemia; history of prematurity, very low birth weight (VLBW), or low birth weight (LBW); cystic fibrosis; human immunodeficiency virus (HIV); necrotizing enterocolitis (NEC); short bowel syndrome; cleft lip or cleft palate; central nervous system disorders resulting in dysphagia; and Crohn's disease.

Oral nutrition products are considered medically necessary when **all** of the following conditions are met:

- a. There is a documented diagnosis in which caloric or dietary nutrients cannot be safely or adequately consumed, absorbed, or metabolized; and
- b. The oral nutrition product is an integral component of a documented medical treatment plan and is ordered in writing by the treating physician, physician's assistant, or nurse practitioner.

Medical necessity of the oral nutrition product is substantiated by documented physical findings, and laboratory data if available, that demonstrate malnutrition or risk of nutritional depletion.

Requirements for coverage

- a. A recipient must be under the care of the ordering physician, physician's assistant, or nurse practitioner who develops a medical treatment plan that incorporates oral nutrition products.
- b. The prescriber may also order a nutrition assessment to aid in the development of a comprehensive oral nutrition therapy plan.
- c. If a nutrition assessment is ordered, it must be conducted by a licensed dietitian/nutritionist (LDN) or registered dietitian (RD).
- d. The prescriber may also order a feeding or swallowing evaluation by a licensed therapist (SLP-CCC or OTR/L).

The above mentioned assessments must be maintained within the clinical health care record as supporting documentation to substantiate medical necessity.

An Oral Nutrition Product Request Form (refer to **Attachment C** for a sample), available online at <http://www.ncdhhs.gov/dma/provider/forms.htm> under Durable Medical Equipment and Supplies, and a CMN/PA must be submitted by the provider along with any supporting documentation (for example, a growth chart or a nutrition assessment).

Medical necessity of oral nutrition product use must be re-established at specific intervals:

- a. For recipients with a diagnosed inborn error of metabolism, the provider shall submit a new Oral Nutrition Product Request Form and CMN/PA every 12 months.
- b. For recipients with other medical conditions necessitating oral nutrition supplementation, the provider shall submit a new Oral Nutrition Product Request Form and CMN/PA every 6 months with documentation supporting the effectiveness of the oral nutrition supplementation.
- c. For recipients receiving modular components and feeding devices the provider shall submit a new Oral Nutrition Product Request Form and a CMN/PA at either the 6-month or 12-month interval, depending on the approved certification period.

Note: Oral nutrition products are not covered when medical necessity is not established, or when they are used as convenient food substitutes.

Note: Oral nutrition products must be billed using a second modifier. Refer to **Attachment A, Section D, Modifiers** for information about the correct modifier to use.

Enteral Nutrition

Enteral nutrition (EN) refers to the medical equipment, supplies, formulae or solutions ordered by a physician, physician assistant, or nurse practitioner and provided according to standards of practice. The allowance for all items includes delivery to a recipient's home.

Enteral nutrition includes the following equipment, supplies, formulae or solutions:

- a. Medical equipment includes the pump used for EN and the IV pole. The equipment is rented if the physician, physician assistant, or nurse practitioner documents that the anticipated need is six months or less. The equipment may be rented or purchased if the physician, physician assistant, or nurse practitioner documents that the anticipated need exceeds six months. Once rental is initiated on an item, a subsequent request for purchase of that item is denied. The item becomes the property of the recipient when the accrued rental payments reach the NCHC allowable purchase price.
- b. Refer to **Attachment A, C Nutrition – Formula and Supplie** .for covered formulae or solutions.

For home infusion therapy nutrition, refer to Clinical Coverage Policy 3H-1, *Home Infusion Therapy*, on DMA's Website at <http://www.ncdhhs.gov/dma/mp/>.

For enteral nutrition (EN) to be covered by NCHC, the recipient shall be under the care of the referring physician, physician assistant, or nurse practitioner who prescribes EN therapy, establishes a plan of care for EN, and monitors the therapy's progress.

A recipient shall meet **all** of the following criteria:

- a. Require infusion therapy on an ongoing basis that is medically indicated for the treatment of his or her condition; and
- b. Have a clinical status that allows EN to be safely administered in his or her home; and
- c. Be unable to tolerate nutrients orally sufficient to maintain life. The recipient is either unable to take oral nutrition or unable to tolerate oral intake. EN is considered reasonable and necessary for a recipient with a functioning gastrointestinal tract who, due to non function of the structures that normally permit food to reach the digestive tract, cannot maintain weight and strength commensurate with his general condition. Examples of conditions that usually indicate the need for EN include dysphagia or aphagia due to a cardiovascular accident, a comatose condition, myasthenia gravis causing inability to swallow due to paralysis of the structure that permits swallowing, or a brain tumor with neurological deficit resulting in the lack of a gag reflex
- d. Understand the purpose and need for the therapy, accepts the associated requirements, and wants to pursue the treatment. When the recipient is unable to comprehend all that is involved, there must be a primary caregiver responsible for the recipient and acting in the recipient's behalf to meet this requirement.
- e. Be in a home environment conducive to the provision of EN—that is, a clean environment with electricity, water, telephone access, refrigeration, and enough space to support EN.
- f. Be capable of self-administering EN or have a primary caregiver who is adequately trained, capable, and willing to administer EN safely and effectively, and
- g. Be psychologically stable—the prospect of adhering to a disciplined medical regimen and coping with infusion therapy at home is realistic.

Infusion Pumps

Enteral and parenteral nutrition infusion pumps are covered by NCHC when a recipient requires medically necessary covered enteral and parenteral nutrition in the home.

For a list of the specific HCPCS codes covered by NCHC refer to Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Nutrition – Formula and Supplies*.

5.3.24 Augmentative and Alternative Communication Devices

Augmentative and alternative communication (AAC) devices help recipients with severe communication impairments to meet their functional communication needs. AAC devices, software, and related accessories are covered when **all** of the following conditions are met:

- a. the device is determined to be medically necessary;
- b. the device is a dedicated communication device;
- c. it is used solely by the recipient; and
- d. the recipient has a long-term severe communication impairment.

Note: A dedicated device is defined as a device that will be used only for communication purposes.

The device may take any of several forms:

- a. A manual device that uses orthographic or picture symbols
- b. A device that produces digitized speech output, using pre-recorded messages (these are typically classified by how much recording time they offer)
- c. A device that produces synthesized speech output, with messages formulated either by direct selection techniques or by any of multiple methods

Note: A laptop computer, desktop computer, personal digital assistant, or other device that has not been modified to run AAC software and is not a device that will be used only for communication purposes (that is, a dedicated device) will not be covered. Laptop computers, personal computers, and personal digital assistants used for purposes other than communication are not primarily medical in nature and do not meet the definition of medical equipment.

AAC software will be covered when a recipient has a laptop computer, desktop computer, or personal digital device in which software can be added to adapt the device for communication purposes.

Prior Approval and Medical Necessity

Speech-generating devices that produce synthesized speech, software, accessories, and AAC repairs require prior approval. To document medical necessity for prior approval, submit the CMN/PA form with the following documentation:

- a. A physician's report with a description of the recipient's current medical status and history
- b. A physician's order for the AAC device, including an itemization of the components (switches, special mounting devices, etc.) required by the recipient
- c. An AAC device evaluation performed by a licensed speech–language pathologist who fulfills either requirements 1 and 3, or requirements 2 and 3, below:
 1. Has a valid license issued by the North Carolina Speech and Language Pathologists and Audiologists Board of Examiners, *and* has a Certificate of Clinical Competence (CCC) from the American Speech–Language–Hearing Association (ASHA)
 2. Has either completed the equivalent educational requirements and work experience necessary for the CCC, *or* has completed the academic program and is acquiring supervised work experience to qualify for the CCC
 3. Has the education and experience in augmentative communication necessary to assess an individual and prescribe an AAC aid, system, or device that will maximize that individual's effective and functional communication

(These education and experience requirements are listed in *Augmentative and Alternative Communication: Knowledge and Skills for Service Delivery*, ASHA Supplement 22 (2002), 97-106.)

Note: The AAC device evaluation must include **all** of the following information:

- a. The language skills, oral and motor speech status, and type and severity of current communication impairment(s) that affect the recipient's abilities to communicate with and without the AAC device
- b. A detailed description of the therapeutic history in the areas of speech-language pathology, occupational therapy, and physical therapy, including the nature, frequency, and duration of treatment and the specific speech-language therapy approaches that have been tried in relation to the need for and use of an AAC device
- c. A detailed description of related impairments, including audiovisual, perceptual, cognitive level, and memory deficits, that would limit the recipient's ability to use a device, or that would require the use of a particular AAC device
- d. A detailed description of each communication device or method of communication tried by the recipient in the past and information on the effectiveness of each
- e. Specific information about the requested device, including the manufacturer's name, catalog number, product description, and list of accessories requested; justification for and use to be made of the device and accessories; and documentation of the manufacturer's price quote
- f. An explanation of the medical necessity of the AAC device, including how the device will be used in the home or in other settings and a statement that the device will be required for 12 months or longer
- g. Demonstration that the recipient possesses a treatment plan that includes a training schedule for the selected device (technical assistance from the AAC vendor must include training on the use of the AAC device)
- h. A statement that the speech-language pathologist performing the AAC device evaluation is neither an employee of nor has a financial relationship with the vendor of the AAC device

Note: Medical necessity must be proven even if prior approval is not required. Therefore, the above-listed requirements also apply to devices that do not require prior approval. In this instance, the information necessary to establish medical necessity must be kept in the recipient's confidential file by the speech-language pathologist responsible for ordering the device.

Rental Period

Any AAC device requiring prior approval must be rented for a one-month period before NCHC will purchase it. All components necessary for the use of the device—such as software, accessories, and mounting must be evaluated during this rental period. The rental fees for the one month period will be applied to the total purchase price. If during the one-month rental the initially approved device is effective for the recipient's communication needs, submit a request for prior approval of purchase of the device. The request must document the effectiveness of the rented device.

When an AAC system is not available for rental, prior approval for purchase may be granted with adequate supporting documentation that the recipient has had recent experience and achieved effective communication with the requested AAC.

A rental period is not required when replacing an existing AAC system unless the recipient's needs have changed and another AAC system is being considered.

Costs, Repairs, and Replacements

The cost of the AAC device, software (including software upgrades necessary to expand or improve the function of the AAC device), mounting system, accessories, and repairs for one recipient shall not exceed \$9,500 for a two-year period. Technical assistance from a qualified augmentative communication technology professional also includes training on use of the AAC equipment and is included in the total purchase price for the AAC device. Technical assistance may not duplicate evaluation and services provided by licensed speech, occupational, or physical therapists.

Repairs of AAC devices must not exceed \$500 annually. Requests for repairs in excess of the capped amount must be approved in advance. Refer to **Subsection 5.8** for details.

The lifetime expectancy for all AAC devices is three years. An AAC device may be modified or replaced in one of the following situations:

- a. The recipient's medical, cognitive, or physical status changes in such a way as to significantly alter the effectiveness of the device.
- b. The AAC device is no longer functional and cannot be repaired.
- c. The manufacturer's warranty or other applicable warranty has expired and repairs to the AAC device are no longer cost effective. An identical or comparable component(s) will be provided if there is documentation from a licensed speech-language pathologist that the AAC device is still effective and appropriate for the recipient's needs.
- d. The device is under manufacturer's warranty, but the repair is not covered by the warranty. Submit documentation from the manufacturer explaining the reason that the repair is not covered.
- e. The AAC device has been damaged or stolen. Submit a copy of the police or fire report if appropriate, and detail the measures to be taken to prevent reoccurrence. Refer to **Subsection 5.9** for details.

Note: All documentation of the history of service, maintenance, and repair of the device must accompany such a request. NCHC will not purchase an extended manufacturer's warranty for any AAC device.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Augmentative and Alternative Communication*.

5.3.25 Standers

A sit-to-stand stander is medical equipment that transitions a recipient who cannot stand on his or her own from a sitting to an upright standing position, with the ability to stop at any point in between and be supported during incremental weight bearing. This stander may include additional accessories for support.

A multi-position stander is medical equipment that transitions a recipient from the horizontal prone or supine position to an upright standing position. It is angle adjustable to provide graduated weight bearing and pressure. It is designed for either prone or supine standing. This stander may include additional accessories for support.

A stander and stander accessories require prior approval and are covered for recipient's ages 6 through 18 years if an evaluation by a physical or occupational therapist documents that the following criteria are met:

- a. The recipient requires moderate to maximal support for standing in the home environment.
- b. The recipient is unable to stand or ambulate due to long term medical conditions and ambulation will most likely not occur.
- c. Effective weight bearing cannot be achieved by any other means.
- d. The stander has been tried and used safely by the recipient.
- e. The recipient's home can accommodate the stander.
- f. The recipient has demonstrated motivation to stand and the recipient's caregiver is willing and able to carry out a prescribed home standing program.

Note: The physical or occupational therapist completing the evaluation cannot be employed by or have a financial relationship with the medical equipment provider.

For prior approval, the medical equipment provider shall submit a completed CMN/PA form and supporting documentation from the physical or occupational therapist demonstrating that the type of stander selected, and each of its components, is medically necessary and is the least expensive device that is appropriate for the recipient's medical condition. Describe other less expensive devices that were considered and provide a rationale as to why they were not appropriate for the recipient. List all accessories included with the stander and document medical necessity for all accessories except the following:

- a. Knee supports
- b. Hip supports
- c. Chest support
- d. Footplate or sandals
- e. Lateral supports
- f. Straps
- g. Tray

Accessories such as a mobile option, power lift option, or glider option are not covered.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Stander*s.

5.3.26 Automatic External Defibrillator, With Integrated Electrocardiogram Analysis, Garment Type (also known as wearable cardioverter defibrillator)

A wearable cardioverter defibrillator (WCD) is an external device (vest like garment) that contains the following components:

- a. cardiac monitor;
- b. electrodes;
- c. alarm system; and
- d. cardioverter-defibrillator.

The WCD monitors cardiac (heart) rhythm and delivers an electrical shock if a life threatening ventricular arrhythmia is detected. The WCD is worn continuously, 24 hours per day.

A Wearable Cardioverter Defibrillator (WCD) requires prior approval and is considered medically necessary and covered for recipients who are at risk for sudden cardiac death, are not a suitable candidate for immediate internal cardiac defibrillator (ICD); and meet any of the following criteria:

- a. A documented episode of ventricular fibrillation or sustained run of ventricular tachycardia lasting 30 seconds or longer. These dysrhythmias may either be spontaneous or induced during an electrophysiologic (EP) study, but may not be due to a transient or reversible cause and not occurring during the first 48 hours of an acute myocardial infarction;
- b. Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmia's such as long QT syndrome, hypertrophic cardiomyopathy;
- c. Either documented prior myocardial infarction or dilated cardiomyopathy and measured left ventricular ejection fraction less than or equal to 35%;
- d. Documentation of a previously implanted defibrillator that due to infection, injury or illness requires a waiting period before ICD reinsertion;
- e. Documentation of an infection or other temporary medical condition that prevents the initial implantation of an ICD.

The U.S. Food and Drug Administration has **not** approved use of the Wearable Cardioverter Defibrillator for the indications listed below. Therefore the WCD is **not medically necessary and not covered** by NCHC for a recipient who meets any one of the following:

- a. Meets the criteria for an ICD or already has an ICD implanted and operating;
- b. **Is under 18 years of age;**
- c. Has a vision or hearing problem that may interfere with reading or hearing the WCD messages;
- d. Is taking medication that would interfere with pushing the response buttons on the WCD alarm module;
- e. Is unwilling or unable to wear the device continuously, except when bathing or showering;
- f. Is pregnant or breast feeding;
- g. Is of childbearing age and not attempting to prevent pregnancy;
- h. Is exposed to excessive electromagnetic interference (EMI) from machinery, such as powerful electric motors, radio transmitters, power lines or electronic security scanners, EMI can prevent the WCD from detecting an abnormal heart rhythm.

The WCD must be ordered by a cardiologist who is experienced in management of recipients at risk for sudden cardiac death, agrees to closely monitor the recipient during the coverage period, and is willing to obtain documentation of recipient compliance with the WCD.

WCD is for rental only and prior approval is given for a maximum time period of 3 months when the recipient meets all medical necessity and coverage criteria.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *External Defibrillator*.

5.3.27 Bath and Toilet Aids

Bath/Shower Chair or Bench

A bath/shower chair sits in the bathtub or shower for bathing in the seated position. A tub transfer bench goes across the side of the tub and allows a recipient to safely slide into the tub and sit for bathing. Prior approval is not required.

A Bath/Shower Chair is considered medically necessary when a recipient cannot stand for bathing. A Tub Transfer Bench is considered medically necessary when a recipient cannot safely get into or out of a bath tub. A heavy duty transfer bench is allowed for a recipient who weighs 250 pounds or more.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Bath/Shower Chair*.

Toilet Seat/Commode Chair

A raised toilet seat clamps on to a standard toilet and elevates the toilet seat 5 inches above the existing toilet. It may include a frame and arm rests. A commode chair may be used as a bedside commode when a pan is added or as a toilet safety frame and elevated toilet seat over the existing toilet.

A raised toilet seat is considered medically necessary when a recipient cannot get up from or down to a standard commode. A commode chair is considered medically necessary for a recipient who is physically incapable of using a standard toilet or who cannot access the bathroom. A commode chair, extra wide or heavy duty is allowed for a recipient who weighs 250 pounds or more.

Pediatric Bath/Shower Chairs and Bath Lifts

Pediatric bath/shower chairs, bath lifts, and bath transfer systems are covered for NCHC recipient's ages 6 through 18 when they are medically necessary in accordance with this policy

A pediatric bath chair provides postural support and stability for a child while bathing. The frame is adjustable to provide tilt/recline to meet various positioning needs. Prior approval is required. The Pediatric Bath Chair is considered medically necessary when a recipient meets any of the following criteria:

- a. Cannot maintain a sitting position independently.
- b. Needs to be positioned in a reclining or tilted position for bathing.
- c. Has poor or limited head control in supported sitting.
- d. Cannot be safely lifted out of a bath tub due to size or weight.
- e. Requires proper positioning and additional support for safe bathing.

The following safety equipment is used in conjunction with a pediatric bath chair. This equipment does not require prior approval and includes the following:

Bath chair lateral supports, chest or pelvic straps, or wedge/pommel cushions are medically necessary when a recipient requires additional support to maintain the head or trunk in proper alignment or to maintain the recipient safely on the bath chair while bathing.

A tub stand or shower stand is medically necessary when the recipient cannot be safely transferred out of the tub from the pediatric bath chair and additional height is needed for safety or when the bath chair is to be used in a shower.

A shower trolley is medically necessary when a recipient cannot be safely lifted and placed onto the bath chair and must be transferred from bed to bath chair and transported into the shower on the shower trolley.

A hand held shower is medically necessary when the shower water must be redirected or diverted for safe and effective bathing.

Bath Support

A bath support consists of a low or hi back wrap around support used to maintain an upright seated position in the bath tub. Prior approval is required. A bath support is considered medically necessary when a recipient meets any one of the following criteria:

- a. Requires minimal to moderate assistance to maintain an upright seated position;
- b. Exhibits extensor thrusting; or
- c. Has abnormal muscle tone.

Bath Lift

A bath lift consists of a seat and a battery powered lift that lowers to the bottom of the tub and then rises back to the top. A reclining model allows for positioning in a semi reclined position or for washing hair safely. Prior approval is required. A bath lift is considered medically necessary when a recipient meets any one of the following criteria:

- a. Needs moderate to maximal assistance to get down into the tub and to get back up and cannot be safely lifted into and out of the tub when wet by caregivers due to size or medical condition;
- b. Has a balance deficit or poor head and trunk control and cannot safely sit on a tub bench or other less supportive equipment; or
- c. Is independent with bathing and positioning and is able to manage the bath lift controls, but cannot transfer into and out of the tub safely.

Shower/Commode Chair

A shower/commode chair is a shower chair with a commode cut out so the chair can be used in the shower for bathing or over the commode for toileting. Prior approval is required. A shower commode chair is considered medically necessary when a recipient meets any one of the following criteria:

- a. Is not able to stand for bathing in the shower;
- b. Cannot be safely assisted into or out of a bath tub for bathing;
- c. Does not have adequate balance or trunk support to sit on a tub bench for bathing; or
- d. Does not have access to a bath tub and cannot stand for bathing in a shower.

All accessories for this chair require medical justification which must be included in the medical information provided.

Tilt/Recline Shower/Commode Chair

A tilt/recline shower/commode chair is a shower chair that can be tilted or reclined to various angles, provides extensive support, and can be rolled into a shower for bathing. This chair can also be rolled over a commode or a commode pan can be added for toileting. Prior approval is required. A tilt/recline shower/commode chair is considered medically necessary when a recipient meets any one of the following criteria:

- a. Has extensive weakness, contractures, or abnormal tone requiring full body support;
- b. Requires total assistance for transfers and bathing;
- c. Cannot sit upright and must be tilted or reclined for safe positioning while bathing;
- d. Has a medical need that requires the tilted or reclined position when upright; or
- e. Requires pressure relief at all times when sitting.

All accessories for this chair require medical justification and must be included in the medical information provided.

Bath Shower Transfer System

A bath shower transfer system is used for positioning and transfers into the bath. It consists of a multi-functional transfer system that includes a roll in shower chair and a bath slider. Prior approval is required. A bath shower transfer system is considered medically necessary when a recipient meets any one of the following criteria:

- a. Requires maximal assistance to sit;
- b. Has extensive weakness, contractures, or abnormal tone requiring full body support;
- c. Requires total assistance for transfers and bathing; or
- d. Must use a bath tub for bathing.

A letter of medical necessity from a physical or occupational therapist involved in the care of the recipient is required for prior approval of all Pediatric Bath/Shower Chairs, Bath Lifts, and Bath Transfer Systems. The physical or occupational therapist completing the evaluation shall not be employed by or have a financial relationship with the medical equipment provider.

For prior approval, the medical equipment provider shall submit a completed CMN/PA form and supporting documentation from the physical or occupational therapist that:

- a. Demonstrates that the bathing device requested, and each of its components, is medically necessary and is the least expensive device that is appropriate for the recipient's medical condition.
- b. Describes other less expensive devices that were considered and provides rationale as to why they were not appropriate for the recipient.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Pediatric Bath/Shower Chair/Lift*.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Toilet Seat/Commode Chair*.

Pediatric Toilet Supports and Systems

Pediatric toilet supports and toileting systems are covered for NCHC recipient's ages 6 through 18 when they are medically necessary and:

- a. the recipient shall be toilet trained; or
- b. capable of being toilet trained within six months and able to participate in a toileting program.

Prior approval is required.

Toilet Seat Reducer Ring

A Toilet Seat Reducer Ring is medical equipment that reduces the size of a commode opening. A Toilet Seat Reducer Ring is considered medically necessary when a recipient is too small to sit safely on a regular commode because the opening is too large, but can safely sit on the commode for toileting with the reducer ring added.

Lo-Back Toilet Support

A Lo-Back Toilet Support is medical equipment that provides a posterior lower trunk support and reduced seat depth for a commode. A Lo-Back Toilet Support is considered medically necessary when a recipient meets any one of the following criteria:

- a. Cannot maintain balance while sitting on a commode and requires pelvic or trunk support to avoid loss of balance;
- b. Has trunk weakness or tonal abnormalities;
- c. Has poor protective reactions resulting in loss of balance and needs support for safety; or
- d. Is unable to sit on a regular toilet seat without assistance of a caregiver to maintain balance.

Potty Trainer

A potty trainer is medical equipment that provides postural support and stability for a child while toileting. It has adjustable components and accessories to allow a customized seating solution for children who cannot use a standard commode or potty chair. A potty trainer is considered medically necessary when any one of the following criteria is met:

- a. Toileting or toilet training needs to take place in locations other than a bathroom;
- b. Cannot be maintained in a stable position while sitting on a commode and requires additional support for recipient to feel secure; or
- c. Has deficits in balance, coordination, or function.

All accessories require prior approval and must be medically necessary to safely support the recipient while toileting.

Toileting System

A toileting system is medical equipment that can be mounted on the commode or used as a free standing system to provide moderate to maximal support for toileting. This system allows for the use of a variety of accessories to provide customized support where needed. A toileting system is considered medically necessary when a recipient meets any one of the following criteria:

- a. Cannot sit on a commode without the complete support of a caregiver;
- b. Has significant deficits in balance, coordination, or abnormalities in tone;
- c. Has poor head or trunk control; or
- d. Will be independent in toileting with the use of this system.

All accessories require prior approval and must be medically necessary to safely support the recipient while toileting.

A letter of medical necessity from a physical or occupational therapist involved in the care of the recipient is required for prior approval of all Pediatric Toilet Supports and Systems. The physical or occupational therapist completing the evaluation shall not be employed by or have a financial relationship with the medical equipment provider.

For prior approval, the medical equipment provider shall submit a completed CMN/PA form and supporting documentation from the physical or occupational therapist that:

- a. Demonstrates that the toileting device requested, and each of its components, is medically necessary and is the least expensive device that is appropriate for the recipient's medical condition.
- b. Describes other less expensive devices that were considered and provides rationale as to why they were not appropriate for the recipient.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C:** Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Pediatric Toilet Supports/Systems*.

5.3.28 Incontinence, Ostomy, and Urinary Catheter Supplies

NCHC shall reimburse medical equipment providers for the provision of incontinence, ostomy and urinary catheter supplies to NCHC-eligible recipients only when they are medically necessary due to a disease, illness or injury. The supplies must be prescribed by a physician, physician assistant or nurse practitioner and the amount delivered must be supported by the recipient's actual medical needs. Medical equipment providers must obtain the written, signed, and dated prescription for the supplies prior to submitting their claim for reimbursement to NCHC. If the provider submits a claim for reimbursement before obtaining the completed prescription, the supplies will be considered not medically necessary. Claims paid for supplies issued before the date of the prescription are subject to recoupment. The prescription must include the type(s) of supplies ordered and the quantity to be used for a specified time (for example per month). All requests for specialty supplies (for example silicone catheter instead of regular latex catheters) must include medical necessity documentation from the physician, physician assistant, or nurse practitioner stating the medical necessity for the specialty supply.

Incontinence supplies (for example diapers) are only covered for recipients 3 years of age and older who are incontinent due to disease, illness or injury.

Incontinence supplies must be in compliance with industry-wide quality standards for rate acquisition, rewet and capacity.

Prior approval is not required for incontinence, ostomy and urinary catheter supplies; however the medical equipment provider must have on file a CMN/PA (completed and signed by the provider as well as the physician, physician assistant, or nurse practitioner) which is valid for no more than 12 months. If the need for the supplies continues beyond 12 months from the date of the last signed CMN/PA a new completed and signed CMN/PA must be obtained and kept on file. The Medical Equipment provider shall obtain the signed CMN/PA before billing for the supplies.

These quantity limitations do not reflect minimum quantities to which the recipient is entitled. These limitations are the maximum quantities allowed for the recipient. The quantities billed must be the quantities that are documented as medically necessary to meet the recipient's needs and the quantity prescribed by the physician, physician assistant or nurse practitioner. The medical equipment provider must make every effort, in coordination with the recipient or their caregiver (such as the Adult Care Home staff), to ensure the quantity of supplies ordered each month remains medically necessary, prior to providing them. This is necessary to eliminate stockpiling of excessive supplies, waste, abuse and the excess cost of unused supplies. Claims that have been paid for supplies that have been stockpiled, wasted or abused are subject to recoupment by NCHC.

Home health agencies shall provide supplies to recipients receiving other home health services. Please refer to NCHC, *Home Health Services (not yet finalized)* (linked from DMA's Web site at <http://www.ncdhhs.gov/dma/hcmp/>).

All requests or orders that exceed the quantity limitations allowed by NCHC must be requested through a Medicare-certified home health agency enrolled as a NCHC provider.

For a list of the specific HCPCS codes covered by NCHC refer to **Attachment A, C: Procedure Code(s) Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, Incontinence, Ostomy, and Urinary Catheter Supplies.**

5.4 Amount of Service

The amount of service is limited to that which is medically necessary as determined by NCHC policies. Refer to **Attachment A, Section C, Procedure Codes**, for a list of the lifetime expectancies and quantity limitations allowed for all equipment and supplies covered by NCHC.

5.5 Durable Medical Equipment and Supplies Limitations

NCHC may place appropriate limits, based on medical necessity criteria, on Durable Medical Equipment and Supplies. When the prescribing physician, physician's assistant or nurse practitioner orders equipment or supplies beyond these limits, the provider must seek authorization for payment for these items from the Division of Medical Assistance (DMA).

The medical equipment provider must send a written override request to DMA which contains the following information:

- a. A statement requesting an override of the quantity or life expectancy limitation and an explanation of why an override is needed.
- b. The item (including HCPCS code) an override is needed for.

- c. A prescription for the additional quantity or item the override is needed for.
- d. A letter of medical necessity stating the medical need for the additional quantity requested, written by the physician, physician's assistant, nurse practitioner, or therapist.
- e. A copy of the remittance and status advice statement showing a denial by NCHC.

The override request will be reviewed for appropriateness and medical necessity and a written decision, either an override letter or a denial letter, will be returned to the medical equipment provider. Recipients will be notified in writing if the override request is denied. Refer to **Attachment A: C** for a listing of the established lifetime expectancies and quantity limitations for Durable Medical Equipment and Supplies covered by NCHC.

5.5.1 Diabetic Supply Override Process

An override process is available for recipients who are not able to obtain reliable results with diabetic supplies from the designated preferred manufacturer's product(s). The provider who will be providing the product for this recipient shall be a medical equipment provider.

The provider shall comply with **Subsection 5.5** above. A request for an override may be considered if the recipient meets one of the following:

- a. The designated preferred manufacturers glucose meter is incompatible with the recipient's current Insulin pump; or
- b. The recipient has diabetes mellitus and is now being referred by his or her healthcare provider because of the ongoing inability to obtain reliable results that can not be resolved with user education

5.6 Delivery of Service

Providers shall dispense Durable Medical Equipment and Supplies as quickly as possible due to the medical necessity identified for an item. However, providers shall not deliver an item requiring prior approval before approval has been received. Providers who deliver before receiving prior approval do so at their own risk.

5.6.1 Delivery directly to the recipient

When an item is delivered directly to a recipient, the delivery slip must be signed by the recipient or a designee. The provider shall assemble the equipment and provide teaching and training on the safe use of the equipment. The provider shall also make sure the equipment or supply is appropriate for the recipient's needs in the home.

5.6.2 Utilizing Delivery or Shipping Service

When a provider utilizes a shipping service or mail order, proof of delivery is required. The provider's records should include the shipping service's package identification number for the package sent to the recipient. The shipping service's tracking slip should reference each individual package, the delivery address, the corresponding package identification number given by the shipping service, and the delivery date. In case of lost, stolen, damaged or incomplete delivery of specified medical equipment or supplies; it is the provider's responsibility to replace the specified medical equipment or supplies without cost to the recipient or North Carolina Medicaid and Health Choice. It is expected that the replacement will occur within 48 hours.

5.7 Monitoring Care

5.7.1 Assuring Continuing Need for Rental Items and Supplies

Providers are expected to be alert to changes in the recipient's needs for rental items and supplies, and work with the physician, physician assistant, or nurse practitioner to implement the changes. At a minimum, the continuing need to provide a rental item (one that is not subject to prior approval) or a supply must be verified with the attending physician, physician assistant, or nurse practitioner at least every twelve months. If there is a need for one of these items beyond twelve months from the date of last signed CMN/PA, a new CMN/PA must be completed and signed by the physician, physician assistant, or nurse practitioner for the continued coverage. The provider shall obtain the signed form before billing for any services beyond twelve months.

5.7.2 Monitoring Enteral Nutrition (EN)

The provider and the physician, physician assistant, or nurse practitioner must ensure sufficient monitoring to protect a recipient's health and well being. The physician, physician assistant, or nurse practitioner orders any other service, such as Home Health skilled nursing visits, that are needed for the recipient.

The provider's responsibilities for monitoring EN include the following:

- a. Supplies, equipment, and formulae must be provided according to orders from the physician, physician assistant, or nurse practitioner. Problems must be resolved immediately without delay. Defective equipment must be repaired or replaced so that there is no lapse in treatment.
- b. The recipient's physician, physician assistant, or nurse practitioner shall be notified when the ordered services do not appear appropriate, there are problems with their provision, or there are concerns about administration.

Note: NCHC does not pay the provider agency for infusion nursing services for EN. When RN monitoring is needed, refer the recipient to Home Health Services. The provider may not bill NCHC for RN monitoring.

5.8 Servicing and Repairing Medical Equipment

Service and repair of medical equipment is handled in one of three ways:

Rental Equipment : Service and repairs are provided as part of the rental arrangement with no additional charge to NCHC.

Purchased Equipment Warranty: Service and repairs are handled under any warranty coverage an item may have. If there is no warranty, providers may request prior approval to perform the needed service and repairs by sending a completed CMN/PA form with a repair estimate to the address listed on the form. The estimate must show a breakdown of charges for parts and the number of hours of labor. No charge is allowed for pick-up or delivery of the item or for the assembly of NCHC-reimbursed parts.

Purchased Equipment Non-Warranty: Service or repair is covered if the equipment is owned by the recipient and if the repair is not covered under the warranty. A repair estimate must be provided. The estimate must show a breakdown of charges for parts and the number of hours of labor. No charge is allowed for pick-up or delivery or for the assembly of NCHC-reimbursed parts or for freight or the provider's travel time or expenses. All of the following information must be entered in block 25 of the CMN/PA form:

- a. The description and HCPCS code of the item being serviced or repaired.

- b. The age of the item.
- c. The number of times it has been previously repaired.
- d. The current replacement cost.

Refer to **Attachment B, Completing the Certificate of Medical Necessity/Prior Approval Form**, for instructions on completing the CMN/PA form.

Note: Providers must have emergency repair service available 24-hours a day, seven days a week for any life-sustaining equipment they provide.

Note: NCHC does not cover maintenance or service contracts.

5.9 Replacing Medical Equipment

NCHC may consider replacing the item when repairing is no longer cost-effective and the item is out of warranty. Refer to **Attachment A, Code(s) Lifetime Expectancies and Quantity Limitations**.

Note: When requesting prior approval for the replacement of an item before its usual life expectancy has ended, explain on the CMN/PA form why the replacement is needed.

Specific documentation, in addition to the prescription and CMN/PA form, is required in the following situations:

- a. In cases of equipment loss or damage beyond repair, a letter from the social worker, case manager or child service coordinator explaining the circumstances.
- b. In cases of theft, a copy of the police report or a letter from the appropriate person with knowledge of the occurrence, such as the school principal, social worker, etc.
- c. In cases of equipment destruction by fire, a copy of the fire report.

Refer to **Attachment B, Completing the Certificate of Medical Necessity/Prior Approval Form**, for instructions on completing the CMN/PA form.

5.10 Changing Suppliers

A change in suppliers may occur for various reasons, including a recipient exercising his freedom of choice of suppliers. When the change involves a transfer of responsibility for providing a rental item or oxygen and oxygen equipment, the transfer must be coordinated with the new supplier and the prescribing physician, physician assistant, or nurse practitioner.

For the new provider to get prior approval to provide rental equipment that has been supplied by the previous provider, the new provider must submit a pick up slip from the first provider showing the equipment has been picked up and new equipment is needed. The previous provider is required to submit a pick up slip that includes the provider's name, recipient's name, item picked up, and date item was picked up. Failure to submit a pick up slip to the new provider within 30 calendar days will result in an investigation and possible recoupment of funds.

5.10.1 Changing Suppliers for Rental Items Other than Oxygen Equipment

The new provider shall obtain a new completed and signed CMN/PA form and a pick-up slip from the former provider. Failure to provide a pick up ticket to the new provider within 30 calendar days may result in investigation and possible recoupment of funds from the previous provider. If the item needs prior approval, the new provider sends the CMN/PA to the address listed on the form. A new prior approval number is issued for the item and assigned to the new supplier.

Note: The allowable rental period on capped rental items carries over from the old to new supplier. The new supplier is able to get rental payments for only the balance of the rental period before the item becomes the property of the recipient.

5.10.2 Changing Suppliers for Oxygen and Oxygen Equipment

The steps for transferring responsibility are as follows:

- a. The new provider asks the previous provider for a copy of the current CMN/PA form.
- b. The previous provider corrects the “TO” date on the form to the last date that it is responsible for service.
- c. The previous provider sends a copy of the corrected CMN/PA to the new provider.
- d. The new provider obtains a new CMN/PA form signed by the physician, physician assistant, or nurse practitioner and forwards it to the address listed on the form along with a copy of the old CMN/PA form.

5.11 Terminating Rentals

The recipient, the physician, physician assistant, or nurse practitioner, the supplier or NCHC may terminate the rental of an item during the rental period. If the rental is terminated, providers may reclaim the equipment from the recipient within 30 calendar days.

Note: Medical equipment rented under the “capped rental” rules becomes the recipient’s property when the total rental payments reach the NCHC-allowable new purchase price for the item. Providers may not reclaim an item after it becomes the recipient’s property.

6.0 Providers Eligible to Bill for the Procedure, Product, or Services

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications

Providers shall be enrolled with NCHC as a Durable Medical Equipment and Supplies provider and meet the following conditions to qualify for participation with NCHC as a provider.

- a. Providers shall not accept prescriptions for NCHC covered equipment from any physician, physician assistant, or nurse practitioner, who has an ownership interest in their agency.
- b. Providers shall be enrolled and participate in Medicare as a medical equipment supplier.
- c. Service must be provided on an emergency basis, 24 hours per day, 7 days per week, for life-sustaining equipment.
- d. The providing agency shall be located within the boundaries of North Carolina or in an adjoining state from which North Carolina recipients living on the border can use the agency as a general practice. Out-of-state providers may enroll with the Division of Medical assistance when the medically necessary product they supply or manufacture

is not reasonably available through an enrolled provider located within the state or N.C. border.

- e. Refer to <http://www.ncbop.org> under the topic *DME Suppliers and Pharmacy Law/Rules* for other rules that may apply to Durable Medical Equipment and Supplies providers.
- f. Providers shall be either:
 - 1. a business entity authorized to conduct business in the state or in the locality where the business site is located. Proof of authorization shall include a certificate of assumed name, certificate of authority, certificate of good standing, license, permit or privilege license; or
 - 2. a NCHC-enrolled home health agency, a state agency, a local health department, a local lead agency for the Community Alternatives Program for Disabled Adults, a local lead agency for the Community Alternatives Program for the Mentally Retarded/Developmentally Disabled, or an agency that provides case management for the Community Alternatives Program for Children.

Note: Providers must be enrolled and meet the provider qualifications on the date that service is provided.

Note: An agency enrolled to provide Home Infusion Therapy (HIT) may also provide EN. (A HIT provider must be a home care agency licensed by the Division of Health Service Regulation to provide infusion nursing services and must have service available 24 hours a day, seven days a week.)

6.2 Federal Laws

Providers shall comply with the following requirements in addition to the laws specifically pertaining to NCHC:

- a. **Title VI of the Civil Rights Act of 1964**, which states that “no person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation under any program or activity receiving federal financial assistance.”
- b. **Section 504 of the Rehabilitation Act of 1973**, as amended, which states that “no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.”
- c. **The Americans with Disabilities Act of 1990**, which prohibits exclusion from participation in or denial of services because the agency’s facilities are not accessible to individuals with a disability.

6.3 Seeking Other Sources of Payment

Providers shall take all reasonable measures to determine the legal liabilities of third parties, including Medicare and private insurance, to pay for services. If third party liability is established, providers must bill the third party before billing NCHC.

6.4 Accepting Payment

Providers shall accept NCHC payment according to the rules and regulations for reimbursement promulgated by the Secretary of the Department of Health and Human Services and the State of North Carolina, and established under the NCHC program. This includes accepting NCHC payment as payment in full.

6.5 Disclosing Ownership Information

Providers shall disclose ownership and control information, and information about the provider's agency's owners or employees that have been convicted of criminal offenses against Medicare or Medicaid.

7.0 Additional Requirements

7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

7.2 Record Keeping

The provider shall furnish any information that the U.S. Department of Health and Human Services and its agents, DMA and its agents or the State Medicaid Fraud Control Unit requests regarding payments received for providing Medicaid services.

Providers shall keep the following documentation of their services:

- a. The prescription for the item signed by the physician, physician assistant, or nurse practitioner specifying the order as much as possible (e.g., number being ordered, frequency to be used, duration of prescription, etc.).
- b. The original CMN/PA form for Durable Medical Equipment and Supplies.
- c. The original orders signed by the physician, physician assistant, or nurse practitioner that were used to provide enteral nutrition.
- d. A full description of all item(s) supplied to a recipient.
- e. The dates the items were supplied—the delivery date for purchased items or the delivery and pickup dates for rental items, including signed pick-up and delivery slips. The delivery slip must be signed by the recipient or the recipient's designee when the delivery is direct to the recipient. When utilizing delivery or shipping services, all requirements as outlined under **Subsection 5.6.2** shall apply.
- f. A full description of any service or repairs, including details of parts and labor, applicable warranty information, and the date of the service or repair. If the item is removed from the recipient's home for service or repair, record the date of removal and the date of return.

Note: All recipient information, including the recipient's NCHC status, must be kept confidential. Provide this information only to those who are authorized to receive it.

7.3 Coordinating Care

The Durable Medical Equipment and Supplies provider shall be responsible for determining what other services the recipient is receiving and for coordinating care to ensure there is no duplication of service.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

| Date | Section Revised | Change |
|------------|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| 07/01/2010 | All sections and attachment(s) | Implementation of Session Law 2009-451, Section 10.31(a) NC Health Choice Transition |
| 10/01/2011 | All sections and attachment(s) | To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 5A under Session Law 2011-145 |
| 05/15/2012 | Attachment A | Removed code E1902 which was end-dated 8/31/11 |
| 07/01/2012 | Subsection 5.3.6 | Added Prior approval criteria on Rental wheelchairs |
| 07/01/2012 | Subsection 5.6.1 | Added Subsection 5.6.1 Delivery directly to the recipient |
| 07/01/2012 | Subsection 5.6.2 | Added Subsection 5.6.2 utilizing delivery or Shipping Service. |
| 07/01/2012 | Subsection 7.2 | Added and referenced Subsection 5.6.1 and 5.6.2 to Subsection 7.2.e Record Keeping |
| 04/01/2013 | All sections and attachment(s) | Termination of NCHC policy which will be superseded by the Combined Template policy to comply with S.L. 2011-145, § 10.41.(b). |

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Professional (CMS-1500/837P transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

The following medical equipment and related supplies require specific ICD-9-CM diagnosis codes for the item to be considered medically necessary:

Osteogenesis Stimulators

| ICD-9 Code(s) | Description |
|-----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 733.82 | non union of a fracture (other than the skull or vertebrae plus the code for the fracture site) |
| 807.00 through 807.3 | Rib(s) and sternum |
| 808.0 through 808.9 | Fracture of pelvis |
| 810.00 through 816.13 | Fracture of clavicle, scapula, humerus, radius, ulna, carpals, metacarpal bone(s), one or more phalanges of the hand |
| 820.00 through 826.1 | Fracture of neck of femur, other and unspecified parts of femur, patella, tibia, fibula, ankle, one or more tarsal or metatarsal bones, one or more phalanges of foot |

Blood Glucose Monitor and Related Supplies and External Insulin Pump

| ICD-9 Code(s) | Description |
|-----------------------|------------------------------------------------------------------|
| 250.00 through 250.93 | Diabetes Mellitus |
| 648.83 | Abnormal glucose tolerance; antepartem condition or complication |
| 271.0 | Glycogen storage disease |

Cough Stimulating Device

| ICD-9 Code(s) | Description |
|-----------------------|-------------------------------------------|
| 138 | Late effects of acute poliomyelitis |
| 335.0 through 335.9 | Anterior horn cell disease |
| 340 | Multiple sclerosis (MS) |
| 344.00 through 344.09 | Quadriplegia |
| 357.0 | Acute infective polyneuritis |
| 358.00 - 358.9 | Myoneural disorders |
| 359.0 | Congenital hereditary muscular dystrophy |
| 359.1 | Hereditary progressive muscular dystrophy |

C. Procedure Code(s)

Refer to the **Durable Medical Equipment Fee Schedule** and the **Orthotic and Prosthetic Devices Fee Schedule** for a list of equipment, supplies, and services covered by NCHC. The fee schedules are available on DMA's Web site at <http://www.ncdhhs.gov/dma/fee/>.

Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| Hospital Beds and Related Supplies | | |
| E0250 | Hospital bed, fixed height, with any type side rails, with mattress | 5 years |
| E0255 | Hospital bed, variable height, hi-lo, with any type side rails, with mattress | 5 years |
| E0260 | Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress | 5 years |
| E0265 | Hospital bed, total electric (head, foot and height adjustments), with any type side rails, with mattress | 5 years |
| E0303 | Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 lbs, but less than or equal to 600 lbs, with any type side rails, with mattress | 5 years |
| E0304 | Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 lbs, with any type side rails, with mattress | 5 years |
| E0271 | Mattress, innerspring | 3 years |
| E0272 | Mattress, foam rubber | 3 years |
| E0305 | Bed side rails, half length | 3 years |
| E0310 | Bed side rails, full length | 3 years |
| E0840 | Traction frame, attached to headboard, cervical traction | 3 years |
| E0890 | Traction frame, attached to footboard, pelvic traction | 3 years |
| E0910 | Trapeze bars, A/K/A patient helper, attached to bed, with grab bar | 3 years |
| E0911 | Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, complete with grab bar | 3 years |
| E0912 | Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar | 3 years |
| E0940 | Trapeze bar, free standing, complete with grab bar | 3 years |
| E0276 | Bed pan, fracture, metal or plastic | 3 years |
| E0280 | Bed cradle, any type | 3 years |
| E0325 | Urinal; male, jug-type, any material | 3 years |
| E0326 | Urinal; female, jug-type, any material | 3 years |
| Pediatric Beds and Cribs | | |
| E0300 | Pediatric crib, hospital grade, fully enclosed | 6 thru 18 years only: 5 years |
| E0316 | Safety enclosure frame/canopy for use with hospital bed, any type | 6 thru 18 years only: 5 years |
| E0328 | Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above spring, includes mattress | 6 thru 18 years only: 5 years |
| E0329 | Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above spring, includes mattress | 6 thru 18 years only: 5 years |
| W4047 | Miscellaneous for pediatric DME | 6 thru 18 years only |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| Pressure Reducing Support Surfaces – Group I | | |
| A4640 | Replacement pad for use with medically necessary alternating pressure pad owned by patient | 2 Years |
| E0181 | Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty | 3 years |
| E0182 | Pump for alternating pressure pad, for replacement only | 3 years |
| E0184 | Dry pressure mattress | 3 years |
| E0185 | Gel or gel-like pressure pad for mattress, standard mattress length and width | 3 years |
| E0186 | Air pressure mattress | 3 years |
| E0187 | Water pressure mattress | 3 years |
| E0196 | Gel pressure mattress | 3 years |
| E0197 | Air pressure pad for mattress, standard mattress length and width | 3 years |
| E0198 | Water pressure pad for mattress, standard mattress length and width | 3 years |
| E0199 | Dry pressure pad for mattress, standard mattress length and width | 3 years |
| Pressure Reducing Support Surfaces – Group 2 | | |
| E0193 | Powered air flotation bed (low air loss therapy) | 5 years |
| E0277 | Powered pressure-reducing air mattress | 5 years |
| E0371 | Non powered advanced pressure reducing overlay for mattress, standard mattress length and width | 5 years |
| E0372 | Powered air overlay for mattress, standard mattress length and width | 5 years |
| E0373 | Non powered advanced pressure reducing mattress | 5 years |
| Pressure Reducing Support Surfaces – Group 3 | | |
| E0194 | Air fluidized bed | N/A (Rental only) |
| Negative Pressure Wound Therapy | | |
| E2402 | Negative pressure wound therapy electrical pump, stationary or portable | N/A (Rental only) |
| A6550 | Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories | 15 per month |
| Manual Wheelchairs | | |
| K0001 | Standard wheelchair | 3 years |
| K0002 | Standard hemi (low seat) wheelchair | 3 years |
| K0003 | Lightweight wheelchair | 3 years |
| K0004 | High strength, lightweight wheelchair | 3 years |
| K0005 | Ultralightweight wheelchair | 3 years |
| K0006 | Heavy duty wheelchair | 3 years |
| K0007 | Extra heavy duty wheelchair | 3 years |
| E1161 | Manual adult size wheelchair, includes tilt in space | 3 years |
| Transport Chairs | | |
| E1031 | Rollabout chair, any and all types with castors 5” or greater | 2 years |
| E1037 | Transport chair, pediatric size | 4 years |
| E1038 | Transport chair, adult size, patient weight capacity up to and including 300 pounds | 4 years |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|------------|------------------------------------------------------------------------------------------|--------------------------------------------|
| E1039 | Transport chair, adult size, heavy duty, patient weight capacity greater than 300 pounds | 4 years |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| Pediatric Manual Wheelchairs | | |
| E1229 | Wheelchair, pediatric size, not otherwise specified | 3 years |
| E1231 | Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system | 3 years |
| E1232 | Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system | 3 years |
| E1233 | Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system | 3 years |
| E1234 | Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system | 3 years |
| E1235 | Wheelchair, pediatric size, rigid, adjustable, with seating system | 3 years |
| E1236 | Wheelchair, pediatric size, folding, adjustable, with seating system | 3 years |
| E1237 | Wheelchair, pediatric size, rigid, adjustable, without seating system | 3 years |
| E1238 | Wheelchair, pediatric size, folding, adjustable, without seating system | 3 years |
| Power Wheelchairs - Standard | | |
| K0813 | Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds | 4 years |
| K0814 | Power wheelchair, group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds | 4 years |
| K0815 | Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds | 4 years |
| K0816 | Power wheelchair, group 1 standard, captains chair, patient weight capacity up to and including 300 pounds | 4 years |
| K0820 | Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds | 4 years |
| K0821 | Power wheelchair, group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds | 4 years |
| K0822 | Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds | 4 years |
| K0823 | Power wheelchair, group 2 standard, captains chair, patient weight capacity up to and including 300 pounds | 4 years |
| K0830 | Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds | 4 years |
| K0831 | Power wheelchair, group 2 standard, seat elevator, captains chair, patient weight capacity up to and including 300 pounds | 4 years |
| Power Wheelchairs – Complex Rehab | | |
| E1239 | Power wheelchair, pediatric size, not otherwise specified | 4 years |
| K0835 | Power wheelchair, group 2 standard, single power option, sling/solid seat back, patient weight capacity up to and including 300 pounds | 4 years |
| K0836 | Power wheelchair, group 2 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds | 4 years |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|------------|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| K0841 | Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | 4 years |
| K0842 | Power wheelchair, group 2 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds | 4 years |
| K0848 | Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds | 4 years |
| K0849 | Power wheelchair, group 3 standard, captains chair, patient weight capacity up to and including 300 pounds | 4 years |
| K0856 | Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | 4 years |
| K0857 | Power wheelchair, group 3 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds | 4 years |
| K0861 | Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | 4 years |
| K0868 | Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds | 4 years |
| K0869 | Power wheelchair, group 4 standard, captains chair, patient weight capacity up to and including 300 pounds | 4 years |
| K0877 | Power wheelchair, group 4 standard, single power option, sling/solid seat back, patient weight capacity up to and including 300 pounds | 4 years |
| K0878 | Power wheelchair, group 4 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds | 4 years |
| K0884 | Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | 4 years |
| K0885 | Power wheelchair, group 4 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds | 4 years |
| | | |
| K0890 | Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds | 4 years |
| K0891 | Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds | 4 years |
| | Power Wheelchairs – Heavy Duty | |
| K0824 | Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds | 4 years |
| K0825 | Power wheelchair, group 2 heavy duty, captains chair, patient weight capacity 301 to 450 pounds | 4 years |
| K0826 | Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds | 4 years |
| K0827 | Power wheelchair, group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds | 4 years |
| K0828 | Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more | 4 years |
| K0829 | Power wheelchair, group 2 extra heavy duty, captains chair, patient weight 601 pounds or more | 4 years |
| K0837 | Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | 4 years |
| K0838 | Power wheelchair, group 2 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds | 4 years |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| K0839 | Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds | 4 years |
| K0840 | Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more | 4 years |
| K0843 | Power wheelchair, group 2 heavy duty, multiple power options, sling/solid seat/back, patient weight capacity 301 to 450 pounds | 4 years |
| K0850 | Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds | 4 years |
| K0851 | Power wheelchair, group 3 heavy duty, captains chair, patient weight capacity 301 to 450 pounds | 4 years |
| K0852 | Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds | 4 years |
| K0853 | Power wheelchair, group 3 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds | 4 years |
| K0854 | Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more | 4 years |
| K0855 | Power wheelchair, group 3 extra heavy duty, captains chair, patient weight capacity 601 pounds or more | 4 years |
| K0858 | Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds | 4 years |
| K0859 | Power wheelchair, group 3 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds | 4 years |
| K0860 | Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds | 4 years |
| K0862 | Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | 4 years |
| K0863 | Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds | 4 years |
| K0864 | Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more | 4 years |
| K0870 | Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds | 4 years |
| K0871 | Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds | 4 years |
| K0879 | Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | 4 years |
| K0880 | Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds | 4 years |
| K0886 | Power wheelchair, group 4 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | 4 years |
| Wheelchair Accessories - Batteries | | |
| E2358 | Power wheelchair accessory, group 34, non-sealed lead acid battery, each | 2 per year |
| <u>E2359</u> | Power wheelchair accessory, group 34, sealed lead acid battery each, e.g. gel-cell, absorbed glass mat | <u>2 per year</u> |
| <u>E2360</u> | Power wheelchair accessory, 22 NF non-sealed lead acid battery, each | <u>2 per year</u> |
| E2361 | Power wheelchair accessory, 22 NF sealed lead acid battery, each, (e.g. gel cell, absorbed glassmat) | 2 per year |
| E2362 | Power wheelchair accessory, group 24 non-sealed lead acid battery, each | 2 per year |
| E2363 | Power wheelchair accessory, group 24 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat) | 2 per year |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| E2364 | Power wheelchair accessory, U-1 non-sealed lead acid battery, each | 2 per year |
| E2365 | Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g., gel cell, absorbed glass mat) | 2 per year |
| E2366 | Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each | 1 year ages 6 thru 18; |
| E2367 | Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each | 1 year ages 6 thru 18; |
| E2371 | Power wheelchair accessory, group 27 sealed lead acid battery, (e.g., gel cell, absorbed glass mat), each | 1 year |
| E2372 | Power wheelchair accessory, group 27 non-sealed lead acid battery, each | 1 year |
| K0733 | Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) | 1 year |
| Wheelchair Accessories – Armrests | | |
| E0973 | Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each | 1 year ages 6 thru 18; |
| E2209 | Accessory arm trough, with or without hand support, each | 3 years |
| K0015 | Detachable, non-adjustable height armrest, each | 3 years |
| K0017 | Detachable, adjustable height armrest, base, each | 3 years |
| K0018 | Detachable, adjustable height armrest, upper portion, each | 3 years |
| K0019 | Arm pad, each | 2 years |
| K0020 | Fixed, adjustable height armrest, pair | 3 years |
| Wheelchair Accessories – Cushions | | |
| E2601 | General use wheelchair seat cushion, width less than 22 inches, any depth | 2 years ages 6 thru 18; |
| E2602 | General use wheelchair seat cushion, width 22 inches or greater, any depth | 2 years ages 6 thru 18; |
| E2603 | Skin protection wheelchair seat cushion, width less than 22 inches, any depth | 3 years |
| E2604 | Skin protection wheelchair seat cushion, width 22 inches or greater, any depth | 3 years |
| E2605 | Positioning wheelchair seat cushion, width less than 22 inches, any depth | 3 years |
| E2606 | Positioning wheelchair seat cushion, width 22 inches or greater, any depth | 3 years |
| E2607 | Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth | 3 years |
| E2608 | Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth | 3 years |
| E2609 | Custom fabricated wheelchair seat cushion, any size | 3 years |
| E2611 | General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware | 3 years |
| E2612 | General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware | 3 years |
| E2613 | Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware | 3 years |
| E2614 | Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware | 3 years |
| E2615 | Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware | 3 years |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| E2616 | Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware | 3 years |
| E2617 | Custom fabricated wheelchair back cushion, any size, including any type mounting hardware | 3 years |
| E2620 | Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware | 2 years ages 6 thru 18; |
| E2621 | Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware | 2 years ages 6 thru 18; |
| E2622 | Skin protection wheelchair seat cushion, adjustable width less than 22 inches, any depth | 3 years |
| E2623 | Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth | 3 years |
| E2624 | Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth | 3 years |
| E2625 | Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth | 3 years |
| <u>E2626</u> | Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable | <u>3 years</u> |
| <u>E2627</u> | Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable Rancho type | <u>3 years</u> |
| <u>E2628</u> | Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, reclining | <u>3 years</u> |
| <u>E2629</u> | Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints) | <u>3 years</u> |
| <u>E2630</u> | Wheelchair accessory, shoulder elbow, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support | <u>3 years</u> |
| <u>E2631</u> | Wheelchair accessory, addition to mobile arm support, elevating proximal arm | <u>3 years</u> |
| <u>E2632</u> | Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control | <u>3 years</u> |
| <u>E2633</u> | Wheelchair accessory, addition to mobile arm support, supinator | <u>3 years</u> |
| | Wheelchair Accessories – Headrests | |
| E0966 | Manual wheelchair accessory, headrest extension, each | 1 year ages 6 thru 18; |
| W4130 | Contoured or 3-piece head/neck supports with hardware | 2 years ages 6 thru 18; |
| W4131 | Basic head/neck support with hardware | 2 years ages 6 thru 18; |
| W4132 | Contoured or 3-piece head/neck support with multi-adjustable hardware | 2 years ages 6 thru 18; |
| W4133 | Basic head/neck support with multi-adjustable hardware | 2 years ages 6 thru 18; |
| | Wheelchair Accessories – Reclining Back | |
| E1226 | Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each | 1 year ages 6 thru 18; |
| | Wheelchair Accessories – Leg Rest | |
| E0990 | Wheelchair accessory, elevating leg rest, complete assembly, each | 1 year ages 6 thru 18; |
| K0046 | Elevating legrest, lower extension tube, each | 3 years |
| K0047 | Elevating legrest, upper hanger bracket, each | 3 years |
| K0195 | Elevating leg rests, pair (for use with capped rental wheelchair base) | 3 years |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|------------|-------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| E1020 | Residual limb support system for wheelchair | 1 year |
| | Wheelchair Accessories – Foot Rest/Shoe Holder | |
| E0951 | Heel loop/holder, any type, with or without ankle strap, each | 2 years |
| E0952 | Toe loop/holder, any type, each | 2 years |
| E0995 | Wheelchair accessory, calf rest/pad, each | 2 years |
| K0037 | High mount flip-up footrest, each | 3 years |
| K0038 | Leg strap, each | 2 years |
| K0039 | Leg strap, H style, each | 2 years |
| K0040 | Adjustable angle footplate, each | 2 years ages 6 thru 18; |
| K0041 | Large size footplate, each | 3 years |
| K0042 | Standard size footplate, each | 3 years |
| K0043 | Footrest, lower extension tube, each | 3 years |
| K0044 | Footrest, upper hanger bracket, each | 3 years |
| K0045 | Footrest, complete assembly | 2 years ages 6 thru 18; |
| K0050 | Ratchet assembly | 3 years |
| K0051 | Cam release assembly, footrest or legrests, each | 3 years |
| K0052 | Swing-away, detachable footrests, each | 3 years |
| K0053 | Elevating footrests, articulating (telescoping), each | 3 years |
| W4143 | Shoe holders with hardware | 2 years |
| W4144 | Foot/legrest cradle | 2 years |
| | Wheelchair Accessories – Seat/Back | |
| K0056 | Seat height less than 17” or equal to or greater than 21” for a high strength, lightweight or ultralightweight wheelchair | 3 years |
| E0981 | Wheelchair accessory, seat upholstery, replacement only, each | 2 years |
| E0982 | Wheelchair accessory, back upholstery, replacement only, each | 2 years |
| E0992 | Manual wheelchair accessory, solid seat insert | 1 year ages 6 thru 18; |
| E2201 | Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches | 3 years |
| E2202 | Manual wheelchair accessory, nonstandard seat frame width, 24-27 inches | 2 years |
| E2203 | Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches | 3 years |
| E2204 | Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 inches | 3 years |
| E2231 | Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware | 1 year ages 6 thru 18, |
| E2291 | Back, planar, for pediatric size wheelchair including fixed attaching hardware | 6 thru 18 years only; 2 years |
| E2292 | Seat, planar, for pediatric size wheelchair including fixed attaching hardware | 6 thru 18 years only; 2 years |
| E2293 | Back, contoured, for pediatric size wheelchair including fixed attaching hardware | 6 thru 18 years only; 2 years |
| E2294 | Seat, contoured, for pediatric size wheelchair including fixed attaching hardware | 6 thru 18 years only; 2 years |
| E2295 | Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features | 6 thru 18 years only; 2 years |
| E2340 | Power wheelchair accessory, non standard seat frame width, 20-23 inches | 4 years |
| E2341 | Power wheelchair accessory, nonstandard seat frame width, 24-27 inches | 4 years |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------|
| E2342 | Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 inches | 4 years |
| E2343 | Power wheelchair accessory, nonstandard seat frame depth, 22-25 inches | 4 years |
| W4119 | Wheelchair seat height, optional | 3 years |
| W4152 | Growth kit | 2 years |
| W/C Accessories – Trunk/Extremity Support | | |
| E0956 | Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each | 2 years ages 6 thru 18; |
| E0957 | Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each | 2 years ages 6 thru 18; |
| E0960 | Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware | 2 years ages 6 thru 18; |
| E0978 | Wheelchair accessory, positioning belts/safety belt/pelvic strap, each | 1 year ages 6 thru 18; |
| E0980 | Safety vest, wheelchair | 3 years |
| W4139 | Sub-asis bars with hardware | 2 years ages 6 thru 18; |
| W4140 | Abductor pads with hardware, pair | 2 years ages 6 thru 18; |
| W4141 | Knee blocks with hardware | 2 years ages 6 thru 18; |
| W4155 | Adductor pads with hardware, pair | 2 years ages 6 thru 18; |
| Wheelchair Accessories – Oversized | | |
| W4713 | Oversized footplates for weights 301# and greater | 3 years |
| W4714 | Swingaway special construction footrests for weights 401# and greater | 3 years |
| W4715 | Swingaway reinforced legrest elevating, for weights 301# to 400# | 3 years |
| W4716 | Swingaway special construction legrest, elevation for weights 401# and greater | 3 years |
| W4717 | Oversized calf pads | 2 years |
| W4718 | Oversized solid seat | 3 years |
| W4719 | Oversized solid back | 3 years |
| W4722 | Oversized full support footboard | 3 years |
| W4723 | Oversized full support calfboard | 3 years |
| Wheelchair Accessories – Power Seating Systems | | |
| E1002 | Wheelchair accessory, power seating system, tilt only | 5 years |
| E1003 | Wheelchair accessory, power seating system, recline only, without shear reduction | 5 years |
| E1004 | Wheelchair accessory, power seating system, recline only, with mechanical shear reduction | 5 years |
| E1005 | Wheelchair accessory, power seating system, recline only, with power shear reduction | 5 years |
| E1006 | Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction | 5 years |
| E1007 | Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction | 5 years |
| E1008 | Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction | 5 years |
| E2300 | Power wheelchair accessory, power seat elevation system | 6 thru 18 years only; 3 years |
| Wheelchair Accessories – Electronics | | |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| E2310 | Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware | 2 years ages 6 thru 18; |
| E2311 | 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 | 2 years ages 6 thru 18; |
| E2312 | Power wheelchair accessory, hand or chin control interface, mini-proportional remote joystick, proportional, including fixed mounting hardware | 2 years ages 6 thru 18; |
| E2313 | Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each | 2 years ages 6 thru 18; |
| E2321 | Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware | 2 years ages 6 thru 18; |
| E2322 | Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware | 2 years ages 6 thru 18; |
| E2323 | Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated | 2 years |
| E2324 | Power wheelchair accessory, chin cup for chin control interface | 2 years |
| E2325 | Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware | 2 years ages 6 thru 18; |
| E2326 | Power wheelchair accessory, breath tube kit for sip and puff interface | 2 years |
| E2327 | Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware | 2 years ages 6 thru 18; |
| E2328 | Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware | 2 years ages 6 thru 18; |
| E2329 | 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 | 2 years ages 6 thru 18; |
| E2330 | 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 | 2 years ages 6 thru 18; |
| E2373 | Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware | 2 years ages 6 thru 18; |
| E2374 | Power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only | 2 years ages 6 thru 18; |
| E2375 | Power wheelchair accessory, non-expandable controller, including all related electronics and mounting hardware, replacement only | 2 years ages 6 thru 18; |
| E2376 | Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only | 2 years ages 6 thru 18; |
| E2377 | Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue | 2 years ages 6 thru 18; |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|------------|------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| | Wheelchair Accessories – Wheels, Tires, Casters | |
| E2205 | Manual wheelchair accessory, handrim without projections (includes ergonomic or contoured), any type, replacement only, each | 3 years |
| E2206 | Manual wheelchair accessory, wheel lock assembly, complete, each | 2 per 3 years |
| E2210 | Wheelchair accessory, bearings, any type, replacement only, each | 1 year |
| E2211 | Manual wheelchair accessory, pneumatic propulsion tire, any size, each | 1 year |
| E2212 | Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each | 1 year |
| E2213 | Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each | 1 year |
| E2214 | Manual wheelchair accessory, pneumatic caster tire, any size, each | 1 year |
| E2215 | Manual wheelchair accessory, tube for pneumatic caster tire, any size, each | 1 year |
| E2216 | Manual wheelchair accessory, foam filled propulsion tire, any size, each | 2 years |
| E2217 | Manual wheelchair accessory, foam filled caster tire, any size, each | 2 years |
| E2218 | Manual wheelchair accessory, foam propulsion tire, any size, each | 1 year |
| E2219 | Manual wheelchair accessory, foam caster tire, any size, each | 1 year |
| E2220 | Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each | 1 year |
| E2221 | Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, each | 1 year |
| E2222 | Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, each | 1 year |
| E2224 | Manual wheelchair accessory, propulsion wheel excludes tire, any size, each | 1 year |
| E2225 | Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each | 1 year |
| E2226 | Manual wheelchair accessory, caster fork, any size, replacement only, each | 1 year |
| E2228 | Manual wheelchair accessory, wheel braking system and lock, complete, each | 1 year |
| E2381 | Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each | 1 year |
| E2382 | Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each | 1 year |
| E2383 | Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each | 1 year |
| E2384 | Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each | 1 year |
| E2385 | Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each | 1 year |
| E2386 | Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each | 1 year |
| E2387 | Power wheelchair accessory, foam filled caster tire, any size, replacement only, each | 1 year |
| E2388 | Power wheelchair accessory, foam drive wheel tire, any size, replacement only, each | 1 year |
| E2389 | Power wheelchair accessory, foam caster tire, any size, replacement only, each | 1 year |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|---------------------------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| E2390 | Power wheelchair accessory, solid (rubber/plastic) drive wheel tire, any size, replacement only, each | 1 year |
| E2391 | Power wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each | 1 year |
| E2392 | Power wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each | 1 year |
| E2394 | Power wheelchair accessory, drive wheel excludes tire, any size, replacement only, each | 1 year |
| E2395 | Power wheelchair accessory, caster wheel excludes tire, any size, replacement only, each | 1 year |
| E2396 | Power wheelchair accessory, caster fork, any size, replacement only, each | 1 year |
| K0065 | Spoke protectors, each | 6 thru 18 years only; 2 years |
| K0069 | Rear wheel assembly, complete, with solid tire, spokes or molded, each | 3 years |
| K0070 | Rear wheel assembly, complete, with pneumatic tire, spokes or molded, each | 3 years |
| K0071 | Front caster assembly, complete, with pneumatic tire, each | 3 years |
| K0072 | Front caster assembly, complete, with semi-pneumatic tire, each | 3 years |
| K0073 | Caster pin lock, each | 3 years |
| K0077 | Front caster assembly, complete, with solid tire, each | 3 years |
| Wheelchair Accessories – Other | | |
| E0950 | Wheelchair accessory, tray, each | 1 year ages 6 thru 18; |
| E0958 | Manual wheelchair accessory, one-arm drive attachment, each | 1 year ages 6 thru 18; |
| E0959 | Manual wheelchair accessory, adapter for amputee, each | 1 year ages 6 thru 18; |
| E0961 | Manual wheelchair accessory, wheel lock brake extension (handle), each | 1 year ages 6 thru 18; |
| E0967 | Manual wheelchair accessory, hand rim with projections, any type, each | 1 year ages 6 thru 18; |
| E0971 | Manual wheelchair accessory, anti-tipping device, each | 2 years |
| E0974 | Manual wheelchair accessory, anti-rollback device, each | 1 year ages 6 thru 18; |
| E1029 | Wheelchair accessory, ventilator tray, fixed | 3 years |
| E1030 | Wheelchair accessory, ventilator tray, gimbale | 3 years |
| E2207 | Manual wheelchair accessory, crutch and cane holder, each | 3 years |
| E2208 | Manual wheelchair accessory, cylinder tank carrier, each | 3 years |
| E2227 | Manual wheelchair accessory, gear reduction drive wheel, each | 1 year |
| E2368 | Power wheelchair component, motor, replacement only | 2 years |
| E2369 | Power wheelchair component, gear box, replacement only | 2 years |
| E2370 | Power wheelchair component, motor and gear box combination, replacement only | 2 years |
| K0105 | IV hanger, each | 3 years |
| W4005 | Unlisted replacement or repair parts | 3 years |
| W4145 | Manual tilt-in-space option | 3 years |
| W4150 | Multi-adjustable tray | 2 years |
| Activity/Positioning Chairs | | |
| W4047 | Miscellaneous for pediatric DME | 6 thru 18 years only |
| Patient Lift | | |
| E0630 | Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s) | 2 years |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| E0621 | Sling or seat, patient lift, canvas or nylon | 2 years |
| | Oxygen Equipment and Supplies | |
| A4615 | Cannula, nasal | N/A |
| A4616 | Tubing (oxygen), per foot | N/A |
| A4617 | Mouth piece | N/A |
| A4618 | Breathing circuits | N/A |
| A7027 | Combination oral/nasal mask, used with continuous positive airway pressure device, each | 2 per year |
| A7028 | Oral cushion for combination oral/nasal mask, replacement only, each | 2 per year |
| A7029 | Nasal pillows for combination oral/nasal mask, replacement only, pair | 2 per year |
| A9284 | Spirometer, non-electronic, includes all accessories | 2 per year |
| E0424 | Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing. | N/A |
| E0431 | Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask and tubing | N/A |
| E0433 | Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge | N/A |
| E0434 | Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing | N/A |
| E0439 | Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask & tubing. | N/A |
| E0441 | Stationary oxygen contents, gaseous, 1 month's supply = 1 unit | N/A |
| E0442 | Stationary oxygen contents, liquid, 1 month's supply = 1 unit | N/A |
| E0443 | Portable oxygen contents, gaseous, 1 month's supply = 1 unit | N/A |
| E0444 | Portable oxygen contents, liquid, 1 month's supply = 1 unit | N/A |
| E0550 | Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery | 2 years |
| E0555 | Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter | 2 years |
| E1354 | Oxygen accessory, wheeled cart for portable cylinder or portable concentrator, any type, replacement only, each | 5 years |
| E1355 | Stand/rack | 5 years |
| E1356 | Oxygen accessory, battery pack/cartridge for portable concentrator, any type, replacement only, each | 1 year |
| E1357 | Oxygen accessory, battery charger for portable concentrator, any type, replacement only, each | 1 year |
| E1358 | Oxygen accessory, DC power adapter for portable concentrator, any type, replacement only, each | 1 year |
| E1390 | Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate | N/A |
| E1392 | Portable oxygen concentrator, rental | N/A |
| K0738 | Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing | N/A |
| S8120 | Oxygen contents, gaseous, 1 unit equals 1 cubic foot | N/A |
| S8121 | Oxygen contents, liquid, 1 unit equals 1 pound | N/A |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| W4001 | CO ₂ saturation monitor with accessories, probes | N/A |
| Pneumatic Compressors | | |
| E0650 | Pneumatic compressor, non-segmental home model | 3 years |
| E0651 | Pneumatic compressor, segmental home model without calibrated gradient pressure | 3 years |
| E0652 | Pneumatic compressor, segmental home model with calibrated gradient pressure | 2 years |
| E0655 | Non-segmental pneumatic appliance for use with pneumatic compressor, half arm | 2 years |
| E0660 | Non-segmental pneumatic appliance for use with pneumatic compressor, full leg | 2 years |
| E0665 | Non-segmental pneumatic appliance for use with pneumatic compressor, full arm | 2 years |
| E0666 | Non-segmental pneumatic appliance for use with pneumatic compressor, half leg | 2 years |
| E0667 | Segmental pneumatic appliance for use with pneumatic compressor, full leg | 2 years |
| E0668 | Segmental pneumatic appliance for use with pneumatic compressor, full arm | 2 years |
| E0669 | Segmental pneumatic appliance for use with pneumatic compressor, half leg | 2 years |
| E0671 | Segmental gradient pressure pneumatic appliance, full leg | 2 years |
| E0672 | Segmental gradient pressure pneumatic appliance, full arm | 2 years |
| E0673 | Segmental gradient pressure pneumatic appliance, half leg | 2 years |
| Respiratory Devices | | |
| E0470 | Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) | 5 years |
| E0471 | Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) | N/A |
| E0561 | Humidifier, non-heated, used with positive airway pressure device | 2 years |
| E0562 | Humidifier, heated, used with positive airway pressure device | 2 years |
| E0601 | Continuous airway pressure (CPAP) device | 5 years |
| A7030 | Full face mask used with positive airway pressure device, each | 2 per year |
| A7031 | Face mask interface, replacement for full face mask, each | 2 per year |
| A7032 | Cushion for use on nasal mask interface, replacement only, each | 2 per year |
| A7033 | Pillow for use on nasal cannula type interface, replacement only, pair | 2 per year |
| A7034 | Nasal interface (mask or cannula type) used with positive airway pressure device with or without head strap | 2 per year |
| A7035 | Headgear used with positive airway pressure device | 2 per year |
| A7036 | Chinstrap used with positive airway pressure device | 1 per year |
| A7037 | Tubing used with positive airway pressure device | 2 per year |
| A7038 | Filter, disposable, used with positive airway pressure device | 1 per month |
| A7039 | Filter, non disposable, used with positive airway pressure device | 6 per year |
| Respiratory Devices - Other | | |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| E0450 | Volume control ventilator, without pressure support mode, may include pressure control mode used with invasive interface (e.g., tracheostomy tube) | N/A |
| E0463 | Pressure support ventilator with volume control mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube) | N/A |
| E0500 | IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source | N/A |
| E0550 | Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery | 2 years |
| E0565 | Compressor, air power source for equipment which is not self-contained or cylinder driven | 2 years |
| E0600 | Respiratory suction pump, home model, portable or stationary, electric | 5 years |
| A4483 | Moisture exchanger, disposable, for use with invasive mechanical ventilation | 60 per month |
| A4611 | Battery, heavy duty; replacement for patient owned ventilator | N/A |
| A4612 | Battery cables; replacement for patient-owned ventilator | N/A |
| A4613 | Battery charger; replacement for patient-owned ventilator | N/A |
| Respiratory Devices - Nebulizers | | |
| E0570 | Nebulizer, with compressor | 3 years |
| E0575 | Nebulizer, ultrasonic, large volume | 2 years |
| A7003 | Administration set, with small volume nonfiltered pneumatic nebulizer, disposable | 1 per month |
| A7004 | Small volume nonfiltered pneumatic nebulizer, disposable | 4 per month |
| A7005 | Administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable | 2 per year |
| A7006 | Administration set, with small volume filtered pneumatic nebulizer | 1 per month |
| A7007 | Large volume nebulizer, disposable, unfilled, used with aerosol compressor | 3 per month |
| A7010 | Corrugated tubing, disposable, used with large volume nebulizer, 100 feet | 1per month |
| A7012 | Water collection device, used with large volume nebulizer | 3 per month |
| A7013 | Filter, disposable, used with aerosol compressor or ultrasonic generator | 1per month |
| A7015 | Aerosol mask, used with DME nebulizer | 4 per month |
| Respiratory Devices – Apnea Monitor | | |
| E0619 | Apnea monitor, with recording feature | N/A |
| A4556 | Electrodes (e.g., apnea monitor), per pair | 2 per month |
| A4557 | Lead wires (e.g., apnea monitor), per pair | 2 per month |
| Respiratory Devices – Percussor | | |
| E0480 | Percussor, electric or pneumatic, home model | 2 years |
| Respiratory Devices – Oximeter | | |
| E0445 | Oximeter device for measuring blood oxygen levels non-invasively | N/A |
| Transcutaneous Electric Nerve Stimulation | | |
| E0720 | Transcutaneous electrical nerve stimulation (TENS) device, two lead, localized stimulation | 2 years |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| E0730 | Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation | 2 years |
| A4595 | Electrical stimulator supplies, 2 lead, per month (e.g., TENS, NMES) | 2 per month |
| Osteogenesis Stimulators | | |
| E0747 | Osteogenesis stimulator, electrical, non-invasive, other than spinal application | N/A |
| E0748 | Osteogenesis stimulator, electrical, noninvasive, spinal applications | N/A |
| E0760 | Osteogenesis stimulator, low intensity ultrasound, non-invasive | N/A |
| External Insulin Infusion Pump | | |
| E0784 | External ambulatory infusion pump, insulin | 5 years |
| A4230 | Infusion set for external insulin pump, non-needle cannula type | 16 per month |
| A4231 | Infusion set for external insulin pump, needle type | 16 per month |
| A6257 | Transparent film, sterile, 16 sq. in. or less, each dressing | 16 per month |
| A6258 | Transparent film, sterile, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing | 16 per month |
| A9274 | External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories | 16 per month |
| K0552 | Supplies for external drug infusion pump, syringe type cartridge, sterile, each | 16 per month |
| K0601 | Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each | 18 per year |
| K0602 | Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each | 18 per year |
| K0603 | Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each | 18 per year |
| K0604 | Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each | 18 per year |
| K0605 | Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each | 18 per year |
| Glucose Monitors and Supplies | | |
| E0607 | Home blood glucose monitor | 2 years |
| E2100 | Blood glucose monitor with integrated voice synthesizer | 3 years |
| A4215 | Needle, sterile, any size, each | 200 per month |
| A4233 | Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each | 8 per year |
| A4234 | Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each | 8 per year |
| A4235 | Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each | 8 per year |
| A4236 | Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each | 8 per year |
| A4244 | Alcohol or peroxide, per pint | 100 per month |
| A4250 | Urine test or reagent strips or tablets (100 tablets or strips) | 1 per month |
| A4252 | Blood Ketone test or reagent strip, each | 100 per calendar month |
| A4253 | Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips | 6 per month |
| A4256 | Normal, low and high calibrator solution/chips | 4 per year |
| A4258 | Spring-powered device for lancet, each | 2 per year |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|------------|-------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| A4259 | Lancets, per box of 100 | 2 per month |
| A9276 | Sensor; invasive (e.g. subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day supply | <u>Allow 30 day supply per calendar month</u> |
| A9277 | Transmitter; external, for use with interstitial continuous glucose monitoring system | 2-3 years |
| A9278 | Receiver (monitor); external, for use with interstitial continuous glucose monitoring system | 2-3 years |
| S5560 | Insulin delivery device, reusable pen; 1.5 ml size | 3 years |
| S5561 | Insulin delivery device, reusable pen; 3 ml size | 3 years |
| S8490 | Insulin syringes (100 syringes, any size) | 2 per month |
| | Phototherapy | |
| E0691 | Ultraviolet light therapy system, includes bulbs/lamps, timer, and eye protection; treatment area 2 square feet or less | N/A |
| E0692 | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 foot panel | N/A |
| | Continuous Passive Motion Exercise Device | |
| E0935 | Continuous passive motion exercise device for use on knee only | N/A |
| | High Frequency Chest Wall Oscillation | |
| E0483 | High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each | Lifetime |
| E0484 | Oscillatory positive expiratory pressure device, non-electric, any type, each | 2 per Lifetime |
| A7025 | High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each | Lifetime |
| A7026 | High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each | Lifetime |
| S8185 | Flutter device | 2 per Lifetime |
| | Cough Stimulating Device | |
| E0482 | Cough stimulating device, alternating positive and negative airway pressure | 5 years |
| A7020 | Interface for cough stimulating device, includes all components, replacement only | 2 per year |
| | Farrell Valve | |
| A9999 | Miscellaneous DME supply or accessory, not otherwise specified (For use with Farrell Valve only) | 1 per day |
| | Canes and Crutches | |
| A4635 | Underarm pad, crutch, replacement, each | 6 months ages 6 thru 18 |
| A4636 | Replacement, handgrip, cane, crutch, or walker, each | 6 months ages 6 thru 18 |
| A4637 | Replacement, tip, cane, crutch, walker, each | 6 months ages 6 thru 18 |
| E0100 | Cane, includes canes of all materials, adjustable or fixed, with tip | 2 years ages 6 thru 18 |
| E0105 | Cane, quad or three prong, includes canes of all materials, adjustable or fixed, with tips | 2 years ages 6 thru 18 |
| E0110 | Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips | 2 years ages 6 thru 18 |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|-------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| E0111 | Crutch forearm, includes crutches of various materials, adjustable or fixed, each, with tips and handgrips | 2 years ages 6 thru 18 |
| E0112 | Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips | 2 years ages 6 thru 18 |
| E0113 | Crutch underarm, wood, adjustable or fixed, each, with pad, tip and handgrip | 2 years ages 6 thru 18 |
| E0114 | Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips | 2 years ages 6 thru 18 |
| E0118 | Crutch substitute, lower leg platform, with or without wheels, each | 3 years |
| Canes and Crutches – Heavy Duty | | |
| W4688 | Single point cane for weights 251# to 500# | 3 years |
| W4689 | Quad cane for weights 251# to 500# | 3 years |
| W4690 | Crutches for weights 251# to 500# | 3 years |
| W4691 | Fixed-height forearm crutches for weights to 600# | 3 years |
| Walkers | | |
| A4636 | Replacement, handgrip, cane, crutch, or walker, each | 6 months ages 6 thru 18 |
| A4637 | Replacement tip, cane, crutch, walker, each | 6 months ages 6 thru 18 |
| E0130 | Walker, rigid (pickup), adjustable or fixed height | 2 years ages 6 thru 18 |
| E0135 | Walker, folding (pickup), adjustable or fixed height | 2 years ages 6 thru 18 |
| E0141 | Walker, rigid, wheeled, adjustable or fixed height | 2 years ages 6 thru 18 |
| E0143 | Walker, folding, wheeled, adjustable or fixed height | 2 years ages 6 thru 18 |
| E0148 | Walker, heavy duty, without wheels, rigid or folding, any type, each | 3 years |
| E0149 | Walker, heavy duty, wheeled, rigid or folding, any type | 3 years |
| E0154 | Platform attachment, walker, each | 2 years ages 6 thru 18 |
| E0155 | Wheel attachment, rigid pick-up walker, per pair | 3 years |
| E0156 | Seat attachment, walker | 3 years |
| E0158 | Leg extensions for walker, per set of four (4) | 3 years |
| W4695 | Glides/skis for use with walker | 2 years |
| Gait Trainers | | |
| E8000 | Gait trainer, pediatric size, posterior support, includes all accessories and components | 6 thru 18 years only |
| E8001 | Gait trainer, pediatric size, upright support, includes all accessories and components | 6 thru 18 years only |
| E8002 | Gait trainer, pediatric size, anterior support, includes all accessories and components | 6 thru 18 years only |
| Miscellaneous Durable Medical Equipment and Supplies | | |
| W4002 | Manual ventilation bag (e.g. Ambu bag) | 2 per year |
| E0860 | Traction equipment, overdoor, cervical | 3 years |
| E0705 | Transfer device, any type, each | 1 year ages 6 thru 18 |
| E0776 | IV pole | 3 years |
| E0235 | Paraffin bath unit, portable | 2 years |
| E1300 | Whirlpool, portable (overtub type) | 2 years |
| A4614 | Peak expiratory flow rate meter, hand held | 2 per year |
| A4627 | Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler | 3 per year |
| W4120 | Disposable bags for Inspirease inhaler system, set of 3 | 4 per year |
| A4927 | Gloves, non-sterile, per 100 | N/A |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|-----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| A4930 | Gloves, sterile, per pair | N/A |
| E0781 | Ambulatory infusion pump, single or multiple channels electric or battery operated with administrative equipment, worn by patient | N/A |
| A4628 | Oropharyngeal suction catheter, each | 4 per month |
| A7000 | Canister, disposable, used with suction pump, each | 10 per month |
| A7001 | Canister, non-disposable, used with suction pump, each | 2 per year |
| A7002 | Tubing, used with suction pump, each | 2 per month |
| W4678 | Replacement battery for portable suction pump | 2 years |
| A4213 | Syringe, sterile, 20cc or greater, each | 50 per month |
| A4217 | Sterile water/saline, 500 ml | 300 per month |
| A4246 | Betadine or pHisoHex solution, per pint | 10 per month |
| A4456 | Adhesive remover, wipes, any type, each | 1 box per month |
| A4623 | Tracheostomy, inner cannula | N/A |
| A4624 | Tracheal suction catheter, any type, other than closed system, each | 720 per month |
| A4625 | Tracheostomy care kit for new tracheostomy | 90 per mth ages 6 thru 18 |
| A4626 | Tracheostomy cleaning brush, each | N/A |
| A4629 | Tracheostomy care kit for established tracheostomy | 90 per mth ages 6 thru 18 |
| A7520 | Tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each | N/A |
| A7521 | Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each | N/A |
| A7522 | Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each | N/A |
| A7525 | Tracheostomy mask, each | N/A |
| A7526 | Tracheostomy tube collar/holder, each | 12 per month |
| L8501 | Tracheostomy speaking valve | 7 per month |
| W4153 | Tracheostomy ties, twill | 2 per day |
| Nutrition – Formula and Supplies | | |
| B4034 | Enteral feeding supply kit; syringe fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape | 1 per day, no more than 31 per month. |
| B4035 | Enteral feeding supply kit; pump fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape | 1 per day, no more than 31 per month. |
| B4036 | Enteral feeding supply kit; gravity fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape | 1 per day, no more than 31 per month. |
| B4081 | Nasogastric tubing with stylet | 3 every 3 months, not to exceed 12 per year. |
| B4082 | Nasogastric tubing without stylet | 3 every 3 months, not to exceed 12 per year. |
| B4083 | Stomach tube—Levine type | 3 every 3 months, not to exceed 12 per year. |
| B4087 | Gastrostomy/jejunostomy tube, standard, any material, any type, each | 1 every 3 months, not to exceed 4 per year |
| B4088 | Gastrostomy/jejunostomy tube, low-profile, any material, any type, each | 1 every 3 months, not to exceed 4 per year |
| B4100 | Food thickener, administered orally, per ounce | N/A |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|-------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|
| B4103 | Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit | Maximum allowed per calendar month is 100 units. |
| B4104 | Additive for enteral formula (e.g., fiber) | N/A |
| B4149 | Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit | Monthly limits depend on the individual recipient's medical/nutritional needs and physician's orders no to exceed 775 units per calendar month. |
| B4150 | Enteral formulae, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories= 1 unit | Monthly limits depend on the individual recipient's medical/nutritional needs and physician's orders no to exceed 775 units per calendar month. |
| B4152 | Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit | Monthly limits depend on the individual recipient's medical/nutritional needs and physician's orders no to exceed 775 units per calendar month. |
| B4153 | Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit | Monthly limits depend on the individual recipient's medical/nutritional needs and physician's orders no to exceed 775 units per calendar month. |
| B4154 | Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories=1 unit | Monthly limits depend on the individual recipient's medical/nutritional needs and physician's orders no to exceed 775 units per calendar month. |
| B4155 | Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g. glucose polymers), proteins/amino acids (e.g. glutamine, arginine), fat (e.g. medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories= 1unit | Monthly limits depend on the individual recipient's medical/nutritional needs and physician's orders no to exceed 775 units per calendar month. |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|
| B4157 | Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit | Monthly limits depend on the individual recipient's medical/nutritional needs and physician's orders no to exceed 775 units per calendar month. |
| B4158 | Enteral formula, for pediatric nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 cal = 1 unit | Monthly limits depend on the individual recipient's medical/nutritional needs and physician's orders no to exceed 775 units per calendar month. |
| B4159 | Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 cal = 1 unit | Monthly limits depend on the individual recipient's medical/nutritional needs and physician's orders no to exceed 775 units per calendar month. |
| B4160 | Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 cal = 1 unit | Monthly limits depend on the individual recipient's medical/nutritional needs and physician's orders no to exceed 775 units per calendar month. |
| B4161 | Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 cal = 1 unit | Monthly limits depend on the individual recipient's medical/nutritional needs and physician's orders no to exceed 775 units per calendar month. |
| B4162 | Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 cal = 1 unit | Monthly limits depend on the individual recipient's medical/nutritional needs and physician's orders no to exceed 775 units per calendar month. |
| B9002 | Enteral nutrition infusion pump - with alarm | 2 years |
| B9004 | Parenteral nutrition infusion pump, portable | 2 years |
| B9006 | Parenteral nutrition infusion pump, stationary | 2 years |
| S8265 | Haberman Feeder for cleft lip/palate | N/A |
| W4211 | Low profile gastrostomy extension/replacement kit tubes for cont. feed. | 2 per month |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| W4212 | Low profile gastrostomy extension/replacement kit for bolus feeding | 2 per month |
| | Augmentative and Alternative Communication | |
| E2500 | Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time | 3 years |
| E2502 | Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time | 3 years |
| E2504 | Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time | 3 years |
| E2506 | Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time | 3 years |
| E2508 | Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device | 3 years |
| E2510 | Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access | 3 years |
| E2511 | Speech generating software program, for personal computer or personal digital assistant | 3 years |
| E2512 | Accessory for speech generating device, mounting system | 3 years |
| E2599 | Accessory for speech generating device, not otherwise specified | 2 years |
| V5336 | Repair/modification of augmentative communicative system or device (excludes adaptive hearing aid) | \$500 per year |
| | Standers | |
| E0637 | Combination sit to stand system, any size including pediatric, with seatlift feature, with or without wheels | 6 thru 18 years only; 3 years |
| E0638 | <u>Standing frame/table system, one position (e.g. upright, supine or prone stander), any size including pediatric, with or without wheels</u> | 6 thru 18 years only; 3 years |
| E0641 | <u>Standing frame/table system, multi-position (e.g. three-way stander), any size including pediatric, with or without wheels</u> | 6 thru 18 years only; 3 years |
| E0642 | <u>Standing frame/table system, mobile (dynamic stander), any size including pediatric</u> | 6 thru 18 years only; 3 years |
| | External Defibrillator | |
| K0606 | Automatic external defibrillator, with integrated electrocardiogram analysis, garment type | 18 years of age and older only |
| | Bath/Shower Chair | |
| E0240 | Bath/shower chair, with or without wheels, any size | 3 years |
| E0247 | Transfer bench for tub or toilet with or without commode opening | 3 years |
| E0248 | Transfer bench, heavy duty, for tub or toilet with or without commode opening | 3 years |
| | Pediatric Bath/Shower Chair/Lift | |
| W4016 | Bath seat, pediatric (e.g., TLC) | 3 years |
| E0700 | Safety equipment, device or accessory, any type | 3 years |
| W4047 | Miscellaneous for pediatric DME | 6 thru 18 years only |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| | Toilet Seat/Commode Chair | |
| E0163 | Commode chair, mobile or stationary, with fixed arms | 3 years |
| E0165 | Commode chair, mobile or stationary, with detachable arms | 3 years |
| E0167 | Pail or pan for use with commode chair, replacement only | 1 year |
| E0168 | Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type each | 3 years |
| E0244 | Raised toilet seat | 3 years |
| | Pediatric Toilet Supports/Systems | |
| W4047 | Miscellaneous for pediatric DME | 6 thru 18 years only |
| | Incontinence, Ostomy, and Urinary Catheter Supplies | |
| A4310 | Insertion tray without drainage bag and without catheter (accessories only) | 2 per month |
| A4311 | Insertion tray without drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.) | 1 per month |
| A4313 | Insertion tray without drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation | 1 per month |
| A4314 | Insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.) | 1 per month |
| A4316 | Insertion tray with drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation | 1 per month |
| A4320 | Irrigation tray with bulb or piston syringe, any purpose | 3 per month |
| A4321 | Therapeutic agent for urinary catheter irrigation | 2 per month |
| A4322 | Irrigation syringe, bulb or piston, each | 2 per month |
| A4328 | Female external urinary collection device; pouch, each | 31 per month |
| A4331 | Extension drainage tubing, any type, any length, with connector/adapter, for use with urinary leg bag or urostomy pouch, each | 2 per month |
| A4334 | Urinary catheter anchoring device, leg strap, each | 2 per month |
| A4335 | Incontinence supply; miscellaneous | 2 per month |
| A4338 | Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each | 1 per month |
| A4340 | Indwelling catheter; specialty type (e.g., coude, mushroom, wing, etc.), each | 1 per month |
| A4344 | Indwelling catheter, Foley type, two-way, all silicone, each | 1 per month |
| A4349 | Male external catheter, with or without adhesive, disposable, each | 35 per month |
| A4351 | Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each | 200 per month |
| A4352 | Intermittent urinary catheter; coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each | 200 per month |
| A4353 | Intermittent urinary catheter, with insertion supplies | 200 per month |
| A4354 | Insertion tray with drainage bag but without catheter | 2 per month |
| A4357 | Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each | 2 per month |
| A4358 | Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each | 2 per month |
| A4361 | Ostomy faceplate, each | 3 per 6 months |
| A4362 | Skin barrier; solid, 4X4 or equivalent; each | 20 per month |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| A4364 | Adhesive, liquid or equal, any type, per oz | 4 oz. per month |
| A4367 | Ostomy belt, each | 1 per month |
| A4368 | Ostomy filter, any type, each | 60 per month |
| A4369 | Ostomy skin barrier, liquid (spray, brush, etc), per oz. | 2 oz. per month |
| A4371 | Ostomy skin barrier, powder, per oz. | 2 oz. per month |
| A4372 | Ostomy skin barrier, solid 4X4 or equivalent, standard wear, with built-in convexity, each | 20 per month |
| A4373 | Ostomy skin barrier, with flange (solid, flexible, or accordion), with built-in convexity, any size, each | 20 per month |
| A4375 | Ostomy pouch, drainable, with faceplate attached, plastic, each | 15 per month |
| A4376 | Ostomy pouch, drainable, with faceplate attached, rubber, each | 3 per month |
| A4377 | Ostomy pouch, drainable, for use on faceplate, plastic each | 10 per month |
| A4378 | Ostomy pouch, drainable, for use on faceplate, rubber, each | 3 per month |
| A4379 | Ostomy pouch, urinary, with faceplate attached, plastic, each | 15 per month |
| A4380 | Ostomy pouch, urinary, with faceplate attached, rubber, each | 3 per month |
| A4381 | Ostomy pouch, urinary, for use on faceplate, plastic each | 10 per month |
| A4382 | Ostomy pouch, urinary, for use on faceplate, heavy plastic, each | 3 per month |
| A4383 | Ostomy pouch, urinary, for use on faceplate, rubber, each | 3 per month |
| A4384 | Ostomy faceplate equivalent, silicone ring, each | 3 per 6 months |
| A4385 | Ostomy skin barrier, solid 4X4 or equivalent, extended wear, without built-in convexity, each | 20 per month |
| A4388 | Ostomy pouch, drainable, with extended wear barrier attached (1 piece), each | 20 per month |
| A4389 | Ostomy pouch, drainable, with barrier attached, with built-in convexity (1 piece), each | 20 per month |
| A4390 | Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each | 20 per month |
| A4391 | Ostomy pouch, urinary, with extended wear barrier attached (1 piece), each | 20 per month |
| A4392 | Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each | 20 per month |
| A4393 | Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each | 20 per month |
| A4394 | Ostomy deodorant, with or without lubricant, for use in ostomy pouch, per fluid ounce | 16 oz. per month |
| A4395 | Ostomy deodorant, for use in ostomy pouch, solid, per tablet | 100 per month |
| A4397 | Irrigation supply; sleeve, each | 4 per month |
| A4398 | Ostomy irrigation supply; bag, each | 2 per 6 months |
| A4399 | Ostomy irrigation supply; cone/catheter, with or without brush | 2 per 6 months |
| A4400 | Ostomy irrigation set | 2 per month |
| A4402 | Lubricant, per ounce | 4 oz. per month |
| A4404 | Ostomy ring, each | 10 per month |
| A4405 | Ostomy skin barrier, non-pectin based, paste, per ounce | 4 oz. per month |
| A4406 | Ostomy skin barrier, pectin-based, paste, per ounce | 4 oz. per month |
| A4407 | Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4X4 inches or smaller, each | 20 per month |
| A4408 | Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, larger than 4X4 inches, each | 20 per month |
| A4409 | Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, 4X4 inches or smaller, each | 20 per month |
| A4410 | Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, larger than 4X4 inches, each | 20 per month |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| A4411 | Ostomy skin barrier, solid 4X4 or equivalent, extended wear, with built-in convexity, each | 20 per month |
| A4414 | Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, 4X4 inches or smaller, each | 20 per month |
| A4415 | Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, larger than 4X4 inches, each | 20 per month |
| A4416 | Ostomy pouch, closed, with barrier attached, with filter (1 piece), each | 60 per month |
| A4417 | Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (1 piece), each | 60 per month |
| A4418 | Ostomy pouch, closed, without barrier attached, with filter (1 piece), each | 60 per month |
| A4419 | Ostomy pouch, closed; for use on barrier with non-locking flange, with filter (2 piece), each | 60 per month |
| A4423 | Ostomy pouch, closed; for use on barrier with locking flange, with filter (2 piece), each | 60 per month |
| A4424 | Ostomy pouch, drainable, with barrier attached, with filter (1 piece), each | 20 per month |
| A4425 | Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (2 piece system), each | 20 per month |
| A4426 | Ostomy pouch, drainable; for use on barrier with locking flange (2 piece system), each | 20 per month |
| A4427 | Ostomy pouch, drainable; for use on barrier with locking flange, with filter (2 piece system), each | 20 per month |
| A4428 | Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (1 piece), each | 20 per month |
| A4429 | Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each | 20 per month |
| A4430 | Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each | 15 per month |
| A4431 | Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (1 piece), each | 20 per month |
| A4432 | Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet-type tap with valve (2 piece), each | 20 per month |
| A4433 | Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each | 20 per month |
| A4450 | Tape, non-waterproof, per 18 square inches | 80 units |
| A4452 | Tape, waterproof, per 18 square inches | 80 units |
| A4455 | Adhesive remover or solvent (for tape, cement or other adhesive), per ounce | 16 oz. per 6 months |
| A4554 | Disposable underpads, all sizes | 150 per month |
| A5051 | Ostomy pouch, closed; with barrier attached (1 piece), each | 60 per month |
| A5052 | Ostomy pouch, closed; without barrier attached (1 piece), each | 60 per month |
| A5053 | Ostomy pouch, closed; for use on faceplate, each | 60 per month |
| A5054 | Ostomy pouch, closed; for use on barrier with flange (2 piece), each | 60 per month |
| A5055 | Stoma cap | 31 per month |
| A5061 | Ostomy pouch, drainable; with barrier attached, (1 piece), each | 20 per month |
| A5056 | Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each | 20 per month |
| A5057 | Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (1 piece), each | 20 per month |
| A5062 | Ostomy pouch, drainable; without barrier attached (1 piece), each | 20 per month |
| A5063 | Ostomy pouch, drainable; for use on barrier with flange (2 piece system), each | 20 per month |

| HCPCS Code | Item Description | Lifetime Expectancy or Quantity Limitation |
|-------------------|----------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| A5071 | Ostomy pouch, urinary; with barrier attached (1 piece), each | 20 per month |
| A5072 | Ostomy pouch, urinary; without barrier attached (1 piece), each | 20 per month |
| A5073 | Ostomy pouch, urinary; for use on barrier with flange (2 piece), each | 20 per month |
| A5093 | Ostomy accessory; convex insert | 10 per month |
| A5102 | Bedside drainage bottle with or without tubing, rigid or expandable, each | 2 per 6 months |
| A5120 | Skin barrier, wipes, or swabs, each | 150 per 6 months |
| A5121 | Skin barrier; solid, 6X6 or equivalent, each | 20 per month |
| A5122 | Skin barrier; solid, 8X8 or equivalent, each | 20 per month |
| A5126 | Adhesive or non-adhesive; disk or foam pad | 20 per month |
| A5131 | Appliance cleaner, incontinence and ostomy appliances, per 16 oz. | 1 per month |
| A6216 | Gauze, non-impregnated, non-sterile, pad size 16 sq. in or less, without adhesive boarder, each dressing | 60 per month |
| T4521 | Adult sized disposable incontinence product, brief/diaper, small, each | 192 per month |
| T4522 | Adult sized disposable incontinence product, brief/diaper, medium, each | 192 per month |
| T4523 | Adult sized disposable incontinence product, brief/diaper, large, each | 192 per month |
| T4524 | Adult sized disposable incontinence product, brief/diaper, extra large, each | 192 per month |
| T4525 | Adult sized disposable incontinence product, protective underwear/pull on, small size, each | 200 per month |
| T4526 | Adult sized disposable incontinence product, protective underwear/pull on, medium size, each | 200 per month |
| T4527 | Adult sized disposable incontinence product, protective underwear/pull on, large size, each | 200 per month |
| T4528 | Adult sized disposable incontinence product, protective underwear/pull on, extra large size, each | 200 per month |
| T4529 | Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each | 192 per month |
| T4530 | Pediatric sized disposable incontinence product, brief/diaper, large size, each | 192 per month |
| T4531 | Pediatric sized disposable incontinence product, protective underwear/pull on, small/medium size, each | 200 per month |
| T4532 | Pediatric sized disposable incontinence product, protective underwear/pull on, large size, each | 200 per month |
| T4533 | Youth sized disposable incontinence product, brief/diaper, each | 192 per month |
| T4534 | Youth-sized disposable incontinence product, protective underwear/pull on, each | 200 per month |
| T4543 | Disposable incontinence product, brief/diaper, bariatric, each | 200 per month |

| Equipment Service and Repair | | |
|-------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| K0739 | Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes | N/A |

D. Modifiers

Providers are required to follow applicable modifier guidelines.

Oral Nutrition:

Oral nutrition products must be billed using a second modifier, the BO modifier.

Oxygen:

If a flow of greater than 4 liters per minute (LPM) is documented as medically necessary, the higher oxygen allowable will be paid to the supplier at 1.5 times the rate. The modifiers listed below are to be added to the oxygen code being used. If either of these modifiers is used, then only the 1.5 times the rate will be reimbursed and there will be no payment for the portable oxygen system.

QF: Prescribed amount of oxygen is greater than 4 LPM and portable oxygen is also prescribed

QG: Prescribed amount of oxygen is greater than 4 LPM and portable oxygen is not prescribed

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

F. Place of Service

Home.

G. Co-payments

NCHC eligible recipients are exempt from co-payments.

H. Reimbursement

Providers must bill their usual and customary charges.

Refer to the Basic Medicaid Billing Guide on DMA's web site at <http://www.ncdhhs.gov/dma/basicmed/> for additional information.

Attachment B: Completing the Certificate of Medical Necessity/Prior Approval Form

The Certificate of Medical Necessity/Prior Approval (CMN/PA) form is completed according to the following instructions. All blocks **must** be completed unless they are listed as optional. An example of a completed form follows the instructions.

| Block #/Description | Instruction |
|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Recipient's Last Name, First, Middle | Enter the recipient's last name, first name, and middle name as it appears on the patient's NCHC ID card. |
| 2. Birth Date (MM/DD/YYYY) | Enter the month, day, and year of the recipient's date of birth. |
| 3. Sex | Enter an F or M to indicate the recipient's sex. |
| 4. Medicare Number | Enter the recipient's Medicare number—nine digits and a letter. Enter N/A if the recipient is not on Medicare. |
| 5. NCHC Number | Enter the recipient's NCHC number—nine digits and a letter. |
| 6. Recipient's Address and Telephone Number | Enter the recipient's street address, city, state and zip code—and phone number with the area code. |
| 7. Provider / Attending Provider Number | Enter the supplier's NCHC provider number—this is a seven-digit number. Note: Attending provider numbers are only required for items on the orthotic and prosthetic fee schedule. |
| 8. Provider Name, Address and Telephone Number | Enter the supplier's name, street address, city, state and zip code—and phone number with the area code. |
| 9. Prescribing Physician Name, Address and Telephone Number | Enter the prescribing physician's name, street address, city, state and zip code—and phone number with the area code. |
| 10. Provider Number | (Optional entry) Enter the physician's NCHC provider number—this is a seven-digit number. |
| 11. ICD-9-CM, Principal Diagnosis, and Date | Enter the description of the principal diagnosis and the date of onset. Entering the ICD-9-CM code is optional unless coverage of the device is restricted to specific codes. (The code is needed on the claim; therefore, it is helpful to obtain it from the physician when completing the CMN/PA.) |
| 12. ICD-9-CM, Other Pertinent Diagnoses and Date | Enter the description of the secondary or pertinent diagnosis (es), and the date(s) of onset. Entering the ICD-9-CM code(s) is optional. |
| 13. CPT-4, Surgical Procedure | If a surgical procedure is related to the need for DME, enter the name of the procedure and the date it was performed. Entering the CPT-4 code is optional. |
| 14 - 23: (completed by physician, non-physician clinician or a physician employee) | For the items 14 through 23, check the applicable blocks to justify the need for the requested item(s). Write additional information as needed for justification. Enter N/A if not applicable to the recipient and the item being provided. The recipient's height and weight is required. |

| Block #/Description | Instruction |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>24. Recipient's status will be monitored by physician while equipment is provided (completed by physician, non-physician clinician or a physician employee)</p> | <p>Check this block if the item requires the physician to provide instructions to the recipient and monitor the recipient's status during the period that the equipment is being used. This block must be checked for percussors (E0480), glucose monitors (E0607), apnea monitors (E0619), external insulin pumps (E0784), ultraviolet lights (E0691 or E0692), photo therapy units (E0202), and continuous passive motion exercise device for use on knee only (E0935).</p> |
| <p>25. Provide objective information to substantiate medical necessity of equipment (completed by physician, non-physician clinician or a physician employee)</p> | <p>Provide additional information to justify the need for the item(s) or special features.</p> |
| <p>26.</p> | <p>Enter information for each item requested EXT: Check if requesting an extension of a previous prior approval. PRIOR APPROVAL NO.: Leave blank. FROM DATE and TO DATE: Other Purchased Equipment and DME-Related Supplies: Enter the date the item is expected to be delivered to the recipient in the FROM box. Enter a date six months after the FROM date in the TO box. Rental Equipment: Enter the anticipated beginning of the rental period in the FROM block. Enter the expected end of the rental period in the TO block. Service and Repairs: Enter the expected date that the item is to be serviced or repaired in the FROM block. Enter a date three months after the FROM date in the TO block. EDS Use Only: Leave blank. R—N - U: Check R for rental, Check N for a new purchase or U for a used purchase. HCPCS CODE: Enter the HCPCS code for the item. EQUIPMENT DESCRIPTION Enter the description that corresponds to the HCPCS code for each item requested.</p> |
| <p>27. Provider Signature/Board Certified Practitioner Signature and Date</p> | <p>An authorized representative of the supplier signs and dates the form to show acceptance of the order and agreement to provide the requested items. A signature stamp is acceptable—stamp all three pages. Note: Board certified practitioner signatures are only required for items on the orthotic and prosthetic fee schedule.</p> |

| Block #/Description | Instruction |
|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 28. Physician, Physician Assistant, or Nurse Practitioner Signature and Date | The physician, physician assistant, or nurse practitioner signs and dates the form to verify the accuracy of the information on the form, the medical necessity for the requested item(s) and, if applicable, the agreement to provide instruction and supervision to the recipient. <i>NOTE: Signature stamps are NOT acceptable for the physician, physician assistant, or nurse practitioner signature.</i> |
| 29. Return Address | Enter your company name and the mailing address that you want the form returned to. You may hand write, type or stamp the information on the form. |

Sample of the New CMN/PA Form

*** DO NOT LEAVE ANY BLOCKS BLANK**
CERTIFICATE OF MEDICAL NECESSITY AND PRIOR APPROVAL FORM FOR DURABLE MEDICAL EQUIPMENT AND ORTHOTIC AND PROSTHETIC DEVICES
North Carolina Division of Medical Assistance - Medicaid Program

| | | | | |
|----------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------|------------------------------------------------------------|
| 1. Patient's Last Name Recipient Jane D. | | 2. Birth Date (MM/DD/YYYY) 10/03/1948 | 3. Sex F | 4. Medicare Number N/A |
| 5. Medicaid Number 999-77-9797T | | 6. Patient's Address 2 Any Street, Any Town, NC 12345 | | Telephone Number 919 246-5432 |
| 7. Provider Number/Attending Number 7705000 | 8. Provider Name Acme Supplies | Address 4 Any Street, Any Town, NC 12345 | | Telephone Number 919 975-1357 |
| 9. Prescribing Physician Name Dr. Joe Provider | | Address 6 Any Street, Any Town, NC 12345 | Telephone Number 919 369-3690 | 10. Provider Number 899999 |
| 11. ICD-9-CM 496.0 | Principal Diagnosis COPD | Date 10/09/04 | 12. ICD-9-CM 411.0 | Other Pertinent Diagnoses S/P Myocardial Infarct |
| 13. CPT-4 356.56 | Surgical Procedure Femoral-Popliteal Bypass | Date 2/10/98 | 443.9 | PVD |
| Date 05/90 | | | | |

MEDICAL AND FUNCTIONAL STATUS

14. **CONDITION** : Stable (Unstable) Height: **5'5"** Weight: **150 lbs.**
15. **PROGNOSIS**: (Terminal) (Poor) (Guarded) Fair (Good) (Excellent)
16. **PATIENT** : (Requires positioning not feasible in ordinary bed) (Unattended for long periods of time) (Lives alone **N/A**)
17. **EQUIPMENT** : Necessary to retard deterioration of condition (Necessary for function: specify _____) (Length of need _____ days/months/years)
18. **MENTAL** : Oriented (Forgetful) (Disoriented) (Agitated) (Comatose) (Depressed) (Lethargic) (Infant) (Other: specify _____)
19. **NEUROLOGICAL** :
Muscle Tone : Normal (Increased) (Decreased) (Fluctuating)
Sensation : Normal (Abnormal: specify _____)
20. **RESPIRATORY** :
(Normal) (SOB on Minimal Exertion) (Tracheostomy)
(O2: Flow Rate: **2LPM** Frequency: **24 hrs.** Test Date: **2/21/05** Results: **PO2 41 on room air**)
21. **SKIN** : Normal (Other: specify _____) (Decubiti: specify _____)
22. **AMBULATORY** :
(Complete bedrest -- or -- (Up as tolerated)
 Transfers bed-chair: (Independently) Wheelchair use: Confined Yes (No) (Walks: (Unassisted) (With assistive device: specify _____)
 With assistance Hours / day **12**
23. Can place of residence physically accommodate equipment being requested? Yes (No) (max distance walked: _____)
24. Patient's status will be monitored by physician while equipment is provided. Yes (No)
25. Provide objective information to substantiate medical necessity of equipment: **Other treatments for shortness of breath have been tried without success including P.T. and medication. Need wheelchair for mobility and function within the home. E.L.R.'s required for relief of LE edema. Head/neck support needed for generalized weakness**

| ITEM NO. | EXT | SERVICE REVIEW NO. (EDS USE ONLY) | FROM DATE | TO DATE | EDS Use Only | R | N | U | HCPCS CODE | EQUIPMENT DESCRIPTION |
|----------|-----|-----------------------------------|-----------|----------|--------------|---|---|---|------------|-------------------------------|
| 1 | | | 03/02/05 | 09/30/05 | | X | | | E1390 | O2 Concentrator |
| 2 | | | 03/02/05 | 09/30/05 | | | X | | K0001 | Standard w/c |
| 3 | | | 03/02/05 | 09/30/05 | | | X | | E0990 | Elev. legrest compl. assembly |
| 4 | | | 03/02/05 | 09/30/05 | | | X | | K0108 | W4131, head/neck support |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |
| 7 | | | | | | | | | | |
| 8 | | | | | | | | | | |
| 9 | | | | | | | | | | |
| 10 | | | | | | | | | | |
| 11 | | | | | | | | | | |
| 12 | | | | | | | | | | |

27. **A Provider** **3/2/05** 28. **A Doctor** **3/2/05**
Provider Signature/Board Certified Practitioner Date Physician, Physician Assistant, Nurse Practitioner Signature Date

29. Return Address
**Acme Supplies
4 Any Street
Any Town, NC 12345**

Return to: EDS/PA
P.O. Box 31188
Raleigh, NC 27622

30. Approval constitutes medical approval for services only. Eligibility for care in the month in which services are provided should be verified from patient's Medicaid card.

Attachment C: Oral Nutrition Product Request Form

As of July 1, 2008, use this form for medically necessary oral nutrition products. Refer to **Subsection 5.3.22, Medically Necessary Oral Nutrition**, for requirements. Copies of this form are available on DMA's Web site (<http://www.ncdhhs.gov/dma/provider/forms.htm>).

| Oral Nutrition Product Request Form | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|-----------------------|-----------------------------------------------------------|
| <p>Prescriber: For medically necessary oral nutrition products, submit this form to the DME provider with a Certificate of Medical Necessity/Prior Approval (CMN/PA) and any supporting documentation (for example, a growth chart or a nutrition assessment).</p> <p>See Section 5.3.22 of Clinical Coverage Policy 5A, <i>Durable Medical Equipment</i>, for more details.</p> | | | |
| Recipient Information | | | |
| Recipient name | | | Date of birth |
| Medicaid ID # | | | |
| Is the recipient eligible for WIC? | Y | N | If yes, list the oral nutrition products supplied by WIC: |
| | | | |
| | | | |
| Product Information | | | |
| Oral nutrition product requested | | | |
| | | | |
| | | | |
| Amount of product needed per month | | | |
| | | | |
| | | | |
| Expected duration of oral nutrition product | | | |
| | | | |
| | | | |
| Medical Diagnosis(es) (list all that are relevant to this request) | | | |
| | | | |
| | | | |
| Supporting Data | | | |
| Current height/length | | Percentile (children) | BMI |
| Current weight | | Percentile (children) | |
| Does the recipient have a history of growth failure or weight loss? | Y | N | (If Yes, provide copy of growth chart or weight history.) |
| Are there laboratory data indicating nutrition depletion? If Yes, please list. | | | |
| Have other nutrition interventions been attempted? If Yes, please list. | | | |
| Provider Contact Information | | | |
| Name | | Telephone | |
| Parent/Guardian or Recipient Contact Information | | | |
| Name | | Telephone | |
| DMA-3125 8/2008, Rev. 1/2009 | | | |

Attachment D: Completing a Claim for DME or EN Services

Refer to the following information for completing a CMS-1500 claim form for DME services.

| Block #/Description | Instruction |
|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. | Place an X in the MEDICAID block. |
| 1a. Insured's ID Number | Enter the recipient's Medicaid ID number (nine digits and the alpha suffix) from the recipient's Medicaid ID card. |
| 2. Recipient's Name | Enter the recipient's last name, first name and middle initial from the Medicaid ID card. |
| 3. Recipient's Birth Date/Sex | Enter eight numbers to show the recipient's date of birth - MMDDYYYY. The birth date is on the Medicaid ID card. <i>EXAMPLE: November 14, 1949 is 11141949.</i> Place an X in the appropriate block to show the recipient's sex. |
| 4. Insured's Name. | Leave blank |
| 5. Recipient's Address | Enter the recipient's street address, including the city, state and zip code. The information is on the Medicaid ID card. Entering the telephone number is optional. |
| 6.—8. | Leave blank. |
| 9. Other Insurer's Name | Enter applicable private insurer's name or the appropriate Medicare override statement if you know that Medicare will not cover the billed item, using the EXACT wording shown below: <i>This is a Medicare non-covered service. Service does not meet Medicare criteria. Medicare benefits are exhausted.</i> REMEMBER: You must have documentation to support the use of any of these statements. |
| 9a.—9d. | Enter applicable insurance information. |
| 10. Is Recipient's Condition...? | Place an X in the appropriate block for each question. |
| 11.—14. | Optional. |
| 15.—16. | Leave blank. |
| 17., 17a., and 18. | Optional. |
| 19. Reserved for Local Use | If the claim is for a Carolina ACCESS participant, enter the primary care provider's referring number—otherwise leave blank. |
| 20. Outside Lab... | Leave blank. |
| 21. Diagnosis or Nature of Illness | Enter the ICD-9-CM code(s) to describe the primary diagnosis related to the service. You may also enter related secondary diagnoses. Entering written descriptions is optional. |
| 22. Medicaid Resubmission Code | Leave blank. |
| 23. Prior Authorization Number | When billing a national miscellaneous code, enter the 11-digit Service Request Number (SRN) from block 26 (Prior Approval No.) on the CMN/PA form. For all other codes, leave this block blank. |

Note: Blocks 24A through 24K are where you provide the details about what you are billing. There are several lines for listing services. Each line is called a “detail.” When completing these blocks:

- Use one line for each HCPCS code that you bill on a given date.
- If you provide more than one unit of the same item on one day, include all the items on the same line. For example, if you provide 100 blood glucose strips (A4253) on August 2, include all of the strips on one line. Enter 2 units in 24G for that date of service.
- Include only dates of service in the SAME calendar month.
- Include only dates of service for which the recipient is eligible for Medicaid.

| Block #/Description | Instruction |
|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>24a. Date(s) of Service, From/To</p> | <p>Your entry depends upon the services:</p> <p>Customized Equipment: You may enter either the date of the physician’s prescription or the date of delivery to the recipient’s home as the date of service. Place the date in the FROM block. Enter the same date in the TO block.</p> <p>Other Purchased Equipment - DME and EN: Enter the date the item is delivered to the recipient in the FROM block. Enter the same date in the TO block.</p> <p>Rental Equipment - DME and EN: For the month being billed, enter the first day in that month that the item is at the recipient’s residence in the FROM block. Enter the last day in that month that the item is at the recipient’s residence in the TO block. Do NOT span calendar months.</p> <p><i>EXAMPLE: An enteral pump is provided from 3/25/02 through 5/15/02. Submit three claims. On March’s claim, enter 032502 in the FROM block and 033102 in the TO block. On April’s claim, enter 040102 in the FROM block and 043002 in the TO block. On May’s claim, enter 050102 in the FROM block and 051502 in the TO block.</i></p> <p>Service and Repairs: Enter the date that the item is serviced or repaired in the recipient’s home as the date of service. If the item is removed from the recipient’s home for service or repairs, enter the date that it is returned. Place the date in the FROM block. Enter the same date in the TO block.</p> <p>DME-Related Supplies: Enter the date that the item is delivered to the recipient’s residence in the FROM block. Enter the same date in the TO block.</p> <p>EN Supply Kits: Enter the date in the month that the therapy begins in the FROM block. If the therapy is continued from the prior month, enter the first of the month in the FROM block. Enter the last day of therapy for the month in the TO block. If the therapy extends into the next month, enter the last day of the current month in the TO block. Do NOT span calendar months. See the <i>EXAMPLE</i> under Rental Equipment for guidance.</p> <p>EN Individual Supply Items: Enter the date that the item is delivered to the recipient in the FROM block. Enter the same date in the TO block.</p> <p>EN Formulae: Enter the service dates for the formula in the FROM and TO blocks..</p> |
| <p>24b. Place of Service</p> | <p>Enter 12 to show the items are provided at the recipient’ residence.</p> |
| <p>24c. Type of Services</p> | <p>Leave blank.</p> |

| Block #/Description | Instruction |
|---------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 24d. Procedures, Services... | Enter the appropriate HCPCS code and modifier: NU for new purchase UE for used purchase RR for rental |
| 24e. Diagnosis Code | Leave blank. |
| 24f. Charges | Enter the total charge for the items on the line. For rental items, enter the full month's rental charge—do not prorate the charge if the item is provided less than a full month. |
| 24g. Days or Units | Enter the number of units as follows: Purchased Equipment (DME and EN): Enter the number of units provided on the date of service. Rental Equipment (DME and EN)—Other than Oxygen: Enter 1 . Oxygen and Oxygen Equipment: Enter the units provided on the date of service. Service and Repair: Enter 1 unit for each 15-minute increment being billed.. DME-Related Supplies: Enter the number of units provided on the date of service. EN Supply Kits: Enter the number of consecutive days shown in 24A. EN Individual Supply Items: Enter the number of units provided on the dates of service. EN Formulae: Enter the number of units provided for the dates of service. |
| 24h.—24i. | Leave blank. |
| 24j.—24k. | Optional. |
| 25. Federal Tax ID Number | Optional |
| 26. Recipient's Account No. | Optional. You may enter your agency's record or account number for the recipient. The entry may be any combination of numbers and letters up to a total of nine characters. If you enter a number, it will appear on your RA. This will assist in reconciling your accounts. |
| 27. Accept Assignment | Leave blank. |
| 28. Total Charge | Enter the sum of the charges listed in Item 24F . |
| 29. Amount Paid | Enter the total amount received from third party payment sources. |
| 30. Balance Due | Subtract the amount in Item 29 from the amount in Item 28 and enter the result here. |
| 31. Signature of Physician or Supplier... | Leave blank if there is a signature on file with Medicaid. Otherwise, an authorized representative of your agency must sign and date the claim in this block. A written signature stamp is acceptable. |
| 32. Name and Address of Facility... | Optional. |
| 33. Physician's/ Supplier's Billing Name... | Enter your agency's name, address, including ZIP code, and phone number. The name and address must be EXACTLY as shown on your Medicaid DME participation agreement. |
| PIN# | Leave blank. |
| GRP# | Enter your seven-digit Medicaid DME provider number. |

Remember: When submitting a claim for other manually priced items (e.g., for external insulin pumps), an invoice must also be attached to the claim.

PLEASE
DO NOT
STAPLE
IN THIS
AREA



Example of Claim Form for DME

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK (LUNG) OTHER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Recipient Joe A.

3. PATIENT'S BIRTH DATE
12 | 18 | 43 M F

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

5. PATIENT'S ADDRESS (No., Street)
123 Any Street

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

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

8. PATIENT STATUS
Single Married Other

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

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE | 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 | authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

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

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

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)

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
04257738906

| 24 | A | B | C | D | E | F | G | H | I | J | K | |
|--------------------|--------------|----|------------------|-----------------|---------------------------------------------------------------------------------------|----------------|------------|---------------|--------------------|-----|-----|------------------------|
| DATE(S) OF SERVICE | From | To | Place of Service | Type of Service | PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/HCP/CS MODIFIER | DIAGNOSIS CODE | \$ CHARGES | DAYS OR UNITS | EP/SDI Family Plan | EMG | COB | RESERVED FOR LOCAL USE |
| 03 28 04 | 03 31 04 | 12 | | | E1390 RR | | 265.51 | 1 | | | | |
| 03 28 04 | 03 31 04 | 12 | | | E0431 RR | | 37.76 | 1 | | | | |
| 03 28 04 | 03 28 04 | 12 | | | K0001 UE | | 415.23 | 1 | | | | |
| 03 28 04 | 03 28 04 | 12 | | | E0607 NU | | 58.71 | 1 | | | | |
| 03 28 04 | 03 28 04 | 12 | | | K0108 NU | | 100.07 | 1 | | | | |
| 04 12 04 | 04 12 04 | 12 | | | E1340 NU | | 33.75 | 3 | | | | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. IAF0009

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO

28. TOTAL CHARGE \$ 911.03

29. AMOUNT PAID \$

30. BALANCE DUE \$ 911.03

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.)
A Provider 4/5/04

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
Acme Medical Supply
123 Any Street
Anytown, NC 28045 7700000

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

Example of Claim Form for EN

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/> | | 18. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 123-45-6789F | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Jane A | | 3. PATIENT'S BIRTH DATE MM DD YY 06 20 44 | |
| 5. PATIENT'S ADDRESS (No., Street) 456 Any Street CITY: Anywhere STATE: NC | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | |
| 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | | 7. INSURED'S ADDRESS (No., Street) | |
| 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> | | CITY | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | STATE | |
| 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | |
| 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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | |
| 19. RESERVED FOR LOCAL USE | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. L 212.1 2. _____ 3. _____ 4. _____ | | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES | |
| 25. FEDERAL TAX I.D. NUMBER | | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. | |
| 26. PATIENT'S ACCOUNT NO. 99AZ0098 | | 23. PRIOR AUTHORIZATION NUMBER | |
| 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24. TABLE OF SERVICES | |
| 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.) A. Provider 10/10/02 SIGNED: _____ DATE: _____ | | 28. TOTAL CHARGE \$ 520.39 29. AMOUNT PAID \$ 00.00 30. BALANCE DUE \$ 520.39 | |
| 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 # A Medical Supply Company 9 South Street Anywhere, NC 27345 919-999-9999 7700000 | |

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION